

**Mindfulness-Based Cognitive Therapy: The experience of practice over time**

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## **UCL Doctorate in Clinical Psychology**

### **Thesis declaration form**

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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## Overview

Mindfulness-Based Cognitive Therapy (MBCT) was developed as a relapse prevention intervention for recurring depression, but has shown promise for other psychological difficulties too. This thesis focuses on the experiences of individuals with depression and anxiety difficulties in using mindfulness practice after an MBCT group intervention.

**Part one** is a meta-synthesis of 12 qualitative studies that explored how MBCT is experienced by service users. Three over-arching themes were identified, pointing to perceived therapeutic benefits of MBCT (e.g., increased awareness, positive changes in relationships) and difficulties with mindfulness practice.

**Part two** reports on a qualitative, longitudinal study of the experience of post-MBCT mindfulness practice. Ten service users were interviewed at three, six and nine months after completing MBCT; transcripts were analysed thematically. Four patterns of practice were identified, as well as several challenges to implementing and sustaining practice. Most participants struggled to maintain independent practice and emphasised the need for continued group support. How clinicians can help users to maintain practice needs further attention.

**Part three** addresses some issues related to carrying out the research in Part 2. It considers the advantages and disadvantages of using a longitudinal design in qualitative research, and reflects on issues that arise when one is personally involved in what is being researched.

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## **Part 1: Literature Review**

**Service users' experiences of Mindfulness-Based Cognitive Therapy:**

**A meta-synthesis of qualitative studies**

## **Abstract**

**Aims:** Mindfulness-Based Cognitive Therapy (MBCT) has been demonstrated as an effective intervention for individuals suffering recurring depression; a small body of evidence suggests it can also be useful for other mental health problems. However, relatively little is known about how and why it is effective, and how individuals experience it. This review aimed to synthesise the findings of qualitative studies that explored how MBCT is experienced by service users with a range of mental health problems, specifically their views of perceived therapeutic processes the impact of MBCT, and the experience of implementing what they had learnt.

**Method:** A systematic search of two databases (PsycInfo and Pubmed) was carried out. Studies were included if they examined the subjective accounts of individuals with any mental health problem who had undertaken MBCT. The methodological quality of studies was appraised using the CQRMG as a set of flexible guidelines. Findings across studies were synthesized using a thematic analysis approach.

**Results:** Twelve studies were reviewed. Three overarching themes were identified: (i) 'Positive effects on awareness and coping with difficulties', (ii) 'Positive changes in relationships and interactions', and (iii) 'Struggle'. Overall, studies reported that participants with a range of depression and anxiety disorders experienced therapeutic benefits, including improved self-regulation and interpersonal relationships; some also reported barriers to implementing and sustaining practice.

**Conclusions:** MBCT may be useful for a range of mental health problems, not limited to recurring depression. Future research should examine possible changes in the domains of self-regulation, interpersonal relationships, and relationship to oneself. How MBCT is used over time, particularly with regards to sustained practice, needs further investigation.

## **Introduction**

Recent years have seen a rise of ‘third wave approaches’ within Cognitive Behavioural Therapy (CBT), which champion teaching clients to relate differently to their mental health difficulties through a combination of cognitive behavioural principles with acceptance and mindfulness (Hofmann & Asmundson, 2007). One such intervention is Mindfulness-Based Cognitive Therapy (MBCT), developed by Segal, Williams and Teasdale (2002) to tackle relapsing depression. MBCT is a fusion of the Mindfulness-Based Stress Reduction program (MBSR), developed initially for stress and physical health conditions (Kabat-Zinn, 1990) and CBT (Beck, 1976).

MBCT combines mindfulness meditation and mindfulness exercises with principles of cognitive behavioural therapy, and is currently delivered in the NHS as a standardized eight-week group course for individuals suffering recurring depression. The theoretical premise of MBCT is that repeated episodes of depression render individuals vulnerable to relapse at times of lowered mood due to association networks between low mood and depressive cognitions (Segal, Williams, Teasdale & Gemar, 1996); these lead to a ‘closed circuit’ of depressive thinking that maintains negative affect (Teasdale, 1999a). MBCT uses attention training to cultivate awareness of these mechanisms to make it possible for individuals to ‘step out of’ such cognitive interlocks and respond helpfully to difficulties through, for example, shifting attention to neutral stimuli, re-formulating one’s understanding of the relevance of thoughts, taking an accepting stance, or engaging in self-care. Teasdale, Segal and Williams (1995, p. 33) describe the aware and mindful state as “to be fully in the present moment, without judging or evaluating it...without attempting to avoid any unpleasant aspect of the present situation.” With an increased awareness



of bodily sensations, feelings and thoughts associated with depressive relapse, patients can learn to relate constructively to these events. MBCT practices and tools include meditations, yoga, and breathing exercises, and daily mindfulness and cognitive behavioural homework tasks. Participants are recommended to maintain these exercises upon completion of the course; the premise is that continuity of practice builds and sustains momentum and motivation to continue relating mindfully to their experience, meaning they may be able to notice and reverse a depressive episode before it escalates (Segal et al., 2002).

The empirical evidence base suggests that MBCT is a potent intervention that may enable individuals who suffer recurrent depression to break the relapsing pattern (Baer, 2003), and it is recommended in national guidelines (NICE, 2010) as relapse prevention for recurring depression. There have been four recent systematic reviews primarily focused on the intervention's effectiveness for recurrent depression (Chiesa & Serretti, 2011; Fjorback, Arendt, Ørnbøl, Fink & Walach, 2011; Galante, Iribarren & Pearce, 2013; Piet & Hougaard, 2011). The findings of the reviews indicate that MBCT significantly reduces relapse rates (reduction rates reported ranged from 34%-43%) in individuals who have experienced three or more episodes of depression, with less clear outcome data for those having experienced fewer than three episodes. This relapse reduction effect was found equal or superior to that of antidepressant medication in all reviews, and was highlighted as superior to treatment as usual in two reviews (Chiesa & Serretti, 2011; Fjorback et al., 2011).

A relatively small number of studies have also presented evidence for the usefulness of MBCT for mental health difficulties other than recurrent depression, primarily anxiety and current depression. For example, MBCT has been shown to alleviate chronic anxiety in patients suffering generalized anxiety disorder and panic

disorder (Evans et al., 2008; Kim et al., 2009), produce significant reductions in scores of active depression (Van Aalderen, Donders, Giommi, Spinhoven, Barendregt, & Speckens, 2012) and active depression with or without co-morbid anxiety (Finucane & Mercer, 2006). MBCT has also been shown to reduce inter-episodic depression and anxiety rates in individuals with bipolar disorder (Williams et al., 2008b) and to be useful for patients suffering insomnia (Heidenreich, Tuin, Pflug, Michal & Michalak, 2006). The theoretical rationale for applying MBCT to anxiety disorders in particular has been suggested as strong (Sipe & Eisendrath, 2012). Namely, worrying is future-related and involves cognitive and behavioural strategies to avoid undesired/feared outcomes. Fostering present-moment awareness may provide a different focus and approach to one's thinking processes and anxiety.

Such promising outcomes have led to a rapidly rising interest in the clinical and research community in terms of "how, why and for whom" (Coelho, Canter & Ernst, 2007, p. 1005) MBCT can be of therapeutic value. Because MBCT is delivered in groups, the potential cost savings for the health care system are also of interest (Kuyken et al., 2008), particularly if it can be offered for a wider range of mental health disorders than previously believed. Bridging the gaps in the literature regarding the potential of the intervention is therefore of importance also for economic reasons.

Whereas quantitative research has provided a growing evidence base for MBCT's effectiveness for particular disorders, what is lacking is an in-depth understanding of precisely how and why it is effective, the mechanisms involved in any change processes, and, of particular importance, what facilitates and hinders sustained practice. Such exploratory and descriptive research aims can be particularly well addressed by qualitative research methods (Barker, Pistrang &

Elliott, 2002) as they allow an “insider’s perspective” (Conrad, 1987) and can thereby capture the complexity and nuance of the subjective experiences that individuals have in a manner that is outside of the scope of most quantitative studies. In recent years there has been a strong emphasis on involving service users in research and evaluation into health care in order to improve health care outcomes and ensure that interventions are experienced as useful, accessible and relevant to patients’ needs (NHS Institute for Innovation and Improvement, 2008). Given that the MBCT intervention is relatively new, obtaining service users’ perspectives is vital in understanding how it can be further developed and improved to meet the needs of those it is offered to.

To date, there has been only one published review of qualitative studies of MBCT (Malpass et al., 2011), which synthesized findings from studies of both MBCT and MBSR (and slightly modified versions). Malpass et al. (2011) aimed to explore how patients experienced the therapeutic processes involved in MBCT and MBSR, and whether these processes were common across different conditions and populations as well as across the two interventions. The authors used the method of meta-ethnography, which is an interpretative approach aiming to translate studies into one another and transfer ideas and meaning across studies in order to generate new theory (Britten et al., 2002). Malpass et al. (2011) presented a synthesis which detailed higher-order constructs related to perceived therapeutic processes (e.g. “coming to terms” and “present-focus”) as located in three temporal phases (“perceived safe uncertainty”, “safe uncertainty” and “grounded flexibility”) during participants’ engagement with the intervention. In combination with group processes, the perceived therapeutic processes were described as enabling a shift from maladaptive coping to a new experience of the self/illness. This shift was found

across different conditions and populations, and were found to apply equally to MBCT and MBSR.

The current review differs from that of Malpass et al. (2011) in several ways. Firstly, it focuses solely on MBCT. Although sharing a theoretical foundation and some clinical components, MBSR and MBCT are two distinct interventions that in theory and practice are offered to slightly different populations, and it therefore makes sense to examine them separately. Secondly, the current review focuses on studies where the target difficulty was a mental health problem (with or without physical co-morbidity), whereas the review by Malpass et al. (2011) included a broader range of conditions including physical health problems. Thirdly, the current review aimed to synthesise accounts not only of any perceived therapeutic processes and the impact of MBCT, but also participants' experiences of implementing (or not) the MBCT tools/skills outside of group sessions and after the intervention. Given that sustained practice is considered a cornerstone of the benefits of MBCT (Segal et al., 2002), this aspect of patients' experiences deserves attention. Finally, the current review aimed to take an aggregating, descriptive approach to the synthesis in order to stay closer to the data, to enable "patients narratives to speak for themselves" (Finucane & Mercer, 2006, p.4).

In summary, the current review aimed to synthesise the findings of qualitative studies that have explored how MBCT is experienced by service users with a range of mental health problems. Specifically, it aimed to aggregate service users' perspectives on the perceived therapeutic processes and impact of MBCT, as well as the experience of implementing what they had learnt.

## **Method**

The search strategy aimed to identify qualitative studies that provided information about the experiences of individuals with mental health problems, who had completed an MBCT course. The process of study selection is described below, followed by details of the method used to appraise the methodological quality of the studies and then procedures for conducting the meta-synthesis.

### **Inclusion Criteria**

To be included in the review, studies had to meet three sets of criteria, pertaining to the nature of the intervention, the participants and the study design.

1. *Nature of intervention:* A Mindfulness-Based Cognitive Therapy (MBCT) course for any type of mental health problem or psychological distress delivered as per the standardised manual by Segal et al. (2002), or with minor adaptations of it to fit a population (e.g. adaptations to consider both anxiety and depression rather than exclusively depression, or adaptations to physical movement exercises for those with reduced mobility) with no substantial deviations from the structure, time length and delivery of the central concepts and exercises. Studies where MBCT had been offered for purely physical health problems or other non-psychological health difficulties were excluded. Studies of Mindfulness-Based Stress Reduction (MBSR) were also excluded, as were any studies of other variations of Mindfulness interventions.

2. *Participants:* Adults whose primary complaint was a self-reported or formally diagnosed mental health problem. There was no restriction on the type of mental health problem, or for co-morbidity with mental and physical health

problems, as long as the mental health problem was the primary problem being addressed. Studies that focused exclusively on physical health complaints were excluded; studies focusing primarily on mental health where there was also a physical health condition were included.

3. *Study design*: Studies using a qualitative methodology e.g. self-report data via interviews from participants and a qualitative analysis of this. If the study used mixed methods design, it needed to have a clear qualitative component in order to be included.

### **Search Strategy**

Studies were identified via electronic database searches, citation searches, examination of reference lists of key papers and a hand search of a key journal. Initially a scoping search was carried out on the PsycInfo database in order to develop and refine an effective search strategy.

For the initial scoping search, a key term search for ‘mindfulness-based cognitive therapy’ (and the un-hyphenated version) was carried out. In order to gauge whether any relevant papers had used a different description of the standardised MBCT intervention, a subsequent search added wider search terms such as ‘mindfulness’ and ‘mindfulness interventions’. This yielded an unwieldy search result in excess of 2000 papers, many of which described versions of mindfulness-based interventions that were not the focus of this review. On closer examination, it was found that all relevant papers had used the full standardised intervention name (‘mindfulness-based cognitive therapy’) in the title and abstract, and that by adding the wider search terms, no further relevant papers were identified.

A search of the abbreviated intervention term ('mbct'), was found to identify no further relevant papers, but added a number of irrelevant papers, where 'mbct' related to e.g. medical procedures. Therefore, it was decided that the final search would only use the search term 'Mindfulness Based Cognitive Therapy' and the hyphenated version 'Mindfulness-Based Cognitive Therapy'. Filters that limited the search to only qualitative papers were applied and were found to exclude relevant papers. Therefore the only filters that were applied to the search were a) peer reviewed journals b) published in the English language. The final search, conducted in July 2014, employed the following keywords:

*mindfulness based cognitive therapy or mindfulness-based cognitive therapy.*

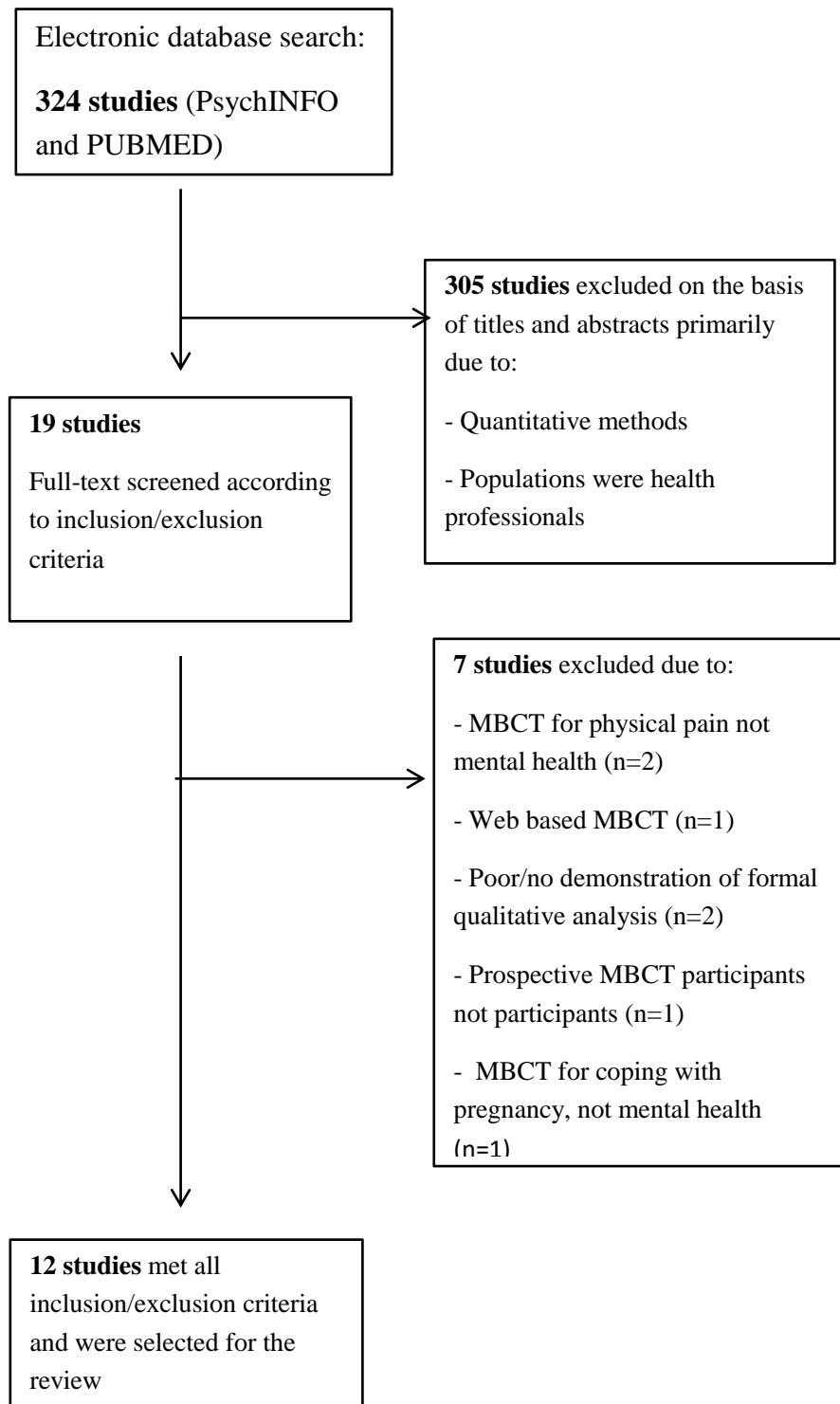
A search of PsycInfo and Pubmed produced 324 results once duplicates were removed. The results were imported into the Endnote software program to monitor the selection process. Following the electronic database search, a citation search of key papers and examination of the reference lists of relevant reviews were carried out, as was a hand search of a key journal in the field ('Mindfulness') neither of which resulted in the identification of any further relevant papers.

### **Study selection**

The process of study selection is illustrated in Figure 1. The first step involved screening papers by reading abstracts and titles, which led to the exclusion of 305 of the 324 papers. The primary reasons for exclusion were that the study employed quantitative methods or that the participants were health professionals. The remaining 19 papers were read in full and evaluated against the inclusion criteria, which eliminated a further seven papers. In total, 12 studies met the

inclusion criteria and were included in this review. Judgements about eligibility were discussed with the author's supervisor when there was uncertainty.





*Figure 1: Process of study selection*

## **Data Extraction**

For each of the studies included in the review, key data were extracted and summarised in a data extraction form. This included author, date, journal, title of study, study design, sample size, participant characteristics, intervention details (i.e. detailing any adaption to the MBCT programme), type of qualitative method and analysis were extracted and summarised in a data extraction form.

## **Rating of Methodological Quality**

The topic of quality appraisal in qualitative research is controversial. Quantitative research usually aims to make predictions, establish causal relationships and generalise the findings to wider situations or groups of people and traditionally uses standardised measures, often under controlled conditions (Barker, Pistrang & Elliott, 2002). Quality appraisal of studies within quantitative research aims to establish the reliability and validity of findings and often employs standardised quality criteria and checklists to do so.

Qualitative research, in contrast, is a naturalistic approach that aims to illuminate and understand social phenomena through interpretation and analysis of participant accounts/observations. It makes no claim of objectivity and does not employ standardised measures or statistical methods (Frost, 2011, p.18). Qualitative research can be carried out from several different paradigms and theoretical schools of thought (e.g. interpretative and critical) meaning that the aims, methods and view of what counts as knowledge and what therefore constitutes study quality, differ vastly within the qualitative field as a whole (Dixon-Woods, Shaw, Agarwal &

Smith, 2004). Some researchers have argued that these differences amongst qualitative methods make it difficult or impossible to formulate standards of study rigour and excellence (Reicher, 2000), and furthermore no consensus remains as to whether any such criteria should be approached as rigid requirements or more flexibly as broad guidelines (Dixon-Woods et al., 2004). Moreover, claims have been made that applying quality criteria threatens researcher creativity and freedom in qualitative research (Parker, 2004). In contrast, others have argued that quality criteria can support and guide good practice as long as the purpose of qualitative research is honoured (Mays & Pope, 2000). For example, Braun and Clarke (2006) provide a checklist of criteria to determine if a thematic analysis is of good quality or not. Edward, Elwyn, Hood, and Rollnick (2000) describes a ‘signal to noise’ approach in appraising the quality of qualitative studies, seeking a balance between considering methodological flaws of the study and the importance and relevance of insights and findings it would add to a meta-synthesis.

In light of the disagreement within the field, the author referred to the Cochrane Qualitative Research Methods Group (CQRMG; Hannes, 2011) for guidance in identifying a suitable method of quality appraisal for this meta-synthesis. The use of an appraisal tool is suggested to aid the appraisal process; however, CQRMG does not prescribe a “gold standard” methodology but instead argues that merit can be found in a range of appraisal approaches. In the current review, studies were evaluated against the four core criteria of qualitative research outlined by the CQRMG: credibility, dependability, confirmability and transferability (see Table 1). Specifically, each study was examined for evidence that some method(s) relevant to each of the core criteria had been used (see second column of Table 1).

Table 1

Core criteria for quality assessment. Taken from *Cochrane Qualitative Research Methods Group Guidance (CQRMG; Hannes, 2011)*

Quality Criterion and definition	Evaluation techniques
Credibility evaluates whether or not the representation of data fits the views of the participants studied, whether the findings hold true.	Member checks, peer debriefing, attention to negative cases, independent analysis of data, verbatim quotes, persistent observation etc.
Transferability evaluates whether research findings are transferable to other specific settings.	Providing details of the study participants , providing contextual background information, demographics, the provision of thick description about both the sending and the receiving context etc.
Dependability evaluates whether the process of research is logical, traceable and clearly documented, particularly on the methods chosen and the decisions made by the researchers.	Peer review, debriefing, audit trails, triangulation, reflexivity and calculation of inter-rater agreements etc
Confirmability evaluates the extent to which findings are qualitatively confirmable through the analysis being grounded in the data and through examination of the audit trail.	Assessing the effects of the researcher during the research process, reflexivity, providing information on the researcher's background, education, perspective, school of thought etc.

## **Procedures for conducting the meta-synthesis**

Approaches for synthesising qualitative findings can be described as falling on a continuum from aggregating/summative approaches that seek to generate themes and categories, (e.g. thematic analysis), to interpretative approaches aiming to generate new theory e.g. meta-ethnography (Noyes & Lewin, 2011). Generally, the review question should guide what approach is chosen (Hannes, 2011). This review sought to aggregate qualitative study findings and the main themes identified in these to answer a specific review question, without generating new theory. The CQRMG (Hannes, 2011) recommends that for this purpose thematic analysis or meta-aggregation are appropriate. Thematic analysis was subsequently chosen as the method of meta-synthesis for the review. Guidelines by Braun and Clarke (2006) detailing a method for conducting thematic analysis, were followed and examples of qualitative meta-synthesis published by the CQRMG were studied (e.g. McInnes & Askie, 2004) for reference.

Whereas in primary research the analysis is carried out on raw data (e.g. interview transcripts), this is not possible in a meta-synthesis, as the primary data are not usually available. This poses challenges as it cannot be known to what extent conclusions of the author and the selected participant quotations accurately and fully represent the raw data (particularly as qualitative researchers do not make a claim of objectivity, but often take an interpretative stance). Every attempt must be made to protect as far as is possible the ‘preservation of meaning’ from the original text (Walsh & Downe, 2004). With this in mind, the current review considered all text found in the results/findings section of the papers as data for the thematic analysis.

Typically this included themes/domains, sub-themes/categories, descriptions of these and participant quotations. The thematic analysis focused on identifying the main ideas and concepts across the presented findings.

### **Steps of thematic analysis**

The thematic analysis was guided by Braun and Clarke's 2006 paper which describes this analytic approach. Firstly, careful repeated reading of the results sections of the included papers were carried out in order for the researcher to familiarise herself with the data, and some initial ideas were recorded. Secondly, line-by-line coding of the data was carried out and a list of codes was recorded for each paper, enabling the researcher to consider and compare patterns across studies. Thirdly, the codes for each paper were organised into meaningful themes and sub-themes. Finally, these themes were compared across studies, and were either grouped together due to their commonalities or differentiated further due to distinctive differences of meaning. The use of a 'thematic map' (Braun & Clarke, 2006) at this step enabled the researcher to develop a visual analytic hierarchy of the overarching themes and sub-themes generated across studies. Refinement of the themes ensured that they accurately illustrated the majority of findings within each paper. Themes were omitted if they were represented in fewer than half of the studies; exceptions were made for two sub-themes that were only generated in four and five of the studies respectively, as these were considered particularly relevant to the review question and for considering future research. The credibility and coherence of the analytic findings were checked by the academic supervisor involved with the research project. All studies were given equal weight in their influence in terms of how their themes and analysis influenced the meta-synthesis, as they had been found to be of acceptable methodological quality.

## **Results**

The results section starts with a summary of the study characteristics of the 12 studies in the review followed by a methodological quality appraisal. The qualitative meta-synthesis is then presented.

### **Characteristics of included studies**

Details regarding the study aims, sample, nature of MBCT intervention, and method of data collection and analysis are summarised in Table 2.

Table 2. Summary of studies

<i>Authors</i>	<i>Aims</i>	<i>Sample and Setting</i>	<i>Nature of MBCT Intervention</i>	<i>Method of data collection and time points</i>	<i>Method of analysis</i>
Allen et al. (2009)	Examine participants' representations of their experiences of MBCT and its value as relapse prevention for depression.	Patients with recurring depression, N=20 (17 females), mean age: 51. Primary care setting.	MBCT	1 semi-structured interview, 12 months post-course completion.	Thematic analysis
Bailie et al. (2011)	Explore how parents with a history of recurrent depression experience their relationships with their children one year after MBCT to elucidate any effects on parenting.	Parents with minimum of 3 episodes of depression, who had undertaken MBCT as part of a clinical trial. N=16 (13 females).	MBCT	1 semi-structured interview, 12 months post-course completion.	Thematic analysis
Bihari & Mullan (2012)	Analyse participant experiences of MBCT and their relationships with others to develop core constructs around interpersonal change processes associated with MBCT.	Adults with a minimum of 3 episodes of depression who had undergone MBCT within the last three years. N=11. No age/gender details. Setting not detailed.	MBCT	Semi-structured interview within 3 years post-course completion.	Grounded Theory



Finucane & Mercer (2006)	Examine the acceptability and effectiveness of MBCT for patients.	Primary care patients with active depression/anxiety and a history of recurring depression. N=13 (10 females), mean age: 43. Primary care service.	MBCT as per the manual but with shortened practice time for longer meditations, to enable patients with active symptoms to participate.	1 semi-structured interview, 3 months post-course completion.	Framework approach
Fitzpatrick et al. (2010)	Explore experiences of participants with Parkinson's Disease who attended an MBCT course.	Individuals with PD with elevated depression/anxiety scores related to the condition. N= 12 (5 females), mean age = 66. NHS older adult service.	MBCT	2 semi-structured interviews, before and after the course, time points not specified.	IPA
Goodman et al. (2013)	(Mixed method study: qualitative component) Analyse feedback about the acceptability and outcomes of an MBCT based intervention in perinatal anxiety.	Pregnant women with self-reported perinatal anxiety confirmed using formal measures, at week 12-27 of gestation. N=24, age >18. Research institution.	MBCT with modifications to focus on pregnancy, labour and parenting related emotional and cognitive difficulties.	Open-ended feedback questionnaire post-course completion, time point not specified.	Qualitative content analysis

Griffiths et al. (2008)	Explore participant experiences of MBCT group adapted for coping with anxiety and stress associated with cardiac rehabilitation.	Cardiac rehabilitation patients with self-reported anxiety, stress or depression regarding condition. N=6 (1 female), age >45. Large urban medical centre.	MBCT as per the manual but with modifications: - tailoring info towards emotions/thoughts typically experienced by cardiac patients - adaptation of physical exercises and positions for meditations.	1 semi-structured interview, 6-12 weeks post-course completion.	IPA
Hertenstein et al. (2012)	Investigate subjective experiences of change and behaviour due to MBCT, perceived helpful/problematic aspects of MBCT and elicit suggestions for adaptations for MBCT for OCD.	Patients diagnosed with OCD according to DSM-IV criteria. N=12 (3 females). Mean age: 41.8. Setting not detailed.	MBCT as per the manual adapted for OCD. Psychoeducation about OCD added to the intervention - Emphasis on utilising exercises when experiencing OCD symptoms.	1 semi-structured interview, time point not detailed except post course completion.	Qualitative content analysis
Langdon et al. (2011)	Develop theory about participants' post-MBCT engagement with mindfulness practice.	Individuals with anxiety/depression or physical health difficulties. N=13 (10 females), age range 31-67. Mental health service or hospital.	One MBCT course for individuals with anxiety/depression, one for individuals with physical illness (minor adaptations for the physical illness course, details not given).	1 semi-structured interview between 3 months and 4.5 years post course completion.	Grounded theory

Mason & Hargreaves (2001)	Explore the therapeutic process involved in MBCT as described by participants themselves.	Patients with minimum of 2 episodes of depression. N= 7 (5 females) Adult mental health service.	MBCT	1 open ended interview, post-course completion (two phases, the first time point not explicitly detailed, the second 12-30 months post completion).	Grounded theory
Smith et al. (2007)	Assess suitability of MBCT for older people, their experience of the intervention, and what modifications may be needed.	Older adults with minimum of 3 episodes of unipolar major depression. N=30, age >65. Setting not detailed.	MBCT with minor modifications to physical movement exercises and meditation positions.	3 semi-structured interviews at assessment, 2 weeks post-course completion, 1 year post-course completion.	Thematic analysis
Williams et al. (2011)	Qualitatively evaluate the perceived effectiveness and acceptability of MBCT for severe health anxiety.	Patients meeting DMS-IV criteria for hypochondriasis. N=9 (7 females), mean age: 49.2. Setting: within Randomized Controlled Trial.	MBCT as per the manual but with modified for health anxiety: - Informed by cognitive model of health anxiety not depression.	1 semi structured interview, 3 months post-course completion.	IPA

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### *Study aims*

All studies aimed to explore qualitatively (two studies used mixed methods so also involved quantitative aspects) participants' accounts of their experiences of an MBCT intervention and the perceived impact of the intervention on mental health difficulties and coping with difficulties. Studies focused primarily within this broad research aim on the acceptability, usefulness and impact of MBCT from participants' perspectives.

Whereas research questions were generally broad, two studies focused specifically on interpersonal changes resulting from MBCT such as parenting (Bailie et al., 2011) and relationship processes (Bihari & Mullan., 2012). Moreover, whereas all studies explored MBCT for mental health difficulties, two studies explored specifically the usefulness of MBCT for mental health difficulties resulting from physical health conditions: cardiovascular conditions (Griffiths et al., 2008) and Parkinson's disease (Fitzpatrick et al., 2010).

### *Sample*

The majority of studies were conducted in the UK. Two were conducted in the USA and one in Germany. Sample size ranged from six to 30 (mean= 14). All studies but one recruited adults of working age (the study by Smith et al., 2007 recruited older adults). All studies recruited participants suffering from self-reported or formally diagnosed mental health problems, most commonly recurrent depression (5/12 studies) but also anxiety disorders (3/12 studies), anxiety/depression stemming from physical health conditions (2/12 studies), and active anxiety/depression (1/12). One study had recruited individuals from two different MBCT courses; one for individuals with physical health conditions and one for individuals with mental

health conditions (Langdon et al., 2011). It was not clear whether participants from the physical health group also experienced mental health problems.

#### *Nature of MBCT intervention*

All studies described the MBCT intervention, with the majority (8/12) reporting that it followed the standardised format as per the manual by Segal et al. (2002); two of these made minor adaptations to the physical movement aspects of the course exercises only to accommodate mobility issues in elderly or physically unwell patients. One study (Finucane & Mercer, 2006) had shortened the practice time for some of the longer meditations to account for participants' concentration difficulties, given that the participants all had current symptoms of depression and it was felt that they would struggle to engage helpfully with the longer practices. The remaining three studies had modified the MBCT intervention in order to tailor it to a specific anxiety disorder (health anxiety, perinatal anxiety and obsessive compulsive disorder, respectively) rather than depression. In these instances, the core principles of the MBCT intervention remained and the exercises and structure followed the standardised manual; however the psychoeducational aspects and cognitive exercises were disorder specific.

#### *Method of data collection and analysis*

Ten of the 12 studies employed semi-structured interviews as the method of data collection. The study by Goodman et al. (2013) used open-ended questionnaires, and the study by Mason and Hargreaves (2001) used an open-ended interview. In terms of data analysis, three studies employed a grounded theory approach, three used interpretive phenomenological analysis (IPA), three utilised thematic analysis, two used qualitative content analysis, and one took a framework analysis approach. The procedure of data analysis was well detailed in all but one study (Goodman et

al., 2013), where only a very brief description of the overarching methods of analysis was given. References for the analytic approach taken were appropriately provided in all but one study (Smith, Graham & Senthinathan, 2007).

### **Methodological appraisal of studies**

This section presents an assessment of the quality of the studies in the review, with reference to the four core areas of credibility, transferability, dependability and confirmability as outlined by CQRMG (Hannes, 2011).

#### *Credibility*

Credibility of qualitative research refers to the extent to which the presented findings are congruent with the views of participants studied and can be understood as equivalent to the ‘internal validity’ criteria applied in quantitative research (Merriam, 1998). It has been argued that credibility checks are one of the most vital criteria for ensuring trustworthiness in qualitative research (Lincoln & Cuba, 1985) and there are a number of techniques for ensuring credibility (see Table 1). All but one study in this review explicitly mentioned some strategies employed to ensure the credibility of findings; the study by Goodman et al. (2013) was the only one to not report or discuss credibility.

All studies utilised participant quotations or statements to illustrate the themes presented, and most studies explicitly demonstrated how the themes and categories were grounded in the data. The exceptions were the studies by Hertenstein et al. (2012) and Smith et al. (2007). Hertenstein et al. (2012) employed a content analysis approach and only presented two categories (out of five) in detail using participant quotations. This made it difficult to assess the credibility of the remaining categories. The study by Smith et al. (2007) did provide a table of the themes of the data, but only presented three participant accounts to convey salient aspects and did

not make clear how the themes were grounded in the data. Whereas presenting detailed accounts from only some participants allowed the reader an in-depth understanding of some important themes, somewhat lacking was a sense of how all the presented themes had been generated and how they occurred across the dataset. However, the data analysis was carried out by several researchers who compared their results, which increases credibility and provides support for the analytic coherence. In contrast, the study by Goodman et al. (2013) and Hertenstein et al. (2012) reported that only one researcher was involved with the qualitative analysis which may call into question the credibility of the findings. However, the categories presented mapped on well to findings of other studies. Member checks, which allow participants to judge the accuracy of the data interpretation, were reported in two of the 12 studies (Bihari & Mullan, 2012; Fitzpatrick, Simpson & Smith, 2010) and the use of independent analysis where more than one researcher analyses the data was explicitly reported in four of the studies (Bailie, Kuyken & Sonnenberg, 2011; Finucane & Mercer, 2006; Fitzpatrick, Simpson & Smith, 2010; Langdon et al., 2011). Attention to negative cases was considered in most of the studies. Overall, all studies gave evidence of meeting at least one form of credibility criteria (but usually several) as presented by the CQRMG (Hannes, 2011).

### *Transferability*

The transferability criterion considers whether research findings are transferable to other specific settings (Hannes, 2011). This can be evaluated by considering the extent to which rich information and descriptions about the study participants (e.g. demographics and background) and the study context (e.g. demographic area, type of service) have been explicitly provided.

All but one study provided basic demographics such as participants' age and gender, and the majority of studies provided information about ethnicity and/or occupational, marital status and other background information. The exception was the study by Bihari and Mullan (2012) where no details about participants were provided except that they were 'adults' who had participated in an MBCT intervention. The vast majority of the studies provided information about the participants' mental health history, such as diagnosis, number of years suffering a particular mental health problem or previous psychological treatments. All but three studies reported use of diagnostic tools such as the ICD-10 or psychological measures of mental health difficulties such as the Beck Depression Inventory (BDI-II: Beck, Steer, & Brown, 1996) to establish participant mental health difficulties for the purpose of recruitment. The exceptions were the studies by Bihari and Mullan (2012) which gave no details about participants' mental health difficulties and Langdon et al. (2011) where no such formal assessment was reported; and the study by Griffiths, Camic and Hutton (2009), which relied on self-report of psychological distress.

The study by Langdon et al. (2011) described recruitment from two different MBCT group cohorts, one for mental health and one for physical illness (where only minor adaptations had been made to the physical illness MBCT group). Information was lacking about whether the participants in the physical illness MBCT group had psychological comorbidity or not. Although detailed demographics for the full sample were provided, relevant contextual information was missing when considering participant quotations, as it was unclear which group participants were in; it is possible that the two distinct groups may have had different experiences. Some studies provided rich participant information regarding, for example, marital



status and socioeconomic status (e.g. Finucane & Mercer, 2006) and important life events (e.g. Smith et al., 2007; Mason & Hargreaves, 2001), which allowed the reader a more comprehensive understanding of participants, their response to the intervention and their qualitative accounts.

Nearly all studies explicitly detailed the nature and structure of the MBCT intervention and any adaptations that had been carried out. Two papers did not report these details (Bihari & Mullan, 2014; Mason & Hargreaves, 2001): however given that MBCT is a manualised intervention it could be assumed that the interventions followed the standard structure. Most studies provided some information about the study context although this was sometimes sparse, something which may complicate assessing the transferability of findings. However, given that all studies but one did provide information about participant characteristics this was not felt to significantly impair this quality criteria overall.

### *Dependability*

This criterion evaluates the extent to which the research process (e.g. methodological decisions and the conclusions arrived at) has been logical, justified and well detailed, and whether it can be traced and reviewed through the clear provision of careful documentation (Hannes, 2011). All studies presented a descriptive account of the research questions/aims, method of recruitment, data collection and data analysis, detailing how data was collected and recorded. Only two studies failed to provide the exact time point of data collection post intervention (Fitzpatrick et al., 2010; Hertenstein et al., 2012). Most studies detailed the development of and/or gave some information about the content of the interview schedules. One exception was the paper by Smith et al. (2007), which only stated

that interviews concerned participants “actual experiences following the course and one year later” (p. 348).

While a clear account of study methodology was presented in the vast majority of papers, what was less clear was how decisions were made regarding some of these methodological choices. For example, very few of the papers provided an explicit rationale or discussion about any possible implications of the length of time between the intervention and being interviewed. The study by Bihari and Mullan (2014) interviewed participants who had completed an MBCT course at different time points in the last three years. There was no rationale presented for recruiting participants who were at such different time points, nor was there a discussion about how the length of time that had passed since the intervention might influence participant accounts. In contrast, the paper by Langdon et al. (2011) detailed how the process of data analysis led the authors to decide to interview participants who had completed the MBCT intervention longer ago than was originally planned (6 months) in order to learn more about long term impact. The time lapsed since course completion was indicated for each participant, allowing the reader to consider each participant account in the context of this. Similarly, the studies by Mason and Hargreaves (2001) and Williams et al., (2011) explicitly set out to explore post-intervention engagement and relapse which justified the data collection at 12-30 and and three months post intervention respectively.

Detailed accounts of the analytic process were provided in the majority of papers, with most making comprehensive reference to existing guidelines in the literature. In terms of the details of the analytic process, there was some variability in how well documented this was. The study by Goodman et al. (2013) gave a very brief description of the main stages of analysis, whereas other studies provided more

of a 'step-by-step' description (e.g. Allen et al., 2009; Bailie et al., 2011; Bihari & Mullan, 2012; Griffiths et al., 2009;). The labelling and structure of categories/themes generally appeared logical across studies and their grounding in the data was generally well demonstrated in the findings. However, as mentioned before, some studies only presented certain categories (Hertenstein et al., 2012) or certain participant accounts (Smith et al., 2007), which complicated the assessment of dependability as many of the themes/categories presented in the theme tables were not presented or discussed in the findings.

### *Confirmability*

This criterion evaluates whether research findings are “qualitatively confirmable through the analysis being grounded in the data” (Hannes, 2011, p. 4) as opposed to resulting from researcher presumptions and bias. All studies but two (Goodman et al., 2013; Griffiths et al., 2008) provided some evidence of having considered the effects of the researcher on the research process and findings, particularly in terms of perspectives and preconceptions brought to the research process. For example, eight studies gave at least basic information about the authors' and research team members' professional background and/or current theoretical clinical perspective. Most of the studies at least explicitly acknowledged, and sometimes reflected on, the perspectives they brought to the research process, with a few providing additional rich accounts on how their 'world view', epistemological position and clinical experience had informed their interest and understanding of the subject they were researching (e.g. Allen et al., 2009; Bihari and Mullan; 2012; Langdon et al., 2011).

Some studies detailed formal procedures to develop reflexivity, though, for example, the keeping of reflective journals during the research process (Bailie et al., 2011;

Fitzpatrick et al., 2010), ‘active questioning’ of the authors’ assumptions during the analysis of the data (Mason & Hargreaves, 2001) and consulting peers to scrutinize their analysis to check for preconceptions into the data (Smith et al., 2007). The study by Williams et al. (2011) made explicit the research team members’ preconceptions about the study subject and took a ‘paper trail approach’ to document the research process. The study by Finucane and Mercer (2006) acknowledged the subjective nature of qualitative research and the associated risk of researcher bias, and therefore took a descriptive rather than interpretative approach, in order to enable the narratives to “speak for themselves”. On the whole, studies in this review provided good evidence of an awareness of the influence of researcher assumptions and knowledge on the research process and subsequent findings, and demonstrated procedures to develop reflexivity.

## **Results**

### **Meta-synthesis**

The meta-synthesis led to the development of nine themes (Table 3) that were organised into three overarching theme domains: “Positive effects on awareness and coping”, referring to the most commonly described positive effects of MBCT; “Positive changes in relationships and interactions”, which refers to intra- and interpersonal improvements; and “Struggle”, which describes difficulties that were reported by some in relation to their experience and practice of MBCT. In order to ground the themes in the data, the frequency of particular reported experiences is provided within each sub-theme. Table 3 shows how the themes generated map on to the themes and categories from the primary studies.

Table 3

*Overarching themes of participants' accounts of their experiences of MBCT and corresponding themes and sub-themes from primary studies*

Overarching themes and sub-themes	Themes in primary studies
<b>1. Positive effects on awareness and coping</b>	
1.1 Developing mindfulness: Increased awareness	<p>Evidence (11 studies)</p> <p><i>Allen et al. 2009</i>; Control, Discerning depressive relapse, Impact of activities  <i>Bailie et al. 2011</i>; Reactivity and escalation of anger  <i>Bihari &amp; Mullan. 2012</i>; Change processes, Enjoying the moment  <i>Finucane &amp; Mercer. 2006</i>; Reported benefits  <i>Fitzpatrick et al. 2010</i>; The role of mindfulness in consolidating existing coping skills in the context of loss  <i>Griffiths et al. 2009</i>; Development of awareness  <i>Hertenstein et al. 2012</i>; Effects: Benefits  <i>Langdon et al. 2011</i>; Positive effects of mindfulness on wellbeing, Integrating Mindfulness into life  <i>Mason &amp; Hargreaves. 2001</i>; Skills  <i>Smith et al. 2007</i>; More awareness, Breath-awareness  <i>Williams et al. 2011</i>; A different outlook on my life in general, Awareness of my anxiety cycle enables me to break it</p>
1.2 A revised understanding of thoughts: thoughts are just thoughts	<p>Evidence (9 studies)</p> <p><i>Allen et al. 2009</i>; Acceptance  <i>Bailie et al. 2011</i>; Empathy and acceptance  <i>Bihair &amp; Mullan. 2012</i>; Climbing out of the spiral, changing course  <i>Goodman et al. 2013</i>; Cognitive changes</p>

*Fitzpatrick et al.* 2010; Changing patterns of coping  
*Hertenstein et al.* 2012; Benefits  
*Mason & Hargreaves.* 2001: Discovery and surprise  
*Smith et al.* 2007; Qualitative analysis of group data, Jean's account  
*Williams et al.* 2011; Awareness of my anxiety cycle enables me to break it

### 1.3 Awareness opens up for more choice: taking action and accepting

Evidence ( 12 studies)

*Allen et al.* 2009; Control  
*Bailie et al.* 2011; Emotion reactivity and regulation  
*Bihair & Mullan.* 2012; Change processes  
*Goodman et al.* 2013; Decreased reactivity, Skill building, Insight, Acceptance and self-kindness  
*Finucane & Mercer.* 2006; Reported benefits  
*Fitzpatrick et al.* 2010; Changing patterns of coping  
*Griffiths et al.* 2009; Development of awareness  
*Hertenstein et al.* 2012; Benefits  
*Langdon et al.* 2011; Virtuous practice cycle  
*Mason & Hargreaves.* 2011; Coming to terms  
*Smith et al.* 2007; More awareness, more control, Breath-awareness  
*Williams et al.* 2011; Cultivation of a new approach to health anxiety and my life in general

## 2. Positive changes in relationships and interactions

### 2.1 Positive effects on relationships with others

Evidence (7 studies)

*Allen et al.* 2009; Relationships  
*Bailie et al.* 2011; Emotional reactivity regulation, Sadness and giving in, Increased empathy and acceptance,

Increased involvement, Emotional availability, Recognition of own needs  
*Bihari & Mullan. 2012*; Changes in relationships  
*Griffiths et al. 2009*; Development of awareness  
*Langdon et al. 2011*; Integrating mindfulness into life  
*Smith et al. 2007*; Getting on with others  
*Williams et al. 2011*; The struggle to find the time: is regular practice worthwhile to me?

## 2.2. A better relationship with myself: kinder and with better self-care

Evidence ( 9 studies)

*Allen et al. 2009*; Relationships, Acceptance: destigmatization  
*Bailie et al. 2011*; Recognition of own needs  
*Bihari & Mullan. 2012*; Change processes, Changes in relationships  
*Goodman et al. 2013*; Acceptance and self-kindness  
*Finucane & Mercer. 2006*; Benefits, Being in a group  
*Smith et al. 2007*; More acceptance of self  
*Williams et al. 2011*; Validation and Normalization of my experiences through MBCT  
*Griffiths et al. 2009*; Within-group experiences  
*Hertenstein et al. 2012*: Being in a group

## 3. Struggle

### 3.1 Loss of the group impacts practice implementation

Evidence (7 studies)

*Allen et al. 2009*; Struggle  
*Goodman et al. 2013*; Qualitative feedback  
*Finucane & Mercer. 2006*; The course exercises  
*Herteinstein et al. 2012*; Struggle  
*Langdon et al. 2011*; Establishing the practice

<p>3.2 External barriers to implementation of practice</p>	<p><i>Williams et al.</i> 2011; The struggle to find time: is regular practice worthwhile to me?  <i>Griffiths et al.</i> 2009; Within group experience  Evidence (4 studies)</p> <p><i>Bihari &amp; Mullan.</i> 2012; MBCT as a life Long process of change  <i>Langdon et al.</i> 2011; Keeping practice Going, Challenges of practice  <i>Smith et al.</i> 2007; Helpfulness of Mindfulness practice – and constraints  <i>Williams et al.</i> 2011; The struggle to find time: is regular practice worthwhile to me?</p>
<p>3.3 Internal struggles related to practice</p>	<p>Evidence: (8 studies)</p> <p><i>Allen et al.</i> 2009; Struggle  <i>Bihari &amp; Mullan et al.</i> 2012; Facing one's state of mind: the importance of timing and support  <i>Finucane &amp; Mercer.</i> 2006; The course exercises  <i>Hertenstein et al.</i> 2012; Struggle  <i>Langdon et al.</i> 2011; Challenges of practice, Obstacles to mindful living  <i>Mason &amp; Hargreaves et al.</i> 2001; Discovery /surprise, Warning bells  <i>Griffiths et al.</i> 2009; Commitment  <i>Williams et al.</i> 2011; The struggle to find time: is regular practice worthwhile to me?</p>
<p>3.4 High expectations of MBCT</p>	<p>Evidence (5 studies)</p> <p><i>Allen et al.</i> 2009; Struggle  <i>Bihari &amp; Mullan.</i> 2012; Facing one's state of mind: the importance of timing and practice  <i>Finucane &amp; Mercer.</i> 2006; Benefits and ongoing practice  <i>Hertenstein et al.</i> 2012; Struggle  <i>Williams et al.</i> 2011; My desire to experience change in the face of initial uncertainties</p>



## **1. Positive effects on awareness and coping**

This overarching theme describes perceived benefits of MBCT pertaining to effects on increased awareness, a new understanding of thoughts and the development of coping strategies in response to difficult internal experiences such as emotional distress and difficult thought processes. Although these effects had considerable overlap and could be considered global to some extent, they are presented as three sub-themes in order to capture the features of closely related yet distinct descriptions of effects of MBCT that were commonly reported across studies.

### *Theme 1.1 Developing Mindfulness: increased awareness*

All studies described how MBCT had helped clients adapt a more ‘mindful’ or ‘aware’ attitude or ability, which was understood as “living in the now” and accepting what happened in the moment (e.g. Bihari & Mullan., 2012) rather than focusing on the past or the future. These accounts resonated strongly with the definition of mindfulness given by Kabat-Zinn (1994, p. 4): “paying attention in a particular way; on purpose, in the present moment, and non- judgmentally”. This mindful ability was understood by clients as resulting from the MBCT practices, through exercises such as the Body Scan, Mindful Walking and breathing focus meditations, where the focus is on allowing the present moment, feelings and thoughts to unfold but to intentionally focus on, for example, one’s breath or physical sensations and bring one’s attention back to that focus when the mind wanders. Most studies described how this increased ability to be mindfully aware of the present moment had led to a variety of general positive effects on clients’ mental health and experiences. For example, it was reported to enhance one’s daily

experiences and enjoyment of these (Bihari & Mullan, 2011; Langdon et al. 2011), make clients feel “more vividly alive” when they were no longer operating on “auto pilot” (Smith et al., 2007), helping clients appreciate the beauty of everyday experiences such as going on a walk and noticing colours, sounds and smells around them (Finucane & Mercer, 2006) and increase clarity of thinking, enabling clients to put things into perspective (Allen et al., 2009). More specifically in relation to clients’ mental health difficulties, the vast majority of studies described how a non-judgmental present moment focus enabled clients to cope better with difficult thoughts and feelings as they recognised they could not control what had already happened in the past or what might happen in the future, but could cope with the present moment difficulties (e.g. Smith et al., 2007).

*Theme 1.2      A revised understanding of thoughts: thoughts are just thoughts*

An increased awareness in general but specifically related to thought processes was paired with a revised understanding of the nature and importance of thoughts, with nine studies reporting that clients had learnt that “thoughts are not facts” (Mason & Hargreaves, 2001, p. 209) and do not always reflect reality. Clients reported that this revised understanding enabled a different response to thoughts: if they do not have to be believed, or acted on, one can simply observe and let them pass without becoming ‘entangled’ or distressed by them. The implications of this new found ability to ‘step back’ from thoughts were wide ranging: for example becoming less concerned about one’s thought patterns, having less of an emotional reaction to them, and being less likely to react automatically in unhelpful ways. Also, several studies (e.g. Allen et al., 2009; Fitzpatrick et al., 2010; Hertenstein et al., 2010) reported an apparently de-stigmatising effect resulting from this new understanding of thoughts, where clients realised that unpleasant thoughts occur to

everybody and are a common feature of the mind, rather than signifying any abnormality: “your thoughts are not a reflection of who you are” (Allen et al., 2009, p. 421).

*Theme 1.3 Awareness opens up more choice: taking action and accepting*

All studies reported how an increased sense of awareness of one’s internal and physical experience in the present moment (i.e. thoughts, feelings and bodily tensions or pains) had led to a perceived sense of having more choice and command in how to respond to these more helpfully. Several studies described the process as knowing one’s “warning bells” that mental health was deteriorating (Mason & Hargreaves, 2001) through heightened awareness of one’s experience. It was reported that this ability to become intentionally aware of one’s present moment internal experience enabled clients to intentionally choose a more helpful response than they may have done in the past, to prevent ‘spiralling’ of their thoughts and feelings.

All studies described how clients purposefully employed MBCT tools for this purpose, e.g. the 3- Minute Breathing Space (e.g. Smith et al., 2007) formal meditation practice (Bailie et al., 2011) or simply engaging in an everyday activity (e.g. doing the dishes or going for a walk) and paying attention to sensory input such as sounds, smells and colours during the activity in order to shift attention away from difficult, towards more neutral thoughts and feelings (Allen et al., 2009). Perhaps paradoxically, within the context of ‘taking action’ in response to difficult internal experiences, the vast majority of studies reported that clients learnt and practiced how to intentionally take an ‘accepting’ stance towards their internal experience i.e. to not judge it or try to change it and to instead ‘sit with’ experience, a central tenet of MBCT practice.

Most studies described that employing MBCT practices at times of distress as described above had a positive impact, such as helping break spiralling emotion cycles (e.g. Bihari & Mullan, 2012; Goodman et al., 2014; Williams et al., 2011), enabling “stepping back before reacting negatively” (Goodman et al., 2013), reducing rumination and worry (Hertenstein et al., 2012), preventing escalation of anger (Bailie et al., 2011) and calming the body and mind at times of stress (Griffiths et al., 2009). Commonly across studies, it was described that this ‘taking action’ (even if that involved simply choosing to sit with the experience and try to accept it) fostered in clients a sense of self-agency and feeling more in control of oneself (e.g. Langdon et al., 2011; Smith et al., 2007) as opposed to a pre-course sense of helplessness when facing emotional distress.

## **2. Positive changes in relationships and interactions**

This overarching theme describes clients’ reported accounts of experiencing positive changes in relationships, both to other and self, and how this was felt to relate to or stem from their MBCT practice.

### *Theme 2.1 Improved relationships with others*

Seven studies described positive changes in relationships and interactions with others as resulting directly from the MBCT experience and/or practice and the associated impact of the practice on the person’s wellbeing and coping strategies. All seven studies described generally relating more to others, with more empathy, warmth and emotional closeness, and four of these studies specifically reported that clients utilised MBCT tools/principles to manage difficult relationships and interactions better.

The seven studies reporting general improvements in relationships with others (e.g. more empathy and closeness) varied in their explanations of this change. Some reported that clients attributed the change to a general improvement in mood following the MBCT intervention, but more specific mechanisms for this change were also suggested. For example a better understanding of one's own needs and emotions were reported to translate into becoming more communicative and more aware of others' needs and emotions (e.g. Bailie, 2011). Moreover, being more aware of the present moment experience rather than paying attention to "baggage of the past" (e.g. Bihari & Mullan, 2014) and greater emotional stability and wellbeing (e.g. Allen et al., 2009; Smith et al., 2007) enabled relationship improvements.

Four studies focused in addition on how clients specifically utilised MBCT principles to respond to difficult interactions, and that this had led to revised communication patterns that were calmer and less reactive (Allen et al., 2009; Bailie et al., 2011; Bihari & Mullan, 2014; Langdon et al., 2011). For example, the study by Bailie et al. (2011) detailed how parents used MBCT tools such as the 3-Minute Breathing Space when they noticed that an interaction with their child was becoming emotionally charged, in order to prevent escalation. Similarly, the study by Bihari and Mullan (2014) described how clients practiced mindfully 'stepping back' into a reflective space, which shifted the interaction away from "habitual rowing" to responsive communication which involved communicating honestly about emotions and hearing the other person's perspective.

Two studies (Allen et al., 2009; Bihari & Mullan, 2014) reported potential negative effects on relationships following from the MBCT practice. They described that as clients were becoming more able to express and attend to their own needs, this could cause tensions in their relationships if there had been long-term patterns of

taking excessive responsibility and putting others' needs ahead of their own.

Nevertheless, for the minority of clients experiencing this, they reported the changes to be positive and “empowering” (Bihari & Mullan., 2014).

*Theme 2.2 A better relationship with myself: kinder and with better self-care*

Nine studies described a positive change in how clients viewed and/or treated themselves and their difficulties resulting from the MBCT intervention and practice. This was contrasted in four of these studies with a long history of being self-critical and judgemental towards themselves (Allen et al., 2009; Bailie et al., 2011; Goodman et al., 2013; Smith et al., 2007; Williams et al., 2011) and how this tendency had triggered or exacerbated mental health difficulties or emotional distress. Moreover, clients had often experienced intense self-blame particularly in relation to mental health problems, which exacerbated the symptoms and reduced their ability to cope with them (e.g. Bailie et al., 2011). Furthermore it was reported that clients had historically put others' needs first and neglected their own needs, which had led to a range of emotional and social difficulties.

Seven of the nine studies reported that following MBCT many clients had learnt to be less self-critical or hard on themselves, and instead a sense of confidence and self-kindness emerged, relating to, for example, feeling “mentally strong” (Bihari & Mullan; Finucane & Mercer), experiencing self-acceptance (e.g. Bailie et al., 2011) and having a sense of “self-worth” (Finucane & Mercer, 2006) and “accepting the whole of myself” (Williams et al., 2011). Several studies attributed this at least in part to a destigmatizing effect of being in a group of people suffering similar difficulties, which enabled clients' to revise their understanding of who suffers from mental health problems, realising that anybody can be affected and

therefore feeling less abnormal (Allen et al., 2009; Finucane & Mercer, 2006; Griffith et al., 2009; Hertenstein et al., 2012; Williams et al., 2011). This shift in self-image appeared to subsequently lead to changes in how clients treated themselves, as they valued themselves more and felt that their needs mattered, with six studies describing how clients were more able to clearly recognise their needs and prioritise and engage in self-caring activities to meet them. For example, some clients were reported to prioritise daily mindfulness practice as a form of self-care (e.g. Allen et al., 2009), give themselves rewards and “nice things” more often (Williams et al., 2011), recognise their limitations and take less on (Bihari & Mullan; Langdon et al., 2011), take nourishing ‘time-outs’ regularly (Bailie et al., 2011) and schedule in pleasant activities like gardening and painting (Smith et al., 2007). One study reported how a client cited “self-worth” resulting from MBCT as the reason she was going back to work after a long break from employment (Finucane & Mercer, 2006).

### **3. Struggle**

This overarching theme describes struggles and disappointments related to the MBCT experience and practice that were reported in a number of studies. Although different kinds of struggles with mindfulness practice were mentioned in many of the studies, the accounts tended to be brief and limited (with the exception of Langdon et al., 2011). A small number of studies reported that the majority of participants were able to sustain some type of practice (Finucane & Mercer, 2006; Smith et al., 2007) or moved in and out of practice (Langdon et al., 2011) after the intervention ended.

#### *Theme 3.1 Loss of the group impacts practice implementation*

In seven studies, mention was made of how group factors had motivated regular practice during the MBCT intervention. These included an “in-group attitude of perseverance and determination” (Finucane & Mercer, 2006) which facilitated commitment to keeping practice going during the course. Several studies reported that some participants expressed a wish to have access to ongoing group practice and booster sessions in order to support maintenance of practice, as they found independent practice challenging to keep up.

### *Theme 3.2 External barriers to implementation of practice*

Another barrier that was noted was finding the time for regular practice in the context of a busy lifestyle (e.g. Allen et al., 2009; Bihari & Mullan., 2012; Langdon et al., 2011). This was seen as requiring a shift in lifestyle and change of priorities (relating to e.g., family commitments, employment) which was for some difficult to organise and maintain.

### *Theme 3.3 Internal struggles related to practice*

Eight studies mentioned struggles with practice that related to internal factors, particularly mental health problems or emotional distress. One’s ‘state of mind’ (e.g. anxiety, depression and stress) could reduce motivation to engage with practice for some participants (Mason & Hargreaves, 2001) or distract from using it (Hertenstein et al., 2012), which was noted as counterproductive in that at times of heightened emotional distress some clients recognised needing the practice more, but struggled to use it (Langdon et al., 2011; Williams et al., 2011). Although a minority, it is worth mentioning that four studies described significantly distressing experiences during practice by a small number of clients. It was reported that “facing one’s state of mind” (Bihari & Mullan, 2012) could lead to painful insights and



memories (Mason & Hargreaves, 2001) and emotional distress (Finucane & Mercer, 2006; Hertenstein et al., 2012) for a small number of patients. This could be particularly problematic for affected clients as one-to-one debriefing/support is not routinely provided during the duration of the MBCT intervention.

#### *Theme 3.4 High expectations of MBCT*

A further pattern of struggle described in five studies was that some individuals held high expectations of MBCT, expecting it to be a “miracle cure” (e.g. Allen et al., 2009; Williams et al., 2011) that would eliminate mental health suffering. This attitude led to some initial disappointment with the limitations of the intervention. However, the vast majority of studies reported that clients acknowledged MBCT’s efficacy in improving mental health and coping but recognised that this effect depended on regular practice, which was “hard strenuous work” (Hertenstein et al., 2012), for all the reasons described above. Whereas some clients initially had hoped for a magic fix for their difficulties, most came to the realisation that they had benefited and could continue to benefit, but that this had required and would continue to require commitment and perseverance on their part.

### **Discussion**

The current review used the method of meta-synthesis to integrate the findings of 12 qualitative studies that explored patients' perspectives of participating in an MBCT intervention and implementing the mindfulness practices. The 12 studies provided insights into how participants experienced different aspects of the intervention.

The findings of this review indicate that individuals with a range of depression and anxiety-related mental health problems found MBCT helpful for their

particular mental health needs. The mental health conditions represented in the review included: recurrent depression, current depression with and without anxiety, perinatal anxiety, OCD, health anxiety, and depression/anxiety related to suffering from a physical health difficulty. This lends support to the small number of quantitative studies suggesting that MBCT's effectiveness is not limited to recurrent depression. In all 12 studies, the vast majority of participants reported experiencing therapeutic benefit.

The meta-synthesis generated nine themes that were organised into three overarching, superordinate themes. The first superordinate theme, 'Positive effects on awareness and coping with difficulties', referred to the most commonly described positive effects of MBCT. In all studies, the majority of participants reported an increase in present-moment awareness of both internal and external experience; for many this led to a sense of increased control and agency of their responses to difficulties, such as taking an accepting stance, engaging with self-care or using MBCT skills. Furthermore, a revised understanding of cognitions allowed participants to 'step back' from difficult thoughts and view them as mental phenomena rather than as true or meaningful.

The second superordinate theme, 'Positive changes in relationships and interactions', referred to intra- and interpersonal improvements reported in the studies. Participants perceived the intervention as impacting positively on relationships, particularly with oneself (specifically feeling kinder and more accepting of oneself and one's difficulties) but also with other people (especially in terms of reduced reactivity and calmer interactions).

Finally, the third superordinate theme, 'Struggle', referred to some difficulties that participants described in relation to their experience of MBCT and

implementing practice. These included the loss of support that had been provided by the MBCT group, which made it difficult to maintain practice; external factors such as busy lifestyles, making it hard to prioritise practice; internal factors such as emotional distress, which prevented effective use of practice; and holding high expectations of the intervention, which led to disappointment. Although only reported by four studies, it is important to be aware of the risk that a small number of individuals may experience distressing experiences during, or resulting from, mindfulness meditation practice, and that the group format of the intervention may not offer the individual support required for those who are affected.

The reported positive effects on awareness and coping with difficulties suggest that individuals' experiences of practicing MBCT map on to the psychological change processes for which the intervention was designed, lending support to its validity. The theme 'Awareness opens up choice' was particularly strong in this review and deserves attention. This theme described a shift away from perceived helplessness in the face of external and internal difficulty, towards a sense of agency and control, which was attributed to MBCT. The processes described in the studies (i.e. bringing awareness to the difficulty, shifting focus of attention, bringing an attitude of acceptance/non-judgment and engaging in nourishing activity) appear to map on to the concept of self-regulation (Brown & Ryan, 2003), which has been previously suggested to link to mindfulness (Masicampo & Baumeister, 2007). As such, the concept of self-agency, enabled through increased awareness, may be a central factor in how MBCT impacts on individuals' ability to cope with their difficulties through 'taking control' of, and regulating, their responses to difficulties.

The evidence base to date has focused on the effect MBCT can have on internal psychological processes. However, the second superordinate theme in this review, ‘Positive changes in relationships and interactions’, reflected positive effects reported also on interpersonal interactions and relationships, highlighting a further potential benefit of the intervention. Over half of the studies included in the review described how participants applied the same MBCT principles to interactions and relationships as they did to internal experiences (e.g. awareness, non-judgment, acceptance, stepping back from automatic reactions), demonstrating transferability of these acquired skills and more global attitudes. Given the bi-directional relationship between relationships/social support and mental health (Thoits, 2011), this reported effect is worthy of attention.

While the studies included in this review provided rich descriptions of patients’ experiences of MBCT, they had a number of limitations that have important implications for what can be currently known about the impact of MBCT and how it is used by patients. Firstly, although some studies did provide some information regarding participants’ implementation of MBCT tools and a very small number of the studies provided information about whether participants continued to practice, the majority of studies did not address in depth (or at all) how participants implemented mindfulness practice after the intervention ended. This makes it difficult to draw conclusions about the benefits reported by participants, as for most of the studies the nature of participants’ ‘practice routine’ (e.g. what particular MBCT practices/tools they implemented, how often, in what situations and settings) was not detailed or explored.

Secondly, all studies but two carried out only one interview with each participant, usually either soon after completion of the intervention (e.g. 3 months),

or in retrospect (e.g. 1-3 years); some studies did not state the time frame between intervention completion and interview at all. Furthermore, most studies gave no rationale for the time frame between intervention and interview. A limitation of only interviewing participants once is that it is not possible to follow their 'journey' of practice, impact and implementation over time. This would be relevant both in terms of understanding the long-term impact and processes of MBCT, but also to understand changes that may occur over time and, importantly, whether practice is sustained or not and what the barriers/facilitators are.

Lastly, although more than half of the studies in this review included participants with mixed presentations (depression and/or anxiety) or pure anxiety presentations, what is known about how MBCT impacts on mental health problems other than recurrent depression is still in its infancy and further research is required to address this gap in knowledge. What is lacking is studies looking into MBCT for other mental health disorders such as eating disorders, personality disorders, etc.

### **Limitations of the review**

The task of synthesising a body of qualitative findings that are often underpinned by diverse research approaches poses challenges. For example, it is possible that different epistemological approaches inherent in the study methodologies may have resulted in the generation of different 'types of knowledge' in the primary studies (Jensen & Allen, 1996), which complicates the act of synthesising this knowledge (Estabrooks, Field & Morse, 1994). Furthermore, a meta-synthesis inevitably involves the interpretation of other researchers' interpretations, creating a 'third level' interpretation (Zimmer, 2006). By taking a descriptive rather than interpretive approach, and paying attention to commonalities

as well as differences across the studies, the current review aimed to illustrate the complexity of findings, while also making these transparent and accessible.

A further challenge of the current review related to quality appraisal. The current review referred to the four core criteria of quality for qualitative research, as presented by the Cochrane Qualitative Research Methods Group (CQRMG; Hannes, 2011) and used these flexibly as a set of guidelines. A formal rating scale was not utilized, which could have increased the risk of including studies of poorer quality. However, the Cochrane guidelines provided a useful framework which enabled the researcher to establish that, overall, the studies were of sound methodological quality.

### **Research and clinical implications**

A number of research and clinical implications can be drawn from the results of this review. First and foremost, given that MBCT was found to be described as a helpful intervention in all studies in the review, including for individuals experiencing anxiety difficulties, there is now a need for further research to understand in greater detail the effect that MBCT can have on a wider range of mental health difficulties. Currently, MBCT is recommended in the NICE (2010) guidelines for recurrent depression, but the growing body of outcome research as well as the findings of this review suggests that the intervention may have a much wider scope.

The findings of this review also strongly suggest that future quantitative research is needed to examine possible changes in the domains of self-regulation, interpersonal relationships, and relationship to oneself, associated with undertaking MBCT. One could speculate that these important aspects of mental health and psychosocial functioning are mechanisms of change involved in the intervention that

may result in symptom reduction, or, alternatively, they could be considered outcomes to be measured in their own right alongside symptom reduction.

Furthermore, the current review indicates that there is a gap in knowledge about how MBCT is used by the individuals it is designed for, particularly over time. This is crucial to examine further, given that one of the cornerstones of MBCT and its suggested benefits is sustained practice. This question lends itself well to qualitative enquiry, which can provide accounts of how the practice implementation aspect of the intervention is perceived and experienced (e.g. what the perceived barriers and facilitators to sustained practice are), and how individuals actually implement (or not) mindfulness practice in their life once the support and structure of the group is no longer available.

Finally, given that the current review suggests that MBCT may lead to improved self-regulation and benefits to relationships, it would seem important for clinicians to pay attention to any such effects. These domains of functioning are arguably central to mental health.

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## **Part 2: Empirical Paper**

### **Mindfulness-Based Cognitive Therapy: The experience of practice over time**

## **Abstract**

**Objective:** The therapeutic benefit of Mindfulness-Based Cognitive Therapy (MBCT) is assumed to depend on continued mindfulness practice. Very little is known, however, about the experience of implementing and maintaining practice after completion of the intervention, and how individuals' practice 'journeys' may evolve over time. The current study aimed to explore longitudinally the subjective experience of post-course practice and what was experienced as helping or hindering practice in the nine months following an MBCT course.

**Method:** Semi-structured interviews were carried out with 10 participants on three occasions over nine months following completion of an MBCT course. Braun and Clarke's (2006) method of thematic analysis was used to identify patterns and themes within the data.

**Results:** Four patterns of practice were identified, illustrating distinct practice trajectories: frequent practice that increased, practice that waxed and waned, practice interrupted by mental health difficulties, and no formal practice ever established. Participants described several challenges to implementing and sustaining practice. These focused on building a routine, the solitary nature of practice, and mental health difficulties having a paradoxical effect on practice. Most participants emphasised a need for continued group practice.

**Conclusions:** Future research is needed to establish whether ongoing group practice can increase the maintenance of independent practice, and whether this improves long-term outcomes. Mental health services and clinicians should aim to support and facilitate MBCT class participants' independent practice after course completion in order to preserve the effect of the intervention.

## Introduction

Mindfulness-Based Cognitive Therapy (MBCT; Segal, Williams, & Teasdale, 2002) has been shown to be an effective relapse prevention intervention for recurrent depression (e.g. Kuyken et al., 2016). In addition, it has shown promise for a range of other psychological conditions, including active depression (Van Aalderen et al., 2012), depression with anxiety (Finucane & Mercer, 2006; Evans et al., 2008), health anxiety (McManus, Surawy, Muse, Vazquez-Montez, & Williams, 2012) and inter-episodic symptoms of depression and anxiety in bipolar disorder (Deckersback et al., 2012; Williams et al., 2008b).

The MBCT course, which is a manualised eight-week group programme, integrates mindfulness meditation practices with elements of cognitive behavioural therapy. Class participants are expected to carry out daily homework consisting of formal mindfulness meditation practice, informal mindfulness practice, and some cognitive behavioural tasks, for the duration of the course; continued daily or frequent formal and informal practice post-intervention is recommended for the long-term in order to integrate mindfulness into their life and ‘way of being’. Formal practice refers to structured, usually longer, meditation practices (typically guided by a CD, lasting 30-45 minutes) that focus on attending to sensations in the body, sounds, thoughts and emotions. It can be carried out lying down or sitting (e.g. Sitting Meditation or the Body Scan) or moving (as in mindful walking and mindful yoga), and also includes a shorter three minute ‘breathing space’ which can be carried out ad-hoc. Informal practice refers to purposeful cultivation of mindfulness in everyday life and routine activities, such as bringing mindful awareness to the moment-to-moment experience of walking, breathing, washing dishes, looking at nature or driving (Kabat-Zinn, 1996). Formal and informal practice place different

demands on the person practising and the context they are within (e.g. needing a place to sit or lie down where one will not be disturbed, or having equipment for playing audio recordings). Hence, the obstacles and facilitating factors, and the experience over time of implementing formal and informal practice, might be very different.

The process of integrating mindfulness practice into one's life has been described as gradual rather than immediate (Grossman & Van Dam, 2011) and requiring persistence and patience (Kabat-Zinn, 1994). The MBCT manual encourages facilitators to inform MBCT users that *"lack of homework will likely affect how much they will get out of the program, but without being critical of them"* (Segal et al., 2002, p. 135). It is assumed that frequent practising of mindful responding to difficult cognitions, emotions and sensations (as opposed to avoiding, or ruminating, on them) increases the likelihood of the individual being able to draw on such skills at difficult times, when they may be more vulnerable to mental health difficulties (Segal, Williams & Teasdale, 2013).

A small number of studies have examined the association between homework practice during the MBCT course and risk of relapse or symptom change (e.g. depressive rumination or anxiety). While the findings have been mixed, the most recent studies have found that patients who engaged in *formal* practice more often (e.g. three or more sessions per week) and for a longer mean duration each time (during the MBCT course) were significantly less likely to relapse or had lower scores of depression and anxiety at follow-up (e.g. Crane et al., 2014; Hawley et al., 2014; Mathew, Whitford, Kenny & Denson, 2010; Perich et al., 2013). These findings are consistent with previous studies showing that homework compliance in CBT predicts therapeutic outcome (Kazantzis, 2010; Schmidt & Woolaway-Bickel,

2000) and support the hypothesis of the developers of MBCT that frequent and greater amounts of practice yield better outcomes. Interestingly, studies have not found an association between the amount of *informal* practice and outcome (Crane et al., 2014; Hawley et al., 2013). Some authors have suggested that this may partly be explained by the difficulty in measuring and capturing informal home practice (Crane et al., 2014); however, the role of informal practice in generalising mindfulness skills to daily life needs further research.

All of the above studies measured practice that occurred while the MBCT intervention was taking place, apart from Perich et al. (2013) and Mathew, Whitford, Kenny and Denson (2010) who also measured how post-intervention practice related to outcome. The former study found no difference in psychological symptoms between those who stopped practising and those who continued, at a 12-month follow-up, while the latter study found that those who continued practising had better outcomes at a two-year follow-up. Other studies have also provided some information about the amount or type of post-intervention practice that participants say they engage in. Most found that a sizeable number of participants reported engaging in some kind of (formal or informal) mindfulness practice at the time of the interview (which varied between three to 12 months post-completion of the MBCT course) but that there were substantial differences in the kind of practices used, the frequency and the time duration of each practice (Finucane & Mercer, 2006; Smith, Graham & Senthinathan, 2007; Meeten, Whiting & Williams, 2015).

Whereas some studies have shown that the protective effect of MBCT can last up to between one and four years (e.g. Munshi, Eisendrath & Delucchi, 2013; Van Aalderen, Donder, Peffer & Speckens, 2015;), other studies have indicated that the positive effects of MBCT start to fade with time: Radford et al. (2012) found that

anxiety, depression and rumination scores increased between the end of treatment and the six-month follow-up; similarly, Mathew et al. (2010) found that depressive symptoms started increasing sometime between 25-35 months post-intervention. Both studies concluded that ongoing practice probably is a pre-requisite for continued therapeutic benefit. Mathew et al. (2010), who also found that those who attended MBCT ‘booster sessions’ had better depression outcomes, suggested that booster sessions perhaps should be part of the standardised MBCT programme rather than used as an adjunct.

Given the limited and mixed evidence, we do not know for certain how long the effects of mindfulness practice will last for individuals who stop practising. It is also likely that the effect (and longevity of the effect) of MBCT is dependent on individual differences (Keng, Smoski & Robins, 2011), such as personality traits, social circumstances and psychopathology; for example, individuals who report childhood trauma appear to benefit especially (Williams et al., 2014). What is clear, is that those who practice more (particularly formally) generally appear to benefit more, which justifies exploration of what can promote sustained, independent practice.

Theories of health behaviour change are frequently drawn on to understand what influences individuals’ engagement, or lack of engagement, with behaviours that influence their health or wellbeing, with the Theory of Planned Behaviour (TPB; Ajzen, 1991) perhaps being one of the most widely referenced. It stipulates that the intention to engage in a behaviour is influenced by attitudes towards the behaviour, subjective norms, and the degree of perceived behavioural control that the individual thinks that they have. Research has yielded mixed results regarding the efficacy of the TPB in explaining behaviour change (e.g. Armitage & Conner, 2001; McEachan,

Conner, Taylor, & Lawton, 2011). In the context of MBCT, Langdon et al. (2011) have suggested that health behaviour theories such as the TPB may not apply fully to mindfulness practice: they argue that mindfulness practice differs to more commonly examined health behaviours, such as diet or exercise, in that it relates more to a change in mental and emotional functioning and a 'way of life', rather than a discrete behaviour. However, the concrete act of sitting down to formal practice is, arguably, a discrete behaviour, regardless of the psychological 'outcome'.

A small number of qualitative studies have provided brief descriptions of difficulties that participants experience with mindfulness practice. Common difficulties include: finding formal practice time consuming and difficult to prioritise (Allen, Bromley, Kuyken & Sonnenberg, 2009; Williams, McManus, Muse & Williams, 2011); finding certain practices more challenging (Griffiths, Camic & Hutton., 2009); mental health difficulties interfering with practice (Finucane & Mercer, 2006; Mason & Hargreaves, 2001); feeling frustrated and self-critical after reducing practice (Allen et al., 2009; Langdon et al., 2011); and finding it challenging to structure and upkeep regular practice without the group practice context and support (e.g. Allen et al., 2009; Finucane & Mercer, 2006; Williams et al., 2011). Some studies have also mentioned factors that facilitate practice, in particular being part of an MBCT group, leading to some participants wishing for ongoing group practice (e.g., Allen et al., 2009; Finucane & Mercer, 2006; Williams et al., 2011).

However, these qualitative studies often have not distinguished between practice during and after or outside of the intervention, and the descriptions about practice have generally been brief and not the main focus of the studies. The one exception is the study by Langdon et al. (2011), whose aim was to explore the

subjective experiences of post-intervention practice and the facilitating/hindering factors to this. Langdon et al. (2011) interviewed individuals suffering with physical and/or mental health difficulties who had participated in an MBCT course in the last 4 ½ years. The method of Grounded Theory was used to develop a theory of post-intervention practice, and the findings indicated that participants ‘moved in and out’ of practice over time, with practice decline being attributed to various obstacles such as psychological struggles, time management difficulties and finding practice challenging. Practice was reinforced by the positive impact it had, which led to a virtuous practice cycle. Facilitating factors included attending refresher sessions, reserving time and space for practice, and doing shorter formal practices. Langdon et al. (2011) provide useful information regarding the post-intervention practice experience, particularly with regards to the finding that individuals’ practice fluctuated over time; this seems important to understand better, given the theoretical importance of upholding consistent frequent practice.

While Langdon et al. (2011) explored the use of both formal and informal practice, the associated facilitating and hindering factors to these distinct practice forms may be different and therefore need to be explored separately. Given that research suggests (e.g. Crane et al., 2014) that formal practice is particularly important, a focus on this is warranted. Another limitation of the Langdon et al. (2011) study is that it used a mixed sample of individuals who had mental health or physical health difficulties and it was not clear to which group participants belonged: it is possible that the implementation of, and the associated challenges and facilitating factors to, practice may differ for mental health and physical health difficulties. In addition, Langdon et al. (2011) conducted only one interview with



each of their participants (at varying lengths of time since the intervention), which provides only a limited picture of how practice implementation evolves over time.

### **Rationale and aims of the current study**

Research suggests that formal practice during the MBCT course is of particular importance, yet we know little about how patients implement, use and maintain formal practice (or not) after the intervention ends. In particular, we lack an in-depth understanding of how the process of practice implementation and maintenance unfolds over time, and what facilitates or hinders continued practice. Part of the rationale for the increasing use of MBCT in the NHS is that its group format delivery make it a low-cost psychological intervention (Piet & Hougaard, 2011), which has been reported to be as cost-effective as antidepressants (Kuyken et al., 2015). This makes it crucial to understand how the people it is designed for go on to utilise it over time, so that clinicians can make treatment decisions based on the likelihood of treatment success.

The present, qualitative study aimed to explore individuals' primarily formal practice experiences over a nine-month period after completing an MBCT course. Qualitative approaches are well suited for providing rich descriptions of complex facets of individuals' lived experience (Barker, Pistrang & Elliott, 2016), and are a valuable tool for elucidating aspects of the experience of receiving therapeutic treatment (Hodgetts & Wright, 2007). Furthermore, the importance and value of listening to service users' perspectives in developing healthcare interventions has been increasingly acknowledged (Thornicroft & Tansella, 2005), and has been reflected in the Department of Health's consultation document "Liberating the NHS: No decision about me, without me" (DoH, 2012).

The study addressed the following research questions:

- 1) How do participants implement and maintain (primarily formal) practice (or not), following completion of the MBCT course? What are their experiences of doing so, and how does this process unfold or change over time?
- 2) What facilitates and hinders formal practice?

## **Method**

### **Ethical Approval**

The study received ethical approval from the National Research Ethics Service (NRES) in February 2014 (Appendix A). All participants were given written information (Appendix B) about the study and provided written consent prior to participating (Appendix C).

### **Setting**

The research took place in a London NHS Foundation Trust, in the Trust's two Improving Access to Psychological Therapy (IAPT) services. These were primary care mental health services that offered Cognitive Behavioural Therapies including Mindfulness-Based Cognitive Therapy to individuals with anxiety and depression disorders.

**Mindfulness-Based Cognitive Therapy (MBCT) course.** MBCT is a standardised eight-week manualised group course developed as a relapse prevention intervention for recurring depression. The course is designed to teach individuals mindfulness and cognitive techniques to cope with and 'step out of' self-perpetuating cognitive patterns of negative thinking that may escalate mood states to depressive relapse (Segal et al., 2002). This learning is promoted through psychoeducation and experiential learning in the form of mindfulness meditations and cognitive therapy

techniques. The standardised manual (Segal et al., 2002) outlines the structure of the sessions as follows:

Session 1: Automatic pilot

Session 2: Dealing with barriers

Session 3: Mindfulness of the breath

Session 4: Staying present

Session 5: Allowing/letting be

Session 6: Thoughts are not facts

Session 7: How can I best take care of myself?

Session 8: Using what has been learned to deal with future moods

The formal inclusion criteria (Segal et al., 2002) are that the patient must have experienced three or more episodes of major depression, be in full or partial remission from depression and be motivated and committed to the MBCT programme. Exclusion criteria include current drug abuse, organic brain damage, current or past psychosis, antisocial behaviour, personality disorder, active self-harm or suicide risk, and currently receiving other talking therapy.

In the IAPT services where the research took place, MBCT courses were run on a regular basis by two senior clinical psychologists. Typically, the groups had 8-15 participants at the start of the course. Where it was deemed clinically justified, the course facilitators occasionally relaxed the inclusion criteria to offer the intervention to patients who did not meet the formal criteria fully. This was grounded on practice-based evidence where the clinicians deemed that an individual was highly likely to gain therapeutic benefit. This included, for example, individuals who had only suffered two episodes of major depression, were still experiencing active depression but judged well enough to participate, or who had a mixed diagnosis of depression with other mental health disorders (such as anxiety disorders), or who suffered anxiety disorder(s) without depression.

## **Recruitment**

**Inclusion criteria.** In order to be eligible to participate in the study, individuals were required to:

1. Have attended a minimum of six sessions of an MBCT course during the last three months in one of the two IAPT services;
2. Understand written and spoken English well enough to provide informed consent and to be able to carry out the interview in English;
3. Be judged well enough to take part in the study by the clinical psychologist facilitating the MBCT course;
4. Have a minimum age of 18.

**Recruitment procedure.** Information about the study was presented verbally and in writing in a brief introductory letter which was given to all participants of three different MBCT courses run between March 2014 and March 2015. This was done in session six, on one occasion by the researcher, and the remaining two times by the clinical psychologist facilitating the course. Those who were interested in learning more about the research signed a tear-off slip on the introductory letter with their contact details and gave this to the group facilitator, who forwarded these slips to the researcher. The researcher then emailed or telephoned the patient (according to patient preference) and supplied more information about the study. Table 1 shows the recruitment process of the total of 26 participants who received the initial information about the study. Sixteen individuals expressed an interest after receiving further information and 10 consented to participate. The remaining six did not get back in touch with the researcher to pursue participation.

*Table 1. Recruitment process*

Stage	Group 1	Group 2	Group 3	Total
Received initial information	10	5	11	26
Expressed interest in further Information	8	2	6	16
Consented to participate	4	2	4	10

### **Characteristics of participants**

Characteristics of the 10 participants (five women, five men) are shown in Table 2. The mean age was 42 (range 27-51). Five participants defined their ethnicity as 'White British' (40%), three as 'Other White', one as 'White Irish', and one as 'Mixed'. Nine participants were in paid employment at the time of the study, one described having occasional work. Eight participants had higher education qualifications (e.g. undergraduate degree or higher), and two had school level qualifications (A-levels).

Depression and anxiety were the most commonly reported problems. Seven participants reported both depression and anxiety, while two reported recurring depression and one reported health anxiety. In addition, half of the participants reported having experienced significant levels of stress periodically, typically relating to work. Two participants reported being in remission at the beginning of the

MBCT course, while the others were experiencing mild residual symptoms or were currently symptomatic.

All participants had received treatment for their mental health difficulties prior to the MBCT intervention. All 10 had been prescribed psychotropic drugs previously, seven were taking psychotropic medication during the MBCT intervention, and one person tapered down their medication during the course. All participants had received talking therapy (e.g., CBT, counselling and psychodynamic therapy) at some stage prior to the MBCT intervention. One participant was seeing a Gestalt therapist during the MBCT intervention, as they had been for the last eight years. All participants had attended a minimum of six, but most had attended all eight of the MBCT sessions.

*Table 2. Participant characteristics*

Pseudonym	Age	Presenting problem
George (M)	42	Depression and social anxiety
Angie (F)	51	Depression and anxiety
Marie (F)	50	Anxiety and depression (and stress)
Stan (M)	46	Recurring Depression (and stress)
Jon (M)	51	Health Anxiety
Luis (M)	47	Depression and anxiety (and stress)
Yosef (M)	38	Depression and anxiety (and stress)
Rebecca (F)	27	Recurring depression
Ana (F)	37	Depression and anxiety (and stress)
Lilian (F)	32	Depression and anxiety

*Note:* All names are pseudonyms

## **Semi-structured Interviews**

Participants were interviewed at three, six and nine months after completion of their MBCT intervention. Two semi-structured interview schedules were developed for the study, the first for the initial interview at three months, and the second for the subsequent interviews (see [Appendix 4](#)). These were developed in liaison with an experienced researcher (the academic supervisor of the study) and after consulting the literature on MBCT. In addition, the interview schedules were informed by the Change Process Research framework (Elliott, Slatick, & Urman, 2001), which was developed to assist in qualitative research focusing on why and how change happens in a given mental health intervention. Specifically, the interview schedules drew on the Change Interview protocol (Elliott, 2010) to enable a rich understanding of any change that had occurred over time, and how participants understood this. Although the interview covered these broader areas, the focus of the current paper is on the experience of mindfulness practice.

The first interview schedule focused on the experience of learning, practising and implementing (or not implementing) mindfulness practice during the course and in the following three months: if and in what way practice was utilised, what had been found helpful or unhelpful, what was perceived to facilitate/make difficult implementation of the mindfulness practice, and any perceived therapeutic impact. The second interview schedule focused specifically on practice, implementation (or lack thereof), and any change experienced (or lack of change), over time.

The interviews were conducted in a flexible manner with the interview schedules serving as a guide, allowing the interviewer to explore the areas of interest while remaining responsive to each participant's account. Questions were open-ended and non-directive to allow participants to talk about what was important to

them. In order to avoid socially desirable responses, participants were encouraged to describe unhelpful, difficult and negative aspects of their experience of MBCT as well as positive aspects.

All of the initial interviews (at three months post-intervention) were conducted face-to-face. Subsequent interviews were carried out face to face, over the telephone or via Skype (Skype Communications, Luxemburg), according to participant preference. The first interview lasted on average 45-60 minutes, and the subsequent interviews lasted on average 20-35 minutes. All interviews were audio-recorded.

### **Qualitative Data Analysis**

The data set consisted of 28 interviews; eight participants took part in interviews at all three time points, and two took part in interviews at two time points (at three- and six-months). The interview recordings were transcribed verbatim (seven by the researcher and 21 by volunteering student assistants); all transcripts were anonymised.

The data were analysed using the method of thematic analysis as outlined by Braun and Clarke (2006). Thematic analysis allows for flexibility particularly with regards to underlying epistemological assumptions, especially regarding the nature of language (Braun & Clarke, 2006). A realist approach was taken to the analysis, holding the assumption that participants' verbal accounts reflected their lived experience. The analysis was driven by the research questions of the project (i.e., the experience of implementing mindfulness practice).

The analysis broadly followed the six phases of thematic analysis described by Braun and Clarke (2006). The first step involved familiarisation with the data set by reading and re-reading all transcripts and noting down any initial observations



relating to the research questions. The second step involved assigning thematically descriptive codes to segments of the data relevant to the research questions. Given the longitudinal nature of this data set, a separate ‘summary code document’ was developed for each participant based on the three interview transcripts. All codes that were relevant to the research questions were collated and organised in a manner which allowed the researcher to hold a temporal focus (i.e., participant experience over time) in mind. In the third phase, codes were grouped together to generate themes that coherently captured meaningful patterns in the data relevant to the research questions, and the subsequent construction of an initial visual representation (‘thematic map’) of these. The fourth phase involved revising the themes to ensure that these coherently ‘fit’ and represented the individual accounts as well as the data set as a whole and that they were distinct, but related. By examining the frequency of relevant material across the data set and within individual transcripts, a final set of themes were generated. In the fifth phase, further analysis and synthesis of the data was carried out, with the intention to capture and refine the central idea or ‘story’ of each theme and naming it. The sixth, final, step, consisted of writing up the themes. This final step is an essential part of the analysis where a coherent integration of the data and the analytic “story” (Braun & Clarke, 2006) take place with the purpose of producing a meaningful and relevant illustration of the data that answers the research questions.

**Credibility checks.** In order to ensure that the analysis was carried out in a rigorous and systematic manner and that the findings were coherent and credible, established quality criteria were used for guidance (e.g. Barker & Pistrang, 2005). Several credibility checks were conducted. Credibility checks serve to ensure the ‘trustworthiness’ of the conclusions that are drawn (Elliott, Fischer, & Rennie,

1999). The first author worked closely with the thesis supervisor during the entire research process, to ensure that interpretations were grounded in the data.

Specifically, the thesis supervisor read multiple interview transcripts, and extracts of transcripts, and reviewed and commented on the coding of these, as well as the grouping of codes and ‘building’ of themes, throughout the analytic process, until a consensus on codes and themes was reached.

In addition, all participants in the study were invited to read extracts of the findings and comment on how accurate and representative these were of their experience, a procedure known as ‘respondent validation’ (Mays & Pope, 2000). A comprehensive audit trail of all research activity was collated during the research process, including all raw and coded data, transcripts, synthesised thematic maps and reflexive notes.

### **Researcher perspective**

Qualitative research inevitably is subjective to some degree in that the researcher influences the research process through what experiences and assumptions they bring to it (Willig, 2013). It has been argued that by providing a transparent account of the assumptions and perspective that the researcher has brought to the research process, the quality of the research is enhanced (Silverman, 2000).

I have a personal and clinical interest in MBCT, having facilitated in the running of, as well as having participated in, an MBCT group as an undergraduate psychology student. Furthermore, I wrote my undergraduate dissertation on the topic using a qualitative approach, focusing on the effect of MBCT. In addition, I have periodically engaged in informal and formal mindfulness practice over the last nine years. Based on my experiences, particularly of interviewing MBCT participants for

my undergraduate research project, I held assumptions that mindfulness practice is and can be a highly effective intervention for a range of mental health difficulties and that most patients who find the intervention helpful wish, and manage, to maintain their personal practice to some degree. I attempted to “bracket” (Smith, 2008) my own assumptions in order to avoid them having an undue influence on the research process, by for example ensuring that the interview questions were neutral, open-ended and allowed for negative and unexpected accounts. Furthermore, I regularly reflected my own experience and ideas with my supervisor with the intention to monitor and, where possible, “set aside” my own perspective, while also acknowledging that my clinical and personal experience could be a source of important insight (Tufford and Newman, 2012) thereby aiding my understanding of the data and its implications.

## **Results**

### **Context: Overall Experience of the MBCT Course**

Nine out of the ten participants described having engaged with the MBCT course, carrying out the homework assignments, including regular mindfulness practice; one described minimal engagement (saying that she had fallen asleep most of the time). Of the nine who had engaged, eight reported that the intervention had had a significant or noticeable positive impact on their mental health, ability to cope with difficulties, and general wellbeing. A range of positive effects were reported, the most common being: relating differently to thoughts and feelings; spending less time ruminating and thinking about difficulties; feeling more in control of, or more able to respond helpfully to, difficult thoughts, feelings and external events; feeling more accepting; and experiencing a greater moment to moment awareness apparent in many contexts and areas of life. The one participant who had engaged with the

course but did not experience noteworthy effects thought that this was due to the severity of his mental health difficulties. All 10 participants reported positive beliefs about mindfulness practice, and its therapeutic potential and usefulness for their particular mental health difficulties. Seven of the participants were taking prescribed psychotropic medication during the intervention (e.g. antidepressants), and one participant tapered down their medication during the MBCT intervention.

## **Themes**

The analysis generated two clusters, or domains, of themes (Table 3). The first domain, 'Patterns of practice', describes how participants approached and implemented (primarily formal) mindfulness practice in the nine months after completion of the intervention. The second domain, 'Challenges to practice', concerns the challenges participants described in establishing and maintaining practice. Each domain of themes is presented in turn. Supporting quotes are denoted by interview time point, i.e., T1, T2 and T3 refer to the first, second and third interviews, respectively.

Table 3: Domains and themes

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<b>Domain 1: Patterns of practice</b>	
Pattern 1: Frequent practice that increased over time	
Pattern 2: Practice waxes and wanes	
Pattern 3: Practice is interrupted by mental health difficulties	
Pattern 4: Formal practice does not get established	
 <b>Domain 2: Challenges to practice</b>	
<b>Themes</b>	<b>Sub-themes</b>
1. Building a routine is hard	1.1 “You can feel lost afterwards”
	1.2 “How do you establish practise?”
	1.3 Practise is time consuming and demanding
2. I can’t do this on my own	2.1 “I don’t have the self-discipline”
	2.2 “Nobody will know”
	2.3 Needing a collective experience
3. The practice paradox	3.1 I can’t use the practice when I struggle and need it the most
	3.2 Feeling well can lead to less practice

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## **Domain 1: Patterns of practice**

Four distinct patterns of practice were identified. These differed in terms of frequency, intensity, maintenance and type of practice over the nine-month period.

### **Pattern 1: Frequent practice that increased over time**

Three participants, Ana, Stan, and Marie, described a pattern of practice characterised by formal, consistent practice that increased over time.

These participants reported that, at three months after completion of the intervention, they had implemented a moderate- to high- frequency practice routine of formal meditation practice, averaging three to seven practice sessions per week, each lasting 10-20 minutes. With every three month interval that elapsed, the minimum number of weekly practice sessions and practice time increased for Stan and Ana so that at the final interview (nine months post-intervention), they reported six to seven weekly practice sessions, each lasting 30-40 minutes. Marie, who did not participate in the final interview for external reasons beyond her control making it difficult to arrange the interview, maintained high frequency practice (four to seven practice sessions of 40-90 minutes per week) for more than six months post-intervention. The most consistent practice for all three participants across time was that of daily practice in the morning before work:

*I do practice the breathing meditation every morning... this helps me to.... be in the moment a lot during the day and to start with more awareness and calm. (Ana, T1)*

*So I know I have got 20-30 minutes of sitting down or standing up [on the commute] so I do it [meditation of the breath] then. Sets me up for the day. (Stan, T2)*

*I normally just do them once a day, listen to the recording when I wake up in the early hours, usually once a day. (Marie, T2)*

All three participants described how a wish to prevent further mental health suffering had led to making a conscious decision to take personal responsibility and control of their mental health. In turn, this commitment to improve emotional wellbeing translated into a disciplined practice routine and mind-set that helped sustain the practice even when common barriers such as a busy life style were experienced. Commenting on what enabled them to make use of the mindfulness practices, participants accounts described their determination to improve their wellbeing:

*Me being the person to make the change I think. And not wanting to be in that position where I was very depressed. (Stan, T1)*

*Just thinking about that I will be better. Making a conscious decision about my life. (Ana, T3)*

*It is (about) changing your mindset.... and it can be hard taking the time to stop and do something that is helpful....so you have to consciously decide to do that sort of thing. (Marie, T2)*

Reflecting on their commitment to look after their mental health using mindfulness practice, Ana, Stan, and Marie described feeling able to ‘plan ahead’ proactively to ensure that they utilised the different practices effectively. For example, Stan reported that he used his work diary to identify upcoming work stressors, and subsequently practiced on the weekend in order to prepare for these:

*Yeah, so I have been doing the practices normally 4 or 5 days during the week and sometimes also once or twice on the weekend. I make a point of doing it if I know I have got something particularly stressful on at work during the week, like a presentation or something. (Stan, T2)*

Similarly, Marie was experiencing high levels of worry in regards to a potential eviction but was able to deliberately utilise practice to reduce the anxiety which enabled her to make a proactive plan for the situation:

Marie: *Well I was very worried about this eviction. But I did consciously do the mindfulness CDs and things and it helped.*

Interviewer: *Mm, so what did you notice?*

Marie: *It's just that I didn't think of things too much... I was able to... I was able to write things down, what I will do if so and so happens. I was getting so stressed I was getting palpitations and it made it easier, I was thinking well I have a back-up plan, which I would have never had before.* (Marie, T2)

Such deliberate use of practices relied on these participants having a good understanding of what kind of difficulty (e.g., anxiety) they might experience in what situations, and furthermore they were able to identify what particular practice might be helpful, beforehand.

Ana's account illustrated this process well. She had a history of interpersonal difficulties and had consciously implemented a strict practice schedule during an extended family holiday in order to reduce her agitation in difficult social interactions. She actively chose practices that focused on compassion and acceptance, specifically for this purpose, to enable herself to engage and respond more helpfully to her family members:

*Mindfulness helps me to get a break and also to think about ...they are just human beings like me, so really if I hadn't done the mindfulness on those days I would have gotten nervous and started answering in a really bad way, shouting maybe, which I am not doing anymore.* (Ana, T3)

While these three participants could identify potential challenges to their continued practice (e.g. a busy schedule) it appeared as though they were able to actively prioritise and stay consistently engaged with practice even at challenging times:



*There are no real obstacles.. I do have the time because I take the time, and even if I don't, I need to do it! If I am more busy I probably need to do it more. (Stan, T2)*

*If I have any more life trauma... but I have been able to use it even though difficult things are happening.. I think I am always going to have trauma, it's just finding the time to be able to use the techniques. (Marie, T1)*

## **Pattern 2: Practice waxes and wanes**

Two participants, George and Luis, described a variable and cyclical pattern of formal and informal practice. Practice frequency and intensity was described to “fade and reignite” (George) over time depending on a range of internal and external factors and conditions, rather than following a particular routine or habit.

*I haven't done any meditation in over a week and a bit now; it tends to wax and wane. (George T1)*

Within this waxing and waning pattern, George and Luis further described that “re-connecting” with practice after a practice-free time interval occurred in a rapid surge onset of practice that then eventually declined over time at a gradual pace:

*I tend to do it in a flair of three or four in a week, until it gradually starts stretching out again. (George, T1)*

*If you had interviewed me three weeks ago I would have told you it was completely vital [to keep up] ... whereas at the moment I have not used it. (Luis, T1)*

Luis and George expressed clearly that despite periodic disengagement from their practice, they viewed it as still available to them, rather than permanently “cast aside” (George) and they were very confident that they would continue to reconnect with practice after any future ‘breaks’:

*We've got this toolbox, we just haven't opened it for a few months. (George, T2)*

Luis, who aspired to set up a mindfulness practice group in his local community, reflected on his original intention and desire to practice every day, and concluded that for him in his current lifestyle, that seemed unrealistic, but did not view this as a failure:

*That is part of the whole awareness and mindfulness practice anyway, there is no right or wrong way of doing it. (Luis, T2)*

Practice was implemented flexibly when internal and external conditions (such as mental health status and having time and privacy) were “right”. Luis described how this flexible approach allowed practice to fit into his life naturally, and while he believed that consistent daily practice would be the most beneficial to him, he was reluctant to attempt to implement a strict routine or schedule given his hectic lifestyle:

*What is comfortable for me at the moment is flexibility. I might not do it today, I might not do it tomorrow.. ...I am going to do it as it comes. I am not making any pressurised plans for myself. (Luis, T2)*

George, while reasonably content with the waxing and waning of practice, explained that even short breaks in practice could lead to a loss of momentum which made re-establishing practice after a break challenging. For this reason he too ideally would have preferred an established, consistent routine without breaks:

*It's far harder to dip in and out than it is to sort of keep it going, even if it just a... low maintenance thing, once or twice a week. (George, T3)*

Both participants described the vast majority of their practice not only as unplanned, but as consisting almost exclusively of unguided exercises (e.g. silence with bells meditation, or meditating on the breath while doing hot yoga) over the course of the nine months following the MBCT course. They also reported engaging

in informal practice such as taking a mindful approach to everyday tasks and experiences, but considered the formal practice to be key:

*95% of what I do is just sitting with bells. (George, T1)*

*No I don't use any guides, I just do it myself. (Luis, T1)*

### **Pattern 3: Practice is interrupted by mental health difficulties**

Three participants, Jon, Lilian, and Rebecca, described a pattern of practice where a fairly steady practice routine was interrupted by mental health difficulties at a relatively early stage. While these participants reported that their mental health improved in time, they did not re-establish practice in its original form.

Immediately upon the MBCT course finishing, a fairly high-frequency (two to five practice sessions weekly), primarily formal guided practice routine was established. Practice was unplanned and did not follow a particular schedule or routine, and the length of practices was reported to be relatively short (10-20 minutes). Rebecca and Jon reflected on the potential impact of these time and frequency reduced practices compared to the routine followed during the course:

*These little practices and this general awareness is you know really helpful but I think... if things got worse, then I'm not sure if they'd sustain me and I might have to go back to doing you know long sustained um practice. (Rebecca, T1)*

*Longer probably is better I would imagine. (Jon, T1)*

Sometime between mid-point of the group intervention and four months after the completion of the MBCT course, these participants experienced an onset or relapse of mental health difficulties, such as health anxiety and depression, which disrupted the practice pattern. These “dips” (Lilian) had such emotional impact that maintaining mindfulness practice was either not considered a priority, or was felt too challenging due to feeling unwell and lacking motivation and energy:

*It was just a case of struggling to get through the day basically, and it didn't really cross my mind particularly. (Lilian, T2)*

*The depressive feelings came first, and that caused the onset of loss of routine because I really felt like "I can't be bothered"... a general loss of proactiveness came along at that time. (Rebecca, T2)*

Jon described how he struggled with health anxiety thoughts again after a time of respite at mid-point of the intervention, and experienced these thoughts and physical sensations with such intensity that they overpowered the perceived potential potency of MBCT. Consequently, Jon lost hope that MBCT could be effective for him:

*My health anxiety problems are too strong. They kind of win kind of thing. It's like a sort of, defeat kind of thing. It's like, it's not going to help because I am too concerned about other things [physical symptoms] (Jon, T1)*

Lilian, unlike Jon, reported a continued conviction in the potential relief that practice could offer for her depression, but that she was unable to utilise it during a depressive episode:

*I was feeling down, low, negative about the future. And I sort of knew that mindfulness would be beneficial for that state of mind but but.. (Lilian, T3)*

These three participants described "coming out of the dip" (Rebecca) after a few days or weeks. However, despite feeling better psychologically, practice was not reinstated in its original pattern:

*I lost touch with the practice [during depressive episode] ....just kind of gradually day by day got better...so yeah I think I just lost touch with the practice and then I got back into my day-to-day routine of things without it being there. (Rebecca, T2)*

*It's like the negative thinking won, it's winning and I don't have the technique, or the willpower or whatever it is, or faith in it, to reapply myself. (Jon, T1)*

Instead, formal practice rapidly dwindled to a very low and irregular frequency and eventually came to a halt around six months after the completion of the course for all three participants.

*What I have completely dropped off and haven't done any of is the sitting, getting one of the guided meditations cued up. (Jon, T3)*

*Not in the way I would have liked to or think you need to use it to benefit really... when things got hard after our last conversation I did not use it despite feeling motivated. (Lilian, T3)*

Lilian and Jon reported that they maintained some very occasional (e.g., twice per month) informal “doing a moment” (Jon) of mindfulness practice at times of distress (e.g., focusing on the breath or attending with awareness to sounds) and reported feeling very confident that they would continue to engage with this kind of ‘minimal’ informal practice occasionally. In reflection on their loss of mindfulness practice, all three participants expressed a wish to re-engage, a belief that MBCT could likely be “really helpful” (Lilian) for their mental health, but that maintaining formal practice independently, as they had tried, was very challenging.

Rebecca described frustration at having lost touch with practice in the penultimate interview but remained optimistic about re-engaging:

*I still think it's a really positive thing and I still feel enthusiastic about the whole practice, I have just fallen out of the habit. (Rebecca, T2)*

Rebecca did not participate in the third and final interview, for reasons she chose to not disclose, but stated in communication that she had been practising “very little, as in not really at all”. Lilian, similarly to Rebecca, expressed frustration; she held a “relaxed” outlook on mindfulness practice, feeling that it was available to her, but frustratingly to her this did not translate into behaviour (i.e., establishing and maintaining practice over time), and therefore was not a helpful view to have:

*I feel that I could sit and do mindfulness practice when we hang up, I feel that it is still available to me... but I don't want it to be a relaxed thing! I don't want to think 'oh I can use it whenever I want' cause I think it's actually really helpful if you do it regularly. So I don't find it particularly comfortable that I know it's there and I can do it. (Lilian, T3)*

#### **Pattern 4: Formal practice does not get established**

Two participants, Yosef and Angie, reported no formal practice in the nine months following the MBCT course, but did describe some limited, occasional informal practice.

During the intervention, Yosef had engaged fully, followed the daily homework assignments, and subsequently reported significant improvements in his ability to cope with stress. Angie described very minimal engagement, having “had a feeling that was going to happen”, and reported that she had “fallen asleep most of the time” and thereby had not experienced an impact on her mental health difficulties. However, what gradually developed over time, for both participants, was low frequency informal practice, specifically mindful focus of specific everyday activities:

*I do tend to think about the mindful focusing for everyday things and I try it when I can, for flossing or getting dressed, which would take longer when I drift off into daydreaming. (Angie, T2)*

*I notice things a lot more than before. I look at the things much more with intent than before. Like making coffee...I look at the dripping and things like that, I never did that before. Again, things like that, I'm more aware and trying to do less automatically. (Yosef, T2)*

The minimal informal practice that was reported six months post-completion of the intervention appeared to have “faded” (Angie) and “not come into mind” (Yosef) during the three months leading up to the final interview:

*I haven't really thought about it. (Yosef, T3)*

Despite the fact that these participants were not utilising any formal practice, and engaged only occasionally with informal practice, it appeared that some of the

philosophy and ideas of MBCT were perceived as useful. They described viewing their performance in different arenas of life more compassionately, something they attributed directly to the intervention:

*A more general attitude I am trying to adopt in my life, I think quite successfully. I think with compassion and attention and listening and letting go.* (Yosef, T2)

*I don't use it formally...but yes like I said I am less hard on myself and I try to be more mindful.* (Angie, T2)

## **Domain 2: Challenges to Practice**

The majority of the participants described challenges to starting and establishing independent practice after the intervention finished, feeling unsure of how to do so, and finding practice demanding. These challenges were a central part of their experience after the MBCT course ended.

### **Theme 1: Building a routine is hard**

Lacking the externally structured and organised 'frame' provided by the MBCT course, participants experienced a sense of feeling lost, a lack of structure and routine, and struggling with the demands of practice.

#### ***Sub-theme 1.1. "You can feel lost afterwards"***

All participants but three (Ana, Stan and Marie) spoke of challenges that they encountered in the first months after the MBCT intervention finished, specifically with regards to establishing independent solitary practice, expressing a sense of uncertainty and disorientation. Luis, a health professional, felt that a discussion and focus of how to make the practice sustainable "was missing" from the intervention alongside "a choice in how to continue or be followed up" and that this directly impacted the potential effect of the practice for him:



*If someone would have helped me continue with the sustainability of the practice, I would say the effect of the anxiety would be significant. I have to say, it is a good intervention, the problem is it needs to be somehow be redefined to be sustainable.*  
(Luis, T1)

Yosef, similarly to Luis, expressed a sense of “where next?” and had wished for a conversation with the MBCT tutor at the end point of the MBCT course, to consolidate and reflect on the experience of the intervention and think together about how to implement and sustain practice going forward:

*A little bit of a one-to-one sessions with the tutor, not practising but a conversation... because it was completely new to me. I wasn't sure what to expect.*  
(Yosef, T1)

Lilian, similarly, explained that had it not been for the upcoming reunion session she would have felt “a bit lost... but knowing that stuff is coming up helps”. The majority of participants described some uncertainty about how and where to access good quality practice materials such as books, meditation audio recordings (“there are 3000 recordings out there”, Luis) and local meditation groups to join:

*I want to find a sitting meditation group to go to every week but I don't know where or how to find it.* (Rebecca T2)

*There should be centres, places where people can drop in to keep their practice going. It's a tremendous intervention but how do you sustain the effect? I think the way practice is offered is messy. People don't know where to go to get it.* (Luis, T2)

*Maybe [if the tutors could] at the end of the course stir people towards, you know... I don't know if there are any secular ones [mindfulness meditation groups]?* (George, T2)

Participants' accounts illustrated the challenges of ‘finding one's feet’ with regards to practice when the course finished, highlighting that the majority did not have a plan for how to continue their practice, a clear idea of how to set this up or where they could go to do so:

*My plan was to do it at least once a day. In what situations I haven't grasped ... I haven't grasped a routine or even you know gone to the places they recommend you to go. (Luis, T1)*

Several participants expressed a wish to partake in the MBCT intervention again, or go through all the worksheets and CDs, seemingly as a way to (re-)orient themselves to their practice and the ideas of MBCT:

*I'd be a bit more focused, writing things down, listening more, implementing things more... the first time it's unknown... it's like reading a book for the first time and then when you read it again you are more focused. I wish I could find the worksheets she gave me to delve a bit more rather than just listening to the same two CDs. (Marie, T1)*

*What I thought would be useful would be to read through all the work packs you were given in each session... you know almost sort of go through it all again. (Lilian, T1)*

### ***Sub-theme 1.2. "How do you establish practice?"***

All participants identified the external structure and routine (e.g. set weekday, time and location) of the weekly group as facilitating their engagement and commitment to the practice. Furthermore, the manualised intervention prescribes set weekly homework. This "external structure" was referred to by all participants as helpful for their practice routine in keeping practice "front and centre" (Jon). Seven of ten participants found that they struggled to establish independent practice habits once that structure was removed.

*During the course it was easy because you knew you were practising a specific theme in anticipation of the class the following week...because of that structure being it was easy to stay on top of. You had the 'we're going to do six of these this week' in order to for that to feed into the class next week. You had that kind of...end-point of the upcoming class...so I think for that lack of external structure it was a bit difficult for me to carry on without it. (Rebecca,T2)*

*It's very difficult to get yourself out of your auto pilot in your life and I think there is intervention needed for that. Maybe some kind of routine, some external routine, which I don't have. (Yosef, T3)*

All participants but one (Angie) actively set out to make mindfulness practice a consistent routine activity in their life. However, six out of those nine participants described challenges with this endeavour, specifically struggling with following a practice schedule, practising as often as desired and making practice a habit:

*I just found it difficult to make that [formal practice] part of my routine or habit so probably didn't do them as often as I should have. (Rebecca, T1)*

*Following a schedule has been difficult for me. (Luis, T3)*

*It hasn't seamlessly blended in with my life, I don't do it automatically, I have to remind myself. (George, T1)*

Most participants believed that in order to sustain practice they needed to establish a consistent practice routine which would, eventually, promote effortless habitual daily practice that would consequently require less effort:

*It almost feels like it hasn't broken down the barrier of being an everyday practice. I imagine if I got through whatever that barrier might be and did it enough times it would be part of my everyday ordinary life. But I haven't done that. (Jon, T1)*

*If I was able to set up an everyday routine the practice wouldn't require as much mental energy and then it would be easier to do. (Lilian, T2)*

Three participants (Stan, Marie and Ana) were able to establish a disciplined practice routine immediately after the intervention finished. While they acknowledged a range of possible challenges in doing so (such as finding the time), they reported no significant difficulties. They described good organisation and structure as part of their personality and lifestyle and suggested this as a facilitating factor in establishing a practice:

*I'm quite a structured person, quite a logical person. So I don't know if that makes a difference. My job is planning, so I'm probably more able to cope with that in my life, some other people probably haven't got the structure. (Stan, T3)*

Furthermore, for these three participants, the experiential therapeutic benefit during the course was described as a reason to establish independent practice:

*Just that it helps me. I think that's why. (Marie, T2)*

Luis, on the topic of structure and routine, hypothesised that the very nature of the mental health problems that MBCT users suffer from (e.g. depression and anxiety) might impact on their ability to implement a practice routine without support:

*The difficulty here is how to help patients who are coming with conditions which in a way implies difficulty having structure... how do you establish practice!? (Luis, T1)*

### ***Sub-theme 1.3. Practice is time consuming and demanding***

Most participants, when reflecting on the challenges of building a practice routine, spoke of the time consuming and mentally/emotionally demanding nature of practices. The length of a meditation practice affected for many whether it was perceived as 'doable': practically (e.g., for time restraints), emotionally (e.g., for tolerating distress) and physically (e.g., for tolerating physical discomfort when sitting for long). The longer practices (over 30 minutes) appeared especially challenging to engage with, leading for several individuals to "resistance" (Jon), particularly in the first few months of independent practice. For some participants, this resistance and difficulty with longer practices remained (e.g. Ana, who despite daily practice felt unable to do the 50 minute meditations at the time of the third interview), whereas others (e.g. Stan and George) adapted and gradually utilised longer practices. Reflecting on the challenge of longer practice, participants said:

*With the guided meditation with the CD's and thing, I know that it lasts 50 minutes...It's something about the 50 minutes...(Lilian, T2)*

*The body scan was much better [than some other practices] but who has 40 minutes in the middle of the day? (Yosef, T1)*

Reasons for resistance to longer practices were described as not only relating to time pressures and a busy life, but rather relating to the experience of 'sitting with' and tolerating a range of uncomfortable emotions, thoughts and physical sensations for a length of time, something which requires mental stamina and patience:

*I find it so so boring.... It just feels like the usual overthinking. (Angie, T1)*

*I actually found that the mindful practice requires mental energy. (Lilian, T1)*

For several participants, "learning to tolerate discomfort" (e.g., George, Ana and Rebecca) was one of the main benefits of MBCT. Ana described an experience where meditation practice led to painful emotions that she would have typically avoided, but now realised that she could "survive". However, some participants described that at times they found it too challenging to gather the mental focus and acceptance required by practice and might be more inclined to seek out distraction through 'keeping busy' instead:

*Sometimes I don't wanna sit still and be quiet and ruminate on that and I'd rather be active.. like occupy myself with some activity to take my mind off it. (Rebecca, T2)*

*That has sort of made it a barrier to me when I just want to distract myself... rather than um.. focus. (Lilian, T1)*

All participants acknowledged and believed that longer practices were important and "helps more" (Ana, T2) and those who struggled with them hoped to discover ways of "getting past the resistance" (Jon, T1).

## **Theme 2: I can't do this on my own**

All participants reported that interpersonal factors experienced during the group intervention were helpful and, for many, significant to practice success; when these were 'lost', the majority of participants struggled to some degree in setting up and maintaining solitary practice.

### ***Sub-theme 2.1. "I don't have the self-discipline"***

After completion of the MBCT course, all participants but one (Angie) set out to establish independent practice with the intention of sustaining it for the long term. However, all but three participants (Stan, Marie and Ana) discovered at an early stage that occasionally, periodically or much of the time, "laziness" (Luis) and "inertia" (Jon) made it difficult to "stick with the discipline" (Lilian):

*I would like to be a little bit more disciplined.* (George, T3)

*I just haven't been doing it. I've tried it for two weeks in a row but I don't have the discipline.* (Angie, T1)

The three participants who did not report struggling with self-discipline and willpower described that the positive effect of the practices on their wellbeing motivated them sufficiently to keep their practice routine up:

*I tell myself 'it does help me so I should do it'.* (Marie, T2)

*I don't think I need anything to help me continue. I think the continued positive feedback from myself. If I see benefit in what I am doing I am going to continue doing it.* (Stan, T2)

For those who did struggle in some way, the positive benefits reported were not sufficient to support continued independent practice. More than half of the

participants spoke of the temptation to skip planned practice altogether at times, or to terminate a practice session prematurely, often due to a feeling that they “could not be bothered” (Lilian).

Most participants reported that during the MBCT intervention the presence of the group had increased their willpower to persist with practice, making it more difficult cancel or terminate a practice, and thereby counteracted a lack self-discipline:

*I find it quite easy to just want to give up after five minutes whereas in the class itself obviously you can't just... give up because everyone's meditation is together and its guided and you're there.. you'll keep going with it and persevere for the whole 15 or 30 minutes or however long it is. (Rebecca, T1)*

*With a group you can't do that [cancel] as easily, (there are) too many people to negotiate or rearrange with. (Lilian, T3)*

Three participants (Lilian, Rebecca and George), reported that they had occasionally practiced with someone else (e.g., partner or friend) after the group had finished, and that this had effectively eliminated the need for self-discipline as they were motivated to uphold practice for the benefit of the other person:

*Having a partner who if anything was more enthusiastic and open to the idea than me. Who, if anything, benefitted more than me. So there's always a feeling I have to keep it going for her. Just being supportive, I don't care how knackered I am. I say to her: If it's important for you to meditate, we'll meditate! (George, T1)*

*Having another person...you know who I cared about a lot and who I wanted to succeed as well... kind of made it important for me to succeed and stick with it...because I wanted him to succeed and do really well with it too..I don't necessarily have a massive amount of discipline a lot of the time and I'm not very proactive I think so having other people around me sometimes propels me to take more action. (Rebecca, T1)*

Those who described lacking willpower and self-discipline described this as a very real threat to the likelihood that they would continue their mindfulness practice

in the long term. Yosef, who had not found himself able to establish a formal practice routine despite experiencing the MBCT intervention as “very helpful” concluded that he needed somebody else to organise and guide his practice and “tell me what to do”, and if this did not happen, he was unlikely to set up and follow a practice routine at all:

*If I were contacted by someone else suggesting or offering or telling me there is a meeting at that and that time, I would go. I know it's kind of needy or demanding of me to suggest that, but it would have worked. (Yosef, T3)*

George reflected on the commonly experienced challenge of lacking willpower and discipline to maintain practice, and how he, and most of his fellow group members, believed they could ‘bypass’ this obstacle if they had access to further group practice, something that perhaps would defeat the purpose of an intervention designed to help participants ‘help themselves’:

*At the same time the whole point of the course was to sort of, you know, teach us to fish, not to endlessly dole out fish... you can't have, you know, endlessly open ended courses forever there, for people just to stop us discontinuing. (George, T2)*

### ***Sub-theme 2.2. “Nobody will know”***

All participants but three described that not having somebody to “report one’s work to” (Angie) and be held “accountable to” (George) was detrimental to sustained consistent practice, whereas somebody else “knowing about” (Rebecca) and monitoring one’s progress was considered helpful:

*If I just do something at home, nobody will know whether I have done it or not and it is only me who will suffer. (Lilian, P3)*

Several participants described how the ‘reporting to’ aspect of the MBCT course reminded them of school, in that there were perceived expectations of commitment and adherence from a tutor and fellow group members. The desire to be



a “good diligent student” (Jon) had reinforced commitment to practice routines and homework during the intervention.

*So it's kind of almost school like, you know. It's homework and then if you don't do your homework you're at a disadvantage sort of thing. (Jon, T1)*

*You don't want to be the kid who hasn't done his homework... you know, it kind of keeps you in check, you know. (George, T2)*

Participants described striving for and enjoying a kind of approval: “not outright praise, but being validated by another person” (Lilian) for engaging with the intervention. Equally participants described wanting to avoid potential negative social and emotional experiences such as guilt or disapproval, that could result from others (i.e., the tutor and group members) knowing that they had not attended a session, or for “dropping this, given the time and effort I've put in, and other people have as well” (Jon, T2).

The notion of others ‘monitoring’ one’s participation and progress could hypothetically be considered stressful or otherwise negative. However, participant accounts illustrated that this perceived ‘pressure’, (which was internal rather than expressed by the tutor or other group members) was considered positive, as it served to ‘push’ them into doing something good for themselves. Many of the participants described how solitary ‘self-care’ had been an area of difficulty for them historically, whereas conforming to a formal group activity and “being led by someone else” (Rebecca) was easier:

*Being obedient helped during the course. And I am very obedient. (Yosef, T1)*

Angie, who despite not engaging with MBCT was an advocate and enthusiast for the potential of the intervention thought that having someone who knew about one’s practice progress was crucial and implied caring support:

*It's always that thing.. if I'm left to my own devices then...I just won't do it. But if someone says I'd like you to do it, and could you tell me that you've done it? I'll feel sort of guilty.. which I know it's not good to feel guilty, but it helps me...It's not a horrible pressure, it's a nice pressure. So for me I need a nice pressure...sort of somebody wants me to do it - they're there for me. (Angie, T3)*

Six participants, including Angie (who never participated actively in practice) described that the research interviews served a similar function (if not as powerful) to the group and tutor context, with regards to the benefits of ‘somebody knowing about’ one’s practice. It was reported that the interviews served to keep participants “connected to the mindfulness” (e.g., Lilian and Rebecca) ideas and practices, and motivated them “get back into it” (George) at times of practice breaks. The interviewer asked neutral questions about their practice or lack thereof and did not attempt to encourage or influence their view or use of MBCT, but the mere act of “checking in with someone” (Rebecca) about practice and their experiences of it, appeared to prompt and motivate participants. More than half of participants spoke of needing such external personal “nudges” (e.g., Jon and Lilian) from somebody else to keep going, and did not think that an impersonal automated digital reminder, for example, would have the same impact. In addition to being “nudged” participants reported that they found the act of thinking of and talking about their practice helped motivate them:

*Talking about it [in the interview] made me want to do it more. (Lilian, T1)*

*I think this interview is helpful in just bringing those things back into my awareness, talking with you about it reminds me why I liked it and encourages me to do it. (Yosef, T2)*

*If you and I didn't have this conversation it would just fall to the side because its just not part of my routine.. because of these conversations, it makes me give it consideration through that process of verbalising it and thinking about it and.... Signposting my progress. I think maybe now I will try and get back into it but that*

*does result from a conversation between you and I. Without something like this to remind me about or consider it again and make me really think about it.. I am not sure I would.* (Rebecca, T2)

### ***Sub-theme 2.3. Needing a collective experience***

Throughout the interviews, participants described and reflected on the process of transitioning from group to solitary practice. Most described an associated ‘loss’ of social experiences that were perceived as significant for more than half of the participants’ practice success, and for some, “central to the impact” (Luis) of the intervention. Firstly, a “reassuring” (Rebecca) process of identifying with and understanding the experiences and struggles of others took place during the MBCT course, reducing the sense of solitude and unusualness of their difficulties:

*These people are like me.* (Jon, T3)

*I realised I was not alone.* (Marie, T1)

*We are all in the same sort of boat.* (Marie, T2)

Through this process and the “strong shared experiences” (George) of practising meditation, reflecting on one’s psychological difficulties, and learning cognitive techniques together, a “community ethos” (Luis) developed. Angie, who did not engage actively with the meditation practice at any stage of the intervention, still experienced this sense of a “community feeling” and found the group context “comforting”. On reflecting about what exactly it was about the group context that was helpful, most participants referred to a sense of shared “collective focus” (George), of “being in this together” (Jon). Some participants referred to more difficult to define social experiences that were described in more spiritual terms:

*You know we're all kind of rooting for each other, so there is bit of a bond made...but it is also more profound than that.* (George, T3)

*Just the energy of the people in the room was.... healing.* (Lilian, T1)

Of the six participants who struggled in some way to maintain consistent practice subsequent to the group finishing, five thought that group practice contained “key” (George) social experiences that were naturally not possible to replicate in solitary practice:

*People need something bigger [than books/audio recordings] to keep it up. You need the moral and social support of other people to do the practice. (Luis T2)*

The collective context and focus was considered especially important for some participants who regularly experienced difficult thought patterns and overwhelming emotions that negatively affected their practice, for example by reducing motivation or sense of worth to engage in self-care. Practising with others appeared to reduce the focus on the self and one’s internal experiences, enabling participants to engage more fully with and feel positive about practice:

*The collective focus enables you to melt into the crowd. (George, T1) “*

*It [solitary practice] feels a bit sort of um indulgent or selfish actually, whereas if someone is doing it with you it feels like it’s a positive thing. (Lilian T1)*

In contrast, three participants (Marie, Stan and Yosef) did not feel that the ‘community feeling’ aspect of group practice was essential to them, but appreciated it and acknowledged that it likely would “help others continue and get support from each other” (Stan). Yosef wished for ongoing group practice for the purpose of it offering structure and routine, whereas Stan and Marie did not feel the need for any further group meetings at all for the purpose of sustaining their personal practice. They did report, however, that they, like other participants, had stayed in contact with some other group members after completion of the group as they cared about one another:

*I dropped an email to one in the group today, you know, asking how she is, and she wasn't doing well for a bit. Last time she said she has stopped for a while and given*

*up so I was saying 'how is it going you still doing the mindfulness stuff'? You know just ask how she is doing and find it out how she is, really. (Stan, T1)*

Apart from these three, the remaining participants concluded that the loss of the community to practice with had had a negative effect on their practice, especially in terms of frequency and consistency. All who struggled to sustain consistent practice with the exception of Angie, wanted to continue, and thought it would aid their emotional wellbeing. These participants repeatedly expressed a wish for the mental health service to provide further group practice opportunities, while at the same time feeling frustrated with themselves for finding solitary practice so challenging:

*It [further group practice] would have kept us on the straight and narrow...but either you learn to do it yourself, or one way or another its gonna end, you know. You can't have your hands held forever. (George,T1)*

*If you can find out why there is this sort of block for people to do it on their own I would love to find out! (Lilian, T3)*

### **Theme 3: The practice paradox**

A common experience reported by the majority of participants was that mental health had a significant impact on their ability and likelihood of engaging with practice. Participants were aware that MBCT is a relapse prevention intervention and that therefore regularity of practice is ideal. However, mental health status sometimes paradoxically 'disabled' some from practising at times of difficulty, and for some led to 'abandoning' practice at times of feeling well, subsequently risking future relapse.

#### ***Sub-theme 3.1. I can't use the practice when I struggle and need it the most***

All participants but two (Stan and Marie) reported having experienced difficulties utilising mindfulness practice at times of depression, stress or anxiety.

This was portrayed as “paradoxical” (Lilian) and “counterproductive” (Jon), as the practices became inaccessible at the time of need, by virtue of the nature of the very mental health difficulty they were hoping to utilise the practices for:

*In a paradoxical way, when my mind is uncalm, less calm, I find it harder to do. And I find it much easier to be welcoming and engaging with the idea of mindfulness and the exercises that we were given when everything is alright. And when the challenges are there, I find it harder. (Jon, T1)*

*I haven't used it for three weeks due to anxiety brought on by interactions with the health care system. I am trying to get my psychiatrist to review my medication.. it's very stressful. (Luis, T1)*

Lilian and Ana described vividly painful experiences of emotional distress that were so psychologically intense that attempts to connect to and use a practice they had deemed potentially helpful to calm their mind were futile, illustrating the complicated experience of living with and similarly attempting to take control of mental health difficulties:

*Last week I had an interview and I was feeling very nervous. Really, I couldn't sit still on the bed, I wanted to move, I just couldn't do it. It was a really stressful day, I was angry about something.. I just stopped the recording and said, 'today is not the day'. (Ana, T3)*

*I just remember sitting down and feeling like.. the floor was disappearing and almost sort of collapsing and I was just trying to do the breathing.. it was too many thoughts or too many feelings, I don't know which, I couldn't control it... I couldn't control my thoughts therefore I felt like I couldn't control any of my actions. (Lilian,T2)*

Jon, who experienced initial relief from his health anxiety thoughts during the first half of the group intervention, unfortunately found that they returned at the mid-point. Despite this, he continued to engage with the MBCT intervention and practices, but found himself so preoccupied with the health anxiety worries some

time after the course finished that he was unable to utilise the practices with sufficient frequency:

*I have not been diligent in applying the techniques on a frequent enough basis for it to be doing anything good to me. Because my fears and general mindset about my health and so forth seems to win. (Jon, T1)*

Rebecca found that a depressive episode led to negative thoughts about the practice and their importance, resulting in her not engaging with them:

*“[You think] ... I really can't be bothered, it doesn't matter” (Rebecca, T2)*

Experiences of finding oneself unable to employ mindfulness practice at “bad moments” (Ana) could lead to frustration and disappointment with oneself that for some participants compounded the effect of the mental health difficulties:

*You think, 'urgh, I can't even do mindfulness! (Lilian, T3)*

*That was a sort of disappointment in myself, yes. (Jon, T1)*

There were, however, numerous accounts of participants utilising mindfulness practice with very good effect at times of mild to moderate emotional struggles. Practices were described as a “first-aid kit” (Lilian) enabling “slowing down and taking a breath” (Stan), “stepping back and looking at things differently”(Marie), “focusing on sounds instead of my own thoughts” (George) and “being able to have a bad afternoon and then draw a line under it when you get home and enjoy a different experience.” (Rebecca). It appeared that the practices could be successfully implemented and effective when the intensity of the mental health distress was not too severe:

*“I will either crash and burn.. or be elevated to a sort of competence, and if I am in that I will do mindfulness.. whereas if I crash and burn...I feel like I am hardly a human being at all, and I can't do stuff. (Lilian, T3)*

### ***Sub-theme 3.2. Feeling well can lead to less practice***

Four participants (George, Lilian, Rebecca and Yosef) reported that in addition to poor mental health making practice difficult, experiencing good mental health had at times led to a decrease in practice, or complete breaks from practice:

*Often if I'm in a really good mind-frame that's when I'm less likely to do a formal practice.* (Rebecca, T1)

*When things are going well you don't bother to do it because then you are feeling happy.* (Lilian, T3)

George, who had fallen out of practice for two months at the second interview, stated, "I'm just feeling good!" to explain this break. Yosef, who had found the course very beneficial for coping with anxiety and stress, had not practiced formally since the course ended and reflected on the reason for this:

*I don't feel any urgency right now. Which is again when I think it about it, when I analyse it, I know that it's wrong! It's to prevent the next emergency, not to respond to the next emergency...* (Yosef, T2)

Two participants (Jon and Rebecca), when reflecting on this challenge, described how the 'infinite' nature of mindfulness practice, without a concrete 'end goal' (except than the avoidance of relapse of mental health difficulties) could be experienced as difficult:

*Just doing something every day without getting to a kind of end point is a little bit...I find it difficult to maintain for a long time.* (Rebecca, T2)



## **Discussion**

This study explored 10 individuals' experiences of attempting to implement and sustain (primarily) formal mindfulness meditation practice over a nine-month period following an MBCT course. Four distinct patterns of practice unfolding over time were identified from participants' accounts: frequent practice that increased; practice that waxed and waned; practice that was interrupted by mental health difficulties; and no formal practice ever established. Participants described several challenges, or obstacles, to implementing and sustaining practice. These focused on difficulties in establishing practice and building a routine, the solitary nature of practice (contrasted to the support and collective experience provided by the group intervention), and mental health difficulties having a paradoxical effect on practice.

While a number of previous studies have documented some challenges and facilitating factors to practice, particularly during the MBCT course, and one study has focused on the experience of post-intervention practice (Langdon et al., 2011), the current study highlights that the implementation and maintenance of formal practice (or lack thereof) over time may be characterised by distinctly different patterns of practice that dynamically evolve over time. This is consistent with the assertion that the process of integration of mindfulness is gradual (Grossman & Van Dam, 2011) and that the implementation is not static, but rather an ongoing process requiring patience and determination (Kabat-Zinn, 1994). Only one out of the four patterns of practice (three out of ten participants) identified in the current study demonstrated frequent practice that was maintained consistently over time; this suggests that more work is needed to understand how individuals with mental health problems can be supported to sustain their post-intervention practice.

Most strikingly, the majority of participants struggled to some degree to implement regular, consistent, ongoing formal practice after the MBCT course ended. This was despite having experienced the course as helpful and having intended to continue to practice at home (for all but one participant). Perhaps this is not surprising; formal practice was perceived as time consuming and challenging, themes that have been reported in other studies (e.g. Finucane & Mercer, 2006; Williams et al., 2011). The challenges in establishing a new habit or health behaviour have been well documented in the wider literature, with several behaviour change theories, such as the Theory of Planned Behaviour (Ajzen, 1991) and Implementation Intentions (Gollwitzer & Sheeran, 2006) proposing a range of mechanisms of successful goal achievement, such as having “if-then plans” and high perceived control. For some participants, a ‘waxing and waning’ of practice illustrated the tension between the aspiration to uphold practice and the associated challenges of maintaining self-discipline, routine and commitment in the context of an often busy life and competing demands. This particular pattern of practice corresponds with the findings of Langdon et al.’s (2011) study, which showed that individuals moved in and out of practice as they encountered obstacles (e.g. mental health or finding the time), and that the positive effects of practice increased motivation to practice more. Notably in the current study, an ambivalence towards fluctuation of practice was reported: while participants appreciated a flexible and non-pressurised practice and mindfully accepted ‘lapses’, they also wished for regular, consistent practice as this was believed to have a stronger therapeutic effect.

The solitary nature of practice post-intervention was highlighted as a major challenge by most participants. Their accounts were characterised by descriptions of powerful, for some almost spiritual, experiences of feeling strongly connected to the

group practice, of sharing practice and practice goals, and of the loss of the group experience after the course ended. The importance of group factors in MBCT has been noted in many previous qualitative studies (e.g. Allen et al., 2009; Finucane & Mercer, 2006; Griffiths, Camic, & Hutton, Fitzpatrick, Simpson, & Smith, 2010; Malpass et al., 2012; Mason & Hargreaves, 2001), commonly referring to a destigmatising, supportive experience that allows identification with others and feeling less lonely with one's difficulties. In the present study, the loss of social group factors were in fact found to be key to practice for many: during the course, social factors were reported to have had promoted adherence to practice and increased willpower and self-discipline. Post-course completion, these social factors and experiences were lost, and self-discipline and rigour of practice declined for most participants, despite high levels of commitment and positive beliefs about mindfulness practice. A sizeable minority of participants remained in contact with one another in order to maintain the group focus and connection with practice; most found that this was enjoyable but could not replace group practice.

The importance of the group reported by participants maps on to well established therapeutic group factors such as cohesion, universality, and learning about recovery from others (Yalom, 1995). The relevance of interpersonal and social factors for engaging in, or abstaining from, specific health-related behaviours is implicit in the theoretical framework underlying the work of several major support organisations, such as Weight Watchers and the fellowship Alcoholics Anonymous (AA). In AA, Members are encouraged to attend their group regularly as group and interpersonal processes (such as sense of belonging) are believed to directly underpin the mechanisms of abstinence (Lloyd Rice & Tonigan, 2012). Some authors (e.g. Allen et al., 2009) have suggested that non-specific factors such as group factors

may reinforce the process of learning mindfulness skills, while others suggest that the provision of ongoing practice (e.g. refresher sessions) is an important part of the intervention (e.g. Finucane & Mercer, 2006). Interestingly, however, a recent pilot RCT has suggested that individual and group MBCT may be equally effective (Schroevers, Tovote, Snippe & Fleer, 2016). Based on the findings of the current study and the theoretical importance of group factors in other interventions, interpersonal factors in MBCT deserve further research attention.

Interestingly and unexpectedly, nearly all participants in this study reported spontaneously that the research interviews (which did not aim to encourage practice or promote MBCT, but consisted of neutral, curious questions about participants' experience and reasoning related to practice) had increased their motivation to practice. The interviews seemed to provide an opportunity to reflect on one's practice trajectory and re-connect with, deepen or reconsider one's practice routine (or lack thereof). Similar experiences were briefly mentioned in Langdon et al.'s (2011) study. Participants' descriptions of this process map on to the processes of Motivational Interviewing (MI; Miller & Rollnick, 2013): a client-centred counselling approach for eliciting behaviour change through conversations defined by empathy, reflective listening and a non-confrontational interviewing style which elicits motivation from the client themselves, rather than trying to confront or convince the client of the benefits of change. However, such 'bursts' of motivation did not result in actual practice for all participants in the current study, specifically not for those whose practice had been interrupted by mental health difficulties.

Some qualitative studies have briefly noted that mental health difficulties can be an obstacle to practice: this includes OCD symptoms interfering (Hertenstein et al., 2012); low mood, anxiety and irritability reducing motivation and ability to

practice (Langdon et al., 2011; Lilja et al., 2015; Mason & Hargreaves, 2001); and for a very small minority, distressing experiences during practice (Bihari & Mullan, 2012; Finucane & Mercer, 2006; Segal et al., 2002). Consistent with this, the present study found that low mood and/or anxiety occasionally had a negative impact on practice for participants. More noteworthy, however, was that, for some participants, mental health difficulties had a substantial impact on formal practice, resulting in disengagement altogether and formal practice subsequently not being re-established despite the wish to do so and the belief that this would be beneficial. Such interruptions led to feelings of frustration, disappointment with oneself and low confidence in one's ability to establish practice without ongoing external support. Finally, the impact of mental health on practice was not limited to times of emotional discord; a two-way paradoxical effect was found whereby, for some participants, a reduction in or disengagement from practice (usually temporary) could also occur at times of good mental health, resulting from a lack of perceived need, from forgetting, or not prioritising, practice.

A small minority of participants were able to establish high frequency (four or more sessions per week) formal practice which increased, and was maintained, over time. Furthermore, these participants, although they valued the social aspects and the structure offered by the course, did not feel that they were necessary for them to maintain practice. It is difficult to know why these individuals differed so much to the majority in their practice trajectory (there were no obvious differences in background, age, gender or presenting problem). It is possible that factors such as personality traits, for example conscientiousness or extraversion and introversion (see e.g., Goldberg, 1993), influence how individuals approach and manage their independent practice. All participants reported some use of informal practice or

bringing the principles of mindfulness into their life, but this reduced over time for those who did not maintain consistent formal practice or stopped altogether. This is consistent with the idea that in order to uphold the effects, it is necessary to sustain formal practice (e.g. Segal et al., 2013).

## **Limitations**

A central limitation of this study is that the participants may not be representative of the broader population of those who take part in MBCT courses. Only individuals who had attended six or more MBCT sessions were invited, and of the 26 who were eligible, only 10 took part. The majority of participants in the study described MBCT as helpful, and all but one had an interest in continued practice. Therefore, the findings may not be applicable to patients who are less motivated or who experience significant challenges with practice implementation during the course.

Although the participants were typical of those using primary care mental health services in terms of their mental health difficulties (primarily mixed or co-morbid depression and anxiety), they were not representative in terms of socio-demographic characteristics. Nine of the ten participants identified themselves as White, eight had higher education qualifications and nine were in paid employment. Given that the majority of these participants experienced struggles in their independent implementation and maintenance of practice, it is likely that such challenges may be even more significant for individuals in less advantageous circumstances.

Finally, the current study did not collect systematic or precise data about practice, e.g., records of frequency, duration and type of practice. Instead,

participants relied on memory in describing their practice and experiences, thereby possibly forgetting or leaving out relevant aspects or inconsistencies. However, conducting three interviews at three month intervals may have helped to minimise such problems.

### **Research implications**

While research suggests that patients in remission as well as those with residual or current symptoms of anxiety and/or depression may benefit from MBCT, this study suggests that some participants may experience symptoms of such significance that it interrupts their mindfulness practice, thereby likely reducing the positive benefits over time. Research should examine the characteristics and subjective experiences of those who discontinue their practice in order to further develop the intervention and how it is offered, to reduce such instances.

Given that participants in several studies including this one have reported that ongoing group practice would increase the likelihood of maintaining their practice, future research needs to examine whether outcomes are better for patients who participate in ongoing group practice or regular ‘booster sessions’ of MBCT post-intervention, compared to those who continue to practice independently. Such research has potential relevance not only to the rationale for offering ongoing group practice post-intervention, but could also inform our understanding of potential therapeutic group factors that may enhance the impact of the intervention or be beneficial in their own right.

Seven participants in this study were taking prescribed psychotropic medication during the intervention; the implications for this on participants’ ability to engage, and the benefit they may derive, in comparison with those who are not

taking prescribed psychotropic medication, short and long term, seems pertinent to explore further.

Importantly, and rather unusually, this study employed a longitudinal design which enabled collection of very rich data over time, offering a more in-depth understanding of the complex experience of implementing a psychologically and practically demanding practice than would have been possible had only one interview been carried out. There is a need to capture subjective experiences of the implementation and practice trajectories over time (in addition to experiences of the therapeutic impact, which has been explored in previous studies), and how these relate to outcome (e.g. symptomology and relapse) to better understand the potential complexities of implementation and long-term experiences of an intervention that is becoming increasingly more available. This study design was able to highlight a number of challenges that individuals may face in this process, and future research would likely benefit from taking a longitudinal approach.

### **Clinical Implications**

One key finding of this study was that most participants expressed a wish and need for continued group practice to enable and support their independent practice. Although some services offer regular ‘booster sessions’ following the MBCT course, such provisions vary greatly (Crane & Kuyken, 2013). As MBCT becomes more widely offered on the NHS, efforts should be made to draw on service-user feedback, such as the findings of this study, to develop the potential and long-term feasibility of the intervention. For clinicians offering MBCT, it is important to devote resources not only to the running of MBCT courses, but also towards facilitating subsequent ongoing group practice after course completion. Given the scarcity of NHS resources, alternative processes for facilitating and supporting



ongoing group practice could also be explored. This could include, for example, establishing and facilitating post-intervention groups initially, but ultimately aiming to support patients to run the groups themselves with limited or periodic input from professionals.

Loss of formal practice was found to be experienced as frustrating, upsetting, and leading to feelings of disappointment with oneself for some participants. Arguably, such experiences may negatively affect mood and wellbeing and may contribute to an existing vulnerability to relapse. It is important that tutors of MBCT courses are aware of the risks of such experiences for their patients, not only during the running of the course, but perhaps more importantly after completion when participants face the challenges of independent practice. Perhaps MBCT tutors could devote more time, during the course, to conversations about the known challenges of establishing and maintaining solitary practice, and how to approach and overcome these. Such an intervention could prepare participants both emotionally and practically, by enabling them to respond pragmatically and with self-compassion if they fall out of practice, thereby avoiding negative experiences of guilt, disappointment and self-criticism.

Given that participants in this study reported the research interviews to increase motivation to practice, regular ‘practice conversations’ with, for example, the MBCT tutor or other suitable professionals may be indicated. An approach such as Motivational Interviewing (Millner & Rollnick, 2013) which is evidence-based for facilitating motivation and health behaviour changes (Rubak et al., 2005), could provide a helpful framework for such conversations.

Finally, some policy and ethical issues need to be considered. MBCT has shown great promise for a range of mental health disorders, most notably depression,

which is one of leading causes of disability in the world (WHO, 2008) and commonly recurrent in nature. It is vital to identify treatments that can prevent relapse, and MBCT has been found as effective as CBT (Biesheuvel-Leliefeld , Kok , Bockting , et al., 2015; Manicavasgar, Parker & Perich, 2011) and antidepressants (Kuyken et al., 2015), making it a valuable option. However, it must be recognised that it is a demanding intervention which requires significant time investment and effort from users, and furthermore research indicates that practice must probably be sustained, at least to some degree, to guarantee the protective effect long-term. This study has shown that independent practice maintenance can be complex, challenging and difficult to achieve; this opens up the possibility of users discontinuing their treatment, unless there are interventions to prevent this. The long-term effect of this cannot be known, and so it becomes crucial to establish a method for identifying those who are likely to sustain mindfulness practice over time (and those who may fare better with other treatment) in order to avoid mental health patients ultimately having ineffective, or worse, negative experiences, of treatment. Perhaps most importantly, the MBCT treatment protocol should be modified to include more comprehensive post-intervention practice support.

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### **Part 3: Critical Appraisal**

This critical appraisal addresses some issues related to carrying out the research reported in Part 2 of this thesis. Firstly, it considers the advantages and disadvantages of using a longitudinal design in qualitative research. Secondly, it reflects on issues that arise when one is personally involved in what is being researched.

### **Using a longitudinal design in qualitative research: advantages and disadvantages**

Despite the fact that qualitative longitudinal research is an established methodology in social sciences, longitudinal studies are relatively rare (Carduff, Murray & Kendall, 2015). This can perhaps be explained by practical difficulties involved with longitudinal research, such as financial constraints, maintaining committed researchers as well as participants over longer time periods, and the logistics of collecting data at multiple time points. Furthermore; the collection, analysis and management of a longitudinal data set is labour intensive (Thomson & Holland, 2003) which may have a somewhat deterring effect.

The advantages of qualitative longitudinal research mainly relate to the capturing of a richer, more comprehensive or complex account of how a phenomenon evolves through time (Carduff et al., 2015). In planning my study of MBCT, I considered there to be a gap and ‘blind spot’ in the literature: a relatively large number of studies existed about the effectiveness and therapeutic potential of MBCT, but very few studies mentioned or explored in detail how individuals went on to use (or not) the mindfulness practices they had been taught on the MBCT course. Those that did address this typically interviewed participants once only, or only briefly touched on the processes involved in maintenance of practice. I found this puzzling, given the explicitly stated assumption (in the practice manual and in

many research articles) that continued practice is essential, and I was curious as to how well a single interview could capture anything that is ‘ongoing’. It was my hope that a longitudinal gaze might allow me “the promise of seeing things differently” (MacMillan, 2011). The process allowed an opportunity for reflecting on the advantages and disadvantages of this approach.

### **Advantages of longitudinal qualitative research**

**The building of a relationship results in better quality of data.** During the process of recruiting participants for the study, I was aware of the commitment that I was asking of participants: three interviews over the course of a period of nine months, with each interview lasting 30-60 minutes. The risk of people dropping out of the study seemed to me very likely. However, one of the major advantages of a longitudinal design, namely, the opportunity to build relationships with participants over time, in the many micro communications (e.g. emails and phone calls to arrange interviews) as well as the research interviews themselves, enabled me to work actively towards preventing attrition.

In any qualitative study, the quality of the data (and ultimately of the final conclusions) rely on participants’ readiness to cooperate with the agenda of the researcher and share personal thoughts and experiences (Karnieli-Miller et al., 2009). Commonly, qualitative research consists of a participant speaking (or otherwise sharing information) with a researcher for one hour or so; arguably, such brief interaction is limited in its ability to develop the trust and familiarity that facilitates the sharing of personal information. In contrast, as I experienced the building and unfolding of a relationship over time with the participants of this study, I noticed an increased willingness of participants to share personal information without much probing; furthermore, I realised that, in the process of getting to know the

participants as individuals, I became more comfortable asking different kinds of follow-up questions. The relevance of the relationship as a ‘vehicle’ for sharing, exploration and mutual understanding became evident to me, not unlike a good therapist-patient relationship, or any well-functioning human relationship, for that matter.

**The essence of time.** In addition to finding that the unfolding of the relationship enabled the collection of richer data, simply spending more time (in this study a total of 85-130 minutes) and at different time points interviewing participants enabled me to capture a more comprehensive complex, “thicker story” of their experiences. This is in contrast to a “summary” snapshot that might have resulted from shorter one-off interviews. Individuals’ experiences of health care and health care interventions occur over time (Grossoehme & Lipstein, 2016), and my understanding of how mindfulness practice is used and implemented by service users would have been dramatically different had I only carried out one interview. This would have had implications for what this study contributed to the literature (or not), as well as for the less formal dissemination of its findings to the mental health services that participants were recruited from, and to clinicians in the field.

**Social desirability and the presentation of self.** By building a relationship with participants over time, I was granted access to accounts that contained information that might be considered ‘socially undesirable’. For example, participants described failures of self-discipline and willpower, “laziness”, and needing others to take control. In a first meeting or interaction, individuals are typically attempting to learn about and understand the other and may have a slightly reserved approach, and because research depends on participants’ generosity and trust in opening up (Raheim et al., 2016) this is a considerable draw-back of one-off

data collection. It is possible that such brief contact with participants may yield data 'polluted' by censoring out of emotionally difficult, embarrassing or otherwise difficult material that may have real relevance to the research topic

. The tendency to present or, perhaps even misrepresent, oneself and one's behaviours in manners that are consistent with current social norms is a well-known threat to the validity of research. In the context of interview studies, Oakley (1981) notes that we know little about what actually goes on between interviewer and interviewee: "*Interviewing is rather like a marriage: everybody knows what it is, an awful lot of people do it, and yet behind each closed front door there is a world of secrets*" (p. 41).

Attempts to reduce the influence of social desirability bias include ensuring confidentiality and communicating that there are no right or wrong answers. I was highly aware of the possibility that participants might hold assumptions about the aim of the research or what I hoped to find, and that this might lead them to attempt to 'please' me by reporting what they thought I hoped to hear (e.g. that they were maintaining mindfulness practice). The longitudinal aspect of the research enabled me to convey repeatedly, both prior to meeting, and just before and during interviews (where appropriate), that I was looking for the bigger picture of what actually happens after the MBCT course; that I had no expectations, just a genuine curiosity, and that all answers were equally relevant and helpful for the research. By returning to this conversation repeatedly, I believe that over time participants shared more about what frustrated them, what they considered failures or disappointment with themselves, and what they had not been able to do despite their best intentions. This might explain why my findings paint a slightly bleaker picture of post-course implementation and maintenance of mindfulness practice than has previously been



reported; it is possible that previous studies, in which only one interview was carried out, were not able to actively counteract the problem of social desirability bias, through building a relationship over time and repeatedly reiterating the aim of the research.

**When the story changes.** In carrying out more than one interview with each participant, I was able to notice and attend to inconsistencies, differences and changes in their accounts over time. For example, an attitude to practice could change from being one of almost evangelical enthusiasm, to sounding frustrated and demoralised, or almost disinterested. By following up on such observations, I was able to obtain a fuller picture of the experience of mindfulness practice and the very human processes surrounding the task of implementing and maintaining a time-consuming, effortful new behaviour. My observations of ambivalence and variability in participants' accounts highlighted to me that their experiences were dynamic rather than static, and that things could "go wrong" with a practice routine fairly rapidly, even when the individual had seemed very committed and confident when we last spoke.

I also noticed that, for some participants, mindfulness practice initially appeared to be seen as an external tool, and shifted to being viewed as a non-negotiable lifestyle choice, a part of one's being and life, signifying integration of practice. This particular aspect of the longitudinal research process has had an influence on how I understand more generally post-therapy maintenance of skills and ideas learnt in the therapy room. Typically, the aim of therapy is for clinicians to collaborate with their clients to find new ways of managing difficulties, revise 'old' behavioural and cognitive patterns with new more helpful ones, and hope that as the treatment has come to a close, the patient will continue to utilise what they have

learnt in therapy, and thereby experience better mental health. My experiences of interviewing patients several times over the course of a longer time period have highlighted to me the complexities involved in making changes in how one looks after one's physical/mental health, especially when the process is skills- and learning-driven to some degree. These observations will influence my own clinical practice, particularly how I approach relapse prevention plans, and how much time I spend thinking with patients about life after therapy and ways to stay connected with what was helpful.

**The value to participants.** Finally, although the research interviews were not intended to be of therapeutic benefit, all participants reported enjoying and finding value in the opportunity to reflect on and talk about their mindfulness practice experience. Despite the fairly demanding nature of committing to the research project, participants seemed to find it worthwhile to stay in the study.

Over time, participants referred back to previous interviews, constructing a coherent temporal narrative of their experience, which they often then used as a backdrop to consider how they would move forward with their mindfulness practice. Indeed, most of the participants reported that the interviews were not only enjoyable, but actively helpful in their mindfulness practice journey, as it kept them connected with MBCT, memories of the MBCT course experiences, and the benefits they had experienced. Furthermore, they reported that they valued speaking with someone who showed a genuine interest in and 'kept a record' of their experiences over time. Interestingly, several reported a sense of accountability to me and the study, which was perceived as helpful. Even for those who struggled significantly with practice, it seemed to help to stay mentally connected with MBCT, which gave them some optimism about re-establishing independent practice.



### **Disadvantages to longitudinal qualitative research**

Despite the many advantages of longitudinal qualitative research, there are some challenges and risks. I would argue that the benefits outweigh the risks, so long as clear protocols and plans for managing them are devised.

**Witnessing a downward spiral.** I bore witness to signs of changes in some participants' wellbeing over time, specifically in terms of them appearing to feel more depressed or anxious. While it could be argued that this is a general challenge in qualitative research, it is further complicated by a longitudinal methodology, where the researcher can observe and compare a respondent's presentation at different time points and notice acute, or more subtle, changes in cognition, affect and behaviour that might signify mental health difficulties. While indications of suicidal ideation and intent would have led me to contact the participant's clinical psychologist or advise them to seek medical attention, as per the study protocol, there was a 'grey zone' of noticing signs of deterioration that was not acute. In such instances, if the participant asked me directly or appeared to be seeking advice for how to cope with any mental health difficulties, I advised them to contact their GP or a mental health professional or service they had the contact details for.

**Blurring of boundaries and the issue of dual-roles.** Related to the above challenge is the risk of blurred boundaries and role confusion, which is inherent to any qualitative research but especially so when participants and researcher meet multiple times. The growing familiarity, and in some cases, increased informality between researcher and research participant (Thomson & Holland, 2003), can threaten the boundaries and subsequently divert participant as well as researcher from the task at hand.

In instances where the researcher is also a clinician (as in this study) and the explicit boundaries usually associated with clinical practice are not in place, the nature of the interviews as research and not as therapeutic interaction must be made explicit. I was especially aware of the ‘therapeutic potential’ (Birch & Miller, 2000) of the second and third interviews as a rapport had in most cases been established by then. Furthermore, as previously described, several participants had experienced a recurrence of mental health problems at those later time points. Meeting with me, a trainee clinical psychologist, to discuss mindfulness practice which was a treatment for their mental health difficulties, could have been experienced by some participants as similar to a therapy appointment, and the lack of clinical input could have been experienced as disappointing, unless our roles, and the aim of the research was clearly communicated.

This ‘dual role’ issue, where a researcher is also a clinician, has been referred to in the literature (e.g., Chew-Graham, May & Perry, 2002) and can include a range of consequences for the research process and its quality. These can include “protecting” the participant from any psychological discomfort by offering positive interpretations or formulations of what is described; avoiding relevant questions; using counselling methods (e.g. Socratic questioning or motivational interviewing) for eliciting relevant material; or simply allowing the interview to morph into a therapy session (Allmark et al., 2009).

On some occasions, particularly in the second or third interviews with participants, I experienced an urge to follow up their statements with questions of a clinical nature and felt pulled into ‘clinician mode’. For example, one participant expressed frustration, sadness and grief over the many missed opportunities that his mental health difficulties had caused; among them the ability to fully engage with

MBCT. I found myself moving into problem-solving and giving advice (e.g. advising the participant that he might benefit from further individual CBT or MBCT sessions), rather than remaining focused on exploring those aspects of the participant's experience that were relevant to the research.

It seems essential that researchers must strike a balance: using their clinical skills and insights, without becoming a clinician; being friendly, open and socially comfortable to be around, without becoming a friend. This task is not without challenges, and in my experience, having carried out several qualitative research projects, the risks of blurred boundaries are more pronounced in longitudinal research. However, they can be carefully managed by having a clear research protocol, clearly defined and communicated boundaries, roles and aims, and access to supervision which utilises reflective principles.

### **Being personally involved in what is being researched**

It is only reasonable that a researcher devotes their time to researching something that they find interesting and important. However, when a researcher has personal and professional experience of what they are researching, their ideas, experiences and assumptions will inevitably impact the research process; and furthermore they may be personally impacted by the research process themselves (Hofman & Barker, 2016). I will now address and reflect on, from my experience, some of these processes.

First, a note on some basic principles of qualitative research for context: qualitative researchers usually reject the epistemological position of positivism, and thereby the notion of total objectivity (Barker, Pistrang, Elliott, 2016). Instead, qualitative research seeks to describe and understand phenomena, rather than test and provide evidence for a set hypothesis. The process of making sense of individuals'

stories and narratives usually occurs through the researcher's conversations with participants or through some other form of immersion in language-based data (e.g. field notes of observations). It is inevitable, therefore, that this process involves the researcher looking at and understanding data through a 'lens' of personal experiences, theoretical knowledge and assumptions, thereby influencing the research process, what questions are asked, what answers they get, the findings that are ultimately arrived at, and how these are presented to others. Reflexivity is therefore a key concept in qualitative research. Willig (2013) distinguishes between two kinds of reflexivity: *epistemological reflexivity* which refers to how the research methods shape or 'construct' what is found, and *personal reflexivity*, which refers to how the researcher's own values and experiences shape the research and also how the research affects the researcher. The latter type of reflexivity is the focus of this section.

### **Researcher background and context to the research project**

The current study was concerned with the experience of implementing, and maintaining (or not) mindfulness meditation practice after completion of an MBCT course, and how this unfolded over time. Nine or so years prior to the current study, when I was an undergraduate psychology student, I co-facilitated the running of MBCT groups together with two senior psychologists. While I facilitated certain parts of the courses, I also participated fully, and thereby got to experience the intervention first hand, more than once.

For the sake of reflexive self-disclosure, I will share that I consider there to be a 'before-and-after mindfulness' for me; I found the intervention powerfully transformative in many ways, experiencing a clarity of thought and ability to focus alongside a calmness of mind. Because I had derived such significant benefit even

without prior mental health difficulties, I became interested in the impact that MBCT could have for someone who struggled with emotional instability, impulsivity or difficulty focusing. As a result, I carried out a qualitative undergraduate research project, interviewing participants about the impact of MBCT practice on their mental health and wellbeing, and found that their stories mirrored my experience; for most, MBCT had provided potent, and for some, life-changing, effects. It is probably fair to say I developed an almost evangelical view of MBCT; and I arrived to clinical training and the prospect of carrying out doctoral research with a desire to further explore the intervention. Interestingly, although I felt that mindfulness practice had left a permanent ‘mark’ on the workings on my mind, I was not practising consistently (usually not at all). I periodically questioned why this was, given how helpful practice had been to me, but usually abandoned this question, possibly because it complicated my otherwise very optimistic and idealistic view of the MBCT intervention.

During the setting up of my doctoral research project, particularly while carrying out the literature review, I became aware of two things that would come to shape the research process. Firstly, I found what I considered a blind spot in the literature (and up to that point, possibly within myself too!): very few studies touched on what happened outside of, and after, the MBCT group intervention, despite stating that continued practice was considered essential.

Secondly, many of the qualitative studies presented MBCT in an almost wholly positive, optimistic, and in some cases, slightly evangelical, manner. Few difficulties and struggles were reported in proportion to the positives and benefits. Having acquired some years of clinical experience at that point, I knew that no one therapeutic model is perfect; I knew that sometimes the delivery or fit for the person



just is not right and, perhaps most importantly, I had learnt that maintaining changes over time is difficult for many people. I came to the conclusion that either researchers were personally and emotionally involved with MBCT (like myself) and were not able to consider or ‘see’ the difficulties, or they had simply not researched in any depth the aspects of MBCT that were challenging. I set out therefore to engage in an exploration of the ‘blind spot’ that I had identified: what happens when MBCT participants ‘graduate’ from the course? During the research process, the questions and assumptions I held would evolve and change as participants shared with me their practice journey, and I found it essential and useful to take a reflexive stance throughout.

### **Advantages and risks of having personal experience of MBCT**

A process of reflexivity was facilitated through ongoing conversation with my supervisor, as well as keeping notes of the process. This enabled me to assess more broadly the influence that my personal experience and involvement with MBCT had on the research process, and I found that there were several advantages, as well as disadvantages.

**My experience enabled me to understand participant accounts.** I found that my own experience of independent mindfulness practice allowed me to follow with ease participants’ verbal accounts and descriptions, rarely needing to stop their train of thought or descriptions to ask for clarification. This created, I believe, a comfortable interview experience allowing the participant to think and speak freely, rather than the ‘stop and start’, experience that can result if a researcher is not well acquainted with what is discussed.

**The risk of assuming similarity of experience.** The concept of ‘false assumed similarity’, discussed by Hofman and Barker (2016), refers to the tendency

to over-identify with, and assume commonalities of experience, with others. While my experiential knowledge of MBCT probably allowed me to understand participants' accounts better, it could have also led to me interpret these so that they 'fit' my experience. In order to stay attentive to divergences, unexpected accounts and anomalies, I took care to reflect back to participants what I thought I had heard, or how I understood their accounts, to enable them to elaborate. Furthermore, I discussed with my supervisor the conclusions I came to during the analysis of the data, and how I understood them to be grounded in the data, in order that she could offer different perspectives and ideas or contest my reasoning. These steps allowed me to limit the risk of assuming that participants' experiences were similar to mine.

**To disclose or not disclose.** The choice of whether to share with participants that one has experience of, or is somehow personally or emotionally involved in, the topic that is being researched has implications for the research process. The advantages and disadvantages of disclosure must be carefully considered.

It is a well-known human social instinct to seek out and ally ourselves with others who are similar to us, who share our experiences and opinions, and who can understand our choices. The need to belong is universal, and humans are forever creating and associating themselves with social groups, both at a macro and micro level. As a researcher, one of the major benefits of sharing one's personal experiences of what is being researched is that it positions you to the interviewee as an 'insider' rather than an 'outsider' – part of their group, or at least as someone who can understand them. This might lead to greater trust and a sense of feeling connected, which probably facilitates more open sharing and less censoring.

However, while disclosure can facilitate a more open sharing of experience, it may also have a negative influence on what participants feel able to say, and how

they say it. For example, if participants in the current study had known details of my mindfulness practice journey and whether I sustained practice or struggled to do so, this might have led them to adjust their accounts to be more in line with mine, or led to social comparison. Furthermore, disclosure of my own experience might have distracted from the focus of the interview, i.e. leading to discussions of my experience rather than an exploration of theirs.

I made the decision to not disclose details about my own experiences of mindfulness practice, except to confirm that I had “some experience” if someone asked or it seemed relevant and appropriate. Most participants did ask me directly, and my rather vague response seemed adequate and acceptable to them.

**Emotional reactions influencing the research process.** Around the time when about half of the interviews had taken place, it became clear to me that the ‘blindspot’ that I thought I had identified in the literature was rather significant; participant after participant told me of challenges to setting up and maintaining independent mindfulness practice. At this stage, I started experiencing a growing frustration with the relative lack of interest in service users’ experiences with independent practice post-course completion. My previous rose-tinted view of MBCT became somewhat tarnished with the realisation that at least within my study, participants very often struggled to use what they had been taught, which led to frustration, self-blame and feelings of failure for some. Consequently, I started considering ethical issues around delivering an intervention which, in its current delivery form, may not be user-friendly to a sizeable proportion of users. From my own clinical placement experiences, I was acutely aware of the shortage of resources characterising the running of many NHS services, and understood why clinicians may have found themselves offering less than comprehensive post-course support;

but I also wondered if an awareness of just how difficult implementation and maintenance can be, particularly for those individuals with more complex social situations, was perhaps largely lacking?

These questions, and my own emotional reaction (e.g., frustration) to learning about participants' challenges, inevitably affected how I approached subsequent interviews. While I followed an interview schedule which addressed broader areas of the experience of MBCT practice (such as its impact), the ongoing process of data analysis highlighted the importance of paying particular attention to what had not been previously reported and represented in the literature. I was aware that my feelings of frustration could lead me to 'seek out' evidence for my concerns, thereby introducing bias. I therefore took steps to foster reflexivity and emotional distance to limit any undue influence such factors might have on the research. By continuously 'checking in' with myself and questioning the ideas and assumptions I held, attempting to establish where these came from (e.g., from experiential or theoretical knowledge, or from interviews with participants), I could "bracket" (Smith, 2008) my assumptions and re-orient myself to my research aims, and approach the interview and analysis process with curiosity and openness.

### **Concluding thoughts**

This reflective account has covered two major areas relevant to the current study: firstly, some of the advantages and disadvantages of longitudinal qualitative research, and secondly, some of the advantages and risks of being personally involved in what is being researched. More broadly, the process of carrying out the research has highlighted for me some of the challenges that researchers encounter, not only in carrying out their own research, but in making sense of and building on others' research.

As with many novel interventions, whether medical or psychological, there is a risk that those who have developed it, and experienced it as helpful (for themselves or for their patients), will feel enthusiastic and keen to ‘spread the word’ to ensure that more individuals can access the treatment. Unfortunately, such enthusiasm can, unless supported by a continuous process of reflexivity, lead to a somewhat idealised, or positively biased, view of the intervention. During the research process, I found that the slightly evangelical tone with which MBCT is discussed in many research studies was one which I myself for a long time adopted, and this had prevented me from considering the limitations of MBCT. Concerns have recently been expressed within the research community (e.g. MacKenzie & Kocovski, 2016) that many of the controlled trials of MBCT have been conducted by its developers, potentially leading to risk of bias seeping in. However, new, less partial researchers are now coming into the arena and examining more varied outcomes and mechanisms of the therapeutic effect of MBCT, meaning that the literature is expanding.

The current study adds to this literature, pointing to aspects of MBCT that have been largely missing from the picture. Knowledge about the limitations and challenges of the intervention is essential in order that the delivery and protocol for the provision of MBCT can be continuously improved. My own view of the intervention has perhaps come full circle, from rose-tinted idealising to a more tempered view. Service users’ voices have on this occasion given a loud and clear message: they value MBCT greatly, but they need help from others to keep mindfulness practice going, or it will be lost for many.

It is clear that there is a place for MBCT in modern psychological health care, but several important questions beckon our attention. How can we support

those who wish to sustain their mindfulness practice to do so? Is it clinically justified and ethically right to offer the intervention if a sizeable proportion of those who undertake it discontinue their practice? What happens over time with the mental health of those very people who are unable to maintain practice? What provision will be made for them? It is time that researchers cast their focus forward to what happens after the intervention, and consider what role clinicians and mental health services could, or should, have in facilitating the maintenance of mindfulness practice.

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## **Appendix: A**

### **Confirmation of ethical approval**

# Health Research Authority

## NRES Committee East of England - Norfolk

Nottingham REC Centre  
The Old Chapel  
Royal Standard Place  
Nottingham  
NG1 6FS

Tele

phone: [REDACTED] 10 February 2014

Prof. Nancy Pistrang

Professor of Clinical Psychology

[REDACTED]

[REDACTED]

[REDACTED]

Dear Prof. Pistrang

<b>Study title:</b>	<b>Mindfulness-Based Cognitive Therapy: The experience of practice and impact over time</b>
<b>REC reference:</b>	<b>14/EE/0040</b>
<b>IRAS project ID:</b>	<b>140288</b>

Thank you for your letter of 05 February 2014, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager Ms Tracy Leavesley,

[REDACTED]

### Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

## Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see “Conditions of the favourable opinion” below).

### Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission (“R&D approval”) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.*

*Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.*

*Where a NHS organisation’s role in the study is limited to identifying and referring potential participants to research sites (“participant identification centre”), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of approvals from host organisations.*

### Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett ( ), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

**You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.**

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

Approved documents

The documents reviewed and approved by the Committee are:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of insurance or indemnity	UCL	18 December 2013
Evidence of insurance or indemnity	Arthur J Gallagher International	26 July 2013
Interview Schedules/Topic Guides	Interviews 2,3 and 4 Version 1	20 November 2013
Interview Schedules/Topic Guides	Interview 1 Version 1	20 November 2013
Investigator CV	Kristin Tollstedt	
Investigator CV	Professor Nancy Pistrang	
Investigator CV	Judith Leibowitz	
Letter of invitation to participant	1	20 November 2013
Other: Letter from Nancy Pistrang		10 January 2014
Participant Consent Form	1	20 November 2013
Participant Information Sheet	1	20 November 2013
Protocol	2	05 February 2014
REC application	140288/549047/1/338	26 November 2013
Response to Request for Further Information	Letter from Nancy Pistrang	05 February 2014

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review  
Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

#### Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

<b>14/EE/0040</b>	<b>Please quote this number on all correspondence</b>
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We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely

**Dr Michael Sheldon**

Chair

Email: [REDACTED]

Enclosures: *"After ethical review – guidance for researchers"*

Copy to: *Dr Clara Kalu*

*Mrs Angela Williams, Camden and Islington NHS Foundation Trust*

## **Appendix: B**

### **Participant Information Sheet**



Version: 1

Date: 20.11.2013

REC reference number: 14/EE/0040      **PARTICIPANT INFORMATION SHEET**

## **Mindfulness-Based Cognitive Therapy: Experience over Time**

(Student Research Project)

*We would like to invite you to take part in this study. Before you decide if you want to take part, it is important for you to understand what the study involves and why we are doing it. The information below will help you to make your decision. Please ask us if there is anything unclear or if you would like more information.*

### **What is the purpose of the study?**

We are interested in finding out about people's experiences after they have completed a Mindfulness-Based Cognitive Therapy (MBCT) course. In particular, we want to know what people find helpful or unhelpful about MBCT and what makes it easier or harder to continue practising the techniques learnt during the course. We are also interested in learning about any benefits of MBCT that may occur over time – for example any changes in thinking, feeling or behaving. The study is being carried out by researchers at University College London and is separate from the psychology services that run the MBCT courses.

### **Why have I been invited to take part?**

We are inviting everyone who has attended at least six out of eight sessions of a recent MBCT group course in Islington or Camden Psychology Services.

### **Do I have to take part?**

Participation is completely voluntary. You are free to withdraw at any point without giving a reason. Your decision will not affect your patient rights or your future care.

### **What does taking part involve for me?**

You will be asked to take part in four interviews (face-to-face or over an online webcam service/telephone) at 3, 6, 9 and 12 months after the MBCT course has finished. The interviews will focus on your experience of practicing MBCT, what makes it easier or harder to practice, and any changes you may have noticed in yourself since completing the course. The first interview should last about 45-60 minutes and the subsequent interviews should last about 15-30 minutes. These will be arranged at a time convenient for you. With your consent, we will audio-record the interviews so that we do not miss anything important that you tell us.

Should you decide to participate in this study, you will be given a copy of this information sheet to keep, and you will be asked to sign a consent form to indicate that you understand the purpose of the study and agree to

participate. As a thank you for your contribution to the study, you will be entered in a price draw where you can win £50. We will also reimburse any travel costs you may have as a result of your participation.

### **What will happen to the information I provide?**

All interviews will be typed up and anonymised (your name or any details which could identify you will be changed or deleted). The research team will analyse the interview transcripts to identify the main ideas expressed by everyone who participated. You will be invited to comment on the analysis if you wish to. The results will be written up as part of the student researcher's doctoral thesis, which may also be published in a peer-reviewed scientific journal. The MBCT tutors will be given a summary report, but will not be told what you have said in the interviews. No one will be able to identify you from any reports.

If you decide to withdraw from the study the information you have provided up to the point of withdrawal will remain in the study.

### **What are the risks and benefits of taking part?**

It is possible, but unlikely, that you could find it upsetting to talk about your experience of MBCT. If this happens, you can ask the researcher to take a break or stop the interview at any time. You do not have to answer any questions you do not feel comfortable answering.

You may find that talking about and reflecting on your experiences is interesting and helpful. We also hope that our findings from this study will benefit other people who may wish to try MBCT.

### **Confidentiality and anonymity**

All data will be collected and stored in accordance with the Data Protection Act 1998. Audio recordings from the interviews will be stored on a password-protected computer and will be deleted once transcripts have been made. Names and other personally identifiable information will be removed from transcripts to ensure anonymity. We may include direct quotations from interviews in published reports but will not include names of participants and we will make sure that any quotations we use cannot be linked to individuals. We will store the anonymous interview transcripts in a secure location for five years after publication of the results. If you tell the researcher something that leads them to think that you or somebody else is at risk of significant harm, they may have to discuss this with somebody to ensure your safety.

### **What if there is a problem?**

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated by members of the research team due to your participation in the research, National Health Service or UCL complaints mechanisms are available to you. Please ask the student researcher if you would like more information on this.

In the unlikely event that taking part in this study harms you, compensation may be available. If you suspect that the harm is the result of the Sponsor's (University College London) or the psychology service's negligence then you may be able to claim compensation. After discussing with the student researcher, please make the claim in writing to Prof. Nancy Pistrang who is the Chief Investigator for the research and is based at UCL. The Chief Investigator will then pass the claim to the sponsor's Insurers, via the Sponsor's office. You may have to bear the costs of the legal action initially, and you should consult a lawyer about this.

### **What do I do now?**



If you would like to take part in this study or if you have any questions, please contact Kristin Tollstedt (see contact details below).

**Contact details**

Kristin Tollstedt, Trainee Clinical Psychologist

████████████████████

██████████

Nancy Pistrang, Prof. of Clinical Psychology

████████████████

Research Department of Clinical, Educational and Health Psychology

University College London

Gower Street

London WC1E 6BT

This study has been reviewed and given favourable opinion by Norfolk Research Ethics Committee

*Thank you for considering taking part in this study!*

## **Appendix C:**

### **Appendix C: Consent form**



Version: 1

Date: 20.11.2013

REC reference number: 14/EE/0040

Participation Identification Number for this study:

### CONSENT FORM

#### Mindfulness-Based Cognitive Therapy: Experience over Time

(Student research project)

Name of Researchers: Nancy Pistrang (Chief Investigator)

Kristin Tollstedt (Researcher)

- 1) I confirm that I have read and understand the information sheet dated 20.11.2013 (v.1) for the above study. I have had the opportunity to consider the information, ask questions and had these answered satisfactorily. ☐
- 2) I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my current or future medical or psychological care or legal rights being affected. I understand that if I withdraw, the information I have provided up to the point of withdrawal will be used in the study. ☐
- 3) I understand that my interviews will be audio-recorded and consent to the use of recordings for the purpose of the study. ☐
- 4) I confirm that I have read and understood the above points and that I consent to participate in the above study. ☐
- 5) I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from UCL, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐

Name of participant

Date

Signature

Name of person taking consent

Date

Signature

**Appendix D:**

**Interview Schedule time point 1**

**Interview Schedule time point 2,3,4**

**Mindfulness-Based Cognitive Therapy: The experience of practice and impact over time (student study)**

**Interview Schedule: interview 1**

**Overview**

What led you to decide to join the mindfulness group in the first place?

What was it like doing the mindfulness group?

How are you doing now in terms of the problems that led you to join the group?

**Helpful and less helpful aspects**

Can you sum up what has been helpful about mindfulness so far?

(Can you give some examples?)

Was any particular session or idea of mindfulness particularly important to you?

(Which one? How was that important to you?)

Is there anything about the mindfulness practice that has been unhelpful for you?

(Can you give examples?)

Were there things about doing the mindfulness group or practicing that were difficult but still OK or perhaps helpful?

(In what way did you find that difficult? What about it made it OK/helpful?)

Do you think there was anything missing from the mindfulness group and practices; anything that would have made it more helpful?

**Changes**

Have you noticed any changes in yourself since you started the mindfulness practice?

(For example, doing, thinking or feeling differently from before?)

What would you say you have learnt from mindfulness so far if anything?

(For example about yourself, other people, psychological problems or ways of coping with distress?)

Is there anything that you wanted to change that hasn't since you started mindfulness practices?

(What do you think got in the way of that change?)

**Attributions of change**

What do you think has brought about the changes you have described to me?

(E.g. particular mindfulness techniques, something unrelated to mindfulness such as changes in relationships or with work?)

What made these changes possible for you?

**Practice of mindfulness skills**

Have you been able to make use of the mindfulness skills in your life at all since finishing the course?

(How? When? Where? How often?)

In what situations have you chosen not to/not been able to make use of the mindfulness techniques?

(Can you tell me more about this, what made it difficult or not appealing to use the techniques at those times?)

What do you think has helped you make use of mindfulness techniques

(E.g. relationships, living situation, support from others..?)

Is there anything that has made it difficult to make use of the mindfulness techniques?)

(E.g. family, job, living arrangements, mental health problems, health?)

Was there anything about the mindfulness ideas or the setup of practice that was difficult to follow in order to improve your wellbeing?

(Is there anything that you think would have made it easier or more doable?)

**Maintenance**

Do you think you will continue practicing the mindfulness techniques?

(How confident are you about this?)

How are you planning to continue practicing?

(How often? In what situations?)

What do you think will help you achieve this?

Is there anything you think might make it difficult to achieve this?

**Close the interview**

Do you have any suggestions for how mindfulness could be improved?

Can you think of anything that would help people keep their practice up after the group finishes?

Is there anything that I haven't asked you about that you think is important?

**Mindfulness-Based Cognitive Therapy: The experience of practice and impact over time (student study)**

**Interview Schedule: interviews 2,3 and 4**

**Practice of mindfulness skills**

Have you been able to make use of the mindfulness techniques at all since we last spoke?

(How? When/where? How often?)

What do you think has helped you make use of mindfulness techniques?

(E.g. relationships, living situation, support from others..)

In what situations have you chosen not to/not been able to make use of the mindfulness techniques?

(Can you tell me more about this, what made it difficult or not appealing to use the techniques at those times?)

Is there anything else that has made it difficult to make use of the mindfulness techniques?

(E.g. family, job, living arrangements, mental health problems, health)

Is there anything about the mindfulness ideas or the setup of practice that is difficult to follow or achieve?

(Is there anything that you think would have made it easier or more doable?)

**Changes**

Have you noticed any changes in yourself or your wellbeing since doing the mindfulness course/using mindfulness techniques?

Last time we talked you mentioned X. Has this continued or changed over the last three months?

What would you say you have you learnt from mindfulness so far if anything?

(for example about yourself, other people, psychological problems or ways of coping with distress.)

Is there anything that you wanted to change that hasn't since you started mindfulness practices?

(What do you think got in the way of that change?)

**Attributions of change**

What do you think has brought about the changes you have described to me?

(E.g. particular mindfulness techniques, something unrelated to mindfulness such as changes in relationships or with work)

(Last time you mentioned that changes came about because of X. Is this something that has continued to bring about changes?)

**Maintenance**

Do you think you will continue practicing the mindfulness techniques?

(How confident are you about this?)

How are you planning to continue practicing?

(How often? In what situations?)

What do you think will help you achieve this?

Is there anything you think might make it difficult to achieve this?

**Close the interview**

Do you have any suggestions for how the mindfulness group and the practice set-up could be improved?

Can you think of anything that would help people keep their practice up after the group finishes?