

TABLE 6.4 Empirically Supported Resources Designed to Maintain Treatment Gains

The Society of Clinical Psychology describes a number of empirically supported resources that apply a cognitive approach to depression. Maintenance of treatment gains is enhanced by booster sessions during the first year after termination. Several variants of cognitive therapy have been developed as more structured relapse prevention programs:

- *Cognitive Therapy–Continuation* (Jarrett & Kraft, 1997) provides 8 to 10 monthly sessions. Patients learn to use emotional distress and depressive symptoms to practice the coping and other skills learned in the acute phase of therapy and to enhance generalization of these skills.
- *Well-Being Therapy* (Fava & Riuni, 2003) provides 8 to 12 sessions designed to facilitate well-being after recovery from depression and reduce the risk of relapse. This therapy is not symptom-focused but rather focuses on building the components of mental health in Ryff's (1989) model: autonomy, personal growth, environmental mastery, purpose, positive relations, self-acceptance. Cognitive restructuring, activity scheduling, assertiveness training, and problem-solving skills are used.
- *Mindfulness-Based Cognitive Therapy* (MBCT; Segal, Williams, & Teasdale, 2001) is an 8-session relapse prevention program that combines mindfulness meditation with cognitive therapy techniques. Patients learn to recognize the negative thought processes associated with depression and to change their relationship with these thoughts. By unhooking from these thoughts and recognizing their transient nature, patients can learn to prevent the downward spiral from negative mood to rumination to depression. MBCT is especially helpful to reduce the risk of relapse in those with chronic depression.