SCHOOL OF PSYCHOLOGY

DOCTORATE IN CLINICAL & COMMUNITY PSYCHOLOGY

Major Research Project

An insider perspective of participants' experiences of the benefits and barriers to attending Mindfulness-based Cognitive Therapy reunion meetings, following completion of their programmes: An interpretative phenomenological analysis.

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This manuscript has been submitted in partial fulfilment of a Doctoral degree in Clinical and Community Psychology

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Word Count: Manuscript: 7832 (excluding titles)

Appendices: 8913 (including extracts and schedule)

(Excluding Titles, Tables, References and Letters)

Title of Nominated Journal: Mindfulness
Acknowledgements

To the women and men who took part in this study: I am very grateful to them for generously sharing their experiences with me. I have been moved by their accounts of courage and strength.

To Professor Willem Kuyken: without whose support, encouragement and patient guidance, I could not have completed this study.

To Dr Janet Smithson: I am grateful for her steadying support and pragmatic supervision.

To my good friends, Ruth & Carl and the Oxfordshire Retreat: I could not have completed this work without their kind support and wise counsel.

To Andrew McCutchion: for teaching me the true meaning of acceptance and compassion.
Declaration

I certify that all materials in this dissertation that is not my own work, has been identified and properly attributed, and that no material is included for which a degree has previously been conferred upon me.

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Abstract

**Background:** Mindfulness-based Cognitive Therapy (MBCT) is a promising approach aimed at the prevention of relapse in people suffering from recurrent depression. Little is known regarding the way that MBCT works and less is known in terms of how any gains from this intervention continue to be maintained in the longer term, and what factors may be supportive of this.

**Aim:** This study examines participants’ experiences of perceived benefits and barriers to MBCT reunion attendance following completion of MBCT.

**Method:** Thirteen people, who had participated in MBCT classes for recurrent depression within a primary care setting, were interviewed using a semi-structured interview schedule. Seven of these had completed their programme within the previous 12 to 18 months at the time of interview, and six had completed their programme between 20 months and 4 years prior to the time of the interview. The focus of the interviews was on participants’ reflections on their experiences of the reunion meetings or their reasons for not attending. Interpretative phenomenological analysis (IPA) was used to analyse participants’ accounts.

**Results and conclusions:** Four themes highlighted the participants’ experiences: In terms of benefits, reunion attendees experienced the reunions as a “booster” reminding them of their mindfulness practices and as a “sanctuary” where these practices were further nurtured within an accepting and compassionate environment. Barriers to reunion attendance were expressed as a difficulty with the group experience and the feeling of some participants to want to put the experience behind them. The theoretical, clinical and research implications are discussed.

**Keywords:** Mindfulness-Based Cognitive Therapy (MBCT), qualitative, interpretative phenomenological analysis (IPA), depression, relapse prevention, MBCT reunion attendance.
Introduction

Mindfulness-based cognitive therapy (MBCT) is a psychological intervention, which has mindfulness\(^1\) meditation at its core. Buddhist scholar Christina Feldman (2005) defines the quality of mindfulness in the following way:

“*The quality of mindfulness is not a neutral or blank presence. True mindfulness is imbued with warmth, compassion and interest. In the light of this engaged attention, we discover it is impossible to hate or fear anything or anyone we truly understand. The nature of mindfulness is engagement: where there is interest, a natural, unforced attention follows.*”

MBCT is drawn from the structure and process of the Mindfulness-Based Stress Reduction (MBSR) programme (Kabat-Zinn 1990) and integrates mindfulness practices\(^2\) with aspects of Cognitive Behavioural Therapy (CBT) for depression (Segal et al. 2002). It is aimed at preventing depressive relapse among people with a history of recurrent depression who are currently in full or partial remission from their last episode of depression (Judd 1997; Mueller et al. 1999; Teasdale et al. 2000; Segal et al. 2002; Ma and Teasdale 2004; NICE 2009). MBCT is a manualised, instructor-led group-skills training programme (Segal et al. 2002). Its primary teaching vehicle is experiential learning through mindfulness practices and it contains three broad elements: the cultivation of awareness through mindfulness practices (e.g. by focusing on the breath and bodily sensations as “anchors”); the development of an attitudinal framework (i.e. non-striving, acceptance and a genuine interest in experience), conveyed through the teaching and modelling of these qualities; and a process of linking the learning to an understanding of working with vulnerability, conveyed through dialogue, reflection, group exercises and teaching (Crane 2009). Its specific focus is on helping participants become more aware of bodily sensations, thoughts and feelings associated with depressive relapse and to relate constructively to these (Lau et al. 2004; Shepherd and

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\(^1\) See Appendix 1a: Additional definitions of mindfulness

\(^2\) See Appendix 1b: Description and aims of mindfulness practices
Teasdale 2004; Crane 2009). It is a practice through which participants are trained to be confident to “turn towards” whatever arises in their experience and is counter to the instinct to avoid the difficult and challenging. These practices may help prevent the cycles of rumination that can initiate, intensify and prolong depression (Teasdale 1999; Teasdale et al. 1995; Teasdale and Bernard 1993; see Baer 2003 for review). Following completion of the programme, participants are invited to attend MBCT reunion meetings\(^3\), where attendees are given the opportunity to discuss themes relating to their ongoing mindfulness practice and relapse prevention\(^4\).

MBCT has a growing evidence base of outcome studies supporting its efficacy (Baer 2003; Coelho et al. 2007). It has been shown to halve the rate of relapse over a 60-week follow-up period compared with usual care (Ma and Teasdale 2004; Teasdale et al. 2000), to be non-inferior to anti-depressants in terms of relapse and superior regarding quality of life and residual depressive symptoms (Kuyken et al. 2008). It is recognized that for the majority of people, practicing mindfulness regularly is necessary in order for lasting and psychological benefits to be achieved (Kabat-Zinn 1990, 1996, 1999, 2003; Santorelli 1999; Segal et al. 2002; Carmody and Baer 2008). Researchers have found that there is a forging of new neural pathways associated with sustained practice (Lutz et al. 2008). The manual for MBCT recommends 45 minutes of daily practice in order to successfully hone mindfulness skills (Segal et al. 2002) and the importance of regular out of class (and post programme) practice is emphasized in Dialectical Behavioural Therapy (DBT) (Linehan 1993a, 1993 b). It is possible that such an emphasis on regular home work practices proves to be a barrier to some individuals and that this is perhaps more problematic following completion of the programme, without the monitoring of home practice by the teacher and/or the group support.

\(^3\) See Appendix 1e: Description of agenda and themes for reunions

\(^4\) See Appendix 1d: Description of Exeter model of MBCT reunion meetings
of peers. This is purely speculative however as little research exists exploring in any detail participants’ experiences of barriers and benefits in continuing in their practices after the programme. Significantly, any perceived benefits or barriers to attendance at MBCT reunions have not been explored in the literature at the time of writing. The maintenance of informal practices in particular is under reported, and although some studies report on the incidence of adherence to formal practices (Williams et al. 2007; Carmody and Baer 2008), informal practices have yet to receive the same attention. Consequently, this is an area of significant uncertainty that requires further investigation regarding which aspects of the skills training is impacting beneficially upon the individual, and how they might be supported, following completion of the programme.

In addressing these gaps in the literature so that MBCT might be more effectively evaluated and developed, it is necessary to explore service-users’ experiences using both quantitative and qualitative approaches (Williams and Moorey 1989; Mason and Hargreaves 2001). To date, few qualitative studies have attempted to gain insight into participants’ experiences of the benefits and barriers to maintaining mindfulness practices following completion of the programme.

Qualitative researchers, Mason and Hargreaves (2001) and Finucane and Mercer (2006) found that MBCT participants reported the development of mindfulness skills, although in both studies their 3 month follow ups did not allow any long-term effects to be adequately explored. At 12-month post MBCT, Ma (2002) restricted questions to “usefulness” and “difficulty” and although several interesting themes emerged, the scope of the enquiry was limited.

The experience of mindfulness and maintenance of practices are highly personal and complex phenomena and is the area of interest for this study. In order to address this aim, a methodology is required that can allow for the research questions to be asked within a
collaborative and flexible framework, to elucidate and map out the overlapping, interconnecting and even sometimes contradictory and complex nature of the lived experience of such complex phenomena. This current study selected a phenomenological approach to conduct such an in-depth exploration of participants’ experiences, as they understand them (Eatough and Smith 2008). Interpretative Phenomenological Analysis (IPA) is a structured method of exploring individuals’ phenomenological experience within a framework that privileges accessing idiographic meaning as directly as possible (Smith and Osborn 2003). Furthermore, IPA’s ideographic nature sets it apart from other qualitative methodologies such as grounded theory or discourse analysis, and makes it the methodology of choice when exploring uncharted areas of research such as the meanings of an experience to an individual.

In this study, participants’ own views and experiences are being sought and the use of semi-structured interviews supports the collaborative nature of this enquiry. MBCT itself has evolved in a very collaborative way involving dialogue with the developers of mindfulness-based stress reduction (Kabat-Zinn 1990), between colleagues and with people going through the eight-week programme (Segal et al. 2002). The open-minded stance of the IPA investigator encapsulates a central feature of mindfulness that of “beginner’s mind” and as such this methodology is in keeping with a key tenet of mindfulness. Furthermore, both MBCT and IPA view participants as playing an active role in the construction and meaningfulness of experiences (Eatough and Smith 2008; Segal et al. 2002).

This study has the following broad aims: to gain an in-depth insider’s perspective of MBCT participants’ experiences of benefits and barriers to attendance at MBCT reunions following completion of the programme, and to compare those experiences of reunion attendees with non-attendees. It is hoped that this study may improve our understanding of

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5 See Appendix 2a: Theoretical and methodological considerations
why individuals attend or decide not to attend MBCT reunions. It also hopes to gain insight into how individuals feel they might be supported in their ongoing practices following completion of the programme, if this feels useful to them. The comparison between MBCT reunion attendees and non-attendees may yield valuable insight into whether the attendance at MBCT reunion groups may have any bearing upon those factors for some.
Method

Study Overview

Thirteen individuals who attended Mindfulness-Based Cognitive Therapy participated in one-to-one interviews following a semi-structured interview schedule. Transcripts of the interviews were produced and provided the raw data for Interpretative Phenomenological Analysis.6

Participant/service user consultation

In an attempt to gain different levels of service-user perspective throughout the research process, the researcher: 1) attended two MBCT reunion meetings (with consent from users and therapists), 2) consulted with Participant 1 (Sarah) following a pilot interview (not included in the analysis), regarding the clarity of language and acceptability of questions. This service user was able to make the language simpler and engaging for participants (Marshall and Rossman 2006), and 3) posted resulting transcripts to research participants so that they were able to request removal of any data, if they so wished, and to provide them with a record of their reflections of their experiences.7 Participants were sent a list of the emerging themes and were invited to attend a presentation of the results at The Mood Disorders Clinic. Those participants who had expressed an interest in receiving a copy of the final written report were sent one accordingly.

Participants

Participants were recruited from the AccEPT Clinic8 at the Mood Disorders Clinic at the University of Exeter. The clinical referral criteria for MBCT are three or more recurrences of depression, in full or partial remission from the last episode, able to engage

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6 See Appendix 2a: Theoretical and methodological considerations
7 See Appendix 2m: Extracts from participant feedback
8 See Appendix 2b: Additional information on the AccEPT Clinic & Mood Disorders Clinic
with MBCT and the absence of substance abuse/dependence or significant self-injury requiring clinical management.

In order to address the research questions, the sample was made up of participants who met the inclusion criteria: a) those who had completed at least half of the eight week programme so that they were exposed to an adequate “dose”\(^9\), b) those who attended MBCT reunions and those who did not\(^10\), so that perceived benefits and barriers to attendance could be explored. Participants were classified as attendees or non-attendees if at the time of the interviews, they had been invited by the clinic and had an opportunity to attend a reunion (an attendee) or had failed to attend (non-attendee). Of those who came forward (n = 21), one participant was thanked for his interest but not included in the study as the attendee sample across time periods was already represented. Three non-attendees emailed the researcher to state that as they had not experienced any benefit from MBCT, they did not feel that they could be helpful to the study and declined to be interviewed. One participant moved house and could not attend interview and three participants did not confirm interviews. Of the thirteen participants recruited, eight were MBCT reunion attendees and was comprised of seven females and one male. Five participants were MBCT non-attendees, two were female and three were male. Twelve participants were Caucasian and British born, and one described herself as “Mixed British”. Tables 1 and 2 provide demographic information for MBCT reunion attendees and non-attendees respectively, and describe participants’ preferred types of mindfulness practices (i.e. informal/formal)\(^11\), maintenance of these practices, whether relapse had occurred since the programme, name of their teacher and duration of interview. Pseudonyms have been used to protect the identity of the participants and teachers. Of the

\(^9\) An ‘adequate dose’ of MBCT was considered to be participation in four of the eight sessions (Kuyken W, Taylor RS, Barrett B, et al., 2008)

\(^10\) See Appendix 2c: Recruitment/sampling strategy

\(^11\) See Appendix 1b: Description and aims of formal and informal mindfulness practices
three teachers included in this study, two were trained by the authors of MBCT and one of these trained the third.

The aim of this study was to explore participants’ experiences in detail with a case-by-case analysis. In order to achieve this aim the total participant number was limited to thirteen as these transcripts yielded rich data addressing the research questions.

**Interview Schedule**

A semi-structured interview schedule\(^1\) was developed to gain insight into the use of mindfulness practices in relation to the participants’ experiences of relapsing depression and participants’ decision to attend or not to attend MBCT reunion meetings\(^2\) following the programme. Participants’ experiences of the following topics were included:

- Experiences of relapse since the completion of their programme
- The eight week programme
- Experiences of mindfulness practices (formal and informal) since completing the programme
- Experiences of the relapse signature
- The MBCT reunion meetings, their decision to attend or not to attend, and their experiences, if applicable.

A digital voice recorder was used to record the interviews.

**Procedure**

The protocol for access to the AccEPT client database was observed\(^3\) and suitable participants were identified. An information sheet detailing the study was sent to potentially interested participants\(^4\). On receiving confirmation of interest, an initial telephone contact

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\(^1\) See Appendix 2d: interview format
\(^2\) See Appendix 1e: description of the Exeter model of reunions
\(^3\) See Appendix 2f: The protocol for access to AccEPT clinic database
\(^4\) See Appendix 2g: Participant information sheet
explored questions a participant had, and a date, time and place to meet was arranged. This was confirmed in a letter to the participant. Formal consent was gained at the beginning of the interview\textsuperscript{16}.

Interviews were conducted over a three months period (October 2010 to December 2010). Participants opted to be interviewed at the University or in their home. Six women and three men chose to be interviewed at home. A lone worker’s policy was adhered to when appropriate\textsuperscript{17}.

All interviews were one to one with the researcher and participant. The duration of interviews ranged from 26 minutes to 50 minutes. Interviews were audio taped and transcribed as soon as possible so that the interview remained fresh in the researcher’s memory. The researcher encouraged participants to articulate their perceptions of the questions through reflective listening techniques. This involved the researcher reflecting back and summarising what participants had said. Additional questions were posed which were aimed at clarifying meaning or asking for examples. Prompts and probes were used when appropriate. These were used to encourage participants to develop an answer already given. Care was taken not to lead the interview (Drever 1995).

Analysis

The transcribed data was analysed using IPA (Smith et al. 1999). This methodology is not intended to test a pre-determined hypothesis but rather ‘to explore, flexibly and in detail, an area of concern’ (Smith & Osborn 2003) and as such allows the researcher to explore the aims of this study. Six stages of analysis were carried out as recommended by Smith et al. (2009; see Table 3). As clusters of “overarching themes” emerged within the data, a master list of these was created. They were arranged in a coherent order and further examined for subcategories within the themes, which point to multiple qualitative facets of areas of

\textsuperscript{16} See Appendix 5a: Participant consent form
\textsuperscript{17} See Appendix 2h: Lone worker’s policy
interest. Themes and categories are not independent entities but rather they are holistic expressions of participants’ experiences.

Checks for integrity of data analysis

The research supervisor and another qualitative researcher reviewed codings generated by the researcher in order to ensure trustworthiness of the interpretations (Smith et al. 2009). A reflective diary\(^{18}\) was used to demonstrate the influence of the researcher on the study findings (Smith and Osborn 2003). This outlines the researcher’s experience of conducting the research as well as their influence on it. An audit trail\(^{19}\) was kept demonstrating how the study was conducted. Research process issues were discussed in supervision with the research supervisor\(^{20}\). Further exploration and clarification was gained in peer supervision with other qualitative researchers.

Dissemination and contextualising the study

Once the emerging themes had been checked for face validity by the research supervisor and another experienced MBCT teacher, a brief synopsis of the aims and resulting themes generated from the IPA was posted on an international scholarly discussion and dissemination link\(^{21,22}\). Participants and reunion attendees were invited to a presentation of the findings.

Reflectivity statement

I am a 46 years old female trainee clinical psychologist in the south west of England with my own mindfulness practice. In addition to this I have observed two MBCT reunion meetings at the MDC, Exeter, led mindfulness skills based groups for people with a diagnosis

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\(^{18}\) See Appendix 2l: Extracts from the reflective diary  
\(^{19}\) See Appendix 2j: Audit Trail  
\(^{20}\) See Appendix 2k: Extracts from supervision  
\(^{21}\) Kent State University List serve: MINDFULNESS@LISTSERV.KENT.EDU  
\(^{22}\) See Appendix 2l: Synopsis for list serve
of psychosis as well as offering individualised MBCT to people with a diagnosis of generalised anxiety disorder (GAD) and borderline personality disorder (BPD). This work was carried out under supervision during my adult mental health clinical placement. Consequently I hold beliefs regarding the efficacy to some individuals of mindfulness-based techniques. This clinical experience has also brought to my attention some of the challenges and barriers that individuals encounter when learning this new approach. For example, the difficulties commonly experienced with completing some of the homework tasks, as well as the challenges inherent in the establishment of regular formal and informal mindfulness practices. I have personal experience of challenges and barriers in establishing and maintaining my own regular practice. Rather than viewing the beliefs and experiences of the researcher as biases that need to be eliminated, IPA adopts the stance that these are inevitable agents in the process of making sense of the experience of others (Smith et al. 1999).

This study was developed for the completion of a Doctorate in Clinical Psychology.
Results

The four master themes that emerged from the transcripts were: reunions as a “booster”, the reunions as a “sanctuary”, difficulty with the group experience and wanting to put it behind me. Table 4 reveals the breakdown of themes.23,24,25

Individuals’ experiences are complex and variable and an attempt to divide these experiences into discrete segments may detract from some of the richness of the accounts. The resulting themes presented here are interrelated and overlapping. However it is hoped that they are represented in an order that describes individuals’ experiences of the perceived benefits and barriers to MBCT reunion attendance, following their programmes. All of the individuals’ accounts speak of their own unique experiences but several of the participants bear striking similarities. Divergences and similarities are explored.

1. Reunions as a “booster”

All of the reunion attendees valued these meetings as an opportunity to remind them of their interest in practices and the challenges many encountered with maintenance of formal practices. For Isobel, reunion attendance was regarded as an effective way to “kick start” her practice, “I started to think of that as a booster really and quite successfully.”

1.1 Reminder of the practices

Participants who had been through their programmes within the last 18 months experienced a reunion half way through their programme26 and had found this experience to be motivating:

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23 See Appendix 3a: Example of transcript coding
24 See Appendix 3b: Extended table of themes
25 See Appendix 3c: Additional extracts supporting themes
26 See Appendix 1e: Description of Exeter model of reunions
Richard: “I wanted to keep up the practice um and always to like when I was doing the course, going to the session just reminded me of how powerful the practices could be and it kind of encouraged me too… to chat to people a bit who had who had done the course before and found it helpful.”

The majority of reunion attendees valued being reminded of the variety of practices available to them. One long-term reunion attendee, Wendy described a formal exercise experienced at her last reunion: “That mindfulness walking around the room is something you never think about doing.” Many participants spoke of the importance of the structure and discipline that the reunion meetings afforded them:

Elizabeth: “Yeah, we have to sit there don’t we for quite some time and that that is good. I don’t, I think I’ve only done that apart from when we were given it as exercises. I think I’ve only done that twice or whatever at home, but coming here and doing it is is great.”

For a reunion attendee, struggling with her formal practice, being in the familiar and structured setting of the reunions enabled her to: “do proper formal reminders that will reinforce stuff in the brain…because you’re in there and you’re in the room.”

1.2 Sharing experiences and learning from each other

The reunions were experienced by some as validating because of the opportunity to share experiences of the challenges of maintaining regular and sustained practices, and ideas about how to overcome them:

Val: “It’s useful to talk about other people about what they’ve been doing and then someone will say, well I try I sometimes do a five minute practise when I do this, and I think oh I might try that. You sort of swap anecdotes with people.”
Meg had recently completed her programme and “liked seeing people at different stages” and hearing from people who were experiencing benefits and challenges to their practice, either having recently completed the programme or from four years previously. Meg explicitly identified being able to meet regularly with people who had an ongoing experience of mindfulness being helpful to them:

“I’m interested in learning skills from other people, hints of what you know worked for them. Partly I’m still interested in how people have integrated mindfulness into their everyday lives.”

1.3 Reunions as an opportunity to contextualise progress

For some individuals, the reunion meetings served as an effective way of contextualising their progress since their last attendance:

Val: “It’s quite reassuring to go to them and think, I’m finding this a lot easier than when I did it the first time round and I’m better isn’t the right word, but I’m further along… I just look back at the person I was then and the person I am now because I’m in the same setting, it makes me realise I’ve gone quite a long way.”

As well as comparisons over time, the reunion meetings provided fertile ground for some people regaining contextual memories:

Rose: “You put yourself in a situation, don’t you back in the room. You’re back in that sort of scenario so then sometimes things come up that you hadn’t remembered for me it’s sort of like situation association I suppose.”

2. The reunion as a sanctuary

Although many participants spoke of the importance of the support they received in being a member of a group, there was a qualitative difference in the accounts of many of the reunion attendees. Elizabeth repeatedly referred to the “calmness” of the reunions and Paula
described the reunions as a “sanctuary”. She valued the feeling of safety and the non-judgemental attitude perceived by her from other attendees and teachers. For Paula the reunion meetings offered a safe, supportive and containing environment:

“It all feels very (pause) um not official, official’s the wrong word and not clinical either, it it feels like we’re going to a place where people know stuff (laughs) you know and that you, you know you’re just held in a very supportive and safe environment, yeah.”

2.1 The importance of a connection with the teacher

The qualities of the MBCT teachers were identified as important to individuals and one of the factors responsible for creating the compassionate space valued by some of the reunion attendees:

“Well she happens to have a very a gentle voice probably not a mindful, not a coincidence but she has a very gentle voice, a very calm, compassionate approach um and I imagine that adds into it, she’s very congruent with her message, her manner is very congruent with her message, um which I think is quite helpful (laughs)”

Reunion attendees attached importance to being able to reconnect with their original teacher at reunions. One long-term reunion attendee, Wendy, felt so strongly about not seeing her teacher at her regular reunion attendance that she repeatedly referenced this throughout her interview: “Because David did our classes that you see, you sort of think, oh well there’s no connection at all to the classes I went to… which is a shame really because you know you, you, you got to know David and you could talk to David (pause) but now you never see him. It’s all strange faces to us.” Without reunion with the original teacher, some people expressed disappointment. Another long-term reunion attendee, Elizabeth also spoke of the need of a continuing relationship with the teacher and emphasised the importance of teachers
demonstrating “calmness, an interest in you, um consistency” and “the teachers you see for eight weeks have got to keep this up.”

2.2 Increased self-compassion

Following her reunion attendance, Paula recognised a more accepting attitude regarding her efforts to practice and the lapses she had experienced in her practice:

“I loved going to the last reunion and I instead of going to the last reunion and thinking, I feel really guilty because I haven’t done anything, I just felt inspired actually…”

Moreover, she described this reunion as encouraging her to facilitate a self-compassionate orientation to conducting her practices in a manageable way for her, “To start again and just to just to take little baby steps.”

This theme of self compassion is not only important regarding its continued encouragement at reunions for this individual, but its presence appears to be helpful to some in terms of overcoming barriers to attendance. Val described the familiar experience of her becoming anxious before going to a meeting, but then being able to prioritise her needs: “It’s not really a social event, is it? It’s a - I’m there for me doing the practise really.”

2.3 Developing compassion for others - interconnectedness

Some participants spoke movingly about their concern for others in the group. For Sophie, this was a major motivation for her to attend the reunions:” To see how other people are getting on and the other people who were in my group.” Sophie experienced concern not only for others, but perceived this as a shared concern within her group, “There is a sense that everyone is rooting for everyone else.” This compassion for others was also demonstrated by Wendy who described her interaction with a fellow reunion attendee who was criticising herself for not doing the practices, “I was saying no, you shouldn’t be like that. I don’t do it all the time but…(pause)”
Meg described experiencing a feeling of connectedness with others that extended beyond her own class group, the reunions and to the wider international mindfulness community:

“In groups meditating with other people I feel a big connection with them even though not necessarily talking that I feel a much stronger connection with those people than I have with a group doing anything else um and I have noticed when I’m meditating on my own as well, I still feel part of a big group and when I’m on my own I feel connected to the group that I learned with even though I haven’t seen any of them since um and I feel connected with a much wider (laughs) sort of international mindful its strange I do feel part of something much bigger which to me is very comforting and I know that there’s people in America doing it with Jon Kabat-Zinn and there’s people here doing it wherever else and in Britain they’re doing it and in that sense I feel part of the group even when I’m on my own. Which I don’t know but to me, is a good feeling.”

This feeling of being connected to other mindfulness practitioners motivated Meg to attend reunions as she valued the importance of “mixing with people who are also doing mindfulness”.

3. Difficulty with the group experience

Participants’ experiences of being in the group programme and of being in the reunion groups were varied and ambiguous for some. Those participants who experienced less benefit from the group experience compared their progress and experiences unfavourably to others. Others disengaged from the group experience (and reunion attendance), through scepticism, “complacency” and/or experiential avoidance.
3.1 Upward social comparisons

Some individuals described experiencing tensions related to being in a group and a tendency to make unhelpful social comparisons. People differed regarding the degree to which they were able to challenge and overcome this barrier and whether it influenced their decision about attending reunions. Isobel, a regular reunion attendee, asserted that she would advise anyone thinking of attending the reunions, not to feel undermined by other’s positive descriptions of their practices:

“At the reunions quite a lot of people talk about, I certainly noticed the first couple I went to, in small groups people talked about how different they felt or how they had almost these mystical experiences in the process of meditation. Interesting because I feel very little in the process of meditation…But there have been times when I’ve been a bit, why haven’t I felt any of this, what they feel? Am I doing it right?”

Difficult feelings induced by such upward social comparison were also described by Richard and was given as a reason for his later non-attendance:

“There’s something slightly off putting about going to a room full of people, half of whom are going to say that you know, it’s great for me. Although that should be inspiring, when I’ve been finding it difficult to practice and having been, it will sort of make me feel worse about that.”

3.2 Not my experience/agenda

For some participants, who were not experiencing any gains, the reported gains that others were experiencing from their practice, was understandably challenging. This increased their feelings of isolation. For one individual, Mark, this was expressed with envy and hostility and directed at the teacher:

Mark: “The person that guided the class was so devoted to their own practice”
Interviewer: “And how did that come across to you?”

Mark: “A bit smug.”

When describing fellow group members, Mark adopted a distanced ‘other perspective’: “Um. They were very enthusiastic and they wanted to talk about how it helped them and how they were getting benefits I found that quite interesting, you know. It was just interesting, you know.”

Despite having reported early benefits from the programme and his practices as “powerful”, Richard struggled with his practice half way through the programme. On reflection, he speculated that his earlier gains might have been attributable to his use of anti-depressants (although he could not remember when he had stopped taking them during the programme). He remained motivated to attend one reunion following his programme. His description of not connecting with other’s experiences bears some resemblance to Mark’s, in that the reports made by others had little resonance for him:

“But I don’t always find that what they’ve got to say is relevant to me… But I find in the reunions often the people who I’m least interested in hearing from are the ones who are talking (laughs) the most.”

Two participants were not comfortable in the group setting and they described their experiences as private. Both James and Rose preferred to continue their practices privately and individually. James described reunion attendance as “not necessary” for him and rather than requiring support and validation from such meetings, he described his experience as a very personal and private matter:

It’s quite a private thing so I didn’t think I would get anything from doing that… I just felt that it was a journey and that it was all up to me.
This preference for privacy was echoed by Rose and was given as her reason for subsequent non-attendance:

“I don’t really like to share, I don’t really like to. I don’t talk to other people about my problem; you know my depression unless I have to.”

3.3 Scepticism

Both Mark and Tim entered the programme with a degree of scepticism. Tim described being convinced that he knew himself well enough to believe that he could not be helped to change his thoughts by meditation. This bore similarities to Mark’s account: “I had to believe that um this quietening of thought, the regular study of my own breathing, was going to help me through my problems with depression and anxiety…I didn’t ever actually think that, so…”

Mark described himself as being “depressed” when he started the programme and by the end, he had not experienced any gains. He had experienced cognitive behavioural therapy (CBT) in the past and reported this as being helpful. He had also experienced meditation in another setting and described this as less helpful. Mark hoped to receive more CBT, in not obtaining this, he felt let down by the service and had become prejudiced towards MBCT. Mark disengaged from the programme and had no wish to attend reunions:

“It felt a bit phoney to me because it was something I had done previously and I’d left it behind and it was like revisiting something again…I don’t find the need in seeing a reason to attend the reunions, no and I don’t want to go. I’m resistant to all that mumbo-jumbo aspect to it all, that’s the truth of it.”

Claire became sceptical in the months following completion of her programme:

“As time went on and the and the course as itself more distant I found it harder to believe um that um that it was actually going to make any difference. I became unconvinced that the fact that the fact that I was alright was anything to do with …the practice.”
4. Wanting to put it behind me

Of the five non-attendees interviewed for this study, three (Claire, Mark and Tim) expressed the need to put the experience of the programme and the group firmly behind them. This was operationalised by complacency and avoidance:

4.1 “Complacency”

This was a recurring theme for Tim and Claire but also for an original, but lapsed, reunion attendee, Richard:

Tim: “It was just that I wanted in in some way to just kind of put the thing behind me because I was feeling better and most most of the time since I’ve done it I felt better.”

Claire: “Then it was so easy just to stop and sort of think you know well I’m fair enough, I’m alright.”

And,

Richard: “I would suggest that a certain amount of complacency almost developed where because my mood improved and because I felt that I got that out of the practice, there was probably a certain extent I was telling myself, oh you’re applying this already.”

4.2 Avoidance

This theme emerged in the accounts of all five non-attendees and one attendee Rose, who was ambiguous about her ongoing attendance. Tim described his discontinuation of his practice; “I basically dropped it like a hot potato.” The practices had been very challenging for Tim who had felt that “being alone with it” had been unhelpful; he had preferred talking to people about his depression as a way of coping. Although Tim had experienced some gains from his body scan practice and had enjoyed the group support, he felt that it would be “hypocritical” of him to attend the reunions. There is a note of regret and shame in his account:
“I’d have felt a bit of a fraud really. Maybe that’s it, I’ve never ever thought about it really, but I know that I didn’t do it and I’m not proud of that really.”

Rose and James described feeling aversion to the group setting in similar ways, both found it challenging to be exposed to negativity from other group members and they had experienced discomfort and a degree of anxiety at the prospect of being with people who might be depressed. They cited these factors as a barrier for their reunion attendance:

James: “I didn’t really gel with anybody; I didn’t think they got it. I thought a lot of people were um quite negative.”

Rose: “I can’t, I can’t be around people now if I think they’re depressed then I can’t, I have to withdraw because because I’m too frightened of being dragged down (laughs).”

For one reunion non-attendee Claire, some contextual memory was distressing and became generalised to remembering when she wasn’t well:

“We had a meeting at (place name) and I can’t go near that building now it absolutely gives me the phantogs it it became...gives me the same feelings ...as thinking about things in my childhood which presumably started all of this…it’s like looking back on it became part of being ill.”

For Claire, the memory of the “same feelings” is re-traumatising and an insurmountable barrier for her attendance at reunions. This is paradoxical for Claire as she recognised that the reunions represented a “type of follow-up” which she repeatedly stated “should” have been helpful to her. It is important to note here that Claire was not introduced to the reunions during her programme as this arrangement predated her MBCT programme.
Discussion

Summary of findings

Four overarching themes emerged from the IPA: *reunions as a booster, the group as a sanctuary, difficulty with the group experience* and *wanting to put it behind me*. Some aspects of these themes overlap with those identified by previous qualitative studies of MBCT for depression. These are discussed below in the context of what appears to be benefits and barriers to some of MBCT reunion attendance. The implications of these to continued practice of mindfulness skills and prevention of depressive relapse are also discussed.

Relating current findings to current literature

Systematic studies (Allen et al. 2009) show that many MBCT participants report the development of mindfulness skills as one of the main benefits, offering a coping response to recognise and interrupt ruminative thought patterns that might lead to depressive relapse. To date, there is limited empirical evidence for the effects of home practice of mindfulness skills in clinical populations (Ramel et al. 2004; Toneatto and Nguyen 2007), and the research remains unclear regarding a straightforward correlation between levels of practice and outcome. Although some studies report a significant correlation with amount of time spent practising and improvements (Kristeller and Hallett 1999; Speca et al. 2000; Carmody and Baer 2008), others do not (Astin 1997; Davidson et al. 2003). This lack of clarity is partly due to the unreliability of self report measures of individuals’ practice, the challenges inherent in measuring clinical outcomes of perceived personal benefit, the degree of perceived benefit, evidence of relapse or time and severity of relapse. Anecdotally those teaching MBCT are aware that there is much variation between individuals with regard to amounts and types of practice and outcome and the participants in our study proved to be no exception. However, it does appear that for the reunion attendees who chose to come into this study, ongoing

27 See Tables 2&3: Participant demographics (descriptions of preferred practice)
attendance at the reunions is an effective and valued way of supporting them in their maintenance of practices, particularly the more challenging formal practices. Not only is the structure and discipline of the reunions valued in this regard, but the culture of the meetings is described as a “sanctuary”, a safe, containing and non-judgemental space where challenges to mindfulness practices are described as being met with acceptance and compassion by teachers and group members. The teachers' embodiment of mindfulness qualities are cited by some as important and are consistent with Ma’s (2002) findings. Reconnecting with this acceptance and compassion are cited by some as the reason they come to the reunions. Acceptance is the pre-requisite to self-compassion and compassion for others.28 Previous qualitative studies have noted this theme (Finucane and Mercer 2006; Ma 2002; Mason and Hargreaves 2001; Allen et al. 2009). Buddhist scholars (Feldman 2005; Kabat-Zinn 1998; Kabat-Zinn 1988) have long argued that mindfulness can enhance an individual’s self-compassion. The development of self-compassion for some individuals in this study appears to be a mechanism which enables challenges and barriers to practice to be met and has been noted in previous qualitative studies (Allen et al. 2009; Williams 2011). Self-compassion appears to provide motivation for continued practice (Kuyken et al. 2010) and this was found to be consistent with the accounts of Paula and Val. It seemed that self-compassion was a mechanism for prioritising their own needs, self-care and motivation to continue attending the reunions and that this in turn was further nurtured and developed at the reunions.

The development of compassion appears important for our emotional and psychological well-being (Gilbert and Proctor 2006; Hutcherson et al. 2008; Lutz et al. 2008; Fredrickson et al. 2008). Some reunion attendees reported feeling compassion towards fellow “sufferers” and this is consistent with quantitative data showing mindfulness to enhance interpersonal relationships (Carson et al. 2004; Singh et al. 2006). Kirsten Neff describes

28 Extract from talk by Christina Feldman, April 2011, Mood Disorders Centre, Exeter, “Compassion in the therapeutic process.”
“common humanity” as perceiving one’s experience as part of the larger human existence” and is one of the three components she describes in her definition of self-compassion (Neff 2003). This is the first qualitative study to present participants’ accounts of compassion felt towards other group members. For some reunion attendees this developed into a feeling of connectedness with others beyond their immediate group and is experienced as compassion for a collective struggle, not only in relation to the challenge of maintaining practices, but in meeting the challenge of living with depression.

Previous qualitative studies have had much to say regarding the beneficial effects of group factors such as destigmatisation, identity and support (Allen et al. 2010; Mason and Hargreaves 2001; Finucane and Mercer 2006). However in this study, experiences were mixed. Most reunion non-attendees expressed feelings of not being part of the group and not relating to other members whose experiences were perceived as being very different from their own. Painful upward social comparisons were made (Ahrens and Alloy 1997) and proved to be a barrier for some to reunion attendance. The inevitable social comparisons that occur in groups (Higgins 1996) appeared to reduce self-devaluative thinking in Allen et al.’s (2010) study. However, in our sample, people engaged more often in the type of social comparisons that had a negative impact upon their mood and is consistent with research describing such affects on those vulnerable to depression (Bazner 2006). Although this was evident in the accounts of the majority of non-attendees, it was also present to a lesser degree in some of the reunion attendees’ accounts. There are many challenges involved regarding teaching MBCT to this client group (Segal et al. 2002) and for some people, who may be more experientially avoidant, (Hayes 1996) the group setting and the sharing of experiences during group discussion will be especially challenging.
The importance that individuals placed upon connecting with their original teacher appears to be more than a preference for familiarity. In Claire’s case\textsuperscript{29}, there seems to be an important attachment component to this relationship (Farber et al. 1995). Facets of mindfulness have been shown to be associated with attachment security (Shaver 2007), thus the consistency of the same teacher(s) at reunions may be pivotal for some regarding the acceptability of the support offered by reunions. Conversely, the difficulty for some to engage with the teacher over a relatively brief 8 session period may also have an attachment component (Mallinckrodt and Chen 2004) resulting in non-engagement with the teacher, the programme, other group members and reunion attendance.

**Limitations of the present study**

Only five non-attendees were recruited and an opportunity was missed regarding the recruitment of participants. The information letter could have more directly referenced the importance of interviewing those who felt they had not benefited from the programme, had disengaged and not attended the reunions. We were not able to explore potential gender differences, as we did not have comparable males to females in our sample. The classification of attendees and non-attendees was problematic when classifying one individual, “Sophie” as she had wanted to attend the reunion meeting she was invited to but had felt too physically unwell to attend. This participant stated that she very much valued the availability of the reunions and voiced her intention to attend future meetings. The researcher made the decision that a reason given (as in this instance “not feeling up to it”) might prove difficult to accurately evaluate (i.e. this could be a valid physical health reason or could be symptomatic of avoidance). Therefore, no interpretation was attempted and failure to attend was noted as non-attendance. In Sophie’s instance, this method of classification may have failed to capture

\textsuperscript{29} See Appendix 3c additional extracts supporting themes
her lived experience and attitudes. Furthermore, there is also the possibility that those participants recently completed their programme, could be subject to recall bias.

Implications for further research

The accounts of individuals provide interesting information regarding the value that reunion attendees placed on reunions supporting the more challenging maintenance of formal practices over informal ones. Reunions were valued as providing a valuable opportunity for the sharing of practical ways of integrating mindfulness practices to everyday life (i.e. informal practices). More reliable measures of practices, particularly with regard to informal practices are needed as the accounts in this study describe different practices being important to different people. This may help to provide guidance to those devising the focus of reunions in what might be most helpful to people in terms of ongoing support of practices and relapse prevention.

Further investigation into the nature of experiential avoidance and how this relates to attachment styles and heightened vulnerability towards disengagement, may assist those developing such interventions to enhance acceptability and effectiveness.

Recommendations for clinical practice

The tension in advising people with a tendency to self-devaluate (Teasdale 1999) that regular practice is fundamental (Segal et al. 2002) is a challenging one. The Exeter model of an early introduction to the reunions appears to be an effective and supportive way to meet this challenge for some reunion attendees. The importance that attendees placed on the reunions being “a sanctuary” is valuable information for teachers, in considering how to involve service-user collaboration to develop the meetings to best meet their needs. A cautious middle-ground approach may be most effective so that this safe and containing experience of the reunions is not undermined.
For one individual, (Claire) the programme had been of some benefit to her but in the absence of her teacher, she had not had sufficient self-motivation to continue with her practices and support those gains. There are possibly dependency issues that first need to be worked on in order to help some individuals shift their mindfulness to a self-compassionate, non-judgemental awareness of the need for the contact with the teacher. Pre-group orientation work of this nature might better prepare some for MBCT within a group setting. It is perhaps unfortunate that Claire did not have the experience of attending a reunion half way through her programme, as that may have supported her in her need for “follow-up” and the ending of the programme in what was perhaps a difficult transition for her. It is also possible that an adequate “dose” had not been received by Claire and for some participants; individual MBCT following the programme may be beneficial. For individuals who may have insecure attachment styles (Bowlby 1980), early preparation for the end of the programme may be helpful. Furthermore for those who have engaged, the therapeutic distancing (Daly and Mallinckrodt 2009) afforded by the quarterly reunion meetings may prove facilitating to those with attachment anxiety to learn to function more autonomously.

Participants ideally enter the programme currently recovered or recovering from depression. Low mood generally hinders a person’s ability to apply themselves to a demanding homework regime of practices. Negative thinking can be an attempt to make sense of not experiencing gains and disengagement an attempt to protect the individual from further aversive experiences (Aldao et al. 2010). Moreover, the experiences of some individuals in this study suggest that in low mood, participants may be more vulnerable to unhelpful social comparison and disengagement. This supports the need for mood to be assessed as close to the beginning of the programme as possible to maximise gains or at least to collaboratively set realistic goals regarding outcome, so that clients and teachers do not
become disheartened. The practice might still be useful but expectations and results might be explained differently.

**Conclusion**

MBCT is a relatively new intervention with an impressive evidence base. However the field has yet to adequately address the relationship of ongoing mindfulness practice to beneficial outcomes and what may be effective in providing ongoing support in this endeavour. Mindfulness is hard work and requires practice (Crane 2009). Moreover, for this client group, the challenge of shifting from experiential avoidance to turning towards and welcoming the difficult is not only counter intuitive, but enormously courageous. Experiencing success in this endeavour results in increases in self-efficacy (Allen et al. 2009) and if maintained is likely to lead to long-term reductions in suffering (Teasdale and Chaskalson (in press). This study’s aim was to gain an in-depth insider’s perspective of MBCT participant’s experiences of benefits and barriers to attendance at MBCT reunions following completion of their programme, and to compare the experiences of reunion attendees with non-attendees. For the reunion attendees in this study, the continued support and validation from others practicing mindfulness appears to be “inspirational” and important in a number of ways. For the non-attendees, the programme and the reunions had failed to engage some, whilst others developed alternative or preferred ways of coping or supporting their practices.

This is the first study to explore the perceived benefits and barriers to reunion attendance and as such may provide insights for the ongoing development of MBCT to enhance its acceptability and effectiveness to this client group. For some individuals, the provision of reunion meetings appears to be a promising and cost effective way to support maintenance of skills and relapse prevention in the longer term.
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Appendices

Appendix 1a: Definitions of Mindfulness

Definitions

To date most definitions of mindfulness have focused on the cultivation of deliberate (intentional) regulation of attention towards experience of external or internal stimuli as they occur from moment-to-moment, together with an attitude of non-judgement and acceptance (Bishop et al., 2004b)

Mindfulness is defined as “paying attention in a particular way, on purpose, in the present moment and non-judgmentally (Kabat-Zinn, 1996, p.4). It is being aware of what I going on, as it is arising, connecting deeply with this and relating to it with acceptance in a powerful act of participatory observation. It is a journey of self-development, self-discovery, learning and healing (Kabat-Zinn, 1990,p.1)

“Mindfulness is a universal human capacity, a way of paying attention to the present moment unfolding of experience that can be cultivated, sustained and integrated into everyday life through in-depth inquiry, fuelled by the ongoing discipline of meditation practice. Its central aim is the relief of suffering and the uncovering of our essential nature.” (Santorelli, 2003, p.1)

“The essence of mindfulness is to be fully aware of our experience in each moment, equally open to whatever it has to offer and free of the domination of habitual, automatic,
cognitive routines that are often goal-oriented and, in one form or another, related to wanting things to be other than they are.” (Teasdale, 1999).
Appendix 1b: Description and aims of mindfulness practices

Formal Practices

1. *Sitting meditation.* This involves bringing awareness to the sensations of the breath within the body whilst sitting. Most individuals experience that the mind does not rest easily on the breath and is easily distracted or has a tendency to wander. The instruction is to gently guide the mind back repeatedly to the direct observation of the breath. An attitude of kindly curiosity is encouraged.

2. *Body scan.* Participants are asked to lie on their back and to spend a few moments focusing on their breath going in and out of their body. Participants are asked to move their minds through the different parts of the body, bringing awareness to each region of the body in turn and exploring the physical sensations that are present in that moment. The intention of this practice is to establish contact with the body whether it is pleasant or unpleasant (Segal et al., 2002). The basic instruction is to bring awareness to a part of the body, hold it in awareness for a short time and finally to release and “let go” of that region before moving on to the next. This ability to take an open and accepting response to a sensation within the body, rather than moving into problem-solving mode is a core skill taught in MBCT (Segal et al., 2002).

3. *Yoga (mindful movement).* This is described as “meditations in motion”. “The focus is on maintaining moment-to-moment awareness of the sensations accompanying our movements, letting go of any thoughts or feelings about the sensations themselves” (Segal et al., 2002, p.180). Practices may be drawn from hatha yoga postures, qi-gong or tai chi. Mindfulness walking is also included and this entails bringing awareness to the physical act of walking, beginning with each step from moment to moment and usually involves combining steps with in breaths.
and out breaths. It is walking for its own sake without any destination (Segal et al., 2002).

4. *The three minute breathing space.* The aim of this ‘mini meditation’ aims to facilitate formal practice to be brought into everyday life. Participants are encouraged to step out of automatic pilot and recognise and accept their current experience; to bring their attention to the breath and to expand the attention using the breath and body as an anchor, whilst opening to the felt experiences.

**Informal Practices**

1. *Awareness of pleasant and unpleasant events.* Participants are asked to complete detailed diaries of how they experience ‘pleasant’ and ‘unpleasant’ events. The aim of this exercise is to cultivate greater awareness of the way “a situation is classified by the mind as ‘pleasant’ or ‘unpleasant’ and the extent to which our thoughts and moods colour such interpretations” (Segal et al., 2002, p.145).

2. *Deliberate awareness of routine activities and events such as eating, walking, the weather, driving, and washing.* Participants are encouraged to bring moment-to-moment awareness to routine activities from week one as part of their home practice.
Appendix 1c: Additional information on the rationale for the use of interpretative phenomenological analysis for this study

There have been few previous qualitative studies of MBCT and these have focused on depression (Allen et al. 2009; Finucane and Mercer 2006; Mason and Hargreaves 2001; Smith et al. 2007). Exploring participants’ experiences and attitudes towards reunion attendances is a new area not yet reported in the literature. Using an experiential approach such as interpretative phenomenological analysis (IPA) (Smith et al. Larkin, 2009) that is well established in applied psychology (Brocki and Wearden 2006; Reid et al. 2005) is well suited to the current study. This is because both IPA and MBCT view participants as playing an active role in the construction and meaningfulness of experiences (Eatough and Smith, 2008; Segal et al. 2002).

Although other qualitative methodologies are appropriate when one is concerned with complexity, process or novelty, or comparing across groups (Grounded theory claims to be best at this), IPA is best at highlighting individuals’ stories or accounts. IPA studies are conducted on small sample sizes. The detailed case-by-case analysis takes a long time and the aim is to say something in detail about the perceptions and understandings of this particular group rather than prematurely making more general claims. The author’s intention with this study was to deepen insight into the subject and to elicit views on the research questions. It was particularly suitable for this study for two reasons. Firstly to examine personal accounts of experiences and attitudes towards MBCT reunion attendance and secondly the researcher believes that the philosophy guiding IPA is close to that of MBCT, as both view the self from a first-person perspective, examine immediate perception and emphasize the construction of meaning as a person-centred process.
Appendix 1d: Description of themes and agenda for MBCT reunion meetings

THEME:

The key themes in follow-up sessions are reinforcing participants’ mindfulness practice, helping people to overcome blocks to continuing practice, identifying positive reasons for doing so and reinforcing changes that are sustaining recovery. Continuing to “weave the parachute” through daily informal and formal mindfulness practice enables people to continue to develop and grow. Use and refinement of relapse signatures and action plans enables participants to begin to realise that they can transform early experiences of depression into opportunities for learning and skilful behaviours. Embodying a focus on the present communicates the programme’s central message powerfully. Work with the present moment. Working with difficulties in follow-ups will be a powerful illustration of the programmes application to recurrent depression.

AGENDA (APART FROM THE OPENING PRACTICE, ITEMS CAN BE INTERCHANGED):

- Practice (Stretching and Sitting Meditation)
- Practice Review
- Review of Practice since the last follow-up (link to positive reasons to continue)
- Weaving the parachute. Customising people’s mindfulness practice (both formal and informal) (pair work)
- Review of use of relapse signatures / action plans since the last follow-up, learning both from people who have relapsed as well as from people whose recovery has continued on without relapse (pair work)
- Keeping the practice fresh – beginner’s mind
- Reading of some poetry and discussion
- 3-minute Breathing Space(s)
Appendix 1e: Description of the Exeter model of reunions

At the time of writing, since 2004, approximately 240 participants have been through the MBCT programme at Exeter. All participants have been invited to MBCT reunions held four times a year. If participants do not attend 3 consecutive reunions (without sending apologies), they are removed from the clinic’s list and do not receive further invitations. Participants are advised of this protocol on completion of their programme.

Two of the Exeter MBCT teachers devised a format in 2009, whereby the reunion meetings occur alongside weeks 3 to 6 of a MBCT programme. Current class participants of the programme are therefore given the opportunity to attend a reunion, to meet people who have been through the programme previously and to experience how reunions are conducted. It is hoped that current class members are thus able to make an informed choice whether or not to attend these reunions offered by the clinic. This experience of a reunion meeting during their programme, may also motivate people to continue with their practice through difficult times having met others who may still be experiencing gains in the long-term following their programme.
Appendix 2a: Theoretical and methodological considerations

It is often said that qualitative approaches are inherently more prone to the risk of bias, subjectivity and collusion. However, best practice in qualitative research is for researchers to make efforts to make this bias known in as transparent a way as possible. In this way the reader might appraise findings accordingly. The research question regarding challenges to the maintenance of mindfulness practices is of considerable personal interest to me as I experience struggles with maintaining my own practice. I use mindfulness practice within my clinical work and it is of significance for me. My clinical work currently involves Cognitive Analytical Therapy (CAT) that values the therapeutic relationship as a key aspect and emphasises the role of attachment styles. The possibility of these influences affecting the analysis was constantly held in mind. At times the research process arose out of an interaction between the data and my inner investigation and clinical experience. I have endeavoured to make this potential bias explicit. Interpretative phenomenological analysis is a qualitative methodology committed to understanding the first-person perspective from the third-person position, so far as is possible, through inter-subjective inquiry and analysis. It recognises that it requires the researcher’s own conceptions and interpretation to make sense of the subject’s personal world (Ma, 2002). My supervision sessions have been particularly valuable in helping me to identify any potential bias.
Appendix 2b. Additional information on The Mood Disorders Centre (MDC)

The Mood Disorders Centre is a partnership between the NHS and the University of Exeter. It provides a centre for research, assessment, treatment and training that aims to benefit people who suffer from mood disorders. It has been offering MBCT as part of its clinical services since 2002. It has received training, supervision and support of the developers of MBCT as well teachers at the Bangor Centre for Mindfulness Research and Practice. As well as clinical and training endeavours the MDC has also been involved in researching MBCT and this research has the added value of cultivating a network of teachers and supporting the development of MBCT services.

AccEPT Clinic

The AccEPT (Accessing Evidence-based Psychological Therapies) Clinic specializes in delivering and developing new treatments for depression. It is constantly evaluating innovative treatments and consequently treatments may vary over time. At the time of writing the clinic offers the following: Group Behavioural Activation (BA) for Current Depression; Individual Cognitive Behavioural Therapy for Depression; Behavioural Couples’ Therapy and Mindfulness-based Cognitive Therapy (MBCT) for Recurrent Depression.

The AccEPT Clinic takes referrals from within the Exeter, Mid Devon and East Devon regions. Referrals are made via General Practitioners and the local Well-Being and Access Service. Following referral all clients are contacted by telephone for a brief discussion about main difficulties and whether the clinic can help them. The client is sometimes invited to the clinic for a more in-depth assessment if appropriate.
Appendix 2c: Recruitment / sampling strategy

Sixty participants on the MDC database, who had consented to being approached for research purposes and met the inclusion criteria, were sent an invitation letter, participant information and consent form. The approach was as inclusive as possible so that we might optimise the chances of harnessing participants who were attendees and non-attendees and those who had recently completed MBCT, pre 18 months, and those that had completed the programme, post 18 months. The aim was not to gain equal numbers of those groups, as IPA does not require this; it was merely to obtain some representation of those groups.

A total of 60 people were written to, 40 were reunion attendees and 20 were non-attendees. Non-attendees were defined as those participants who had completed their MBCT programme, had attended a reunion during their programme (where applicable, i.e. since the introduction of the Exeter model, see appendix 1e) but had not attended subsequent reunion meetings. Unfortunately there was some difficulty in identifying true non-attendees as some had been removed from the database and attendees did not always sign the MDC attendance register. This resulted in them being recorded as (false) non-attendees. A total of 19 responses were received:

- Eight were reunion attendees. Two were MBCT completers post 18 months and six were pre 18 months. Seven were women and one was a man.
- Five were reunion non-attendees. One was MBCT completer, pre 18 months and four were post 18 months. Two were women and three were men.
- 1 woman and 2 men declined, as they had not found MBCT helpful.
- 1 woman had moved and it proved difficult to arrange an interview.
- 1 woman did not get back to the researcher to arrange an interview date.
- 1 man could not be interviewed until late January by which time his demographic group had been represented (i.e. attendee pre 18 months). He was
contacted by the researcher, thanked for his interest but not invited for interest and the reason for this was explained.
Appendix 2d: Interview schedule

Individual semi-structured interview questions:

Thank you for agreeing to participate in this research and consenting to this interview today. Please be reminded of confidentiality as set out in the participant information sheet (review this with participant if required) and also of your right to withdraw from the study without giving a reason. I will be asking you approximately 15 or so questions and we may be talking for about 60 minutes. Please let me know if you should require a break at any time or whether you might wish to bring the interview to an earlier close.

The focus of this research is two-fold. Firstly we would like to find out more from participants, in their own words, of their experiences of the skills learned in MBCT and their ongoing practice of those skills in the months and years that follow. Secondly we are interested in participants’ experiences of attendance at MBCT reunion meetings and also of the decision by some not to attend.

Do you have any questions before we begin?

1. Have you had any near relapses or relapses since completing the programme, A) if so when? B) if not, what do you think might have kept you well / prevented relapse?
2. Which aspects of the MBCT programme have remained most helpful to you in the months/years since completing the programme? What do you continue to use in your day-to-day life? In what ways exactly has this been helpful? Can you give me some examples of when this helped?

3. Do you have any ideas about what might be helpful to you after the end of the MBCT course in terms of helping you to stay well? How might this have been helpful? Can you give some specific examples of how this might have helped you?

4. Can you tell me about any formal mindfulness practices you continue to use after the course (e.g. mindfulness meditation, body scan, yoga, three minute breathing space)? If so, how is this helpful? What helps you keep these practices going? What makes it difficult to keep these practices going?

5. Do you notice any differences for you regarding the experience of meditating alone or in a group?

6. Can you tell me about any informal mindfulness practices you might use (e.g. taking more time to walk to a destination and notice your surroundings)? If so how is this helpful to you?

7. What about the relapse signature and action plans you developed in the group. Can you tell me whether this has been helpful since the end of the course? In what ways?

8. Have you attended any of the reunion sessions offered by the Clinic?
9 If yes: What motivated you to attend these sessions? What did you find helpful / unhelpful about these sessions?

10 If no: What were your reasons for not attending these sessions? Link to answers above.

Prompts:

In addition to the above questions, prompts will also be used such as:

“Can you tell me a little more about that?” “Can you give me an example of what you mean?” “How did you feel about that?” “What do you think changed?” “Why?” “How?” “When?”
Appendix 2e: Additional information on ethical considerations

There is a potential for service-users to feel pressurised into participating in research. Therefore, only those participants who had first provided the Mood Disorder’s Centre (MDC) with formal consent were approached to participate in this study. They were sent an invitation letter and participation information regarding the study. Participants were asked to complete and return the consent form if they wished to participate. Twenty-one consent forms were returned, of these fourteen arranged to meet for an interview. One participant did not confirm an interview date following three emails and two telephone calls at which point the researcher took the decision not to pursue her further.

Although research suggests that people welcome the opportunity to offer feedback on therapy (Singer, 2005), it is possible that for some reflecting upon their experiences could raise emotional issues for participants. Therefore the researcher allowed time in the interview to discuss any issues or distress that may have come up for the participant. Throughout the interview, empathic therapeutic techniques were used to support the participants in discussing their stories. One participant disclosed suicidal intent following the interview. The MDC Research Risk Protocol was observed as well as the researcher meeting with the research supervisor immediately afterwards to give a full debriefing of the interview and comments made by the interviewee following the interview. Consent was obtained from the participants to write to their GP in order to inform them of their patient’s involvement in this study.

Information identifying participants was stored on a separate encrypted data stick to protect the confidentiality of the participants. Any identifying information (with the exception of age and gender) was excluded from the study.
Appendix 2f: Protocol for agreeing access to AccEPT client database for research

All clients referred to the AccEPT Clinic are asked to consent to their data being available for audit and to their contact details being accessible so that they can be invited to take part in future research. This protocol sets out a process for managing access to this data that balances patient confidentiality, autonomy to give informed consent to future studies, patient welfare and Mood Disorders Centre researchers’ needs to recruit participants to their studies.

Only the patients who have endorsed the following statement at intake may be screened: “I agree to my contact details being added to the Mood Disorders database so that I might be invited in the future to take part in research conducted by Mood Disorders Centre staff and postgraduate students.” As such this protocol applies only to Mood Disorders Centre staff and postgraduate students.

All requests for access to the database should be made to the Clinic Lead (Dr Catherine Gallop) via email (c.a.gallop@exeter.ac.uk)

**In the event of a request for access to the clinic database for research purposes the following process should be followed:**

1. Researchers should provide the Clinic Lead with an outline of their study, any participant information and proof of School Ethics Committee (a copy of the ethics letter should be viewed).

2. Routine proposals will be reviewed in an ongoing way by the Clinic Lead. Some proposals may raise more significant implications in terms of methodology, participant burden and client welfare. These will be reviewed by the regular monthly Clinic meetings.

3. If permission for access to patients is given, the researchers will then be given approval to search the SPSS database for appropriate cases (noting exclusion criteria). The SPSS database can be found at: N:\projects\Mood Disorders
Centre\RESEARCH\Clinic SPSS_Access\SPSS. The SPSS database should be opened as a read-only document.

4. Researchers should draft a letter to patients (on behalf of the Clinic Lead) that contains a brief outline of their study with the contact details of the researcher. This should be sent to the Clinic Lead to approve. A pro forma is appended to this protocol.

5. The researchers will then be required to sign the AccEPT Clinic confidentiality statement and given the password for the “Patient contact details agreed to research contact” document found at: N:\projects\Mood Disorders Centre\RESEARCH\Clinic SPSS_Access to gain the names and contact information of the patients who meet their criteria. This document contains only those patients who have consented to being contacted and therefore the patients identified on the SPSS database will be filtered by this criteria at this stage.

6. The researcher should then provide the Clinic Lead with a list of the patients that they wish to approach. This list should include the following information for each patient as ascertained from the “Log of researcher contact with Clinic patients” found at N:\projects\Mood Disorders Centre\RESEARCH\Clinic SPSS_Access:

- Date of last invite
- Number of invites in past 6 months
- Whether currently involved in another trial
- Any relevant qualitative data as noted in the comments field

The lead may then seek advice from relevant Clinic staff on whether there are any reasons why any of the patients should not be approached for the particular study (e.g., they do not meet the study’s inclusion criteria or their welfare may be compromised by participation in the study).

7. The researcher will then send out the letters on behalf of the Clinic Lead to participants asking them if they would be interested in participating in the research, including information
sheet, and asking them to respond by email, phone or on SAE slip to the researcher if they are interested. (Thus making it an opt-in system for each participant).

8. Participants should be given the option to inform the Clinic Lead or researcher that they are not interested in being contacted for future research. The Clinic Administrator should be informed to update the database accordingly.

9. The researcher is also responsible for informing the Clinic Administrator about any change in information (e.g., change of contact details).

10. All research contact up to the stage of recruitment (e.g. letters, emails, telephone conversations) should be recorded by the researcher against the patient ID in the “Log of researcher contact with Clinic patients” found at: N:\projects\Mood Disorders Centre\RESEARCH\Clinic SPSS_Access, including the details of their invitation (date and study name), and the outcome of that invitation (e.g. whether the patient has been recruited and if so the estimated discharge date) so that a log of invitations and studies completed is available to future researchers. Researchers should also update this record with any relevant qualitative data such as complaints and requests, and with the date when the participant is discharged.
INFORMED CONSENT:

PARTICIPANT INFORMATION AND CONSENT FORMS

Participant information sheet:

What endures beyond Mindfulness-based Cognitive Therapy (MBCT)? An exploration of the experiences of mindfulness and relapse prevention in MBCT reunion attendees and non-attendees: an interpretative phenomenological analysis.

Thank you for your interest in this research. My name is Vivienne Hopkins and I am a trainee clinical psychologist at the University of Exeter. I work for Dorset Primary Care Trust, and I am conducting this research as part of my training.

You are being invited to take part in a research study about how the MBCT course you participated in may or may not currently affect your life. We are also very interested in your experiences of attending MBCT reunion meetings as well as your decision not to attend (if applicable).

However, before you decide whether or not you would like to take part, please read this information sheet carefully. You may also like to discuss taking part in this research with your family, friends or GP. Should you wish to take part we will notify your GP of your involvement in this study. You would also receive a payment of £10 for out of pocket expenses payable following your involvement in the study.
If you have any questions after reading this, please feel free to contact me directly (contact details are given below). It is important to take the time to read this information and to allow time to ask me any questions about any aspect of this study. Please do not hesitate to ask me about anything that is not quite clear. Thank you for taking the time to read this.

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

To better understand a person’s experiences of the MBCT programme and importantly how they may or may not go on to implement and develop skills learned in the programme during the months and years that follow. We are also interested in looking at what might challenge or help a person in the ongoing practice of these skills. The information gained from this study may improve treatment and better inform ongoing support to people suffering with depression.

**Do I have to take part?**

No, your taking part in this research would be entirely your choice. If you decide you would like to take part, you would be asked to sign a consent form but even then you would still be free to withdraw at any time without giving a reason and this would not affect the standard of your care. If you would like to take part, please sign the enclosed consent form and return it to me using the enclosed stamped addressed envelope.

**What would taking part involve?**

I will ask you to come to the University to take part in a private, individual interview with me in one of the available rooms in the Mood Disorders Centre. You would be reimbursed for any travel expenses. If you would prefer I am also happy to interview you in your own home. I would ask you several questions and the interview would last approximately 1 hour. The interview will be recorded to make sure I have an accurate record of what we talk about and from which I can analyse your responses. The following are some examples of the sort of questions you will be asked:

- Can you tell me about any formal mindfulness practices you continue to use after the course (e.g. mindfulness meditation, body scan, yoga, three minute breathing space)? If so, how is this helpful? What helps you keep these practices going? What makes it difficult to keep these practices going?

- Can you tell me about any informal mindfulness practices you might use (e.g. taking more time to walk to a destination and notice your surroundings)? If so how is this helpful to you?
Will it be confidential?

The tapes from your interview will be destroyed once they have been transcribed. The resulting transcripts will be anonymised and will be stored on the hard drive of a password protected computer. All of the information that you provide will be kept confidential. Your name and data would be coded and kept separately from each other at all times in locked boxes at the University. Further to this, resulting data analysis will be stored on a computer that is password protected. I will only discuss your experiences anonymously, (without identifying you), with my research supervisor, Professor Willem Kuyken, (Professor of Clinical Psychology) and with colleagues in a research group aimed to increase the quality of the research. The only exception would be if I was concerned about risks of danger to yourself (e.g. risk from suicide) or others, in which case I will inform you that I must break confidentiality and speak to my supervisor and the relevant clinicians, e.g. your GP, or other services.

Will people know it's me in your written report?

I will be coding and analysing the data myself. I will write up the research findings and hand them in to Exeter University, as this is a requirement of my training. You would be anonymous in the written report and although direct quotes from your interview may be used, any information which could potentially identify you, will be removed from the quote. Consequently, there would be no information individually identifying you in the report. I would submit the written report for publication in an academic journal and may present the research findings at training events and conferences. At no point would you be personally identified in the written report.

What will happen to my information?

Your contact details, identification codes and transcripts will always be stored separately from each other. Contact details and identification codes will be destroyed after 1 year following completion of the study. The anonymised data will be securely stored on a hard drive on a password protected computer at the university and destroyed after 20 years.

What are the benefits of taking part?

We cannot promise the study will help you but it could be helpful to you to discuss your experience. Also, the information we get from this study may help improve the treatment of people with recurring depression. This study specifically aims to increase understanding of how MBCT enhances more effective management of emotions and mood in many people and how this may be supported beyond the programme. This could potentially help to inform and improve therapeutic interventions.

What are the disadvantages of taking part?

You might find that talking about your difficulties temporarily lowers your mood. Should that happen we can allow some time to talk through any difficulties if that
might be helpful. If your mood should become worse it might be appropriate to withdraw you from the study and inform your GP.

What if something goes wrong?

If you experience problems or feel that something is going wrong such as you experiencing some distress in the interview, please bring it to our attention immediately. In such an eventuality, the following 3 stage process will be followed: Firstly, you can talk to me, Vivienne Hopkins directly or secondly, you may contact Willem Kuyken, my supervisor (contact details below) and thirdly the normal National Health Service complaints mechanism is also available to you (Patient Advice & Liaison Service FREEPHONE 0800 073 0741 or 01392 403621).

Who has reviewed this study?

All research in the NHS is examined by an independent group of people called Research Ethics Committee to protect your interests. This study has been reviewed and given favourable opinion by South West 2 Research Ethics Committee

How will I know what your research found?

I will offer to send you a copy of the written report and will present the findings at a mindfulness re-union group meeting to which you will be invited.

What if I change my mind during the study?

You are free to withdraw from the study at any time and without being obliged to give a reason. If you decide after your participation that you would like to withdraw your data, you would be free to do so but I would only be able to withdraw your data before January 2011 so please let me know before that time.

Thank you for taking the time to read this information. If you would like to take part please complete and return the enclosed consent form in the stamped and addressed envelope provided. You will be given a copy of the participant information form and a signed copy of the consent form for your records.

If you have any questions please do not hesitate to contact me or my research supervisor (contact details below).

Researcher Contact details:
Researcher: Vivienne Hopkins, trainee clinical psychologist
Address: Clinical psychology doctoral programme, Washington Singer, Perry Rd, Exeter, EX4 4QG
Telephone: Please leave a message with Emma Woodcock, administrator, on 01392 262459 and I will return your call.
Email: vh220@exeter.ac.uk
Supervisor: Professor Willem Kuyken, Professor of Clinical Psychology and Co-Founder Mood Disorders Centre University of Exeter
Exeter EX4 4QG

Email: w.kuyken@exeter.ac.uk
Website: http://www.exeter.ac.uk/mooddisorders
Address: Clinical psychology doctoral programme, Washington Singer, Perry Rd, Exeter, EX4 4QG
Appendix 2h: Lone worker’s policy

Mood Disorders Centre Lone Worker Safety Policy

This policy applies to researchers visiting participants in their own homes or alternative venues other than their GP surgery, including visits outside normal working hours.

Each researcher must complete the contact details form (Appendix A). It is the responsibility of the researcher to ensure that this is updated as necessary.

It is the supervisor’s / principal investigator’s responsibility to ensure that he/she has completed and agreed risk assessment (Appendix B) with respect to lone working as part of his / her project.

Researcher

Identify a member of staff who will receive phone calls and ensure that they know the location and details of the appointment, and the expected duration of the appointment. This could be any member of the research team, or another member of staff if they were not available.

On arrival at the participant’s home, tell them that it is our policy to let a member of staff know of your arrival and call the member of staff to tell them that you have arrived.

At the end of the assessment when you have left the participant’s home or alternative location, telephone the designated person to say that the appointment is complete and that you are safe.

If the assessment is taking an unusually long time, please telephone the designated person at an appropriate time during the assessment to let them know that the assessment is still underway.

If at any time during the appointment you do not feel safe, explain that you need to fetch some paper work from the car and exit the patient’s home to phone the designated person to discuss what action to take.

In the event of an untoward event, telephone the designated person and follow departmental procedure.

Designated person

It is the responsibility of this person to receive phone calls from the researcher on arrival and departure from the appointment. You should agree with the researcher how long you should wait before contacting them if they do not call to let you know the appointment has finished. As a guideline we recommend that this is 30 minutes after the expected end time of the appointment.
If the researcher has not telephoned within 30 minutes of the expected end time, telephone them to see if they are ok. If there is no reply, leave a message for them to call and continue to call every 10 minutes until they respond.

If there is no response after a further 30 minutes, telephone the participant’s home or alternative location to ask if the researcher is still present.

If the researcher is still present, ask to speak to them and check that everything is ok. Ask them to give an estimated completion time.

If the researcher is not present, ask what time they left. If it has only been a few minutes, wait until they are likely to have completed the return journey if they are not answering their telephone. If they left some time ago, check the time to see if they should have returned and telephone again. If there is still no reply, follow procedure on flow chart below.

**General Advice for fieldwork visits:**

The following points are useful guidelines for general arrangement of fieldwork visits:

- It is advisable to have spoken to the participant on the telephone before the actual fieldwork visit.
- University ID should be carried at all times when conducting fieldwork.
- Researchers should carry a mobile phone with them.
- Researchers should not give their home telephone number, personal mobile phone number or address to interviewees.
- It is sensible to avoid locations known to be dangerous after dark and taking unnecessary risks, such as walking/waiting for a bus at night in an unfamiliar area.
- When conducting home visits, consideration should be given to the interview room. The researcher should ensure that they know where exit is and that they have clear access to this.
- Researchers should carry the following equipment in their cars to aid them with emergencies:
  - Contact information for Designated Person
  - Spare car tyre
  - Torch and spare batteries
  - Maps of area
  - Money for taxi/telephone
- Other safety tips include:
  - Always locking themselves into their car during field visits.
  - Researchers may wish to carry a screech alarm for additional protection.
Researchers should have adequate Car Breakdown cover and Business insurance when using their personal cars for work-related field work.

**Other action**

In the unlikely event of an accident or incident, these should be recorded on a University accident report and details given to supervisors. Safety and good practice should be reviewed regularly during the life of a research project.
**Standard Operating Procedure for Fieldwork visits conducted by Project Researchers:**

*Name of project:*

*Name of Researchers:*

*Designated Persons (Normal working Hours):*

*Designated Persons (Out of Office Hours/Annual Leave/Sickness):*

---

**Fieldworker received notification of/has an appointment for a research visit.**

**Fieldworker obtains the following details:**
- Name of individual visiting
- Full address including postcode
- Contact telephone number of person visiting
- Time of visit
  - **Expected time of departure** from visit

Researcher informs the Designated Person (DP) of above information and logs expected time of departure for potential usage. Researcher is responsible for contacting DP prior to or at expected time of departure and informing them of where they intend to go next.

---

**Did Researcher contact DP prior to expected time of departure?**

- **Yes**
  - No further action necessary by DP or Researcher until next visit.

- **No**
  - Points of Action to take in chronological order if no response from Researcher at any point:
    - DP calls mobile of Researcher after agreed time has elapsed since expected time of departure and request a call-back on their contact number if no response.
    - If no response after 5-10 minutes, DP calls every 10 minutes until 30 mins has elapsed
    - If no response after 30 mins DP contacts participant’s home to check whereabouts of Researcher
    - Allowing time for journey if just left, DP telephones researcher again
    - If no response, DP to contact next of kin
    - If no response, DP to contact Emergency Services and inform them of last known whereabouts.
    - DP to log process of actions taken, date and time.
**Appendix A: Contact Details for Emergencies**

<table>
<thead>
<tr>
<th>NAME:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HOME ADDRESS:</td>
<td></td>
</tr>
<tr>
<td>TELEPHONE NUMBERS:</td>
<td>HOME: MOBILE:</td>
</tr>
<tr>
<td></td>
<td>WORK:</td>
</tr>
<tr>
<td></td>
<td>WORK MOBILE:</td>
</tr>
<tr>
<td>CAR DETAILS:</td>
<td>REGISTRATION:</td>
</tr>
<tr>
<td></td>
<td>MAKE &amp; MODEL:</td>
</tr>
<tr>
<td></td>
<td>COLOUR:</td>
</tr>
<tr>
<td>E-MAIL ADDRESS:</td>
<td></td>
</tr>
<tr>
<td>NEXT OF KIN: (Emergency contact)</td>
<td>NAME:</td>
</tr>
<tr>
<td></td>
<td>CONTACT NUMBERS:</td>
</tr>
<tr>
<td></td>
<td>ADDRESS:</td>
</tr>
</tbody>
</table>

N.B. When you have completed this please return to Trial Co-ordinator
Appendix B: FIELDWORK RISK ASSESSMENT FORM (complete once per project)

Name of Project: 
Name of supervisor / PI: 

Signature of supervisor / PI: __________________________ Date: ____________________________

<table>
<thead>
<tr>
<th>Who might be harmed?</th>
<th>In what ways could the risks be managed/minimized?</th>
<th>What action is necessary?</th>
<th>Dates of action performed/review of risks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2i: Extracts from Reflective Diary

October 2010

I have just had a telephone conversation with a participant who has completed and returned her consent form but who is not able to arrange a definite date for interview. I am aware of the tension between trying to adhere to a research time line but to prioritise the needs and wishes of the service-user and not to apply any pressure. Although this individual originally had a face to face conversation with me at one of the MBCT reunions I attended, has sent me a few emails to express their interest and we have now had 3 attempts via telephone conversations to confirm a date for interview, I feel it is appropriate and respectful to leave it to them to contact me further.

November 2010

I have started conducting my interviews and I am noticing a tension between what I consider to be a research interview, by that I mean a neutral stance of an almost factual enquiry, and a clinical interview. My clinical experience and training has honed listening skills which is helpful to this research but my nurturing orientation and tendency to want to empathically support an interviewee by way of body language and smiles and nods may be less so. Reflecting upon this, I have to find the middle ground here in terms of using my skills of engagement to best advantage, to engage in reflective listening and provide pocket summaries to check meaning with participants, but without leading the interview.

December 2010

Some of my participants have been quite anxious at the beginning of the interview and I have a growing sense of the importance of putting my participants at ease and
engaging them well before commencing the interview. This client group may need more sensitivity in this regard than others due to the vulnerability of some to anxiety.

I have just interviewed a participant who has made negative comments about my supervisor. She was very clear that she did not wish for any of this content to be removed from the transcript which she knew I would be looking at with him, although she also knew that she would not be identified. I was unsure what to do about this and I wondered if perhaps she had used the opportunity of the interview to air a number of grievances that she had with the clinic. This led me to reflect upon the potential of selection bias within my study in terms of only interviewing those who wanted to be interviewed and their individual motivation. Some of my participants may want to be interviewed because they have had a very positive experience of MBCT and continue to experience benefits from reunion attendance, others however may wish to use the interview as a vehicle of complaint. However even if I have an over representation of “complainers”, the inclusion of reunion non-attendees in this study will hopefully provide valuable information regarding what has not been helpful to some.

**February 2011 – during analysis**

The interviews have yielded a lot of rich data and there are several themes with subthemes that will be beyond the scope of this research. The resulting analysis provides more than enough data for two papers. I need to make a clear decision on where to place the focus of this study. The areas of exploring participants’ experiences of ongoing mindfulness practice, relapse plans and MBCT reunion attendance are all interesting fields of enquiry. In supervision, my research supervisor pointed out participants’ experiences of reunions was an important area because those conducting reunions were
unsure how best to do this. Consequently, any insights gained from my study were likely to be received with interest by the mindfulness community. After careful thought I therefore decided to focus upon participants’ experiences of the perceived benefits and barriers to reunion attendance. The analyses in relation to participants’ experiences of their relapse signatures and ongoing mindfulness practices are intended to be written up in a second paper.

I am noticing a tension when categorising my themes between that of an openly curious stance in terms of exploring what is coming up for participants (which feels very congruent with mindfulness’ non-judgemental and accepting orientation) and the categorisation process, which feels like “judging”. This caused me to reflect further on the difficulty of inhabiting these two worlds effectively, that of the goal focussed and driven research (and clinical training) world alongside the underpinning qualities of mindfulness: openness, acceptance and non-striving. However in order for this project to be completed on time, there is perhaps a need for me to temporarily leave these core principles to one side, or at least to modify them a little. The challenges for mindfulness practitioners and researchers is to enter this paradox but at the same time perhaps to take care to balance their time between inward reflection, practice and family commitments with the needs of the project or work in hand.
Appendix 2j: Audit trail

<table>
<thead>
<tr>
<th>Research protocol devised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethical application approved</td>
</tr>
<tr>
<td>Participant Recruitment</td>
</tr>
<tr>
<td>Participants from MDC meeting inclusion criteria selected</td>
</tr>
<tr>
<td>(MDC research protocol observed)</td>
</tr>
<tr>
<td>Selected names sent to Clinical Lead</td>
</tr>
<tr>
<td>Clinical Lead checked suitability with appropriate therapists, permission to approach given</td>
</tr>
<tr>
<td>Participant information consent form approved by Clinical Lead</td>
</tr>
<tr>
<td>Participant &amp; consent form posted to suitable participants n = 60</td>
</tr>
<tr>
<td>Consent forms returned n = 19</td>
</tr>
<tr>
<td>Telephone contact made, information gathered regarding attendee/non-attendee status, date of course</td>
</tr>
<tr>
<td>Appointment suggested, clinic space booked, appointment letter sent</td>
</tr>
<tr>
<td>Pseudonyms and participant number allocated</td>
</tr>
<tr>
<td>Interviews conducted and transcribed n = 13</td>
</tr>
<tr>
<td>MDC Risk protocol invoked for 1 participant</td>
</tr>
<tr>
<td>Letters sent to participants’ General Practitioners</td>
</tr>
<tr>
<td>MDC database updated</td>
</tr>
<tr>
<td>Analysis of transcripts, integrity checks with other qualitative researchers</td>
</tr>
<tr>
<td>Copies of transcripts &amp; themes sent to participants, invitation for feedback</td>
</tr>
<tr>
<td>Project Written up</td>
</tr>
<tr>
<td>Letters sent to participants inviting them to presentation of research project. A copy of report sent to those participants who requested one.</td>
</tr>
</tbody>
</table>
Appendix 2.k: Extracts from supervision

December 2010

The general vagueness of the relapse signatures was discussed with my research supervisor. This might be to do with the teacher and the delivery of it. I need to check whose participants are saying this or if it is right across the board. A strength of my design is that I have participants who have been taught by 3 separate teachers. From a scientific perspective, it is preferable that there is heterogeneity regarding teachers so that any affects cannot be overly attributed to one teacher.

We discussed the theme of the importance of the relationship with the teacher for some individuals. The development of trust, confidence and intimacy that occurs during the programme may still be sought at attendance at the reunions. I noticed that 2 of my long-term attendees were very vocal in their disappointment at no longer seeing their original teacher at the reunions they regularly attended. My research supervisor was able to describe the two types of “enquiry” that MBCT teachers conduct with participants. One is more in depth (“vertical”) whilst the other is more general (“horizontal.”). The horizontal enquiry has been adopted for the larger reunion groups. This is an example of the interactional process inherent in our supervision. My research supervisor has contributed to this research with his experience and knowledge of teaching MBCT to participants, conducting reunion meetings and training MBCT teachers. This has been invaluable in terms of setting emerging themes in context.

January 2011

I discussed the process of analysis with my supervisor; I have decided not to separate the transcripts into two separate groups as this may inadvertently encourage a
focus on finding differences between groups. The decision was made to work through the transcripts in the order in which individuals were interviewed on a case-by-case basis. It is recognised that I am gathering information from one interview to the next and in a sense I am a different researcher with each of these experiences and this process continues to unfold throughout the analysis of the transcripts.

**February 2011**

We discussed the pros and cons of discussing the emerging themes with participants. My research supervisor was sceptical about the take up and this caused me to reflect upon the aims of checking in with my participants in this way. This may provide a further bias in terms of those who attend and validate themes that have resonance with them. IPA takes the stance that the researcher’s interpretation of the subjective accounts of individuals is a central part of the analysis and does not recommend checking that interpretation with participants for reasons of validity. This caused me to reflect upon the wider methodological issue of whether there is anything to be gained by interpreting participants’ interpretation of the researcher’s interpretation! I decided that in the interest of courtesy to my participants, that I would post them copies of their transcripts as many had requested a copy of their reflections and a copy of the analysis and report. Although I invited participants to comment upon the analysis if they so wished, this would not subsequently influence the analysis.

**March 2011**

The varieties of practices people are reporting are varied and there is rich description of informal practices that is very under researched. My research supervisor set the value of this data in context as the current research is ambiguous regarding amounts
of practice and benefits. Anecdotally MBCT teachers know that this varies a great deal amongst participants. There is enough data for at least two papers and careful consideration needs to be given in terms of where I place the focus for my DClinPsy Major Research Project and which data I reserve for a second paper. My research supervisor suggested that in addition, I post further analysis on a website so that this valuable information can be disseminated.
Appendix 2l: Synopsis for scholarly link

I am currently completing some qualitative research at the University of Exeter Mood Disorders Centre, exploring participants’ experiences of MBCT reunion attendance. In our Centre people attending an MBCT class are invited to an MBCT reunion meeting between weeks 3 and 6 of the 8-week programme. These reunions are held four times a year and are attended by people who have been through earlier programmes (ranging from the most recent programme to the initial ones of six years ago). We have between 25 and 45 people attending reunions.

This provides MBCT participants with an experience of the reunions to help them decide whether they would like to attend them after completing the programme. Participants might benefit from information sharing with others who have been through the programme and may gain encouragement from the benefits that longer-term mindfulness practitioners are enjoying over time.

Thirteen semi-structured interviews were conducted with eight reunion attendees and five non-attendees to explore their experiences. The following themes emerged from the interpretative phenomenological analysis:

<table>
<thead>
<tr>
<th></th>
<th>Reunions as a “booster”</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Reminder of practices</td>
</tr>
<tr>
<td>1.2</td>
<td>Sharing experiences and learning from each other</td>
</tr>
<tr>
<td>1.3</td>
<td>Reunions as an opportunity to contextualise progress</td>
</tr>
<tr>
<td>2.</td>
<td>Reunions as a sanctuary</td>
</tr>
<tr>
<td>2.1</td>
<td>Importance of the teacher</td>
</tr>
<tr>
<td>2.2</td>
<td>Increasing self-compassion</td>
</tr>
<tr>
<td>2.3</td>
<td>Developing compassion for others - interconnectedness</td>
</tr>
<tr>
<td>3.</td>
<td>Difficulties with the group experience</td>
</tr>
<tr>
<td>3.1</td>
<td>Upward social comparisons</td>
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<td>3.2</td>
<td>Not my experience/agenda</td>
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<td>3.3</td>
<td>Scepticism</td>
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<td>4.</td>
<td>Wanting to put it behind me</td>
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<tr>
<td>4.1</td>
<td>“Complacency”</td>
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<tr>
<td>4.2</td>
<td>Avoidance</td>
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</table>

I would be grateful to hear from other MBCT researchers and/or clinicians if they know of any reunions that programmes are running, the form they take, the general rate of uptake and whether participants experience them as effective in supporting their continued practice of mindfulness skills. This would help me place my findings in context.
Appendix 2m: Summary of feedback from participants

On receiving copies of their transcripts:

“It was really interesting to have a record of my interview. Reading through it made me wonder why I don’t practice more!”

Paula (attendee)

“I think I did the right thing talking to you about my experiences. It has been a problem for me to talk about my feelings…not being able to talk about these things. This marks progress for me so yes, very helpful, thank you for my transcript.”

Sophie (non-attendee)

“Well I didn’t get what I hoped I was being referred for, but you know I don’t want to ruin it for others and I think I made that clear in the interview like it says. It wasn’t a wholly bad experience, it just wasn’t for me as I said.”

Mark (non-attendee)

“Thanks for my transcript. I very much enjoyed reading through it but I didn’t realise I said so many ums! I’m looking forward to reading your report.”

Richard (attendee)

On receiving the table of themes:

“I liked the theme of “sanctuary”, it really does feel like that for me. It’s being able to put the time aside to do a formal practice again…so a “booster” too, yeah. I always feel better after a reunion, sort of rejuvenated somehow. It’s really important to be with others like the “sharing experiences” theme. I need to practise it with others who respect what you’re
doing, who believe it as well. The “teacher” theme was good too.”

Val (attendee)

“The compassion…the interconnectedness is very true for me.”

Meg (attendee)

“It’s nice to see other people getting on and I do feel connected, so the interconnectedness and compassion makes sense. But sometimes this seems selfish too that I’m reassured by others’ getting something from it. So the sharing experiences made a lot of sense to me. I feel sad for those wanting to put it behind them, that’s hard for me to understand. Reunion as a sanctuary is lovely, and the importance of the teacher…that calmness. Compassion is really, really important to me after MBCT, it’s at the core of my experience.”

Sophie (non-attendee, later attendee)

“I’m not sure about some of the themes. Obviously the first lot didn’t mean anything to me because I didn’t attend. I don’t think I have a problem with being in a group; it’s just the same in that I wouldn’t go to a political meeting I didn’t agree with. I just didn’t believe it, that’s all. Scepticism is true; I think I told you about that. I don’t envy others if they get something from it, I just felt I couldn’t say it wasn’t working in the group in case I was ostracised that’s all.”

Mark (non-attendee)

“Well, a lot of the themes didn’t apply to me. I don’t have a problem in a group situation; I was just sceptical about the whole thing really. I didn’t go back to the reunions because my heart wasn’t in it.”

Tim (non-attendee)
Appendix 3a: Example of transcript coding

...and it felt um because I hadn't done the course very long ago, I...

(laughs) sounds a bit pathetic but I felt you know (laughs) if I was going to be, if I was going to be a decent pupil then um, then um I needed to...

do the practice then and as time went on and I was still ok...

I: Hmm...

C: Then um then it was so easy just to just to stop and sort of think you know well I'm far enough I'm alright and that means that tonight I'll have to do so and so and so and so and so and so and so it as always you know it was always the easy thing just to um, just to stop doing.

I: What makes it difficult to keep these practices going for you?

C: Well part of it is the the time thing um I know that's but I do think that's true you can always find time for what you really want to find time for...

I: Hmm

C: But um but that but that definitely was part of it because as well as work um I got a very um a very active social life and so I did find it hard from that point of view but the other thing was was time went on...

and the and the course as itself more distant I found it harder to believe um that um that it was actually going to make any difference. I I I I became unconvinced that the fact that the fact that I was alright was anything to do with the with um the with the practice.

I: Hmm. What do you think looking back on it now, reflecting back to that time, do you still hold that view or do you have a different view?

C: No I think (long pause) I I I've (pause) I think I think that it would have helped me, but as I say for me it as just such a you know like a...
### Appendix 3b: Extended table of themes

<table>
<thead>
<tr>
<th><strong>Appendix 3b: Extended table of themes</strong></th>
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<tbody>
<tr>
<td><strong>Reunions as “booster”</strong></td>
</tr>
<tr>
<td>Reminder of practices</td>
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<tr>
<td>Sharing experiences and learning from each other</td>
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<tr>
<td>Reunions as an opportunity to contextualize progress</td>
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<tr>
<td><strong>The reunions as a “sanctuary”</strong></td>
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<tr>
<td>Importance of the teacher</td>
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<tr>
<td>Increasing self-compassion</td>
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<tr>
<td>Developing compassion for others - interconnectedness</td>
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<tr>
<td><strong>Difficulties with the group experience</strong></td>
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<tr>
<td>Upward social comparison</td>
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<tr>
<td>Not my experience/agenda</td>
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<tr>
<td>Scepticism</td>
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<tr>
<td><strong>Wanting to put it behind me</strong></td>
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<tr>
<td>“Complacency”</td>
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<td>Avoidance</td>
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Appendix 3c: Additional extracts supporting themes
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<tr>
<th>1.0</th>
<th>Reunions as “booster”</th>
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<tbody>
<tr>
<td>1.1</td>
<td>Reminder of practices</td>
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<td></td>
<td>“yes, I mean, I think back to what we do at the meetings. I try and carry out some of the most basic things and I think that helps.” (Elizabeth)</td>
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<td></td>
<td>“To keep myself knowing what I should be doing and not drift all together away from it.” (Wendy)</td>
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<td></td>
<td>“I know that going to a reunion group and having that you know, at regular intervals will help me keep my motivation to the mindfulness” (Meg)</td>
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<td></td>
<td>“I did the reunion, um I started to do a few more formal mindfulness practices and that was fantastic and I did Paula possess me um so that’s my motivation and it’s also to reignite my passion for MBCT “ (Paula)</td>
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<td></td>
<td>“Um I think because I didn’t want to forget the things I’d learned and also because I know it’s going to make me do a formal practice and sometimes I think, well ok if I don’t find time at home, that’s fine but if I make myself go to the odd reunion” (Val)</td>
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<td></td>
<td>“So it just wouldn’t reinforces my yeah it might reinforce my or remind you of things on the course that you’d forgotten” (Rose)</td>
</tr>
</tbody>
</table>

| 1.2 | Sharing experiences and learning from each other |
|     | “You do meet up with people who have done your course as well and meeting other people and listening to other people’s you know verdicts on what they’ve learned from it as well.” (Wendy) |
“Also um I liked seeing people at different stages sort of people who have maybe just finished their course, the one before me and people who have done it 4 years ago” (Meg)

“I felt quite energised and I just said yes, yes and I want to carry on and hearing about what some other people were doing” (Isobel)

<table>
<thead>
<tr>
<th>1.3</th>
<th><strong>Reunions as an opportunity to contextualise progress</strong></th>
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<td></td>
<td>“I’m doing really well so it’s kind of a good reaffirming of that because I think to myself well actually I’m doing really well because this is quite easy now. Just when I started it, I look at the person I was when I started the course and remembering I was quite anxious and depressed and not very well” (Val)</td>
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<td></td>
<td>“There was one lady who was obviously really struggling and I thought well actually she is where I was. So that was that was quite interesting so really it did serve as a reminder to me that because we’re talking you’ve just got to carry on. “ (Rose)</td>
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<th>2.0</th>
<th><strong>The reunions as a sanctuary</strong></th>
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<tr>
<td>2.1</td>
<td><strong>Importance of the teacher</strong></td>
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<td>Calmness, an interest in you, um consistency, following things doing. It’s as simple as that really. I think the people here are, I think they’re smashing really. And certainly people like me, if I haven’t felt that, I would say, oh forget it, I’m not going down that route. Um it’s the same at my goodness, it revolves so much around those that are doing it. (Elizabeth)</td>
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</table>
“Well I think it’s been very helpful to keep on course with the sort of structure of it because it is like your personal teacher (smiles) with you for a while and I needed that when the group finished” (Meg)

Just the the support and the guidance actually, the guidance um from the from the girls that have run the course in the past and just that knowledge that they’re always there you know once you’ve been through the system it’s all there for you you don’t just get chucked out to the lions you know you’ve always got that support. (Paula)

“Without someone without someone to to because I’m a bit of a teacher’s pet so without without the the feeling that someone was keeping an eye on me wanting me to do well and so forth it when it was just for me, I I didn’t matter enough for it to be worth the effort.” (Claire)

2.2 Increasing self-compassion

“Personally when I went to the last um reunion I sat there and I thought gosh (name) part of my whole illness cycle is that I don’t look after myself.” (Paula)

“The reunions remind me to take time out for myself” (Wendy)

“”There was something about a given different permission to stop rather than
2.3 Developing compassion for others - interconnectedness  
“So it’s to light the flames again, that’s one of the reasons why I go and often it’s the support because often you go there and people say oh I haven’t done it either, don’t worry about it, you know (laughs) and it’s the nice it’s like well actually we’re all human.” (Isobel)

3.0 Difficulties with the group experience

3.1 Upward social comparison  
“I wasn’t managing to do it very well, if I was in a group I often look up and see everyone doing it really well and think oh I’m doing a really bad job here. So sometimes it’s nicer to do it alone beginning I think I would look at others and think well they they seem to be doing it right and i’m not, you know.” (Isobel)  
“I couldn’t ever really say what I wanted to say because it wouldn’t have been – it would have been negative for the people who were getting positives from it, so I just didn’t see any point in that.” (Mark)

3.2 Not my experience/agenda  
“You know or take over the leader and I was sitting there thinking, I don’t need this. I don’t want to come here if this is going
to happen every time.

“Because there were loads of other people there that day that were trying to get a word in edgeways.” (Wendy)

I was just getting the same old, same old and it just didn’t seem appropriate to me.” (Mark)

“I think a few people were making some negative comments and I just thought well I just don’t, I just wouldn’t put myself out to be with them. It just wasn’t you socialise in the group after a little bit but um there really wasn’t anybody and I wasn’t interested in making the effort.” (James)

3.3 Scepticism

“I was very cautious because previously it was kind of ‘er a cultish kind of sectish you know like a sect and that I thought well I don’t want to go back into anything like that or people like that and I was quite um I became a little bit hostile and I thought well this is the NHS and this is the University and they’re pushing this stuff out again.” (Mark)

“I would be prepared to do anything to feel better and he referred me to this and I did go into it with an amount of scepticism.” (Tim)

4.0 Wanting to put it behind me

4.1 Complacency

“I felt that I hadn’t, I never, I hadn’t got the time and because I was alright then it although I know this is difficult this is undermining yourself but er but I I felt it wasn’t because I was alright it wasn’t because the things
that I needed to find time for.” (Claire)

“I sort of think that I should apologise for that but I don’t
do any of them now that’s partly because at the moment I feel fine.” (Tim)

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<th>4.2</th>
<th>Avoidance</th>
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| “Sophie in my life um and er I just, I wasn’t I didn’t have enough strength to
actually I’m afraid that I would um well I was just afraid that I would
perhaps not be able to cope with with the reunions um
I thought that I might find the um er doing the er meditations a little bit
too much for me. I didn’t want to break down.” (Sophie)
| “No no no. Well if I say to myself well I won’t go I’m too busy then I
know I don’t really have to go (laughs) because that’s what I do I get
really busy and don’t take notice of the things that I should take notice of.”
(Rose)
| “I think it it would just be really um I wanted to try and move on a
little bit really. I didn’t want to have to keep going back and and
and you know revisiting the MBCT because as you can probably
tell it’s not something that I’ve used in my life um and I think if
had I gone back I probably would have felt that it was a bit sort
of um er almost hypocritical to go back.” (Tim) |
Appendix 4a: Additional discussion points

One size does not fit all and the MCBT programme cannot hope to be an effective or acceptable intervention for everyone. Two of the reunion non-attendees entered the programme with self-disclosed scepticism that the mindfulness techniques would not work for them. Not only will the programme embrace a variety of individuals with different attitudes but also at different stages in their depression thus accessibility will vary. The group format is challenging for some also and following completion of the programme some may prefer (as in this study) to support their practices in alternative ways to reunion attendance. Data gathered regarding alternative support for mindfulness practices is intended for a subsequent paper but it is worthy of note here that two of the non-attendees cited the importance of reading as supportive of their practice. For them ongoing mindfulness practice is a private and lone pursuit but none the less richer or effective.

Individuals will vary in their reasons and motivations for reunion attendance or decisions not to attend. Those that do attend regularly however are likely to shape the culture of those reunions. Keeping reunions open and accessible to as many as may find them useful presents a challenge to MBCT teachers. The theme of reunions being a “sanctuary” had high resonance for many of the reunion attendees and it seems important for this containing and safe environment to be preserved. Any modifications to reunions as a response to services users’ requests may need a light touch and a middle ground approach. Dominant voices or subcultures forming within the large group of the reunions may require tactful facilitation by the teachers. Ultimately these challenges, particularly
regarding aversion to change or meeting with the difficult may all provide valuable “grist to the mill” to be worked with in the containing space of reunion meetings.
Appendix 5a: Consent Form

Study Number:

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: What endures beyond Mindfulness-based Cognitive Therapy (MBCT)? An exploration of the experiences of mindfulness and relapse prevention in MBCT reunion attendees and non-attendees: an interpretative phenomenological analysis.

Name of Researcher: Vivienne Hopkins, trainee clinical psychologist, University of Exeter
Supervisor: Professor Willem Kuyken, Willem Kuyken Professor of Clinical Psychology and Co-Founder Mood Disorders Centre, University of Exeter
(Full contact details below)

Please initial box

1. I confirm that I have read and understand the information sheet (version 2 dated 11th October, 2010) for the above study. I have had the opportunity to consider the information, ask questions and have 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 medical care or legal rights being affected.

3. I understand that my GP will be informed of my participation in this study.

3.4. I understand that anonymised data collected during the study, may be looked at by individuals from the Mood Disorders Centre, 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 this data.

5. I understand that my information will be anonymised in the written report and stored securely?

6. I understand that if I report information about risks or serious danger to myself e.g. suicide or others, the researcher will have to break confidentiality and inform the relevant clinicians and/or services?

7. I agree to take part in the above study.

Name of Participant: Date: Signature:

Name of Person: Date: Signature:

(1 copy for participant; 1 for researcher site file)

Please use the stamped and addressed envelope enclosed.

Researcher Contact details:
Researcher: Vivienne Hopkins, trainee clinical psychologist
Address: Clinical psychology doctoral programme, Washington Singer, Perry Rd, Exeter, EX4 4QG
Telephone: Please leave a message with Emma Woodcock, administrator, on 01392 262459 and I will return your call.
Email: yh220@exeter.ac.uk
Supervisor: Professor Willem Kuyken, Professor of Clinical Psychology
and Co- Founder Mood Disorders Centre
University of Exeter
Exeter EX4 4QG

Email: w.kuyken@exeter.ac.uk
Website: http://www.exeter.ac.uk/mooddisorders
Address: Clinical psychology doctoral programme, Washington Singer, Perry Rd,

Exeter, EX4 4QG
Appendix 5b1, 2 & 3: Ethics approval letters
To Whom It May Concern

Our ref: J081103 27 July, 2010

Zurich Municipal Customer: University of Exeter

This is to confirm that University of Exeter have in force with this Company until the policy expiry on 31 July 2011 insurance incorporating the following features:

Policy Number: NHE-05CA01-0013

Limit of Indemnity:

Public Liability: £ 50,000,000 any one event

Products Liability: £ 50,000,000 for all claims in the period

Pollution: £ 50,000,000 aggregate during any one period of insurance

Employers' Liability: £ 50,000,000 any one event inclusive of costs

Excess:

Public Liability/Products Liability/Pollution: £ 50 any one event

Employers' Liability: £ 50 any one claim

Indemnity to Principals:

Covers include a standard indemnity to Principals Clause in respect of contractual obligations.

Full Policy:

The policy documents should be referred to for details of full cover.

Yours faithfully

Alison Cliff
Underwriting Services
Zurich Municipal
Farnborough
Dear Ms Hopkins

Study No: PCT0795 (REC ref 10/H0268/37) Title “What endures beyond mindfulness-based Cognitive Therapy (MBCT)?” an exploration of the experiences of mindfulness and relapse prevention in MBCT reunion attendees and non attendees: an interpretative phenomenological analysis.

I have reviewed the Trust Research Governance file for you and I am happy to give approval on behalf of the Trust. This approval extends to the study being carried out in NHS Devon and the Mood disorder Centre.

Adverse Events
Can I remind you that you must report to the Research Support Service any serious adverse event occurring during the study quoting the study reference number. This requirement is in addition to informing the Chairman of the Local Ethics Committee.

Outcome and publications
You must also submit to the Research Support Service a final outcome report on completion of your study. If your study takes longer than a year annual reports on progress will be needed. If you publish please send copies to the NHS Devon Research Support Service, NHS Devon Primary Care Trust, 1st Floor (above St Leonard’s Pharmacy), Athelstan Road, Exeter, EX1 1SE for inclusion in our Research Governance file for your study.

Research Governance
I would like to take this opportunity to remind you of your responsibilities as an NHS researcher. These are:
1. Work must be carried out in line with the new Research Governance Framework for Health and Social Services, which details the responsibilities for everyone involved in research
2. The Data Protection Act 1995 requires you to follow the eight principles of “good information handling”
3. You must be aware of, and comply with, Health and Safety standards in relation to your research.

More information about all these responsibilities can be found on the NHS Devon Research Support Service website at www.swpdresearch.nhs.uk

If you have any queries relating to this study or letter of approval, please contact the NHS Devon Research Support Service Research Governance Lead at the address above or call 01392 287786.

With best wishes for a successful study
Yours sincerely

Dr Iain Lang
Consultant in Public Health
Research Governance Lead, NHS Devon

cc. NHS Devon Research Support Service
To: Vivienne Hopkins  
From: Cris Burgess  
CC: Willem Kuyken  

Date:

The School of Psychology Ethics Committee has now met and your NHS Local Research Ethics Committee application and approval were reviewed. In line with our procedures, and assuming that you have met the conditions as laid out by the LREC (their ref. 10/H0206/37), your application to the Psychology Research Ethics Committee is now de facto approved.

The agreement of the Committee is subject to your compliance with the British Psychological Society Code of Conduct and the University of Exeter procedures for data protection (http://www.ex.ac.uk/admin/academic/datapro/). In any correspondence with the Ethics Committee about this application, please quote the reference number above.

I wish you every success with your research.

Yours sincerely,
Cris Burgess
Chair of School Ethics Committee
Dear ------(INSERT NAME OF GP)

This letter is to notify you that your patient, (INSERT NAME, DOB, ADDRESS) has consented to take part in the following study:

“What endures beyond Mindfulness-based Cognitive Therapy (MBCT)? An exploration of the experiences of mindfulness and relapse prevention in MBCT reunion attendees and non-attendees: an interpretative phenomenological analysis.”

This will entail (INSERT PATIENT’S NAME) being interviewed by me, Vivienne Hopkins, Trainee Clinical Psychologist, regarding their experiences of the MBCT course they attended in The Mood Disorder’s Centre (MDC) at the University of Exeter.

It is anticipated that the interview will take between 30 minutes and an hour. The resulting transcripts will be analysed for themes and participants will receive a copy of the resulting report, submitted as the research component of Exeter’s DClinPsy. All data will be anonymised and confidentiality observed at all times. Further to this the MDC protocol regarding management and reporting of risk will be observed.

If during any part of the research process (INSERT NAME) discloses that he or she is unwell, they will be removed from the study and you will be contacted.

Should you have any questions with regard to this study, please do not hesitate to contact me via email on vh220@exeter.ac.uk or at the University address listed above.

Yours sincerely,

Vivienne Hopkins

Chief Investigator & Trainee Clinical Psychologist at the University of Exeter.
Appendix 5.d: The Mood Disorder’s Risk Protocol

MOOD DISORDERS CENTRE
PROTOCOL FOR ASSESSING AND REPORTING RISK

The following principles and procedures govern risk assessment and reporting in the Mood Disorders Centre (MDC). The MDC does not manage risk.

General principles

MDC clinical academic faculty are responsible for risk assessment in their research programmes. This includes ensuring that staff, students and interns working with them receive adequate induction and training prior to participant contact in which risk could be disclosed and ongoing supervision during their research work.

Many of the research projects in the MDC will include supplementary and more detailed protocols for risk assessment.

The AccEPT Clinic Lead (for new assessments) and clinic therapists (for patients in therapy) are responsible for risk assessment in the AccEPT clinic.

General procedures

Background training materials are available on the shared directory.

Whenever any significant risk is identified a risk assessment should be completed and (counter-) signed by the responsible member of staff. If at all possible this should be done at the time of the assessment, or as soon afterwards as possible.

Any significant, but not imminent risk should be reported to the person’s GP and, if appropriate, other health care professionals, as soon as is reasonably possible.
For research outside of the local area, PIs / supervisors should familiarise themselves with the local providers’ risk procedures, and researchers should hold the relevant contact details needed in the case of immediate risk.

When clinical academic staff are away from the Centre they should ensure appropriate cover is arranged for any risk issues that might arise in their absence.

When conducting telephone interviews in which risk may be disclosed, the interviewer should establish the location of the participant at the start of the call, and clarify the boundaries of confidentiality (as per trial / clinic protocol).

**Applying MDC Risk Protocol to the AccEPT Clinical Service**

Typically risk may be detected at three stages during a client’s contact with the clinic:

1. At telephone screening
2. At face-to-face assessment
3. During therapy, and before discharge from the Clinic.

**1. Telephone screening**

The MDC risk protocol should be enacted if any of the following boxes in section 2.1 are ticked:

*Hopeless/Suicide*

- Feeling hopeless or suicidal
- Feeling persists
- Considered self-harm
- Did self-harm

The outcome should be recorded in the telephone interview form.

Staff / interns undertaking telephone screening under supervision should ensure they seek supervision for any risk assessments and have their reports and letters countersigned.
2. At face-to-face assessment
Client should be asked directly about whether suicidal ideation is present (usually as part of the current SCID, unless he/she is not currently experiencing depression). If there is any indication that this is the case from questioning/discussion, or from scores on self-report measures (score > 0 on CORE item 6 or PHQ-9 item 9 or BDI-II item 9), the risk protocol should be enacted.

Particular attention should be paid to checking whether any client who reported significant levels of risk at the telephone assessment (action taken was B) have spoken with his/her GP (see protocol).

The outcome of any risk assessment (including action taken) should be recorded in the client’s notes and communicated to the GP or others involved in the patient’s care as appropriate Staff/interns undertaking assessments under supervision should ensure they seek supervision for any risk assessments and have their reports and letters countersigned.

3. During therapy
In individual therapy sessions risk should be assessed for clients reporting current suicidal ideation (either through questionnaire responses or during therapy discussion), following the MDC protocol. Group interventions should specify the trigger for further investigation of risk (for example, in the BA group risk is assessed if the client scores above 1 on BDI-II item 9, or changes from 0 to 1 on this item) and should assess risk using the MDC protocol.

Clinicians are expected to exercise clinical judgment in determining suitable strategies for reporting and managing risk with regard to individual clients whose level of risk is assessed as being at ‘B’. For clients at immediate risk, the MDC risk protocol should be followed.

Therapists are responsible for discharging patients back to the care of their GPs as soon after therapy is concluded as possible. This discharge summary should include
reporting any risk issues, so that GPs can manage patient’s safety as part of their care plan.

**Exeter emergency contact numbers**

- Crisis Resolution Home Treatment Team (East and Mid Devon) 07968 845048

*Please note, this number is to make an urgent referral to the Crisis Team and should not be given out to participants / clients / members of the public under any circumstances. The participant’s / client’s GP can also make an urgent referral to the Crisis Team and should be the first port of call.*

- Exeter Accident and Emergency Department
  This is located at the Royal Devon and Exeter Hospital (Wonford), Barrack Road, Exeter, EX2 5DW
Exploring Risk in Research Interviews

THOUGHTS

“I see that you’ve said / you mentioned that ……... These are thoughts / feelings that people suffering from depression often have, but it’s important to make sure you are receiving the right kind of support. So if it’s OK, I would now like to ask you some more questions that will explore these feelings in a little more depth.”

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<thead>
<tr>
<th>PLAN</th>
<th>Question</th>
<th>Response</th>
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<tbody>
<tr>
<td>1</td>
<td>Do you know how you would kill yourself?</td>
<td>Yes / No</td>
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<tr>
<td></td>
<td>If yes – details</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Have you made any actual plans to end your life?</td>
<td>Yes / No</td>
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<td></td>
<td>If yes – details</td>
<td></td>
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<tr>
<td>3</td>
<td>Have you made any actual preparations to kill yourself?</td>
<td>Yes / No</td>
</tr>
<tr>
<td></td>
<td>If yes – details</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Have you ever attempted suicide in the past?</td>
<td>Yes / No</td>
</tr>
<tr>
<td></td>
<td>If yes – details</td>
<td></td>
</tr>
</tbody>
</table>

PREVENTION

5  Is there anything stopping you killing or harming yourself at the moment? | Yes / No |
| If yes – details |

6  Do you feel that there is any immediate danger that you will harm or kill yourself? | Yes / No |
| Details: |

FOLLOW-UP FROM PREVIOUS CONTACT
7  If Action B was enacted at previous assessment and level B risk is identified at current assessment: Last time we met I suggested that you spoke to your GP about these thoughts, and I also wrote to your GP about this. Have you been able to speak with your GP about these thoughts since we last met?

Yes / No

See risk table overleaf for appropriate actions
Researcher Risk Protocol

To be used following any indication of risk from questionnaire items, responses to interview questions or any other sources. Look at answers from the sheet to determine the level of risk, A B or C:

**Actions by Researcher**

All answers ‘no’ apart from Q5 ‘yes’:

| A | I can see that things have been very difficult for you, but it seems to me these thoughts about death are not ones you would act on – would this be how you see things? (if they say yes) I would advise you to make an appointment to see your GP to talk about these feelings (as per trial protocol). |

‘Yes’ for any **one** of Qs 1-4; plus ‘yes’ for Q5 and ‘no’ for Q6

| B1 | Things seem to be very hard for you right now and I think it would help if you were to speak to your GP about these feelings. I will be writing to your GP to tell them that you have been here today and have been having some troubling thoughts. I would also advise you to make an appointment to see your GP to talk about these feelings. (as per trial protocol). I think it’s important that your GP knows how difficult things are for you right now. I will be telephoning your GP to speak with him/her and suggest that you meet with one another. I also advise that you make an appointment to see your GP to talk about these feelings. (as per trial protocol). N.B. telephone call to GP to be followed up by letter. The letter should include the statement “the clinical management of this patient remains your responsibility, but it is part of our protocol to inform you of any risks disclosed to ourselves so that you can take account of them in your care plan.” |

‘Yes’ for any **one** of Qs 1-4; plus ‘yes’ for Q5 and ‘no’ for Q6 and ‘no’ to Q7

| B2 | I am very concerned about your safety at this moment, I am not a clinician but I would like you to talk to one right now. I am going to make some telephone calls now to arrange for your GP Care Co-ordinator / Crisis Management team/the emergency services to let them know how you are feeling and to arrange for you to receive immediate help. |

Scoring ‘no’ to Q5 or ‘yes’ to Q6

| C Actively Suicidal | |
Action to take in the case of immediate risk:
Participant needs immediate help – **do not leave them alone, or if on telephone, do not hang up.** Follow your trial’s chain of supervisory clinical contact in order to involve supervisory clinician right away. Then (with clinician if possible) follow the chain of contact below:
1. GP / out of hours GP; if not  
2. Crisis team; if not  
3. Clinician accompanies to A&E; if not (or interview is over telephone)  
4. Call ambulance.
Appendix 1  
Risk Report

Patient name: _____________________  DOB: __________________

Suicide risk information:

Include whether the participant has reported any of the following:

- History of previous suicide attempts
- Current suicidal ideation
- Relevant inventory scores (e.g., BDI item 9)
- Suicide plans / preparations
- Protective factors
- Regular contact with GP?

Date reported: ___/___/___

Additional notes / actions taken:

As part of the MDC risk protocol, suicide risk is managed by the patient’s GP.

Date action taken: ___/___/___

Researcher / assessor: ________________ Signed: ______________ Date: ___/___/___
Dear (INSERT PATIENT NAME),

In the past you attended the AccEPT Clinic at the Mood Disorders Centre, University of Exeter. During that time you signed a consent form and ticked a box to say that you would be happy to be contacted in the future to be invited to take part in research studies within the Mood Disorders Centre.

A researcher at the centre, Vivienne Hopkins, will be carrying out a study entitled “What endures beyond Mindfulness-based Cognitive Therapy (MBCT)?” – an exploration of the experiences of mindfulness and relapse prevention in MBCT reunion attendees and non-attendees: an interpretative phenomenological analysis, and is looking to recruit participants. The study has been approved by the South West Research Ethics Committee. To be eligible for the study participants need to have attended one of the MBCT courses that we have offer in the AccEPT Clinic.

Our records show that you attended a course with us.

Attached is a Participant Information Sheet which explains what the study is about, and what participation involves. Upon reading this Information Sheet, if you are interested in
taking part please contact Vivienne Hopkins either by email vh220@exeter.ac.uk or telephone 07715557354. If you have any questions about the study, Vivienne will be happy to discuss these with you.

Yours sincerely,

Dr Catherine Gallop
AccEPT Clinic Lead
20th April, 2011

Dear -------

Following your involvement in the research project:“What endures beyond Mindfulness-based Cognitive Therapy?” I am writing to thank you for your participation and to inform you of the results.

It was really interesting to hear about your experiences of the programme, the mindfulness practices and your experiences of attending the reunions or your decision not to attend. I am grateful for you taking the time to meet with me and for describing your experiences so well. From our interview and the interviews I conducted with other individuals, I have drawn out the themes attached. These themes represent some of the content of conversations regarding participants’ experiences. You may notice that there are some themes that were not present in your interview; however these themes were important to others.

There will be an opportunity for me to present the research findings following the MBCT reunion meeting in September. I will write to you again nearer the time, once this date has been confirmed.

If you have any comments or if you would prefer not to be invited, please feel free to contact me on the telephone number or email address below.

Best wishes,

Ms Vivienne Hopkins
Trainee Clinical and Community Psychologist, Exeter University.
Tel: 07714512307  email: vh220@exeter.ac.uk
Appendix 6.d: Table of themes for participants

**Themes:** The four master themes that emerged from the transcripts were: reunions as a “booster”, the reunions as a sanctuary, difficulty with the group experience and wanting to put it behind me.

1. **Reunions as a “booster”**
   This theme was of central importance for the majority of MBCT reunion attendees who valued these meetings as an opportunity to remind them of their interest in the practices and provided an opportunity to “kick start” practices.

   1.1 **Reminder of practices**
   The majority of reunion attendees valued being reminded of the variety of practices available. Many participants spoke of the importance of the structure and discipline that the reunions offered, particularly with regard to formal practices like meditation.

   1.2 **Sharing experiences and learning from each other**
   Many reunion attendees valued the opportunity to share their experiences of the challenges of maintaining regular and sustained practice. Some reunion attendees valued the importance of sharing tips and hearing from others, in terms of what worked for them.

   1.3 **Reunions as an opportunity to contextualise progress**
   Some reunion attendees described the reunions as an effective way of contextualising their personal progress since their last attendance. Being in the same setting helped some to remember content from the programme.

2. **The reunion as a sanctuary**
   Many reunion attendees described the calmness of the reunions and referred to it as a safe, supportive and containing environment.

   2.1 **Importance of the teacher**
   The qualities of the MBCT teachers were identified as important to many individuals. Some reunion attendees described qualities of calmness and gentleness as being very important in creating the safe, supportive and containing environment of the reunions. It was very important for some reunion attendees to be able to reconnect with their teacher at the reunions.

   2.2 **Increasing self-compassion**
   Some participants described self-compassion as being encouraged at reunions and its presence was described by some as helpful in overcoming barriers to reunion attendance.

   2.3 **Developing compassion for others – interconnectedness**
   Some reunion attendees spoke of their concern for others in the group and this provided motivation for attending the reunions in order to meet with them. One attendee described a feeling of connectedness with others that extended beyond her own class group, the reunions and on to the wider international community.

3. **Difficulty with the group experience**
   Participants’ experiences of being in the group programme were varied and ambiguous for some. Some participants, who experienced fewer benefits from the group experience, compared their progress and experiences unfavourably to others.

   3.1 **Upward social comparisons**
Some reunion non-attendees described experiencing tensions relating to being in a group and tended to make unhelpful social comparisons with others who appeared to be enjoying greater benefits than them.

3.2 **Not my experience/agenda**
Some participants, who had experienced fewer gains from MBCT, described some difficulty in relating to others’ positive experiences. For some individuals this sense of not connecting with others’ experiences increased their feelings of isolation. Some participants described their experiences as private and expressed a preference not to share these with others in the group setting and thus preferred not to attend reunions.

3.3 **Scepticism**
Some reunion non-attendees had been skeptical of the possibility that the programme would be able to help them. They described difficulty in fully engaging with the programme. One reunion non-attendee became skeptical some months after finishing the programme and described that as time went on, it became more difficult to believe that the reason she was well was attributable to the practice.

4. **Wanting to put it behind me**
Some reunion non-attendees described a feeling of wanting to put the experience of the programme and the group firmly behind them.

4.1 **“Complacency”**
This was a theme for two non-attendees and also one lapsed attendee. This theme describes the difficulty these individuals encountered with maintaining a belief that establishing regular mindfulness practice would help prevent relapse and their subsequent struggle to find the motivation to practice.

4.2 **Avoidance**
This theme emerged in the accounts of all 5 non-attendees. These individuals had experienced fewer gains from the programme and some had preferred alternative ways of coping. For some of the reunion non-attendees it was challenging to be in the company of others who might be describing low mood and their struggle with the practices. For one non-attendee the memory of doing the programme had brought back memories of being depressed in the past and she feared that attendance at the reunions might remind her of this also.
Appendix 7.a: Dissemination plan

1. Participants were sent a version of the results and this was discussed with them on the telephone. A version of the report will be made available to those who have expressed an interest in receiving one.

2. A brief synopsis of results was posted on line to a scholarly link.

3. An oral presentation will be given to any interested participants who took part in the study and current attendees at the MBCT reunions. The presentation will take place following September’s MBCT reunion at the University of Exeter.

4. Opportunities to present findings at relevant local or national conferences will be explored.

5. This paper will be submitted for publication in the journal Mindfulness. This journal has published qualitative papers on the topic of mindfulness. (See appendix 7b: publication guidelines).

This dissemination plan allows for the research to be disseminated to an extensive audience including those involved in the study, those directly involved in the service and to the wider audience of those who are interested in gaining insight into the experiences of service-users.
Appendix 7b: Guidelines on submission for the Journal

Mindfulness is an international journal with a focus on the advancement of research, clinical practice and theory on mindfulness. It publishes peer-reviewed papers that examine the latest research and best practices in mindfulness. It explores the nature and foundations of mindfulness, its mechanisms of actions and its use across cultures. The journal addresses issues involving the training of clinicians, institutional staff, teachers, parents and industry personnel in mindful provision of services.

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors internationally.

2. Length

There is no page limit, but authors should strive for brevity.

3. Submission and reviewing

The journal uses Editorial Manager™ as its submission and peer review tracking system. Authors can use the Editorial Manager to track the review of their manuscript in real time. Manuscripts are submitted online by connecting directly to the site: http://mindfulness.edmgr.com. Instructions are given on screen.

All manuscripts are subject to peer review. The reviews are single-blind, with the reviewers having access to the author’s names and affiliations. Generally, manuscripts are judged in terms of the following criteria: originality, contribution to the existing research literature, methodological soundness and readability.
4. Manuscript requirements

- Manuscripts should be prepared electronically and submitted online in a standard word processing format. Microsoft word® is preferred. Manuscripts should be formatted to print out double-spaced at standard 8” x 11” paper dimensions, using a 10 pt. font size and a default typeface (recommended fonts are Times, Times New Roman, Calibri and Arial).

- Margins should be set at one inch and the right margin not justified. The whole manuscript should be double-spaced, including title page, abstract, list of references, tables and figure captions. Pages should be numbered consecutively after the title page.

- The title page should include: 1) the title (maximum of 15 words; 2) full names of the authors (without degree), with a bullet between the names of the authors; 3) brief running head; 4) the corresponding author’s initials and last name, affiliation, mailing address and email address should be listed at the bottom of the title page.

- The abstract should be between 200 and 250 words. A brief summary of the paper’s purpose, method (design of the study, main outcome measures and age range of subjects), results (major findings), and clinical significance.

- A list of 5 keywords is to be provided below the abstract.


- Tables should follow the Reference section. These should be created in Word®

- Figures should follow the tables and submitted in electronic form.
5. **Publication ethics**

The journal considers manuscripts for publication with the understanding that they represent original material that has not been published, submitted or accepted elsewhere, either in whole or in any substantial part. Manuscripts should report sufficient new data to make a contribution to its field of research.

Authors are advised of a decision within 8 to 10 weeks. Reviewer’s comments are sent with the decision. Accepted papers are subjected to editorial revisions and copyediting although the contents of the paper remain the responsibility of the author.

6. **Copyright**

A statement transferring copyright from the authors (or their employers, if they hold the copyright) to Springer Science+Business Media, Inc will be required before the manuscript can be accepted for publication.
### Table 1. Demographics of MBCT Reunion Attendees (participants invited to attend a reunion by the clinic and attending at least one reunion since completing their MBCT programme) n = 8

<table>
<thead>
<tr>
<th>Participant Pseudonym</th>
<th>Sex</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Time since MBCT</th>
<th>No. of Reunions</th>
<th>Practice &amp; maintenance</th>
<th>Mood since MBCT</th>
<th>Therapist</th>
<th>Interview Duration (mins)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elizabeth</td>
<td>F</td>
<td>67</td>
<td>White British</td>
<td>&gt;48 months</td>
<td>12</td>
<td>Informal (regular)</td>
<td>Experiencing “dips” in mood. Not relapsed</td>
<td>Carol</td>
<td>47</td>
</tr>
<tr>
<td>Wendy</td>
<td>F</td>
<td>66</td>
<td>White British</td>
<td>&gt;48 months</td>
<td>4</td>
<td>Formal and Informal (regular)</td>
<td>Experienced “near relapses”. Not relapsed</td>
<td>David</td>
<td>26</td>
</tr>
<tr>
<td>Richard</td>
<td>M</td>
<td>23</td>
<td>White British</td>
<td>16 months</td>
<td>1</td>
<td>Some “sporadic” Informal</td>
<td>Depression “of a similar nature to before the programme”</td>
<td>Carol</td>
<td>46</td>
</tr>
<tr>
<td>Meg</td>
<td>F</td>
<td>50</td>
<td>White British</td>
<td>16 months</td>
<td>1</td>
<td>Formal and Informal (regular)</td>
<td>Stayed well</td>
<td>Carol</td>
<td>50</td>
</tr>
<tr>
<td>Paula</td>
<td>F</td>
<td>38</td>
<td>White British</td>
<td>16 months</td>
<td>3</td>
<td>Some informal (trying to regain formal)</td>
<td>Experienced a “dip” when formal practices lapsed. Not relapsed</td>
<td>Anna</td>
<td>46</td>
</tr>
<tr>
<td>Isobel</td>
<td>F</td>
<td>47</td>
<td>Mixed</td>
<td>16 months</td>
<td>4</td>
<td>Formal and Informal (regular)</td>
<td>Experienced “lowering of mood”. Not relapsed</td>
<td>Anna</td>
<td>35</td>
</tr>
<tr>
<td>Rose</td>
<td>F</td>
<td>52</td>
<td>White British</td>
<td>10 months</td>
<td>2</td>
<td>Predominantly – informal &amp; formal (3MBS*)</td>
<td>Relapsed but “periods between relapses are longer since the programme”</td>
<td>David</td>
<td>31</td>
</tr>
<tr>
<td>Val</td>
<td>F</td>
<td>45</td>
<td>White British</td>
<td>12 months</td>
<td>2</td>
<td>Informal (regular)</td>
<td>Experienced “lowering of mood”. Not relapsed</td>
<td>Carol</td>
<td>39</td>
</tr>
</tbody>
</table>

ψ These participants attended reunions between sessions 3 and 6 of their programmes.
Table 2. Demographics of Reunion Non-Attendees (participants invited to attend a reunion by the clinic but not having attended at the time of interview) n=5

<table>
<thead>
<tr>
<th>Participant Pseudonym</th>
<th>Sex</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Time since MBCT</th>
<th>Practice &amp; maintenance</th>
<th>Mood since MBCT</th>
<th>Therapist</th>
<th>Interview Duration (mins)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sophie</td>
<td>F</td>
<td>58</td>
<td>White British</td>
<td>4 months</td>
<td>Formal &amp; Informal (regular)</td>
<td>Experiencing “dips” in mood. Not relapsed</td>
<td>Carol</td>
<td>40</td>
</tr>
<tr>
<td>Mark</td>
<td>M</td>
<td>54</td>
<td>White British</td>
<td>20 months</td>
<td>None</td>
<td>Relapsed</td>
<td>Carol</td>
<td>30</td>
</tr>
<tr>
<td>Claire</td>
<td>F</td>
<td>57</td>
<td>White British</td>
<td>&gt;48 months</td>
<td>None</td>
<td>Relapsed</td>
<td>David</td>
<td>30</td>
</tr>
<tr>
<td>James</td>
<td>M</td>
<td>39</td>
<td>White British</td>
<td>10 months</td>
<td>Predominantly informal &amp; some formal (3MBS*)</td>
<td>Experienced “some anxiety” but stayed well</td>
<td>David</td>
<td>26</td>
</tr>
<tr>
<td>Tim</td>
<td>M</td>
<td>40</td>
<td>White British</td>
<td>8 months</td>
<td>None</td>
<td>Relapsed but currently well on medication</td>
<td>Carol</td>
<td>30</td>
</tr>
</tbody>
</table>

*3MBS = Three minute breathing spaces
** These participants attended reunions between sessions 3 and 6 of their programmes.
Table 3: Analysis procedure (Smith and Osborn, 2003)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description of stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1: Reading and re-reading of the transcript</td>
<td>Researcher notes anything of interest or apparent significance</td>
</tr>
<tr>
<td>Stage 2: Initial annotations</td>
<td>Use of language and semantic content are explored. Anything of interest is noted in the transcript’s left hand side of the margin. (Comments can be at a linguistic, conceptual or descriptive level).</td>
</tr>
<tr>
<td>Stage 3: The development of emergent themes</td>
<td>Material of interest is reduced whilst preserving complexity. Connections, patterns and relationships of these emerging overarching themes is mapped and noted in the right hand side of the transcript’s margin.</td>
</tr>
<tr>
<td>Stage 4: Developing connections between emergent themes</td>
<td>Connections are made between different themes. Themes are reduced in order to develop more inclusive and stronger themes (sub categories).</td>
</tr>
<tr>
<td>Stage 5: Moving on to the next case</td>
<td>The analysis proceeds to the next case. Stages 1 to 4 are repeated.</td>
</tr>
<tr>
<td>Stage 6: Looking for patterns across cases</td>
<td>Patterns are explored across cases. Re-labelling and refining may occur. So that themes crossing different cases may be explored, a table of themes is produced. Deeper levels of interpretation are explored and super-ordinate themes develop.</td>
</tr>
</tbody>
</table>
Table 4: Table of Themes

<table>
<thead>
<tr>
<th>1.</th>
<th>Reunions as a “booster”</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Reminder of practices</td>
</tr>
<tr>
<td>1.2</td>
<td>Sharing experiences and learning from each other</td>
</tr>
<tr>
<td>1.3</td>
<td>Reunions as an opportunity to contextualise progress</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2.</th>
<th>The reunion as a sanctuary</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Importance of the teacher</td>
</tr>
<tr>
<td>2.2</td>
<td>Increasing self-compassion</td>
</tr>
<tr>
<td>2.3</td>
<td>Developing compassion for others - interconnectedness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.</th>
<th>Difficulty with the group experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Upward social comparisons</td>
</tr>
<tr>
<td>3.2</td>
<td>Not my experience/agenda</td>
</tr>
<tr>
<td>3.3</td>
<td>Scepticism</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4.</th>
<th>Wanting to put it behind me</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Complacency</td>
</tr>
<tr>
<td>4.2</td>
<td>Avoidance</td>
</tr>
</tbody>
</table>