

Original Article

The effectiveness of mindfulness-based cognitive therapy on psychological well-being and cognitive emotion regulation strategies in patients with depressive disorder

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Abstract

The aim of this study was to evaluate the effectiveness of mindfulness-based cognitive therapy training on psychological well-being and cognitive emotion regulation strategies in patients with chronic depressive disorder. By purposive sampling method, 30 patients with a diagnosis of chronic depressive disorder were admitted to the Aramesh Psychiatric Care Center in Tehran and randomly assigned to the experimental group (n = 15) and the control group (n = 15). The instruments included mindfulness-based cognitive therapy protocol (MBCT) by Garnfski et al. (2006) Cognitive Emotion Regulation and Ryff Psychological Well-Being Questionnaires (1989). The results of the analysis of covariance showed that at the level of $p < .05$ there was a significant difference in the variables of psychological well-being and cognitive emotion regulation between the experimental and control groups. In psychological well-being ($F = 174.30$, $p < .05$), and effect size equal to 0.87, in adaptive cognitive emotion regulation ($F = 99.20$, $p < .05$) and effect size (0.80), in cognitive emotion regulation incompatibility ($F = 93.87$, $p < .05$) and effect size (0.79) and a significant difference at the significance level of $p < .05$ were observed between the experimental groups and the control group. Therefore, mindfulness training had a significant effect on psychological well-being and cognitive emotion regulation of people with depressive disorder.

Keywords

Mindfulness-based cognitive therapy, psychological well-being, cognitive emotion regulation, depression.

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Introduction

According to the Diagnostic and Statistical Manual of Mental Disorder-Fifth Edition [DSM-5] (American Psychiatric Association, 2013), two general types of mood disorders have been identified: disorders that include only depressive symptoms and disorders that include manic symptoms. There are generally four categories of symptoms for depression, including mood, cognitive, motivational, and physical symptoms. Depression, as one of the major mental health problems, has dramatic effects on the general health of the world; the effects of depression on the development of children and increase the risk of dementia to suicide, premature death and various physical disorders have been reported (Reynold & Patel, 2017) An estimated 300 million people worldwide suffer from depression (World Health Organization [WHO], 2020). While 14% of the global

weight of the disease is attributed to mental disorders, 75% of most patients in many low-income countries do not have access to treatment and are left untreated. Remain (WHO, 2020). For this reason, new research seeks affordable and low-cost treatments (Dickerson et al., 2018). Symptoms of depression can be classified into three dimensions: (1) psychiatric symptoms, a broad concept that often includes the main symptoms of a depressed or unhappy mood, as well as feelings of worthlessness, guilt, and thoughts, (2) cognitive symptoms, such as impaired ability to think or concentrate, and (3) vegetative nerve symptoms, such as sleep problems, fatigue or loss of energy, and changes in appetite (Majd et al., 2020). But what is important are the factors that are less considered in the development of chronic depression, as factors in the persistence of depression and lead to resistance to its treatment (Klein et al., 2014). Mindfulness-based cognitive therapy (MBCT) is an evidence-based psychotherapeutic intervention that

integrates selected elements of cognitive behavioral therapy for depression with the clinical application of mindfulness meditation (Segal et al., 2013). MBCT is currently recommended in several national clinical guidelines as a prophylactic treatment for recurrent major depressive disorder (National Institute for Clinical Excellence, 2009), and is considered a cost-effective intervention. MBCT takes the form of 8 weekly group sessions, an all-day silent retreat, and individual daily homework in between sessions. Since the first edition of the MBCT manual was published in 2002, there has been a mounting interest in MBCT and its clinical potential in the prophylactic treatment of depressive disorders (Williams & Kuyken, 2012). MBCT is based on a model of cognitive vulnerability to depressive relapse and recurrence (Segal et al., 2013). The model states that patients who have experienced several episodes of major depression have a heightened cognitive vulnerability to depressive relapse and recurrence. This heightened cognitive vulnerability is proposed to be a consequence of increased connectivity between depressed mood and depressogenic cognition having developed during successive episodes of major depression (Kuyken, Crane & Dalgleish, 2012; Segal et al., 2013). MBCT was developed to target this cognitive vulnerability, and thereby reduce the likelihood of the configuration of a depressive episode becoming re-established. In addition, a few studies have indicated that MBCT may also reduce residual depressive symptoms and possibly the risk of relapse for patients highly vulnerable to dysphoria-induced depressogenic thinking who have had 2 or fewer previous episodes of depression, although further research is warranted (Geswind et al., 2012; Piet & Hougaard, 2011).

In fact, cognitive emotion regulation is a set of processes by which individuals modulate emotional responses, what emotions they have, when they have them, and how they respond to them (Gross & John, 2003; Nolen & Hooksma, 2012). Emotion regulation refers to processes that change the frequency, intensity, and duration of emotional states (Gross, 2014; Gross, 2015). These are those that indicate ways in which a person copes with stressful situations or unfortunate events (Fassbinder et al., 2016). Research evidence has shown that emotional regulation by changing the emotional and cognitive processes of individuals is one of the main factors influencing the incidence of depression (Goldain & Gross, 2010; Narimani et al., 2011). In this regard, Hutt et al., (2021) and Schirda et al., (2020) concluded that mindfulness training is associated with a reduction in emotion regulation problems compared to adaptive cognitive and control training.

Psychological well-being is also one of the notable structures in the field of depressive and mind-awareness disorders, which was first proposed by Ryff (1989). With a transformational view of human abilities, this model considers psychological well-being to consist of self-acceptance, purpose in life, personal growth, having

a positive relationship with others, mastering the environment, and self-reliance or autonomy (Hojman & Miranda, 2018). According to Luhman (2017) The science of subjective well-being (SWB) focuses on the definition, measurement, and correlates of happiness. Subjective well-being encompasses people's emotional experiences (i.e. positive and negative emotions and moods) as well as their evaluations of their lives (i.e. life satisfaction). SWB is an inherently subjective experience, meaning that each person knows best whether he or she is happy.

Therefore, one of the important therapeutic interventions that increases the psychological well-being of individuals is mindfulness-based therapeutic intervention (Howell, 2010; Brown & Ryan, 2015). Bajaj, & Pand (2016) conducted a study among 327 university students in India and showed that mindfulness has a positive effect on psychological well-being and life satisfaction. Research evidence suggests that mindfulness is involved in the treatment of chronic depressive disorder and the reduction of depressive symptoms (Dhillon et al., 2017; Miklovitz et al., 2015; Hoffman et al., 2010) and through effect Reducing negative emotions, adjusting to a bad mood, and self-acceptance play an important role in preventing and modulating depressive symptoms (Jimenez et al., 2010). Therefore, considering that on the one hand, in the day care centers for chronic psychiatric patients, the space has emotional, and social problems, and most of the patients living in these centers in terms of psychological, social, and cognitive development of their peers, whose Families live, they are behind (Piet & Hoggard, 2011) and On the other hand, considering the importance of depression in these patients and the importance of psychological education along with meeting the basic needs of this segment of society, which leads to increasing the empowerment of these people and their more effective presence in the future society, the present study Aimed to study mindfulness-based cognitive therapy training in the form of a therapeutic intervention aimed at increasing psychological well-being and cognitive emotion regulation and in order to reduce the symptoms of chronic depression. Therefore, the aim of answering the question was whether mindfulness-based cognitive therapy is effective on psychological well-being, cognitive emotion regulation and cognitive flexibility of patients diagnosed with chronic depressive disorder?

Method

Participants

The design of the present experimental study was pretest-posttest with a control group. The population of the present study included all male patients with a diagnosis of chronic depressive disorder hospitalized in chronic psychiatric care centers in Mallard, Tehran in 2021. The sample was selected using purposive

sampling of 30 patients diagnosed with chronic depressive disorder hospitalized in the care and rehabilitation center for chronic psychiatric patients based on the psychiatrist's diagnostic interview in the patient file and structured clinical interview in this study. They were randomly assigned to the experimental group (n = 15) and the control group (n = 15). The participants completed Beck Depression Inventory, Cognitive Emotion Regulation, and Psychological Well-Being Questionnaire in two sessions (pre-test and post-test). It was considered and was not presented to the educational control group during this period. Multivariate analysis of covariance was used for data analysis.

Procedure

In the present study, after coordination between the patients of the center based on the report of the center psychiatrist's diagnostic interview in the patient file and clinical interview, SCID was performed by a clinical psychologist with a Ph.D. degree and MBCT certification. Thirty patients with diagnostic criteria for chronic major depressive disorder were selected by purposive sampling method and randomly assigned to the experimental group (n = 15) and the control group (n = 15). The participants of the experimental group were trained for eight sessions (one and a half hours each session) using mindfulness-based cognitive therapy (MBCT) techniques by an interventionist with a doctorate in psychology with a certified MBCT course and Practiced. At the end of each session, participants were given homework. In order to ensure that mindfulness exercises are performed at rest (at home, outside of practice times), people were given an exercise registration checklist and asked to do the exercise at least twice a day and mark it on the relevant checklist. At the beginning of the next session, after receiving the checklist, the educational materials of the previous session were reviewed and the questions of the people were answered. After training and practice, in the experimental group, measurements related to each variable and a questionnaire were performed in both groups. Inclusion criteria: Individuals in the age range of 20 to 65 years who had been hospitalized for at least one year and had not undergone any other psychological treatment for 3 months before the treatment. A score higher than 30 in the Beck Depression Inventory and the drug dose remained constant for 8 weeks were among the inclusion criteria. Exclusion criteria: Patients who during treatment sessions, according to the diagnosis of the center psychiatrist, had a disorder other than depression and had suicidal ideation or attempted suicide in the past, also; Drug abuse, the presence of physical illnesses that cause symptoms (such as hypothyroidism), and two consecutive absences were considered as exclusion criteria.

Instrument

Beck Depression Inventory (Second Edition) (BDI-II):

In this 21-item questionnaire and self-report scale, by Beck, Steer and Brown (1996), according to the Likert scale, a score between 0 and 3 for each item has been compiled. These items in areas such as sadness, pessimism, feelings of disability and failure, guilt, sleep disturbance, change of appetite, self-loathing, etc. are so that 2 items are dedicated to cognition, 2 items to overt behaviors, 5 items to physical signs and 1 item to interpersonal semiotics. The validity and reliability of the original version have been confirmed in studies, including the Carmodi study in which the reliability coefficient (Cronbach's alpha) was 0.91 and the validity was 0.86 (Carmodi, 2005). Zemestani, & Fazeli Niker, (2020) research, the convergent and Cronbach's alpha coefficients of this scale were 0.78 and 0.82, respectively. This tool is used to measure the severity of depression in adults who have received a diagnosis of depressive disorder. And that's why we chose this tool.

Structured clinical interview, clinical version of chronic depressive disorder (SCID-5-CV DSM-5):

This clinical interview is a diagnostic tool, the first version of which was prepared by First, Spitz, Gibbon, Williams in 1992. The reliability of SCID for several disorders was evaluated by group interviews through seven interviews and the acceptable kappa coefficient was reported to be 0.6 (The same source). But another study conducted in 2018 reported a Cronbach's alpha of more than 0.80 (Shankman et al., 2018). The main advantage of this tool is its ease of use in clinical trials. Various studies have shown that the validity and validity of structured clinical interviews are desirable (Grant et al., 2004 ; Sharifi et al., 2009). Was (with a coefficient above 0.6) and the overall agreement or total coefficient of 0.52 was good for the total review and 0.55 for the total lifetime diagnoses (Sharifi et al., 2009). In general, various studies on the validity and reliability of structured clinical interviews are desirable (Grant et al., 2004; Sharifi et al., 2009) in a study examining the normative characteristics of this tool in the Iranian population. In this study, the reliability coefficient a three-day to one-week retest was reported for various disorders from 0.74 to 0.98 and it was found that the sensitivity coefficient (0.54 to 0.86) and specific coefficient (0.63 to 0.96) were satisfactory.

Cognitive emotion regulation (CERQ):

The questionnaire was developed in the Netherlands and has two versions, English and Dutch, and is a self-report tool that has 36 items in a five-point Likert form with a special form for adults and children (Garnfski & Kreich, 2006). In Samani and Sadeghi (2011) in the second-order factor analysis on the primary factors of the Cognitive Emotion Regulation Questionnaire, two general factors called maladaptive strategies (self-

blame, rumination, catastrophizing and blaming others) And adaptive strategies (positive refocus, planning, positive evaluation, vision development) were obtained, and because of measuring the cognitive regulation strategies of individuals in response to life-threatening events, who have experienced negative events, this tool was selected. [Garnfski et al. \(2006\)](#) reported good validity and validity for this questionnaire. The alpha coefficient for the subscales of this questionnaire was reported by [Granefski et al. \(2006\)](#) in the range of 0.71 to 0.81. Psychometric adequacy of the Cognitive Emotion Regulation Questionnaire in Iran has been reported by [Samani and Sadeghi \(2011\)](#). The alpha coefficient for these factors in Samani and Sadeghi research has been reported in the range of 0.62 to 0.92 and its retest coefficient in the range of 0.79 to 0.88.

Psychological well-being questionnaire:

Psychological Well-Being Questionnaire (18-item short form) was designed by [Ryff \(1989\)](#) and revised in 2002. This version includes independence, mastery of the environment, personal growth, positive communication with others, purpose in life and self-acceptance. The

sum of the scores of these six factors is calculated as the total score of psychological well-being. This test is a kind of self-assessment tool that is answered in a 6-point appendix from strongly agree to strongly disagree, with a higher score indicating better psychological well-being. [Ryff \(1989\)](#) presented the coefficient of similarity of the scales as follows: self-acceptance, 0.93, positive relationships with others 0.91, autonomy 0.76, mastery of the environment 0.90, purposeful life 0.90 and personal growth 0.87.

Mindfulness Based Cognitive Therapy Protocol (MBCT):

This protocol is further explained in the book ([Crane, 2009](#)) and selected from this book and is presented in Table 1. The meeting instructions are also contained in the book by [Segal et al., 2002](#)). Mindfulness-based cognitive therapy training was conducted in the form of 90-minute training sessions and 2 sessions per week for the experimental group. During the training sessions, all subjects of the experimental group were present and the description of the sessions is reported in the Table 1 below:

Table 1. Summary of mindfulness training sessions

Meetings	Objectives and content of the meetings
First	Familiarity with depressive symptoms, treatment introduction and brief description of 8 sessions. Perform meditations on eating a raisin, 30 minutes of body scan meditation. Homework and distribution of tapes
Second	Meditation Scanning the body Reviewing homework, barriers to practice, and mindfulness program solutions for them to do meditation while sitting; and assigning homework: Relevant homework
Third	Practice seeing and hearing sitting meditation and breathing according to the bodily senses; Three minutes of breathing space training, mindfulness movement training; Assignments: Sitting meditation, body scan, 3-minute breathing space exercise, mindfulness of a new activity, and mindfulness of unpleasant events
Fourth	Sitting meditation based on breathing, body sound and thoughts (which is a four-dimensional sitting meditation); discussing a person's stress responses and reactions to difficult situations and alternative attitudes and behaviors; mindful walking exercises and homework: Relevant homework.
Fifth	Three-minute breathing space exercise; Discuss homework in groups of two; Mood exercises, thinking, separate perspectives, four meditation exercises for 7 hours in a row; Tasks of choosing a combination and preferences of meditations Breathing for three minutes in an unpleasant event and being mindful
sixth	Four-dimensional meditation and instant awareness: the best way to take care of yourself is to provide an exercise that identifies unpleasant events, a three-minute breathing space; Homework: Do a combination of meditation, three minutes of breathing in an unpleasant event.
Seventh	Discussion about the task of the previous session, practicing 3-minute breathing space; asking questions about the overall efficiency of the sessions and the desire to continue
Eighth	Prepare subjects to complete treatment, summarize sessions, provide additional tips, and perform post-tests.

Results

Demographic information of the research sample showed that the general sample of the study includes 30 male patients with a diagnosis of chronic depressive disorder and are in the age range (20-65 years). The frequency of the age group is in the range of 20-45 years with a frequency of 15 people and the frequency of the age group is in the range of 46-65 years with a

frequency of 15 people. The mean and standard deviation of the whole sample is equal to 75/21 ± 10/03. Similarly, in terms of the level of education, 11 people had not formal education, 13 were undergraduates and 6 people had university education. Under the marital status, 14 were married, 7 were single and 9 had a deceased spouse.

Table 2. Descriptive statistics in cognitive regulation of emotion and psychological well-being

Variable	group	Test	Descriptive statistics			
			Mean	Std. Error	Skewness	kurtosis
Adaptive emotion adjustment	Experimental	pre-test	52.13	9.97	0.41	-1.06
		Post-test	60/60	9.12	0.17	-1.25
	Control	pre-test	52.06	8.94	0.38	-1.23
		Post-test	51.13	9/97	0.51	-0.97
Incompatible emotion regulation	Experimental	pre-test	49.86	10.19	0.19	-1.17
		Post-test	39.60	8.76	-0.02	-0.79
	Control	pre-test	51.26	9.39	0.17	-1.17
		Post-test	52.00	9.86	-0.06	-0.87
Psychological well-being	Experimental	pre-test	145.07	9.85	-1.22	1/96
		Post-test	170.07	7.40	-0.17	-1.36
	Control	pre-test	141.13	6.79	0.44	-0.79
		Post-test	138.53	9.16	0.03	-0.81

The results of Table 2 show that in psychological well-being and adaptive emotion regulation, in the experimental group, the mean of post-test scores increased compared to the pre-test, and in the maladaptive emotion regulation variable in the experimental group, the mean of post-test scores increased. The test is reduced compared to the pre-test, but in the control group, no change is observed. In order to analyze the data and evaluate the effectiveness of the trainings on the research variables, the multivariate analysis of covariance test was used, so first, the underlying assumptions of this test were examined.

In Table 2, the central indicators of mean and dispersion indices of standard deviation, skewness and elongation in the variables of cognitive regulation of emotion and psychological well-being are observed. Based on most sources, the distribution of scores in the range (-2 and 2) and the elongation in the range (-3 and 3) can be assumed to be normal. Therefore, the distribution of scores of cognitive emotion regulation (adaptive and maladaptive) and psychological well-being variables in both groups is normal.

Table 3. Box's test of equality of covariance matrices

Box's M	f	df1	df2	Sig
4.224	0.622	6	5680.302	0.713

Before performing the analysis of covariance, its assumptions are examined in Table 3. The similarity of the variance-covariance matrices was observed (sig, $0.713 < .05$, $F = 0.622$, Box's $M = 4.22$). Then, the absence of effective skew data in the research variables, according to the skewness and elongation indices, was ensured. Also, Levene's test was used to test the assumption of homogeneity of variances which was consistent in the emotion regulation variable (Sig. = $0.581 < .01$, $F = 0.313$), inconsistent (Sig. = $0.035 < .05$, psychological well-being ($F = 2.36$) (Sig. = 0.0124 , $F =$

2.51) were not significant. Therefore, the assumption of homogeneity of variances of all three variables was confirmed. According to the results of the hypotheses, the analysis of covariance was used. Then, we used covariance to compare the experimental and control groups based on post-test scores, after controlling the effect of pre-tests, to determine the effect of mind-awareness-based cognitive therapy training intervention on emotion regulation and psychological well-being of the analysis. The results of the post-test are given in Table 4.

Table 4. Multivariate analysis of covariance to compare experimental group independent variables

	Test	Value	Df	F	Eta squared	Significance level
group	Pilay effect	0.95	3	148.79	0.95	0.001
	Lambda Wilkes	0.04	3	148.79	0.95	0.001
	The effect of hoteling	19.40	3	148.79	0.95	0.001
	The biggest root of the error	19.40	3	148.79	0.95	0.001

Significance levels of all tests in the Table 4 indicate that there is a significant difference between the experimental and control groups in at least one of the dependent variables (Sig. $< .05$). To find out in which

variable there is a difference between the two groups, univariate analysis of covariance was used in the MANCOVA test, the results of which are reported in Table 5:

Table 5. Results of analysis of covariance by controlling the effect of pretest

Variable	df	Ms	F	Eta Squared	Significance level
Adaptive emotion adjustment	1	594.08	101.43	0.80	0.001
Incompatible emotion regulation	1	904.55	93.24	0.78	0.001
Psychological well-being	1	5880.56	134.17	0.84	0.001

According to the results of analysis of covariance and F statistics and Sig. < .05, there is a significant difference in the variables of psychological well-being and adjustment of adaptive and maladaptive emotion between the experimental and control groups. There is a significant difference in the adaptive emotion regulation variable ($F = 99.20$, Sig. < .05) compared to the control group; therefore, the null hypothesis is rejected. The effect size is 0.80, which means 80% of the differences between individuals in the post-test scores of the relevant adaptive emotion regulation scale were due to experimental intervention (mindfulness training). In adjusting for maladaptive emotion, there is a significant difference in the post-test scores of the experimental and control groups according to ($F = 93.87$ and Sig. < .05). The effect size is equal to 0.79. That is, 79% of the differences in the scores of individuals in the maladaptive emotion regulation test is related to experimental intervention (mindfulness training).

In the psychological well-being scale, according to ($F = 174.30$ and Sig. < .05), there is a significant difference in the post-test scores of the experimental and control groups and the effect size is equal to 0.87. In other words, membership in the experimental group explains about 87% the difference in post-test scores between the experimental and control groups. About 87% of the differences between the experimental and control groups on this scale was due to group membership and experimental intervention (mindfulness-based cognitive therapy training).

Discussion

As the results show, there is a significant difference between the experimental and control groups in at least one of the dependent variables. According to the results obtained from the analysis of covariance, there is a significant difference in the variables of psychological well-being and cognitive emotion regulation between the experimental and control groups. There is a significant difference in the psychological well-being variable compared to the control group; therefore, the null hypothesis is rejected. The effect size is equal to 87%; in other words, 87% of the differences between individuals in the post-test scores of psychological well-being was related to the effect of experimental intervention (mindfulness training). MBCT gives participants advanced self-awareness to better cope with stress and better interpersonal performance (Lau et al., 2007). Their findings show that traditional cognitive-behavioral interventions such as activating behavior and creating a maintenance plan, may not be as necessary as previously thought to prevent recurrence.

The findings of the present study are consistent with

the findings of Beyramey et al., and Yaghoubi et al. (2017), Jana-abadi et al., (2017), each of whom recognized the effectiveness of mindfulness skills training on the welfare and psychological component. The findings of the present study are also consistent with the studies of Howell et al. (2010), Brown and Ryan (2015), Bajaj and Pand (2016), Fontaine-Zaragoza and Prakash (2017), which provide evidence of improved psychological and physical well-being. They introduced mindfulness training.

In recent years, there has been a growing interest in the study of psychological well-being, and study in this area can be very important, especially for people with psychological disorders, because in these people are more likely to face difficult situations. Accordingly, one of the most important factors that lead to a negative change in nature and help us better understand the abilities of people with major depressive disorder is psychological well-being (Melendez et al., 2015). Consistent with the present finding, the study by Xiang and Yuan (2021) showed that "mindfulness directly and indirectly, through mediating variables, reduces negative emotion and leads to increased psychological well-being of individual" (p. 10). In fact, mindful people are better able to recognize, manage, and solve everyday problems (Statz, 2015; Zidane et al., 2010). In fact, when mindfulness increases, people's ability to stand back and observe states such as anxiety and depression increases. As a result, they are freed from automatic behavioral patterns and are no longer controlled through perceptions and re-perceptions of states such as anxiety and depression; rather, it uses the information that comes from these states and is associated with emotions, resulting in increased psychological well-being.

On the other hand, the findings of the present study showed that there is a significant difference in the post-test scores of the experimental and control groups on the scale of cognitive emotion regulation. The findings of the present study were in line with the findings of Salajegheh et al., (2020), Zemestani and Fazeli Niker (2020), Rocky and Naderi (2019) and Izadi and Taghiradeh (2022), which are evidence of effectiveness. They introduced mindfulness training in cognitive emotion regulation.

Research has shown that emotional regulation by changing the emotional and cognitive processes of individuals is the main factor in the incidence of depression (Goldain & Gross, 2010; Narimani et al., 2011). In fact, the use of mindfulness therapy and the subsequent improvement of emotions enhances the individual's ability to regulate emotions and improve overall performance, allowing the individual to try and suppress emotion instead of trying to suppress it. They

accept their emotions (Huh et al., 2017). Research has shown that mindfulness therapy is associated with lower scores in emotion dysregulation and emotional avoidance. Based on such findings, it seems that mindfulness in this way can be effective on cognitive regulation of emotion in people with major depressive disorders.

Conclusion

In general, following the changes and deficiencies that occur during the hospitalization period of chronically depressed patients, it is necessary to develop a type of intervention that will help these individuals to achieve optimal strategies for better adaptation to the environment. The inactivity of depressed people and those living in chronic conditions and disability have led to research that made recommendations for special and disable groups and optimal health results from them, which is in line with WHO policies (Bull, et al., 2020). Mindfulness-based cognitive therapy is an integral part of mindfulness-based stress reduction therapy presented by Kabat-Zinn and Beck's cognitive therapy. This therapy was developed as a group therapy for people, who have a history of depression (Nobakht & Nikmanesh, 2019). Mindfulness is one of the therapies whose effect on reducing psychological problems in various samples and especially depression has been confirmed (Goodarzi et al., 2019; Tabatabai Nejad et al., 2019). In fact, the effectiveness of mindfulness in improving the regulation of emotion, mood and emotions of depressed people based on principles such as staying in the present, observation without judgment, acceptance, raising awareness of experience and creating a consistent reaction is significant. Mindfulness improves the psychological well-being of the individual by increasing the level of concentration and level of collective consciousness during the day and night and reducing the inner resistance of the person in the implementation of personal decisions. Inside the person and increasing his level of concentration and not attaching to people's judgments at any time increases the improvement of life and emotions. Training to observe disturbing thoughts and emotions without judgment and receptivity instead of avoiding or engaging them mentally leads to increased awareness of experience and conscious and adaptive reactions and better control of unpleasant thoughts and emotions in patients with major depressive disorder, therefore, the continuation of mind exercises.

Disclosure Statement

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