



Comparative Effectiveness Research Series

Mindfulness-Based Cognitive Therapy

An Informational Resource

2012

This document about Mindfulness-Based Cognitive Therapy (MBCT) is part of a series on evidence-based practices evaluated in comparative effectiveness research studies. The document is designed to inform practitioners and other decisionmakers who are considering the adoption of evidence-based practices in their organization. General information about MBCT and results of studies assessing MBCT efficacy are included, along with details related to cost and examples of MBCT interventions for implementation in primary care and behavioral health settings. The decision to adopt and implement evidence-based practices is guided by many factors that may not be covered here. The authors of this document hope it can assist in making an informed decision on the implementation of this treatment model.

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Mindfulness-Based Cognitive Therapy

Mindfulness-Based Cognitive Therapy (MBCT) is a treatment designed to help individuals suffering from recurring depression to prevent major depression relapse. It combines the ideas of cognitive therapy with meditative practices and attitudes about the cultivation of mindfulness. The ultimate aim of MBCT is to prevent depression relapse by changing the way individuals identify and respond to symptomatic thoughts, feelings, and bodily sensations.¹

Drs. Zindel Segal, John Teasdale, and Mark Williams developed MBCT in 1995 and conducted clinical trials on the program's effectiveness through several grants from agencies in the United States and the United Kingdom. MBCT is based in part on components of the Mindfulness-Based Stress Reduction (MBSR) intervention developed by Dr. Jon Kabat-Zinn. A core principle of both MBSR and MBCT is "mindfulness," a mental state in which one attends to and purposefully manages awareness of what is happening in the moment. MBCT sessions and mindfulness exercises help participants determine how to effectively respond to sad feelings to prevent them from leading to recurrent depression.

MBCT combines elements of MBSR and cognitive therapy to prevent depression relapse. The eight-session program helps participants become aware of different mental modes and emotions and appropriately respond to lessen the physiological and psychological impact of sad feelings, ultimately preventing further depression.

The Practice of MBCT

MBCT is an 8-week course of instruction and exercises to help participants who have suffered from depression in the past to—

- ▶ Learn skills to help prevent depression from coming back.
- ▶ Become more aware of bodily sensations, feelings, and thoughts, from moment to moment.
- ▶ Develop a different way of relating to sensations, thoughts, and feelings; specifically, mindful acceptance and acknowledgment of unwanted feelings and thoughts, rather than habitual, automatic, preprogrammed responses.
- ▶ Choose the most skillful response to any unpleasant thoughts, feelings, or situations they experience.

MBCT teaches participants the ability to recognize indicators of potential depression relapse and respond by shifting away from the indicators to prevent symptoms from worsening. The risk of not being mindful to these initial symptoms is that they can multiply and deepen, and eventually lead to depressive relapse. The MBCT therapist helps clients process depression-related information in ways that are less likely to provoke relapse by teaching the client to separate from the "doing mode" and enter the "being mode." The differences between these two modes appear in Table 1.

Table 1. Contrasting “Doing Mode” and “Being Mode”

Doing Mode	Being Mode
Goal oriented	Focus on disconnection of thought and feeling from goal-related action
Driven to reduce the gap between how things are and how we would like them to be	Focus is on “accepting” and “allowing” what is, without any immediate pressure to change it
Attention is devoted to the narrow focus on discrepancies between desired and actual states	Direct, immediate, intimate experience of the present

Adapted from Segal, Williams, & Teasdale¹

The aim of early sessions is to teach participants to recognize “doing mode” in its many manifestations and begin the cultivation of “being mode” by intensive, formal mindfulness practice. The mindfulness exercises and homework are designed to help participants recognize when being mode is no longer present, to disengage from the doing mode, and to return to mindful being mode. The MBCT treatment manual outlines the course of treatment as follows:

- ▶ Providing intensive training in mindfulness meditation
- ▶ Increasing a patient’s awareness of present, moment-to-moment experience
- ▶ Recognizing when, in everyday life, negative emotions and reactions trigger doing mode, and learning how to disengage from that mode and enter being mode
- ▶ Providing patients with additional coping strategies and a range of options to respond effectively to negative emotions
- ▶ Integrating all these skills through continued mindfulness practice to stay well and prevent future relapse

Core Components and Understanding the MBCT Approach

The MBCT program consists of an initial one-on-one orientation session, eight 2-hour core sessions delivered weekly in a group format, and up to four 2-hour reinforcement sessions in a group format 4–12 months after completion of the eight core sessions.

The initial assessment interview (approximately 1 hour) reviews material sent to participants in advance, which explain aspects of depression and the MBCT program. The goals of the initial interview are to learn about individual factors associated with the onset of depression, explain the background and benefits of MBCT, and emphasize the work required to participate in the MBCT program to determine whether the participant is likely to benefit from the approach.

The eight core sessions are delivered weekly to a group, with homework assignments between sessions. The main work of the program is done at home between classes, using CDs with guided meditations that support participants’ developing practice outside of class. During each session,

participants engage in a mixture of activities including the formal practice of mindfulness meditation and discussion of relevant issues and assigned homework. Learning to pay attention is the focus of sessions 1–4. The goals of the initial sessions follow:

- ▶ **Session 1: Automatic Pilot.** This is an introduction to the practice of mindfulness and recognition of the tendency to be on automatic pilot.
- ▶ **Session 2: Dealing with Barriers.** Further focus on the body begins to show more clearly the chatter of the mind, and how it tends to control our reactions to everyday events.
- ▶ **Session 3: Mindfulness of the Breath.** With a greater awareness of how the mind can be busy and scattered, participants learn to intentionally focus on the breath.
- ▶ **Session 4: Staying Present.** Participants learn mindfulness to stay present to widen their perspective on how they relate to experiences.

Sessions 5–8 focus on teaching participants to handle mood shifts by employing cognitive approaches as well as mindfulness. The goals of each session follow:

- ▶ **Session 5: Allowing/Letting Be.** Participants practice “allowing” experience or emotion to “just be” without judgment or trying to make it different. This approach allows one to see things more clearly and to decide what, if anything, needs to change.
- ▶ **Session 6: Thoughts Are Not Facts.** Participants learn to recognize thoughts as merely thoughts, not reality. Negative thoughts can restrict our ability to relate differently to experience.
- ▶ **Session 7: How Can I Best Take Care of Myself?** Patients learn specific, individual strategies that can be done when depression threatens. Each participant will learn his or her unique warning signs of relapse and help others make plans for how best to respond to those signs.
- ▶ **Session 8: Using What Has Been Learned To Deal With Future Moods.** Patients learn that maintaining a balance in life is helped by regular mindfulness practice.

Reinforcement sessions are designed to review mindfulness and cognitive techniques learned during the core sessions, identify any obstacles to practicing MBCT, and develop strategies for continued skill reinforcement. The program developers recommend that up to four 2-hour group reinforcement sessions be delivered 4–12 months after participation in the eight core sessions.

What the Evidence Tells Us About MBCT's Effectiveness

Comparative Effectiveness Research and Systematic Reviews

MBCT can be implemented in both hospital and community-based settings and is compatible with concurrent medication use and/or psychotherapy.

MBCT is recognized as an evidence-based practice (EBP) because it has been scientifically evaluated, demonstrated to be effective, and recognized by Federal registries and other organizations as an EBP. The effectiveness of MBCT has been evaluated in dozens of studies, including comparative effectiveness research (CER), where it has been compared to alternative treatments for depression such as usual clinical care and the use of antidepressant medication. CER studies compare the benefits and harms of different interventions and strategies to prevent, diagnose, treat, and monitor community health and the nation's health care system. The Agency for Healthcare Research and Quality defines CER as a way to develop, expand, and use a variety of data sources and methods to conduct research and disseminate results in a form that is quickly usable by clinicians, clients, policymakers, and health plans and other payers.²

MBCT has been evaluated in several randomized controlled clinical trials, meta-analyses, and systematic reviews. MBCT studies and reviews show reductions in depressive symptoms and anxiety and improvements in indicators of quality of life,^{3,4} particularly with individuals diagnosed with major recurrent depressive disorder.⁵ A study conducted by Kuyken et al.⁴ found that patients participating in MBCT compared to maintenance antidepressant medication showed better outcomes in reducing depressive symptoms and psychiatric comorbidity and improving quality of life.

Systematic reviews indicate that MBCT—

- ▶ Can be compatible with other treatments for depression; studies suggest that when MBCT is combined with usual care, treatment outcomes are superior than usual care alone³
- ▶ Is effective in reducing anxiety symptoms in individuals diagnosed with other psychiatric disorder (e.g., bipolar disorder, general anxiety disorder)³
- ▶ May be as effective as maintenance antidepressant medication for individuals at risk of relapse in recurrent major depressive disorder and particularly effective for clients with three or more previous major depressive disorder episodes⁵

MBCT has been recognized by the National Institute for Health and Clinical Excellence in the United Kingdom as an effective treatment for the prevention of relapse for those who have been clinically depressed three or more times. It has also been rated as well supported by research evidence by the California Evidence-Based Clearinghouse for Child Welfare. In March 2012, MBCT was reviewed for inclusion in the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices.⁶

MBCT Adaptations for Implementation in Real-World Settings

To meet the specific needs of health care settings and the clients they serve, MBCT adaptations have been evaluated in specific populations, including adults with a history of medical treatment for major depression, anxiety, and suicidal behavior, and children with attention and behavior problems. Most recently, MBCT has been evaluated in the treatment of adults with other medical conditions including hypochondriasis,⁷ cardiac rehabilitation, Parkinson's disease, and cancer patients.

In addition to academic teaching hospitals where it originally was offered, MBCT is provided in community-based settings, mental health clinics, primary care centers, and general hospitals. The materials for MBCT have been translated into French, Italian, and Spanish.

Examples of Interventions Using MBCT

MBCT for Cancer

Foley and colleagues examined MBCT on outcomes of distress and quality of life among cancer patients. The intervention was modified for this population by including didactic information on cancer symptoms, making modifications for the length of the session depending on the fatigue of the individual, and including caregivers where needed. Compared to a wait-list control group, the individuals receiving MBCT showed reductions in depression, anxiety, and distress.⁸

MBCT for Cardiac Rehabilitation Patients

Considering the impact of symptoms such as stress and anxiety that are present in cardiac rehabilitation patients, a group of researchers examined the effectiveness of MBCT for this population. They adapted the MBCT handouts to tailor information around emotions typically experienced by cardiac patients. They also included seated stretching and breathing exercises in lieu of yoga and modified the meditative positions. Following the intervention, participants reported increased awareness that led to reported reductions in stress and worry regarding their cardiac condition.⁹

MBCT for Bipolar Disorder

MBCT was adapted to focus on anxiety and depressive symptoms for patients currently in remission from bipolar disorder and was found to improve immediate outcomes of those symptoms. It may also be effective in alleviating suicidal ideation and behavior.¹⁰

MBCT for Patients With Parkinson's Disease

The complications of Parkinson's disease can have considerable physical and psychological effects. For example, depression is diagnosed in 40 percent of Parkinson's patients.¹¹ Research on the impact of antidepressant medications for Parkinson's patients is unclear, and MBCT may provide a viable alternative for addressing depressive symptoms. A qualitative analysis of 12 Parkinson's patients receiving MBCT found the intervention may be beneficial, based on the participation of patients in both the core course sessions and followup sessions.¹²

MBCT for Patients With Insomnia

MBCT has also been examined for patients previously diagnosed with anxiety or depression who are currently experiencing insomnia. Results suggest MBCT may be effective in reducing insomnia symptoms by using mindfulness techniques to address associated anxiety.¹³

Organizational Readiness To Adopt MBCT

There are several factors to consider when an organization is deciding whether to adopt a new practice. The Institute of Behavioral Research at Texas Christian University has identified five broad categories of organizational readiness for change based on extensive research findings related to technology transfer and the adoption of EBPs (<http://www.ibr.tcu.edu/evidence/evi-orc.html>):

- ▶ Motivational readiness: program needs, training needs, and pressures for change
- ▶ Institutional resources: offices, staffing, training, and equipment
- ▶ Staff attributes: growth, efficacy, influence, adaptability, and orientation
- ▶ Organizational climate: clarity of mission and goals, cohesion, autonomy, openness to communication, stress, and openness to change
- ▶ Costs: cost of materials, training, supervision, and loss of billable hours associated with training and supervision; reimbursement practices

Organizations and individuals interested in implementing the MBCT program should consider several aspects of the intervention in addition to the organizational readiness indicators described above.

Clinicians are required to establish their own mindfulness practice to have firsthand ongoing experience of this essential element of the program. The developers recommend that, at a minimum, prospective instructors use mindfulness in their own daily lives before they embark on teaching it to clients. Clinicians must also have at least 1 year of experience working with mood disorder patients.

The program is designed for adults with recurring depression who are currently recovered. Core session participants should not be currently exhibiting major depressive symptoms, but they can be on a course of prescription medication to treat depression. The initial one-on-one orientation session will determine if prospective participants are appropriate for the program.

The group format of the core sessions is essential to the didactic and experiential nature of the program, as opposed to a more therapeutic one. Sessions with fewer than the recommended number of members (9–15) may tend more toward therapeutic sessions of individual challenges as opposed to learning the approach and techniques for daily mindfulness practice.

Each MBCT session requires planning; for example, having relevant handouts to distribute; tapes and reading material available; and the room set up appropriately, with key themes on a blackboard and chairs positioned.

Dissemination and Implementation Resources

Dissemination Resources

The main vehicles for MBCT dissemination are the practice Web sites:

- ▶ United States MBCT Web site www.mbct.com
- ▶ United Kingdom MBCT Web site <http://mbct.co.uk/>

Implementation Materials

The primary resource for details on implementing MBCT is *Mindfulness-Based Cognitive Therapy for Depression* (2nd ed.).¹⁴ This treatment manual presents detailed, step-by-step guidance for practitioners to conduct mindfulness practices and cognitive behavioral interventions to prevent depression relapse. It includes information on additional treatment components, summaries of multiple studies assessing the effectiveness of MBCT and MBCT adaptations, and access to companion Web sites to help practitioners and their clients to practice guided meditation exercises.

Training Resources for Providers

Training is required and provided by the developer, and individual supervision is available to help implementers build proficiency in intervention delivery. A 5-day intensive training for clinicians is led by the developers of MBCT with senior therapists and mindfulness teachers. The training emphasizes the importance of the clinician's own meditation practice and self-inquiry. Through role-play, simulated classroom, and patient-practitioner encounters, the training explores the actual application of mindfulness practices in working with clients. The curriculum integrates didactic, experiential, and small group learning and includes daily meditations, yoga and mindful movement, and periods of silence.

Training is open to health care professionals who already have a mindfulness meditation practice and a clinical background. It is recommended that training participants have—

- ▶ An advanced degree in a mental health-related field (e.g., psychology, social work, counseling)
- ▶ Prior training in mindfulness-based meditation techniques (e.g., Vipassana or Insight Meditation) and a personal commitment to an established daily meditation practice
- ▶ Familiarity with cognitive behavioral therapy techniques
- ▶ Experience with and an understanding of models of depression
- ▶ Experience facilitating group process

At the conclusion of the 5-day intensive training, participants should be able to teach the curriculum for each of the eight group sessions, understand the role of mindfulness in preventing depressive relapse, articulate the importance of ongoing mindfulness within a psychotherapy framework, develop one's own mindfulness meditation practice in daily life, and demonstrate the clinical skills necessary to facilitate MBCT groups.

Several online resources, including audio files for practicing mindfulness meditation techniques and helpful articles, are available to support training and intervention delivery. Training resources in the United States and abroad include the following:

- ▶ Mindfulness-Based Cognitive Therapy: A 5-Day Professional Training for the Prevention of Depressive Relapse, offered through the Center for Mindfulness at the University of California, San Diego (http://cme.ucsd.edu/mindfulness/mbct_021912_home.html)
- ▶ The Centre for Mindfulness Studies in Toronto (for upcoming MBCT training dates see <http://www.mindfulnessstudies.com/professional-development/mbct-professional-teacher-training-intensive/>)
- ▶ The Oxford Cognitive Therapy Centre (for upcoming MBCT training dates see <http://www.octc.co.uk/index.asp?ID=5&PageID=11>)
- ▶ MBCT audiotapes for clinicians to practice mindfulness themselves can be purchased from Stress Reduction Tapes, P.O. Box 547, Lexington, MA 02420, or www.stressreductiontapes.com

Quality Assurance Tools

The MBCT treatment manual includes structured session content to facilitate success in maintaining intervention fidelity. The MBCT Adherence Rating Scale is intended for rating audio or videotapes of MBCT treatment for fidelity to the treatment protocol as outlined in the manual.

Adherence ratings for MBCT treatment are intended to assess the extent to which the therapist conveys the core themes of MBCT treatment to patients through specific interventions and through his or her manner during the session.

Cost

Table 2 outlines the costs of dissemination components and other information from the MBCT developer.

Table 2. Costs of Dissemination Components

Item	Cost
<i>Mindfulness-Based Cognitive Therapy for Depression</i> (2nd ed.) ¹⁴	\$46.75
<i>The Mindful Way Through Depression: Freeing Yourself From Chronic Unhappiness</i> ¹⁵	\$35, includes book and audio CD
Mindfulness meditation audio files for personal practice	Free
Five-day offsite training	\$1,000 to \$1,250 per participant*
Individual implementation supervision	\$100–\$150 per hour, depending on the consultant
Adherence Rating Scale	Free
Adherence Scale Rating Form	Free

*In the United States and Canada

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- ⁶ Substance Abuse and Mental Health Services Administration. (2012). Mindfulness-based cognitive behavioral therapy. Accessed at the National Registry of Evidence-based Programs and Practices Web site <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=239>
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Glossary

Adaptation: A modest to significant modification of an intervention to meet the needs of different people, situations, or settings.

Being mode: The opposite of the “doing mode” and not driven by the need to achieve particular goals. Instead, the focus is on accepting and allowing what is, without any immediate pressure to change it. The being mode is characterized by direct, immediate, intimate experience of the present, with a focus on disconnection of thought and feeling from goal-related action.

CER (comparative effectiveness research): The Federal Coordinating Council on Comparative Effectiveness Research defines CER in part as the conduct and synthesis of research comparing the benefits and harms of different interventions and strategies (e.g., medications, procedures, medical and assistive devices and technologies, diagnostic testing, behavioral change, delivery system strategies) to prevent, diagnose, treat, and monitor health conditions in real-world settings.

Cognitive therapy: Seeks to help patients overcome difficulties by identifying and changing dysfunctional thinking, behavior, and emotional responses. The treatment helps patients develop skills for modifying beliefs, identifying distorted thinking, relating to others in different ways, and changing behaviors. Therapy may consist of testing one’s assumptions and identifying which of those assumptions may be distorted or unhelpful.

Comparison group: A group of individuals that serves as the basis for comparison when assessing the effects of an intervention on a treatment group. A comparison group typically receives some treatment other than what they would normally receive and is therefore distinguished from a control group, which often receives no treatment or “usual” treatment. To make the comparison valid, the composition and characteristics of the comparison group should resemble the treatment group as closely as possible. Some studies use a control group in addition to a comparison group.

Core components: These refer to the most essential and indispensable components of an intervention (core intervention components) or the most essential and indispensable components of an implementation program (core implementation components).

Dissemination: The targeted distribution of program information and materials to a specific audience. The intent is to spread knowledge about the program and encourage its use.

Doing mode: This mode is triggered when the mind registers discrepancies between an idea of how things are and an idea of how things should be. The mode is goal oriented, driven to reduce the gap between how things are and how we would like them to be; attention is devoted to the narrow focus on discrepancies between desired and actual states.

Evidence-based practices: Programs or practices that effectively integrate the best research evidence with clinical expertise, cultural competence, and the values of the persons receiving the services.

Implementation: The use of a prevention or treatment intervention in a specific community-based or clinical practice setting with a particular target audience.

Intervention: A strategy or approach intended to prevent an undesirable outcome (preventive intervention), promote a desirable outcome (promotion intervention), or alter the course of an existing condition (treatment intervention).

Mindfulness: Paying attention in a particular way, on purpose, in the present moment and nonjudgmentally; awareness of patterns of thought, feelings, and bodily sensations.

Mindfulness-Based Stress Reduction (MBSR): A form of psychoeducational training for adolescents and adults with emotional or psychological distress resulting from medical conditions, physical pain, or life events. The intervention is designed to reduce stress and anxiety symptoms, negative mood-related feelings, and depression symptoms; increase self-esteem; and improve general mental health and functioning. The program is based on the core principle of “mindfulness,” a mental state where one attends to and purposefully manages one's awareness of what is happening in the moment. MBSR helps participants to develop a mindful cognitive state and incorporate it into everyday life as a coping resource to deal with intense physical, emotional, and situational stressors.

Additional Resources

Healing From Within is a documentary describing the MBSR Program at the University of Massachusetts Medical Center; it can be used with MBCT participants in Sessions 4 and 5. www.ambrosevideo.com

Full Catastrophe Living describes MBSR and provides an introduction to its clinical applications. Kabat-Zinn, J., & University of Massachusetts Medical Center, Worcester. (1990). *Full Catastrophe Living: Using the Wisdom of Your Body and Mind To Face Stress, Pain, and Illness*. New York: Random House.

Wherever You Go, There You Are provides tools for incorporating mindfulness into everyday practice. Kabat-Zinn, J. (1994). *Wherever You Go, There You Are: Mindfulness Meditation in Everyday Life*. New York: Hyperion.

Seeking the Heart of Wisdom describes the practice of mindfulness. Goldstein, J., & Kornfield, J. (1987). *Seeking the Heart of Wisdom: The Path of Insight Meditation*. Boston: Shambhala.

Introduction to Insight Meditation, developed by Sharon Salzberg and Joseph Goldstein, is a 12-month course that includes 12 audiocassettes, a workbook, and personal guidance via email and other means. www.soundstrue.com

Insight Meditation Society provides information about personal instructors in mindfulness and meditation. www.dharma.org

Mindfulness Research Guide is a comprehensive electronic resource and publication database that provides information to researchers, practitioners, and the public on the scientific study of mindfulness and the latest advances in mindfulness research and practice. <http://www.mindfulexperience.org/>

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