Psychology in Spain, 2009, Vol. 13. No 1, 9-16

THE EFFECTS OF MINDFULNESS-BASED COGNITIVE THERAPY: A QUALITATIVE APPROACH

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Mindfulness-Based Cognitive Therapy (MBCT) is an 8-week group treatment program originally developed for the prevention of relapses in depression (Segal, Teasdale & Williams, 2003). In this article we present the qualitative aspects of an MBCT efficacy study in public Mental Health Units of Tenerife island (Canary Island, Spain) with anxious and depressive symptoms. Thirty-two participants in an MBCT efficacy study answered an open questionnaire at the end of the treatment and three months later. The text of their responses was analyzed using the content analysis technique. The results show that MBCT has a good level of acceptance, and that most of the patients noticed changes in their way of thinking, feeling and in their relations with others.
Keywords: *Mindfulness-Based Cognitive Therapy, Content Analysis*

La Terapia Cognitiva basada en la Atención Plena (Segal, Williams y Teasdale, 2002) es un tratamiento de ocho semanas de duración desarrollado inicialmente para la prevención de recaídas en depresión. En este artículo se presentan los aspectos cualitativos de la aplicación de un programa en TCAP en Unidades de Salud Mental en la isla de Tenerife (Islas Canarias, España) con sintomatología ansiosa y depresiva. Un total de 32 participantes que habían participado en un estudio de eficacia de la TCAP respondieron a un cuestionario de preguntas abiertas al terminar el tratamiento y a los tres meses finalizado éste. Estos textos se analizaron mediante la técnica del análisis de contenido. Muestran que la TCAP tiene buenos niveles de aceptación, y que la mayoría de participantes nota cambios en su forma de pensar, de sentir, y en su relación con los demás.
Palabras clave: *Terapia Cognitiva Basada en la Atención Plena, Análisis de Contenido.*

Mindfulness-Based Cognitive Therapy (MBCT) is the result of integrating Cognitive Therapy with Kabat-Zinn's (1985) Mindfulness-Based Stress Reduction (MBSR) program. The treatment involves a total of 8 weekly two-hour sessions. In the sessions, participants are taught to meditate in groups and given homework tasks (self-recording of thoughts, feelings and emotions, meditation practice with a CD guide, etc.). The creators of MBCT, J. Teasdale, Z. Segal and M. Williams set out to find a group-based alternative within cognitive therapy based on the conclusions they had reached in their theoretical model, the ICS for the prevention of relapses in depression. According to this model, psychological intervention should train the capacity to redirect attention toward cognitive modes that break with the mechanism of depression which can trigger a relapse into a depressive episode. Their objective was to create a group treatment for training attention, and which would offer new mental modes and forms of dealing with one's own thoughts, thus impeding access to depressive mechanisms. In their quest for a suitable group treatment for this type of approach they came across Jon Kabat-Zinn and his *Mindfulness-Based Stress Reduction* (MBSR) program at the University of Massachusetts. This is a therapeutic program that has been validated as effective in the reduction of stress, and has been studied above all in medical illnesses in which the stress component is a key element in their development.

The strategy for avoiding relapses, according to MBCT, is to help patients rid themselves of these self-perpetuating and ruminative processes when they feel sad, since behind such ruminative processes is the concept of a "discrepancy": the current state is continually checked against the desired, required or expected state. That is, the person is constantly comparing "how he/she is" with "how he/she ought to be" and measuring the distance between them. The essence of Mindfulness is the intentional use of attention for establishing an alternative configuration of information processing, which is incompatible with the configuration of the depressive mechanism (Teasdale, 1999). Training in Mindfulness increases the

The original Spanish version of this paper has been previously published in *Apuntes de Psicología*, 2008, No 2, 257-268

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metacognitive capacity for de-focusing, that is, the ability to take perspective, and permits patients to use it when their thoughts and feelings are out of control or when maladaptive cognitive styles –such as rumination or worrying– are activated. Table 1 shows the basic techniques trained in MBCT. Each and every one of these techniques should be trained with an attitude of equanimity and compassion, avoiding the demands of perfect execution or the struggle against oneself.

Recent years have seen an increase in the number of studies on the efficacy of therapies that use Mindfulness with a wide variety of disorders and symptoms (Baer, 2003; Hayes, Follete & Linehan, 2004). There are five main therapies that use training in Mindfulness. On the one hand are those that use meditation in its Buddhist or most traditional form to teach Mindfulness, including the Relapse-Prevention in Addictions Program (Witkiewitz, Marlatt & Walter, 2006), the Mindfulness-Based Stress Reduction Program (Kabat-Zinn, 1990; MBSR) and Mindfulness-Based Cognitive Therapy (Segal, Teasdale & Williams, 2003; MBCT; Teasdale, Segal, Williams, Ridgeway, Soulsby & Lau, 2000); on the other are those therapies that use Mindfulness components as part of the therapeutic packages they propose, but which in no case are applied through formal mediation. This latter category would include Acceptance and Commitment Therapy (Hayes, Strosahl & Wilson, 1999; ACT) and Dialectical Behaviour Therapy (Linehan, 1993; DBT). Although there are differences between these therapies, they have in common the role of the acceptance of the experience, whatever it may be (pleasant or unpleasant), as one of the routes for the improvement of both mental and physical health, and the use of the stimulation and learning of Mindfulness for achieving this.

Mindfulness is defined as an ability consisting in "focusing attention in an intentional way: on an object, on the present moment, and without judging" (Jon Kabat-Zinn, 1990). Human beings are normally scarcely aware of their experience from moment to moment, usually acting on "automatic pilot"; however, Mindfulness is a common state that all of us have felt at some time and which we are all capable of developing.

The development of this ability is gradual and progressive, and requires regular practice. The usual way is to practice through meditation. The capacity to become aware of experience from moment to moment generates a richer and more vital sense of life. Thus, persistently observing, without judging, one's mental content gradually increases the capacity to perceive our own mental responses to external and internal stimuli, which leads to an increase of effective action in the world and therefore an increased perception of control (Grossman et al., 2004).

The action mechanisms of Mindfulness and its role in treatments have been a source of debate among therapists working on and using this ability. The hypothesis with the greatest weight is that which refers to its effect on the stimulation of metacognitive skills (Teasdale, 1999; Cebolla, 2007), though authors also speak of relaxation, hypnosis, exposure, and so on (Baer, 2003; Lynn, Lama Surya Das, Hallquist & Williams, 2006).

Research on the efficacy of a therapy, whether it includes training and/or stimulation in Mindfulness or not, normally involves the use of measurement instruments whose aim is to check whether there are significant pre-post-treatment differences through quantitative analysis. This means reducing the experience to scores and systematizing the changes; but information is lost with respect to the experiences lived through or the ways of constructing the changes that take place during the therapeutic process. In relation to this, it has been suggested to introduce qualitative methodologies together with quantitative ones, in a so-called mixed methodology (Onwuegbuzie & Leech, 2006). In the past, these two methodologies have been understood as opposing methods in the search for processes of change in research on psychotherapy; but mixed methodology proposes that, in reality, the two work in different areas and are complementary.

In 2005, a foundation for health research in the Canary Islands (*Fundación Canaria de Investigación en Salud*, FUNCIS) financed a study on the efficacy of TCAP in reducing depression and anxiety symptoms in the context of a Mental Health Unit. The aim of the project was to find an effective and efficient solution to two of the chronic problems of the majority of public mental health services: saturation of the units and the stress levels of health professionals. The proposed response to these situations was a group treatment of short duration for anxiety and depression, which are the most common disorders and those which generate the greatest demand. In this context, MBCT emerged as an efficient solution for treating users with depressive and/or anxious symptomatology, but it was still necessary to check its clinical efficacy.

Although MBCT may have been initially designed for preventing relapses in depression (in populations without symptoms), in the adaptation made for the present study we worked with a population *with* symptoms; thus, we adapted the treatment, emphasizing the work on cognitive styles, leaving aside the specific differential aspects of anxiety and

depression and working on the common ones (such as cognitive styles). Several authors have argued that the psychological mechanisms underlying anxiety disorders can be explained in a very similar way to depression (Papageorgiou & Wells, 2003; Nolen-Hoeksema, 1991, 2000). The two types of disorder have in common the use of maladaptive cognitive strategies such as rumination or worrying. Moreover, in the clinical context there is a high level of comorbidity between anxiety and depression symptoms, to the extent that it is often very difficult to separate them. These strategies can be worked on within MBCT making only slight adaptations.

Another of the adaptations made in this research is the inclusion of practical exercises based on Convivial Cognitive Therapy (Palm, Beskow & Miró, 2004). In this form of Cognitive Therapy patients are invited to consider conviviality as a "open space" that is created when the person behaves in such a way as to permit the emergence of the other as a legitimate other in conviviality with him/herself. To this end, patients are trained to understand the differences between the internal perspective –the view one has of oneself from inside–, with the possibility of acceding to the private data of one's own self-awareness, and the external perspective –the view one has of others or of oneself considered from the point of view of others (Miró, 2005). In this way, patients can work with the disturbing emotions that originate in the negative judgement of others, which is present in both depression and anxiety cases; even though the situations that trigger the negative view of others may be different, the judgement mechanism is similar in the two types of disorder. Faced with making a judgement, patients are encouraged to explore the differences between the internal and external perspectives, as well as the notions of acceptance of others and dignity in the face of suffering. In reality, it is a case of taking the Mindfulness ability from the intrapersonal to the interpersonal realm, using the mechanism learned during meditation not in the relationship with oneself, but in the relationship with others.

METHOD

Participants in this qualitative study were 32 users of two Mental Health Units in Tenerife (Spain) who had participated in an 8-week Mindfulness-Based Cognitive Therapy program.

On the basis of previous qualitative studies on MBCT (Mason, Hargreaves, 2001; Finucane & Mercer, 2006), a questionnaire was developed with 11 open questions in order to enlarge the research from a qualitative point of view and complement the information on the treatment effects. On the last day of treatment this questionnaire was given to 32 participants on an 8-week MBCT program. The aims of the questionnaire were: a) to obtain the study participants' opinion of the training, b) to see whether they had noticed any change over the course of the process that more standard questionnaires could not detect, c) to find out which parts they had not liked or had not reached them, with a view to gathering information that could help us to adapt the program and improve it. Measurements were made at the end of the treatment and 3 months after it had finished.

In this questionnaire participants were asked what they had learned in the training and about changes in their mood, at a cognitive level, in conviviality with others and in their perception of pain. The qualitative analysis methodology employed was content analysis: their responses were grouped by category and the frequency of the responses was calculated for each of these categories, for subsequent conversion into percentages.

RESULTS

Although it is not the object of this article, the quantitative data from the study showed that MBCT is effective in the reduction of anxious and depressive symptomatology, in the reduction of maladaptive cognitive styles such as rumination or worrying, and in the increase of metacognitive skills (Cebolla & Miró, 2007; Cebolla, 2007).

The first question in the protocol of narratives on perceived changes as a result of MBCT was *What did you think of the training?* The results are that 31 participants responded with some type of positive adjective, with only one responding that he found it "just OK". The largest number of responses to this question (53.1% of cases) referred to it as a positive experience (good, interesting, brilliant, etc.), followed by those (32% of cases) referring to its utility (beneficial, useful, of great help). This first question is very general because we were interested in focusing the participants, and going from the highly general to the more specific.

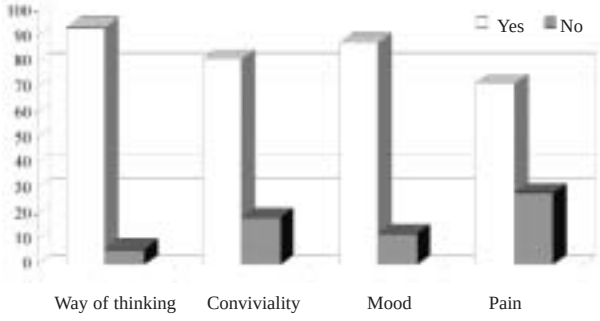
The second question refers to difficulties encountered at the beginning of the treatment (*What difficulties did you find at the beginning of the treatment?*). In the MBCT program there is a session devoted entirely to this issue and to the solution of difficulties, since it is normal for problems to appear, especially on doing meditation at home. The most common difficulties for participants are anxiety-related symptoms (feelings of panic, distress and loss of control and breathing problems) that emerge during the practice – 37.5% have difficulties at this level. Faced with such sensations, the

instruction given is not to allow them to carry you away and to introduce them into the meditation as another object of observation, without trying to control them; the aim here is that they are accepted, and allowed to occur, without being rejected.

A total of 43.7% acknowledge having difficulties with concentration, especially with regard to intrusive thoughts. The instructions given by the therapists during the practice are that participants should not try to control the thoughts, and that it is normal for intrusive thoughts to appear; indeed, the main part of meditation in Mindfulness is the observation of this coming and going of thoughts. In spite of this, many participants continued to think that the presence of thoughts in the meditation implied bad practice, and this caused them a good deal of distress. In 15.6% of cases the participants claimed to have no type of bodily sensation when they did the exercise on the contemplation of sensations; however, this lack of sensations began to disappear as they practised more. Thus, difficulties were solved as the number of sessions increased, and especially the number of meditations carried out at home.

From previous experience we had found that many of those participating in MBCT groups had difficulty in understanding the reasons behind meditation as a tool. This is due to the fact that the treatment has a substantial experiential component: its objective is that it is the participants themselves, through their own experience, who discover the purpose of the meditation or the true meaning of the training, so that the interventions never involve much direct guidance. The danger of this is that there are people who fail to understand the meaning of the practice or of the homework tasks, or even the reason for meditating. On being asked *When did you begin to understand the meaning of the treatment?*, it emerges that 43.7% of the participants began to understand the meaning of the treatment in the first two weeks, 21.8% after the second week, and 15.6% around the fourth week. On the other hand, 9.3% of the participants were not clear about the meaning of the treatment until the final weeks, and 6.2% actually ended the training without really understanding its objective.

Figure 1
Changes after the treatment



Four questions are asked about the changes felt at four levels – thoughts, conviviality, mood and pain. In answer to the question *Have you noticed any changes in your mood?*", 87.5% of the participants in this study acknowledge having noticed some type of improvement in their positive mood (happier, more confident, more motivated, etc.) (see Figure 1). Of these, 62.5% report increased positive mood, 12.5% reply with some reference to a clear reduction of symptoms, and 7.1% claim to feel more sure of themselves.

Changes in cognitive variables were asked about in the following way: *Have you noticed changes in your way of thinking?* In response to this question, 93.8% acknowledge having noticed them. Of these, 32% report thinking more positively, while 15.6% have increased their patience/calm, give things less importance and do not let things "get on top of them" so much. In 34.3% of cases, participants claim to have increased their abilities related to Mindfulness, insofar as they give more importance to the body, focus their thoughts on the present and cope effectively with states of dysphoria.

This training program devoted more time than the original version of the MBCT program to conviviality. This aspect was introduced in the homework tasks, through exercises, and also in the sessions. Many of the patient demands in the group had to do with this level. The way of working is through acceptance of the other, and his or her legitimation as a different being. On being asked *Have you noticed any changes in your relations with others?*, 81.3% report having noticed some change for the better at this level. Of those who noticed changes, 37.5% acknowledge having increased their capacity to accept others and to have become more tolerant and patient; 15.6% report having improved their social skills; and 9.3% feel that they can be more assertive.

Over the eight sessions many references are made to pain, given that in the actual practice of meditation there may emerge painful sensations due to posture. Sensations of pain may also appear during the yoga exercises, since during the stretching there is continual stimulation of the observation of physical sensations, including discomfort that emerges, but without exceeding the pain threshold.

The way in which MBCT works with pain is to include painful sensations in the practice, as just another sensation, without judging it or trying to modify it, and

taking the breathing to the appropriate point using the imagination. What is promoted is an approach to painful sensations in a state of calm. Of the 32 people participating in this narrative study, 21 acknowledge having had some experience of physical pain during the training period. Of these, 71.5% report having noticed some positive change in the experience of pain, 57.6% of whom report that the meditation in Mindfulness reduced the intensity of pain and increased their capacity for coping with it. Of the six women with fibromyalgia, the majority did not notice a decrease in the intensity of the pain; rather, they experienced it in a different way. As one patient puts it, "it hurts the same, but now I feel I can do more things; now it doesn't worry me as much".

In response to the question *What skills do you think you have learned?*, the majority (46.8%) refer to skills related to Mindfulness, such as those of being in the present or accepting experiences (see Table 2). Curiously, 25% report having learned to relax. Another 21.8% have learned the skill of stopping intrusive thoughts and reducing rumination, while 37.5% have learned to breathe, that is, they have learned about the therapeutic power of concentration in breathing. In addition to these, 9.3% acknowledge having increased their feeling of self-control, while another 9.3% feel they have increased their ability to concentrate.

In answering the question *What do you think meditation does for you?*, 40.6% said that it helped one to get to know oneself better (spirituality, self-esteem, exploring one's conscience) (see Figure 2). Another 40.6 % replied that meditating helps them to relax or feel calm, 21.8% said that it helps them to live in the present and stops the mind wandering to the past or the future, 25% claimed that it increases effective coping, stimulates good habits, increases time for oneself and helps to "recharge one's batteries", while 21.8% make reference to self-control, through the channelling of the emotions or the reduction of rumination.

To the question *Are you going to continue meditating?, How often?"*, 84.3% of those interviewed were intending to continue meditating – 50% at least once a week and 12.5% between 3 and 4 times per week. The rest did not know. There were no replies referring to giving up meditation completely.

Another question asked was *What role are you going to give meditation in your life?*, to which 32.5% of those interviewed replied that meditation is a tool for moments of suffering, and as such serves as a kind of medication or aid; 37.5% considered that the practice of meditation is important or essential for feeling good, and would never give it up.

After these questions a space was left for participants to give their opinion on MBCT, via the question *"Would you make any changes to the treatment?"* The most interesting data that can be extracted in this case are that 27.5% would extend the training by increasing the number of sessions or even increasing the number of hours of group meditation; at the same time, 24% complain that the treatment should be more oriented to group dynamics, and that there is little space for group therapy and the narrative reconstruction work. There is a warning about this aspect at the beginning of the training, insofar as it is stressed that it is not a group therapy but a form of training, so that if a need is felt to work on personal aspects external to the practice, participants should consult professionals from the mental health units. This strict approach is due to certain factors: a) it is a treatment with few sessions, in which efficiency is a priority, b) in order to understand the treatment it is necessary to practice, not to convince in any way, and c) this training was designed so that it

Figure 2
Responses to the question
What do you think meditation does for you?

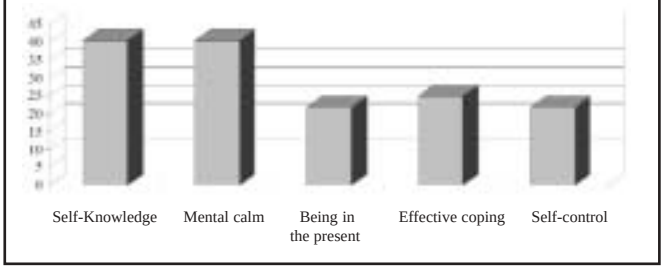


Table 1
Percentages for each response to the questions asked

Skills learned	Using attention in breathing	46.8%
	Learning to stop thoughts	21.8%
	Learning to relax	25%
	Skills related to Mindfulness (living in the present, accepting, patience, identifying emotions, concentration)	37.5%
	Greater feeling of control	9.3%
	Being more positive	9.3%
Changes in conviviality	Greater capacity for accepting others	37.5%
	Improved social skills	15.6%
	Greater assertiveness	9.3%
Changes in mood	Improved mood (more positive, more motivated, better mood)	62.5%
	Reduction of symptoms (Anxiety or depression)	12.5%
	Greater self-confidence	10.7%
	Enjoying little things	7.1%
	Internal peace	7.1%
Changes in way of thinking	More positive and optimistic thinking	32%
	Increased patience/calm, not giving things importance, not letting things get on top of you	15.6%

could be applied by people without training in group therapy. As regards the homework tasks, 53.1% have a positive view of these, considering them useful, advantageous or important for the treatment, while 34.3% replied with negative adjectives, referring to them as boring, repetitive or an obligation.

In the measure taken after three months there was also space for 4 open questions. The first of these was about the skills that had been maintained after three months, 68.7% reporting that they had continued to pay attention to breathing as a basic tool of emotional self-regulation, with high levels of maintenance of the three-minute breathing technique. Moreover, 37.5% reported that they had maintained Mindfulness skills, such as not judging, living in the present, connecting with oneself or concentrating.

As regards changes in the way of thinking or feeling that had been maintained in these three months, 87.5% said the changes that had occurred on finishing the treatment were maintained in time. Of these, 42.8% said that they were surer and more accepting of themselves, 21.4% reported having maintained the ability to think before acting and to analyze situations, 17.8% felt they had greater self-control, and 14.2% felt more optimistic.

In the three-month measure participants were again asked about the maintenance or appearance of changes in relations with others: *Have you noticed any changes in your way of thinking or feeling since the training finished?* A total of 78% had indeed noticed changes in the time since the end of the training. Of those who had noticed some change, 44% had increased their ability to legitimate others, and had thus improved their conviviality, resulting in a perception of greater confidence in relationships, greater acceptance of others and less preoccupation with what others think about oneself. In turn, 32% perceived themselves to be more assertive and 20% felt they had increased their sociability.

DISCUSSION

The most interesting result of the present study was that MBCT is very well accepted among participants, many of whom indeed asked for a continuation or maintenance sessions, since they felt that coming to the group sessions helped them to practice at home and to feel better. The vast majority perceived changes in the four areas about which they were asked, namely: in the cognitive area or way of thinking, in mood, in conviviality and in coping with physical pain. The majority of the participants reported improved mood, a more positive way of thinking, being more focused on the present and judging their experience less. The results obtained are similar to those from qualitative studies carried out by other authors (Mason & Hargreaves, 2001; Finucane & Mercer, 2006).

One of the most interesting findings of these analyses is the increase in the capacity for conviviality. It would appear that the generalization of what has been learned about oneself to the area of conviviality produces an increased capacity to accept and legitimate others. Up to now there have not been many Mindfulness-based approaches to conviviality, with just a few applications in the area of parenting skills (Santamaría, Cebolla, Rodríguez & Miró, 2007; Kabat-Zinn & Kabat-Zinn, 1997; Dumas, 2005) and a Mindfulness treatment focused on increased intimacy in the couple (Carson, Gil & Baucum, 2004). There is one element that has scarcely been mentioned but which is present in all of these therapies, and in the treatment presented here: compassion. In Christian philosophy, compassion includes a component of pity (*definition*: a feeling of sympathy and sorrow for the misfortunes of others), whilst in Buddhism it is no more than the conviction that everyone deserves to be happy, and the desire for this to be so. This emotion is stimulated in therapy, is sometimes included in the meditation sessions, and is becoming more and more important for understanding certain interpersonal processes (Gilbert, 2005).

Mindfulness in its application to coping with chronic pain is perhaps one of the most widely studied approaches, and one of the most interesting types of intervention at an experiential level; indeed, the first validation of the MBSR program was in the context of the treatment of chronic pain. The group included several cases of persons with chronic pain who after the program acknowledged that their relationship to the pain had changed, that the acceptance of the pain sensation attenuated it, and that although the feeling was the same unpleasant one, they felt they could live a fuller life. The data with respect to pain confirm those of previous studies, especially those involving MBSR (Kabat-Zinn, 1982; Kabat-Zinn, Lipworth & Burney, 1993), though it should be borne in mind that the data considered are exclusively qualitative, and that no standardized instrument was used in their measurement, since this was not a priority objective of the research.

As regards the skills learned, there is a notably high percentage of persons who reported having learned to relax through the acceptance and observation of bodily sensations and breathing. As regards the meaning of the technique, the vast majority intend to continue meditating, and find the technique useful for coping with suffering and for getting to know oneself better.

With a view to improving the treatment, participants were asked about aspects they did not like, and the main criticisms concerned the number of sessions (too few), the lack of group dynamics and the boringness of the tasks (though the tasks were also well accepted by a large percentage of participants).

SUMMARY AND CONCLUSION

The results obtained are in line with previous qualitative approaches in the context of MBCT. In practically all the areas about which participants were asked they report changes, with regard to both cognitive and emotional aspects. The main limitation of the study is that the ability to respond to open questions is not the same in all participants. The high levels of acceptance found for the treatment may have been the result of social desirability, but even so they are sufficiently high to be taken into account in relation to the possible integration of MBCT in public health services.

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