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Abstract Mindfulness-based Cognitive Therapy (MBCT) has been evidenced as a relapse prevention strategy for depression. Depression often influences and is influenced by intimate-partnerships, thus it makes sense to include both individuals in interventions. This study aimed to develop a theory of the process of engaging in MBCT as a partnership. As there was no theory or research that could be directly applied to understanding the process of engaging in MBCT for depression, as a partnership, an exploratory grounded theory study seemed appropriate to generate rich data and a theory. Twelve participants who had attended an MBCT course as a partnership were interviewed. Analysis and interviews ran simultaneously, so that initial findings influenced subsequent data collection. Constant comparison of data and higher-level concepts facilitated generation of a theory grounded in the data. The proposed theory captured the ‘process of learning new mindfulness skills together’. The partnership’s rationale for pursuing MBCT together seemed to influence engagement with the course. Participants’ accounts suggested that learning mindfulness skills together led to shifts in the relationship and how they managed depression. While partnerships learned similar mindfulness skills as in individual MBCT courses, learning as a partnership seemed to facilitate home practice, attendance and a sense of mutual support, which led to unique outcomes for the partnership and their sense of responsibility for each others’ wellbeing. It may be helpful for course facilitators to consider inviting intimate-partners to attend where both partners are suffering, or there is a willing partnership.

Keywords Mindfulness-based cognitive therapy – MBCT – Mindfulness – Relationships – Interpersonal – Qualitative

Introduction

In the literature, there has been a shift from thinking about depression as a time-limited disorder to acknowledging relapses are common (Judd, 1997; Hughes & Cohen, 2009; Kupfer, 1991; The National Institute for Health and Clinical Excellence [NICE], 2009). For people with depression living with a partner, depression does not occur in isolation (Joiner & Coyne, 1999). There appears to be a bidirectional relationship between interpersonal processes and depression whereby intimate-partners are both affected by depression (Benazon & Coyne, 2000) and involved in the maintenance of depression and relapse (Joiner & Coyne, 1999).

Evidence and theory highlight how depression may be influenced by intimate-partner variables. 'Expressed Emotion' and 'Perceived Criticism' have found some support as predictors of relapse (Hooley, 1986; Hooley & Teasdale, 1989; Kwon et al., 2006; Okasha et al., 1994; Vaughn & Leff, 1976), although there have also been inconsistent findings (Hayshurst, Cooper, Paykel, Vearnals & Ramana, 1997; Hinrichsen and Pollack, 1997; Kronmüller et al., 2008). More recently, different psychosocial risk-factors for depressive relapse have been explored: Backs-Dermott, Dobson and Jones (2010) found that intimate-partner social support and coping predicted relapse. While the findings appear somewhat mixed, these interpersonal processes may play a role in relapse and could be helpfully addressed in relapse prevention interventions.

Depression also appears to influence the intimate-partner, causing stress and depressive symptoms (Benazon & Coyne, 2000; Jeglic et al., 2005; van Wijngaarden, Schene & Koeter, 2004). Within interpersonal theories of depression, intimate-partner burden may be conceptualised as part of a complex feedback system that influences the onset, maintenance and relapse of depressive symptoms (Jones & Asen, 2000). Interpersonal theories of depression suggest that processes such as excessive-reassurance seeking (Coyne, 1976) and negative-feedback seeking (Giesler & Swan, 1999) by the depressed person, marital discord (Beach, Sandeen, & O'Leary, 1990) and intimate-partner over-involvement (Hooley, 2007) may generate stress in both partners. These are hypothesised to lead to reduced support (Hammen, 1991; Joiner & Coyne, 1999), rejection (Coyne, 1976), expressed emotion and criticism (Hooley, 1986), which further impact upon depression and stress (Jones & Asen, 2000).

Considering depression affects both partners, and the potential for the intimate-partner to contribute to or protect against relapse, partnership interventions appear warranted. Marital therapy is the most researched conjoint intervention for depression, but the evidence is limited for relapse prevention (Bodenmann et al., 2008; Jacobson, Fruzzetti, Dobson, Whisman & Hops, 1993; O'Leary & Beach, 1990) and the mechanism of change

is unclear. Furthermore, systemic (Jones & Asen, 2000) and interactional theories (Joiner & Coyne, 1999) suggest that marital discord might not be a causal problem. Interpersonal therapy, which is an individual treatment that formulates depression as a response to current difficulties in relationships has showed efficacy in treating symptoms of depression and preventing relapse (Cuijpers, Geraedts, van Oppen, Andersson, Markowitz, & van Straten, 2011).

Given that interpersonal processes appear to influence depressive relapse, helping couples to develop greater awareness and compassion would seem to have the potential to counteract these factors. Mindfulness, which has been defined as “paying attention in a particular way, on purpose, in the present moment, non-judgmentally” (Kabat-Zinn, 1994, p. 4), may be a way of developing this. Mindfulness has been linked to greater empathy, relationship satisfaction (Wachs & Cordova, 2007), and more adaptive dyadic coping in response to stress (Barnes, Brown, Krusemark, Campbell & Rogge, 2007), representing a different way of relating to the interpersonal processes associated with stress and depressive relapse.

In addition, mindfulness-based interventions have demonstrated effectiveness in relapse prevention for depression (Kuyken et al., 2008; Ma & Teasdale, 2004; Teasdale et al., 2000), improving ability to cope with stress in caregivers (Cohen-Katz, Wiley, Capuano, Baker & Shapiro, 2005) and improved dyadic coping in healthy couples (Carson, Carson, Gil & Baucom, 2004; 2006; 2007). Thus there is reason to consider Mindfulness-based cognitive therapy (MBCT; Segal, Williams & Teasdale, 2002) as an intervention for partnerships where one or both partners have experienced depression.

MBCT was developed based on the premise that relapses frequently occur in depression because exposure to negative events triggers sad mood and reactivates a depressive cycle. Through developing mindfulness skills, individuals can become aware of their mental processes and learn to intentionally step out of ‘doing’ mode into ‘being’ mode when negative thoughts are in the driving seat (Kabat-Zinn, 1994), which has been linked to reduced cognitive reactivity to sad mood (Raes, Dewulf, Van Heeringen & Williams, 2009). Developing these skills as an intimate-partnership may provide opportunities to improve interpersonal functioning (Carson et al., 2006) and potentially exit unhelpful interpersonal processes which may influence depressive relapse.

Practising mindfulness might also lead to shifts in depressive relapse through fostering increased self- and other-compassion (Baer, 2010; Shapiro, Astin, Bishop & Cordova, 2005), which are linked to psychological wellbeing and reduced personal distress (Neff, 2009). However, individual mindfulness only predicts individual outcome,

thus it is suggested that for mindfulness training to be effective for both partners, they need to engage together (Barnes et al., 2007; Eubanks Gambrel & Keeling, 2010).

Engaging together in a self-broadening activity, such as mindfulness, appears to increase relationship satisfaction (Carson et al., 2006), as predicted in Aron and Aron's (1997) self-expansion model of relationships. These findings emerged in non-clinical settings, but are consistent with interpersonal theories of depression which suggest that improving relationship satisfaction may alleviate depression (Beach, Sandeen & O'Leary, 1990). Thus engaging in mindfulness as a partnership might address depressive relapse via several mechanisms including, improving both partners' ability to cope with stress, increasing compassion and awareness in the partnership, and improving relationship satisfaction.

Although clinicians and researchers have advocated integrating mindfulness within family/ couples therapy (Cohen-Katz, 2004; Eubanks Gambrel & Keeling, 2010; Quintiliani, 2010), there is presently no research into the use of MBCT for partnerships with depression. While there is existing theory providing some ideas about the interpersonal processes relevant to depression and how MBCT might influence the partnership, these cannot be applied to explain the process of engaging in MBCT as a partnership.

The present study aimed to address this gap by developing a theory of the process of engaging in MBCT as a partnership. As this presented a new, previously uninvestigated clinical intervention, a qualitative study seemed suitable. Grounded theory (GT; Glaser & Strauss, 1967) was selected because it can explore social processes over time and be used to generate a theory, with practical implications, grounded in the rich experiences of participants. This was conducted from a critical realist philosophical position, assuming real events occur, but are coloured by an individual's social and cultural experiences (Corbin & Strauss, 2008). It was hoped that developing a theory of the process of engaging in MBCT as a partnership may lead to developing this intervention further.

Method

The study was reviewed and approved by local National Health Service Research Ethics Committee. Informed consent was gained from all participants. Pseudonyms were used to protect anonymity. The British Psychological Society Code of Conduct (BPS, 2006) was followed.

Participants

Participants were nine women and seven men, aged between 46 and 72 (Mean = 58 years-old), who had attended an MBCT course for partnerships. Twelve participants took part in an interview, the length of time since finishing the course ranged from 1 month to 1 year. All participants were White-British and came from a metropolitan area. Seven were currently working, six were retired and three were unemployed.

Table. 1 about here please.

Context

Participants attended one of three MBCT courses run for service-users with a history of depression and their partners. They had been referred by health professionals and had chosen to attend a partnership group. Groups were co-facilitated by experienced MBCT teachers, one clinical psychologist and one family therapist who have both trained at the Oxford Mindfulness Centre and Bangor Centre of Mindfulness Research and Practice. Both have been teaching and co-teaching MBCT groups for over four years and follow strict adherence to the Good Practice Guidelines (UK Network of Mindfulness-Based Teacher Trainers, 2010). Courses adhered to the 8-week MBCT programme (Segal et al., 2002), with minor adjustments for partnerships, for example, completing the automatic thoughts questionnaire and warning signals exercise together to facilitate increased understanding of signs of relapse.

Data collection and analysis

An interview schedule was developed, which aimed to explore the process of engaging in MBCT with an intimate-partner. Interviews were semi-structured, guided by the use of open questions and prompts, while enabling responsiveness to what participants shared to generate rich data (Smith, 1995). As is normal for GT, the interview schedule was revised to explore emergent hypotheses from previous interviews and initial analyses. The first author carried out the interviews and also transcribed and conducted the analysis, following methods described in Corbin and Strauss (2008), with auditing from a GT consultant.

Nine interviews were conducted from MBCT cohorts 1 and 2. In line with the GT principles, data analysis ran concurrently with data collection, after every 1-3 interviews transcription, coding and comparison took place, informing future interviews. Extensive microanalysis was used in analysing the first interview to 'break into the

data' and sensitise the first author to different interpretations. Line-by-line coding was used to break the interviews into chunks of raw data. 'Constant comparison' (Glaser & Strauss, 1967) was made between chunks of data for similarity and differences, facilitating the development of properties and dimensions within data. Memo writing and diagramming were used concurrently to begin conceptual development and elucidate possible relationships between concepts.

Once initial categories were formed, questions and hypotheses arose around how partnerships engaged in the sessions together. Following the GT principles of 'theoretical sampling' the first author attended the MBCT course completed by cohort 3 as a participant-observer to explore this. Sessions were audio-recorded for analysis using focussed coding, while remaining open to new categories and comparing to interview data. By this point a theory was emerging and the interview schedule was amended to test.

Final interviews involved more confirmatory questions whereby participants were asked to reflect on experiences relevant to emergent categories. For example, "Some people have talked about approaching depression as a 'partnership' since engaging in MBCT together; I wondered if you could tell me whether this is relevant to your experience?" Three participants were selected from Cohort 3 to test the model. These data enriched the model and no new concepts arose.

Quality Assurance Methods

Yardley's (2000) guidelines for qualitative research were considered to ensure quality control. The research team were experienced in mindfulness; this facilitated *sensitivity to the context* that was being explored. *Commitment, rigour, transparency and coherence* were achieved through line-by-line coding, constantly moving back and forth between the data and emerging concepts, checking out hypotheses with participants and presenting the model grounded in data, audited by a GT consultant. Triangulation of interview data, Cohort 3 session data and MBCT facilitator validation added further coherence. MBCT facilitator validation involved consulting the MBCT facilitator on emerging concepts, for example, participants' reported that attending as a partnership seemed easier, the MBCT facilitator also had this impression and was able to check attendance records across individual and partnership groups to provide additional data to support this. A reflective diary and supervision were used to facilitate 'owning one's perspective' and reflection on how this influenced the data. Although a small step, this research has theoretical *impact and importance* in providing an initial conceptualisation of how intimate-partnerships engage in and use MBCT, which is important to explore if this approach is to be applied further.

Results

Overview of the model

The model presented diagrammatically in Fig 1. illustrates the process of engaging in MBCT as a partnership. At the top of the model, contextual factors that influenced engagement with the course are outlined. These led into partnership influence on engagement with the course, which was influenced by the group process and interacted with learning new mindfulness skills. The interaction of these processes is linked to unique outcomes outlined in the influence of MBCT on the partnership. There is also an arrow in the opposite direction to highlight that these outcomes (e.g. reduced worry) seemed to reinforce the practice of mindfulness skills. A more tentative process is represented for those who did not fully engage with learning mindfulness skills, which seemed to lead to ‘valuing the group process’ in the absence of other changes detailed in the influence of MBCT on the partnership.

Core category: Learning new mindfulness skills together

The core category linking all the data together is the process of learning new mindfulness skills together, for example, “... you can share that and learn something new between you” (Bill). Partnerships’ expectations before the group influenced how they engaged with learning new skills together and in turn learning new skills together seemed to influence the partnership and how they coped with depression.

Figure 1. about here please.

Table 2. about here please

Category A: Context for engagement with learning mindfulness

The categories comprising the “context for engagement with learning mindfulness” included subcategories “hoping to learn new skills” and “depression causes strain”, which was provided as a rationale by service-users and their partners who felt it made sense to engage together because depression impacted them both:

“I think that is why it is quite important for the partners to be included because the strains on the partners can be probably as bad as the person going through it themselves” (Linda).

In the case of two service-users, which could be seen as negative cases, the partnerships did not fully engage in learning mindfulness skills, “meditation [...] wasn’t really for me” (Rachel). These partnerships appeared to practice less, “we didn’t always do the homework, we’d skip bits” (Belinda). This seemed to play a key role in not learning mindfulness, for example, “I’m sure there are other people that would get more from it than me if they could do the body scan” (Rachel).

There were several potential reasons for this, found in the data, although these have been presented tentatively because evidence came from only two service-users. There appeared to be a passive rather than active approach to the MBCT course, for example, “it can’t do any harm” (Rachel) and a perceived lack of control over wellbeing, for example, “maybe it’s just my time to be better” (Rachel). This has been labelled “passive approach to wellbeing”, as mindfulness requires an active approach to looking after yourself, for example, regular practice and looking for warning signs. Another factor that seemed to play a role was the “severity of depression” during the course, for example, “I still wasn’t properly well” (Rachel), which may have hindered engagement with mindfulness, “... relaxation, I find that really difficult, especially the 40 minutes lying and thoughts just going to dark memories” (Belinda). These participants did not report the same perceived changes as other partnerships, although they reported valuing the group process, “nice to know that somebody else was suffering a bit like you” (Rachel).

It appeared that the “quality of the relationship” did not have a strong influence on engagement with the course, as partnerships who reported they had always led fairly separate lives, “we still do our own thing” (Janine), reported similar outcomes to those who felt they had “drifted apart” (Jeff) prior to the group, and those who described team working, “we’ve always worked as a team” (Bill). The perceived outcomes of engaging with MBCT together are discussed later.

Category B: Learning new mindfulness skills

Participants reported several skills learned through the MBCT course, which interacted with partnership processes and were linked to positive changes.

Using the breathing space to cope with stress

The majority of participants described using the breathing space as a new way of coping with stress, “If these thoughts come into my mind of a night time, I think breathing exercises [...] whereas before I’d be awake half the night.”(Rose). In partnerships who practised together, both partners reported benefitting from the breathing space:

“The thing we both get out of it, [...] is the breathing technique, um so, when I feel in times of trouble or stress, I just sort of try to switch off and breathe and you said that as well [talking to partner], when you’re on the counter at work.”(Jeff)

Changing relationship with thoughts

This subcategory refers to “talking about thoughts not being facts that really opened my mind” (Rose), MBCT appeared to help people to step back from thoughts to “see the wood for the trees” (Bill). This was important for half of the participants.

This skill was often applied to difficulties within the relationship and pertaining to the interpersonal strain of depression, highlighting the perceived bidirectional relationship between mindfulness and partnership processes. For example, letting go of thoughts rather than ruminating on them or worrying about the future, appeared to help the relationship:

“Well it was just the thoughts, you know that go through your mind, yes what if he does it again, I won’t let him do that to me again [threaten suicide], and just thinking over and over again... it was just compounding it really, not letting it go, and the mindfulness thing, just let it go, it’s gone.” (Rose).

Noticing more

Five participants also reported “taking a bit more notice of yourself” (Bill) and the world through engaging in mindfulness practice. Paying attention in a different way was experienced as self-broadening and it was felt that mindfulness practices “enriched the day” (Sam).

“I notice things a lot more, particularly in the outdoor world, the bird sounds and trees growing, things like that that you realise you never really stop and look and consider when everything’s sort of very rushed.” (Janine).

Category C: Partnership influence on engagement with MBCT course

There were significant features of engaging as an intimate-partnership that influenced the process of learning new mindfulness skills.

Mutual support for learning new skills

It appeared that engaging in the course together often facilitated increased “commitment” to the “joint project” (Sam) of learning new skills and feelings of mutual or “collegic support” (Sam). In turn, engaging together appeared to lead to positive shifts in the partnership, further discussed in Category D.

Attendance improved

Participants reported “we enjoyed coming together” (Rachel) and felt this facilitated attendance, which could be difficult when depressed and anxious, “I don’t know that she would’ve gone to [...] every meeting if she had been on her own” (William). These data were supported by 8 participants’ interviews and validated by the MBCT course facilitator who compared attendance records and noted that partnership groups were better attended than individuals’ groups.

It was hypothesised that the drop-out rates and attendance may be better in the partnership group because “discussion still goes on at home” (Tom), which may help to overcome initial scepticism, “I was a very sceptical person 8 weeks ago” (Eric). Another important factor seemed to be mutual support and increased commitment because both partners had an interest in finding ways to cope with stress. This was reflected in the MBCT facilitator’s experience that partnership groups seemed to move on from their initial doubt more quickly than groups for individuals.

Need to understand mindfulness to support it

It was widely reported that mindfulness was not something you could easily explain to your partner, “... if I tried to go home and sort of say to Linda, OK what we did today [...] it would be so [...] diluted that she wouldn’t get anything out of it” (Bill). Consequently, partnership benefits might not have been gained if only one partner had done the MBCT course and could even lead to resentment, for example, “I understand what she’s doing so there’s no sense of resentment or discontent about her going off to do something like that.” (Sam).

Partnership influence on home practice

There was a continuum of influence from “commitment to practising together”, “if you’re on your own, you tend to say, ah I’ll do that later and whatever [...] whereas if you’ve got a partner, you can sort of remind each other and encourage each other to do, to take time out you know” (Linda), to “mentoring”, where the partner took on an active role of supporting and encouraging, “I did have to be prompted, you know if I could get away

with not doing it, I would... William would be reminding me” (Rachel), through to partnerships who “did them separately... I think we just maybe found different periods of time during the day where we were free” (Sam).

Some partners started with a mentoring mindset but practised together to support their partner and this seemed to lead to both individuals benefitting from mindfulness.

“... if doing it together means you will do it then that’s what I’ll do. But I also found in my daily work [...] I would take 3 or 4 minutes just to reassess and do a 3 minute breathing space [...] I’ve approached things in different ways because of it, um so yes I think it’s something that everybody can, time allowing slot into their lives.” (Jane)

Category D: Influence of MBCT on the partnership

Participants reported various changes and improvements that they linked to engaging in the MBCT course together.

Increased empathy and understanding

Doing the course together seemed to facilitate increased understanding of how they each ‘suffer’ (Bill), “I’ve gained from the course, a little bit of understanding and a little bit of somewhere I can come to listen to what has been going on” (Jane) and a more “sympathetic attitude” (Sam) towards suffering.

Six participants referred to increased empathy and the data suggested that these effects were not solely due to learning mindfulness skills, but through the interaction of learning mindfulness skills together.

Reconnecting with each other

Through doing the MBCT course together, the partnerships felt they were “really communicating” (Bill) in a way they had not for a while. Many people described that the process “brought us closer” (Jeff) or that their relationship was “stronger, I mean we were a strong couple anyway, but I think our foundations were shaken” (Rose). Eight participants referred to this and it seemed particularly important for partnerships where depression had caused stress for both partners.

Sharing relapse prevention

It could be hypothesised that any kind of partnership intervention might lead to “reconnecting”. However, MBCT seemed to add something on top of the fact that they attended in partnership; for four partnerships it

seemed to provide a shared resource that they could turn to in times of stress. This was referred to as “skilling the carer” in that “it gave the person who was well, like a tool to be able to use it to encourage their partner to participate and do things” (Sam). This process seemed to transform ‘depression’ and ‘stress’ into something that can be shared by the partnership, “... this is another thing that you can work on together” (Bill).

Feeling better, doing more

There appeared to be a positive cycle of feeling better and doing more, reported by six participants, which was entered during the MBCT course. This appeared to be connected to learning mindfulness skills, for example, having the breathing space to draw upon, and also feeling less alone in depression.

“I was becoming quite insular, as I said last week and I couldn’t be bothered to do things. Whereas this past week, well you know I went to lunch with my friend last week and that was really nice and that was quite a big thing for me.” (Claire).

Reduced worry

This was reported in two partnerships, by both the ‘service-user’, “it’s really all come together now, I think that’s due to the mindfulness course again because I think because I’m more settled and I don’t worry” (Tom) and by ‘partners’, “he doesn’t seem worried about anything like that at all, his attitude towards people has changed, I think he can really see things as they are” (Linda). This could be connected to mindfulness skills of changing relationship with thoughts and living in the present and was experienced as a dramatic change, for example, “I used to famously say, if I had nothing to worry about, I was worried” (Tom).

Category E: Group Process

The group was experienced by most participants as a safe, equal learning environment that facilitated learning new skills. This group process of sharing and normalising was valued even when participants did not fully engage with learning new mindfulness skills.

Learning in a safe, equal environment

It seemed an important foundation for sharing and learning that the group was a safe space. This was experienced as a positive part of the MBCT course, “It was brilliant because it was non-judgemental, you didn’t know which one had the depression... it was fabulous.” (Rose).

Sharing helps

Sharing experiences with other partnerships who had gone through similar challenges was experienced as helpful for both partners, “I think one of the good things about the groups is that you can talk to people who are going through exactly the same situation as yourself and I think that is a huge benefit” (Linda).

Putting problems in perspective

The process of sharing experiences in the group also facilitated normalising and putting problems in perspective for five participants, this was linked to feeling better about one’s own position, “I just felt quite lucky actually that I hadn’t been that bad” (Bill).

Level of commitment to the group

These positive factors about the group were experienced to different degrees. In Cohort 1 there was a large group of committed partnerships and the group process was experienced as a very positive and valuable part of the learning, “it was so good that all the people came to every session... because we were all getting so much from it” (Rose). In contrast, Cohort 2 experienced high drop-out and this seemed to negatively impact on the group experience, “it sort of broke the group” (Sam). There were views about those who struggled in the group, some people linked this to not being well enough to attend, “if you’re poorly, I do realise how at times how tough it can be” (Sam). It seemed a frustrating and isolating experience to be in a group with someone whose ‘mind was closed’ (Janine), for example, “we felt like the only couple who were positive really about what was going on” (Janine).

Valuing the group process over mindfulness

For those who appeared less engaged with learning mindfulness skills, there was still a sense that they valued the group process and gained something from this. Speaking about the group experience, Rachel said: “I enjoy that, I was keen to hear what other people had to say”; her partner also felt sharing in the group was positive for her, “... it made her realise that she could do things” (William)

Category F: Outside influences on perceived change

Perceived changes and improvements were thought to be facilitated by a combination of factors, not just engaging in MBCT together.

Coming to a time in our lives where we can focus on ourselves

For some, it was difficult to untangle the different factors that may have influenced change, although mindfulness was positioned as an important factor, “I think it’s possibly not just the course, I think it’s everything. I think the course has been a part of the jigsaw” (Jane) “an important part” (Jeff). Some participants noted that they had more time for each other since retiring, or since their children had grown up they “haven’t got the distractions of children” (Bill) and in that context they felt “It just suited us both being there, at that time of life” (Jeff). Thus, the partnership’s context appeared to impact on how much they engaged with the MBCT course and the impact it had on them.

Discussion

The purpose of this study was to develop a model of the process of engaging in an MBCT course as a partnership. The model depicts the journey that most partnerships followed when learning new mindfulness skills together. This process incorporates how expectations, experience of depression and quality of relationship prior to engaging in MBCT appeared to influence course engagement. It presents an explanatory map of how mindfulness skills appeared to be learned, in the context of the partnership, supported to a lesser or greater degree by the group process. The model shows how the reciprocal influences of partnership engagement and MBCT appeared to lead to some unique outcomes for individuals and the partnership. More tentatively an alternative journey for partnerships who were less engaged in the core process of learning new mindfulness skills together is also included.

Some of the findings are consistent with proposed mechanisms of mindfulness outlined in the introduction, notably decentering (Sauer & Baer, 2010), self-compassion (Baer, 2010) and self-broadening (Carson et al., 2006; 2007). Whilst the partnerships in this study were not experiencing significant marital distress, they did present an interpersonal picture of stress and depression causing strain on both partners that reflected systemic theory (Jones & Asen, 2000). Some of the findings can be helpfully framed within interpersonal theories of depression.

Positive outcomes seemed to transpire for partnerships who described themselves as a good ‘team’ equally to those who had ‘drifted apart’ and those who seemed to lead fairly ‘separate lives’. While it was positive that a similar process was followed regardless of the quality of the relationship, it is important to note that these variations in the relationship were within the context of non-discordant intimate-partnerships where partners

were willing to engage in MBCT together. Thus, although there was some variation in relationship quality, they were on the whole stable and supportive. Thus, the process depicted by this model may not apply to discordant intimate-partnerships. A uniting factor across the partnerships was that all partners felt that depression had caused strain on both of them, which presented a rationale for engaging together.

Although those who led fairly separate lives tended to practise separately, they still discussed mindfulness at home and noted greater commitment to the course. Similarly, those who had drifted apart started with a mentoring approach to practice, but appeared to become more committed to practising together as mutual benefits were noticed. This finding is consistent with Intentional Systemic Mindfulness (ISM; Shapiro & Schwartz, 2000), which proposes a feedback loop, where cultivating mindfulness facilitates further intention to practice and mindfulness continues growing. ISM focuses on the individual, thus the proposed model extends this idea to partnerships. Additionally, committing to practise together appeared to bolster home practice as participants could encourage each other to practice.

Validating participant data, MBCT course facilitators noted that partnership groups showed better attendance and engagement with home practice than individual groups. Research has related amount of home practice to improvements in mindfulness, symptoms and wellbeing (Carmody & Baer, 2008; Orzech, Shapiro, Brown & McKay, 2009). Small scale studies have suggested that, among other variables, lack of group support, motivation, and negative views of others may hinder practice (e.g. Langdon, Jones & Hutton, 2011). The present model suggests that engaging together may facilitate greater engagement with home practice, potentially because it addresses some of these hindering factors.

The group process was positioned as valuable, particularly sharing and feeling less isolated through hearing others' experiences and putting one's own problems into perspective, reflecting Yalom's group therapeutic factor of *universality* (Yalom & Leszcz, 2005). Similarly, the concept of *cohesiveness* could be applied to understanding the divergent process of Cohort 2. In Cohort 1 and 3, the data around 'sharing helps' indicated that the group members felt a sense of belonging, acceptance and validation in the group setting. Within Yalom's theory this could be framed as a cohesive group that facilitated personal growth. In contrast, Cohort 2 seemed to struggle to develop a sense of cohesion in view of the high drop-out and perceived challenges in this group. One of the perceived challenges was participants' frustration that others were not open-minded. Open-mindedness has been positioned as a helpful starting point for learning mindfulness skills (Kabat-Zinn, 1994).

There was a process for a minority of participants of valuing the group experience over learning mindfulness skills. This echoed previous research on mindfulness groups, for example, Dobkin (2008) found that participants valued the group experience, feeling that it was more powerful than engaging as an individual. It was not completely evident what conditions led to this alternative process, although, having more severe depressive symptoms during the course appeared to hinder engagement with home practice. MBCT is positioned as a relapse prevention intervention, thus it is ideally offered while the person is in recovery (Segal et al., 2002). Another potentially significant factor was a passive approach to well-being, which has arisen in a similar GT study where one participant positioned herself as in receipt of a treatment and therefore did not engage with home practice and reported little improvement (Mason & Hargreaves, 2001). These pathways require further exploration.

The process of noticing more and reconnecting with each other through engaging in MBCT together could be understood in line with Carson et al.'s (2006) positioning of mindfulness as a self-broadening activity and Aron and Aron's (1997) self-expansion model of relationships. Participants' accounts suggest that MBCT was a self-broadening experience and facilitated different conversations and ways of being together, which led to feeling more connected and noticing improvements in their relationship. Consistent with the Intentional Systemic Mindfulness model (Shapiro & Schwartz, 2000), noticing the growth of mindfulness in daily life and relationships may have contributed to increased commitment to practice both informally and formally.

Qualities of empathy and mindfulness have been linked in research (Wachs & Cordova, 2007). The current model suggests a process of increased empathy and understanding through engaging in the course together. It could be hypothesised that increased empathy and compassion might protect against depression in the longer-term, as theoretically it appears to be the antithesis of high expressed-emotion, and improving the interpersonal relationship may protect against depression (Beach et al., 1990). This could also be helpfully considered within attachment theory, as developing mindfulness has the potential to enhance emotional attunement and increase receptivity (Siegal, 2007), which may provide a way of theoretically understanding how practising mindfulness together appears to lead to these improvements in relationships and protect against depression. This requires testing longitudinally, and would likely depend on whether partnerships continue with practice.

The model depicts a process of learning different ways to cope with stress, such as using the breathing space to switch out of autopilot and letting go of worries. This appears consistent with 'decentering' as a mechanism of change in mindfulness (Sauer & Baer, 2010). Additionally, engaging as an intimate-partnership appeared to be

related to unique outcomes not identified in previous literature, notably, 'sharing relapse prevention', which is linked to both partners having mindfulness and decentering skills to draw on when stress arises. While Carson et al (2004) were not investigating depression, they did find improved 'dyadic coping' in healthy couples following MBSR, which may present a similar process.

Systemic couples theory (Jones & Asen, 2000) can be applied to consider the process of decentering in a partnership. Some partnerships described previous patterns of communicating whereby the partner suffering low mood was met with anger or silence, which fed into a systemic feedback loop. In the process of 'changing relationship with thoughts', it appeared that both partners were more able to let go of anger and worries or to suggest using the breathing space as a way of approaching stress (e.g. 'sharing relapse prevention'). Decentering from negative thoughts in an interpersonal context potentially provides an exit from complex feedback systems, as partnerships become more aware of their internal and interpersonal processes through practising mindful awareness.

In view of the small sample size, this model was tentative and findings should be treated with caution. The participants were all White-British and came from a metropolitan area, which limits the transferability of the findings to different cultures. Furthermore, in view of the partially self-selected sample, it was not clear whether the theory would apply to discordant partnerships or partnerships who left the MBCT course early, who arguably had more ambivalent feelings about the course. Similarly, it was not entirely clear why some people did not fully engage in learning mindfulness skills: due to the small subset that followed this journey these categories were not saturated and required further testing.

It would be valuable to monitor relapse rates from the partnership group compared to individuals' groups to see whether involving an intimate-partner is related to reduced relapse. In line with the focus on understanding the process of engaging as a partnership, it would be helpful to measure variables that indicate potential mechanisms of change, such as self-compassion, relational empathy, mindfulness, decentering, self-broadening, quality of relationship, dyadic coping and interpersonal predictors of depressive relapse (e.g. expressed emotion, perceived criticism, social support).

Partnerships reported enjoying attending the MBCT course together and felt a sense of mutual support for learning new skills that facilitated commitment to the course. In view of the numerous positive experiences and absence of negative experiences, it seems valuable to recommend that healthcare practitioners consider

providing partnership groups. This might be a useful way to engage partners in service-user care in line with policy (DoH, 2002).

Some partnerships directly applied mindfulness skills to their relationship. This might have reflected differences in need. However, those who were able to apply mindfulness in the context of the intimate-partnership appeared to value this, for example, letting go of anger pertaining to a partner's depression and increasing empathy. Integrating systemic and mindfulness theory in light of these findings, it could be suggested that turning mindful awareness towards the relationship context potentially enables stepping out of complex feedback systems that may provoke depressive relapse and caregiver burden. It might be beneficial to consider this more explicitly in the MBCT course for partnerships, to encourage partnerships to think about how they can apply mindfulness skills together.

In conclusion, the grounded theory of 'learning new mindfulness skills together' represented a preliminary theory of the interacting processes involved in engaging with MBCT as a partnership. For most participants, there seemed to be reciprocal influences of learning mindfulness skills and engaging in a self-broadening activity as a partnership that positively influenced each other in a feedback system, leading to a more mindful, compassionate, shared approach to stress and depression. This provided a new synthesis across a range of interpersonal and mindfulness theories to offer a tentative new theory with unique elements. Further qualitative and quantitative research should be undertaken to refine aspects of the model and test hypotheses pertaining to intimate-partnership and mindfulness processes in depressive relapse.

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Table 1.

Participant characteristics.

Pseudonym	Gender	Months since finished
Bill*	M	9
Linda	F	9
Rachel*	F	9
William	M	9
Belinda*	F	12
Rose	F	12
Tom*	M	12
Sam	M	4
Janine*	F	4
Jeff*	M	1
Jane	F	1
Claire*	F	2
Eric	M	#
Rowena*	F	#
Ken	M	#
Kelly*	F	#

Partnerships are grouped together in the same row

* denotes the referred partner e.g. 'service-user'

denotes participants who were not interviewed, but whose group data were included.

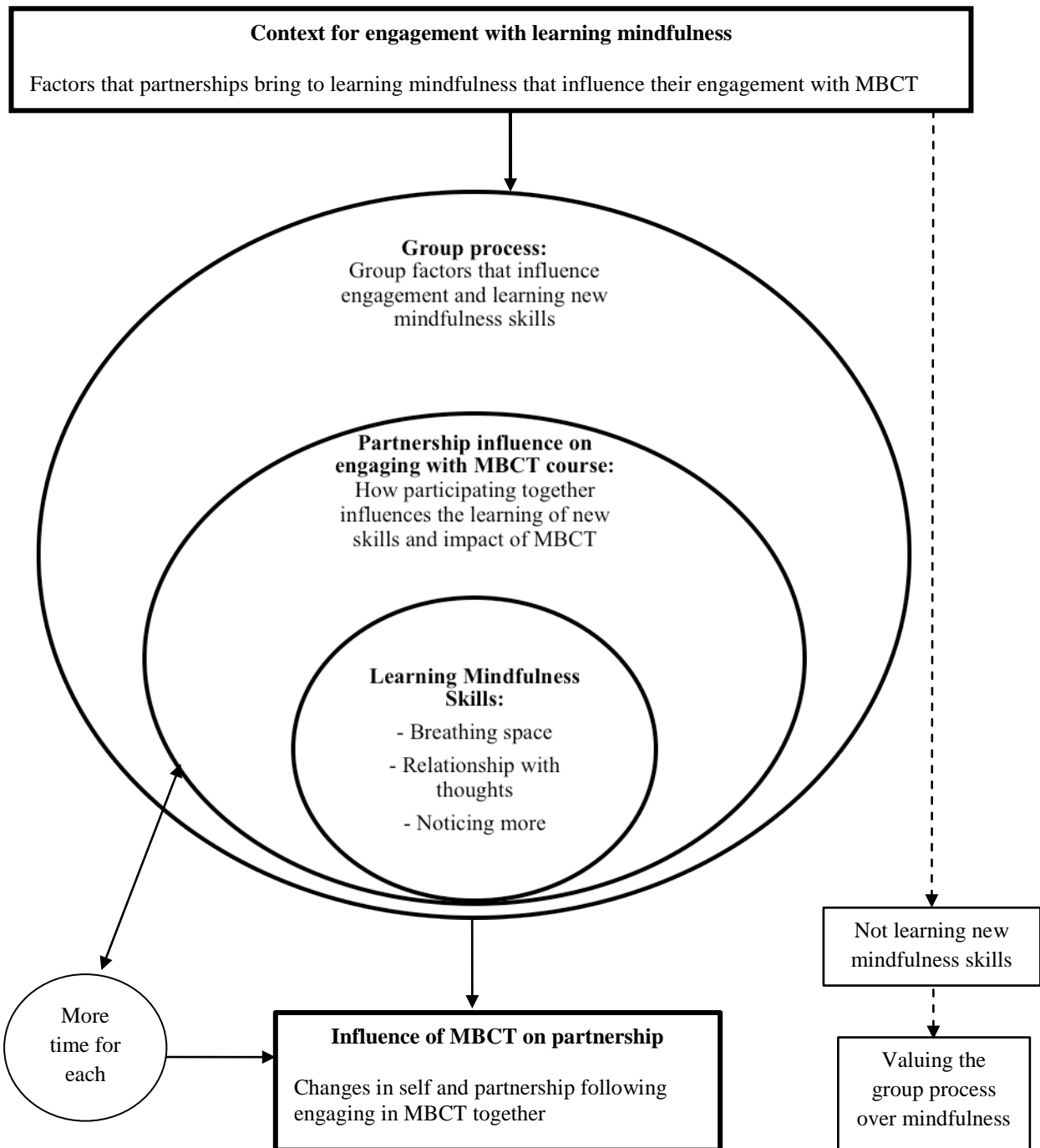


Fig 1. Learning new mindfulness skills together – a model of the process of engaging in MBCT as a partnership.

Table 2.

Learning new mindfulness skills together

Categories	Subcategories
A. Context for engagement with learning mindfulness	1. Depression causes strain on partner 2. Makes sense to engage together 3. Active (Hoping to learn new skills) 4. Passive approach to wellbeing 5. Severity of depression 6. Quality of relationship (continuum of separate lives through to team working)
B. Learning mindfulness skills	7. Using breathing space to cope with stress 8. Changing relationship with thoughts 9. Noticing more
C. Partnership influence on engaging with the MBCT course	10. Mutual support in learning 11. Improving attendance 12. Need to understand mindfulness to support it 13. Facilitating home practice Commitment to practising together Mentoring Separate practice
D. Influence of MBCT on partnership	14. Increased understanding and empathy 15. Reconnecting with each other 16. Sharing relapse prevention 17. Reduced worry 18. Feeling better, doing more
E. Group process	19. Learning in a safe, equal environment 20. Sharing in a group helps 21. Putting problems in perspective 22. Level of commitment to the group 23. Valuing the group process over mindfulness
F. Outside influences on perceived change	24. More time for each other