

Does Mindfulness Meditation Improve Anxiety and Mood Symptoms? A Review of the Controlled Research

Tony Toneatto, PhD^{1,2}, Linda Nguyen, BSc³

Objective: To review the impact of mindfulness-based stress reduction (MBSR) on symptoms of anxiety and depression in a range of clinical populations.

Method: Our review included any study that was published in a peer-reviewed journal, used a control group, and reported outcomes related to changes in depression and anxiety. We extracted the following key variables from each of the 15 studies identified: anxiety or depression outcomes after the MBSR program, measurement of compliance with MBSR instructions, type of control group included, type of clinical population studied, and length of follow-up. We also summarized modifications to the MBSR program.

Results: Measures of depression and anxiety were included as outcome variables for a broad range of medical and emotional disorders. Evidence for a beneficial effect of MBSR on depression and anxiety was equivocal. When active control groups were used, MBSR did not show an effect on depression and anxiety. Adherence to the MBSR program was infrequently assessed. Where it was assessed, the relation between practising mindfulness and changes in depression and anxiety was equivocal.

Conclusions: MBSR does not have a reliable effect on depression and anxiety.

(Can J Psychiatry 2007;52:260–266)

Information on funding and support and author affiliations appears at the end of the article.

Clinical Implications

- MBSR is increasingly being used to improve medical and emotional symptoms in a wide range of clinical populations.
- Depression and anxiety are almost always measured in such research and may be the mechanism by which improvement in quality of life and improved functioning occur.
- Evaluating the effect of MBSR on depression and anxiety is important to evaluate the effectiveness of this emerging modality.

Limitations

- Methodological variability in the studies reviewed precludes strong conclusions.
- The paucity of randomized clinical trials with active control groups limits the support for the unique efficacy of MBSR when changes in depression and anxiety symptoms are found.
- Depression and anxiety do not reliably improve after patient participation in MBSR.

Key Words: *mindfulness-based stress reduction, depression, anxiety, review, therapy*

Mood and anxiety disorders are among the most common psychiatric disorders in Canada and are frequently comorbid with other mental and medical disorders.^{1,2} Despite the growing availability of effective pharmacotherapies and psychotherapies specific to anxiety and depressive disorders,^{3,4} innovative conceptual and therapeutic models of care continue to emerge that may be relevant to the amelioration of anxiety and depression in a broad range of medical and emotional disorders. MBSR, in particular, has emerged as one of the better-known clinical applications of mindfulness meditation,^{5,6} that has been shown to significantly benefit individuals with a diverse set of medical and psychiatric conditions, including chronic pain,⁵ cancer,⁷ anxiety disorders,⁸ depression,⁹ eating disorders,¹⁰ and fibromyalgia.¹¹ (Kabat-Zinn defines mindfulness as the “awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment.”^{12, p 145}) The reduction of depression and anxiety symptoms after MBSR may be a primary pathway by which an individual experiences enhanced mental and physical health (for example, through less pain, reduced disability, or greater hope and confidence) and thus may be an important indicator of the efficacy of MBSR, given the often chronic and recurrent nature of many of the medical conditions (such as cancer) with which MBSR participants present.

Persistent symptoms of depression and anxiety possibly reflect deficiencies in coping that MBSR may be able to improve. Segal and colleagues⁹ have defined the core mindfulness skill as the capacity to respond to aversive cognitions, sensations, and emotions with an attitude of nonjudgmental, accepting, present-moment awareness. The ability to recognize and disengage from dysfunctional thinking patterns (that is, process focus) associated with chronic medical and emotional disorders is a defining feature of mindfulness that is in contrast to approaches that attempt to change specific beliefs (content focus), common within traditional psychotherapies. Salmon and associates have summarized mindfulness practices as the

- (a) conscious allocation of attention in the service of
- (b) non-judgmental awareness; ideally cultivated (but not necessarily limited to) a state of (c) physiological hypo-arousal; with the intention of (d) enhancing

Abbreviations used in this article

BDI	Beck Depression Inventory
DAS	Dysfunctional Attitudes Scale
MBSR	mindfulness-based stress reduction
POMS	Profile of Mood States
SCL-90	Symptom Check List-90
STAI	State-Trait Anxiety Inventory

present-moment awareness and (e) diminishing habitual patterns of cognitive, behavioral and physiological reactivity.^{13, p 436}

Thus regular mindfulness practice may produce improvements in mood and anxiety symptoms by reducing the tendency to react to negative mental and physical states with ruminative thought or maladaptive behaviour (for example, phobic behaviour or impulsivity). Individuals suffering from anxiety disorders may misconstrue experiences that others may judge as normative in such a way as to elicit intense feelings of panic and fear. Individuals suffering from depression may hold their negative self-perceptions with excessive conviction. Sustained mindfulness practice, through its repeated return of conscious awareness to the breath or the immediate present, interrupts the anxiogenic or depressogenic thought patterns that would otherwise increase the probability of maladaptive behaviours (such as phobic behaviour, social withdrawal, substance abuse, and suicidality).^{14,15} Salmon et al¹³ argued that mindfulness meditation may lead to the detection of early signs of stress, ruminative thought, and physiological arousal and thereby afford the individual an opportunity to respond with more effective coping responses.

The goal of this article is to review the empirical evidence for the effectiveness of mindfulness meditation on symptoms of mood and anxiety in a wide range of clinical populations.

Method

Through a literature search conducted on MEDLINE, we identified controlled studies that administered MBSR to a clinical (that is, medical or psychiatric) population, including those adopting a waiting list or no-treatment control group and published in peer-reviewed journals. Although most studies randomized participants, we also included studies that adopted a quasi-experimental or convenience comparison sample. We reviewed each study for basic descriptive variables (sample size, clinical population, and age), measures of depression or anxiety, depression or anxiety outcomes, adherence to MBSR practice recommendations, follow-up, and modifications to the standard MBSR program.

Results

We identified 15 studies,^{7,11,16-29} which are summarized in Table 1. Diversity in the subject samples and methodologies (for example, sample size, control group, follow-up, randomization, and assessment methods) was evident. Only 4 studies^{19,26,27,29} explicitly treated individuals with mood disorders, while the remainder included populations with medical conditions (such as pain, cancer, and heart disease) or nonclinical populations (such as community samples and undergraduates). Program adherence and follow-up data were relatively

Table 1 Summary of studies included in the review

Study	Sample	Groups compared	Mean age	Randomization to condition	Adherence to MBSR	Measures	Follow-up	Results
Goldenberg ¹¹	Fibromyalgia	WL, n = 42 SRCBT, n = 87	47 46	no	no	SCL-90R	no	74% of SRCBT improved, compared with 36% of WL on SCL-90R
Astin ¹⁶	Undergraduate	WL, n = 14 SRP, n = 14	—	yes	yes	SCL-90R	6 to 9 months for 5/12 SRP subjects	Significant group effect for SRP only on SCL-90R GSI and on anxiety and depression subscales at postintervention but not at follow-up
Shapiro ¹⁷	Medical and premedical students	WL, n = 41 SRP, n = 37	—	yes	yes	SCL-90, STAI	no	Significant group effect on SCL-90 GSI and depression subscale but not STAI for SRP only
Kabat-Zinn ¹⁸	Psoriasis	TAU, n = 18 TAU + MBSR, n = 19	43	yes	no	SCL-90-R, STAI	no	No significant group differences on either measure
Teasdale ¹⁹	Recurrent major depressive disorder	TAU, n = 69 MBCT, n = 76	46 41	yes	no	HDRS, BAI	60 weeks post baseline	Those with ≥ 3 previous depressive episodes showed significant MBCT effect; at follow-up, 40% of MBCT with major depression, compared with 66% of TAU
Williams ²⁰	Stressed community sample	Control, n = 44 MBSR, n = 59	43	yes	yes	HSCl	3 months	No significant group improvement at postintervention for either group; significant improvement ($P < 0.06$) at 3-months postintervention
Marcus ²¹	Drug users in therapeutic community	Control, n = 18 MBSR, n = 18	36 32	no	no	SCL-90	no	No significant decrease in anxiety and depression for MBSR only
Carlson ²² ; Speca ⁷	Cancer outpatients	WL, n = 48 MBSR, n = 61	49 55	yes	yes	POMS	6 months	Significant decrease in anxiety and depression subscales for MBSR only; significant reductions in intent-to-treat analysis only with change, not raw, scores
McMillan ²³	Attentional problems after closed head brain injury	ACT, n = 44 PhysEx, n = 38 Control, n = 48	35 31 36	yes	no	HADS-A HADS-D	12 months	No significant group differences
Davidson ²⁴	Health employees	WL, n = 16 MBSR, n = 25	36	yes	yes	PANAS, STAI	no	Significant group × time interaction on STAI Trait only
Taconi ²⁵	Women with heart disease	WL, n = 9 MBSR, n = 9	61	yes	no	STAI	no	Significant effect for MBSR on STAI State for MBSR only

Table 1 continued

Study	Sample	Groups compared	Mean age	Randomization to condition	Adherence to MBSR	Measures	Follow-up	Results
Ma ²⁶	Recurrent major depressive disorder	TAU, n = 38 MBCT, n = 37	46 43	yes	no	BDI, HDRS	12 months	Those with ≥ 3 previous depressive episodes showed significant MBCT effect; at follow-up, 36% of MBCT with major depression, compared with 78% of TAU
Ramel ²⁷	Veterans with mood and anxiety disorders	WL, n = 11 MBSR, n = 23	51	no	yes	BDI, STAI, DAS, RSQ	no	No significant group × time interaction on BDI, STAI Trait, DAS but significant effect on Ruminations (RSQ) in matched sample; significant within-subject effect on BDI, STAI trait and DAS for MBSR only
Sagula ²⁸	Chronic pain	WL, n = 22 MBSR, n = 49	—	no	no	STAI, BDI	no	Significant group effects on BDI and STAI State anxiety for MBSR only
Weiss ²⁹	Outpatient therapy patients	Therapy, n = 16 Therapy + MBSR, n = 15	45 41	no	no	SCL-90	no	No significant group effect on SCL-90 GSI

HDRS = Hamilton Depression Rating Scale; HSCL = Hopkins Symptom Check List; PANAS = Positive and Negative Affect Scale; RSQ = Response Style Questionnaire; HADS-A = Hospital Anxiety and Depression Scale-Anxiety; HADS-D = Hospital Anxiety and Depression Scale-Depression; WL = waiting list; ACT = attentional control training; TAU = treatment as usual; PhysEx = physical exercise; MBCT = mindfulness-based cognitive therapy; SRCBT = stress reduction cognitive-behavioral therapy; SRP = stress reduction and relaxation program; GSI = Global Severity Index; — = no data

infrequent. The most frequent measures of depression and anxiety were the SCL-90, the STAI, and the BDI.

Table 2 summarizes the key findings contained in Table 1. About one-half (8/15) of the studies reported a statistically significant reduction in anxiety or depression after MBSR. Unfortunately, none of these studies included an active control group. In other words, the positive findings were only found when waiting list or treatment-as-usual groups were used as control subjects. In the 2 studies that explicitly evaluated mindfulness-based cognitive therapy,^{19,26} which is an adaptation of MBSR for the prevention of depressive relapse, a role for mindfulness was found as a relapse-preventive approach. In the 2 studies that did use an active control group (subjects undergoing light treatment for psoriasis or psychotherapy outpatients),^{18,29} the MBSR intervention did not show a significant group or interaction effect on symptoms of depression and anxiety. With 8 of the 15 studies adopting a waiting list control group, it is not possible to attribute the reduction of symptoms of depression and anxiety to MBSR per se, since a comparable intervention or nonspecific factors also might have produced the observed benefits. The durability of the outcomes is also difficult to evaluate because only 6 studies reported follow-up data.

Six studies reported data measuring the practice of mindfulness by program attendees (Table 2). Three of these studies investigated the relation between mindfulness practice and reduction in anxiety and depression symptoms. Specia and colleagues⁷ found that the number of minutes meditated daily explained 15.5% of the variance in mood improvement as measured by the POMS. Astin,¹⁶ however, found the amount of time practising mindfulness skills did not correlate with the change in SCL-90-R scores. Mixed results were reported by Ramel and associates,²⁷ who found that the amount of time meditating did not predict follow-up anxiety and depression symptoms or DAS scores after controlling for baseline values; however, the amount of time meditating did significantly predict rumination. Little is known about how much subjects actually practised the core mindfulness skills that were taught.

Table 3 describes the modifications to the standard MBSR program (such as regulating the breath, relaxation, body scan, yoga, and meditation) made to reflect the unique needs of the population

Table 2 Summary of key study variables

Study	Positive change on depression or anxiety	Compliance with mindfulness measured	Active control group used	Random assignment	Follow-up
Goldenberg ¹¹	√				
Astin ¹⁶		√		√	√
Shapiro ¹⁷	√	√		√	
Kabat-Zinn ¹⁸			√	√	
Teasdale ¹⁹	√			√	√
Williams ²⁰		√		√	√
Marcus ²¹					
Carlson ²² ; Speca ⁷	√	√		√	√
McMillan ²³				√	√
Davidson ²⁴	√	√		√	
Tacon ²⁵	√			√	
Ma ²⁶	√			√	√
Ramel ²⁷		√			
Sagula ²⁸	√				
Weiss ²⁹			√		

studied. The most common difference was the exclusion of the day-long retreat advocated by Kabat-Zinn.⁵ This modification would reduce by up to 8 hours any additional training and practice in mindfulness. Other changes included variability in the recommended length of time for daily meditation (ranging from 20 to 60 minutes) and the inclusion of additional components and exercises that were unique to a specific study (such as loving-kindness, stress management, exercises, and readings). It is difficult to evaluate the impact of these program changes on the changes in anxiety and depression because the results of studies that most closely adhered to the MBSR model did not differ from those of the modified interventions.

Conclusion

On the basis of this overview's results, MBSR appears to have equivocal effects on symptoms of anxiety and depression. The benefits of MBSR were most evident when there was no active control group, suggesting that the symptomatic improvements might have been due to nonspecific variables rather than the effect of mindfulness intervention per se. Better controlled studies found no evidence for the efficacy of MBSR. Since the empirical evaluation of MBSR is relatively new, the adoption of waiting list control subjects may be justified in the effort to establish the effectiveness of MBSR. As this area of research matures, increased emphasis on research designs with active control groups will be necessary to assess the unique efficacy of this intervention. Symptoms of

depression and anxiety may not ameliorate when they are not the explicit focus of an MBSR intervention (that is, when subjects with medical conditions are included). However, the risk for relapse after successfully treated depression does appear to be reduced by exposure to an MBSR-influenced intervention, suggesting that the benefits of this approach for alleviating anxiety and depression may be most evident when it is used as an adjunctive treatment rather than as the primary intervention. In a recent metaanalysis of mindfulness-based interventions⁶ demonstrating a medium effect size (clustering around a coefficient of 0.50), only 1 of the 10 controlled studies included in that review was actually published,⁷ in contrast to our study.

An issue that has yet to be adequately addressed is the extent and quality of the mindfulness practice during the intervention period. In this review, the few studies that actually did measure mindfulness practices and correlate them with outcomes did not find support for the amount of mindfulness practice, calling into question the role of mindfulness practice as the mechanism for the symptomatic improvements. To evaluate the unique efficacy of this intervention, researchers will need to ensure that their research design is able to validly measure the practice of mindfulness during and between treatment sessions.

Funding and Support

This study received no funding and no support.

Table 3 Modifications to the MBSR program

Study	Duration	Day-long retreat	Core MBSR Components			Modifications to the MBSR Program
			Breath	Sitting meditation, mindfulness	Yoga, body scan	
Goldenberg ¹¹	10 sessions, 2 hours weekly	no	√	√	√	Readings assigned; advised to meditate 20 minutes daily; audio tapes provided
Astin ¹⁶	8 weeks, 2 hours weekly	no	√	√	√	Asked to meditate 5 times weekly
Shapiro ¹⁷	7 weeks, 2.5 hours weekly	no	√	√	√	Loving-kindness and forgiveness meditation; exercises to develop empathy and listening skills; information on physiology and psychology of stress
Kabat-Zinn ¹⁸	40 sessions over 13 weeks	no	√	√		Delivered by audiotope; visualize ultraviolet light and (or) medication slowing down skin cell division; discouraged from meditating at home; tapes not taken home
Marcus ²¹	8 weeks, 2.5 hours weekly	no		√	√	Yoga emphasized; breathing and sitting meditation deemphasized; practice 45 to 60 minutes of meditation daily; information on stress;
Williams ²⁰	8 sessions, 2.5 hours weekly	yes, 8 hours	√	√	√	Reading, assessment and planning materials (e.g. Stress Map Inventory, Action Planning Workbook; Full Catastrophe Living); encouraged to meditate 60 minutes daily
Carlson ²² ; Speca ⁷	7 weeks, 90 minutes	no	√	√	√	Audiotope with relaxation induction and guided meditation
Teasdale ¹⁹	8 sessions, 2 hours weekly	no	√	√		Follow-up meetings at 1, 2, 3, and 4 months post-MBCT
McMillan ²³	5 sessions, each 45 minutes, over 4 weeks	no	√		√	Audiotope provided; breathing exercises to improve concentration and relaxation
Davidson ²⁴	8 weeks, 2.5 hours weekly	yes, 7 hours	√	√	√	Meditate daily for 60 minutes, 6 days weekly
Tacon ²⁵	8 weeks, 2 hours weekly	no	√	√	√	Provided with audiotapes;
Ramel ²⁷	8 weeks, 2 hours weekly	yes, one-half day	√	√	√	30 minutes of meditation daily without audiotape or 45 minutes daily meditation with audiotape
Sagula ²⁸	8 sessions, each 90 minutes'	no	√	√	√	Instructed to meditate 20 minutes daily
Ma ²⁶	8 weeks, 2 hours weekly	no	√	√		Follow-up meetings at 1 and 6 months post-MBCT
Weiss ²⁹	8 sessions, each 60 minutes, over 12 weeks	no	√	√	√	Sessions 2 to 7 combined therapy and MBSR; practice meditation 30 minutes daily, 6 days weekly; audiotapes

References

- Patten SB, Wang JL, Williams JVA, et al. Descriptive epidemiology of major depression in Canada. *Can J Psychiatry*. 2006;51(2):84–90.
- Somers JM, Goldner EM, Waraich P, et al. Prevalence and incidence studies of anxiety disorders: a systematic review of the literature. *Can J Psychiatry*. 2006;51(2):100–113.
- Gotlib I, Hammen CL, editors. *Handbook of depression*. New York: Guilford Press; 2002.
- Stein DJ, Hollander E, editors. *Textbook of anxiety disorders*. Washington: American Psychiatric Publishing; 2002.
- Kabat-Zinn J. *Full catastrophe living: using the wisdom of your body and mind to face stress, pain, and illness*. New York: Delacorte; 1990.
- Grossman P, Niemann L, Schmidt S, Walach H. Mindfulness-based stress reduction and health benefits: a meta-analysis. *J Psychosom Res*. 2004;57(1):35–43.
- Specia M, Carlson LE, Goodey E, et al. A randomized, wait-list controlled clinical trial: the effect of a mindfulness meditation-based stress reduction program on mood and symptoms of stress in cancer outpatients. *Psychosom Med*. 2000;62(5):613–622.
- Kabat-Zinn J, Massion AO, Kristeller J, et al. Effectiveness of a meditation-based stress reduction program in the treatment of anxiety disorders. *Am J Psychiatry*. 1992;149(7):936–943.
- Segal Z, Williams JMG, Teasdale, JD. *Mindfulness-based cognitive therapy for depression*. New York: Guilford Press; 2002.
- Kristeller JL, Hallett CB. An exploratory study of a meditation-based intervention for binge eating disorder. *J Health Psychol*. 1999;4(3):357–363.
- Goldenberg DL, Kaplan KH, Nadeau MG, et al. A controlled study of a stress-reduction, cognitive-behavioral treatment program in fibromyalgia. *J Musculoskeletal Pain*. 1994;2(2):53–66.
- Kabat-Zinn J. Mindfulness-based interventions in context: past, present and future. *Clin Psychol Sci Pract*. 2003;10(2):144–156.
- Salmon P, Sephton S, Weissbecker I, et al. Mindfulness meditation in clinical practice. *Cogn Behav Pract*. 2004;11(4):434–446.
- Breslin FC, Zack M, McMain S. An information-processing analysis of mindfulness: implications for relapse prevention in the treatment of substance abuse. *Clin Psychol Sci Pract*. 2002;9(3):275–299.
- Toneatto T. Metacognitive therapy for anxiety disorders: Buddhist psychology applied. *Cogn Behav Pract*. 2002;9(1):72–78.
- Astin JA. Stress reduction through mindfulness meditation. *Psychother Psychosom*. 1997;66:97–106.
- Shapiro S, Schwartz GE, Bonner G. Effects of mindfulness-based stress reduction on medical and premedical students. *J Behav Med*. 1998;21(6):581–599.
- Kabat-Zinn J, Wheeler E, Light T, et al. Influence of a mindfulness meditation-based stress reduction intervention on rates of skin clearing in patients with moderate to severe psoriasis undergoing phototherapy (UVB) and photochemotherapy (PUVA). *Psychosom Med*. 1998;60(5):625–632.
- Teasdale JD, Segal ZV, Williams JMG, et al. Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *J Consult Clin Psychol*. 2000;68(4):615–623.
- Williams KA, Kolar MM, Reger BE, et al. Evaluation of a wellness-based mindfulness stress reduction intervention: a controlled trial. *Am J Health Promot*. 2001;15(6):422–432.
- Marcus MT, Fine M, Kouzekanani K. Mindfulness-based meditation in a therapeutic community. *J Subst Use*. 2001;5(Suppl):305–311.
- Carlson LE, Ursuliak Z, Goodey E, et al. The effects of a mindfulness meditation-based stress reduction program on mood and symptoms of stress in cancer outpatients: 6-month follow-up. *Support Care Cancer*. 2001;9(2):112–123.
- McMillan T, Robertson IH, Brock D, et al. Brief mindfulness training for attentional problems after traumatic brain injury: a randomized control treatment trial. *Neuropsychol Rehab*. 2002;12(2):117–125.
- Davidson RJ, Kabat-Zinn J, Schumacher J, et al. Alterations in brain and immune function produced by mindfulness meditation. *Psychosom Med*. 2003;65(4):564–570.
- Tacon AM, McComb J, Caldera Y, et al. Mindfulness meditation, anxiety reduction and heart disease: a pilot study. *Fam Comm Health*. 2003;26(1):25–33.
- Ma SH, Teasdale JD. Mindfulness-based cognitive therapy for depression: replication and exploration of differential relapse prevention effects. *J Consult Clin Psychol*. 2004;72(1):31–40.
- Ramel W, Goldin PR, Carmona PE, et al. The effects of mindfulness meditation on cognitive processes and affect in patients with past depression. *Cog Ther Res*. 2004;28(4):433–455.
- Sagula D, Rice KG. The effectiveness of mindfulness training on the grieving process and emotional well-being of chronic pain patients. *J Clin Psychol Med Settings*. 2004;11(4):333–342.
- Weiss M, Nordlie JW, Siegel EP. Mindfulness-based stress reduction as an adjunct to outpatient psychotherapy. *Psychother Psychosom*. 2005;74(2):108–112.

Manuscript received August 2006, revised, and accepted October 2006.

¹Senior Scientist, Centre for Addiction and Mental Health, Toronto, Ontario.

²Associate Professor, Departments of Psychiatry and Public Health Sciences, University of Toronto, Toronto, Ontario.

³Student, Faculty of Nursing, University of Toronto, Toronto, Ontario.

Address for correspondence: Dr T Toneatto, Clinical Research Department, Centre for Addiction and Mental Health, 33 Russell St., Toronto, ON M5S 2S1; tony_toneatto@camh.net

Résumé : La méditation de pleine conscience améliore-t-elle les symptômes d'anxiété et de l'humeur? Une étude de la recherche contrôlée

Objectif : Étudier l'effet de la réduction du stress par la pleine conscience (RSPC) sur les symptômes d'anxiété et de dépression dans un éventail de populations cliniques.

Méthode : Notre revue comprenait toute étude qui a été publiée dans une revue révisée par les pairs, qui utilisait un groupe témoin, et qui présentait des résultats relatifs aux changements dans la dépression et l'anxiété. Nous avons extrait les variables clés suivantes de chacune des 15 études repérées : les résultats de l'anxiété ou de la dépression après le programme de RSPC, la mesure de l'observance des instructions de RSPC, le type de groupe témoin inclus, le type de population clinique étudiée, et la durée du suivi. Nous avons également résumé les modifications apportées au programme de RSPC.

Résultats : Les mesures de la dépression et de l'anxiété étaient comprises comme variables de résultats pour un vaste éventail d'affections médicales et de troubles émotionnels. Les preuves d'un effet bénéfique de la RSPC sur la dépression et l'anxiété étaient équivoques. Quand des groupes témoins actifs étaient utilisés, la RSPC ne montrait pas d'effet sur la dépression et l'anxiété. L'observance du programme de RSPC n'était pas souvent évaluée. Quand elle l'était, la relation entre la pratique de la pleine conscience et les changements dans la dépression et l'anxiété était équivoque.

Conclusions : La RSPC n'a pas d'effet fiable sur la dépression et l'anxiété.