Exploring Mindfulness-based Cognitive Therapy (MBCT) from both participant and clinician perspectives

A thesis submitted to the University of Manchester for the degree of

Doctor of Clinical Psychology in the Faculty of Biology, Medicine, and Health

Doctorate in Clinical Psychology

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School of Health Sciences. Division of Psychology and Mental Health

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Covid-19 Impact Statement

The covid-19 pandemic began two months after I returned to training following maternity leave. As the focus of and plan for my thesis project changed on returning from maternity leave, the timing of both the pandemic and my return fortunately allowed me to develop a project that could be carried out remotely. However, although our then one year-old son was attending nursery at the time, there were a few times where he was required to self-isolate at home for between 10-14 days which impacted on my ability to dedicate time to the work in this thesis. I believe and hope that the work in this thesis meets the quality required, but I would like to acknowledge the impact that the increased childcare requirements had.

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Word Counts

Individual paper word counts include the main text, tables and figures, but exclude the abstracts, any author notes, references, supplementary materials, and appendices

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Actual words: (5,966 plus 33 words in Figure 2.1) **= 5,999**

Paper Three: Journal target: 35 pages.

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Paper Four: = **4,578**

Total across all four papers: **24,977**

Total across the whole thesis: **49,026**

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Abstract

Mindfulness-based Cognitive Therapy (MBCT) is an eight-week NHS-recommended intervention and shows efficacy in reducing relapse into depression.

In **Paper One**, a systematic review and meta-synthesis of 19 qualitative studies of MBCT for depression was conducted, using a meta-ethnographic approach. Three overarching themes were developed: “Becoming skilled and taking action”, “Acceptance”, and “Ambivalence and variability”. The findings provide an understanding of the experiences of MBCT for people with depression whereby MBCT can be beneficial whilst simultaneously bring challenges.

In **Paper Two**, in order to more comprehensively explore experiences of MBCT for depression, a secondary database of 35 interviews post-MBCT and during a 12-month follow-up was analysed. Using reflexive thematic analysis, two overarching themes were developed: “Reconnection” and “Process”. Participants described changing relationships with their experience, self, and others, alongside recognition of gradual changes. The findings have clinical implications in terms of encouraging recognition of an ongoing, gradual move towards reconnection with experiences which may have been lost during depression.

In **Paper Three**, clinicians’ views around access to, delivery of, and adaptations to MBCT were explored as provision of MBCT across the UK remains limited and may not always be delivered in line with the evidence-base. A two-stage Delphi approach was used to develop 59 statements which were rated by 25 clinicians in three online rating rounds. Most statements reached consensus; 15 statements did not. The findings highlight the importance of a delicate balance between adherence to the evidence-base and a client-centred, transparent approach in access to, delivery of, and adaptations in MBCT.

Paper Four includes a critical discussion of each paper, reflections around the thesis changes, cultural considerations, and overall clinical and research implications.

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Declaration

To ensure full clarity, the qualitative data which is analysed in **Paper Two** was collected by me during my previous PhD at The University of Manchester (2013-2017). None of the qualitative data was analysed or presented within my previous PhD submission. The data presented in **Paper Two** has been analysed and presented by me for the first time as a secondary dataset as part of this submission for the Doctorate in Clinical Psychology.

It should also be noted that brief demographic details (age, gender, mood rating score, and number of previous episodes of depression) have been included in the results section of **Paper Two** to provide some context regarding the study participants; these brief demographics were included in my previous PhD submission (Williams, 2018).

No portion of the remaining work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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Copyright Statement

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Thank you to Susanne Langer for your help and insightful comments and thank you to Melissa Sinha for your help with the quality appraisal and general thesis motivation. I feel very lucky to have worked within two fantastic DClinPsy cohorts – thank you to both for general support, motivation, and opportunities to vent!

Thank you to my husband and best friend Tom for listening to me (even when I'm repeating myself!) for supporting and encouraging me non-stop, especially over the last eight years. I promise not to undertake any more doctorates. And finally thank you to our son Dylan who is my constant inspiration and has taught me the importance and value of a work-life balance.

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Thesis Format

This thesis has been prepared in journal format in line with the Doctorate of Clinical Psychology thesis guidelines and to help to facilitate the author’s career by producing novel research papers which are ready for publication.

Individual Contributions

Under supervision of the two thesis supervisors (PT, SH), the researcher designed, conducted, analysed, and prepared each of the four papers presented in this thesis. Both supervisors have contributed comments to the thesis paper drafts.

Paper One includes two additional co-authors (SL, MM): SL contributed comments during the design stage and to the editing of the final manuscript. MM contributed to the database searches and provided comments on the final manuscript. **Paper Two** includes four additional authors (IA, KB, MD, RE): IA and RE were the supervisors for the author’s previous PhD from which the data for **Paper Two** was obtained. KB co-facilitated the MBCT groups and MD transcribed a proportion of the qualitative interviews (see **Paper Two**). All four co-authors contributed comments to the final editing of the manuscript. **Paper Three** does not include any additional co-authors.

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Paper One

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A systematic review and meta-ethnographic synthesis of Mindfulness-based Cognitive Therapy (MBCT) for people with depression

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Abstract words: 249

This paper was submitted to the **Journal of Affective Disorders** on the 21st April 2021. The author guidelines are in **Appendix One**.

Author note

Please note that in some of the quotations from papers included in the results section, some words are spelt in US-English; these have not been corrected as they are direct quotes.

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Abstract

Background

MBCT is a relapse-prevention intervention for people experiencing depression. Three qualitative meta-syntheses investigating experiences of taking part in MBCT and/or Mindfulness-based Stress Reduction (MBSR) across different diagnostic populations reported themes including control, choice, group processes, relationships, and struggles. As multiple studies have been published since, we aimed to update, systematically review, and synthesise the experiences of participants with depression taking part in MBCT.

Methods

Four databases were searched systematically (PsycInfo, Web of Science, Medline, CINAHL) up to and including the 2nd October 2020. Nineteen qualitative studies met the review criteria. All papers were rated as fair using a quality appraisal tool. Meta-ethnography was applied.

Results

Across 19 studies of participants with current or previous depression who had participated in MBCT, three overarching themes were developed: “Becoming skilled and taking action”, “Acceptance”, and “Ambivalence and variability”. Participants became skilled through engagement in mindfulness practices, reporting increased awareness, perspective, and agency over their experiences. Participants developed acceptance towards their experiences, self, and others. There was variability and ambivalence regarding participants’ expectations and difficulties within mindfulness practices.

Limitations

Many studies were conducted in MBCT-research centres who may hold conflicts of interest. Many studies did not address the impact of the participant-researcher relationship thus potentially affecting their interpretations. Studies were skewed towards the experiences of female participants.

Conclusions

Our findings help to enhance participant confidence in MBCT, alongside understanding the processes of change and the potential for difficulties. MBCT is beneficial and provides meaningful change for many, but remains challenging for some.

PROSPERO Registration Number: CRD42020170979

Keywords: Mindfulness-based Cognitive Therapy; MBCT; Depression; Qualitative; Meta-synthesis; Meta-ethnography

Highlights

- A meta-ethnography of 19 qualitative studies generated three overarching themes
- MBCT enables the development of new skills and different ways of responding
- MBCT enables a shift towards accepting experience, self, and others
- Meaningful change is variable and there is the potential for difficult experiences

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Introduction

Depression affects approximately 264 million people worldwide and has an estimated lifetime prevalence of 10.8% (James et al., 2018; Lim et al., 2018). Individuals can experience multiple episodes of depression with the risk of further depression increasing to 90% for people with three or more past episodes (Kessing et al., 2004; Kupfer, 1991). The cognitive vulnerability theory of depression proposed that relapse into depression is maintained by each episode subsequently embedding the associations between low mood and negative thinking (Segal et al., 2013; Lau et al., 2004). As a result, Mindfulness-based Cognitive Therapy (MBCT; Segal et al., 2013) was developed by combining an experiential understanding of mindfulness-based meditation with cognitive therapy. MBCT focuses on developing awareness of triggers to depression and adoption of a kinder, non-judgemental attitude to internal experiences (Segal et al., 2013). MBCT is recommended by the National Institute for Health and Care Excellence (NICE; 2017) as a relapse-prevention intervention for recurrent depression. Two meta-analyses of 14 and 9 randomised controlled trials (RCTs) have shown that MBCT is effective in preventing relapse when compared to a treatment as usual (TAU) group (McCartney et al., 2021; Kuyken et al., 2016).

Simultaneously, a number of qualitative studies have attempted to explore the experiences of MBCT for individuals with depression. Three qualitative meta-syntheses have synthesised these studies: two reviews focused on both MBCT and Mindfulness-based Stress Reduction (MBSR; Wyatt et al., 2014 [15 studies]; Malpass et al., 2012 [14 studies]) and a third review focused only on MBCT but across diagnostic groups additional to depression (Cairns & Murray, 2015 [7 studies]). In the two meta-syntheses exploring both MBCT and MBSR, a number of themes were reported around participants' experiences. For example, although not exhaustive, participants described becoming aware of maladaptive coping strategies and moving towards learning new skills; participants reported benefits and difficulties within group processes, improved relationships, increases in personal control, choice, alongside ongoing struggles with mindfulness (Wyatt et al., 2014; Malpass et al., 2012). Specific to MBCT, Cairns and Murray (2015) reported similar themes as well as describing that participants noticed increased feelings of acceptance around their experiences (e.g., thoughts, feelings), the role of expectations on overall outcome, and changing feelings towards the self.

However, over the last few years, 13 additional qualitative studies exploring MBCT for depression have been published. This is a notable increase which warrants not only an update to the findings, but also a more specific understanding and synthesis of MBCT for people with experiences of depression. Such an understanding might help to highlight the processes of change following MBCT which could subsequently refine the delivery of MBCT in clinical practice through ways to support and encourage these change processes. A meta-ethnographic approach was applied which, instead of an aggregation of study findings, moves beyond the individual "parts" of studies towards a "greater whole", allowing for novel interpretations (Noblit & Hare, 1988). Our primary research question was "How do participants with depression experience the therapeutic processes within MBCT?" with a focus on what was helpful alongside the challenges of MBCT.

Method

Protocol Pre-Registration

The review protocol was pre-registered on the International Prospective Register of Systematic Reviews (PROSPERO; registration number CRD42020170979). This review was conducted in line with both the updated "Preferred Reporting Items for Systematic Reviews and Meta-analyses" (PRISMA; Page et al., 2021) and the "Improving Reporting of Meta-

Ethnography" (eMERGe reporting guidance; France et al., 2019) guidelines. **Supplementary Materials S1.1 and S1.2** include the completed checklists.

Search Terms

The search was conducted across four databases: PsycInfo, Web of Science, Medline, and CINAHL. The following search terms were used: (mindfulness* or mindfulness-based* or MBCT) and (depress*) and (interview* or focus group* or case stud* or experience* or qualitative or mixed method*). MeSH terms were selected in PsycInfo and Medline ("mindfulness-based interventions", "mindfulness", "major depression", "qualitative methods", and "mixed methods research") with "suggested subject terms" selected instead on Web of Science and CINAHL (e.g., "mindfulness", "depression", "treatment outcomes"). There were no prior date limits to enable identification of all relevant papers published up until the 2nd October 2020.

Inclusion and Exclusion Criteria

Inclusion criteria. The intervention must have been MBCT (i.e., not MBSR or another mindfulness-based intervention [MBI]), delivered in a group or one-to-one setting, and either face-to-face or via remote methods (e.g., online). Minor amendments to MBCT were acceptable provided they did not deviate from the focus on relapse-prevention in depression or extensively from the manual (Segal et al., 2013). Participants must have either experienced symptoms in line with a diagnosis of depression, or were currently self-reporting or had previously experienced self-reported symptoms of depression. Both adults and adolescents could be included, provided that adolescents were aged over 12 years to reduce significant MBCT adaptations and to ensure participants could adequately self-report on their experiences (both studies with adolescents included age ranges with a minimum age of 12; see the **results** section). Studies were either peer-reviewed or unpublished publications and had to have employed qualitative or mixed methodologies. All studies were required to be written in English.

Exclusion criteria. Studies reporting solely on quantitative methods, systematic reviews, meta-analyses, commentaries, narrative reviews, protocols, and case studies were excluded. Studies of other psychological therapies, other MBIs (e.g., MBSR), or studies including Acceptance and Commitment Therapy (ACT; Hayes et al., 1999), Dialectical Behaviour Therapy (DBT; Linehan, 1993), or Yoga were excluded. Although the latter interventions contained elements of mindfulness, they constituted significant deviations from the manualised MBCT.

Search Strategy

Duplicate publications were manually removed. Titles and abstracts were screened by the lead researcher to determine eligibility. Studies not meeting the inclusion criteria at this stage were excluded. All remaining studies were taken forward for full text screening to determine eligibility. To check for additional papers not detected by the search, we checked reference lists from the included studies, three reviews (Wyatt et al., 2014; Cairns & Murray, 2015; Malpass et al., 2012), and forward citation searching. All study authors were emailed to enquire about any further publications, either unpublished or in preparation; all authors replied but no eligible studies were identified. Three authors were contacted for clarification over study methods (**Supplementary Material S1.3**). Fifteen percent of papers were screened in parallel by an independent researcher resulting in 95.45% agreement. Discrepancies were discussed and resolved, with both researchers coming to 100% agreement over the final inclusion of studies.

Quality Appraisal

The Critical Appraisal Skills Programme (CASP, 2018) was used for quality appraisal, due to its consideration of reflexivity in qualitative studies. The CASP was not used to exclude or categorise studies. Ratings were carried out by the lead researcher and an independent researcher (Trainee Clinical Psychologist), with discrepancies discussed and resolved as required.

Analysis

We followed the seven steps of meta-ethnography (Noblit and Hare, 1988; **Supplementary Material S1.4**) alongside additional, updated methodology guidance from Sattar et al. (2021), France et al. (2019), and Toye et al. (2014). Studies were uploaded into NVivo (QSR International, 1999) and coded verbatim, using the original authors' own words with minor paraphrasing. To become immersed in the data, the lead researcher read the studies multiple times noting down key concepts and themes (Cahill et al., 2018; Lee et al., 2015). Only second-order constructs (study author's themes, subthemes, and interpretations) were analysed as first-order quotes have been purposely selected by the study authors and may not sufficiently represent all participants (France et al., 2019; Lee et al., 2015; Atkins et al., 2008). Indeed, Noblit and Hare (1988) advised that meta-ethnographies should not involve analysis of raw participant data, but instead analyse the interpretations from study authors. However, as a sensitivity analysis, the first-order constructs are in **Supplementary Material S1.5**; there were no major differences between the first- and second-order constructs. Key themes, concepts, and interpretations were coded in batches; two studies with methodological concerns (both unpublished theses) and two studies which included younger populations were initially coded separately to assess how they differed to the remaining studies; there were no substantive differences therefore all codes were combined in further steps.

Second-order constructs were condensed into categories to identify the similarities and differences across the studies (**Supplementary Material S1.6**). In order to preserve the context and meaning of the relationships between the second-order constructs within and across studies, we conducted a reciprocal translation (Noblit & Hare, 1988) through constructing narrative comparisons and visual maps for individual second-order constructs (Melendez-Torres et al., 2015). Similar translation categories were clustered together and we used a line of argument synthesis to develop third-order constructs (new interpretations of the relationships between the second-order constructs; Toye et al., 2014; Noblit & Hare, 1988).

Reflexivity

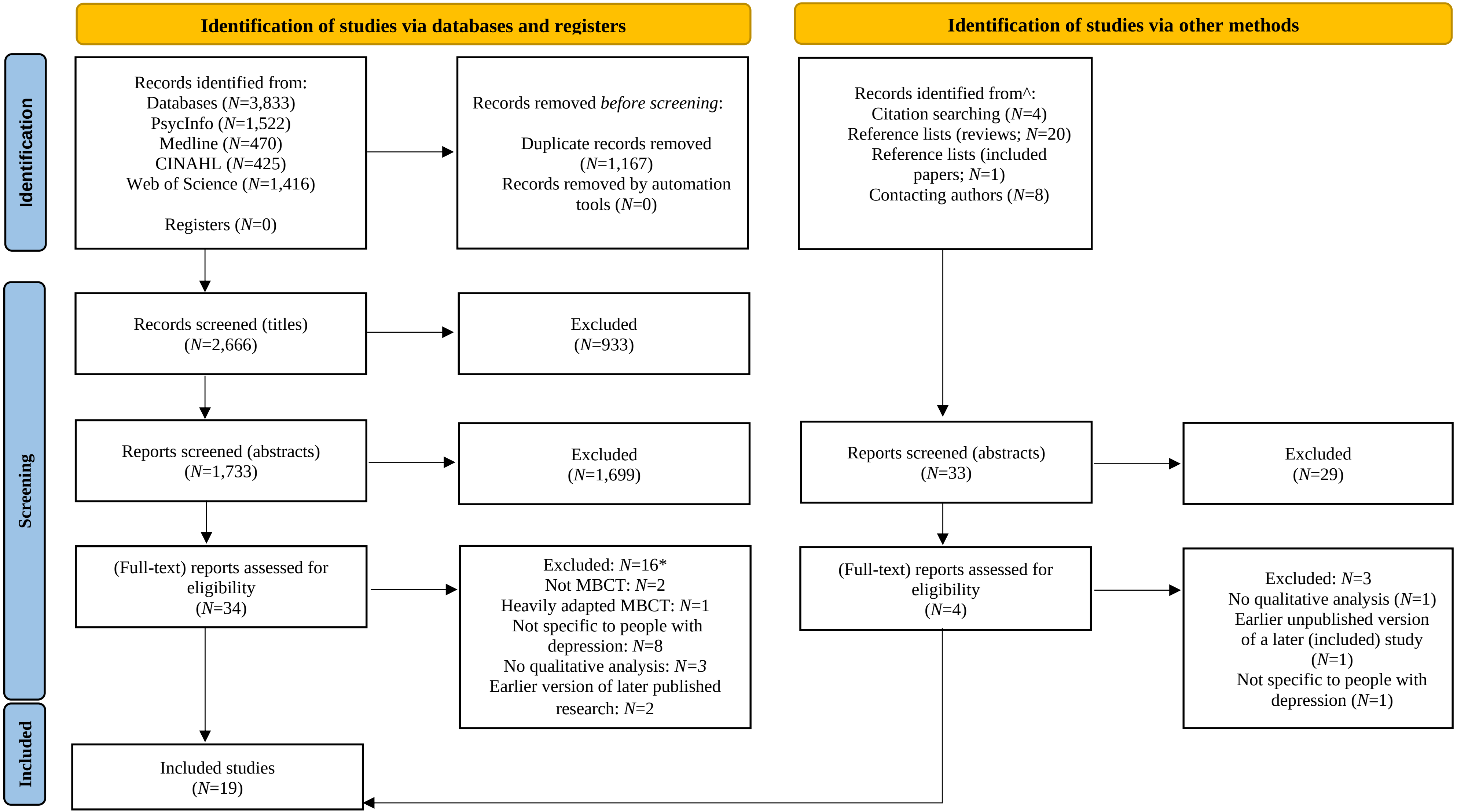
A critical realist approach was adopted during the analysis process, whereby an ultimate reality exists whilst acknowledging that this reality is shaped by the researcher's and participants' assumptions, experiences, culture, social and political experiences. The lead researcher was aware that they held an interest in, knowledge of, and experience with facilitating MBCT groups and researching MBCT for depression, therefore potentially impacting on the interpretations of the individual studies. In line with a critical realist approach, they maintained a reflective log to document expectations, assumptions, and interpretations throughout analysis. The lead researcher engaged in supervision with researchers who do not have experience with MBCT thus helping to reflect on their active role within the analysis process.

Results

Screening

Nineteen studies were included in the synthesis. **Figure 1.1** details the search process.

Figure 1.1. PRISMA flow diagram (Page et al., 2021)



Note. ^dates these searches were conducted are in **Supplementary Material S1.3**; *full reasons are in **Supplementary Material S1.7**

Study Characteristics

Study characteristics are in **Table 1.1**. Most studies were conducted in the UK (*N*=13), with others across mainland Europe (*N*=3) or the USA (*N*=3). Seventeen studies included adult samples; two studies included adolescent samples. Only 14 studies reported on gender which was skewed towards female (range 63-100%). The majority of studies reported on group-based, face-to-face delivery of MBCT (*N*=18) with one study delivering online MBCT. Most studies (*N*=16) included participants with histories of multiple “episodes” of depression but were either currently free from symptoms (“full remission”) or experiencing mild symptoms (“partial remission”). The remaining studies (*N*=3) included participants who were currently experiencing symptoms in line with “mild” to “moderate” severities. Interviews were conducted either post-MBCT (*N*=5; one of which included pre-MBCT), during follow-up (*N*=9), or at both post-MBCT and follow-up (*N*=5, one of which included pre-MBCT). Semi-structured or open interviews were administered (*N*=16); the remaining studies used written questionnaires (*N*=1) or a mix of interviews and questionnaires (*N*=2). All studies employed qualitative analysis.

One study also included interviews with parents and staff; only the findings from interviews with adolescents were included. Although parents participated in MBCT, this was to better support their child through depression (see **Supplementary Material S1.7**). Whilst most studies aimed to explore therapeutic processes of MBCT, two studies focused specifically on exploring the relationship with the body (Worsfold, 2013) or thoughts (Murphy & Lahtinen, 2015). Finally, nine studies were conducted in Universities connected with extensive clinical and research expertise in MBCT which may have enriched the findings but may have led to unintended assumptions and expectations impacting on their interpretations.

Table 1.1. Study characteristics

Authors	Year Country	N	Age Age range Gender	MBCT delivery	Depression	Time of interview	Data collection	Analysis	Aims/Focus
Mason & Hargreaves[1]	2001 UK	7	M=43.14 SD=12.12 24-59 71% female	Group Face:face 8 weeks	Full/partial remission	*N*=4 post-MBCT *N*=3 12-30 months post-MBCT	Open interviews (*N*=4) which guided interviews for *N*=3	Grounded theory	Therapeutic processes involved in MBCT
Ma[1,2]	2002 UK	35	M=42.89 SD=8.39 - 73% female	Group Face:face 8 weeks	Full/partial remission	12 months post-MBCT	Semi-structured interviews Mixed methods thesis	IPA	To understand MBCT in preventing relapse
Finucane & Mercer	2006 UK	11	M=43.08 SD=9.38 29-58 77% female	Group Face:face 8 weeks	Current symptoms of depression.	3 months post-MBCT	Semi-structured interviews Mixed methods	Framework approach, including thematic matrices	Acceptability and feasibility of MBCT in primary care
Smith et al.	2007 UK	30	M=70.5 - 65-88 63% female	Group Face:face 8 weeks	Full/partial remission	2 weeks post-MBCT After 12-13 months	Interviews Mixed methods	Thematic analysis	What MBCT characteristics were helpful/not helpful
Allen et al.[1]	2009 UK	20	M=51.45 SD=9.51 - 85% female	Group Face:face 8 weeks	Full/partial remission	12 months post-MBCT	Semi-structured interviews. (RCT)	Thematic Analysis	Experiences of MBCT
Cebolla & Barrachina[2]	2009 SPAIN	32	- *(Adults)*	Group Face:face 8 weeks[4]	Current depression and/or anxiety	Post-MBCT 3 months follow-up	Written questionnaires	Content analysis	Experiences of MBCT

Authors	**Year** **Country**	**N**	**Age** **Age range** **Gender**	**MBCT delivery**	**Depression**	**Time of interview**	**Data collection**	**Analysis**	**Aims/Focus**
Baillie et al.[1,3]	2012 UK	16	- *(Adults)*	Group Face:face 8 weeks	Full/partial remission	12 months post-MBCT	Interviews Embedded in an RCT	Thematic Analysis	Parents with recurrent depression and relationships with their children
Hopkins & Kuyken[1]	2012 UK	13	M=48.92 SD=12.22 23-67 69% female	Group Face:face 8 weeks	Full/partial remission	Within 4 years post-MBCT	Semi-structured interviews	IPA	Benefits and barriers to attending reunions
Worsfold	2013 DENMARK	15	- *(Adults)* 93% female	Group Face:face 8 weeks	Full/partial remission	Pre- and post-MBCT	Semi-structured interviews	Phenomeno-logical approach	Body awareness and MBCT
Ames et al.	2014 UK	7	- 12-18 100% female	Group Face:face 8 weeks	Symptoms of depression, with/without anxiety	Post-MBCT 1 month follow-up	Semi-structured interviews Mixed methods	IPA	MBCT for adolescents
Bihari & Mullan[1]	2014 UK	11	- *(Adults)*	Group Face:face 8 weeks	Full/partial remission	MBCT within the last 3 years	Semi-structured interviews	Grounded theory	Interpersonal change processes
Boggs et al.[1]	2014 USA	38	M=46.89 SD=12.38 71.1% female	Web-based (MMB)	Full/partial remission	Exit interview after MMB	Interviews Mixed methods	Content analysis, grounded theory	Experiences of MBCT
Lilja et al.	2015 SWEDEN	19	- 30-68 -	Group Face:face 8 weeks	Full remission	12 months post-MBCT	Semi-structured interviews	Thematic analysis	How primary care participants perceive MBCT
Murphy & Lahtinen	2015 UK	6	- 41-60 83% female	Group Face:face 8 weeks	Full/partial remission	Between 3 & 12 months post-MBCT	Semi-structured interviews	IPA	Relationship with thoughts in MBCT

Authors	**Year** **Country**	**N**	**Age** **Age range** **Gender**	**MBCT delivery**	**Depression**	**Time of interview**	**Data collection**	**Analysis**	**Aims/Focus**
Di Toro	2017 USA	11	M=52.45 - 31-70 73% female	Group Face:face 8 weeks	Mild to moderate symptoms	Post-MBCT	Open-ended interviews Mixed methods thesis	Thematic analysis	Feasibility of MBCT in primary care
Chesin et al.	2018 USA	15[5] 4[6]	M=41.6 SD=14.4 - 80% female	Group Face:face 9 weeks	Full/partial remission Current suicidal ideation	3 weeks post-MBCT[5] 1 week post-MBCT[6]	Online surveys[5] Focus groups[6]	Thematic analysis	MBCT for people at high risk of suicide.
Racey et al.[1,7]	2018 UK	7	- 14-18 Unclear gender split	Group Face:face 8 weeks[4]	Full/partial remission	Post-MBCT	Semi-structured interviews. Mixed methods	Thematic analysis	Feasibility and acceptability for adolescents
Williams et al.	2018 UK	13	M=71.25 SD=4.07 65-78 69% female	Group Face:face 8 weeks	Full/partial remission	Pre- and post-MBCT 6 months post-MBCT	Semi-structured interviews	Thematic analysis	Reflections on MBCT
Tickell et al.[1,2]	2020 UK	42	M=51.88 SD=10.51 25-72 74% female	Group Face:face 8 weeks	Full/partial remission	Post-MBCT 2 years follow-up	Written post-MBCT Semi-structured interviews follow-up (RCT)	Thematic analysis	Experiences of MBCT and AD to support recovery

Note. “-”=data not given/able to be calculated; [1]conducted in centres with MBCT expertise; [2]authors contacted further; [3]participants were parents for at least one child; [4]minor content adjustments to suit population; [5]online surveys; [6]focus groups; [7]only data from young people is included; IPA=Interpretive Phenomenological Analysis; (RCT)=(Took place within a) Randomised Controlled Trial; MMB=Mindful Mood Balance; AD=antidepressants

Quality Appraisal

The quality of the studies was fair, with eight studies rated as lower quality overall (**Table 1.2**). Only ten studies sufficiently justified their choice of qualitative design and analysis. Twelve studies lacked information regarding the participant-researcher relationship, therefore it is difficult to assess the impact this had on the researcher's interpretations in the original studies. Full details are in **Supplementary Material S1.8**.

Table 1.2. CASP quality appraisal

Study*	1.Aims stated	2.Appropriate for Qualitative methods	3.Appropriate research design	4.Appropriate recruitment strategy	5.Appropriate data collection	6.Participant researcher relationship	7.Ethical issues	8.Rigorous analysis	9.Statement of findings	10.Value
1	✓	✓	✓	?	✓	✓	✗	✓	✓	?
2	✓	✓	✓	✓	✓	✗	✓	✓	?	?
3	✓	✓	?	✓	✓	?	✓	✓	✓	✓
4	✓	✓	✓	✓	?	?	?	✓	✓	✓
5	✓	✓	✓	✓	✓	?	✓	✓	✓	✓
6	✗	✓	?	✗	✓	✗	✗	✗	?	✗
7	✓	✓	✓	✓	✓	✓	?	✓	✓	✓
8	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
9	✓	✓	?	✓	✓	✗	?	?	?	✓
10	✓	✓	?	?	?	?	✓	✗	✓	✓
11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
12	✓	✓	?	?	✓	?	✓	✓	✓	✓
13	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
14	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
15	✓	✓	✗	✓	✓	?	✓	✓	✓	✓
16	✓	✓	?	✓	✓	✗	✓	✓	✓	✓
17	✓	✓	✗	✓	✓	✗	✓	?	?	✓
18	✓	✓	✓	✓	✓	?	✓	✓	✓	✓
19	✓	✓	?	✓	✓	✓	✓	✓	✓	✓

Note. **Appendix Two** includes a blank copy of the CASP; Individual item ratings: ✓=″Yes”, ✗=“No, ?=“Can’t tell”; *Study: 1=Mason & Hargreaves; 2=Ma; 3=Finucane & Mercer; 4=Smith et al.; 5=Allen et al.; 6=Cebolla & Barrachina; 7=Baillie et al.; 8=Hopkins & Kuyken; 9=Worsfold; 10=Ames et al.; 11=Bihari & Mullan; 12=Boggs et al.; 13=Lilja et al.; 14=Murphy & Lahtinen; 15=Di Toro; 16=Chesin et al.; 17=Racey et al.; 18=Williams et al.; 19=Tickell et al.

Translation and Synthesis of Second-Order Constructs

Table 1.3 details the synthesis results including the higher-order, overarching themes, 18 second-order constructs, the studies in which they appear, as well as descriptions and quotes. **Figure 1.2** includes a visual representation of the synthesis and the proposed interactions between the overarching themes. Briefly, **Figure 1.2** shows how participating in MBCT allowed for becoming skilled in mindfulness and taking action through engaging in mindfulness practice, developing increased awareness and perspective, as well as personal agency over experience and depression. Having developed this, participants began shifting towards acceptance of their experiences, self, others, and depression. Although ambivalence and variability of experiences were present somewhat throughout the overarching themes, the core second-order constructs focusing on ambivalence and variability were grouped together. Change within the model was not always linear with interconnections between the themes. Of note, six studies described participants' prior experiences with depression, however we have not included these here as they do not fit with the study aims of understanding experiences of MBCT. However, the analysis is presented in **Supplementary Material S1.9**.

Despite some differences between the studies in terms of participant age, depression symptoms, interview timing, and analysis, most second-order constructs were present across multiple studies. Few differences were identified between participant experiences either post-MBCT or during follow-up; this may be because the majority of studies included analysis at either both or predominantly follow-up timepoints. This may also suggest that participants' experiences were stable over time. However, there were some differences between study characteristics: two studies included adolescent participants, one study focused on participants' experience of reducing antidepressants, and two studies respectively focused on body sensations and relationships with thoughts. These different focuses may have impacted on the synthesis and have been highlighted throughout the results.

Table 1.3. Overarching themes and translations

Overarching Theme (3^{rd-}order construct)	**2nd-order constructs**	**Translation of 2nd-order construct**	**2nd-order example quote (studies*)**	**Studies***
Becoming skilled and Taking action	Practices	Preferences for different practices.	"Participants used both formal and informal practice on a weekly basis and had incorporated some sort of daily mindfulness exercise as an everyday habit" (13)	1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 16, 17, 18, 19
	Intentions to Practice	Either ongoing or intentions to continue practice and using skills post-MBCT.	"Most of the course participants continued to use some of the mindfulness exercises three months after the course ended" (3)	2, 3, 4, 5, 6, 7, 8, 15, 18
	3-Minute Breathing Space (3MBS)	Regular engagement in the 3MBS. Proactive use of the 3MBS.	"Participants found the 3-min breathing space helpful" (10)	3, 10, 16, 18
	Awareness and Perspective	Increased awareness of and perspective around relationships with thoughts, emotions, sensations, and depression. Slowing down, stepping back, and creating distance (reduced reactivity).	Mindfulness practice "enabled them to calm down and step back from reacting automatically" (11)	1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 18, 19
	Agency and control around depression	Shifting to a sense of agency and control around depression. Feeling skilled in understanding warning signs, relapse, and recognising the responsibility over depression this brings.	"Participants named this as acquiring a skill or having a psychological tool and this evolved into feeling psychologically self-reliant" (14)	1, 2, 3, 4, 5, 6, 7, 9, 11, 12, 13, 14, 15, 16, 18, 19

Overarching Theme (3rd-order construct)	**2nd-order constructs**	**Translation of 2nd-order construct**	**2nd-order example quote (studies*)**	**Studies***
Acceptance	Acceptance	Acceptance of thoughts and emotions, and what can and cannot be changed. Challenges around acceptance.	Participants "had learned a more accepting way to deal with experiences…in the sense of seeing themselves and their mental health as it really was" (1)	1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 13, 14, 18, 19
	Aliveness	More actively involved in and enjoyment of life, feeling happier, calm, and more alive.	MBCT "had an active focus on positive functioning, and encouraged them to take part in activities that brought happiness and joy" (19)	1, 2, 3, 4, 5, 6, 7, 9, 11, 12, 13, 15, 18, 19
	Acceptance of depression	Increased knowledge of and acceptance of depression	"The overarching theme of acceptance incorporates a number of processes that appear to have increased their capacity to accommodate these ongoing depression-related phenomena with less distress" (5)	5, 13, 19
	New understanding of depression	Enhanced understanding, challenging stereotypes, and shifting beliefs from a biomedical understanding of depression	Participants "learned a different model of depression and developed a better understanding of 'how the mind works'" (19)	1, 5, 7, 13, 18, 19
	Permission around self-care	A move towards prioritising the self through permission to prioritise self-care, better communication of needs, and increased self-compassion, alongside struggles to engage in self-care	"Participants realised that they were not indispensable and that they could afford time to recharge" (13)	2, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 18, 19
	Group process: a safe and shared experience	Importance of others in the group in enabling safety and sharing experiences. A shared group experience helped to feel understood and supported.	The importance of "being understood by the group, realising that you were not alone and being able to show emotion in a safe environment" (3)	1, 2, 3, 4, 5, 7, 8, 10, 11, 14, 15, 16, 17, 18, 19

Overarching Theme (3^{rd-}order construct)	**2nd-order constructs**	**Translation of 2nd-order construct**	**2nd-order example quote (studies*)**	**Studies***
	Relationships with others	Improved closeness, bonding, communication with, and emotional availability for others. Others noticing changes. Ongoing struggles or no changes.	"They had experienced an increased ability to see that there were a number of reasons for their child's behaviour…related to increased empathy and acceptance towards themselves and their children" (7)	2, 4, 5, 6, 7, 8, 11, 12, 13, 15, 17, 18
Ambivalence and Variability	Group processes: difficulties	Group tensions, negative comparisons with others, challenges hearing others' experiences. Different opinions around the group experience.	"Some individuals described experiencing tensions related to being in a group and a tendency to make social comparisons" (8)	2, 3, 6, 8, 12, 15, 16, 18
	Confronting difficulty	Feelings of vulnerability, hopelessness, and feeling out of control at times during MBCT. Struggles with some practices eliciting difficult experiences	"Participants expressed challenges in tolerating an increase of reported symptoms of depression and anxiety" (2)	1, 2, 3, 11, 15, 16,
	Challenging but enjoyable	Simultaneously difficult and enjoyable aspects of MBCT	"There was a wish to keep going with 'mindfulness' alongside recognition that this was challenging." (10)	1, 3, 10, 11, 16
	Variable change	More than more/less change, but change that was individually meaningful to participants. Depression as part of a lifelong process.	"It was not a simple case of more or less change" (11)	2, 5, 11, 13
	Expectations	Different initial expectations and impact on outcome.	"Those with open and flexible expectations described fewer barriers and initial negative experiences than those with rigid, and highly optimistic, ones" (1)	1, 2, 3, 5, 6, 8, 10, 11, 12, 15, 16, 18, 19

Overarching Theme (3^rd-order construct)	**2^nd-order constructs**	**Translation of 2^nd-order construct**	**2^nd-order example quote (studies*)**	**Studies***
	MBCT engagement	Many found MBCT acceptable, useful, helpful, and supportive. However, there were logistical, practical, and emotional impacts on attending MBCT and/or engaging in practices.	"They found this type of intervention acceptable, and were able to comply with the demands of the course" (18) "Scheduling problems (*were*) a barrier to joining the group" (15)	1, 2, 3, 4, 5, 6, 8, 10, 11, 12, 15, 16, 17, 18, 19

Note. *Studies: 1=Mason & Hargreaves; 2=Ma; 3=Finucane & Mercer; 4=Smith et al.; 5=Allen et al.; 6=Cebolla & Barrachina; 7=Baillie et al.; 8=Hopkins & Kuyken; 9=Worsfold; 10=Ames et al.; 11=Bihari & Mullan; 12=Boggs et al.; 13=Lilja et al.; 14=Murphy & Lahtinen; 15=Di Toro; 16=Chesin et al.; 17=Racey et al.; 18=Williams et al.; 19=Tickell et al.

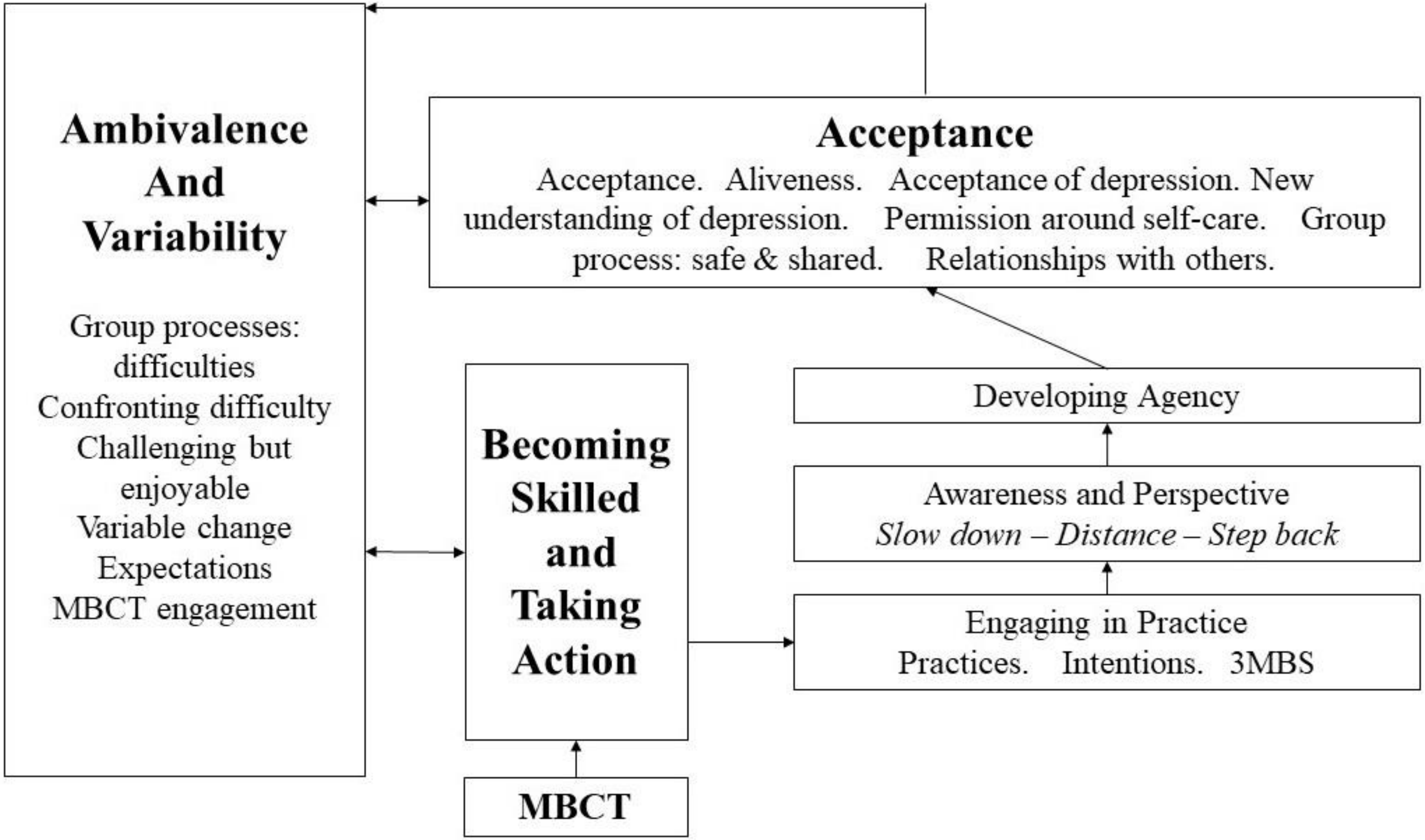


Figure 1.2. Meta-synthesis of participants' experiences of MBCT

Overarching Theme One: Becoming Skilled and Taking Action

Engaging in practice. Across all but one study (*N*=18), participants described their preferences for and intentions to engage with mindfulness practices including formal breathing meditations and body scans, alongside informal practices (e.g., mindful movement). A consistent finding across studies was that participants felt able to choose which practices they engaged with. For example, whilst some described persisting with the longer practices "because they allowed time for the mind to slow down and focus" (Boggs et al., 2014), others reported engaging in shorter or more informal practices (they "favoured the shorter practices and tended to drop the longer ones"; Williams et al., 2018). Indeed, some participants chose not to practice formal mindfulness meditations, choosing instead to incorporate informal practices into daily "activities such as walking the dog or washing the dishes" (Finucane & Mercer, 2006).

Many participants reflected on how they developed a proactive way of practicing (some "used mindfulness practice to help themselves to cope with crises"; Bihari & Mullan, 2014). However, for others it became difficult to engage in "when their mood was in decline" (Lilja et al., 2015) or to believe that practices could help "when feeling very distressed" and so "did not practice" (Ames et al., 2014). One practice which was more easily incorporated into daily life and used proactively was the 3-minute breathing space (3MBS) which was often referred to as a short, "accessible", and "useful" practice (Chesin et al., 2018; Smith et al., 2007) and noticing changes in mood as a result ("changes in irritability and anger"; Baillie et al., 2012). This was particularly evident during follow-up whereby engaging in practices may have become harder without the structure and support of MBCT ("the majority continued to use the three minute breathing space"; Finucane & Mercer, 2006). Hopkins and Kuyken (2012) who specifically focused on participants' experiences of MBCT reunion sessions during follow-up reported that, for some, reunions enabled a reconnection with the practices and validation around the difficulty in sustaining practice beyond MBCT due to the "opportunity to share experiences of the challenges of maintaining regular and sustained practices".

Awareness and perspective. Across 16 studies, engaging in MBCT allowed for increased awareness of and a different, broader perspective on experiences. Many participants reflected on their increased awareness of depression-specific thoughts, emotions, and body sensations and particularly those "behaviors that signal relapse" (Boggs et al., 2014). Developing this awareness provided a foundation in being able to slow down, create "distance" from experiences (Mason & Hargreaves, 2001), "stepping back" (Ames et al., 2014), and provide an ability to "observe and describe their emotions and negative thought processes" (Lilja et al., 2015). As a result, participants noticed how thoughts and feelings became less emotionally charged and more transient, as well as noticing reduced levels of both internal (e.g., to thoughts) and external reactivity (e.g., with others; Lilja et al., 2015; Bihari & Mullan, 2014; Baillie et al., 2012).

Many studies highlighted participants' different relationships with rumination, now feeling able to notice the subtleties of rumination, feeling less "attached to thoughts" (Di Toro, 2017), spending "less time ruminating" (Baillie et al., 2012; Cebolla & Barrachina, 2009; Smith et al., 2007), and feeling "able to break these destructive thought cycles" (Murphy & Lahtinen, 2015). In one study which focused specifically on body awareness, participants commented on a sense of increased control over their body, recognising its power over reducing attachment to negative thinking (mindful walking engaged "thinking, leaving less room for unpleasant thoughts"; Worsfold, 2013). The relationship with rumination seemed less about "an absence of threatening thoughts" but signalled a change in awareness of and engagement with thoughts, with participants feeling more skilled in being able to "manage and negotiate around and away from" (Murphy & Lahtinen, 2015) rumination.

Developing agency. Many participants across 16 studies subsequently spoke about noticing shifts from a passive to a more active "sense of personal agency" and control over depression, warning signs, (e.g., Chesin et al., 2018; Boggs et al., 2014; Allen et al., 2009), and antidepressant use in Tickell et al. (2020). As a result of increased agency, some felt they could "identify with depression with less distress" (Allen et al., 2009) and held a better understanding of warning signs which may signify an impending relapse ("developing awareness of personal indicators of worsening mental state"; Mason & Hargreaves, 2001). However, for some, this shift came with a sense of responsibility and "unhelpful pressure", preferring instead to have a "guarantee" of antidepressants as the active agent in their depression (Tickell et al., 2020).

Overarching Theme Two: Acceptance

Accepting experiences and depression. Through engagement in MBCT, and having developed changes in awareness, perspective, and agency, participants across 14 studies described acceptance towards their depression-related thoughts and emotions, noticing the ability to "accept thoughts and feelings" (Allen et al., 2009), "allowing" space for difficult or unpleasant emotions (Worsfold, 2013) without feeling overwhelmed, and feeling able to "turn towards" body sensations and pain (Lilja et al., 2015). Participants developed acceptance of the present moment, moving away from pulls into negative thoughts or worries and "letting go of anxiety and re-discovering joy" (Finucane & Mercer, 2006). Acceptance helped participants to feel "vividly alive" and "energetic" (both Smith et al., 2007).

Three studies specifically described shifts towards acceptance of a lifelong difficulty with depression, through shifts away from a "negative" depressed identity to acceptance of depression as "an aspect of human experience" (Tickell et al., 2020). However, acceptance of depression was sometimes challenging as acceptance implied a shift from an illness model of depression towards having responsibility and control over depression ("its presence no longer expresses an external contingency (for which a person cannot be blamed) but an internal contingency"; Allen et al., 2009). Similarly, others reported difficulty with accepting a psychological versus a biomedical understanding of depression, leading to more self-blame during experiences of low mood or relapse ("when people developed a psychological understanding and then went on to relapse, they blamed themselves"; Tickell et al., 2020). As a result, some participants expressed desires to stay with a biomedical understanding (Tickell et al., 2020).

Permission for self-care. Fourteen studies described shifts in self-acceptance. Studies described how participants developed acceptance and responsibility to take care of themselves and "prioritise their own needs before others" (Lilja et al., 2015). Some could reframe self-care as a "necessary part of their ongoing recovery", no longer seeing self-care as "fluffy" (both quotes from Tickell et al., 2020). With permission to engage in self-care, participants noticed increased self-compassion, "self-esteem" (Cebolla & Barrachina, 2009), and feeling better able to "accept their own fallibilities…without judgement" (Murphy & Lahtinen, 2015). Of course, acceptance was not easy and these changes varied amongst participants experiencing ongoing "guilt or self-blame" (Allen et al., 2009), with some describing their experience as being "almost with compassion" (Murphy & Lahtinen, 2015) in recognition of a gradual, ongoing change towards self-compassion.

A shared group experience. Across 15 studies, participants described how the MBCT group and its facilitators helped to foster a safe and shared experience. Specifically, participants described feeling "understood", cared for, and feeling "able to show emotion in a safe environment" (Finucane & Mercer, 2006). A number of participants commented on how being able to share and identify "with other people who suffer depression" (Allen et al., 2009) contributed to a reframing of a depressed identity and increased acceptance of depression through reduction of isolation and stigma (“no longer feeling alone or different”; Bihari & Mullan, 2014).

Relationships with others. Across 12 studies, and especially in Bihari & Mullan (2014), many participants reported changes in interpersonal relationships following MBCT. For example, participants reported more relaxed and loving relationships, increased intimacy (“greater emotional closeness”; Allen et al., 2009), empathy, and “more mindful, responsive communication” (Bihari & Mullan, 2014). Many participants described how owing to a better ability to relate differently to their experiences and increased self-acceptance, they felt less judgemental of others’ feelings and perspectives (“relating mindfully to their own experiences…led to increased understanding…in their relationships”; Bihari & Mullan, 2014). Participants noted feeling more accepted by others, feeling “better able to talk about their depression with their family and friends”, and how others had “noticed changes” in them (Ma, 2002; Smith et al., 2007). In one study focused on the parenting relationship, participants described “increased bonding” with and having more “emotional availability” for their children (Baillie et al., 2012). Similarly, from the child’s perspective, Racey et al. (2018) described how young people felt more able to approach and engage with their parents (“improved relationships within the wider family”).

In contrast, some participants reported that MBCT “had no effect on their relationships” (Allen et al., 2009) with others reporting “continuing difficulties” and “feelings of frustration” in their relationships, although for some this may have been due to less engagement with mindfulness practice (all Baillie et al., 2012). It was noticeable how the only study delivering online MBCT with no live group option did not report changes in interpersonal relationships (“little evidence of themes indicating improved relationships”; Boggs et al., 2014), suggesting an important relationship between engaging in group-based MBCT and interpersonal changes.

Overarching Theme Three. Ambivalence and Variability

Group processes: difficulties. Although being in a group gave some participants a sense of safety and security, eight studies described how being in a group prompted difficult feelings. Specifically, being in a group meant that some participants made negative “social comparisons” or found it “challenging” to be with others who are or have been depressed (Hopkins & Kuyken, 2012). Additionally, listening to others’ experiences sometimes felt triggering if “discussion turned to suicidal behavior or interpersonal loss” (Chesin et al., 2018). In contrast, in the study delivering online MBCT, some preferred the flexibility and reduced pressure of an online, no-group format, indicating that they were not “group learners” (Boggs et al., 2014).

Variable difficulties and change. Across six studies, many participants reflected on difficult feelings whereby mindfulness practices led to “increase(*d*) feelings of vulnerability” or “hopelessness” (all quotes Bihari & Mullan, 2014). Whilst for some participants these “experiences were described as transient” (Chesin et al., 2018), they were not transient for everyone and engaging in mindfulness-based practices subsequently led to more distressing experiences. This was especially highlighted by Finucane and Mercer (2006) whereby two participants with previous traumatic experiences found that engaging in the body scan prompted intense, painful memories and/or flashbacks. One participant felt able to adapt their mindfulness practice and chose to engage in a 3MBS instead having found it “a useful exercise and continued to use it regularly”. Another participant, with experiences of childhood sexual abuse, enjoyed engaging with the body scan and “continued to practice the longer meditation practices several times a week” (Finucane & Mercer, 2006). In five studies, participants described a contrast between how MBCT could prompt difficult thoughts or feelings but commented that MBCT was still “enjoyable and beneficial albeit challenging” (Bihari & Mullan, 2014) because of the benefits arising from it. Finally, four studies specifically described how change varied between participants and that it was less about a quantifiable or “one single path to change” (Ma, 2002). Instead, change was viewed as individually meaningful to participants’ lives (“it was not simply a case of participants experiencing more or less change”; Bihari & Mullan, 2014).

Expectations and engagement. Thirteen studies described participants’ initial expectations for MBCT and, for some, the subsequent impact on their engagement with MBCT. Some participants had hoped for a “cure” to take away their depression (Tickell et al., 2020; Mason & Hargreaves, 2001) or held pre-existing “high expectations” (Finucane & Mercer, 2006). For some, their experience of MBCT did not meet their expectations and they had hoped “to receive more CBT” (Hopkins & Kuyken, 2012) or wanted longer sessions (“most of the group would have liked…another 3–4 weeks”; Finucane & Mercer, 2006). Others had expressed apprehension around participating in a group or were “unsure” or sceptical about mindfulness (Chesin et al., 2018). Those who held open-minded expectations subsequently reported “fewer barriers” to engagement (Mason & Hargreaves, 2001). However, for those holding either “unrealistically positive” or “very negative” expectations, these became a barrier for engagement in MBCT (Tickell et al., 2020). Even where MBCT fell short of their expectations, some participants persisted with MBCT because of their original motivations in reducing or avoiding medication or their motivation to address “the chronicity of their problems with anxiety and depression” (Finucane & Mercer, 2006).

Across 11 studies, MBCT was described as “acceptable” (e.g., Ames et al., 2014; Chesin et al., 2018; Racey et al., 2018), helpful, and an “enjoyable, beneficial experience” (Bihari & Mullan, 2014), particularly in terms of the support provided by the facilitators and the group (Williams et al., 2018; Smith et al., 2007). However, some participants described a range of difficulties impacting on their ability to engage in MBCT and the mindfulness practices. Difficulties included practical and logistical impacts on getting to the MBCT (e.g., childcare commitments, transport), physical limitations (e.g., pain), and finding both physical and mental space to accommodate the mindfulness practices during follow-up once MBCT had finished, whereby it became “difficult for people to engage in an approach that required time and effort” (Tickell et al, 2020).

Discussion

Across 19 qualitative studies, we aimed to systematically review and synthesise the experiences of MBCT for people with depression. Using reciprocal translation, we reported 18 second-order constructs that appeared within and across the 19 studies. Using a line of argument synthesis, we developed three overarching themes (third-order constructs): “Becoming skilled and taking action”, “Acceptance”, and “Ambivalence and variability”.

Our findings replicate and extend the findings of the earlier meta-syntheses (Wyatt et al., 2014; Cairns & Murray, 2015; Malpass et al., 2012) in terms of understanding MBCT and participants’ accounts of increasing awareness, control, relating differently to experience, relationships, and struggles. However, our findings contribute further towards understanding MBCT more specifically for people with depression and highlight the importance of developing a sense of agency and the processes involved in developing this (e.g., engaging in practice, awareness, agency). Further, our meta-synthesis positions “acceptance” as an overarching theme encompassing many changes in the relationship with depression, self, and others, whilst enabling feelings of vitality and “aliveness”. Finally, “ambivalence and variability” was positioned as a key theme which, although reported in other meta-syntheses, was not previously identified as a core theme.

The first overarching theme “becoming skilled and taking action” highlighted three cumulative and interrelated levels beginning with engaging in mindfulness practice, to developing awareness and perspective, and subsequent agency and control over experience.

Quantitative studies have also reported increases in attention and awareness following MBCT (van den Hurk et al., 2012) as well as changes in reactivity and rumination (van der Velden et al., 2015; van Vugt et al., 2012; Britton et al., 2012); however, studies have generally reported less around agency and control. This overarching theme reflects the core aims of MBCT as through engagement in and development of an experiential understanding of mindfulness practices and principles, participants develop a greater awareness of all experiences (e.g., thoughts, emotions, sensations; Segal et al., 2013), including automatic or ingrained processes such as rumination, self-criticism, and experiential avoidance (Alloy et al., 2018; Segal et al., 2013; Cribb et al., 2006; Koster et al., 2011; Cantazaro & Wei, 2010; Watkins, 2008; Mongrain & Leather, 2006; Hayes et al., 2004). Further, developing a sense of personal agency and control can be a particularly meaningful change in those experiencing depression where they may have previously felt powerless or hopeless (Gilbert, 2017).

The second overarching theme described acceptance towards a range of experience, depression, self, and others, enabling an increased sense of aliveness, self-care, and improved relationships. Acceptance and principles of mindfulness are closely linked, whereby engaging in mindfulness and adopting a non-judgemental and curious attitude to experience can lead to a re-framing of experience (e.g., thoughts) as transient mental events rather than as truths (Cavanagh et al., 2014). Developing acceptance may also enable an ability to step back from getting caught up in difficulties (Crane, 2009). Our findings are in line with the aims and quantitative studies of MBCT whereby MBCT encourages a shift towards letting go of judgements and reactive, automatic ways of responding, whilst developing a kinder, more compassionate approach to experience, including self and others (van der Velden et al., 2015; Segal et al., 2013; Crane, 2009). Our findings also suggest that through belonging to a safe group in which to share feelings and experiences with depression, this may have encouraged self-acceptance and acceptance from others, particularly as disclosing personal inadequacies can lead to increased acceptance by others in a therapy group (Yalom, 1995).

Our third overarching theme of “ambivalence and variability” incorporated different experiences around taking part in a group and being with others, feelings towards the self, and difficult experiences. This theme also incorporated participants’ expectations around taking part, as well as contrasts between participants finding MBCT to be an acceptable intervention and those who reported practical or logistical impacts on engagement. The poor fit between initial expectations and reality may contribute to ambivalence about MBCT as a useful approach. Expectations play an important role in future outcome, where client expectations for therapy have been consistently shown to impact therapy outcome (Cuijpers et al., 2019; Constantino et al., 2018; Wampold, 2015). The relationship between expectations and outcome may be more complex for participants with long histories of depression, however, given that a higher number of “episodes” of depression has shown to be negatively correlated with initial expectations for change (Vîslă et al., 2019).

For some, engaging in MBCT was sometimes understandably challenging as MBCT invites participants to turn towards difficult or painful experiences, that might usually be avoided (e.g., difficult thoughts, emotions, sensations; Crane et al., 2014; Segal et al., 2013). Although there is an emerging literature around the potential for adverse effects of mindfulness meditation (Lindahl et al., 2017) and of mindfulness-based practices found in interventions like MBCT (Baer et al., 2020) there is still much that we do not know. Thus, it is important to bear in mind that experiences during and beyond MBCT will differ between participants and that whilst some unpleasant or negative experiences may be expected during MBCT, there is also the potential for adverse effects which may be more long-lasting.

Implications

Our study highlights a number of findings relevant for people with experiences of depression, which may contribute to further confidence in MBCT. MBCT teachers could incorporate these findings when discussing with participants the possible benefits of engaging in mindfulness practice (e.g., increasing awareness, perspective, agency, and acceptance) as well as bearing in mind individual experiences in terms of who benefits from and who may experience difficulties, above and beyond what might be expected in MBCT. All MBCT teachers, whether in clinical, community, or research settings, should ensure that all participants are given the opportunity to discuss their expectations, with importance also given to the potential for difficult experiences during MBCT.

As mentioned in the results, most second-order constructs were present across multiple studies which supports the strength of the overarching themes as participants reported changes in line with the underlying principles of MBCT, suggesting that MBCT is working as intended. However, it could also be argued that there may be some questions that are not explored or some participant experiences that are missed; this may be the case for those participants who drop out or do not sign up to an MBCT group. Exploring these perspectives in future research would help to clarify this. Our findings highlight the importance of considering the qualitative experiences of MBCT, especially in light of our findings around variable change that is individually meaningful, as meaning becomes a difficult concept to quantify.

Limitations of the Included Studies

Twelve studies did not specifically acknowledge the impact of the participant-researcher relationship thus we cannot be certain what effect this may have had on the original authors' interpretations. A number of studies included researchers who have been extensively involved in MBCT practice and research whose particular biases, expectations, and conflicts of interest may have impacted on study findings. However, the inclusion of studies which were conducted in non-expert MBCT centres of research works to mitigate this. There were a number of similarities across the different study characteristics, although there were significantly fewer studies focused on adolescent and older adult experiences, where there may be different considerations and experiences. Gender distribution within studies was skewed towards participants identifying as female. This might be explained by higher proportions of women experiencing depression (Kuehner, 2017) or suggest that MBCT is initially attractive to people identifying as female, but it warrants further investigation into the experiences of MBCT for people identifying as male.

Limitations of the Meta-Synthesis

The lead researcher was interested in and experienced in delivering and researching MBCT, which may have impacted on the interpretations made in this synthesis. However, efforts to mitigate this were made through use of the reflective log and in-team discussions. All studies were required to be written in English which may have meant that we missed some studies. Finally, although unpublished theses and conference abstracts were detected by our search strategy, we did not specifically search any grey literature databases thus may have missed other, unpublished studies.

Conclusion

Across 19 qualitative studies, we found three overarching themes specifically relevant to participants' experiences of MBCT including "Becoming skilled and taking action", "Acceptance", and "Ambivalence and Variability". Our findings provide an update and a more specifically tailored meta-synthesis of qualitative studies for participants with depression participating in MBCT. Our study suggests that whilst MBCT is beneficial for and can lead to meaningful change for many, MBCT may continue to be experienced as challenging for some. Our findings may help to enhance confidence in MBCT, to further understand the processes involved in change following MBCT, and to better understand who may experience difficulties.

Acknowledgements

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Conflicts of Interest

The study authors have no conflicts of interest to declare.

References

Note. The 19 included studies are indicated below using an asterisk

*Allen, M., Bromley, A., Kuyken, W., & Sonnenberg, S. J. (2009). Participants' experiences of mindfulness-based cognitive therapy: It changed me in just about every way possible. *Behavioural and Cognitive Psychotherapy, 37(4),* 413–430. https://doi.org/10.1017/S135246580999004X

Alloy, L. B., Burke, T. A., O'Garro-Moore, J., & Abramson, L. Y. (2018). Cognitive vulnerability to depression and bipolar disorder. In R. L. Leahy (Ed.), *Science and practice in cognitive therapy: Foundations, mechanisms, and applications* (105–123). Guilford Press.

*Ames, C. S., Richardson, J., Payne, S., Smith, P., & Leigh, E. (2014). Mindfulness-based cognitive therapy for depression in adolescents. *Child and Adolescent Mental Health, 19(1),* 74–78. https://doi.org/10.1111/camh.12034

Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A., & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: Lessons learnt. *BMC Medical Research Methodology, 8(1),* 21. https://doi.org/10.1186/1471-2288-8-21

Baer, R., Crane, C., Montero-Marin, J., Phillips, A., Taylor, L., Tickell, A., & Kuyken, W. (2020). Frequency of self-reported unpleasant events and harm in a mindfulness-based program in two general population samples. *Mindfulness, 12(3),* 763–774. https://doi.org/10.1007/s12671-020-01547-8

*Bailie, C., Kuyken, W., & Sonnenberg, S. (2012). The experiences of parents in mindfulness-based cognitive therapy. *Clinical Child Psychology and Psychiatry, 17(1),* 103–119. https://doi.org/10.1177/1359104510392296

*Bihari, J. L. N., & Mullan, E. G. (2014). Relating mindfully: A qualitative exploration of changes in relationships through mindfulness-based cognitive therapy. *Mindfulness, 5(1),* 46–59. https://doi.org/10.1007/s12671-012-0146-x

*Boggs, J. M., Beck, A., Felder, J. N., Dimidjian, S., Metcalf, C. A., & Segal, Z. V. (2014). Web-based intervention in mindfulness meditation for reducing residual depressive symptoms and relapse prophylaxis: A qualitative study. *Journal of Medical Internet Research, 16(3),* e87. https://doi.org/10.2196/jmir.3129

Britton, W. B., Shahar, B., Szepsenwol, O., & Jacobs, W. J. (2012). Mindfulness-based cognitive therapy improves emotional reactivity to social stress: results from a randomized controlled trial. *Behavior Therapy, 43(2),* 365–380. https://doi.org/10.1016/j.beth.2011.08.006

Cahill, M., Robinson, K., Pettigrew, J., Galvin, R., & Stanley, M. (2018). Qualitative synthesis: A guide to conducting a meta-ethnography. *British Journal of Occupational Therapy, 81(3),* 129–137. https://doi.org/10.1177/0308022617745016

Cairns, V., & Murray, C. (2015). How do the features of mindfulness-based cognitive therapy contribute to positive therapeutic change? A meta-synthesis of qualitative studies. *Behavioural and Cognitive Psychotherapy, 43(3),* 342–359. https://doi.org/10.1017/S1352465813000945

Cantazaro, A., & Wei, M. (2010). Adult attachment, dependence, self-criticism, and depressive symptoms: A test of a mediational model. *Journal of Personality, 78(4),*1135-1162. https://doi.org/10.1111/j.1467-6494.2010.00645.x

Cavanagh, K., Strauss, C., Forder, L., & Jones, F. (2014). Can mindfulness and acceptance be learnt by self-help? A systematic review and meta-analysis of mindfulness and acceptance-based self-help interventions. *Clinical Psychology Review, 34(2),* 118–129.. https://doi.org/10.1016/j.cpr.2014.01.001

*Cebolla i Martí, A. & Miró Barrachina, M. T. (2009). The effects of mindfulness-based cognitive therapy: a qualitative approach. *Psychology in Spain, 13(1),* 9 - 16

*Chesin, M. S., Brodsky, B. S., Beeler, B., Benjamin-Phillips, C. A., Taghavi, I., & Stanley, B. (2018). Perceptions of adjunctive mindfulness-based cognitive therapy to prevent suicidal behavior among high suicide-risk outpatient participants. *Crisis, 39(6),* 451–460. https://doi.org/10.1027/0227-5910/a000519

Constantino, M. J., Visla, A., Coyne, A. E., & Boswell, J. F. (2018). A meta-analysis of the association between patients' early treatment outcome expectation and their post-treatment outcomes. *Psychotherapy*, *55(4)*, 473–485. https://doi.org/10.1037/pst0000169

Crane, R. (2009). *Mindfulness-based cognitive therapy. The CBT distinctive features series.* Routledge

Crane, C., Crane, R. S., Eames, C., Fennell, M. J. V., Silverton, S., Williams, J. M. G., & Barnhofer, T. (2014). The effects of amount of home meditation practice in mindfulness-based cognitive therapy on hazard of relapse to depression in the staying well after depression trial. *Behaviour Research and Therapy*, *63*, 17–24. https://doi.org/10.1016/j.brat.2014.08.015

Cribb, G., Moulds, M. L., & Carter, S. (2006). Rumination and experiential avoidance in depression. *Behaviour Change*, *23(3),* 165–176. https://doi.org/10.1375/bech.23.3.165

Critical Appraisal Skills Programme (2018). CASP Qualitative Studies Checklist. [online] Available at: https://casp-uk.net/wp-content/uploads/2018/03/CASP-Qualitative-Checklist-2018_fillable_form.pdf. Accessed: 7th February 2021

Cuijpers, P., Reijnders, M., & Huibers, M. J. H. (2019). The role of common factors in psychotherapy outcome. *Annual Review of Clinical Psychology*, *15*, 207–231. https://doi.org/10.1146/annurev-clinpsy-050718-095424

*Di Toro, B. M. (2016). *A pilot study of feasibility factors in mindfulness-based cognitive therapy in depressed primary care patients*. [PsyD Thesis, California School of

Professional Psychology at Alliant International University, San Diego]. ProQuest. https://search.proquest.com/openview/ee86a7d4b5b84a0b831b785fd5c5126e/1.pdf?pq-origsite=gscholar&cbl=18750&diss=y

*Finucane, A., & Mercer, S. W. (2006). An exploratory mixed methods study of the acceptability and effectiveness mindfulness-based cognitive therapy for patients with active depression and anxiety in primary care. *BMC Psychiatry, 6(1),* 14. https://doi.org/10.1186/1471-244X-6-14

France, E. F., Cunningham, M., Ring, N., Uny, I., Duncan, E. A. S., Jepson, R. G., Maxwell, M., Roberts, R. J., Turley, R. L., Booth, A., Britten, N., Flemming, K., Gallagher, I., Garside, R., Hannes, K., Lewin, S., Noblit, G. W., Pope, C., Thomas, J., … Noyes, J. (2019). Improving reporting of meta-ethnography: The eMERGe reporting guidance. *Psycho-Oncology, 28(3),* 447–458. https://doi.org/10.1002/pon.4915

Gilbert, P. (2017). *Depression. The evolution of powerlessness.* Routledge, Oxon

Hayes, S. C. (2004). Acceptance and commitment therapy, relational frame theory, and the third wave of behavioral and cognitive therapies. *Behavior Therapy, 35(4),* 639–665. https://doi.org/10.1016/S0005-7894(04)80013-3

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change.* Guilford Press

*Hopkins, V., & Kuyken, W. (2012). Benefits and barriers to attending MBCT reunion meetings: An insider perspective. *Mindfulness, 3(2),* 139–150. https://doi.org/10.1007/s12671-012-0088-3

James, S. L., Abate, D., Abate, K. H., Abay, S. M., Abbafati, C., Abbasi, N., Abbastabar, H., Abd-Allah, F., Abdela, J., Abdelalim, A., Abdollahpour, I., Abdulkader, R. S., Abebe, Z., Abera, S. F., Abil, O. Z., Abraha, H. N., Abu-Raddad, L. J., Abu-Rmeileh, N. M. E., Accrombessi, M. M. K., … Murray, C. J. L. (2018). Global, regional, and national incidence, prevalence, and years lived with disability for 354 diseases and injuries for 195 countries and territories, 1990-2017: A systematic analysis for the global burden of disease study 2017. *The Lancet, 392(10159),* 1789–1858. https://doi.org/10.1016/S0140-6736(18)32279-7

Kessing, L. V., Hansen, M. G., Andersen, P. K., & Angst, J. (2004). The predictive effect of episodes on the risk of recurrence in depressive and bipolar disorders - a life-long perspective. *Acta Psychiatrica Scandinavica, 109(5),* 339–344. https://doi.org/10.1046/j.1600-0447.2003.00266.x

Kuehner, C. (2017). Why is depression more common among women than among men? *The Lancet Psychiatry, 4(2),* 146-158.

Koster, E. H. W., De Lissnyder, E., Derakshan, N., & De Raedt, R. (2011). Understanding depressive rumination from a cognitive science perspective: The impaired disengagement hypothesis. *Clinical Psychology Review, 31(1),* 138–145. https://doi.org/10.1016/j.cpr.2010.08.005

Kupfer, D. J. (1991). Long-term treatment of depression. *The Journal of Clinical Psychiatry, 52 Suppl*, 28–34. http://www.ncbi.nlm.nih.gov/pubmed/1903134

Kuyken, W., Warren, F. C., Taylor, R. S., Whalley, B., Crane, C., Bondolfi, G., Hayes, R., Huijbers, M., Ma, H., Schweizer, S., Segal, Z., Speckens, A., Teasdale, J. D., Van Heeringen, K., Williams, M., Byford, S., Byng, R., & Dalgleish, T. (2016). Efficacy of mindfulness-based cognitive therapy in prevention of depressive relapse: An individual patient data meta-analysis from randomized trials. *JAMA Psychiatry, 73(6)*, 565-574. https://doi.org/10.1001/jamapsychiatry.2016.0076

Lau, M. A., Segal, Z. V., & Williams, J. M. G. (2004). Teasdale’s differential activation hypothesis: Implications for mechanisms of depressive relapse and suicidal behaviour. *Behaviour Research and Therapy, 42(9),* 1001–1017.

https://doi.org/10.1016/j.brat.2004.03.003

Lee, R. P., Hart, R. I., Watson, R. M., & Rapley, T. (2015). Qualitative synthesis in practice: some pragmatics of meta-ethnography. *Qualitative Research, 15(3),* 334–350. https://doi.org/10.1177/1468794114524221

*Lilja, J. L., Broberg, M., Norlander, T., & Broberg, A. G. (2015). Mindfulness-based cognitive therapy: primary care patients' experiences of outcomes in everyday life and relapse prevention. *Psychology*, *06(04),* 464–477. https://doi.org/10.4236/psych.2015.64044

Lim, G. Y., Tam, W. W., Lu, Y., Ho, C. S., Zhang, M. W., & Ho, R. C. (2018). Prevalence of depression in the community from 30 countries between 1994 and 2014. *Scientific Reports, 8(1),* 1–10. https://doi.org/10.1038/s41598-018-21243-x

Lindahl, J. R., Fisher, N. E., Cooper, D. J., Rosen, R. K., & Britton, W. B. (2017). The varieties of contemplative experience: A mixed-methods study of meditation-related challenges in western buddhists. *PLOS ONE, 12(5),* e0176239. https://doi.org/10.1371/journal.pone.0176239

Linehan, M. (1993). *Skills training manual for treating borderline personality disorder*. Guilford Press.

*Ma, S. H. (2002). *Prevention of relapse/recurrence in recurrent major depression by mindfulness-based cognitive therapy.* [PhD Thesis, The University of Cambridge]. Sent via personal communication

Malpass, A., Carel, H., Ridd, M., Shaw, A., Kessler, D., Sharp, D., Bowden, M., & Wallond, J. (2012). Transforming the perceptual situation: A meta-ethnography of qualitative work reporting patients' experiences of mindfulness-based approaches. *Mindfulness, 3(1),* 60–75. https://doi.org/10.1007/s12671-011-0081-2

*Mason, O., & Hargreaves, I. (2001). A qualitative study of mindfulness-based cognitive therapy for depression. *British Journal of Medical Psychology, 74(2),* 197–212. https://doi.org/10.1348/000711201160911

McCartney, M., Nevitt, S., Lloyd, A., Hill, R., White, R., & Duarte, R. (2021). Mindfulness-based cognitive therapy for prevention and time to depressive relapse: Systematic review and network meta-analysis. *Acta Psychiatrica Scandinavica, 143(1),* 6–21. https://doi.org/10.1111/acps.13242

Melendez-Torres, G. J., Grant, S., & Bonell, C. (2015). A systematic review and critical appraisal of qualitative metasynthetic practice in public health to develop a taxonomy of operations of reciprocal translation. *Research Synthesis Methods, 6(4),* 357–371. https://doi.org/10.1002/jrsm.1161

Mongrain, M., & Leather, F. (2006). Immature dependence and self-criticism predict the recurrence of major depression. *Journal of Clinical Psychology, 62(6),* 705–713. https://doi.org/10.1002/jclp.20263

*Murphy, H., & Lahtinen, M. (2015). ‘To me, it’s like a little box of tricks’: Breaking the depressive interlock as a programme participant in mindfulness-based cognitive therapy. *Psychology and Psychotherapy: Theory, Research and Practice, 88(2),* 210–226. https://doi.org/10.1111/papt.12041

National Institute for Health and Clinical Excellence. (2017). *Depression in adults. Recognition and management.* (CG90). Retrieved from https://www.nice.org.uk/guidance/cg90

Noblit, G., & Hare, D. (1988). *Meta-ethnography: Synthesizing qualitative studies*. Sage.

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., … Moher, D. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ, 372,* n71. https://doi.org/10.1136/bmj.n71

QSR International. (1999). *NVivo Qualitative Data Analysis Software* (Version 12) [Software]. QSR International. Available from https://qsrinternational.com/nvivo/nvivo-products/

*Racey, D. N., Fox, J., Berry, V. L., Blockley, K. V., Longridge, R. A., Simmons, J. L., Janssens, A., Kuyken, W., & Ford, T. J. (2018). Mindfulness-based cognitive therapy for young people and their carers: a mixed-method feasibility study. *Mindfulness, 9(4),* 1063–1075. https://doi.org/10.1007/s12671-017-0842-7

Sattar, R., Lawton, R., Panagioti, M., & Johnson, J. (2021). Meta-ethnography in healthcare research: a guide to using a meta-ethnographic approach for literature synthesis. *BMC Health Services Research, 21(1),* 50. https://doi.org/10.1186/s12913-020-06049-w

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2013). *Mindfulness-based Cognitive Therapy for Depression*. Guilford Press

*Smith, A., Graham, L., & Senthinathan, S. (2007). Mindfulness-based cognitive therapy for recurring depression in older people: A qualitative study. *Aging and Mental Health, 11(3),* 346–357. https://doi.org/10.1080/13607860601086256

*Tickell, A., Byng, R., Crane, C., Gradinger, F., Hayes, R., Robson, J., Cardy, J., Weaver, A., Morant, N., & Kuyken, W. (2020). Recovery from recurrent depression with mindfulness-based cognitive therapy and antidepressants: A qualitative study with illustrative case studies. *BMJ Open, 10(2).* https://doi.org/10.1136/bmjopen-2019-033892

Toye, F., Seers, K., Allcock, N., Briggs, M., Carr, E., & Barker, K. (2014). Meta-ethnography 25 years on: Challenges and insights for synthesising a large number of qualitative studies. *BMC Medical Research Methodology, 14(1),* 80. https://doi.org/10.1186/1471-2288-14-80 van den Hurk P. A. M., van Aalderen, J. R., Giommi, F., Donders, R. A. R. T., Barendregt, H. P., & Speckens, A. E. M. (2012). An investigation of the role of attention in mindfulness-based cognitive therapy for recurrently depressed patients. *Journal of Experimental Psychopathology, 3(1),* 103-120. doi:10.5127/jep.024811

van der Velden, A. M., Kuyken, W., Wattar, U., Crane, C., Pallesen, K. J., Dahlgaard, J., Fjorback, L. O., & Piet, J. (2015). A systematic review of mechanisms of change in mindfulness-based cognitive therapy in the treatment of recurrent major depressive disorder. *Clinical Psychology Review*, *37*, 26–39. https://doi.org/10.1016/j.cpr.2015.02.001

van Vugt, M. K., Hitchcock, P., Shahar, B., & Britton, W. (2012). The effects of mindfulness-based cognitive therapy on affective memory recall dynamics in depression: a mechanistic model of rumination. *Frontiers in Human Neuroscience*, *6,* 257. https://doi.org/10.3389/fnhum.2012.00257

Vîslă, A., Flückiger, C., Constantino, M. J., Krieger, T., & Grosse Holtforth, M. (2019). Patient characteristics and the therapist as predictors of depressed patients' outcome expectation over time: A multilevel analysis. *Psychotherapy Research*, *29(6)*, 709–722. https://doi.org/10.1080/10503307.2018.1428379

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, *14(3)*, 270–277. https://doi.org/10.1002/wps.20238

Watkins, E. R. (2008). Constructive and unconstructive repetitive thought. *Psychological Bulletin*, *134(2),* 163–206. https://doi.org/10.1037/0033-2909.134.2.163

*Williams, C. M., Meeten, F., & Whiting, S. (2018). 'I had a sort of epiphany!' An exploratory study of group mindfulness-based cognitive therapy for older people with depression. *Aging and Mental Health*, *22(2)*, 208–217. https://doi.org/10.1080/13607863.2016.1247415

*Worsfold, K. E. (2013). Embodied reflection in mindfulness-based cognitive therapy for depression. *Humanistic Psychologist*, *41(1),* 54–69. https://doi.org/10.1080/08873267.2012.732154

Wyatt, C., Harper, B., & Weatherhead, S. (2014). The experience of group mindfulness-based interventions for individuals with mental health difficulties: A meta-synthesis. *Psychotherapy Research*, *24(2),* 214–228. https://doi.org/10.1080/10503307.2013.864788

Yalom, I. D. (1995). *The theory and practice of group psychotherapy* (4th ed.). Basic Books.

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Paper Two

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An ongoing process of reconnection. A qualitative exploration of Mindfulness-based Cognitive Therapy for adults in remission from depression.

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Words: including main text, tables, and figures (Figure 2.1=33 words), but excluding the abstract, statement around the data, author note, and references = 5,999

Words in the abstract: 238

Keywords: Mindfulness-based Cognitive Therapy; MBCT; Depression; Qualitative; Connection; Relationships; Process of change

This paper was submitted to “Psychology and Psychotherapy: Theory, Research, and Practice” on the 22nd March 2021. **Appendix Three** includes the author guidelines.

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Statement around the Data in Paper Two

This qualitative data was collected during the lead researcher’s PhD (2013-2017). The data presented in this thesis was analysed as a secondary dataset and has been analysed and presented for the first time in this submission as part of the Doctorate in Clinical Psychology. Whilst a small proportion of the qualitative transcripts were previously transcribed by a research assistant (14%; see **page 85**), all remaining interviews were transcribed by the lead researcher as part of the analysis process for this doctorate thesis submission. However, it should be noted that brief demographic details have been included in the results section to provide some context regarding the study participants; these demographics were included in the researcher’s PhD (Williams, 2018).

Author Note

The **Supplementary Materials** include additional details relevant to the paper and were included in the submission for publication. The **Appendices** have been included only for the purposes of the thesis submission and were not included in the submission for publication.

Abstract

Objectives. Mindfulness-based Cognitive Therapy (MBCT) is an eight-week relapse-prevention intervention designed for people who have experienced multiple episodes of depression and remain vulnerable to relapse. Previous qualitative explorations of the effects of MBCT for people in remission from depression have suggested a number of themes regarding changes arising from participating in MBCT ranging from awareness, agency, perspective, group processes, self-related change, and new ways of understanding depression. We aimed to qualitatively explore how participants in remission from depression experienced MBCT both post-MBCT and during a follow-up period.

Methods. In a preference-choice trial design, 35 participants took part in qualitative interviews and assessments post-MBCT and at three timepoints during a 12-month follow-up. Data were analysed using reflexive thematic analysis.

Results. Two overarching themes were developed: “Reconnection” with experience and “Process”. Under “Reconnection”, sub-themes captured participants’ experiences of increasing levels of awareness of their experience (e.g., thoughts, emotions, sensations, present moment) from which they described changes in their relationship with experience describing increases in control, choice, acceptance, and calm. Participants described shifts towards reconnection with aspects of the self and relationships with others. Under “Process”, sub-themes reflected participants’ conflict between avoidance and engagement in mindfulness practices, and the recognition of the gradual change following MBCT and long-term investment needed in mindfulness practices.

Conclusions. Our findings have clinical implications in terms of facilitating MBCT and point to important themes around recognising the ongoing process of reconnection with experiences, self, and others.

Practitioner Points

- Participants with histories of depression may have experienced disconnection and isolation from internal experiences (e.g., thoughts, emotions), self, and others; MBCT encourages a deliberate shift towards reconnection with these experiences.
- Practitioners could encourage more psychoeducation and discussions around depression during MBCT to encourage reflections on the process of reconnection
- Practitioners should maintain an awareness of the ongoing, gradual processes of change and potential for conflict experienced during MBCT
- Practitioners could provide a stronger emphasis on building awareness of body sensations during MBCT

Introduction

Mindfulness-based Cognitive Therapy (MBCT) was designed for people who have experienced multiple episodes of depression and remain vulnerable to relapse (Kuyken et al., 2016; Segal et al., 2013). Two recent meta-analyses have shown that MBCT can prevent relapse up to 60 weeks post-MBCT compared with Treatment as Usual (TAU) and those on maintenance antidepressant treatment (Kuyken et al., 2016), and that MBCT was more effective than TAU in preventing relapse, although the latter study included samples with remitted, current, and bipolar depression (McCartney et al., 2021). MBCT is an eight-week intervention, typically delivered in groups, with an all-day mindfulness practice session around week six and regular reunion sessions post-MBCT. MBCT encourages an experiential participation in mindfulness practice to enable increasing awareness of depression-related triggers or warning signs, complemented by psychoeducation and thought challenging exercises from Cognitive Therapy (Segal et al., 2013).

A number of studies have employed qualitative approaches to explore participants' experiences of taking part in MBCT. Cairns and Murray (2015) conducted a meta-synthesis of seven studies reporting five themes including a sense of increased control, the impact of the group setting (e.g., support, decreased isolation), changes in feelings towards the self, the importance of taking skills into daily life and expectations around MBCT, although this meta-synthesis included participants with cardiac conditions or Parkinson's disease thus was not specific to participants with depression. More recent studies specific to participants with recurrent depression have highlighted additional themes including increased self-acceptance, awareness and control of depression-related thoughts and emotions, reduced rumination, improved relationships and communication with others, and increased self-care (Tickell et al., 2020; Williams et al., 2018; Bihari & Mullan, 2014; Lilja et al., 2015). In a systematic review and meta-synthesis of 19 qualitative studies exploring the experiences of participants with depression taking part in MBCT, we identified three overarching themes around “Becoming skilled and taking action”, “Acceptance”, and “Ambivalence and variability” (Williams et al., under review; **Paper One**).

Across the qualitative studies to date, some only interviewed participants during follow-up (typically between 12 and 36 months since MBCT) thus potentially missing early changes attributable to MBCT or interviewed participants when the link between their current situation and awareness of the impact of MBCT may have faded. Others interviewed participants at pre- and post-MBCT with no follow-up, potentially missing the long-term impact of MBCT. Two studies conducted interviews both post-MBCT and during follow-up, although these were specific to older adult populations with some subsequent adaptations to content and style (Smith et al., 2007; Williams et al., 2018). Tickell et al. (2020) conducted interviews both post-MBCT and at follow-up although the sample was purposively sampled and restricted only to participants using antidepressants. Therefore, a comprehensive exploration of qualitative experiences both post-MBCT and during follow-up in adults with recurrent depression is warranted; we aimed to address this need in this study. Further, exploring participant experiences at both post-MBCT and follow-up may allow for further understanding of how and whether participants continue to practice and engage with the principles of MBCT beyond the acute intervention phase. Our primary research question focused on: “How did participants with depression experience taking part in MBCT?”, with a focus on the potential benefits and challenges of MBCT.

Method

Study Context

This study formed part of a larger preference-choice mechanistic trial (Williams et al., 2018; 2020); only the qualitative data was analysed and reported in this study. Ethical approval was granted by the NHS (North West - Preston Research Ethics Committee; **Appendix Four**). We followed the Consolidated Criteria for Reporting Qualitative research (COREQ; Tong et al., 2007) guidelines when drafting this manuscript (**Supplementary Material S2.1**).

Design

Participants were recruited from the north-west of England either from an existing departmental database of previous study participants who provided consent for contact in future studies, or had responded to adverts which were placed in health centres, University campus and online announcements, social media, and community websites (e.g., Gumtree). Participants contacted the lead researcher and were sent study information. Participants chose to either take part in MBCT+TAU or a TAU group; the latter did not undertake MBCT. All qualitative interviews were carried out by the lead researcher. Interviews were carried out at baseline (*N*=53), post-MBCT (*N*=35), and during the 12-month follow up period (three [*N*=29], six [*N*=35], and twelve [*N*=35] months). Attrition between baseline and post-MBCT was due to participants deciding not to continue with MBCT; the main study recruitment flow chart details the specific reasons (Williams et al., 2020). All baseline and post-MBCT interviews were audio recorded in a face-to-face setting in the research department; two participants preferred to write their responses. All follow-up data were captured on a written document completed online.

Participants

Participants were aged 18 years or over and had experienced at least two self-reported episodes of major depression, defined using the DSM-IV criteria and assessed using the Mini International Neuropsychiatric Interview (M.I.N.I.; Sheehan et al., 1998). Participants were defined as meeting criteria for either full or partial remission, and were therefore either free from, or experiencing mild symptoms of depression (defined by scoring below a cut-off score of 12 on the Montgomery Åsberg Depression Rating Scale; MADRS; Montgomery & Åsberg, 1979). Participants were included if they were currently taking antidepressants provided there had been no changes in the last three months or upcoming medication changes. Participants were excluded if they met criteria for additional DSM-IV diagnoses other than major depression or comorbid anxiety, if they had previously engaged in a similar mindfulness-based intervention (MBI), had a current meditation practice, or had completed psychotherapy in the last twelve months.

Intervention

MBCT was delivered across five groups with approximately ten participants in each group between 2015-2017; MBCT groups were co-facilitated by two of the authors (KW; KB), both who had completed relevant training in facilitating MBCT. MBCT groups were delivered in accordance with the manual (Segal et al., 2013) and the Good Practice Guidelines (Crane et al., 2011) and included two-hour weekly sessions across eight weeks, with an all-day session around week six. Participants were also offered four optional reunion sessions during the follow-up period.

Data Collection

The semi-structured interviews were conducted by the lead researcher. Interview schedules were used to guide the interview content post-MBCT and were used as specific questions at follow-up. The semi-structured interviews included prompts for participants to consider the potential benefits, challenges, barriers, facilitators, and intentions to continue practice. Full interview schedules are in **Supplementary Material S2.2**.

Analysis

Reflexive Thematic Analysis (TA) was conducted in line with the recently updated six-step guidelines from Braun and Clarke (2021; 2020; 2013; 2006; **Supplementary Material S2.3**). Reflexive TA allows for identification of key themes in keeping with a "critical realist" framework acknowledging the space for an "ultimate reality" whilst accounting for the potential impact of the researcher's assumptions and the individual social and cultural contexts of participants (Braun & Clarke, 2013; 2006). To mitigate the potential impact of the researcher's experience with and knowledge of MBCT, the lead researcher maintained a reflective log and discussed the themes with the wider team (Braun & Clarke, 2013; **Supplementary Materials S2.1** and **S2.4**). All interviews were listened to multiple times and transcribed verbatim. A proportion of the interviews (*N*=28; 14%) were transcribed by a Research Assistant (MD) and cross-checked for accuracy by the lead researcher, who subsequently transcribed and checked all remaining interviews (*N*=175; 86%).

Transcripts were entered into NVivo 12 (QSR International, 1999) and in line with a critical realist framework, were coded at a data-derived, semantic level (remaining close to the actual content and mirroring participants' language and concepts; Braun & Clarke, 2013) to limit the impact of researcher assumptions and expectations (Braun & Clarke, 2006). Transcripts were coded by the lead researcher in five timepoint-specific batches (baseline, post-MBCT, three, six, and twelve months). However, due to similarities across codes, all follow-up data were combined and analysed in one batch. **Supplementary Material S2.5** includes an example of the coding tree. Codes were developed into themes which were mapped out visually and refined by ongoing checking against the entire dataset (transcripts and codes) and through discussions with the research team. Due to similarities in themes across timepoints, the post-MBCT and follow-up themes were combined. To ensure fidelity with the analytic process, Braun and Clarke's 15-point checklist for TA was completed (2006; **Supplementary Material S2.6**). Additionally, two researchers, one with and one without MBCT experience, offered reflections and thoughts on the themes; both researchers stated that the themes fit with either their understanding of or expectations of MBCT. Finally, as our research question focused on the experiences of taking part in MBCT, rather than pre-existing beliefs and expectations, baseline data was not included but has been analysed (**Appendix Five**) and discussed in **Paper Four**. A completed quality appraisal checklist has been included in **Appendix Six**.

Results

Table 2.1 details the demographics both at baseline and post-MBCT. As described above, there was some attrition between baseline and post-MBCT. By the 12-month follow-up, 28.6% (*N*=10) of the sample had experienced at least one relapse into depression (i.e., meeting criteria for a DSM-IV diagnosis of depression). Further details regarding demographics and attrition are in the main trial publications (Williams et al., 2020; 2018).

Table 2.1. Demographics

	Baseline **_N_=53**	**Post-MBCT** **_N_=35**	**3 months** **_N_=29**	**6 months** **_N_=35**	**12 months** **_N_=35**
Age	M=37.04 (*SD=10.56*)	M=37.60 (*SD=10.99*)	36.31 (*SD=10.11*)	M=37.60 (*SD=10.99*)	M=37.60 (*SD=10.99*)
Gender (% female)	75%	74%	72%	74%	74%
N previous episodes	6.50 (*SD=4.22*)	6.79 *(SD=4.83)*	7.03 (*SD=5.03*)	6.79 *(SD=4.83)*	6.79 *(SD=4.83)*
MADRS	M=4.89 (*SD=4.74*)*	M=4.53 (*SD=6.71*)*	M=4.61 (*SD=6.41*)*	M=4.18 (*SD=5.40*)*	M=6.53 (*SD=7.27*)*

Note. Demographics here were previously included in the lead researcher's PhD (Williams, 2018); MADRS=Montgomery Åsberg Depression Rating Scale (1979); *F(4,124)=0.96, *p*=.43

As seen in **Figure 2.1**, taking part in MBCT and across a 12-month follow-up, participants reported changes across two overarching themes. The first overarching theme, reconnection, comprised three sub-themes including participants' connection with, or (in light of previous depression experiences) reconnection with, awareness, relationship with experience, and enhanced connection with self and others. The second overarching theme, process, includes two sub-themes comprising the recognition of processes of avoidance versus engagement with experience and the long-term investment in an ongoing process of change. **Table 2.2** includes brief descriptions of the overarching themes.

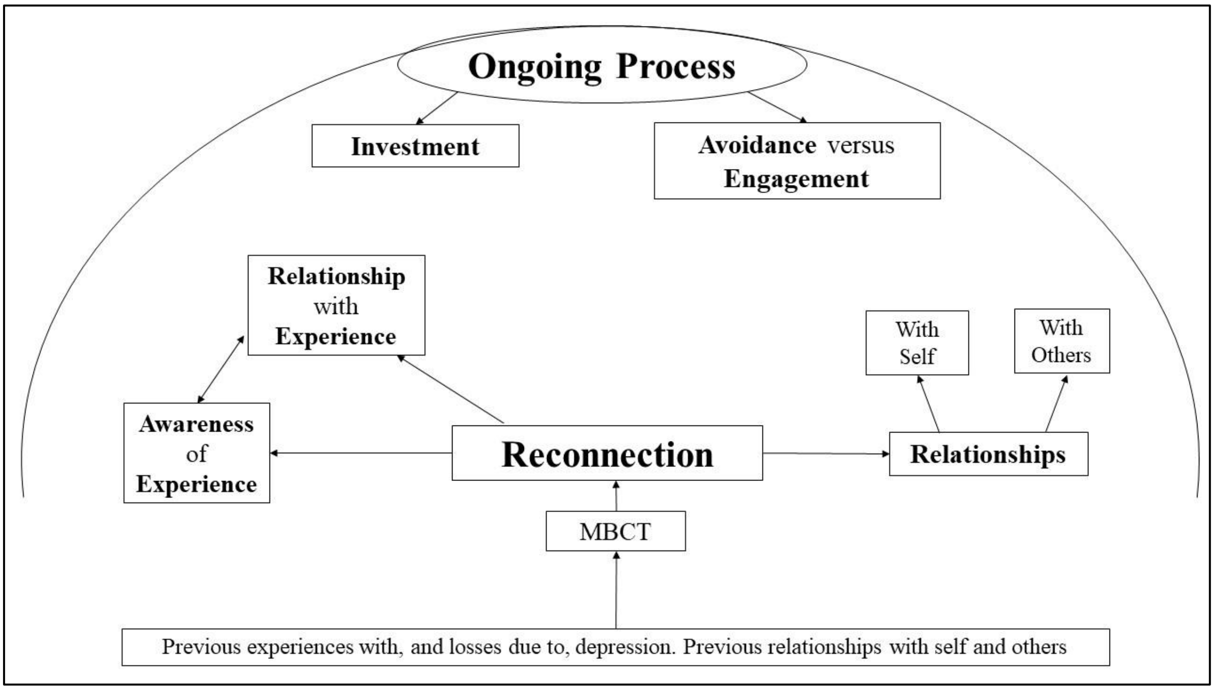

Figure 2.1. Participants' experiences of MBCT

Overarching Theme One: Reconnection

This theme reflected how participants have gained something which they perceived themselves as having previously lost or become disconnected from during their experiences of depression. Specifically, participants described how prior to MBCT they felt "overwhelmed" by or easily caught up in thoughts ("overthinking", "catastrophising"), emotions ("caught in a cycle of worry"), and described less conscious, automatic, "reactive" relationships to their thoughts or emotions ("a small intrusive thought that just ends up spiralling into something completely ridiculous"). Participants described feeling "dislocated" or "isolated" from how they felt about themselves and in their relationships with others. Following MBCT, participants described shifts towards a reconnection with their experiences, acknowledging that this was not easy nor the same for every participant. In this overarching theme, themes were developed around awareness, changing relationships with experience, self, and others, which although constitute distinct themes, are inter-related to an extent under the umbrella of reconnection.

Table 2.2. Overarching themes and descriptions

Themes	**Core ideas**
Overarching theme 1: Reconnection	
Awareness	Increased awareness through connecting with the present moment, noticing more thoughts, emotions, and body sensations. Automaticity of thoughts and emotions.
Relationship with experience	Less reactivity. Distance between reacting and responding to thoughts and emotions through control and choice, acceptance, and calm Control over depression Acceptance of emotions and depression Effortless calm, resistance to calm
Relationships with self and others	Reconnecting with the self, worthy of self-care. Confident and empowered Shifts from self-criticism to self-compassion MBCT group experienced as a safe, normalising, shared place, helping to foster healthier, joyful, more communicative, and appreciative relationships
Overarching theme 2: Process	
Avoidance versus Engagement	Practical, logistical, and psychological impacts on avoidance and engagement in mindfulness practices. Benefits and conflicts around the “sitting with difficulty” practice Avoidance of difficulty practice and a lack of group support during follow-up.
Investment	Gradual change Recognising the commitment and space needed to facilitate ongoing practice. Reflections on intentions/choices to continue practice.

Awareness

Participants described becoming more aware of the present moment, recognising tendencies to “go into autopilot” and feeling more present with their thoughts and emotions. One participant reflected that practicing mindfulness and staying “present” helped them to feel like they now lived “in the present instead of worrying about the future and getting upset about the past”. Some reported regret of time spent ruminating or worrying when “living in the past or the future”. Further, through connecting with the present moment, participants recognised the urges to engage in “doing” mode versus “being” able to allow experience to be there and to “appreciate the present moment”. This was not always easy, as one participant described how “I found it very difficult…being in the moment, rather than…fixing something”.

Participants reflected on how mindfulness practice allowed for an increased awareness of thoughts (“becoming more aware of some of my thought patterns”) and emotions (“I am more aware of my feelings…when I'm getting anxious, stressed, emotional”). Participants noticed the, at times, hidden automaticity of thoughts and emotions (“I can make myself quite…anxious and…upset without even realising”). Although described less often and in less depth than for either thoughts or emotions, some participants reported increased noticing of and ability to pay attention to their body. Specifically, participants reflected that they became “more aware of sensory sensations”, “more aware of *(my)* breathing”, and how “*(I)* can pay attention to what *(I)* am doing or how *(my)* body is feeling”. One participant wondered “is that (*pain*) there all the time?...it makes me think my body’s really tense even when I feel relaxed”.

Relationship with Experience

Participants described how through having increased awareness, they noticed changes in their relationships with experience. Specifically, participants noted shifts in reactivity whereby they now felt able to “step back” and allow “space” and a more responsive, as opposed to reactive, interaction with thoughts and emotions (“I don't react as quickly any more which gives me more time to think through a more appropriate response”). Participants described gaining control over their thoughts and tendencies to catastrophise and ruminate ("there's definitely a tendency to make up stories and imagine the worst, which I feel like I'm getting control of now"). For participants who have experienced multiple episodes of depression and potentially engaged in ruminative strategies over many years, gaining control and choice over thought processes felt "life-changing" and, for some, they no longer felt they were a passive recipient or "hostage" but instead felt more active control over negative thoughts. Specifically, one participant realised that since taking part in MBCT they could choose not to engage in a familiar, ruminative thought cycle:

> "there's probably been about three situations where I thought I can actually choose not to go down this horrible ruminating self-torture response to this thought and I've never thought that I could actually do that".

This shift from reactivity to feeling in control also applied to emotions with participants describing previous hypervigilance or rumination over the meaning of or the urge to "fix" emotions, yet reflecting that they now had space to "step back" and observe emotions. However, this was not easy and for some, engaging in mindfulness practice felt intense and contributed to feelings of uncontrollability and distress around thoughts and emotions; one participant explains how:

> "difficult thoughts and emotions simply took over…I found it incredibly difficult to settle myself so that I felt anything other than a deep distress".

Many participants reflected on an increased sense of control over their understanding of and vulnerability to depression. Some described feeling equipped and "empowered" with knowledge and "tools" for recognising and attending to negative depression-related thoughts and emotions "before they become a real problem". Some described how prior to MBCT the "lows would have been worse" or "longer". Following MBCT, many commented on how they hoped that their experience of depression might be different in the future, "at the start I was resigned to the fact that I would probably have depression again…whereas now I'm hopeful that I might not".

Participants developed a "greater acceptance and tolerance" towards their experience, through accepting the presence of emotions ("it's possible for me to feel something and for that to just be") and what can or cannot be changed ("it's ok to feel when you are feeling down"). Participants described resilience alongside acceptance ("suffering is temporary and I can cope with it"). Participants reported feeling able to "let go" of their desire to "fix" depression and accept that MBCT would not provide a "miracle cure". One participant reflected:

> "When I originally signed up I thought…I'll find a way to fix depression, or…fix me… I think I held onto that illusion for longer than maybe I should have".

Participants reflected on feeling "calmer" and having developed feelings of gratitude, both around their experience of MBCT and the facilitators. Some participants expressed gratitude and protectiveness over their experience of MBCT, describing it as "a special thing" and "just for me". It was particularly noticeable how many participants described an "effortless calm", taking a "more measured" approach for "things that would have rattled me before". However, this sense of calm was not relevant to all participants as some described resistance to it; one participant reflected that "I'm not sure I want to be that calm all the time" but spoke instead of redirecting their attention and making a choice about what they needed at that specific moment ("spending a bit more time with myself but not necessarily doing a practice"). Overall, new ways of relating to experiences encompassed interconnections between awareness, control, choice, acceptance, and calm. Indeed, one participant described these interconnections between reactivity, rumination, awareness, and acceptance:

> "If you've had several periods of depression, you start looking for stuff and you worry desperately all the time…is this a sign? You try and think of ways that you will be able to hold it off. *(Now)* I don't have to do that…I can just be aware that it's happening, that it might be the start of a pattern, or it might not".

Relationships with Self and Others

Firstly, some participants reported feeling lost or "disconnected" with their sense of self when depressed. MBCT had provided space and an ability to reconnect with their "old self", with many participants commenting on how their "energy levels are better", they felt a sense of relief ("a bit of weight off of my shoulders"), "happier", and "less despondent"; some had reconnected with a loss of libido (the body scan "has helped me to regain some of the drive"). A number of participants described feeling more "empowered", "more assertive" and confident around making decisions.

Participants described their familiar, well-established thoughts and emotions related to self-criticism, "blame", "self-disgust", "shame", and "guilt" and the difficulties in feeling self-compassionate prior to MBCT. Following MBCT, participants reported how whilst self-critical thoughts were still present, the intensity and power of such thoughts and emotions was lessening and, similar to rumination, participants could "step back" and allow "distance" from such thoughts and emotions. Participants commented on how they felt less "judgemental" and "critical", and "haven't beaten *(myself)* up". One participant described how they now "feel a tiny bit freer from the self-disgust and shame" and another reflected how whilst they cannot "immediately go down the positive path…*(I)* can stop being so critical of myself". Participants reflected on a different way of relating to themselves through becoming more "compassionate", "patient", "kinder", "forgiving", and taking a "softer approach to thoughts" alongside a realisation that they are worthy of "taking the time to feel good" and prioritising self-care as they recognised their "value". Some described how they could extend self-compassion to difficult memories ("I suddenly felt so sorry for myself…from that moment…I've…learnt to be kind to myself"). As is a common experience for people who have experienced depression, self-compassion can feel like unfamiliar territory, as one participant describes how they now:

> "feel a lot more compassionate *(to myself)* which I've never felt...never, ever, ever felt that ever…not for one minute have I ever felt like I want to be kind to myself…and I do now".

Participants described their sense of improved relationships with others both in the MBCT group and in a wider context (with family, friends, colleagues). This theme was strongly represented across both timepoints, suggesting that relationships with others was an important aspect of participants' experience of MBCT. Whilst some participants felt reticent about taking part in a group ("something I wasn't looking forward to"; "*(I'm)* not particularly good with groups"), participants described it as a "pleasant", "friendly", enjoyable, "supportive and convivial" experience, with a sense of "peer support". Participants described how listening to others' experiences with depression helped to create a "safe", "shared" experience ("we're in it together"), where participants felt understood, less isolated and "less stigmatised" ("other people are also having the same feelings"; "it's not just me it's happening to"). Once MBCT had finished, some expressed feelings of loss through "missing the weekly meetings", having valued "the practice atmosphere…and practicing with others".

Particularly during follow-up, participants described feeling better able to relate to others in a "healthier" way, expressing "joy" in spending time with family and friends. Some reflected on how they were able to distance themselves from others' reactions ("can't control others' reactions") recognising that there may be different explanations, breaking down a sense of "me versus them" ("it doesn't feel like (*I'm*) being permanently singled out and bombarded with things going wrong”). Some described feeling content and relieved that they felt “much more communicative” with others and that others now related differently to them (“everyone seems to smile at me now…I think it’s because I’m smiling!”), fostering a greater appreciation of relationships with others. One participant commented on how they now felt able to “seek help from other people quicker” as the stigma and sense of isolation from others had lessened. Finally, many participants described the joy in noticing changes in other participants and expressed hope that others might benefit similarly from MBCT (“it was good to see other people benefitting”).

Overarching Theme Two: Ongoing Process

This overarching theme captured participants’ conflict around avoidance versus engagement patterns, as well as their recognition of the immediacy of change and their investment in mindfulness practices. As depicted in **Figure 2.1**, this theme also encompassed many of the changes in the overarching “reconnection” theme whereby participants were on different trajectories of change, acknowledging that MBCT allowed for a gradual change to what are often lifelong patterns of relating to experience, self, and others (“it feels like it’s just the beginning”).

Avoidance versus engagement. Prior to MBCT, participants described tendencies to avoid difficult thoughts or emotions (“easier to…push them down and not actually deal with them”). Following MBCT, there remained a consistent conflict between the desire or inclination to avoid versus engage, particularly in mindfulness practices and MBCT itself. Specifically, many participants reported obstacles around time (e.g., “physical time constraints” against participation, “struggle to form new habits”), logistics (e.g., other commitments, “lack of suitable space to practice”), and psychological barriers (“if I was having a stressful day, I’d avoid it”, impacts of guilt, low mood, or anxiety). Participants described difficulties being with others in the group ("general awkwardness"), but a large proportion of the conflict appeared in reflections around the sitting with difficulty practice. For some, this practice enabled a safe space to explore difficult emotions which they may otherwise have ignored or attempted to suppress ("I feel a lot more comfortable facing and thinking about my more uncomfortable feelings"). Some reflected on how sitting with their difficulty meant that they felt lighter around feelings of "guilt and self-blame" and their impact (felt "able to release them") and noted a less painful connection with their experience: "in the moment I burst into tears because it was an extremely painful memory. But by the end of it (*practice*), it felt more distant and it didn't feel like it had such a hold on me". However, for some self-worth was an inhibiting factor contributing to the avoidance ("I practise less than I hoped…because I purposely do little self-care…linked to my negative self-worth"). Others commented on how they "would like to do sitting with difficulty more often" but at the same time felt worried or fearful of what might arise ("worried to confront feelings of inadequacy").

Whilst reflections around the conflict between avoidance and engagement continued during follow-up, fewer of the reflections focused on the "sitting with difficulty" practice specifically and centred more around the impacts of time, other commitments, motivation, or lack of habit. Some participants commented on the lack of group support and how engaging in practices which were more likely to elicit difficult thoughts and feelings felt much harder without the group support. Despite the difficulties expressed, some participants acknowledged the value of these practices:

> "if you're feeling anxious or miserable…it (*sitting with difficulty*) can intensify those feelings so…I didn't want to engage in them like the body scan. Although, I realise that I see it as a way of building tolerance to that feeling".

Investment. Some participants described MBCT as “life-changing” and the beginning of a “long-term investment” in mindfulness practice and principles, acknowledging the need for ongoing commitment to practice, and the “space” and “discipline” needed to facilitate this. Some participants acknowledged that change was not immediate, but gradual and required trust in the process. One participant described the changes as “I feel happy that I'm a work in progress and not perfect”, recognising that “the journey is still ongoing, but it has started”. Participants also acknowledged that these changes were not easy (“still feels like I’m learning it”) and continued to feel unfamiliar at times, particularly considering the long histories participants had with depression (“not spending my life beating myself up is a very new way of living”). Participants reflected on the non-linear trajectory whereby if the habit of mindfulness practice is disrupted, “it’s something you can just step back into”.

During follow-up, participants expressed their intentions to continue practicing mindfulness although some decided to continue more with informal practices (“I try to incorporate very informal mindfulness practices when I can”) or to use mindfulness practices reactively when feeling low or stressed (if “something was bothering me I feel like that might help me to regain a bit of calm”). However, for a few participants, taking part helped them to make informed decisions that mindfulness practice was not for them: “I made a conscious decision that any kind of formal practice wasn't for me”.

Discussion

Using reflexive thematic analysis, we aimed to explore the experiences of participants with recurrent depression post-MBCT and during a 12-month follow-up period. Across timepoints, we described two overarching themes comprising a number of interconnected themes. Our findings suggest that MBCT enables an ongoing process for reconnection with experience, through increased awareness of experience (e.g., present moment, thoughts, emotions, sensations, depression) and a changing relationship with experience (e.g., through reduced reactivity and shifts from passive to active relationships around control, choice, and acceptance). Participants described a process of reconnection with aspects of their sense of self and others which were previously lost through depression. Reconnection with experience was part of a gradual and long-term ongoing process of change incorporating an understanding of the investment needed for mindfulness practice and tendencies to be in conflict around avoiding or engaging with experience, particularly with the ability to stay with the difficult aspects of experiences.

Overall, our findings fit with those from other qualitative investigations of MBCT (Tickell et al., 2020; Williams et al., 2018; Chesin et al., 2018; Murphy & Lahtinen, 2015; Lilja et al., 2015; Cairns & Murray, 2015; Wyatt et al., 2014; Malpass et al., 2012). Interestingly, our findings fit most similarly with the "relating mindfully" model proposed by Bihari and Mullan (2014). In their model, the authors described similar changes but with a stronger emphasis on the impact of intrapersonal change on interpersonal change. However, our study adds to and expands on previous research by directly positioning our findings in terms of the reconnection with experience, as well as relationships with the self and others, alongside the recognition of an ongoing, long-term process of change. Further, in contrast to previous studies, our findings were taken from both the immediate post-MBCT stage and during a 12-month follow-up allowing for a more comprehensive exploration of changes. Interestingly, however, our findings suggest that the core themes were similar across timepoints. For some specific experiences, the intensities sometimes varied as, for example, there were fewer comments around the "sitting with difficulty" practice during follow-up, which may suggest that participants practiced this less or felt less connected with it once they were no longer in the MBCT group environment. Finally, this research was conducted in a research centre with no links to any major MBCT research or teacher training centre.

In our first overarching theme of reconnection, participants described becoming more aware, shifting away from a passive, reactive, disconnected and isolated relationship with experience, self, and others. Becoming more aware of experience may have allowed for disengaging or decentring from difficult or ruminative thoughts, emotions, and sensations (Farb et al., 2018; van der Velden et al., 2015; Siegel et al., 2009), in line with the aims of MBCT (Segal et al., 2013; Crane, 2009; Barnhofer & Crane, 2009). Further, the change towards a less reactive, more accepting relationship with experience and an understanding of “suffering” may have enabled participants to decentre from a self-critical, isolating standpoint with a realisation that “suffering” is a fundamental part of being human (Teasdale & Chaskalson, 2011). Our findings suggested shifts towards a more compassionate attitude towards the self as well as discovering more joyful, communicative, open, and less stigmatised relationships with others. These changes fit with the aims of MBCT (Segal et al., 2013; Kuyken et al., 2010) as well as psychotherapy more broadly in terms of groups fostering change more broadly in interpersonal relationships (Yalom, 1995). Finally, our findings are particularly important to individuals with long histories of depression whereby links between thoughts, emotions, and body sensations may have become strengthened through each episode of depression, with the subsequent re-experiencing of these more easily triggering depression (Barnhofer & Crane, 2009; Teasdale, 1999). Given that depression often encompasses lifelong accounts of loss, disconnection, and isolation from experience, sense of self, and others (Saris et al., 2017; Renner et al., 2012; Morgan, 2005), our findings suggest that a key therapeutic process of MBCT may be through encouraging a shift towards reconnection with experience in a realistic way through recognising the ongoing process.

It is not unusual to experience some difficulty or uncertainty in mindfulness practice (Moss et al., 2008), especially as it embraces learning to face all experience (positive, negative, or neutral). Indeed, Kabat-Zinn (1990) emphasised the importance of exposure to all emotions in order to achieve the benefits of mindfulness. Our theme of avoidance versus engagement may tie in with ongoing experiential avoidance linked with depression (Tull et al., 2004), whereby difficult thoughts, emotions, and body sensations may be too difficult to be in touch with and are therefore avoided (Barnhofer et al., 2014; Crane, 2009; Aldao et al., 2010; Hayes et al., 2004). One of the core foundations of MBCT involves the acknowledgement of experiential avoidance and the developing of skills to turn towards experience (Segal et al., 2013; Crane, 2009).

Although participants were able to turn towards experience, our findings highlighted an ongoing conflict between avoidance and engagement, as engagement in mindfulness practice was not easy with participants acknowledging the ongoing, long-term process. This is especially important in light of the relapsing nature of recurrent depression and, indeed, the fact that nearly 30 percent of our sample experienced at least one relapse during follow-up. Participants described the realisation that some lifelong patterns (e.g., rumination, self-criticism) were not resolved or “fixed” but with new ways of relating to these, participants spoke to allowing for trust in an ongoing process (Harris, 2014). Other qualitative explorations of MBCT for participants with depression have reported that change varied between participants and was not a case of simply more or less change, but was variable and focused on individual trajectories of change (Bihari & Mullan, 2014; Allen et al., 2009; Ma, 2002). Finally, it should be noted that for some participants in our study, engaging in mindfulness practices felt too intense. Whilst there is an emerging evidence-base regarding the potential for adverse effects of mindfulness (Baer et al., 2020; van Gordon et al., 2017; Farias & Wikholm, 2016), much still remains unknown and it is worth acknowledging that not all difficulties arising from a mindfulness practice can or should be tolerated.

Limitations

Participants took part in a non-randomised preference-choice trial, therefore, participants were interested in and chose to take part in MBCT and so the sample may be distinct in some ways if compared to those who chose not to take part in MBCT. Additionally, this may have impacted participants' responses as they may have felt more hopeful for positive experiences from MBCT. The different data collection methods may have impacted on what participants felt able to comment on (either in a face-to-face interview or a written document), particularly given that the lead researcher also co-led the MBCT groups. As the lead researcher took the lead in coding, generating, and refining themes, interpretations were inevitably drawn in line with the researcher's expectations, knowledge of, and interest in MBCT, and potentially influenced by the key research themes of self-compassion and rumination in the main trial (Williams, 2018). Regular discussions and reflections with the research team helped to mitigate this, particularly as the two supervisors of this analysis were not involved in the original trial nor trained in MBCT.

Further, it should be noted that the research team and the majority of participants were white and predominantly middle-class thus limiting the transferability of the experiences of our sample. Therefore, it is difficult to know whether people of other ethnicities and demographics would feel safe enough to participate in MBCT or whether they would feel heard in terms of their individual and collective experiences, particularly with regards to racial trauma and inequality (Ahsan, 2020). Future studies might benefit from longer follow-ups to explore whether themes continue beyond twelve months. In light of our findings around avoidance and engagement, it would be beneficial to understand the reasons for drop out post-MBCT for which there may be a number of reasons including the lack of ongoing group support but potentially also due to not wanting to let others down, finding the group aspect more supportive than mindfulness, or dropping out when it felt "easier" to do so.

Clinical Implications

Our findings have direct clinical implications in terms of encouraging MBCT facilitators to recognise themes of reconnection in light of experiences of depression, possibly through increased emphasis on psychoeducation and reflection around depression experiences during MBCT. Further, our findings highlight the importance of acknowledging a steady, long-term process of change and the conflict participants might experience whilst learning and engaging in mindfulness-based practices. Despite the focus in MBCT on developing awareness of body sensations (Segal et al., 2013), this was not as prevalent as other themes in our data (e.g., thought awareness). This may reflect how prevalent experiential avoidance of difficult emotions and sensations is in depression (Hayes et al., 1996), even during remission (Barnhofer et al., 2014). Our limited findings regarding body awareness suggest that there may be a need for more emphasis on developing body awareness in MBCT for depression, especially given that experiential avoidance and cognitive processes are key factors in the risk of relapse (Spinhoven et al., 2016). Overall, our findings suggest that MBCT allows for an ongoing process of moving towards deliberate reconnection with experience through increased awareness, a changing relationship with experience, self, and others, alongside an understanding of the ongoing process of change. Our finding that participants were at different trajectories in their mindfulness learning may suggest that MBCT facilitators could offer additional opportunities for engagement in MBCT through ongoing practice days, reunion sessions, or follow-up mindfulness-based groups (e.g., Mindfulness-based Compassionate Living; Bartels-Velthuis et al., 2016).

References

Ahsan, S. (2020). Holding up the mirror: Deconstructing whiteness in clinical psychology. *The Journal of Critical Psychology, Counselling and Psychotherapy, 20(3),* 45–55.

Aldao, A., Nolen-Hoeksema, S., & Schweizer, S. (2010). Emotion-regulation strategies across psychopathology: A meta-analytic review. *Clinical Psychology Review, 30(2),* 217–237. https://doi.org/10.1016/j.cpr.2009.11.004

Allen, M., Bromley, A., Kuyken, W., & Sonnenberg, S. J. (2009). Participants' experiences of mindfulness-based cognitive therapy: It changed me in just about every way possible. *Behavioural and Cognitive Psychotherapy, 37(4),* 413–430. https://doi.org/10.1017/S135246580999004X

Baer, R., Crane, C., Montero-Marin, J., Phillips, A., Taylor, L., Tickell, A., Kuyken, W., & The MYRIAD Team. (2020). Frequency of self-reported unpleasant events and harm in a mindfulness-based program in two general population samples. Mindfulness, 12, 763 - 774 https://doi.org/10.1007/s12671-020-01547-8

Barnhofer, T. & Crane, C. (2009). Mindfulness-based cognitive therapy for depression and suicidality. In F. Didonna (Ed.), *Clinical Handbook of Mindfulness* (pp. 221 – 243). Springer.

Barnhofer, T., Brennan, K., Crane, C., Duggan, D., & Williams, J. M. G. (2014). A comparison of vulnerability factors in patients with persistent and remitting lifetime symptom course of depression. *Journal of Affective Disorders, 152–154(1),* 155–161. https://doi.org/10.1016/j.jad.2013.09.001

Bartels-Velthuis, A. A., Schroevers, M. J., van der Ploeg, K., Koster, F., Fleer, J., & van den Brink, E. (2016). A mindfulness-based compassionate living training in a heterogeneous sample of psychiatric outpatients: a feasibility study. *Mindfulness, 7(4),* 809–818. https://doi.org/10.1007/s12671-016-0518-8

Bihari, J. L. N., & Mullan, E. G. (2014). Relating mindfully: A qualitative exploration of changes in relationships through mindfulness-based cognitive therapy. *Mindfulness, 5(1),* 46–59. https://doi.org/10.1007/s12671-012-0146-x

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3(2)*, 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V. & Clarke, V. (2013). *Successful qualitative research. A practical guide for beginners* (1st ed.). Sage UK

Braun, V., & Clarke, V. (2020). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, 1–25. https://doi.org/10.1080/14780887.2020.1769238

Braun, V., & Clarke, V. (2021). Thematic analysis. In E. Lyons & A. Cole (Eds.). *Analysing qualitative data in psychology* (128-147). Sage.

Cairns, V., & Murray, C. (2015). How do the features of mindfulness-based cognitive therapy contribute to positive therapeutic change? A meta-synthesis of qualitative studies. *Behavioural and Cognitive Psychotherapy*, *43(3)*, 342–359. https://doi.org/10.1017/S1352465813000945

Chesin, M. S., Brodsky, B. S., Beeler, B., Benjamin-Phillips, C. A., Taghavi, I., & Stanley, B. (2018). Perceptions of adjunctive mindfulness-based cognitive therapy to prevent suicidal behavior among high suicide-risk outpatient participants. *Crisis*, *39(6)*, 451–460. https://doi.org/10.1027/0227-5910/a000519

Crane, R. S. (2009). *Mindfulness-based Cognitive Therapy: Distinctive Features (CBT)* (1st Ed.) Routledge

Crane, R. S. (2011). The UK good practice guidelines for mindfulness-based teachers. Retrieved 06/02/2021, from https://bamba.org.uk/wp-content/uploads/2019/06/UK-MB-teacher-GPG-2015-final-2.pdf

Farb, N., Anderson, A., Ravindran, A., Hawley, L., Irving, J., Mancuso, E., Gulamani, T., Williams, G., Ferguson, A., & Segal, Z. V. (2018). Prevention of relapse/recurrence in major depressive disorder with either mindfulness-based cognitive therapy or cognitive therapy. *Journal of Consulting and Clinical Psychology, 86(2),* 200–204. https://doi.org/10.1037/ccp0000266

Farias, Miguel, & Wikholm, C. (2016). Has the science of mindfulness lost its mind? *BJPsych Bulletin, 40(6),* 329–332. https://doi.org/10.1192/pb.bp.116.053686

Harris, S. (2014). *Waking up: a guide to spirituality without religion.* Simon & Schuster

Hayes, S. C. (2004). Acceptance and commitment therapy, relational frame theory, and the third wave of behavioral and cognitive therapies. *Behavior Therapy, 35(4),* 639–665. https://doi.org/10.1016/S0005-7894(04)80013-3

Hayes, S. C., Wilson, K. G., Gifford, E. V., Follette, V. M., & Strosahl, K. (1996). Experiential avoidance and behavioral disorders: A functional dimensional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology, 64(6),* 1152–1168. https://doi.org/10.1037/0022-006X.64.6.1152

Kabat-Zinn, J. (1990). *Full Catastrophe Living: How to cope with stress, pain and illness using mindfulness meditation*. Penguin Random House Ltd.

Kuyken, W., Warren, F. C., Taylor, R. S., Whalley, B., Crane, C., Bondolfi, G., Hayes, R., Huijbers, M., Ma, H., Schweizer, S., Segal, Z., Speckens, A., Teasdale, J. D., Van Heeringen, K., Williams, M., Byford, S., Byng, R., & Dalgleish, T. (2016). Efficacy of mindfulness-based cognitive therapy in prevention of depressive relapse: An individual patient data meta-analysis from randomized trials. *JAMA Psychiatry, 73(6),* 565-574. https://doi.org/10.1001/jamapsychiatry.2016.0076

Kuyken, W., Watkins, E., Holden, E., White, K., Taylor, R. S., Byford, S., Evans, A., Radford, S., Teasdale, J. D., & Dalgleish, T. (2010). How does mindfulness-based cognitive therapy work? *Behaviour Research and Therapy, 48(11),* 1105–1112. https://doi.org/10.1016/j.brat.2010.08.003

Lilja, J. L., Broberg, M., Norlander, T., & Broberg, A. G. (2015). Mindfulness-based cognitive therapy: primary care patients' experiences of outcomes in everyday life and relapse prevention. *Psychology, 06(04),* 464–477. https://doi.org/10.4236/psych.2015.64044

Ma, S. H. (2002). *Prevention of relapse/recurrence in recurrent major depression by mindfulness-based cognitive therapy.* [PhD Thesis, The University of Cambridge]. Sent via personal communication

Malpass, A., Carel, H., Ridd, M., Shaw, A., Kessler, D., Sharp, D., Bowden, M., & Wallond, J. (2012). Transforming the perceptual situation: A meta-ethnography of qualitative work reporting patients' experiences of mindfulness-based approaches. *Mindfulness, 3(1),* 60–75. https://doi.org/10.1007/s12671-011-0081-2

McCartney, M., Nevitt, S., Lloyd, A., Hill, R., White, R., & Duarte, R. (2021). Mindfulness-based cognitive therapy for prevention and time to depressive relapse: Systematic review and network meta-analysis. *Acta Psychiatrica Scandinavica, 143(1),* 6–21. https://doi.org/10.1111/acps.13242

Montgomery, S. A., & Asberg, M. (1979). A new depression scale designed to be sensitive to change. *British Journal of Psychiatry, 134(9),* 382-389.

Morgan, S. P. (2005). Depression. In C. K. Germer, R. D. Siegel, P. R. Fulton (Eds.) *Mindfulness and Psychotherapy* (pp 130-151). Guilford Press

Moss, D., Waugh, M., & Barnes, R. (2008). A tool for life? Mindfulness as self-help or safe uncertainty. *International Journal of Qualitative Studies on Health and Well-Being, 3(3),* 132–142. https://doi.org/10.1080/17482620801939592

Murphy, H., & Lahtinen, M. (2015). 'To me, it's like a little box of tricks': Breaking the depressive interlock as a programme participant in mindfulness-based cognitive therapy. *Psychology and Psychotherapy: Theory, Research and Practice, 88(2),* 210–226. https://doi.org/10.1111/papt.12041

QSR International. (1999). *NVivo Qualitative Data Analysis Software* (Version 12) [Software]. QSR International. Available from https://qsrinternational.com/nvivo/nvivo-products/

Renner, F., Jarrett, R. B., Vittengl, J. R., Barrett, M. S., Clark, L. A., & Thase, M. E. (2012). Interpersonal problems as predictors of therapeutic alliance and symptom improvement in cognitive therapy for depression. *Journal of Affective Disorders*, *138(3),* 458–467. https://doi.org/10.1016/j.jad.2011.12.044

Saris, I. M. J., Aghajani, M., van der Werff, S. J. A., van der Wee, N. J. A., & Penninx, B. W. J. H. (2017). Social functioning in patients with depressive and anxiety disorders. *Acta Psychiatrica Scandinavica*, *136(4),* 352–361. https://doi.org/10.1111/acps.12774

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2013). *Mindfulness-based Cognitive Therapy for Depression*. Guildford Press

Sheehan, D. V, Lecrubier, Y., Sheehan, K. H., Amorim, P., Janavs, J., Weiller, E., Hergueta, T., Baker, R., & Dunbar, G. C. (1998). The mini-international neuropsychiatric interview (M.I.N.I.): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *The Journal of Clinical Psychiatry*, *59 Suppl 20*, 22-33. http://www.ncbi.nlm.nih.gov/pubmed/9881538

Siegel, R. D. (2009). *The mindfulness solution. Everyday practices for everyday problems.* Guilford Press

Smith, A., Graham, L., & Senthinathan, S. (2007). Mindfulness-based cognitive therapy for recurring depression in older people: A qualitative study. *Aging and Mental Health*, *11(3),* 346–357. https://doi.org/10.1080/13607860601086256

Spinhoven, P., Drost, J., de Rooij, M., van Hemert, A. M., & Penninx, B. W. J. H. (2016). Is experiential avoidance a mediating, moderating, independent, overlapping, or proxy risk factor in the onset, relapse and maintenance of depressive disorders? *Cognitive Therapy and Research*, *40(2),* 150–163. https://doi.org/10.1007/s10608-015-9747-8

Teasdale, J. D. (1999). Metacognition, mindfulness and the modification of mood disorders. *Clinical Psychology & Psychotherapy*, *6(2),* 146–155. https://doi.org/10.1002/(SICI)1099-0879(199905)6:2<146::AID-CPP195>3.0.CO;2-E

Teasdale, J. D., & Chaskalson (Kulananda), M. (2011). How does mindfulness transform suffering? I: the nature and origins of dukkha. *Contemporary Buddhism*, *12(1),* 89–102. https://doi.org/10.1080/14639947.2011.564824

Tickell, A., Byng, R., Crane, C., Gradinger, F., Hayes, R., Robson, J., Cardy, J., Weaver, A., Morant, N., & Kuyken, W. (2020). Recovery from recurrent depression with mindfulness-based cognitive therapy and antidepressants: A qualitative study with illustrative case studies. *BMJ Open*, *10(2)*. https://doi.org/10.1136/bmjopen-2019-033892

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care, 19(6),* 349–357. https://doi.org/10.1093/intqhc/mzm042

Tull, M. T., Gratz, K. L., Salters, K., & Roemer, L. (2004). The role of experiential avoidance in posttraumatic stress symptoms and symptoms of depression, anxiety, and somatization. *Journal of Nervous and Mental Disease*, *192(11),* 754–761. https://doi.org/10.1097/01.nmd.0000144694.30121.89

van der Velden, A. M., Kuyken, W., Wattar, U., Crane, C., Pallesen, K. J., Dahlgaard, J., Fjorback, L. O., & Piet, J. (2015). A systematic review of mechanisms of change in mindfulness-based cognitive therapy in the treatment of recurrent major depressive disorder. *Clinical Psychology Review, 37,* 26–39. https://doi.org/10.1016/j.cpr.2015.02.001

van Gordon, W., Shonin, E., & Garcia-Campayo, (2017). Are there adverse effects associated with mindfulness? *Australian and New Zealand Journal of Psychiatry, 51(10)*, 977 - 979. DOI: 10.1177/0004867417716309

Williams, C. M., Meeten, F., & Whiting, S. (2018). 'I had a sort of epiphany!' An exploratory study of group mindfulness-based cognitive therapy for older people with depression. *Aging and Mental Health, 22(2),* 208–217. https://doi.org/10.1080/13607863.2016.1247415

Williams, K. (2018). *Neuropsychological mechanisms of Mindfulness-based Cognitive Therapy for Depression.* [PhD Thesis, The University of Manchester]. The British Library. https://ethos.bl.uk/OrderDetails.do?uin=uk.bl.ethos.748014

Williams, K., Elliott, R., Barnhofer, T., Zahn, R., & Anderson, I. M. (2020). Positive shifts in emotion evaluation following mindfulness-based cognitive therapy (MBCT) in remitted depressed participants. *Mindfulness, 12,* 623-635. https://doi.org/10.1007/s12671-020-01521-4

Wyatt, C., Harper, B., & Weatherhead, S. (2014). The experience of group mindfulness-based interventions for individuals with mental health difficulties: A meta-synthesis. *Psychotherapy Research*, *24(2),* 214–228. https://doi.org/10.1080/10503307.2013.864788

Yalom, I. D. (1995). *The theory and practice of group psychotherapy* (4th ed.). Basic Books.

Paper Three

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A Delphi study investigating clinicians' views on access to, delivery of, and adaptations of MBCT in clinical settings

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Abstract

Objectives. Mindfulness-based Cognitive Therapy (MBCT) is a well-evidenced relapse-prevention intervention for depression with a growing evidence-base for use in other clinical populations. UK initiatives have outlined plans for increasing access to MBCT in clinical settings, although evidence suggests that access remains limited. Given the increased popularity and access to MBCT, there may be deviations from the evidence-base and potential risks of harm. We aimed to understand what clinicians believe should be best clinical practice regarding access to, delivery of, and adaptations to MBCT.

Methods. We employed a two-stage Delphi methodology. First, to develop statements around best practice we consulted with five mindfulness-based experts and reviewed the literature. Second, a total of 59 statements were taken forward into three survey rating rounds.

Results. Twenty-nine clinicians completed round one, with 25 subsequently completing both rounds two and three. Forty-four statements reached consensus; 15 statements did not. Clinicians agreed with statements regarding sufficient preparation for accessing MBCT, adherence to the evidence-base and good practice guidelines, consideration of risks, sufficient access to training, support, and resources within services, and carefully considered adaptations. Consensus was not reached on statements which reflected a lack of evidence-base for specific clinical populations or the complex decision-making processes involved in delivering and making adaptations to MBCT.

Conclusions. Our findings highlight the delicate balance of maintaining a client-centred and transparent approach whilst adhering to the evidence-base in clinical decisions around access to, delivery of, and adaptations in MBCT. Our findings have implications at clinical, research, service, and policy levels.

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Introduction

Mindfulness-based Cognitive Therapy (MBCT) aims to teach new ways of relating to inner experience (e.g., thoughts, emotions, sensations) through mindfulness-based meditation alongside psychoeducation around depression and negative thinking styles (Segal et al., 2013). MBCT is a NICE-recommended (National Institute for Health and Care Excellence; 2017) intervention for people who have experienced at least two previous ‘episodes’ of major depression (Kuyken et al., 2016; Segal et al., 2013). MBCT has been shown to reduce the risk of relapse up to 60 weeks post-MBCT, compared with treatment as usual (TAU), in a meta-analysis of nine Randomised Controlled Trials (RCTs; Kuyken et al., 2016). Since its initial development, MBCT has been adapted for use in a range of clinical populations including people with a diagnosis of current depression (Goldberg et al., 2019), bipolar disorder (Lovas & Schuman-Olivier, 2018), social anxiety (Strege et al., 2018), and post-traumatic stress disorder (PTSD; Boyd et al., 2018). Further, another meta-analysis reported that across 14 RCTs including 2077 participants, MBCT was more effective than TAU in preventing relapse, although this also included participants with remitted, current, and bipolar depression (McCartney et al., 2021).

Following recommendations from the Mindful Nation report (Mindfulness All Party Parliamentary Group; 2015), there has been a recent push to increase the delivery of MBCT in the UK through the Improving Access to Psychological Therapy (IAPT) programme which is primarily designed to provide treatment for those with depression and/or anxiety. However, evidence suggests that MBCT is not being accessed in line with either NICE guidance or MBCT implementation guidelines (Kuyken et al., 2012) across the NHS. Specifically, Crane and Kuyken (2013) reported that 59% of services offered no MBCT provision with only 9% reporting a “thriving” MBCT service. More recently, Rycroft-Malone et al. (2019; 2017) reported that only 4/40 services were delivering MBCT in accordance with NICE guidelines.

The authors reported that access to MBCT in the NHS remains limited, with reports of services deviating from evidence-based MBCT through developing an adapted hybrid of MBCT to accommodate service restrictions (Rycroft-Malone et al., 2019; 2017).

MBCT, alongside other mindfulness-based interventions (MBIs), has become increasingly popular in the UK and internationally (Morone et al., 2017), reflected in the wide range of available courses, self-help books, and mindfulness app availability (e.g., Headspace; Puddicombe, 2010), as well as freely available, yet often unmonitored, online materials. Further, there is increased conviction in and assumptions that MBCT, and related MBIs, may function as a “panacea” with MBCT professionals advocating for a cautious approach towards implementation, incorporating an awareness of the limitations and unknowns alongside the benefits of MBCT (van Dam et al., 2018; Farias & Wikholm, 2016). With increased popularity comes the danger that delivery of MBCT may deviate from the evidence-base, particularly in clinical services often limited by funding and resource restrictions.

As above, due to busy and overstretched services, services may make adaptations to MBCT. The UK network for mindfulness-based teachers’ good practice guidelines (GPG; Crane et al., 2011) highlight the importance of adhering to the evidence-base when teaching MBCT. Additionally, both Crane et al. (2016) and Dimidjian and Segal (2015) reflected on how minor adaptations in terms of client group or context may be needed, but exercise caution that adaptations should stay in line with the theoretical underpinnings of and evidence-base for MBCT. Ultimately, adaptations made to MBCT, without consideration of the underlying evidence-base, may risk going against guidelines and/or the evidence-base.

Not delivering MBCT in line with MBCT guidelines may increase the risk of exposing clients to potential harm (Britton, 2019). Studies have suggested that engaging in meditation can, in some participants, induce disturbances in perception (e.g., hallucinations), affective (e.g., paranoia), somatic (e.g., sleep), and behavioural states (e.g., anhedonia), as well as a loss in the sense of self and social impairment (Lindahl et al., 2017). Others have proposed that such harm arises more from participants taking part in intense meditative activities (e.g., silent retreats) as opposed to comparatively shorter, less intense practices typically found within MBCT (Baer et al., 2019). However, there are reports of negative effects resulting from shorter practices, similar to those taught within MBCT (Lindahl et al., 2017).

Given the evidence regarding limited access to yet increasing popularity of and delivery of MBCT, adaptations which may deviate from the evidence-base, and the potential for harm, we aimed to assess the views of those delivering MBCT in clinical settings with respect to best practice for MBCT. We anticipated that the results of this study would further extend our understanding around what constitutes best clinical practice, amongst the expert clinicians actually delivering MBCT. To our knowledge, there are no existing studies which have explored expert consensus around best practice within MBCT. Therefore, using a Delphi methodology, we aimed to develop consensus amongst clinicians' views with regards to sufficient access to, delivery of (with consideration of client population, risks, adherence to good practice guidelines, teacher training and personal meditation practice, service support, and sufficient resources), and adaptations to MBCT.

Method

Design

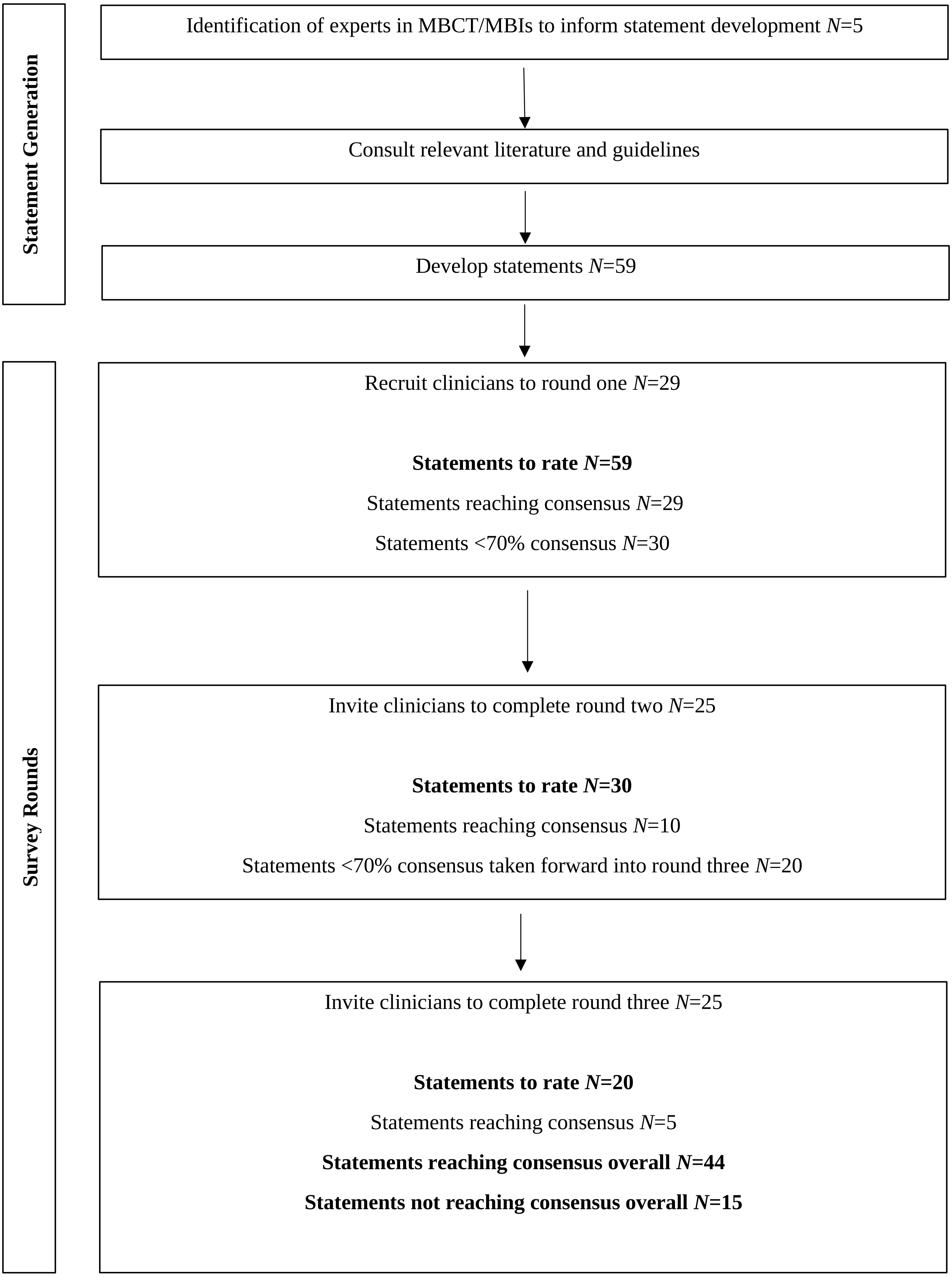
This study used a Delphi approach, defined as an iterative process which is designed to move group opinion towards a group consensus (de Meyrick, 2003; Graham & Milne, 2003; Hasson et al., 2000). This Delphi study was adapted to incorporate two stages. Stage one invited consultation with “experts” in either MBCT and/or MBIs to inform the development of the statements. Stage two included an online survey inviting expert clinicians to rate statements across three rounds; online Delphi methods have been shown to be feasible (Khodyakov et al., 2020). **Figure 3.1** below details the Delphi procedure outline. All participants gave informed consent and ethical approval for both stages was given by The Psychology and Mental Health Division Panel, at The University of Manchester (see **Appendix Eight**). Additionally, two external clinicians were consulted and gave positive feedback regarding the design, feasibility and accessibility (**Supplementary Material S3.1**).

Stage One. Statement Generation

Participants. Participants were recruited through social media adverts and emails to specific mindfulness-based organisations, charities, and Universities.

Inclusion and exclusion criteria. Participants had extensive experience (e.g., at least five years and/or had delivered at least five MBCT/MBIs) with self-reported ‘good knowledge’ of delivering MBCT/MBIs in accordance with GPG (Crane et al., 2011). Participants did not need to be currently or have previously worked in the NHS, nor be qualified as a ‘clinical practitioner’ as their expertise was either within MBCT and/or MBIs. A broad criterion around either MBCT or MBIs was adopted to allow for a range of relevant expertise for developing a wide pool of possible statements. Five participants were recruited; all had between 10 and 20+ years of personal mindfulness meditation experience and undertaken recognised mindfulness-based teacher training courses at UK-based Universities.

Figure 3.1. Delphi procedure



Procedure. Following initial email contact, participants were emailed the participant information sheet and asked to sign an online consent form if interested. An audio recorded telephone interview was scheduled, lasting up to 30 minutes, and followed an interview guide with conversation prompts (**Supplementary Material S3.2**). Further information was gathered from additional sources including the evidence-base for MBCT/MBIs, GPG for delivery of MBIs (Crane et al., 2011), and NICE guidelines for depression (2017).

Data Analyses. Audio recordings were transcribed, uploaded into Nvivo 12 (QSR International, 1999) for coding and generation of themes. Themes were combined with the literature review to develop a range of statements. Revisions to the statements were made within the research team and two external, non-mindfulness-based researchers gave feedback on all statements; both researchers found the statements feasible, understandable, and timely to rate. Fifty-nine statements were taken forward into stage two (**Supplementary Material S3.3)**.

Stage Two. Survey Rating Rounds

Participants. Participants were recruited using purposive and snowball sampling methods targeted towards a range of outlets including special interest mindfulness groups and organisations, social media, UK-based Doctorate in Clinical Psychology courses, the Psychological Professions Network, and the University of Manchester announcement service. Turoff and Linstone (1975) recommend between 10 and 50 participants whereas Hasson et al. (2000) suggest 20 participants is sufficient for Delphi studies. We aimed to recruit 24 participants, accounting for potential dropout between rounds (estimated attrition rate between 76-91%, based on Hall et al., 2018).

Inclusion and exclusion criteria. Participants were either qualified or in training as a clinical psychologist, psychiatrist, CBT therapist, psychological wellbeing practitioner, counsellor, psychotherapist, or mental health nurse. Participants were either currently or had recently worked within the NHS, third sector, or private sector (at least within the last 5 years). Participants needed to have delivered either MBCT or a related MBI either to groups or in a one-to-one capacity, within any clinical service.

Design. For each round, statements were compiled into an online survey (Select Survey) hosted by the University of Manchester. Participants rated each statement on a five-point Likert scale, dependent on the type of statement: either a rating of importance (“*1=completely unimportant”, “2=somewhat unimportant”, “3=neither important or unimportant”, “4=somewhat important”, “5=very important”*) or to rate their agreement (*“1=strongly disagree”, “2=disagree”, “3=neither agree nor disagree”, “4=agree”, “5=strongly agree”*). A total of three rounds was chosen to provide a balance between the risk of insufficient data and participant fatigue (Hasson et al., 2000; Green et al., 1999).

Procedure. Once participants made contact, they were emailed the participant information sheet and gave informed consent at the start of the survey. At each round, participants were emailed up to three times (including reminders) with survey links. Demographics regarding age, gender, profession, service, experience with MBCT and mindfulness meditation experience were obtained. Optional comments were invited after each statement. In each of rounds two and three, participants were provided with results from the previous round and were asked to re-rate all of the statements which did not reach consensus of at least 70%. Each round remained open for approximately one month (or until all responses had been gathered), with approximately one additional month in-between rounds.

Analysis. We followed the analysis procedures outlined in Langlands et al. (2008), with slight modifications to the percentage at which consensus was reached (70%), adjusted to reflect a strong majority consensus and varying consensus levels within the literature (50-97% in Diamond et al., 2014; 70% in Veugelers et al., 2020). Full consensus for each statement (100%) was not required (Hsu & Sandford, 2007). The level of consensus was calculated for each statement and statements reaching consensus of at least 70% (across combined rating responses of either 1 and 2, or 4 and 5) were not taken into the next round.

Results

Demographics

Table 3.1 displays the demographics. Briefly, 29 clinicians took part in round one, with a mean age of 45.38 years (*SD=12.21*) and 62.1% identifying as female. Most clinicians were employed as either a CBT Therapist, Clinical Psychologist (qualified or in training), or service lead. The majority were delivering MBCT in the NHS (86.2%) with over 50% delivering MBCT in North-West England. The majority (89.7%) based their answers on their experience of teaching MBCT via groups, 6.9% via one-to-one, and 3.4% via telephone. The majority maintained a personal mindfulness practice (93.1%) with most having either completed or currently in MBCT teacher training (combined 75.8%).

Table 3.1. Baseline demographics

	***N*=29**
Age	M=45.38 *(SD=12.21)*
Gender (% female*)	62.1
Length of time in current service (years)	M=7.46 *(SD=6.04)*
Job title	
CBT Therapist	*N*=7; 24.1%
Clinical Psychologist	*N*=6; 20.7%
Service Lead	*N*=4; 13.8%
Trainee Clinical Psychologist	*N*=3; 10.3%
High Intensity Therapist	*N*=2; 6.9%
Psychological Wellbeing Practitioner	*N*=2; 6.9%
Psychotherapist	*N*=2; 6.9%
Assistant Psychologist	*N*=1; 3.4%
MBCT teacher (*as a sole profession*)	*N*=1; 3.4%
Occupational Therapist	*N*=1; 3.4%

Sector	
NHS	*N*=25; 86.2%
Private	*N*=2; 6.9%
NHS and Private	*N*=1; 3.4%
Charity	*N*=1; 3.4%
Service Location	
North-West England	*N*=15; 51.7%
Yorkshire	*N*=4; 13.8%
North-East England	*N*=3; 10.3%
Wales	*N*=2; 6.9%
Midlands	*N*=2; 6.9%
East/South-East England	*N*=2; 6.9%
Scotland	*N*=1; 3.4%
Teacher Training	
Completed	N=21; 72.4%
Considering training	*N*=4; 13.8%
Not in training	*N*=3; 10.3%
In training	*N*=1; 3.4%
Mindfulness experience	
Personal practice (%)	*N*=27; 93.1%
Length of practice (years)	M=12.67 (*SD=12.57*)

Note. *all participants identified as either female or male

Survey Rounds

Twenty-nine clinicians completed round one, with 25 subsequently completing both of rounds 2 and 3 (14% attrition). A move towards consensus was gradual with 29/59 statements reaching at least 70% consensus in round one, a further 10 statements in round two, and a further five statements in round three; a total of 15/59 statements did not reach consensus. **Tables 3.2 and 3.3** display the results from all rounds, for statements reaching and not reaching consensus, respectively, followed by a narrative description. Of note, for 18 statements which concerned the population that MBCT could be delivered to, we offered a “don’t know” option. This option was rarely used but for completeness, **Supplementary Material S3.4** shows these results.

Table 3.2. Statements with consensus

	Round 1 percentage *N*=29	Round 2 percentage *N*=25	Round 3 percentage *N*=25
Consensus towards "strongly disagree/disagree"			
Delivery-Population			
Clients experiencing symptoms in line with a 'crisis' or acute illness	44.83	72.00	
Adaptations–Course structure			
Delivering MBCT as the full 8 week programme is not feasible in clinical settings	89.29		
It is acceptable to shorten individual sessions/course length to accommodate service needs	65.52	84.00	
Adaptations-Types			
There should be fewer home practice requirements	65.52	76.00	
Consensus towards "strongly agree/agree"			
Preparation and ease of access			
The potential risks and difficulties of MBCT are fully discussed with clients before MBCT starts*	96.43		
MBCT should be more widely available across services	96.43		
A comprehensive assessment with each client should be carried out prior to starting MBCT*	92.86		
MBCT should be accessible across all styles of services	89.29		
Delivery-Population			
Clients…			
…experiencing symptoms in line with anxiety	100		
…who are currently well but who experience recurrent depression	96.55		
…with "long-term physical health conditions" (e.g., cancer)	93.10		
…experiencing symptoms in line with current depression	89.66		
…experiencing symptoms in line with a diagnosis of "borderline personality disorder"	58.62	80.00	
…with histories of trauma	79.31		
…experiencing multiple comorbid difficulties	48.28	64.00	76.00
…who are experiencing a significant life event	55.17	60.00	72.00

MBCT should be adapted to work with people with a history of trauma (e.g., trauma-sensitive mindfulness)	93.10		
With careful adaptations, anybody can take part in it	62.07	80.00	
Delivery-risks			
Negative effects of meditation can occur if the meditation is not guided safely or held wisely by the teacher	89.66		
Negative effects of meditation can occur irrespective of the teacher's delivery and holding of the group	82.76		
It is potentially harmful if MBCT courses do not have an underlying evidence-based foundation	58.62	68.00	76.00
Delivery-GPG			
The Good Practice Guidelines (GPG) for MBCT teachers should be adhered to when delivering MBCT courses	93.10		
It is more important that the teacher has sufficient experience delivering MBCT, than if they are strictly adhering to GPG	44.83	68.00	72.00
Delivery–Teacher training and personal practice			
Before teaching MBCT, teachers should participate in an MBCT or similar mindfulness-based course themselves	96.55		
Staff cannot effectively teach MBCT if they do not have personal experience of mindfulness meditation	96.55		
Teaching MBCT should be based in an experiential understanding whereby teachers are familiar with the language/territory of mindfulness	96.55		
Staff teaching MBCT should have access to initial training courses as part of their job role	96.55		
Staff teaching MBCT should have access to ongoing supervision and training as part of their job role	96.55		
Without sufficient training in delivering MBCT, harm could be done	86.21		
MBCT teacher training is not taken as seriously compared to other therapies	44.83	68.00	76.00
Mindfulness-informed therapy is more accessible than delivering a full MBCT course	55.17	72.00	
Delivery-Services			
MBCT needs to be properly resourced with sufficient numbers of trained teachers	96.55		
MBCT cannot thrive in a service without adequate support from managers/service leads	96.30		
Services need to have a better understanding of MBCT to be able to offer it effectively for clients	93.10		
Delivery-Resources			
Sufficient resources to deliver MBCT should be provided by the service	100.00		
The lack of sufficient funding for MBCT puts clients at risk with MBCT being delivered in a non-evidence based manner	65.52	84.00	
Adaptations–Course structure			
The MBCT curriculum (e.g., duration, content) can be adapted and tailored to the needs of the group/individual	89.66		
It is acceptable to deliver MBCT either in a group or one-to-one format	86.21		
It is acceptable to shorten individual sessions or the course length to accommodate client needs	51.72	80.00	

It is acceptable to teach elements of the MBCT curriculum rather than the full MBCT curriculum	62.07	76.00
Adaptations-Types		
Adaptations should reflect the needs of clients but also be in line with the core philosophy of MBCT	93.10	
Adaptations to MBCT must ensure that they are in line with the underlying evidence base for the population	86.21	
If a full MBCT course cannot be delivered, then adaptations should be as close to the original programme as possible	82.76	
Shorter meditation practices during MBCT may help increase participant engagement	65.52	76.00

Note. *ratings for these items were “completely important/somewhat important”; GPG=Good Practice Guidelines

Table 3.3. Statements without consensus

	Round 1 percentage	Round 2 percentage	Round 3 percentage
	N=29	*N*=25	*N*=25
Consensus towards "strongly disagree/disagree"			
Access-Ease			
MBCT in its standard format is too much of a commitment	50.00	48.00	60.00
MBCT should be accessible for all clients who want to take part in it, irrespective of difficulties or service context	35.71	44.00	56.00
MBCT carries a stigma; clients and/or services may perceive it as "airy fairy"/lacking credibility	46.43	64.00	56.00
Delivery-Population			
Anybody who wants to take part in it	34.48	44.00	52.00
Clients experiencing dissociative symptoms/dissociation	37.93	52.00	52.00
Delivery–risks			
MBCT should be delivered to clients only when there is a sound, underlying theoretical rationale for doing so	31.03	28.00	48.00
Consensus towards "strongly agree/agree"			
Delivery-Population			
Clients…			
…experiencing symptoms in line with an eating disorder	48.28	48.00	64.00
…with current suicidal ideation	55.17	52.00	64.00
…experiencing symptoms in line with a bipolar diagnosis	58.62	68.00	64.00
…experiencing symptoms in line with psychosis	41.38	44.00	52.00
…with difficulties with alcohol or substance use/dependence	55.17	44.00	48.00
Delivery–Population risks			
The potential risks or side effects of MBCT are often understated	37.93	48.00	60.00
Delivery-Services			
Staff are teaching MBCT without sufficient training because of service restrictions	51.72	48.00	56.00
Services who cannot properly fund MBCT should not offer it at all	27.59	24.00	24.00
Adaptations-Types			
Practices could be graded by intensity (less intense practices could be offered first)	62.07	64.00	60.00

Note. **Supplementary Material S3.5** includes individual statement ratings to show the spread of responses

Access

Four of seven statements reached consensus in round one. Specifically, clinicians agreed with statements around preparation and ease of access to MBCT agreeing with the importance of providing clients with a thorough assessment, comprehensive discussions of the risks, difficulties, and expectations prior to MBCT, and ensuring that MBCT is accessible across a range of services. Three statements did not reach consensus and concerned the accessibility of MBCT for all clients, the level of commitment required, and whether MBCT holds a stigma or lacks credibility. Although not reaching consensus, these three statements were rated towards a direction of disagreement. Firstly, clinicians reflected on the importance of delivering MBCT to clients for whom there is an evidence-base ("it should be offered if there is an evidence base for it being helpful"), as well as a consideration of individual needs and "suitability of the client" before offering MBCT. Secondly, reflections on the commitment required generated different views from highlighting the individual client variation ("for some people it is (*too long*), for others it is too little"), population ("it depends on the client group"), and an acknowledgement that although MBCT can seem like a big commitment, the evidence-base suggests that optimum benefit comes from attendance, engagement, and practice. Thirdly, with regards to stigma and/or a potential lack of credibility around MBCT, some clinicians wondered whether education around the misconceptions of MBCT would help ("MBCT is well researched and has a good evidence-base…ensuring that clients are aware of this might reduce such beliefs"). Some wondered whether MBCT attracts teachers from particular backgrounds which may add to cultural divides ("MBCT attracts a lot of white middle-class individuals"), whilst others were unaware of any stigma or lack of credibility.

Delivery

Population. Eleven of eighteen statements reached consensus. Clinicians agreed that MBCT could be delivered to people with either recurrent or current depression, anxiety, comorbidities, histories of trauma, and long-term physical health conditions. For some populations, consensus took longer to reach and this was reflected in the comments by an uncertainty around the lack of evidence for that specific condition (e.g., people with diagnoses of "Borderline Personality Disorder"), that adaptations may be necessary to account for risk, safety, and timing of MBCT (e.g., MBCT could be too "heavy"), and consideration of trauma-sensitive adaptations (e.g., for clients experiencing significant life events or in acute crisis).

Seven statements did not reach consensus. These statements included considerations of whether anybody can take part, and specific population "groups" including clients experiencing dissociation/dissociative symptoms, current suicidal ideation, diagnoses of bipolar, psychosis, eating disorders, or substance abuse/dependence. Largely, clinicians did not agree in either direction and the comments were replicated across most statements through emphasising a need for careful decision-making regarding the delivery of MBCT. Firstly, clinicians commented on the need to ensure that relevant qualifications or experience with both MBCT and the client group were in place (the "training of (*the*) practitioner needs to be considered"). Secondly, clinicians reflected that they were either unfamiliar or unaware of an evidence-base for that condition; one clinician reflected that any MBCT intervention "if offered in the NHS, needs to be evidence-based". Thirdly, clinicians reflected on the need for person-centred approaches whilst acknowledging the severity of a client's current difficulties, additional support or ongoing therapy, and the need for a thorough formulation, care plan, and risk assessment ("risks and expectations need to be managed").

Risks. Three of five statements reached consensus. One statement related to the potential for harm if MBCT is not taught from its evidence-based foundation. Two statements prompted clinicians to reflect on the "cause" of potential harm, either through the presence of or a lack of teacher guidance or holding of the group. Interestingly, clinicians agreed with both statements suggesting that harm can arise through different routes ("harm doesn't come from theory, it comes from insensitivity" or from the "intentions of the teacher"). Clinicians described giving clients choice and the ability to "opt out" of practices, as well as clarifying expectations around MBCT. Importantly, the potential for harm and distress can be interpreted differently and, of course, can be a natural, expected outcome of meditation ("clients may experience distress in relation to internal experiences"), but clinicians emphasised the importance of the teacher in being able to recognise, support, and manage these risks.

Two statements did not reach consensus. First, clinicians did not reach consensus around whether MBCT should be delivered to clients *only* when there is a sound underlying theoretical rationale. Clinicians commented that a flexible approach to delivery of MBCT may be required ("I agree that we should recognise the research basis…but without being excessively purist"). Second, with regards to whether potential side effects are understated, clinicians rated towards "strongly agree/agree" with reflections that side effects are a risk across all therapies, not just MBCT. Clinicians highlighted the need for more research and in ensuring that everything is invitational.

Good Practice Guidelines (GPG). Two statements reached consensus with agreement that that the GPG should be adhered to, alongside a recognition that it is somewhat rigid to always adhere to the GPG. Clinicians described how both experience with MBCT and adherence to GPG were important and reflected that "there isn't a trade off" and that there should be a “careful balance between the two”. Clinicians commented that through following GPG, MBCT teachers would naturally embody mindfulness-based principles.

Teacher training and personal practice. All eight statements reached a consensus towards agreement. Six statements reached consensus by round one whereby clinicians agreed that to teach MBCT effectively, teachers should have an experiential understanding of mindfulness through personal participation in MBCT/MBI, that access to both training and supervision should be available, and that without sufficient training, there is potential for harm. There was strong agreement towards having an experiential understanding affording teachers a deeper, embodied understanding of MBCT (it is “vital to understand the process from the inside out”). Some clinicians questioned how MBCT can be taught effectively without personal meditation experience (“the base in 'mindfulness-based' comes from within, without it, it isn't teaching”). There was strong consensus around access to training and supervision whereby one clinician commented: “no supervision? No groups!”. The complexities around the potential for harm were acknowledged and whilst one clinician wondered whether teaching MBCT without previous mindfulness experience could “damage the reputation of mindfulness”, another wondered whether harm could be done even with sufficient training.

Two statements gained consensus by later rounds and prompted mixed comments. Whilst clinicians agreed that mindfulness-informed therapy is more accessible, some wondered whether this risks missing key MBCT teachings and “won’t embed the key ideas that repeated practice and teaching will”. Clinicians agreed that MBCT may be taken less seriously than other therapies with some wondering whether mindfulness is “seen as the easy route into professional practice”. Others questioned why MBCT is not offered more widely within training courses (e.g., DClinPsy) and reflected that there may be negative top-down perceptions from service managers who regard MBCT less seriously than other therapies.

Services. Three of five statements reached consensus. These statements reached consensus in round one and clinicians agreed with the importance of needing trained MBCT teachers in services, alongside supportive managers. Some clinicians commented on their experience of having delivered mindfulness-based classes for staff who were then able to better understand MBCT and subsequently refer clients more effectively. Whilst agreement was high, some commented that a properly resourced service for delivering MBCT is "an ideal and not always practically possible" when balancing all resource demands across all therapies in services.

Consensus was not reached for two statements which firstly, proposed that services should not deliver MBCT if they cannot adequately fund it and, secondly, that as a result of service restrictions, staff teach MBCT without sufficient training. Both statements tended to be rated as "neither agree nor disagree" with no clear direction towards consensus and prompted mixed comments. For the first statement, some clinicians wondered whether "underfunded MBCT is better than no MBCT". However, others commented that MBCT should be properly funded and questioned "if there is insufficient funding to offer it properly, is it even ethical to do so?". For the second statement, no consensus was reached and clinicians commented that they were unsure how to rate as they were unaware of staff teaching without training.

Resources. Both statements reached consensus. Firstly, clinicians agreed that services should provide sufficient resources, but with an acknowledgement that some resources are easier to source these days (e.g., access to online instead of CD-based audio). The second statement (whether a lack of resources puts clients at risk of a non-evidence-based MBCT) reached consensus by round two and elicited fewer but mixed comments. One clinician commented that this becomes an "ethical issue for teachers" who should, if aware that there is insufficient funding and resources, raise it as an issue and subsequently not teach MBCT.

Another clinician commented on their experience of making changes to MBCT because of service restrictions, commenting on how they felt that the resultant course was not as effective (they made “major changes to…meet service demands and (*I*) know they have been less effective”).

Adaptations

Course structure. All six statements reached consensus, albeit with ratings in different directions. Firstly, clinicians disagreed with the statement which suggested that delivering MBCT as a full eight-week programme is not feasible, but acknowledged that adaptations may be needed (e.g., in acute settings). Secondly, clinicians disagreed that it is acceptable to shorten sessions or course length to accommodate service needs describing fears that MBCT would “lose it’s integrity”; such decisions should “be led by the needs of that population and not service restrictions”.

For the remaining four statements, clinicians agreed that it is acceptable to deliver MBCT in groups or one-to-one settings, to teach only elements of the MBCT course, and to adapt and/or tailor MBCT or MBCT session duration or length to meet individual client needs. Most comments centred around ensuring all adaptations reflect a client-centred approach, particularly as “each group has different needs”. One clinician commented that learning to sit for longer periods of time is integral to the learning and that to shorten MBCT would work “against the principles of mindfulness”; others reflected that there is a “need (*for*) more evidence on the effectiveness of shorter programmes”. There was some reticence around adaptations through only teaching elements of MBCT with the recognition that “MBCT in its own right is comprehensive” but that clients should be made aware that they are not receiving full MBCT (“don’t call it MBCT…it could be an introduction to mindfulness”).

Types of adaptations. Five of six statements reached consensus whereby clinicians agreed that shorter practices could increase engagement and that any adaptations should reflect the client needs, the core philosophy of MBCT, and should not deviate significantly from the evidence-base. Clinicians reflected that this is “a very carefully considered balancing act”. Clinicians agreed that whilst shorter practices may help to increase engagement, they disagreed that there should be fewer home practice requirements, reflecting that home practice is a “vital element of MBCT” and by reducing these requirements, MBCT could differ “so much that it bears little resemblance and has no valid research-base”. Overall, clinicians recognised the complexity of making decisions around adaptations which could be “more flexible and reasonable depending on demands and stressors in an individual’s life”.

No consensus was reached for whether practices could be graded by intensity (e.g., offering less intense practices first such as grounding exercises). This statement elicited similar views around consideration of client needs whilst reflecting the evidence-base. One clinician reflected on how the learning in MBCT arises through those practices that may be harder or that people “struggle” with, highlighting the importance of maintaining these. However, clinicians also recognised that some adaptations may be dependent on the client group.

Discussion

We aimed to establish consensus amongst clinicians with expertise in MBCT in clinical settings, regarding their views on what should be best practice in terms of access to, delivery of, and adaptations to MBCT. Following an initial consultation period and review of the literature, expert clinicians rated 59 statements across three rating rounds.

Overall, clinicians reached a consensus on 44 statements concerning the importance of ensuring sufficient preparation for and ease of accessing MBCT, careful consideration around who might benefit from MBCT with regards to the evidence-base, consideration of potential risks, adherence to GPG, and the importance of an experiential understanding of mindfulness developed through personal meditation practice. Further, clinicians agreed with statements concerning sufficient initial and ongoing training in MBCT, adherence to MBCT teacher guidelines, support from and sufficient resources within services, and carefully considered adaptations. Overall, clinicians agreed with the core, underlying aspects of MBCT in clinical settings as reflected in the GPG and wider evidence-base. Clinicians agreed with statements reflecting the essential and the flexible components required in MBIs (Crane et al., 2016) including the emphasis on the underlying evidence-base and core philosophy of MBCT, teacher embodiment of mindfulness-based qualities, engagement in ongoing training and adherence to guidelines, whilst staying attuned to individual client needs, making careful adaptations as required.

Fifteen statements did not reach consensus. In general, and reflected in many of the comments, the non-consensus generally reflected either mixed opinions around the statement or an unfamiliarity with the evidence-base. At times, the non-consensus was reflective of the complexities involved in making decisions around MBCT in clinical settings. Consensus was not reached on statements related to questions around the level of commitment required for MBCT, potential credibility and stigma surrounding MBCT, the evidence-base and application of MBCT for certain populations, whether the risks of MBCT are understated, the impact of service restrictions on the delivery of MBCT, and decisions around adaptations to specific practices.

Key Implications and Recommendations

The evidence-base. The majority of comments reflected on the importance of the underlying evidence-base and recognised the complexity involved in decision-making. Clinicians agreed with the delivery of MBCT for populations with the strongest evidence base; specifically, for people with recurrent or current depression (Goldberg et al., 2019; Mackenzie et al., 2018; Kuyken et al., 2016), histories of trauma (Williams et al., 2014), and anxiety and long-term physical health conditions, although there is more evidence for Mindfulness-based Stress Reduction (MBSR; Kabat-Zinn, 1990) for the latter two populations (Ninomyia et al., 2020; Compen et al., 2018; Strege et al., 2018; Rodrigues et al., 2017; Chiesa & Serretti, 2011). There were some populations for whom clinicians reflected on either their unfamiliarity with or the lack of available evidence-base. Overall, more research is needed around the efficacy of MBCT for populations including people with symptoms of dissociation, bipolar, current suicidal ideation, psychosis, eating disorders, and substance abuse/dependence.

Whilst of course no therapy is risk free (Jonsson et al., 2014), the lack of evidence-base led clinicians to exert caution around MBCT for certain population groups. There are many unknowns regarding the potential harm from MBCT, and somewhat in line with our clinicians' ratings, others have cautioned against MBIs for people with current suicidal ideation, psychosis, and substance dependence (Kuyken et al., 2012; Santorelli et al., 2017). Two studies have suggested that the most common harmful experiences arising from MBCT are (new-onset of) depression and anxiety as well as depersonalisation and reexperiencing of trauma, and psychotic experiences, although it should be noted that these studies either included non-clinical participants (Baer et al., 2020) or participants taking part in different MBIs or more intense meditations (Farias et al., 2020). Whilst unpleasant experiences are an expected natural consequence of taking part in meditation, it remains that there are unknowns regarding the potential for longer-lasting harm from MBCT in clinical populations. Further research around the potential for harm from MBCT is warranted.

Client-centred approach. Repeated across a number of statements and comments, clinicians reflected on the importance of the delicate balance in maintaining a flexible client-centred approach, whereby the individual needs, expectations, and safety of the client are prioritised, whilst staying close to the evidence-base, GPG, and the core underlying philosophy of MBCT. This is especially important given the potential for busy, over-stretched services to require changes to MBCT in light of restricted funding or resources. Maintaining a client-centred approach is reflected in the wider literature (Crane et al., 2016) whereby all mindfulness-based practices are invitational alongside a core understanding of humility whereby the client is the expert of their individual experience (Segal et al., 2013; Kabat-Zinn, 1990). Others have also noted the delicate balance between increasing access whilst maintaining integrity of MBCT (Williams & Birtwell, 2018) as well as the importance of ensuring the client is fully aware of the potential risks, the presence of support should difficult experiences arise, and that clients have the choice as to whether they continue participation in MBCT (Farias & Wikholm, 2016). Overall, our results provide evidence in support of the GPG with further suggestions around important considerations specifically for MBCT teachers within clinical settings. For example, the GPG could be amended to explicitly emphasise the delicate but complex balance between remaining client-centred whilst adhering to the evidence-base.

Honesty and transparency. Another repeated theme reflected the need for ensuring honesty and transparency through discussions with clients and services around expectations, misconceptions, potential for harm and/or distress, the value of and potential learning derived from engaging in longer practices and in home practice, ensuring an invitational stance, and ensuring transparency around adaptations. Ensuring clients are aware of and have the opportunity to address any misconceptions fits with other studies reporting how MBCT participants had either expected a "cure" or that their misconceptions around MBCT later impacted on their ability to either maintain a mindfulness practice or fully benefit from MBCT (Bihari & Mullan, 2014; Finucane & Mercer, 2006; Mason & Hargreaves, 2001). Additionally, ensuring transparency is important given the popularity of MBCT and the recent push to increase access to MBCT in the NHS (Mindfulness All Party Parliamentary Group, 2015). Finally, it is important to ensure clinicians and services remain transparent about what MBCT is being delivered, particularly in light of the report from Rycroft-Malone et al. (2019; 2017) on the "patchy" delivery of MBCT, adaptations in response to target-driven and financial pressures, and limited access to training and supervision. Therefore, services should ensure a careful consideration of adequate funding (for training, supervision, and sufficient resources), and consider the ethical considerations if the above are not available. In addition to discussing and educating clients about potential misconceptions or their expectations about MBCT, increased education for service managers and leads may help in ensuring an increased understanding of MBCT and more effective referral process.

Strengths and Limitations

Our recruitment of a range of clinicians from different specialties and training levels adds a broader perspective to our findings. However, it should be noted that over 50% of our sample consisted of CBT therapists, Clinical Psychologists, or service leads, but this may reflect the likely demographics of who predominantly teaches MBCT in clinical settings. Although efforts were made to recruit psychiatrists, none responded to the adverts. Not all of the clinicians provided qualitative comments for every statement making it difficult to know whether all comments reflected everyone's views, although of course the agreement rating helps reassure us of clinicians views regarding each statement. Finally, it should be noted that as we recruited expert clinicians with a keen professional, and possibly personal, interest and expertise in MBCT, this will have inevitably affected their ratings; whether the views of clinicians would fit with what clients want and value from MBCT is unknown and warrants further research.

Conclusions

Twenty-nine clinicians rated 59 statements regarding their views on what should be considered best practice in the access to, delivery of, and adaptations to MBCT in clinical settings. The majority of statements reached consensus amongst clinicians, with 15 statements not reaching consensus either due to a lack of evidence-base, unfamiliarity, or uncertainty around complex decision-making processes. Our findings highlight the importance of an awareness of and adherence to the evidence-base whilst maintaining a client-centred, honest, and transparent approach in access to, delivery of, and adaptations in MBCT. Our findings have implications at a clinical, research, service, and policy level.

References

Baer, R., Crane, C., Miller, E., & Kuyken, W. (2019). Doing no harm in mindfulness-based programs: conceptual issues and empirical findings. *Clinical Psychology Review*, *71,* 101–114. https://doi.org/10.1016/j.cpr.2019.01.001

Baer, R., Crane, C., Montero-Marin, J., Phillips, A., Taylor, L., Tickell, A., & Kuyken, W. (2020). Frequency of self-reported unpleasant events and harm in a mindfulness-based program in two general population samples. *Mindfulness*, *12,* 763-774. https://doi.org/10.1007/s12671-020-01547-8

Bihari, J. L. N., & Mullan, E. G. (2014). Relating Mindfully: A qualitative exploration of changes in relationships through mindfulness-based cognitive therapy. *Mindfulness, 5(1),* 46–59. https://doi.org/10.1007/s12671-012-0146-x

Boyd, J. E., Lanius, R. A., & McKinnon, M. C. (2018). Mindfulness-based treatments for posttraumatic stress disorder: a review of the treatment literature and neurobiological evidence. *Journal of psychiatry & neuroscience, 42(6),* 170021. https://doi.org/10.1503/jpn.170021

Britton, W. B. (2019). Can mindfulness be too much of a good thing? The value of a middle way. *Current Opinion in Psychology, 28,* 159–165. https://doi.org/10.1016/j.copsyc.2018.12.011

Chiesa, A., & Serretti, A. (2011). Mindfulness based cognitive therapy for psychiatric disorders: A systematic review and meta-analysis. *Psychiatry Research, 187(3),* 441–453. https://doi.org/10.1016/j.psychres.2010.08.011

Compen, F., Bisseling, E., Schellekens, M., Donders, R., Carlson, L., van der Lee, M., & Speckens, A. (2018). Face-to-face and internet-based mindfulness-based cognitive therapy compared with treatment as usual in reducing psychological distress in patients with cancer: A multicenter randomized controlled trial. *Journal of Clinical Oncology,* *36(23)*, 2413–2421. https://doi.org/10.1200/JCO.2017.76.5669

Crane, R. S. (2011). The UK good practice guidelines for mindfulness-based teachers. Retrieved 26/01/2021, from https://bamba.org.uk/wp-content/uploads/2019/06/UK-MB-teacher-GPG-2015-final-2.pdf

Crane, R. S., Brewer, J., Feldman, C., Kabat-Zinn, J., Santorelli, S., Williams, J. M. G., & Kuyken, W. (2016). What defines mindfulness-based programs? the warp and the weft. *Psychological Medicine*, *47(6)*, 990–999. https://doi.org/10.1017/S0033291716003317

Crane, R. S., & Kuyken, W. (2013). The implementation of mindfulness-based cognitive therapy: learning from the UK health service experience. *Mindfulness*, *4(3)*, 246–254. https://doi.org/10.1007/s12671-012-0121-6

de Meyrick, J. (2003). The delphi method and health research. *Health Education*, *103(1)*, 7–16). https://doi.org/10.1108/09654280310459112

Diamond, I. R., Grant, R. C., Feldman, B. M., Pencharz, P. B., Ling, S. C., Moore, A. M., & Wales, P. W. (2014). Defining consensus: a systematic review recommends methodologic criteria for reporting of delphi studies. *Journal of Clinical Epidemiology*, *67(4)*, 401–409. https://doi.org/10.1016/j.jclinepi.2013.12.002

Dimidjian, S., & Segal, Z. V. (2015). Prospects for a clinical science of mindfulness-based intervention. *American Psychologist*, *70(7)*, 593–620. https://doi.org/10.1037/a0039589

Farias, M., Maraldi, E., Wallenkampf, K. C., & Lucchetti, G. (2020). Adverse events in meditation practices and meditation-based therapies: a systematic review. *Acta Psychiatrica Scandinavica*, *142(5)*, 374–393. https://doi.org/10.1111/acps.13225

Farias, Miguel, & Wikholm, C. (2016). Has the science of mindfulness lost its mind? *BJPsych Bulletin*, *40(6)*, 329–332. https://doi.org/10.1192/pb.bp.116.053686

Finucane, A., & Mercer, S. W. (2006). An exploratory mixed-methods study of the acceptability and effectiveness mindfulness-based cognitive therapy for patients with active depression and anxiety in primary care. *BMC Psychiatry*, *6,* 14. https://doi.org/10.1186/1471-244X-6-14

Goldberg, S. B., Tucker, R. P., Greene, P. A., Davidson, R. J., Kearney, D. J., & Simpson, T. L. (2019). Mindfulness-based cognitive therapy for the treatment of current depressive symptoms: a meta-analysis. *Cognitive Behaviour Therapy*, *48(6),* 445–462. https://doi.org/10.1080/16506073.2018.1556330

Graham, L. F., & Milne, D. L. (2003). Developing basic training programmes: a case study illustration using the delphi method in clinical psychology. *Clinical Psychology & Psychotherapy, 10(1),* 55–63. https://doi.org/10.1002/cpp.353

Green, B., Jones, M., Hughes, D., & Williams, A. (1999). Applying the delphi technique in a study of GPs' information requirements. *Health and Social Care in the Community*, *7(3),* 198–205. https://doi.org/10.1046/j.1365-2524.1999.00176.x

Hall, D. A., Smith, H., Heffernan, E., & Fackrell, K. (2018). Recruiting and retaining participants in e-delphi surveys for core outcome set development: Evaluating the COMiT'ID study. *PLoS ONE, 13(7).* https://doi.org/10.1371/journal.pone.0201378

Hasson, F., Keeney, S., & McKenna, H. (2000). Research guidelines for the delphi survey technique. *Journal of Advanced Nursing, 32(4),* 1008–1015. https://doi.org/10.1046/j.1365-2648.2000.t01-1-01567.x

Hsu, C.-C., & Sandford, B. A. (2007). The delphi technique: making sense of consensus. *Practical Assessment, Research, and Evaluation*, *12*, 10. https://doi.org/10.7275/pdz9-th90

Jonsson, U., Alaie, I., Parling, T., & Arnberg, F. K. (2014). Reporting of harms in randomized controlled trials of psychological interventions for mental and behavioral disorders: A review of current practice. *Contemporary Clinical Trials, 38(1),* 1–8. https://doi.org/10.1016/j.cct.2014.02.005

Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain and illness.* Delacorte.

Khodyakov, D., Grant, S., Denger, B., Kinnett, K., Martin, A., Peay, H., & Coulter, I. (2020). Practical considerations in using online modified-delphi approaches to engage patients and other stakeholders in clinical practice guideline development. *Patient, 13(1),* 11–21. https://doi.org/10.1007/s40271-019-00389-4

Kuyken, W., Crane, R., & Williams, M. (2012). *Mindfulness-based cognitive therapy (MBCT) implementation resources.* University of Oxford, University of Exeter, Bangor University

Kuyken, W., Warren, F. C., Taylor, R. S., Whalley, B., Crane, C., Bondolfi, G., Hayes, R., Huijbers, M., Ma, H., Schweizer, S., Segal, Z., Speckens, A., Teasdale, J. D., Van Heeringen, K., Williams, M., Byford, S., Byng, R., & Dalgleish, T. (2016). Efficacy of mindfulness-based cognitive therapy in prevention of depressive relapse: An individual patient data meta-analysis from randomized trials. *JAMA Psychiatry, 73(6),* 565-574. https://doi.org/10.1001/jamapsychiatry.2016.0076

Langlands, R. L., Jorm, A. F., Kelly, C. M., & Kitchener, B. A. (2008). First aid for depression: A delphi consensus study with consumers, carers and clinicians. *Journal of Affective Disorders*, *105(1–3),* 157–165. https://doi.org/10.1016/j.jad.2007.05.004

Lindahl, J. R., Fisher, N. E., Cooper, D. J., Rosen, R. K., & Britton, W. B. (2017). The varieties of contemplative experience: A mixed-methods study of meditation-related challenges in Western Buddhists. *PLOS ONE, 12(5),* e0176239. https://doi.org/10.1371/journal.pone.0176239

Lovas, D. A., & Schuman-Olivier, Z. (2018). Mindfulness-based cognitive therapy for bipolar disorder: A systematic review. *Journal of Affective Disorders, 240,* 247–261. https://doi.org/10.1016/j.jad.2018.06.017

Mackenzie, M. B., Abbott, K. A., & Kocovski, N. L. (2018). Mindfulness-based cognitive therapy in patients with depression: Current perspectives. *Neuropsychiatric Disease and Treatment, 14,* 1599–1605. https://doi.org/10.2147/NDT.S160761

Mason, O., & Hargreaves, I. (2001). A qualitative study of mindfulness-based cognitive therapy for depression. *British Journal of Medical Psychology*, *74(2),* 197–212. https://doi.org/10.1348/000711201160911

McCartney, M., Nevitt, S., Lloyd, A., Hill, R., White, R., & Duarte, R. (2021). Mindfulness-based cognitive therapy for prevention and time to depressive relapse: Systematic review and network meta-analysis. *Acta Psychiatrica Scandinavica*, *143(1),* 6–21. https://doi.org/10.1111/acps.13242

Mindfulness All Party Parliamentary Group. (2015). *Mindful nation UK*. Westminster, London, UK. https://www.themindfulnessinitiative.org/mindful-nation-report

Morone, N. E., Moore, C. G., & Greco, C. M. (2017). Characteristics of adults who used mindfulness meditation: United States, 2012. *Journal of Alternative and Complementary Medicine*, *23(7),* 545–550. https://doi.org/10.1089/acm.2016.0099

National Institute for Health and Clinical Excellence. (2017). *Depression in adults. Recognition and management.* (CG90). Retrieved from https://www.nice.org.uk/guidance/cg90

Ninomiya, A., Sado, M., Park, S., Fujisawa, D., Kosugi, T., Nakagawa, A., Shirahase, J., & Mimura, M. (2020). Effectiveness of mindfulness-based cognitive therapy in patients with anxiety disorders in secondary-care settings: A randomized controlled trial. *Psychiatry and Clinical Neurosciences, 74(2),* 132–139. https://doi.org/10.1111/pcn.12960

Puddicombe (2010). *Headspace.* [Mobile application software]. https://www.headspace.com/

QSR International. (1999). *NVivo Qualitative Data Analysis Software* (Version 12)

[Software]. QSR International. Available from https://qsrinternational.com/nvivo/nvivo-products/

Rodrigues, M. F., Nardi, A. E., & Levitan, M. (2017). Mindfulness in mood and anxiety disorders: a review of the literature. *Trends in Psychiatry and Psychotherapy, 39(3),* 207–215. https://doi.org/10.1590/2237-6089-2016-0051

Rycroft-Malone, J., Gradinger, F., Griffiths, H. O., Crane, R., Gibson, A., Mercer, S., Anderson, R., & Kuyken, W. (2017). Accessibility and implementation in the UK NHS services of an effective depression relapse prevention programme: learning from mindfulness-based cognitive therapy through a mixed-methods study. *Health Services and Delivery Research, 5(14),* 1–190. https://doi.org/10.3310/hsdr05140

Rycroft-Malone, J., Gradinger, F., Owen Griffiths, H., Anderson, R., Crane, R. S., Gibson, A., Mercer, S. W., & Kuyken, W. (2019). “Mind the gaps”: The accessibility and implementation of an effective depression relapse prevention programme in UK NHS services: learning from mindfulness-based cognitive therapy through a mixed methods study. *BMJ Open, 9(9),* 26244. https://doi.org/10.1136/bmjopen-2018-026244

Santorelli, S., Meleo-Meyer, F., & Koerbel, L. (2017). *Mindfulness-based stress reduction (MBSR) authorized curriculum guide*. Center for Mindfulness in Medicine, Health Care, and Society (CFM)

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2013). *Mindfulness-based Cognitive Therapy for Depression*. Guildford Press

Strege, M. V., Swain, D., Bochicchio, L., Valdespino, A., & Richey, J. A. (2018). A pilot study of the effects of mindfulness-based cognitive therapy on positive affect and social anxiety symptoms. *Frontiers in Psychology, 9(866),* 1-11. https://doi.org/10.3389/fpsyg.2018.00866

Turoff, M., & Linstone, H. A. (1975). *The Delphi method-techniques and applications*.

Addison-Wesley Pub. Co.

van Dam, N. T., van Vugt, M. K., Vago, D. R., Schmalzl, L., Saron, C. D., Olendzki, A., Meissner, T., Lazar, S. W., Kerr, C. E., Gorchov, J., Fox, K. C. R., Field, B. A., Britton, W. B., Brefczynski-Lewis, J. A., & Meyer, D. E. (2018). Mind the hype: a critical evaluation and prescriptive agenda for research on mindfulness and meditation. *Perspectives on Psychological Science, 13(1),* 36–61. https://doi.org/10.1177/1745691617709589

Veugelers, R., Gaakeer, M. I., Patka, P., & Huijsman, R. (2020). Improving design choices in Delphi studies in medicine: The case of an exemplary physician multi-round panel study with 100% response. *BMC Medical Research Methodology*, *20(1), 156,* 1-15. https://doi.org/10.1186/s12874-020-01029-4

Williams, J. M. G., Crane, C., Barnhofer, T., Brennan, K., Duggan, D. S., Fennell, M. J. V., Hackmann, A., Krusche, A., Muse, K., Von Rohr, I. R., Shah, D., Crane, R. S., Eames, C., Jones, M., Radford, S., Silverton, S., Sun, Y., Weatherley-Jones, E., Whitaker, C. J., & Russell, I. T. (2014). Mindfulness-based cognitive therapy for preventing relapse in recurrent depression: A randomized dismantling trial. *Journal of Consulting and Clinical Psychology, 82(2),* 275–286. https://doi.org/10.1037/a0035036

Williams, K., & Birtwell, K. (2018). The double-edged sword of mindfulness: maintaining integrity whilst increasing access. *Clinical Psychology Forum, 306.* http://man.ac.uk/04Y6Bo

Paper Four

Critical Appraisal

Word count (excluding references): 4,578

As **Paper Four** is not intended for publication, it has not been prepared in line with a particular journal but it has been written in accordance with an APA 7 style.

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Introduction

This paper includes reflections around the changes made to the thesis project and shifting from quantitative to qualitative approaches. A critical discussion of each paper is presented, followed by cultural considerations and overall clinical and research implications. As I have included considerations around reflexivity, an example reflective log is in **Appendix Nine**.

Project Changes

At the beginning of my training in 2017, I was part of a large-scale research project (LSRP) with two other trainees. This project was a longitudinal quantitative study of brief Cognitive Analytic Therapy (CAT) for people who self-injure, with a planned review around self-compassion and self-injury. However, on returning from maternity, the project had progressed and I could no longer add anything further to it, therefore my supervisors and I decided to change my LSRP. There was limited time remaining until submission (May 2021) and I expressed an interest in returning to my previous interests in MBCT. This decision was further informed by my aspirations to work towards a combined clinical and academic career.

Focusing **Paper One** on qualitative experiences of MBCT was driven by the need for an update on participants' experiences of MBCT and the lack of qualitative reviews specifically focused on both MBCT and depression. The decision to conduct two empirical studies was driven by the presence of an unanalysed qualitative dataset from my PhD which alone was not sufficient for this doctoral thesis and so my supervisors and I added the Delphi study. Therefore, **Paper Two** would include a secondary analysis of an unanalysed qualitative dataset. I acknowledge that as the data and participants were well-known to me, this afforded me some advantages. However, given the time constraints, wealth of qualitative data to transcribe and analyse, and my unfamiliarity with qualitative methods there was plenty to learn. Finally, in an effort to move beyond participant experiences and include clinician experiences, a Delphi study was chosen for **Paper Three**.

Shifting from Quantitative to Qualitative Analysis

Although I had conducted the qualitative interviews during my PhD, I had not previously been involved in any large-scale qualitative analysis. However, as a quantitative MBCT researcher, I had often felt that something was lacking and whilst quantitative methods were useful and provided a wealth of data, I suspected that they could not fully capture the experience of taking part in a complex intervention like MBCT. Beginning to learn about qualitative research allowed me to incorporate a “bigger picture” and to feel that I was able to explore participants’ experiences in more depth.

Paper One

In this section, I discuss considerations around key methodological decisions, quality appraisal, limitations, personal reflections, and dissemination.

Methodological Decisions

Regarding individual meta-ethnography steps, in step three, either a top-down (framework) or bottom-up (data-driven) approach could have been used for coding the studies (Pope, 2000). A top-down approach may have allowed us to adopt themes from previous literature and apply these to a framework in which to begin coding, whilst a bottom-up approach could have enabled us to be guided by the data and allow for development of themes (Mohammed et al., 2016). A bottom-up approach was taken firstly because mindfulness-based research is quickly developing, as shown by the 13 new qualitative publications in MBCT for depression since the previous meta-syntheses (see **Paper One**). Further, given that the previous meta-syntheses were conducted between six and nine years ago, using a top-down approach may have risked missing different findings from the newly published studies or potentially been out-of-date. Finally, by employing a framework approach, the analysis may have become deductive and hypothesis-driven as opposed to inductive and data-driven, with the latter in line with Noblit & Hare's (1988) intentions for meta-ethnography.

There are different types of translation (step three) including reciprocal (concepts in one study incorporate those of another study) and refutational (differences, exceptions, and inconsistencies exist between studies; Sattar et al., 2021). The choice does not have to be exclusive and both could be employed (Sattar et al., 2021; France et al., 2019). At this stage, due to the similarities between the studies, a reciprocal translation was selected. There are a number of techniques to conduct reciprocal translation, for example, through visual representation (maps and grids to visualise themes and concepts), thematic extraction (solely coding original study themes), key paper integration (chronological ordering and comparison of studies), and line-by-line coding (detailed coding; Melendez-Torres et al., 2015). Visual representation methods are encouraged in meta-syntheses where the aims are to develop higher-order interpretations as these enable a detailed understanding of the similarities between second-order constructs both within and across studies (Melendez-Torres et al., 2015). Further, it was not clear that there was one early "key" paper on which to conduct a chronological key paper integration method and this method risked missing key themes generated in later publications, as data saturation was reached (Melendez-Torres et al., 2015).

Quality Appraisal

There are mixed views around quality appraisals of qualitative studies. Some argue that the process and outcome of quality appraisal is not compatible with qualitative research, whereas others argue that if such a meta-synthesis is used to inform clinical practice, its quality must be appraised (Toye et al., 2013; Sattar et al., 2021). There are potential difficulties in appraising qualitative studies due to subjectivity and different epistemologies (Dixon-Woods et al., 2007). Sattar et al. (2021) recommend using either the Critical Appraisal Skills Programme (CASP; 2018) or the Qualitative Assessment and Review Instrument (JB-QARI; Lockwood et al., 2015). The CASP was selected based on its specificity in assessing qualitative research and consideration of the participant-researcher relationship (Sattar et al., 2021). The CASP was also useful for reading the included studies systematically, which enabled a deeper understanding of the variations in quality within and across the studies.

Rather than being used to exclude studies, the CASP enabled us to understand how much weight could be given to individual studies in our interpretations. Some researchers believe that methodologically "weak" studies should be excluded, whereas others believe that studies could still be included so as to recognise and incorporate their potential meanings in light of what might be fairly minor weaknesses (Toye et al., 2013; Dixon-Woods, 2005). Studies can be limited in different ways and yet together still provide some weight of evidence thus it may be excessive to exclude them completely. Some studies may appear weaker as some journals allow limited space thus potentially limiting the level of detail that could be given to describe methodology or analysis (Atkins et al., 2008). Overall, even lower quality studies can include worthwhile and meaningful contributions to the literature, thus appraising the studies by quality allows the reader to ultimately judge what conclusions to take, rather than leading it up to the researcher to make those decisions.

Limitations

In addition to the limitations outlined in **Paper One**, it should be noted that individual studies came from different underlying epistemological positions and analysis methods which should be considered when synthesising results. Some researchers have outlined concerns around differing theoretical underpinnings, whereas others are less concerned and instead advocate assimilation of different epistemologies due to their complementary methodologies (Finfgeld, 2003; Sandelowski et al., 1997). Synthesising qualitative findings could be regarded as a positivist approach whereby we may be vulnerable to drawing interpretations based on quantifying the results (Atkins et al., 2008). However, the risk of not synthesising qualitative research means that key meanings from individual studies may be lost in the large numbers of studies for that particular topic (Toye et al., 2013; Sandelowski et al., 1997).

Personal Reflections

At times, conducting a meta-ethnography and following the, at times ambiguous, guidance felt confusing, vague, and uncertain. I was aware that third-order interpretations were far-removed from the original participants' voices. Each study represented only one possible interpretation by one study team, highlighting the subjective nature of the methodology, reminding me to hold the findings lightly whilst simultaneously acknowledging the importance of meta-synthesis in raising individual experiences and voices. At times I noticed feelings of responsibility to the wider MBCT field to carry out this meta-ethnography sufficiently given that it included a number of studies and researchers. Having attended a mindfulness-based conference in 2013 where the results of the meta-synthesis by Malpass et al. (2012) had just been published and were being excitedly discussed, I was aware of this memory throughout analysis and felt the potential importance of this work for some as well as recognising that this could have affected my interpretations. In an attempt to work with this, I tried to hold this memory lightly, maintain my awareness of feelings of pressure to get the review "right", and remember that my attempt is just one attempt in a very large MBCT research pool. This enabled me to step back from it and return with fresh eyes.

Dissemination

Paper One was submitted to the Journal of Affective Disorders on the 21st April 2021 and is under review. This journal was chosen due to its focus on affective disorders, including depression, its invitation for qualitative reviews, and interdisciplinary nature thus attracting a wide readership. The findings will be submitted to relevant mindfulness-based and clinical psychology conferences. Finally, the paper will be shared widely on my professional social media account. As Toye et al. (2014) highlighted, the process of meta-synthesis should not end with the final report but should be disseminated widely in order to impact on and improve clinical practice.

Paper Two

In this section, I discuss considerations around study design, analysis, baseline data, reflexivity, relationships with the data, limitations, and dissemination.

Study Design

In the original study, unfortunately there were no consultations with patient and public involvement (PPI) groups. Involving PPI groups has been regarded as valuable by clients (Brett et al., 2014), and researchers and trial managers (Dudley et al., 2015). Had this been included, this could have enhanced the development of the original design, including the interview schedules. However, as mentioned in **Paper Two**, whilst completing the analysis, two individuals were consulted: one with expertise in MBCT and one without. Both provided insights into the development of the themes which added depth to the analysis and discussion.

Selecting Thematic Analysis

A range of qualitative methodologies could have been employed in **Paper Two**, for example Grounded Theory (Charmaz, 2014) or Interpretive Phenomenological Analysis

(IPA; Smith et al., 2009), each including different methodologies, epistemologies, and analysis methods. Generally, reflexive thematic analysis (TA; Braun & Clarke, 2021; 2020; 2006) remains free from an epistemological underpinning thus allowing for a flexible yet detailed analysis (Braun & Clarke, 2021; 2020; 2006). Given that the research question was fairly open and aimed at understanding participants' experiences of MBCT for depression, reflexive TA was a good fit in terms of analysing, deriving meaning from the data, and sufficiently accounting for participants' experiences (Willig, 2013). Reflexive TA involves an active development of themes alongside an acknowledgement that the researcher cannot be separate from this process, and therefore need to maintain a reflexive stance regarding their assumptions and expectations (Braun & Clarke, 2020). This analysis is in line with a critical realist approach whereby reality exists, but it is not a single reality and remains influenced by the researchers' and participants' preconceptions, assumptions, knowledge, and expectations, alongside the impact of cultural, social, and wider political influences on the interpretations made (Tebes, 2005).

Decisions around Baseline Data

Qualitative data were also available for baseline with participants discussing their reasons for taking part and their expectations. I was unsure as to whether to include this data as although it felt important to acknowledge the findings in terms of the context of participants' experience, arguably they did not fit with the research question. I analysed the baseline findings and had planned to incorporate them in the results. However, the results did not fit with the overall story or provide much context, and left more questions unanswered; had we included them, the paper may have become unfocused and difficult to make sense of, especially given the depth and number of themes that were developed during analysis. Thus, it was decided to not include the baseline data but include it in an appendix.

Reflexivity

As acknowledged in **Paper Two**, I have experience and knowledge in MBCT and inevitably hold assumptions and expectations which may have contributed to the interpretations made (Binder et al., 2012). However, prior to analysis, I was largely unaware of the qualitative MBCT literature as my experience and knowledge was with the quantitative literature. I began analysing the data for **Paper Two** before starting **Paper One** thus I deliberately did not read the studies before coding and generating themes to ensure that the analysis remained data-driven, and, as much as possible, was not influenced by the interpretations of prior studies. Indeed, Braun and Clarke (2006) argued that reading prior studies in-depth before analysing could lead to a narrowing of ideas around coding and themes. By maintaining a reflective log, I was able to look back on my expectations, assumptions, and comments I had made during transcription allowing me to check that any interpretations were not unduly influenced. Additionally, once themes had been generated, on two separate occasions during analysis I took a two-month break to focus on the other papers. Although themes are never finite, on returning to the data I found that I could refine themes with “fresh eyes” and learned to value the non-linear process of analysis. This also helped highlight the balance between knowing the data in-depth but also maintaining some distance from it.

Relationship with the Data

I found it challenging to write a narrative around each theme whilst wanting to ensure a balance between fully capturing participants’ voices and writing concisely. At times, it became difficult to “let go” of quotes as even though the participants’ voices were captured in the results, some quotes were removed in light of word counts and efforts to write succinctly. Simultaneously, I was aware of not getting caught up in some participants’ powerful words and emotions when describing MBCT. I endeavoured to ensure that all views were represented, particularly given the excitement and potential for over-confidence in mindfulness-based approaches (van Dam et al., 2018).

Limitations

In **Paper Two**, we noted the non-randomised, preference-choice design as a limitation. Additionally, the study took place in a research setting without waiting lists to access MBCT; this could have impacted positively on the findings as participants may have expressed feelings of gratitude and benefit from MBCT, compared with a study conducted in an NHS setting (e.g., if participants had been on lengthy waiting lists).

Dissemination

Paper Two was submitted to "Psychology and Psychotherapy: Theory, Research, and Practice" on the 22nd March 2021 and is under review. This journal was selected due to its acceptance of qualitative research and focus on understanding the processes of psychological therapies. The emerging themes were presented in an accepted talk at the Mind and Life Research Conference (USA) in November 2020 via Zoom; I gave a 15 minute oral presentation on the themes and implications to an audience of clinical practitioners and academics in mindfulness-based approaches. The session prompted interesting discussions and useful networking opportunities. I am continuing to look for other events in which to share the findings. Ideally, I wanted to share these findings with study participants, particularly as their involvement in the wider study was extensive (Williams, 2018). However, it was not explicitly stated in the original ethics documents that contact details would be retained for dissemination and especially in light of recent data protection changes, unfortunately this was not possible or ethical to do. Once published, the findings will be shared via my professional social media account.

Paper Three

In this section, I discuss considerations around the Delphi study design, analysis, strengths and limitations, and dissemination.

Design

Methodology. There are a range of possible methods for consensus development. The Delphi method aims to invite experts to anonymously rate and re-rate statements to reach group consensus (Hasson et al., 2000; McKenna, 1994). Other methods include the nominal group technique (independent idea-generation moving towards group consensus; Nair et al., 2011; Delbecq & van de Ven, 1971), consensus development conferences (discussion on key issues between stakeholders; Halcomb et al., 2008), and focus groups (Casey & Krueger, 1994). Q methodology was considered but instead of looking towards gaining an expert consensus through determining the percentage of agreement with statements, the Q methodology allows for multiple perspectives to emerge (Watts & Stenner, 2005). Although a consensus might emerge, it is not necessarily the goal of Q methodology (Watts & Stenner, 2012). It was also important to select a method for consensus development alongside the time remaining on the programme and covid-19 restrictions which would impact on face-to-face recruitment.

Advantages and disadvantages. In a Delphi study, opinions are gathered anonymously thus limiting the influence from group processes such as groupthink or conformity bias (Hasson et al., 2000; Murphy et al., 1998). Delphi studies are iterative processes by inviting participants to rate and re-rate statements after viewing the collated feedback from the previous round, allowing participants the space for reflection, convergence, and/or divergence of ratings (Daniels, 2017; Hsu & Sandford, 2007). Online formats further allow for removal of power differentials as participants do not interact face-to-face and allow participants to participate from any geographical location (Sinha et al., 2011). Further, online formats increase the possibility for larger and more diverse sample sizes whilst reducing administrative and time costs (Hall et al., 2018). However, the disadvantages to using a Delphi include the subjective definitions of the "expert" and limited potential for generalisability beyond the specific sample (Nair et al., 2011). Further, a Delphi involves significant time contributions (Donohoe et al., 2012) and if participants are recruited from geographically similar areas, they may work in similar services and possibly share similar opinions (Fink-Hafner et al., 2019).

Statement development. Whilst stage one included a literature review, it was not possible to conduct a systematic review for time and practical reasons; some articles may have been missed through lack of awareness or less in-depth literature searching. However, as stage one included consultation with five expert mindfulness-based practitioners, this helped to balance any potential bias through ensuring that others' perspectives were considered. Further, as I have experience in MBCT research, this could have biased the development of the statements, analysis, and results. To mitigate this I sought opinions and feedback from others when designing the study, developing the statements and survey, through supervision, and I maintained a reflective log.

Analysis

There are a number of ways to determine consensus and using percent agreement is one of the most widely used techniques (Diamond et al., 2014); others have used proportions or interquartile ranges (Hsu & Sandford, 2007; Black et al., 1999) but it was felt that percent agreement allowed for a straightforward, easily interpretable, and realistic majority consensus. A qualitative analysis of clinicians' comments was not conducted as all comments were optional to ensure a balance between participant burden and capturing clarification and reflections. Therefore, as not all clinicians provided comments, it was not possible to ensure that all viewpoints would have been represented in a qualitative analysis.

Strengths and Limitations

Paper Three detailed the key strengths and limitations. Clinicians appeared interested and well-invested, reflected in their timely responses, detailed comments, and low attrition. However, in light of covid-19 restrictions, I could not physically visit clinical sites and therefore did not include this in the ethics application (submitted mid-March 2020). It may have been useful to have visited clinical settings to advertise and discuss the study with staff. Additionally, sample demographics were collected at baseline only; collecting these at subsequent rounds may have enabled an understanding as to which participant characteristics formed our final sample. However, attrition was low therefore our final sample characteristics should not differ largely from baseline.

Dissemination

Paper Three was submitted to “Mindfulness” on the 27th January 2021 due to their focus on mindfulness-based research and “best practices in mindfulness”. “Mindfulness” is well-read amongst mindfulness-based researchers, particularly in the UK, thus relevant and applicable for MBCT clinicians and researchers to read and hopefully incorporate the findings. The findings will be submitted to a conference soon. All participants consented to be contacted with the findings, therefore the draft paper was emailed to all on the 28th January 2021. Once published, the paper will be shared on social media and with special interest groups.

Cultural Considerations

In **Paper One**, the sample ethnicities were largely unknown and in **Papers Two** and **Three**, data on ethnicity was unfortunately not obtained. Exploring whether the experiences across these papers also reflected those from individuals from a range of cultural backgrounds and experiences was important and should have been explored to better understand feelings of safety when taking part in therapy, particularly with regard to racial trauma and inequality (Ahsan, 2020). In **Paper Two**, the decision not to obtain demographics around ethnicity was felt to be unnecessary and potentially intrusive as it was not part of the study aims. However, I now believe that this is incorrect, particularly in light of the events and increased discussions around the Black Lives Matter movement during 2020 which have highlighted important discussions around racism.

In **Paper Three**, one clinician commented on the cultural diversity of MBCT teachers, who, anecdotally, tend to be white and middle-class; little evidence exists for understanding the diversity of MBCT teachers, although I am aware of ongoing research in this at The University of Bangor's Centre for Mindfulness and Research. However, in our sample, as many clinicians were either CBT therapists or Clinical Psychologists, and given the findings in a British Psychological Society (BPS; 2015) report that 88% and 80% of clinical psychologists are white and female respectively, it is likely that they were white females. Ensuring that demographics in relation to ethnicity and race are taken is important in regards to acknowledging and moving towards decolonisation of Clinical Psychology (Hicks & Butler, 2020). It is important to understand who participates in and who teaches MBCT, as a way of furthering our understanding of cultural awareness and moving to reduce white imperialism to ensure equal access to and delivery of MBCT for all clients, regardless of background.

Comparing Papers One and Two

It is important to note that in both **Papers One** and **Two** the findings across timepoints of both post-MBCT and follow-up did not seem to elicit different themes. It might have been expected that immediately post-MBCT participants were more connected with their experience and perhaps felt more strongly, whilst feeling more distant from their experiences during follow-up. However, neither paper found that this was the case. There could be many reasons for this including the fact that all participants were taking part in an MBCT-specific research study thus were still a member of a research study, wanting to “please” the researcher knowing that they may expect a certain result, and the setting of a research study acting, potentially, in some way to continue holding participants’ experiences. In **Paper Two** especially, there may have been additional participant demand characteristics as the researcher both co-facilitated the MBCT groups and conducted the qualitative interviews.

Overall Implications Across all Papers

Summary

A number of themes were repeated across all papers. **Table 4.1** below highlights the main findings from each paper. Specifically, across **Papers One** and **Two** there were similar findings across changes in experience by becoming skilled through engaging in mindfulness practices, enhanced acceptance of, connection, and relationships with experience, self, and others, being with difficulty, as well as recognising the potential for adverse events, and the ongoing process of change. In **Paper Three**, key findings centred around the importance of navigating a delicate balance between remaining client-centred and adhering to the evidence-base, guidelines, and core principles underlying MBCT.

Table 4.1. Main findings

Paper	Findings
One	Becoming skilled and taking action
	Acceptance
	Ambivalence and variability
Two	Reconnection with experience
	(Ongoing) Process
Three	Consensus reached:
	- Preparation for & ease of accessing MBCT
	- Who benefits
	- Adverse events
	- Adherence to GPG
	- Experiential understanding
	- Sufficient training
	- Sufficient resources and support
	- Carefully considered adaptations
	No consensus reached:
	For statements eliciting mixed opinions or less familiarity with the evidence-base
	- Commitment required
	- Credibility and stigma
	- Delivery with less evidence-based populations
	- Risks
	- Service restrictions
	- Adaptations to specific practices

Note. GPG=Good Practice Guidelines

Clinical and Research Implications and Recommendations

Firstly, our findings have highlighted a key role for understanding how MBCT implicates change at a number of levels of relationships with experience (e.g., awareness, agency, acceptance), self, and with others. Similarly, but in non-clinical populations, Baker (2016) described how for trainee psychotherapists, engaging in and learning mindfulness-based techniques enabled a deeper connection and attunement between the therapist and client, which subsequently enabled enhanced attunement between the client and their experiences. Practically, when delivering MBCT, clinicians could highlight the potential for changes in connection with and relationships with experience, self, and others in early pre-

MBCT discussions as well as asking clients to consider relationships with experience, self, and others in their relapse-prevention plans developed during MBCT. Clinicians delivering MBCT could incorporate more opportunities for group-based follow-up sessions or courses (e.g., Mindfulness-based Compassionate Living; Bartels-Velthuis et al., 2016). Further research could build on these findings by quantitatively investigating participants' experiences of connections with experience, self, and others, and could explore repositioning MBCT as not only based on a cognitive theory of relapse vulnerability, but also from a relational perspective.

Secondly, a key theme across all papers was the recognition of variability of experiences, in terms of difficulty, adverse effects, ongoing process, variability in changes between participants, and unfamiliarity with or caution around the evidence-base. Many participants benefit from MBCT and in particular, each of the three papers highlight the importance of MBCT for many participants. However, there are some for whom MBCT is not beneficial and, at worst, could prompt significant distress or harm. Findings from **Paper Three** suggest that for some populations, there remains a lack of evidence around the efficacy of MBCT for certain populations meaning that MBCT may not be offered. Clinicians should take care to adhere to the evidence-base in terms of who benefits or who may find MBCT distressing or harmful, whilst also offering clients full opportunities for informed consent through honest and transparent discussions around the benefits and potential difficulties within MBCT. Wider investigation of adverse effects is warranted as well as in-depth qualitative explorations of what, how, and why distress is encountered by some participants to further understand individual experiences. This would also be important to consider in those who dropped out but maybe did not feel able to express their distress during participation.

Finally, it is recognised that the first two papers in this thesis were diagnostic as they focused solely on experiences of participants with depression. MBCT was initially based on a rationale of relapse-prevention in depression and it is important to thoroughly investigate experiences for those whom an intervention was originally targeted towards, as if interventions are adapted too quickly, this risks moving too far from the core rationale and purpose potentially diluting the effects of an intervention (Dimidjian & Segal, 2015). However, in practice, MBCT is being extended to include other populations and indeed, **Paper Three** suggests that clinicians are hopeful yet remain cautious around its delivery to different populations, particularly those with less of an evidence-base. Overall, it is hoped that the findings in this thesis can further contribute to the awareness of the benefits of MBCT arising from both participant and clinician experiences, as well as increasing awareness of and consideration of the potential difficulties arising from MBCT.

References

Ahsan, S. (2020). Holding up the mirror: Deconstructing whiteness in clinical psychology. *The Journal of Critical Psychology, Counselling and Psychotherapy*, *20(3),* 45–55.

Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A., & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: Lessons learnt. *BMC Medical Research Methodology*, *8(1),* 21. https://doi.org/10.1186/1471-2288-8-21

Baker, S. (2016). Working in the present moment: The impact of mindfulness on trainee psychotherapists' experience of relational depth. *Counselling and Psychotherapy Research*, *16(1),* 5–14. https://doi.org/10.1002/capr.12038

Bartels-Velthuis, A. A., Schroevers, M. J., van der Ploeg, K., Koster, F., Fleer, J., & van den Brink, E. (2016). A mindfulness-based compassionate living training in a heterogeneous sample of psychiatric outpatients: a feasibility study. *Mindfulness*, *7(4),* 809–818. https://doi.org/10.1007/s12671-016-0518-8

Binder, P. E., Holgersen, H., & Moltu, C. (2012). Staying close and reflexive: An explorative and reflexive approach to qualitative research on psychotherapy. *Nordic Psychology*, *64(2),* 103–117. https://doi.org/10.1080/19012276.2012.726815

Black, N., Murphy, M., Lamping, D., McKee, M., Sanderson, C., Askham, J., & Marteau, T. (1999). Consensus development methods: A review of best practice in creating clinical guidelines. *Journal of Health Services Research and Policy, 4(4),* 236–248. https://doi.org/10.1177/135581969900400410

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3(2),* 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2020). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, 1–25. https://doi.org/10.1080/14780887.2020.1769238

Braun, V., & Clarke, V. (2021). Thematic analysis. In E. Lyons & A. Cole (Eds.). *Analysing qualitative data in psychology* (128-147). Sage.

Brett, J., Staniszewska, S., Mockford, C., Herron-Marx, S., Hughes, J., Tysall, C., & Suleman, R. (2014). A systematic review of the impact of patient and public involvement on service users, researchers and communities. *Patient, 7(4),* 387–395 https://doi.org/10.1007/s40271-014-0065-0

British Psychological Society. (2015). *Clinical Psychology Workforce Project. Division of Clinical Psychology*. https://www.bps.org.uk/sites/www.bps.org.uk/files/Page%20-%20Files/Clinical%20Psychology%20Workforce%20Report%20%282015%29.pdf

Casey M. A., Krueger R. A. (1994). Focus group interviewing. In MacFie H. J. H., & Thomson D. M. H. (Eds). *Measurement of Food Preferences*. Springer

Charmaz, K. (2014). *Constructing grounded theory*. Sage.

Critical Appraisal Skills Programme (2018). CASP Qualitative Studies Checklist. [online] Available at: https://casp-uk.net/wp-content/uploads/2018/03/CASP-Qualitative-Checklist-2018_fillable_form.pdf. Accessed: 1st April 2021

Daniels, J. (2017). A matter of opinion: The delphi method in the social sciences. *Sage Research Methods Cases*. SAGE. https://doi.org/10.4135/9781526410603

Delbecq, A. L., & van de Ven, A. H. (1971). A group process model for problem identification and program planning. *The Journal of Applied Behavioral Science, 7(4),* 466–492. https://doi.org/10.1177/002188637100700404

Diamond, I. R., Grant, R. C., Feldman, B. M., Pencharz, P. B., Ling, S. C., Moore, A. M., & Wales, P. W. (2014). Defining consensus: A systematic review recommends methodologic criteria for reporting of Delphi studies. *Journal of Clinical Epidemiology, 67(4),* 401–409. https://doi.org/10.1016/j.jclinepi.2013.12.002

Dimidjian, S., & Segal, Z. V. (2015). Prospects for a clinical science of mindfulness-based intervention. *American Psychologist, 70(7),* 593–620. https://doi.org/10.1037/a0039589

Dixon-Woods, M., Agarwal, S., Jones, D., Young, B., & Sutton, A. (2005). Synthesising qualitative and quantitative evidence: A review of possible methods. *Journal of Health Services Research & Policy, 10(1),* 45–53. https://doi.org/10.1177/135581960501000110

Dixon-Woods, M., Sutton, A., Shaw, R., Miller, T., Smith, J., Young, B., Bonas, S., Booth, A., & Jones, D. (2007). Appraising qualitative research for inclusion in systematic reviews: A quantitative and qualitative comparison of three methods. *Journal of Health Services Research and Policy, 12(1),* 42–47. https://doi.org/10.1258/135581907779497486

Donohoe, H., Stellefson, M., & Tennant, B. (2012). Advantages and limitations of the e-delphi technique: Implications for health education researchers. *American Journal Health Education, 43(1),* 38-46. https://doi.org/10.1080/19325037.2012.10599216

Dudley, L., Gamble, C., Preston, J., Buck, D., Hanley, B., Williamson, P., & Young, B. (2015). What difference does patient and public involvement make and what are its pathways to impact? Qualitative study of patients and researchers from a cohort of randomised clinical trials. *PLOS ONE, 10(6),* e0128817. https://doi.org/10.1371/journal.pone.0128817

Finfgeld, D. L. (2003). Metasynthesis: The state of the art - so far. *Qualitative Health Research, 13(7),* 893–904. https://doi.org/10.1177/1049732303253462

Fink-Hafner, D., Dagen, T., Doušak, M., Novak, M., & Hafner-Fink, M. (2019). Delphi method: strengths and weaknesses. *Metodološki zvezki, 16(2),* 1-19

France, E. F., Uny, I., Ring, N., Turley, R. L., Maxwell, M., Duncan, E. A. S., Jepson, R. G., Roberts, R. J., & Noyes, J. (2019). A methodological systematic review of meta-ethnography conduct to articulate the complex analytical phases. *BMC Medical*

Research Methodology, 19(1), 1126-1139. https://doi.org/10.1186/s12874-019-0670-7

Halcomb, E., Davidson, P., & Hardaker, L. (2008). Using the consensus development conference method in healthcare research. *Nurse researcher, 16(1),* 56–71. https://doi.org/10.7748/nr2008.10.16.1.56.c6753

Hall, D. A., Smith, H., Heffernan, E., & Fackrell, K. (2018). Recruiting and retaining participants in e-Delphi surveys for core outcome set development: Evaluating the COMiT'ID study. *PLoS ONE, 13(7),* e0201378. https://doi.org/10.1371/journal.pone.0201378

Hasson, F., Keeney, S., & McKenna, H. (2000). Research guidelines for the delphi survey technique. *Journal of Advanced Nursing, 32(4),* 1008–1015. https://doi.org/10.1046/j.1365-2648.2000.t01-1-01567.x

Hicks, S., & Butler, C. (2020). A framework for clinical psychologists to understand and talk about race. *Critical Psychology, Counselling and Psychotherapy, 20(3),* 72–84.

Hsu, C.-C., & Sandford, B. A. (2007). The delphi technique: making sense of consensus. *Practical Assessment, Research, and Evaluation, 12,* 10. https://doi.org/10.7275/pdz9-th90

Lockwood, C., Munn, Z., & Porritt, K. (2015). Qualitative research synthesis: Methodological guidance for systematic reviewers utilizing meta-aggregation. *International Journal of Evidence-Based Healthcare, 13(3),* 179–187. https://doi.org/10.1097/XEB.0000000000000062

Malpass, A., Carel, H., Ridd, M., Shaw, A., Kessler, D., Sharp, D., Bowden, M., & Wallond, J. (2012). Transforming the perceptual situation: A meta-ethnography of qualitative work reporting patients' experiences of mindfulness-based approaches. *Mindfulness, 3(1),* 60–75. https://doi.org/10.1007/s12671-011-0081-2

McKenna, H. P. (1994). The Delphi technique: a worthwhile research approach for nursing?

Journal of Advanced Nursing, 19(6), 1221–1225. https://doi.org/10.1111/j.1365-2648.1994.tb01207.x

Melendez-Torres, G. J., Grant, S., & Bonell, C. (2015). A systematic review and critical appraisal of qualitative metasynthetic practice in public health to develop a taxonomy of operations of reciprocal translation. *Research Synthesis Methods, 6(4),* 357–371. https://doi.org/10.1002/jrsm.1161

Mohammed, M. A., Moles, R. J., & Chen, T. F. (2016). Meta-synthesis of qualitative research: the challenges and opportunities. *International Journal of Clinical Pharmacy, 38(3),* 695–704. https://doi.org/10.1007/s11096-016-0289-2

Murphy, M. K., Sanderson, C., Black, N. A., Askham, J., Lamping, D. L., Marteau, T., & Mckee, C. M. (1998). Consensus development methods, and their use in clinical guideline development. *HTA Health Technology Assessment NHS R&D HTA Programme Health Technology Assessment,* 2(3). www.hta.ac.uk/htacd.htm

Nair, R., Aggarwal, R., & Khanna, D. (2011). Methods of formal consensus in classification/diagnostic criteria and guideline development. *Seminars in Arthritis and Rheumatism, 41(2),* 95–105. https://doi.org/10.1016/j.semarthrit.2010.12.001

Noblit, G., & Hare, D. (1988). *Meta-ethnography: Synthesizing qualitative studies.* Sage

Pope, C. (2000). Qualitative research in health care: Analysing qualitative data. *BMJ, 320(7227),* 114–116. https://doi.org/10.1136/bmj.320.7227.114

Sandelowski, M., Docherty, S., & Emden, C. (1997). Qualitative metasynthesis: Issues and techniques. *Research in Nursing & Health, 20(4),* 365–371. https://doi.org/10.1002/(SICI)1098-240X(199708)20:4<365::AID-NUR9>3.0.CO;2-E

Sattar, R., Lawton, R., Panagioti, M., & Johnson, J. (2021). Meta-ethnography in healthcare research: a guide to using a meta-ethnographic approach for literature synthesis. *BMC Health Services Research, 21(1),* 50. https://doi.org/10.1186/s12913-020-06049-w

Sinha, I. P., Smyth, R. L., & Williamson, P. R. (2011). Using the delphi technique to determine which outcomes to measure in clinical trials: recommendations for the future based on a systematic review of existing studies. *PLoS Medicine, 8(1),* e1000393. https://doi.org/10.1371/journal.pmed.1000393

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: theory, method and research.* SAGE

Tebes, J. K. (2005). Community science, philosophy of science, and the practice of research. *American Journal of Community Psychology, 35(3–4),* 213–230. https://doi.org/10.1007/s10464-005-3399-x

Toye, F., Seers, K., Allcock, N., Briggs, M., Carr, E., Andrews, J., & Barker, K. (2013). "Trying to pin down jelly" - exploring intuitive processes in quality assessment for meta-ethnography. *BMC Medical Research Methodology, 13,* 46 http://www.biomedcentral.com/1471-2288/13/46

Toye, F., Seers, K., Allcock, N., Briggs, M., Carr, E., & Barker, K. (2014). Meta-ethnography 25 years on: Challenges and insights for synthesising a large number of qualitative studies. *BMC Medical Research Methodology, 14(1),* 80. https://doi.org/10.1186/1471-2288-14-80

van Dam, N. T., van Vugt, M. K., Vago, D. R., Schmalzl, L., Saron, C. D., Olendzki, A., Meissner, T., Lazar, S. W., Kerr, C. E., Gorchov, J., Fox, K. C. R., Field, B. A., Britton, W. B., Brefczynski-Lewis, J. A., & Meyer, D. E. (2018). Mind the hype: A critical evaluation and prescriptive agenda for research on mindfulness and meditation. *Perspectives on Psychological Science, 13(1),* 36–61. https://doi.org/10.1177/1745691617709589

Watts, S., & Stenner, P. (2005). Doing Q methodology: theory, method and interpretation. *Qualitative Research in Psychology, 2(1),* 67–91.

https://doi.org/10.1191/1478088705qp022oa

Watts, S. & Stenner, P. (2012). *Doing Q methodological research theory, method & interpretation.* Open University Books.

Williams, K. (2018). *Neuropsychological mechanisms of Mindfulness-based Cognitive Therapy for Depression.* [PhD Thesis, The University of Manchester]. The British Library. https://ethos.bl.uk/OrderDetails.do?uin=uk.bl.ethos.748014

Willig, C. (2013). *Introducing qualitative research in psychology*. Open University Press

Supplementary Material

Supplementary Material. Paper One

S1.1 PRISMA Checklists

These checklists are taken from the recent publication by Page et al. (2021) who have updated the PRISMA 2009 statement.

Table S1.A. PRISMA checklist

Section and Topic	Item #	Checklist item	Location
TITLE			
Title	1	Identify the report as a systematic review.	25
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	Supplementary Material
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	31-32
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	32
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	33
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	33-34 Supplementary Material
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	33
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	34
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	34

Section and Topic	Item #	Checklist item	Location
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	34-36
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	33-36
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	34
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	N/A
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	Supplementary Material
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	33-36
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	34-36
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	34-36
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	34-36
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	35 Supplementary Material
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	34
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	34-36

Section and Topic	Item #	Checklist item	Location
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	37
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	37 Supplementary Material
Study characteristics	17	Cite each included study and present its characteristics.	38-41
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	42-44
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	44-57
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	42 44
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	NA
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	Contained within 44-57
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	35 Supplementary Material
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	Contained within 44-57

Section and Topic	Item #	Checklist item	Location
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	34-35 43
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	57-62
	23b	Discuss any limitations of the evidence included in the review.	61
	23c	Discuss any limitations of the review processes used.	61
	23d	Discuss implications of the results for practice, policy, and future research.	58-62
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	28 33
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	28 32
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	NA
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	63
Competing interests	26	Declare any competing interests of review authors.	63
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	Supplementary Material

Table S1.B. PRISMA abstracts checklist (Page et al., 2021)

Section and Topic	Item #	Checklist item	Present?
Title			
Title	1	Identify the report as a systematic review.	Yes (main title and in the method)
Background			
Objectives	2	Provide an explicit statement of the main objective(s) or question(s) the review addresses.	Yes
Methods			
Eligibility criteria	3	Specify the inclusion and exclusion criteria for the review	No, due to space limitations. However we specify that 19 studies met the study criteria.
Information sources	4	Specify the information sources (e.g. databases, registers) used to identify studies and the date when each was last searched.	Yes
Risk of bias	5	Specify the methods used to assess risk of bias in the included studies	Yes
Synthesis of results	6	Specify the methods used to present and synthesise results.	Yes
Results			
Included studies	7	Give the total number of included studies and participants and summarise relevant characteristics of studies.	Yes
Synthesis of results	8	Present results for main outcomes, preferably indicating the number of included studies and participants for each. If meta-analysis was done, report the summary estimate and confidence/credible interval. If comparing groups, indicate the direction of the effect (i.e. which group is favoured).	Yes

Section and Topic	Item #	Checklist item	Present?
Discussion			
Limitations of evidence	9	Provide a brief summary of the limitations of the evidence included in the review (e.g. study risk of bias, inconsistency and imprecision).	Yes
Interpretation	10	Provide a general interpretation of the results and important implications.	Yes
Other			
Funding	11	Specify the primary source of funding for the review.	No, but this has been included at the end of the manuscript as per the target journal requirements
Registration	12	Provide the register name and registration number.	Yes

S1.2. eMERGE guidance

Table S1.C. eMERGE guidance

			Reported on Page(s):
Phase 1—Selecting meta-ethnography and getting started			
Introduction			
1	Rationale and context for the meta-ethnography	Describe the gap in research or knowledge to be filled by the meta-ethnography, and the wider context of the meta-ethnography	31-32
2	Aim(s) of the meta-ethnography	Describe the meta-ethnography aim(s)	32
3	Focus of the meta-ethnography	Describe the meta-ethnography review question(s) (or objectives)	32
4	Rationale for using meta-ethnography	Explain why meta-ethnography was considered the most appropriate qualitative synthesis methodology	32 Paper Four
Phase 2—Deciding what is relevant			
Methods			
5	Search strategy	Describe the rationale for the literature search strategy	33-34
6	Search processes	Describe how the literature searching was carried out and by whom	33-35
7	Selecting primary studies	Describe the process of study screening and selection, and who was involved	33-35
Findings			
8	Outcome of study selection	Describe the results of study searches and screening	36-37
Phase 3—Reading included studies			
Methods			
9	Reading and data extraction approach	Describe the reading and data extraction method and processes	34
Findings			
10	Presenting characteristics of included studies	Describe characteristics of the included studies	38-41
Phase 4—Determining how studies are related			
Methods			
11	Process for determining how studies are related	Describe the methods and processes for determining how the included studies are related:	34
		- Which aspects of studies were compared	34
		AND	
		- How the studies were compared	34
Findings			
12	Outcome of relating studies	Describe how studies relate to each other	38-41
Phase 5—Translating studies into one another			
Methods			
13	Process of translating studies	Describe the methods of translation**:**	35

		- Describe steps taken to preserve the context and meaning of the relationships between concepts within and across studies	35
		- Describe how the reciprocal and refutational translations were conducted	35
		- Describe how potential alternative interpretations or explanations were considered in the translations	35 Paper Four
Findings			
14	Outcome of translation	Describe the interpretive findings of the translation.	44-57
Phase 6—Synthesizing translations			
Methods			
15	Synthesis process	Describe the methods used to develop overarching concepts (“synthesized translations”)	35
		Describe how potential alternative interpretations or explanations were considered in the synthesis	Paper Four
Findings			
16	Outcome of synthesis process	Describe the new theory, conceptual framework, model, configuration, or interpretation of data developed from the synthesis	44-57
Phase 7—Expressing the synthesis			
Discussion			
17	Summary of findings	Summarize the main interpretive findings of the translation and synthesis and compare them to existing literature	57-59
18	Strengths, limitations, and reflexivity	Reflect on and describe the strengths and limitations of the synthesis:	
		- Methodological aspects—for example, describe how the synthesis findings were influenced by the nature of the included studies and how the meta-ethnography was conducted.	60-61
		-Reflexivity—for example, the impact of the research team on the synthesis findings	60-61
19	Recommendations and conclusions	Describe the implications of the synthesis	60-61

S1.3. Checking Additional Sources

Table S1.D. Dates for checking additional sources

Additional source checked	**Date**
Reference lists of previous meta-syntheses	16th October 2020
Reference lists of the included studies	16th October 2020
Forward citation searching	27th October 2020
Correspondence with all study authors regarding further publications	All were contacted between the 16th and 27th October 2020
Correspondence with authors for further clarification	Between the 26th October and 7th December 2020

S1.4. Meta-ethnography Steps

Table S1.E. Meta-ethnography steps

Step	Task
1	Formulating the research question
	Identifying the need for a meta-ethnographic approach in an area of interest.
2	Deciding what is relevant
	Defining the focus, systematic search, selection of studies, and quality assessment
3	Repeated reading of the studies, becoming familiar with and noting key concepts, themes, metaphors, and author interpretations.
	Coding data verbatim into 1st and 2nd order constructs on NVivo
	Extracting of key study characteristics
4	Deciding how the studies relate to/differ from one another. Examining relationships between studies and condensing themes into relevant categories.
5	Translation of studies into one another using reciprocal and/or refutational translations.
	Comparison and condensing of categories from each paper into all other papers, ensuring contextual meaning within and across studies is preserved to form translations which give rise to 3rd order constructs
6	Synthesising translations using a line of argument synthesis to give new concepts or new understandings
7	Expressing the synthesis

S1.5. Sensitivity Analysis

There were no major differences identified between the second-order and first-order constructs. However, it should be noted that there was less depth within these first-order categories, compared with second-order categories, with fewer studies identified per category and indeed some studies did not include any first-order constructs (participant quotes).

Table S1.F. Step 4. First-order categories across studies

Category	Studies*
Mindfulness practice	1, 2, 3, 9, 10, 11, 12, 13, 15, 16, 18
Positive aspects of MBCT	2, 3, 4, 5, 10, 11, 12, 14, 15, 16, 17, 18
Awareness	1, 2, 4, 5, 10, 11, 12, 14, 15, 16, 18, 19
Agency, choice, control	1, 2, 3, 4, 5, 13, 14, 15, 16, 17, 19
Perspective	1, 2, 3, 4, 5, 9, 10, 11, 12, 13, 14, 15, 18
Relationships with self	2, 5, 11, 12, 13, 14, 15, 16, 19
Relationships with experience	1, 2, 5, 10, 11, 12, 13, 14, 15, 16, 18, 19
Group processes	1, 2, 3, 4, 5, 10, 11, 12, 13, 15, 16, 17, 18
Relationships with others	2, 4, 5, 11, 13, 14, 15, 17, 18, 19
Acceptance	1, 2, 3, 5, 10, 18, 19
Expectations	1, 2, 3, 4, 5, 14, 15, 16, 17, 18
Difficult aspects of MBCT	2, 3, 4, 13, 15, 16
Variable change	4, 11, 13, 14, 18
Prior experiences	1, 2, 5, 11, 14, 18
Models of depression	1, 5, 11, 14, 19

Note. *Studies: 1=Mason & Hargreaves; 2=Ma; 3=Finucane & Mercer; 4=Smith et al.; 5=Allen et al.; 6=Cebolla & Barrachina; 7=Baillie et al.; 8=Hopkins & Kuyken; 9=Worsfold; 10=Ames et al.; 11=Bihari & Mullan; 12=Boggs et al.; 13=Lilja et al.; 14=Murphy & Lahtinen; 15=Di Toro; 16=Chesin et al.; 17=Racey et al.; 18=Williams et al.; 19=Tickell et al.

S1.6. Second-order categories

Table S1.G. Step 4. Second-order categories across studies

	Studies*																			
2nd-order constructs (categories) Sub-Categories	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**Totals^**
Mindfulness practice																				**19**
Benefits			🟨	🟨		🟨	🟨		🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨		🟨		
Difficulties (psychological, practical/logistical)	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	
Styles (formal, informal, proactive/reactive use)	🟨	🟨	🟨	🟨	🟨	🟨	🟨			🟨		🟨	🟨	🟨			🟨	🟨	🟨	
Motivations/intentions to continue	🟨	🟨	🟨	🟨		🟨	🟨	🟨	🟨	🟨			🟨		🟨		🟨	🟨		
Positive aspects of MBCT																				**18**
Useful, helpful, enjoyable	🟨	🟨	🟨	🟨	🟨	🟨	🟨			🟨	🟨	🟨	🟨	🟨		🟨	🟨	🟨	🟨	
Positive effects on mental health		🟨	🟨	🟨	🟨	🟨	🟨		🟨		🟨	🟨	🟨	🟨	🟨		🟨	🟨	🟨	
Calmer, relaxed	🟨	🟨	🟨	🟨	🟨	🟨	🟨		🟨				🟨	🟨	🟨			🟨		
Experiencing more positive emotions	🟨	🟨	🟨						🟨			🟨						🟨		
Challenging but worth it										🟨	🟨									
Awareness																				**17**
Experience (thoughts, emotions, sensations, reactions, and actions/behaviours)	🟨	🟨	🟨	🟨	🟨	🟨	🟨		🟨	🟨	🟨	🟨	🟨	🟨	🟨			🟨	🟨	
Warning signals, coping strategies, and relapse risk		🟨			🟨					🟨		🟨	🟨	🟨		🟨		🟨	🟨	
Agency, choice, and control																				**16**
Agency and choice over ADMs																			🟨	
Choice around thoughts, feelings, and reactions				🟨	🟨	🟨	🟨				🟨		🟨	🟨	🟨				🟨	
Agency and control around ability to cope, depression, warning signs, ADMs, relapse	🟨	🟨	🟨	🟨	🟨	🟨	🟨		🟨		🟨	🟨	🟨	🟨	🟨	🟨		🟨	🟨	
Perspective																				**16**
Thoughts, emotions, behaviour				🟨	🟨	🟨	🟨			🟨	🟨	🟨	🟨	🟨						
Self-perspective				🟨		🟨	🟨		🟨				🟨							
Present moment, appreciating life, more positive outlook	🟨	🟨	🟨	🟨		🟨	🟨		🟨	🟨	🟨	🟨	🟨		🟨			🟨	🟨	

	Studies*																			
2nd-order constructs (categories) Sub-Categories	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**Totals^**
Relationships with experience																				**16**
Stopping/slowing, step back, space from experience	🟨	🟨	🟨	🟨	🟨	🟨	🟨		🟨	🟨	🟨	🟨	🟨	🟨				🟨		
Reacting vs responding, relating more mindfully	🟨	🟨		🟨		🟨	🟨			🟨	🟨		🟨	🟨				🟨		
Reduced rumination, depressive thinking styles		🟨		🟨		🟨	🟨		🟨		🟨		🟨	🟨	🟨				🟨	
Relationships with the self																				**16**
Self-care, acknowledging needs and feelings		🟨	🟨		🟨	🟨	🟨	🟨			🟨		🟨						🟨	
Struggle with self-care/prioritising self			🟨		🟨															
Ongoing self-blame, guilt, shame		🟨			🟨		🟨					🟨							🟨	
Emotion regulation					🟨	🟨	🟨		🟨		🟨		🟨			🟨			🟨	
Confidence, feelings of empowerment, autonomy		🟨		🟨	🟨	🟨	🟨		🟨		🟨		🟨	🟨					🟨	
Changing feelings towards depression identity, self-compassion, self-worth, self-criticism		🟨	🟨	🟨	🟨	🟨	🟨	🟨			🟨		🟨	🟨	🟨			🟨	🟨	
Group processes																				**15**
Shared experience	🟨	🟨	🟨	🟨	🟨			🟨		🟨	🟨	🟨		🟨	🟨	🟨		🟨	🟨	
Social experience			🟨		🟨					🟨	🟨					🟨		🟨	🟨	
Safety, trust, validation (with group or instructor)		🟨	🟨		🟨			🟨			🟨			🟨	🟨			🟨		
Difficulty with the group/lack of group experience		🟨	🟨			🟨		🟨		🟨	🟨	🟨			🟨	🟨		🟨		
Group support	🟨	🟨	🟨	🟨	🟨			🟨		🟨	🟨				🟨	🟨		🟨	🟨	
Acceptance																				**14**
Of experience (thoughts, emotions, pain/sensations)	🟨			🟨	🟨	🟨			🟨		🟨		🟨	🟨		🟨		🟨	🟨	
Depression as an illness													🟨						🟨	
ADMs																			🟨	
Self			🟨	🟨			🟨												🟨	
Towards others/by others					🟨	🟨	🟨											🟨		
Struggles with acceptance	🟨	🟨			🟨															
Relationships with others																				**13**
Positive change: enhanced connections, intimacy, tolerance/patience, understanding others' needs		🟨		🟨	🟨	🟨	🟨	🟨	🟨		🟨		🟨		🟨		🟨	🟨		
Ongoing difficulties relating to others							🟨	🟨												

	Studies*																			
2nd-order constructs (categories) Sub-Categories	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**Totals^**
No changes					■		■					■								
Connection with something bigger		■						■												
Expectations																				**12**
High expectations, expecting a cure	■		■								■								■	
Disappointment	■		■					■							■				■	
Open mind, no preconceptions	■																		■	
Impact of expectations on outcome	■					■										■			■	
Wanted more support during/after MBCT		■	■							■	■	■			■					
Concerns pre-MBCT	■							■								■		■	■	
Difficult aspects of MBCT																				**10**
Practical/logistical barriers		■													■				■	
Difficulty engaging in, or dislikes about, MBCT		■	■								■	■			■	■	■		■	
Vulnerability, psychological and physical health barriers.	■	■	■	■							■				■	■	■			
Transient negative effects	■	■	■	■							■				■	■	■			
Variance of change																				**5**
Lifelong change											■		■	■						
Variable change		■			■						■									
Models of depression																				**5**
Beliefs about causes of and treatment for depression					■														■	
Different understanding/relationship with depression	■				■						■							■	■	
Prior experiences/descriptions of depression																				**4**
Disconnection with, fear of upsetting others											■									
Helplessness, perceived inability to cope	■				■															
Descriptions of previous depression	■													■						

Note. *Studies: 1=Mason & Hargreaves; 2=Ma; 3=Finucane & Mercer; 4=Smith et al.; 5=Allen et al.; 6=Cebolla & Barrachina; 7=Baillie et al.; 8=Hopkins & Kuyken; 9=Worsfold; 10=Ames et al.; 11=Bihari & Mullan; 12=Boggs et al.; 13=Lilja et al.; 14=Murphy & Lahtinen; 15=Di Toro; 16=Chesin et al.; 17=Racey et al.; 18=Williams et al.; 19=Tickell et al.; ^total number of studies within each category; ADMs=antidepressant medication

S1.7. Full Text Screening Decisions

Table S1.H. Full text screening decisions

Article		Decision	MBCT	Depression	Adults/ Adolescents	English written	Qualitative analysis	Comment
Papers Included								
1	Allen, M., et al. (2009).	Yes	Yes	Yes	Yes	Yes	Yes	
2	Ames, C. S., et al. (2014).	Yes	Yes	Yes	Yes	Yes	Yes	
3	Baillie et al. (2012)	Yes	Yes	Yes*	Yes	Yes	Yes	*The sampling was focused on recruiting parents who had histories of recurrent depression and had participated in MBCT
4	Bihari, J. L. N. and E. G. Mullan (2014).	Yes	Yes	Yes	Yes	Yes	Yes	
5	Boggs, J. M., et al. (2014).	Yes	Yes*	Yes	Yes	Yes	Yes	*Online MBCT delivery
6	Cebolla i Marti and Barrachina (2009).	Yes	Yes	Yes	Yes	Yes	Yes	
7	Chesin, M. S., et al. (2018).	Yes	Yes	Yes	Yes	Yes	Yes	
8	Di Toro, B. M. (2017).	Yes*	Yes	Yes	Yes	Yes	Yes	*PhD thesis
9	Finucane, A. and S. W. Mercer (2006).	Yes	Yes	Yes	Yes	Yes	Yes	
10	Hopkins, V. and W. Kuyken (2012).	Yes*	Yes	Yes	Yes	Yes	Yes	*This study specifically asked participants about their experiences of the MBCT reunions sessions (which take place after the course has finished). Following our inclusion criteria, this study was included because we wanted participants who have taken part in MBCT.

Article		Decision	MBCT	Depression	Adults/ Adolescents	English written	Qualitative analysis	Comment
11	Lilja, J. L., et al. (2015).	Yes	Yes	Yes	Yes	Yes	Yes	
12	Ma (2002)	Yes*	Yes	Yes	Yes	Yes	Yes	*PhD thesis
13	Mason, O. and I. Hargreaves (2001).	Yes	Yes	Yes	Yes	Yes	Yes	
14	Murphy, H. and M. Lahtinen (2015).	Yes	Yes	Yes	Yes	Yes	Yes	
15	Racey, D. N., et al. (2018).	Yes*	Yes	Yes	Yes	Yes	Yes	*This study was a feasibility and acceptability study with a TA qualitative analysis. The study included young peoples', parents', and clinician views; only young peoples' views were included. Clinician views were excluded as there was no data on whether clinicians had previous experiences with depression and they did not take part in MBCT. Parents' views were excluded as although parents had prior experiences with depression, the aim of the MBCT group for parents was to better support their children through depression and help to model principles of MBCT for their children.
16	Smith, A., et al. (2007)	Yes	Yes	Yes	Yes	Yes	Yes	
17	Tickell (2020)	Yes	Yes	Yes	Yes	Yes	Yes	
18	Williams, C. M., et al. (2018).	Yes	Yes	Yes	Yes	Yes	Yes	
19	Worsfold, K. E. (2013).	Yes	Yes	Yes	Yes	Yes	Yes	
Papers Excluded								
1	Alsubaie, M., et al. (2018).	No	No*	Yes*	Yes	Yes	Yes	*Participants had a diagnosis of cardiovascular disease and a history of major depression or current mild

Article		Decision	MBCT	Depression	Adults/ Adolescents	English written	Qualitative analysis	Comment
								depression symptoms. The main reason for exclusion, however, is **because the focus and themes of MBCT were adapted significantly** to include teaching relevant to cardiovascular disease (CVD) and **therefore not specific to depression and relapse prevention**. More specifically, the **focus was moved away from depressive relapse and instead moved onto recognising bodily experiences associated with CVD.** There was also a shift from focusing on depressogenic thinking instead onto ways in which physical symptoms were interpreted.
2	Chesin, M. S., et al. (2015).	No	Yes*	Yes	Yes	Yes	No*	***No qualitative analysis**, no themes present
3	Foulk, M. A., et al. (2014).	No	Yes	Yes*	Yes	Yes	No*	*Not all participants had experienced depression *This was a feasibility/accessibility study and **did not include any qualitative analysis** and instead only presented case studies.
4	Garriz, M., et al. (2020).	No*	Yes	Not all*	Yes	Yes	Yes	*The qualitative study took place within the context of a mixed-method study. Total sample=269 participants, of which **only 23% had a diagnosis of depression**. **As only 14/269 participants took part in the qualitative aspect of the study, it is difficult to know whether any of these 14 participants had a diagnosis of depression**.
5	Hortynska, K., et al. (2016).	No	Yes	Unclear*	Yes	Yes	Yes	*Some participants had experienced depression but the authors had not categorised their sample by diagnostic categories therefore the sample also included many other 'diagnoses', **meaning it was difficult to identify experiences specific to people with depression**.

Article		**Decision**	**MBCT**	**Depression**	**Adults/ Adolescents**	**English written**	**Qualitative analysis**	**Comment**
								Other presenting problems included anxiety, PTSD, bipolar, body dysmorphia, early trauma, worries, rumination, panic attacks, work stress, OCD, chronic pain, self-criticism, complex bereavement, self-blame, social anxiety, health anxiety, generalized anxiety, health problems, suicidal ideation and intrusive thoughts
6	Hunter-Jones, J. J., et al. (2019).	No	No*	Yes*	Yes	Yes	Yes	*Adapted MBCT into a program called UPLIFT (Using Practice and Learning to Increase Favourable Thoughts) which when looking at the session content, **it is completely different to standardised MBCT** (e.g., the UPLIFT program in this study was developed for people with epilepsy and CF, does not introduce meditation until session 4, includes more CBT exercises than standardised MBCT, relaxation, and has less emphasis on relapse prevention). *Participants had diagnoses of comorbid HIV/AIDS and depression (although this is not the reason for exclusion)
7	Kristofersson, G. K. (2013).	No	No*	No*	Yes	Yes	Yes	***Not MBCT.** MBSR (Mindfulness-based Stress Reduction) *Participants **did not have diagnoses of depression** but instead diagnoses of substance misuse and traumatic brain injury
8	Langdon et al., 2011	No	Yes	Unclear*	Yes	Yes	Yes	*Participants had experienced depression, anxiety, or chronic health problems (e.g., heart disease). One MBCT course was run only for physical illness and the other was for dep & anxiety and **it is not possible to identify/isolate which themes are taken from which course/which depressed sample**

Article		Decision	MBCT	Depression	Adults/ Adolescents	English written	Qualitative analysis	Comment
9	Lockman, S. C. (2015).	No*	No*	Yes*	Yes	Yes	Yes	Thesis ***Not MBCT** as participants were only required to have had a basic mindfulness practice for the last 8 weeks.
10	Lomas, T., et al. (2015).	No	No*	No*	Yes	Yes	Yes	***Not MBCT,** general meditation experience ***Not specific to depression**
11	Malpass, A., et al. (2015).	No	Yes*	No*	Yes	Yes	Yes	*Primary diagnoses were asthma & Chronic Obstructive Pulmonary Disease (COPD), then depression and/or anxiety as secondary diagnoses. Therefore, **experiences of depression and/or anxiety were a secondary focus**. Further, **there is no data on diagnoses of depression/anxiety** and so it is hard to tell what proportion of the sample had this, and therefore whether the themes relate to experiences of depression (the focus of our review). Finally, the themes of this study were primarily focused with experiences of COPD and asthma. *MBCT was delivered but the session content was adapted to fit with learning acceptance towards living with asthma and COPD
12	Nangia & Sharma, 2012	No*	Yes*	Yes	Yes	Yes	No	*although the method states TA, there is no further detail given and only titles of themes given in the results section, with no supporting data (quotes, descriptions, or interpretations). Therefore, this has been excluded due to there being **no qualitative analysis** *Some minor adaptations to the length of MBCT (e.g., ranging between 8-12 sessions), which incorporated

Article		Decision	MBCT	Depression	Adults/ Adolescents	English written	Qualitative analysis	Comment
								one-to-one assessment sessions either side of the 8 week group.
13	Rycroft-Malone et al., 2019	No*	Yes	Not all*	Yes	Yes	Yes	*The sample **included only 16 clients out of a sample of 91** (which included service managers, commissioners, and MBCT teachers) making it hard to draw out useable data re clients' themes
14	Smith, A. (2004).	No*	Yes*	No*	Yes	Yes	Yes	*The author combined 6 groups **- 3 MBSR** for anxiety/chronic pain and 3 MBCT groups for recurrent depression. So the themes emerged based on these 6 combined groups meaning that **half the sample didn't have depression and didn't take part in an MBCT group specific to depression.**
15	Smith, A. (2006).	No*	Yes	Yes	Yes	Yes	Yes	This book chapter reported exactly the same data that was later published in Smith (2007) paper which is included above in the synthesis. Therefore, it is excluded **here to avoid duplication.**
16	Smith, E. (2012).	No*	Yes	Yes	Yes	Yes	Yes	*This is the earlier dissertation/thesis from Smith (2015) which **was later published and is included in our synthesis above.**
17	Smith, E. L., et al. (2015).	No	Yes*	Not all*	Yes	Yes	Yes	*This study involved clients and their partners. **Clients had a history of depression but their partners did not.** Themes were focused on the experiences of taking part in **MBCT as a couple**. The themes here **were developed based on both participant and partners**, so not two separate groups and therefore **themes could not be isolated.** Only slight adaptations made to MBCT and so it still focused on relapse prevention
18	Ter Avest, M. J., et al. (2019).	No*	Yes	Yes	Yes	Yes	No*	***No qualitative analysis**.

Article		Decision	MBCT	Depression	Adults/ Adolescents	English written	Qualitative analysis	Comment
19	Weaver, 2015	No*	Yes	Yes	Yes	Yes	Yes	*Upon closer examination, we found that **this thesis was the precursor to the later published paper** by Tickell et al. (2020; included above in the included studies; both studies have the same sample sizes and characteristics) therefore it was treated as a duplication here. This was also clarified with the original study authors. It was decided within the wider research team to only include the themes by Tickell et al. (2020) as this included additional follow-up data, a more comprehensive analysis process, and had been through the peer-review process. *Doctoral thesis

Note. TA=Thematic Analysis

S1.8. CASP results

Table S1.I. CASP quality results by study

Study *	1. Aims	2. Qual. methods	3. Design	4. Recruitment strategy	5. Data collection	6. Participant researcher relationship	7. Ethical issues	8. Rigorous analysis	9. Statement of findings	10. Value	Comment
1	✓	✓	✓	?	✓	✓	×	✓	✓	?	4 –more detail needed regarding participant drop out/retention 7 – No details for ethical approval or consent 10 – more detail needed
2*	✓	✓	✓	✓	✓	×	✓	✓	?	?	6 – no detail 9 – could benefit from a summary around key findings 10 – limited mention of key contributions/ new avenues for research *unpublished PhD thesis
3	✓	✓	?	✓	✓	?	✓	✓	✓	✓	3 – justification of choice of qualitative method is not clear 6 – brief statement in the method but more detail could be given
4	✓	✓	✓	✓	?	?	?	✓	✓	✓	5 – could benefit from a topic/interview guide 6 – some detail given, but could be more explicit 7 – the authors mention informed consent but do not mention NHS/local ethical approval

Study *	1. Aims	2. Qual. methods	3. Design	4. Recruitment strategy	5. Data collection	6. Participant researcher relationship	7. Ethical issues	8. Rigorous analysis	9. Statement of findings	10. Value	Comment
5	✓	✓	✓	✓	✓*	?	✓*	✓	✓	✓	The authors only illustrate three participant case studies in detail 5 - Interview schedule not given 6 - Although author experience and potential biases are listed, there is no real analysis regarding reflexivity and the role of the researchers 7 – more detail needed regarding informed consent and confidentiality
6	✗	✓	?	✗	✓	✗	✗	✗	?	✗	1 – study aims not clear 3 –it is hard to tell whether the research design is appropriate 4 – no specific detail about recruitment (e.g., selection of participants, details around attrition: one part mentions 31 responses, another mentions 32) 6 – no reflexivity mentioned 7 – no mention of ethics 8 – brief mention of content analysis. 9 – needs more discussion around credibility of findings 10 – unclear what the implications of the findings are

Study *	**1. Aims**	**2. Qual. methods**	**3. Design**	**4. Recruitment strategy**	**5. Data collection**	**6. Participant researcher relationship**	**7. Ethical issues**	**8. Rigorous analysis**	**9. Statement of findings**	**10. Value**	**Comment**
											*study is suspected to be a service evaluation but unclear
7	✓	✓	✓	✓	✓	✓	?	✓	✓	✓	7 – more detail needed for consent & confidentiality
8	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	5 – more detail could be given around the interview topic guide (if there was one)
9	✓	✓	?	✓	✓	✗	?	?	?	✓	3 – unclear on analysis 6 – no detail given 7 – the author states that participants gave informed written consent but there are no details regarding ethical approval 8 – analysis method not clear 9 - no details on credibility of findings
10	✓	✓	?	?	?	?	✓	✗	✓	✓	3 – no justification regarding the choice of qualitative methods 4 – more detail could be given 5 – more detail needed around the interview schedule 6 – acknowledgement that the researcher has both a personal and professional interest in MBCT, but no expansion around the potential impact of this

Study *	1. Aims	2. Qual. methods	3. Design	4. Recruitment strategy	5. Data collection	6. Participant researcher relationship	7. Ethical issues	8. Rigorous analysis	9. Statement of findings	10. Value	Comment
											8 – no in depth discussion around the analysis. No acknowledgement of reflexivity. Limited quotes from participants
11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
12	✓	✓	?	?	✓	?	✓	✓	✓	✓*	3 – no justification for the choice of qualitative methods 4 - no interviews with participants who didn't complete the full course despite there initially being 100 participants in the study. No explanation why they dropped out. 6 – brief acknowledgement in the discussion regarding the potential impact of the relationship between researchers and participants. Nothing in relation to the design or analysis process, however. 10 – mostly this is considered, but some more detail needed
13	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
14	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
15	✓	✓	✗	✓	✓	?	✓	✓	✓	✓	3 – no sufficient detail around justification of the qualitative

Study *	1. Aims	2. Qual. methods	3. Design	4. Recruitment strategy	5. Data collection	6. Participant researcher relationship	7. Ethical issues	8. Rigorous analysis	9. Statement of findings	10. Value	Comment
											design, specifically the choice of thematic analysis. 6 – brief statement around the potential for the halo effect whereby participants wanted to answer positively for the researcher. *unpublished doctoral thesis
16	✓	✓	?	✓	✓	✗	✓	✓	✓	✓	3 - some justification of the method but more detail about the analysis method needed 6 – a brief statement is given regarding the authors' beliefs about the programme efficacy but the link between that and outcome is not made explicit.
17	✓	✓	✗	✓	✓	✗	✓	?	?	✓	3 – justification of choice of qualitative method is unclear 6 – no consideration 8 – they say they developed a topic guide but we can't see it 9 – could benefit from more detail regarding credibility of findings (e.g., triangulation, multiple analysts) *service evaluation
18	✓	✓	✓	✓	✓	?*	✓	✓	✓	✓	6 – authors feedback their themes to study participants and

Study *	1. Aims	2. Qual. methods	3. Design	4. Recruitment strategy	5. Data collection	6. Participant researcher relationship	7. Ethical issues	8. Rigorous analysis	9. Statement of findings	10. Value	Comment
											disclosed their experience with MBCT; no specific statement of the potential for bias
19	✓	✓	?	✓	✓	✓	✓	✓	✓	✓	3 - justification of choice of TA is unclear Good reflection on researcher relationship, topic guide & booklets although some may be leading questions.

Note. *additional information given or needed here; Individual item ratings are rated either ✓=“Yes”, ×=“No, or ?=“Can’t tell”; *Studies: 1=Mason & Hargreaves; 2=Ma; 3=Finucane & Mercer; 4=Smith et al.; 5=Allen et al.; 6=Cebolla & Barrachina; 7=Baillie et al.; 8=Hopkins & Kuyken; 9=Worsfold; 10=Ames et al.; 11=Bihari & Mullan; 12=Boggs et al.; 13=Lilja et al.; 14=Murphy & Lahtinen; 15=Di Toro; 16=Chesin et al.; 17=Racey et al.; 18=Williams et al.; 19=Tickell et al.;

S1.9. Prior Experiences with Depression

Six studies explicitly described participants’ prior experiences with depression, largely reflecting negative feelings towards the self and interpersonal difficulties. **Table S1.J** below includes details and an example quote.

Table S1.J. Second-order construct and example quote

2nd-order constructs	Translation of 2nd-order construct	2nd-order example quote (studies*)	Studies*
Prior experiences of depression	Feelings of helplessness, withdrawal from others, and efforts to put on a “front”. Struggles with “problematic thinking”.	“Prior to MBCT the majority of participants stated that they had viewed depression as an opaque process over which they felt helpless”(5)	5, 7, 11, 14, 19

Note. *Studies: 5=Allen et al.; 7=Baillie et al.; 11=Bihari & Mullan; 14=Murphy & Lahtinen; 19=Tickell et al.

Specifically, participants described feelings of helplessness, guilt, and inadequacy around experiences of depression, and named “problematic thinking” and “thought overload” (Mason & Hargreaves, 2001) alongside struggles to "extricate" themselves from downward trajectories (Murphy & Lahtinen, 2015). Some commented on difficulties with interpersonal relationships and increased levels of reactivity to others (“criticising others…getting caught up in distressing, repetitive rows and arguments”; Bihari & Mullan, 2014). Some described “withdrawing and feeling isolated from others” (Bihari & Mullan, 2014), and having “learned to mask their feelings” (Allen et al., 2009) from others to give the perception that they could cope.

Supplementary Material. Paper Two

S2.1. COREQ

Table S2.A. COREQ Checklist

Topic	Item No.	Guide Questions/Description	Details OR Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	The lead researcher **Method**
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	In progress: DClinPsy (due to complete 2021) Completed: PhD, MSc, BSc
Occupation	3	What was their occupation at the time of the study?	Trainee Clinical Psychologist
Gender	4	Was the researcher male or female?	Female
Experience and training	5	What experience or training did the researcher have?	At the time of conducting the qualitative interviews, the researcher was experienced in clinical research, conducting semi-structured interviews, and assessment, and was completing their PhD. At the time of analysis, the lead researcher had completed their PhD and was employed as and training as a Trainee Clinical Psychologist.
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	No
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	The lead researcher knew the participants in both a research capacity and through co-facilitating the MBCT groups; the participants were aware that the interviews were being carried out as part of a PhD.
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	The lead researcher is aware that their professional and personal interest in MBCT, and mindfulness-based meditation more generally, may have an impact on the results presented

			here. The lead researcher maintained this awareness throughout the process of conducting and analysing this study, and regularly reflected on this in a reflexive log and in discussions with the wider research teams. The lead researcher's professional interest in MBCT: - having started their MBCT teacher training in 2014 - held a personal meditation practice since 2011 - completed a PhD specifically investigating the neuropsychological mechanisms of MBCT - has published in the field of MBCT.
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	Reflexive Thematic Analysis **Method**
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	**Method**
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	**Method**
Sample size	12	How many participants were in the study?	**Method**
Non-participation	13	How many people refused to participate or dropped out? Reasons?	**Method**
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	**Method**
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	No
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	**Method** **Results**

Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	**Supplementary Material** **Interview guides were not pilot tested, unfortunately**
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	**Method**
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	**Method**
Field notes	20	Were field notes made during and/or after the inter view or focus group?	No field notes were taken during the interviews.
Duration	21	What was the duration of the interviews or focus group?	No time limit for individual interviews, but on average the face-to-face interviews lasted 30-45 minutes per participant. Written feedback during follow-up had no time limit.
Data saturation	22	Was data saturation discussed?	No. All interviews were analysed in accordance with the theoretical framework, Reflexive Thematic Analysis (TA). Reflexive TA does not encourage working towards data saturation as they argue that this is subjective and cannot be determined a priori (Braun & Clarke, 2019)
Transcripts returned	23	Were transcripts returned to participants for comment and/or correction?	No, this was an unfortunate oversight and participants were not specifically consented for this.
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	One. **Method**
Description of the coding tree	25	Did authors provide a description of the coding tree?	Yes. See Supplementary Material 4. This is signposted to within the **Method**
Derivation of themes	26	Were themes identified in advance or derived from the data?	Themes were derived entirely from the data. **Method**
Software	27	What software, if applicable, was used to manage the data?	**NVivo** **Method**
Participant checking	28	Did participants provide feedback on the findings?	No, see point 23 above. However, we asked two independent research clinicians to comment on the themes – one of which had experience with MBCT and one who did not have experience with MBCT.

			Method
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	Yes, see the **Results** section All quotes are anonymous.
Data and findings consistent	30	Was there consistency between the data presented and the findings?	Yes.
Clarity of major themes	31	Were major themes clearly presented in the findings?	Yes, see the **Results** section
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	Yes, see the **Results and Discussion** sections

Note. COREQ=COnsolidated criteria for REporting Qualitative research

S2.2. Qualitative Interview Schedules

Baseline

1. Have you had previous meditation, ‘mindfulness’ or yoga experience?

   (This may include evening or day courses, online courses, books, events)

   a. If yes, what have you tried?
   b. If no, have you ever been interested in trying meditation or mindfulness-based approaches?
2. What motivated you to take part in this MBCT course?
3. What do you hope to gain from this MBCT course?
4. What do you feel may be the challenges or difficulties of taking part in this MBCT course?

Post-MBCT

1. Have you attended any further mindfulness or meditation classes since finishing your course with us?

   (This could include evening or day courses, online courses, books, events)
2. If you have not been practising formal or informal mindfulness or have practised less than you had hoped, what do you feel are your personal barriers to practice?
3. What do you feel you have gained from this MBCT course?

   (What have you learned, how has your life changed/not changed?

   Prompts only if necessary: better mood, reduced anxiety, feeling empowered, valued, understood, calmer, improved wellbeing, a sense of control, acceptance, improved relationships…)

   What did you like or enjoy?

4. What do you feel have been the challenges or difficulties of taking part in this MBCT course? *Were there any particular difficulties, downsides or aspects of the course you did not like or did not enjoy?*
5. Which aspects of the MBCT course do you feel were helpful to you? Were there any aspects of the course that were unhelpful to you? (open question)
6. Do you intend to continue with your current mindfulness practice? If yes, how often and which exercises?
7. Why do you continue/intend to continue to practise mindfulness?
8. Any other comments:

Follow-up

1. Have you attended any further mindfulness or meditation classes since your last visit with us?
   (This could include evening or day courses, online courses, books, events)
2. If you have not been practising formal or informal mindfulness or have practised less than you had hoped, what do you feel are your personal barriers to practice?
3. Do you intend to continue with your current mindfulness practice? If yes, how often and which exercises?
4. Why do you continue/intend to continue to practise mindfulness?
5. What do you feel are the benefits or changes for you having completed the MBCT course?
6. What do you feel are the disadvantages/downsides for you having completed the MBCT course?

Any other comments:

S2.3. Reflexive Thematic Analysis Steps

Table S2.B. Braun and Clarke's six steps to Reflexive Thematic Analysis

Step	Detail
One	**Familiarisation** Familiarising self with the data. Transcribing verbatim. Reading and re-reading of transcripts to ensure familiarity with the data. Developing a reflective log and noting down early ideas regarding the data and own reflections
Two	**Data coding** Generating initial codes. Systematically coding aspects of the data within each and across the transcripts
Three	**Generating initial themes** Sorting codes into relevant, potential themes
Four	**Reviewing and developing themes.** The themes are checked against the original codes and transcripts (within the data), and across the entire dataset (all transcripts and all codes)
Five	**Refining, defining, and naming themes**. Ongoing refining of themes and the overall "story". Ensuring that there are clear and specific names and definitions for each theme
Six	**Writing the report.** Selecting extracts which best illustrate the themes and overall "story". Ongoing checking back to the original study question and wider literature.

Note. Adapted from Braun and Clarke; 2006

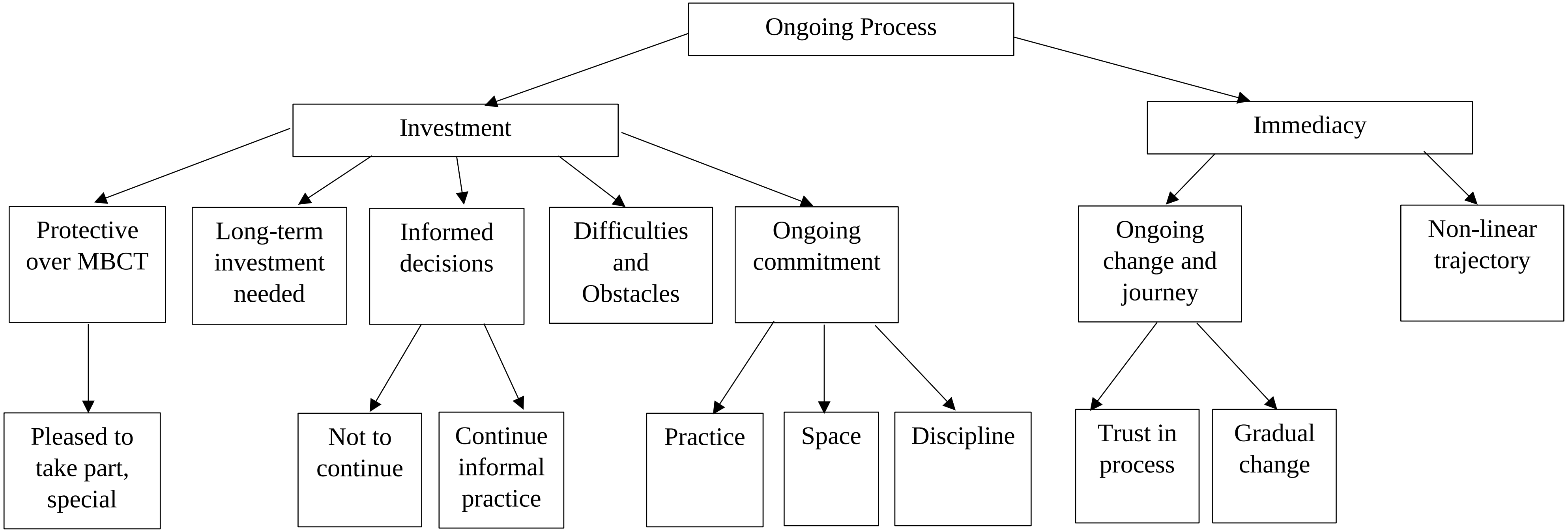
S2.4. Reflexive Statement

This analysis was completed whilst the lead researcher was employed as a Trainee Clinical Psychologist. The lead researcher has experience both professionally and personally with MBCT and related mindfulness-based approaches. Specifically, the lead researcher holds a PhD which examined the neuropsychological mechanisms of MBCT for people with previous experience of depression. Further, the lead researcher has experience with teaching MBCT groups, holds a personal meditation practice, and has published scientific papers regarding MBCT and relevant mindfulness-based approaches. The lead researcher is aware that both their professional and personal interest in MBCT, and mindfulness-based meditation more generally, may impact on the analysis and results presented here. The lead researcher maintained this awareness throughout the process of conducting and analysing this study, and regularly reflected on this in a reflexive log and in discussions with the wider research teams.

KB is a trained MBCT teacher, and an accredited person-centred counsellor. KB holds a PhD in the development of lower-intensity mindfulness-based interventions. The remaining authors are academic and/or clinical practitioners (Clinical Psychologists: PT, SH; Psychiatrist: IA; Academic Professor: RE; Research Assistant and Assistant Psychologist: MD). IA and RE supervised the initial study (data collection during the PhD), and PT and SH supervised the secondary data analysis presented in this paper (during the DClinPsy). All authors acknowledge that their clinical and academic knowledge and experience, particularly regarding depression and the application of mindfulness-based approaches may impact on the study results. However, whilst KW and KB held arguably more knowledge and specific training in MBCT, other authors did not have this specific experience with MBCT and, we believe, were therefore able to balance out the potential impacts on the credibility of the findings. Thus, regular discussions and reflections were held within the wider study team as a way to mitigate against this.

S2.5. Example Coding Tree

Supplementary Figure S2.A. Coding Tree



S2.6. Thematic Analysis Checklist

Table S2.C. 15-point TA checklist (Braun & Clarke, 2006)

Process	No.	Criteria	Criteria Met?	Date
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'	Yes	05/06/2017 (checked MD) 19/06/2020 (checked all)
Coding	2	Each data item has been given equal attention in the coding process.	Yes	31/07/2020
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.	Yes	01/09/2020
	4	All relevant extracts for all / each theme have been collated.	Yes	01/09/2020
	5	Themes have been checked against each other and back to the original data set.	Yes	01/09/2020 20/11/2020
	6	Themes are internally coherent, consistent, and distinctive.	Yes	20/11/2020
Analysis	7	Data have been analysed / interpreted, made sense of / rather than just paraphrased or described.	Yes	23/11/2020
	8	Analysis and data match each other / the extracts illustrate the analytic claims.	Yes	24/11/2020
	9	Analysis tells a convincing and well-organized story about the data and topic.	Yes	24/11/2020
	10	A good balance between analytic narrative and illustrative extracts is provided.	Yes	24/11/2020

Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.	Yes	25/11/2020
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.	Yes	05/02/2021
	13	There is a good fit between what you claim you do, and what you show you have done / ie, described method and reported analysis are consistent.	Yes	05/02/2021
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.	Yes	05/02/2021
	15	The researcher is positioned as active in the research process; themes do not just ‘emerge’.	Yes	05/02/2021

Supplementary Material. Paper Three

S3.1. Thoughts from External Clinicians

Clinician One, NHS CMHT

“Immediate thoughts are that people who are passionate about MBCT are quite concerned about the drift away from proper practise to lots of clinicians finding things online and sharing them so would welcome a study like this and the opportunity to have their say. It doesn't seem overly onerous to me in terms of time needed etc.”

Clinician Two, NHS Psychotherapy service

“This sounds really interesting and well thought out in terms of design. I think stage 2 of the study is definitely feasible for clinicians to complete particularly as the majority of the questionnaire is getting them to rate on a scale so in terms of time demand it doesn’t seem onerous. Also each round is spread out every couple of months which means it isn’t a huge demand on their time in one go. Your recruitment numbers also seem realistic and I do think it is a good idea to recruit from various sources as I know the provision of MBCT in Manchester NHS services has been limited.”

S3.2. Stage One. Consultation Interview Guide

Thank you for agreeing to take part in this consultation. As discussed, we would like to take an audio recording of this conversation so that we have a record of what was discussed. Is that OK? If so, I will start recording now.

Demographics

1. Duration of any personal mindfulness experience (e.g., months, years):
2. Details of where and when you carried out your mindfulness training and/or gained mindfulness-based qualifications:

Developing the statements

We are looking to develop a range of statements concerning best practice for Mindfulness-based Cognitive Therapy (MBCT). Based on your experience, we would like to ask you for your thoughts around the following questions in relation to MBCT/MBIs. Based on your thoughts, we would like to generate statements on which we will then ask clinical practitioners to rate their agreement in the next stage of the research. These statements will be broadly around access to, delivery of, and adaptations made to MBCT in clinical settings.

We are aware that your expertise may lie in either MBCT or another type of MBI; this is fine, please answer in line with your own expertise and experience. The below questions are designed as prompts – please feel free to comment on anything else which you feel is particularly relevant.

Interview prompts.

1. What do you feel are the core components of a MBCT course/MBI?

   a. For clients. E.g., are there specific clients/populations who you feel may benefit more/less? Are there any client groups or contexts where you do not think it would be appropriate to use MBI/MBCT?
   b. How widely available do you think MBCT should be within current mental health services? Where should this be available as a frontline treatment? Are there any settings where you think MBCT might be less useful? Are there any client groups or contexts where MBCT should always be considered as a first line of intervention?
   c. For teachers/facilitators. E.g., is it necessary for teachers and facilitators to have a regular mindfulness practice? Why? How much training is necessary for teachers/facilitators? Are there any exceptions?
2. From your own experience, what aspects of a MBCT course/MBI are most valuable?
3. From your own experience, are there any particular aspects of a MBCT course/MBI which are not entirely necessary or valuable?
4. Do you think it is acceptable to adapt MBCT/an MBI for a particular group or context? If so, when might this be? How might this look? Why might these adaptations be made? E.g., duration, timings, content, language, client base, What about adaptions in terms of online or remotely delivered interventions (including self-help interventions)?
5. Are there cases or clients for whom MBCT/MBIs are better suited? Are there cases or clients for whom MBCT/MBIs are not well suited?
6. Are you aware of the UK Mindfulness Network Good Practice Guidelines for Mindfulness Teachers? Is there anything you think might be useful to add into these? Is there anything which you think could be taken out of the guidelines?

7. Is there anything we have not talked about that you think would be relevant to consider?

S3.3. Statements

<u>Access</u>

Preparation to access MBCT

Q. To what extent do you believe the following statements are important?

Completely unimportant – Somewhat unimportant – Neither important or unimportant – Somewhat Important – Very important -– Open comments

1) A comprehensive assessment with each client should be carried out prior to starting MBCT (e.g. to discuss expectations, timing/readiness, contraindications)
2) The potential risks and difficulties of MBCT are fully discussed with clients before MBCT starts

Ease of access to MBCT

Q. To what extent do you agree that …

Strongly disagree – Disagree – Neither agree nor disagree – Agree - Strongly agree – Open comments

3) MBCT should be accessible for all clients who want to take part in it, irrespective of difficulties or service context.
4) MBCT should be more widely available across services
5) MBCT should be accessible across all styles of services (e.g., IAPT, CMHT, EI, inpatient, specialist services etc.)
6) MBCT in its standard format is too much of a commitment (e.g., total course duration, session length, amount of home practice)
7) MBCT carries a stigma; clients and/or services may perceive it as “airy fairy” or lacking credibility

Delivery

Q. To what extent do you agree that MBCT could be considered as an intervention for…

Strongly disagree – Disagree – Neither agree nor disagree – Agree - Strongly agree – Don't know - Open comments

1. Anybody who wants to take part in it
2. With careful adaptations, anybody can take part in it
3. Clients who are currently well but who experience recurrent depression
4. Clients experiencing symptoms in line with current depression
5. Clients with current suicidal ideation
6. Clients experiencing multiple comorbid difficulties (e.g., depression, trauma, substance use).
7. Clients experiencing symptoms in line with a bipolar diagnosis
8. Clients experiencing symptoms in line with anxiety
9. Clients experiencing symptoms in line with psychosis
10. Clients experiencing dissociative symptoms/dissociation
11. Clients with histories of trauma
12. MBCT should be adapted to work with people with a history of trauma (e.g., trauma sensitive mindfulness)
13. Clients experiencing symptoms in line with a 'crisis' or acute illness
14. Clients with 'long-term physical health conditions' (e.g., cancer, chronic pain, diabetes, tinnitus, multiple sclerosis)
15. Clients experiencing symptoms in line with a diagnosis of 'borderline personality disorder'
16. Clients experiencing symptoms in line with an eating disorder

17. Clients who are experiencing a significant life event
18. Clients who have difficulties with alcohol or substance use/dependence

Risks of MBCT

Q. To what extent do you agree that …

Strongly disagree – Disagree – Neither agree nor disagree – Agree - Strongly agree – Open comments

19. MBCT should be delivered to clients only when there is a sound, underlying theoretical rationale for doing so (e.g., cognitive vulnerability to depression)
20. It is potentially harmful if MBCT courses do not have an underlying evidence-based foundation
21. Negative effects of meditation can occur if the meditation is not guided safely or held wisely by the teacher
22. Negative effects of meditation can occur irrespective of the teacher's delivery and holding of the group
23. The potential risks or side effects of MBCT are often understated

Good Practice Guidelines (GPG)

Q. To what extent do you agree that…?

Strongly disagree – Disagree – Neither agree nor disagree – Agree - Strongly agree – Open comments

24. The Good Practice Guidelines (GPG) for MBCT teachers should be adhered to when delivering MBCT courses (https://bamba.org.uk/wp-content/uploads/2019/06/UK-MB-teacher-GPG-2015-final-2.pdf)
25. It is more important that the teacher has sufficient experience delivering MBCT, than if they are strictly adhering to the GPG guidelines

Teacher training and personal practice

Q. To what extent do you agree that…?

Strongly disagree – Disagree – Neither agree nor disagree – Agree - Strongly agree – Open comments

26. Before teaching MBCT, teachers should participate in an MBCT or similar mindfulness-based course themselves
27. Staff cannot effectively teach MBCT if they do not have personal experience of mindfulness meditation
28. Teaching MBCT should be based in an experiential understanding whereby teachers are familiar with the language/territory of mindfulness
29. Staff teaching MBCT should have access to initial training courses as part of their job role
30. Staff teaching MBCT should have access to ongoing supervision and training (e.g., workshops, retreats) as part of their job role
31. Without sufficient training in delivering MBCT, harm could be done
32. Mindfulness-informed therapy is more accessible than delivering a full MBCT course
33. MBCT teacher training is not taken as seriously compared to other therapies (e.g., EMDR, CBT)

Support and understanding within services

Q. To what extent do you agree that…?

Strongly disagree – Disagree – Neither agree nor disagree – Agree - Strongly agree – Open comments

34. MBCT cannot thrive in a service without adequate support from managers/service leads
35. Services who cannot properly fund MBCT should not offer it at all

36. MBCT needs to be properly resourced with sufficient numbers of trained teachers (e.g., to avoid losing the MBCT group if staff leave the service)
37. Staff are teaching MBCT without sufficient training because of service restrictions (e.g., lack of funding)
38. Services need to have a better understanding of MBCT to be able to offer it effectively for clients

Sufficient resources for delivering MBCT

Q. To what extent do you agree that…?

Strongly disagree – Disagree – Neither agree nor disagree – Agree - Strongly agree – Open comments

39. Sufficient resources to deliver MBCT (e.g., adequate space, mats, handouts, CDs) should be provided by the service
40. The lack of sufficient funding for MBCT puts clients at risk with MBCT being delivered in a non-evidence based manner

<u>Adaptations</u>

Adapting the structure of an MBCT course

Q. To what extent do you agree that…?

Strongly disagree – Disagree – Neither agree nor disagree – Agree - Strongly agree – Open comments

1. It is acceptable to deliver MBCT either in a group or one-to-one format
2. It is acceptable to teach elements of the MBCT curriculum rather than the full MBCT curriculum
3. The MBCT curriculum (e.g., duration, content) can be adapted and tailored to the needs of the group/individual
4. Delivering MBCT as the full 8 week programme is not feasible in clinical settings

5. It is acceptable to shorten individual sessions or the course length to accommodate client needs
6. It is acceptable to shorten individual sessions or the course length to accommodate service needs

Types of adaptations

Q. To what extent do you agree that…?

Strongly disagree – Disagree – Neither agree nor disagree – Agree - Strongly agree – Open comments

7. Shorter meditation practices during MBCT may help increase participant engagement
8. Practices could be graded by intensity. For example less intense practices could be offered first (e.g., FOFBOC, grounding exercises)
9. There should be fewer home practice requirements
10. Adaptations to MBCT must ensure that they are in line with the underlying evidence base for the population
11. Adaptations should reflect the needs of clients but also be in line with the core philosophy of MBCT
12. If a full MBCT course cannot be delivered, then adaptations should be as close to the original programme as possible

S3.4. Stage Two. Results for the “don’t know” option

Table S3.A. Results for the “don’t know” option across all three rounds

Statement	**Round 1. Number of responses**	**Rationale (if given)**	**Round 2. Number of responses**	**Rationale (if given)**	**Round 3. Number of responses**	**Rationale (if given)**
Anybody who wants to take part	2	Screening is important for expectations and motivation	2	No comments	NA	NA
With careful adaptations, anybody who wants to take part	1	No comments	1	No comments	NA	NA
Recurrent depression	0	NA	NA	NA	NA	NA
Depression	0	NA	NA	NA	NA	NA
Suicidal intent	0	NA	0	NA	NA	NA
Comorbid difficulties	1	No comments	0	NA	NA	NA
Bipolar	3	Lack of clinical experience with bipolar	2	No comments	1	I have no experience working with MBCT and clients in this area
Anxiety	0	NA	NA	NA	NA	NA
Psychosis	2	Lack of clinical experience with psychosis	2	No comments	1	I have no experience working with MBCT and clients in this area
Dissociation	3	No comments	0	NA	NA	NA
Trauma	1	No comments	NA	NA	NA	NA
Trauma sensitive adaptations	0	NA	NA	NA	NA	NA
In current crisis/acute symptoms	1	No comments	1	No comments	NA	NA
Long term physical health conditions	0	NA	NA	NA	NA	NA

A diagnosis of borderline personality disorder	3	Lack of clinical experience with BPD	0	NA	NA	NA
Eating disorder	3	Not something they know much about	2	I have no experience of working with this group using MBCT. Mindfulness however should not be ruled out.	1	No comments
Significant life events	0	NA	0	NA	NA	NA
Alcohol or substance misuse	1	No comments	1	No comments	NA	NA

Note. A total of 18 statements for “delivery” of MBCT; NA=not applicable (either because the statement had reached consensus in an earlier round or participants had not rated “don’t know” for this option at that particular round.

S3.5. Non-consensus Statement Scoring

Table S3.B. Final round scoring for non-consensus statements (percentages for each rating)

Statement	**Strongly disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly agree**	**Don't know**
Access-ease						
MBCT should be accessible for all clients who want to take part in it, irrespective of difficulties or service context.	0	56	16	20	8	NA
MBCT in its standard format is too much of a commitment (e.g., total course duration, session length, amount of home practice)	12	48	8	32	0	NA
MBCT carries a stigma; clients and/or services may perceive it as "airy fairy" or lacking credibility	8	48	20	24	0	NA
Delivery-population						
Anybody who wants to take part in it	4	48	4	44	0	0
Clients experiencing dissociative symptoms/dissociation	8	44	32	16	0	0
Clients with current suicidal ideation	0	24	12	60	4	0
Clients experiencing symptoms in line with a bipolar diagnosis	0	0	32	64	0	4
Clients experiencing symptoms in line with psychosis	0	8	36	48	4	4
Clients experiencing symptoms in line with an eating disorder	0	0	32	64	0	4
Clients who have difficulties with alcohol or substance use/dependence	4	8	40	48	0	0
Delivery–risks						
MBCT should be delivered to clients only when there is a sound, underlying theoretical rationale for doing so (e.g., cognitive vulnerability to depression)	0	48	20	24	8	NA
The potential risks or side effects of MBCT are often understated	0	12	28	60	0	NA
Delivery–services						
Services who cannot properly fund MBCT should not offer it at all	0	20	56	20	4	NA
Staff are teaching MBCT without sufficient training because of service restrictions (e.g., lack of funding)	0	4	40	48	8	NA
Adaptations-types						
Practices could be graded by intensity. For example less intense practices could be offered first (e.g., FOFBOC, grounding exercises)	0	16	24	48	12	NA

Appendices

Appendix One. Paper One Author Guidelines

JOURNAL OF AFFECTIVE DISORDERS
Official Journal of the International Society for Affective Disorders

AUTHOR INFORMATION PACK

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Cancer Research UK, 1975. Cancer statistics reports for the UK. http://www.cancerresearchuk.org/aboutcancer/statistics/cancerstatsreport/ (accessed 13 March 2003).
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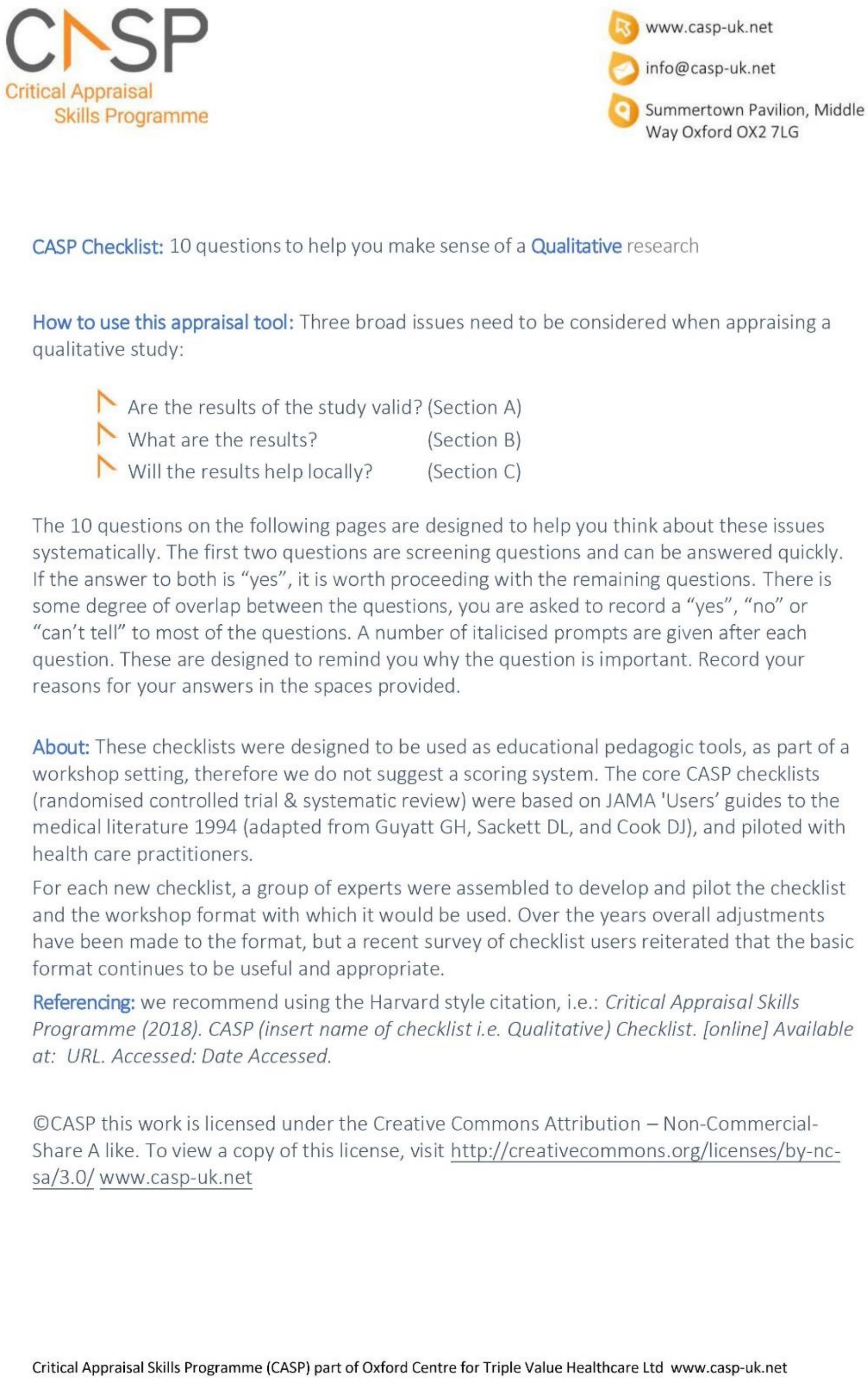

CASP
Critical Appraisal
Skills Programme

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Summertown Pavilion, Middle
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CASP Checklist: 10 questions to help you make sense of a **Qualitative** research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

Critical Appraisal Skills Programme (CASP) part of Oxford Centre for Triple Value Healthcare Ltd www.casp-uk.net

Paper for appraisal and reference: ....

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ☐
Can’t Tell ☐
No ☐

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments:

2. Is a qualitative methodology appropriate?

Yes ☐
Can’t Tell ☐
No ☐

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments:

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ☐
Can’t Tell ☐
No ☐

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:

4. Was the recruitment strategy appropriate to the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:

5. Was the data collected in a way that addressed the research issue?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:

6. Has the relationship between researcher and participants been adequately considered?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider

- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:

8. Was the data analysis sufficiently rigorous?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments:

9. Is there a clear statement of findings?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

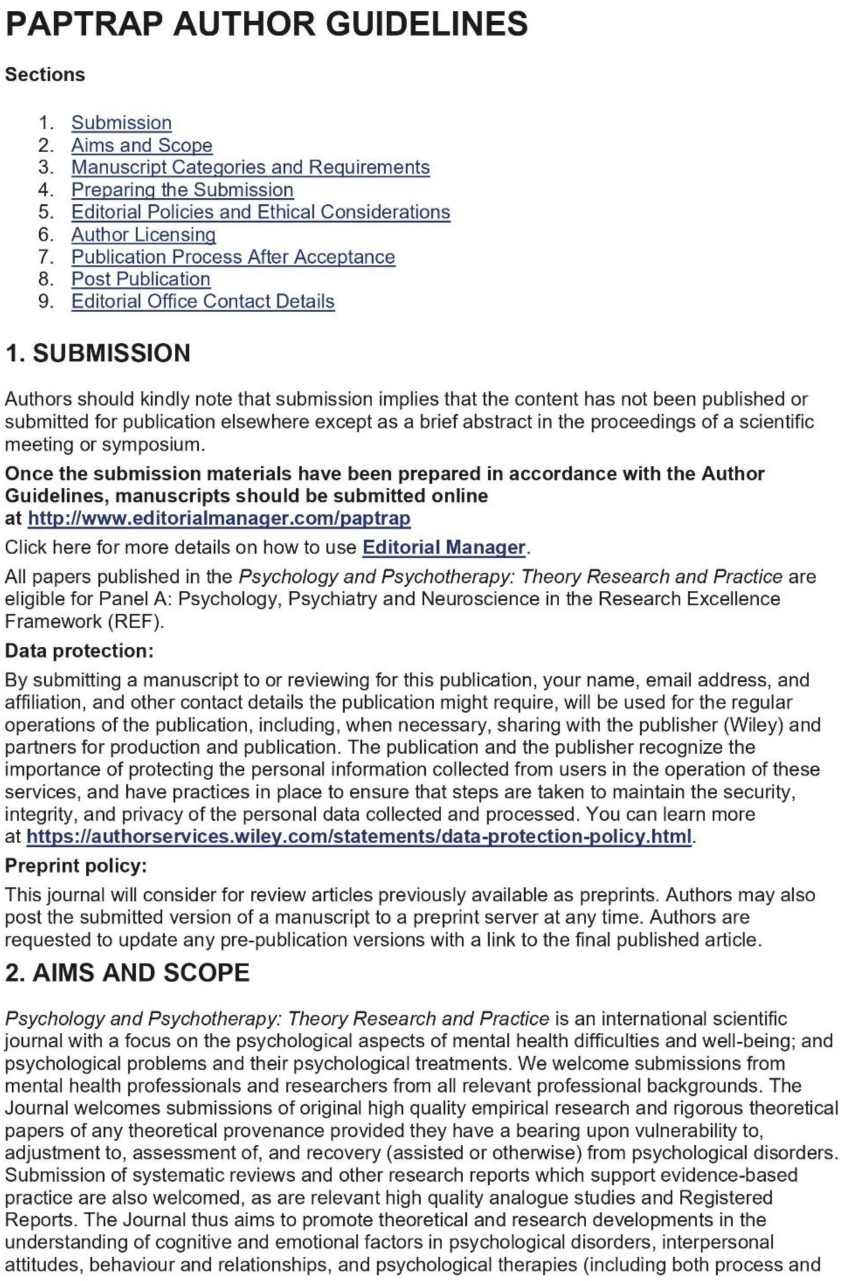
Comments:

Section C: Will the results help locally?

10. How valuable is the research?	HINT: Consider • If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature • If they identify new areas where research is necessary • If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:

Appendix Three. Paper Two. Author Guidelines



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3. Manuscript Categories and Requirements
4. Preparing the Submission
5. Editorial Policies and Ethical Considerations
6. Author Licensing
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For help with submissions, please contact: Hannah Wakley, Associate Managing Editor (**papt@wiley.com**) or phone +44 (0) 116 252 9504.

Author Guidelines updated 28th August 2019

Appendix Four. Paper Two. Ethical Approval

NHS
Health Research Authority

National Research Ethics Service

NRES Committee North West - Preston

Barlow House

3rd Floor

4 Minshull Street

Manchester

M1 3DZ

Telephone: 0161 625 7818

Fax:0161 625 7299

11 November 2014

Ms Kate Williams

Room G712, Stopford Building

The University of Manchester

Oxford Road

M13 9PT

Dear Ms Williams

Study title: **Investigating underlying mechanisms of Mindfulness Based Cognitive Therapy (MBCT)**
REC reference: **14/NW/1389**
IRAS project ID: **160802**

Thank you for responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Mrs Carol Ebenezer, nrescommittee.northwest-preston@nhs.net.

Confirmation of ethical opinion

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

Conditions of the favourable opinion

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

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

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.
For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation. Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

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

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

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

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

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

Ethical review of research sites

NHS sites

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

Non-NHS sites

The Committee has not yet completed any site-specific assessment (SSA) for the non-NHS research site(s) taking part in this study. The favourable opinion does not therefore apply to any non-NHS site at present. We will write to you again as soon as an SSA application(s) has been reviewed. In the meantime no study procedures should be initiated at non-NHS sites.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of advertisement materials for research participants [HV MBCT poster]	1	12 August 2014
Copies of advertisement materials for research participants [MBCT rMDD advert]	1	12 August 2014
Copies of advertisement materials for research participants [Social media advert]	1	12 August 2014
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [CT confirmation]		30 May 2014
GP/consultant information sheets or letters [MBCT GP leaflet]	1	12 August 2014
GP/consultant information sheets or letters [GP letter HV]	1	12 August 2014
GP/consultant information sheets or letters [GP letter rmdd]	1	12 August 2014
Interview schedules or topic guides for participants [LIFE interview]		
Interview schedules or topic guides for participants [MBCT course outline]		
Interview schedules or topic guides for participants [MINI 5 Interview]		
Letter from sponsor [Letter from sponsor]		06 October 2014
Other [CV Supervisor]		15 August 2014
Other [certificate of liability insurance]		01 June 2014
Other [CV MBCT co-teacher]		22 August 2014
Other [CV Supervisor]		12 August 2014
Other [PI confirmation]		30 May 2014
Other [Letter from sponsor 2]		06 October 2014
Other [Cover letter for response to provisional opinion 05.11.14]		
Participant consent form [Imaging PIC rMDD]	v1.1	05 November 2014
Participant consent form [PIC Healthy Volunteer]	1.1	05 November 2014
Participant consent form [PIC rMDD]	1.1	05 November 2014

Participant information sheet (PIS) [PIL HV]	v1.1	05 November 2014
Participant information sheet (PIS) [Imaging PIL rMDD]	1.1	05 November 2014
Participant information sheet (PIS) [PIL rMDD]	1.1	05 November 2014
REC Application Form [REC_Form_10102014]		10 October 2014
Research protocol or project proposal [MBCT mechanisms protocol v1 06.10.14]	1	12 August 2014
Summary CV for Chief Investigator (CI) [KW Researcher CV]		14 August 2014
Summary CV for supervisor (student research) [IA Supervisor CV]		13 October 2014
Validated questionnaire [PDF documents/questionnaires]*		

*This has been highlighted for the purposes of this thesis. This document contained the interview guides

Statement of compliance

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

After ethical review

Reporting requirements

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

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

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

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The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/qualityassurance/

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14/NW/1389	**Please quote this number on all correspondence**

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

Yours sincerely

pp.

Dr Patricia Wilkinson Chair

Email:nrescommittee.northwest-preston@nhs.net

Enclosures: “After ethical review – guidance for researchers”

Copy to: *Ms Lynne Macrae*

Appendix Five. Paper Two. Analysis of Baseline Data

At baseline, participants described a range of expectations regarding MBCT, ranging from positive, negative, to neutral or open-minded expectations. Participants described hopes for developing tools for control over their difficulties e.g., their thinking styles, depression, relapse, wellbeing, and hopes to enhance their ability to engage more in life and with others. Some participants described worries around difficulties with meditating, being in a group, practical concerns, and preconceptions around MBCT. Participants described their pre-existing interest in MBCT and in the specific research study. Participants described the hope that the research findings might help others with depression as motivating factors to take part. Many participants described the difficulty in accessing MBCT in the NHS and the cost in accessing MBCT privately, and described the importance of the timing of MBCT.

Appendix Table 1. Baseline themes and sub-themes

Theme	Subtheme	Description	Quotes
Expectations	Positive expectations	Wanting to gain control over thought processes. To feel more skilled around recognising and paying attention to ruminative and catastrophic thoughts which impact negatively on mood.	Something to help "the problems…of the thinking I guess you know…the sort of ruminating about things and things from the past that although you can change…sometimes it's difficult to stop yourself from constantly going over…even though it's traumatic…'cause you're reliving things all the time so I'm looking for something that will help that I can do on me own when I'm on my own" "I suppose I'm hoping to find a way to erm…recognise some of my intrusive particularly my like self-critical thoughts…and to be able to disregard them I suppose or find a way to manage them so I'm not ending up just like getting caught in a cycle of worry and catastrophising"

Theme	Subtheme	Description	Quotes
		Desire to gain some control over and prevent future episodes or experiences of depression. To gain control over antidepressant use.	“just a way to deal with…feelings when I feel like I’m going to relapse, just how to…deal with it, control it” “be able to recognise, and I’m learning to recognise, but sometimes I get into the depression, and I realise I’m now depressed and I want to catch it earlier” “my medium long term aim is to get off citalopram and to try and avoid future relapses”
		Engage more actively in life and with others (both in general and in the MBCT group itself). Wanting to engage with people who have had similar experiences.	“hopefully to give myself the opportunity of having a chance at trying to have a more productive, positive life” “with people who understand a bit more what you’re …where you’re coming from. If they’ve been in a similar situation”
		Hopeful of a way to feel better, more resilient. Hopeful that MBCT will help to improve general wellbeing. Feeling hopeful that something has to work, given earlier, often lifelong experiences with depression. Holding faith and believing in the evidence-base around MBCT.	“I keep hoping that something will work so I’m very hopeful because I have to be hopeful I have to be hopeful that this will be the thing that works” “from my point of view now you can’t help but think…is it…is this gonna work…is this gonna be the thing that works because I’ve tried this and I’ve tried that and sometimes when you’ve tried different avenues…it’s hard then it’s hard to start thinking...and to kind of put sort of put all your eggs in the basket and think I’ll concentrate because this is bound to be the thing that works” Hopeful that “someday someone comes up with a solution for this conundrum (*depression*)”
		Desire to gain new tools for working with depression, and for recognising triggers and early warning signs. To learn a new skill, and to gain tools	“some tools? To stop that kind of thing happening. It’s the spiralling really, that I can see, I can hear it happening in my head and I can’t stop it. And I’d like to be able to have some sort of control over it because I recognise that it’s irrational that I’ve gone from one small …worry to blowing it up hugely but I can’t, I don’t have the tools to solve that, so that’s what I’d want”

Theme	Subtheme	Description	Quotes
		for learning how to cope with depression	
		Wanting to understand mindfulness better and wanting to engage with it better. More engagement with the present moment	“understand mindfulness, …get a lot of benefit from it, and be able to do it …most days or whenever I can…and feel better by doing it” “I just want, thinking of a way to sort of…work mindfulness into me life, be able to keep doing it, to keep focusing on it, or just live more mindfully”
	Negative expectations	Anticipating difficulties in meditating, worries over whether meditation can be “done” correctly or at all.	“in the past, I’ve struggled to do mindfulness, I’ve struggled keeping up with it, so yeah, I just think some of it will be quite challenging” Wondering “whether or not I’m capable of doing meditation or whether my mind just wanders all the time”
		Anticipating difficulties with the group process, worries around feeling vulnerable in the group setting, possible group dynamics	“it might be a challenge of being in the group…feeling comfortable in the group” “I am a bit worried that it might bring up some negative things that I haven’t thought about for a while”
		Feeling cynical towards mindfulness as an approach, and recognising prior judgements or preconceptions, or misconceptions around it.	“sometimes you know, I can be quite cynical about things but it’s good to try these things if you can” “mindfulness meditation only seems to be associated with…Buddhism and some kind of some spirituality which I find a real turn off”
		Logistical and practical concerns around accessing the location, and finding space and time to practice at home, as well as the impact of and interaction with low mood	“there’s, there’s always the challenge of committing to something that’s on a weekly basis because with erm depression you never know about with moods but I might how that kind of affects me on a daily basis but I managed to commit to my CBT course” Concerned that “I don’t have time erm and of course one has to make time and I quite prepared to do that but I will have to challenge those little gremlins in

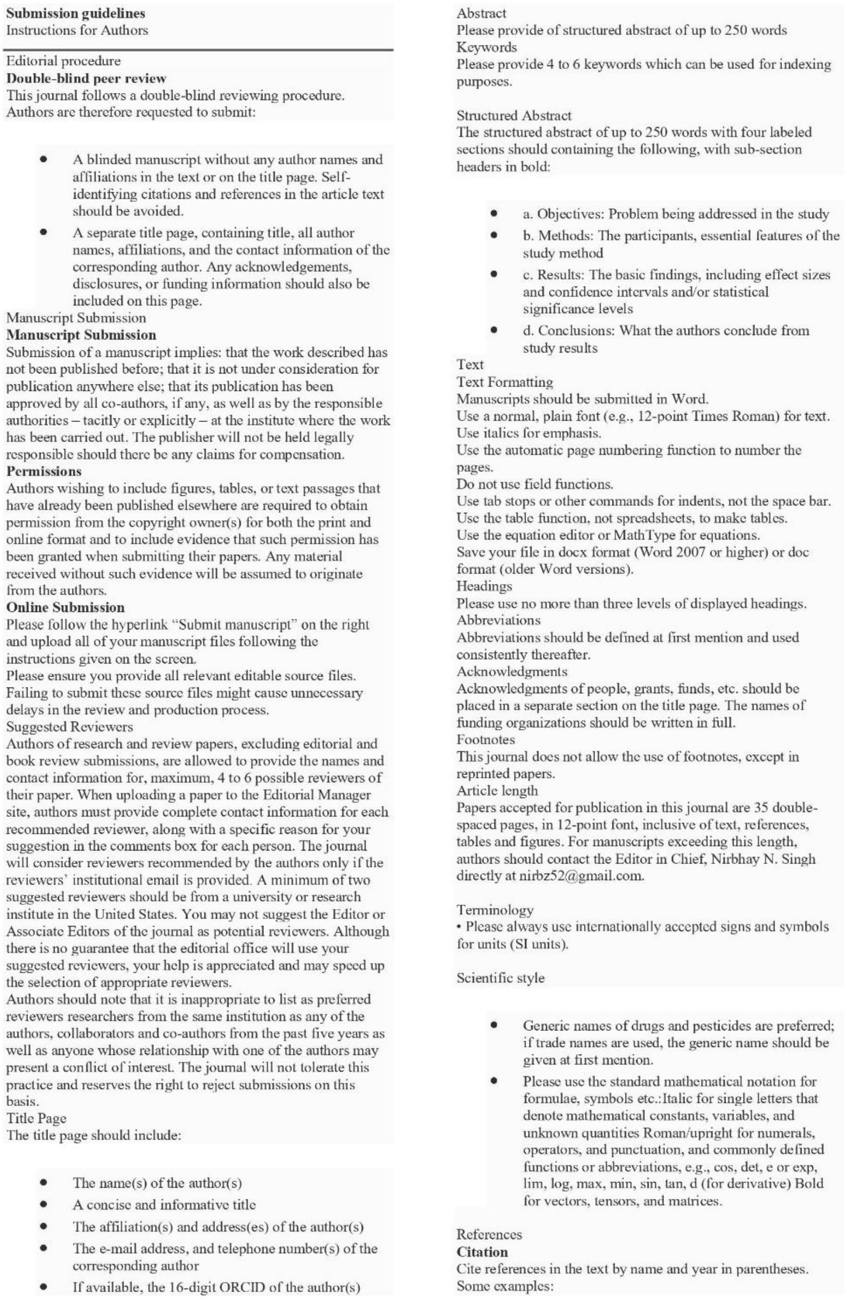
Theme	Subtheme	Description	Quotes
			my head that are telling me that my job's too busy…that won't work you know…all nonsense" "I think the biggest thing is like getting here really. I do fully anticipate and fully intend to come along and make every one and do it do you know what I mean really the best I can"
	No prior or neutral expectations	Maintaining an open mind. Thoughts around seeing how it goes, approaching MBCT with an open mind and no major anticipations either way (positive or negative).	"I don't think it would do any damage. You know, I'm not…cz I'm not that pliable that if it doesn't work, I don't see it as a disaster. I think it will. I think, I'm a big believer in the power of the mind, and that type of thing. And so…I think there will be some benefits, whatever they might be." I'll go in with "an open mind…if, if er there's any benefits to it then great but if there isn't then I've not lost anything"
		Realistic expectations. Realising MBCT is not a cure, or a quick fix, and that participants can stop or withdraw from the course at any time	"I think I'm quite realistic in that as I say I don't expect to walk in one person and walk out a different person" "I'm not expecting that it's necessarily going to be the saviour...it might work for me, it might not, but I won't know until I try"
Interest as a motivating factor	General interest in MBCT/mindfulness	General interest in MBCT and mindfulness more generally, having heard positive things about it from others and within the news.	"I think it will be interesting. I like stuff like this." "I know that there's a good evidence base for it erm and I'd read some information about some of the background and stuff and I was impressed with some of the concepts"
	In research	Being accountable to someone's research study	"helping with a study…was an impetus to do it cz I couldn't just bunk off, cz it's like…if someone says do mindfulness on your own, you're like, yeah I'll do it in a minute, but if someone else… is relying on you to do it for a reason, it's like a double thing, it's like I wanna do it but also it helps that I'm within a program"

Theme	**Subtheme**	**Description**	**Quotes**
		The importance of helping with research directly relevant to depression and improving understanding of depression. It might be beneficial for others	“I thought right I’ll do my bit for science and get something out of it for myself too” “I’m very keen to raise awareness about mental health erm issues and help other people in the future…and that’s what the research should accomplish”
		General interest in the research findings	“It sounds so good that maybe you’re going to be writing some paper about it, and reading the benefit of that or reading the outcome of that”
Lack of access to MBCT in the NHS	-	Not easily accessible within the NHS. MBCT can be expensive to access privately	“I’d looked at whether or not it was available on the NHS and it just doesn’t seem to be readily available so when I saw this I thought brilliant!”
		MBCT/mindfulness is less stigmatised now, and therefore feels more accessible	“Meditation is getting talked about a lot more now…I don’t think it’s seen as a hippie thing anymore I think it had a hippie kind of image before whereas now it’s more sort of a medical and people can use it every day and it’s not weird”
Appropriate timing of MBCT	-	Appropriate timing to access MBCT. Some described feeling ready, strong enough, and having support in place to engage with MBCT.	“To have a…a group to talk to about those things as well, I think will be really, really useful for me…it’s perfect, it really is perfectly timed for me” “I feel ready to do that now whereas before I don’t think I’ve ever been…ready, …or maybe prepared to do it. I’m at a more settled place”

Appendix Six. Paper Two. Completed CASP checklist

CASP item	Rating	Comment
1. Was there a clear statement of the aims of the research?	Yes	Provided at the end of the introduction
2. Is a qualitative methodology appropriate?	Yes	
3. Was the research design appropriate to address the aims of the research?	Yes	
4. Was the recruitment strategy appropriate to the aims of the research?	Yes*	*It has been noted in the method and limitations section of the results that this was a preference-choice trial, which, as discussed in the discussion, may have had implications for the outcomes.
5. Was the data collected in a way that addressed the research issue?	Yes*	*It has been noted in the method and discussion that there were differences in data collection methods at post-MBCT and during follow-up; there may have been implications on the outcomes as a result
6. Has the relationship between researcher and participants been adequately considered?	Yes	
7. Have ethical issues been taken into consideration?	Yes	
8. Was the data analysis sufficiently rigorous?	Yes	
9. Is there a clear statement of findings?	Yes	
10. How valuable is the research?	Yes	

Appendix Seven. Paper Three. Author Guidelines



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The title page should include:

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- The e-mail address, and telephone number(s) of the corresponding author
- If available, the 16-digit ORCID of the author(s)

Abstract
Please provide of structured abstract of up to 250 words
Keywords
Please provide 4 to 6 keywords which can be used for indexing purposes.

Structured Abstract
The structured abstract of up to 250 words with four labeled sections should containing the following, with sub-section headers in bold:

- a. Objectives: Problem being addressed in the study
- b. Methods: The participants, essential features of the study method
- c. Results: The basic findings, including effect sizes and confidence intervals and/or statistical significance levels
- d. Conclusions: What the authors conclude from study results

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Use the automatic page numbering function to number the pages.
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References
Citation
Cite references in the text by name and year in parentheses. Some examples:

- Negotiation research spans many disciplines (Thompson, 1990).
- This result was later contradicted by Becker and Seligman (1996).
- This effect has been widely studied (Abbott, 1991; Barakat et al., 1995; Kelso & Smith, 1998; Medvec et al., 1999).

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The list of references should only include works that are cited in the text and that have been published or accepted for publication. Personal communications and unpublished works should only be mentioned in the text.

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- Article by DOI Hong, I., Knox, S., Pryor, L., Mroz, T. M., Graham, J., Shields, M. F., & Reistetter, T. A. (2020). Is referral to home health rehabilitation following inpatient rehabilitation facility associated with 90-day hospital readmission for adult patients with stroke? *American Journal of Physical Medicine & Rehabilitation*. Advance online publication. https://doi.org/10.1097/PHM.0000000000001435
- Book Sapolsky, R. M. (2017). *Behave: The biology of humans at our best and worst*. Penguin Books.
- Book chapter Dillard, J. P. (2020). Currents in the study of persuasion. In M. B. Oliver, A. A. Raney, & J. Bryant (Eds.), *Media effects: Advances in theory and research* (4th ed., pp. 115–129). Routledge.
- Online document Fagan, J. (2019, March 25). *Nursing clinical brain*. OER Commons. Retrieved January 7, 2020, from https://www.oercommons.org/authoring/53029-nursing-clinical-brain/view

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Tables

- All tables are to be numbered using Arabic numerals.
- Tables should always be cited in text in consecutive numerical order.
- For each table, please supply a table caption (title) explaining the components of the table.
- Identify any previously published material by giving the original source in the form of a reference at the end of the table caption.
- Footnotes to tables should be indicated by superscript lower-case letters (or asterisks for significance values and other statistical data) and included beneath the table body.

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- Supply all figures electronically.
- Indicate what graphics program was used to create the artwork.
- For vector graphics, the preferred format is EPS; for halftones, please use TIFF format. MSOffice files are also acceptable.
- Vector graphics containing fonts must have the fonts embedded in the files.
- Name your figure files with "Fig" and the figure number, e.g., Fig1.eps.

Line Art

- Definition: Black and white graphic with no shading.
- Do not use faint lines and/or lettering and check that all lines and lettering within the figures are legible at final size.
- All lines should be at least 0.1 mm (0.3 pt) wide.
- Scanned line drawings and line drawings in bitmap format should have a minimum resolution of 1200 dpi.
- Vector graphics containing fonts must have the fonts embedded in the files.

Halftone Art

- Definition: Photographs, drawings, or paintings with fine shading, etc.
- If any magnification is used in the photographs, indicate this by using scale bars within the figures themselves.
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Color Art

- Color art is free of charge for online publication.
- If black and white will be shown in the print version, make sure that the main information will still be visible. Many colors are not distinguishable from one another when converted to black and white. A simple way to check this is to make a xerographic copy to see if the necessary distinctions between the different colors are still apparent.
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- Color illustrations should be submitted as RGB (8 bits per channel).

Figure Lettering

- To add lettering, it is best to use Helvetica or Arial (sans serif fonts).
- Keep lettering consistently sized throughout your final-sized artwork, usually about 2–3 mm (8–12 pt).
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- Do not include titles or captions within your illustrations.

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- Each figure should have a concise caption describing accurately what the figure depicts. Include the captions in the text file of the manuscript, not in the figure file.
- Figure captions begin with the term Fig. in bold type, followed by the figure number, also in bold type.
- No punctuation is to be included after the number, nor is any punctuation to be placed at the end of the caption.
- Identify all elements found in the figure in the figure caption; and use boxes, circles, etc., as coordinate points in graphs.
- Identify previously published material by giving the original source in the form of a reference citation at the end of the figure caption.

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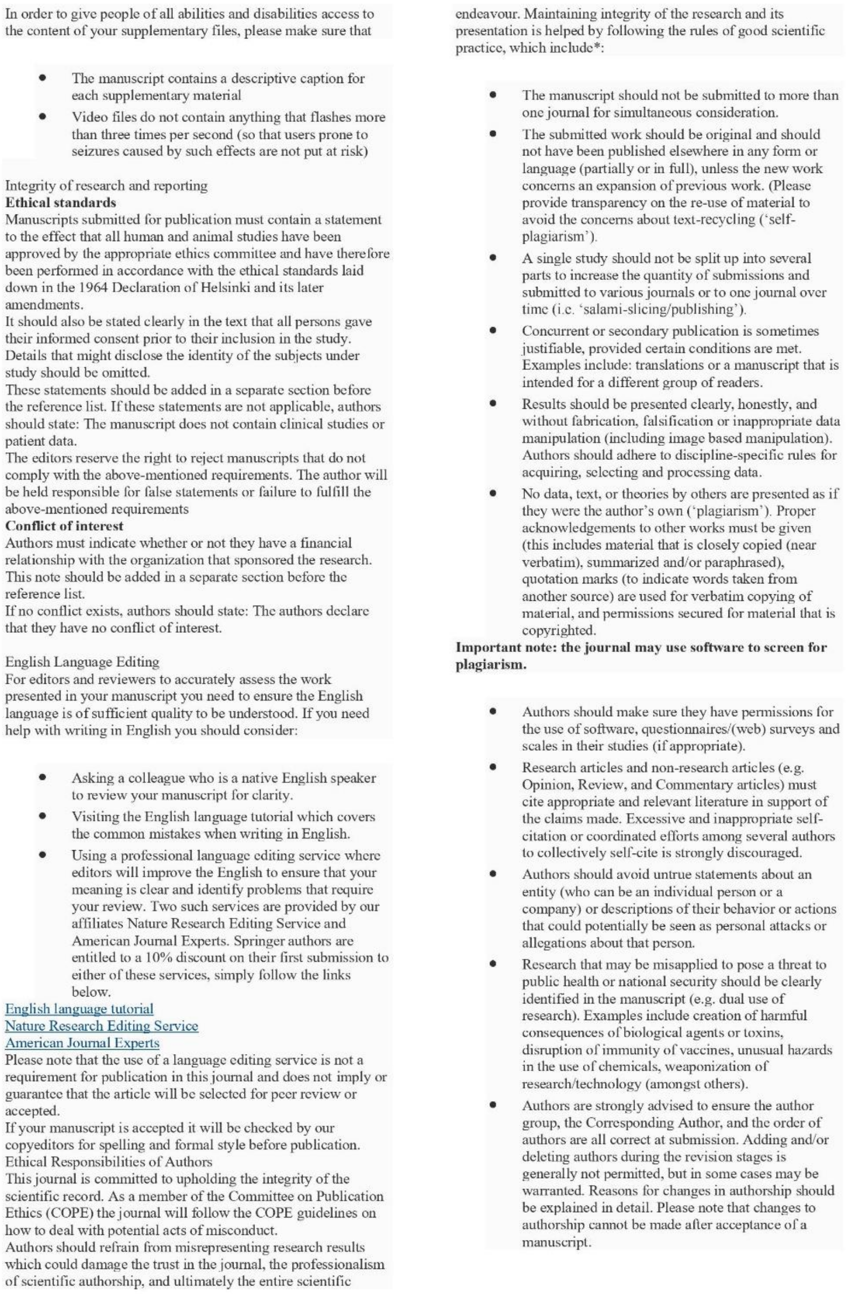

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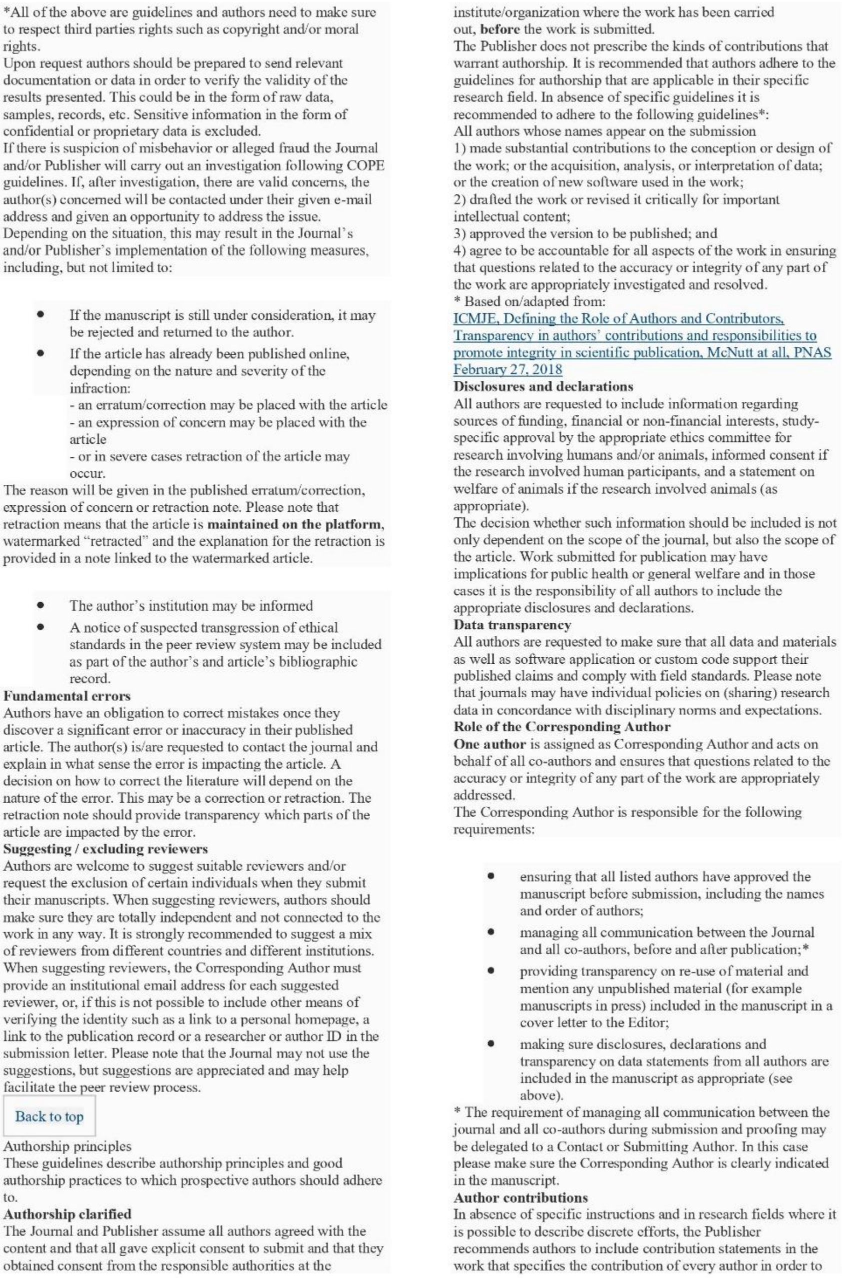

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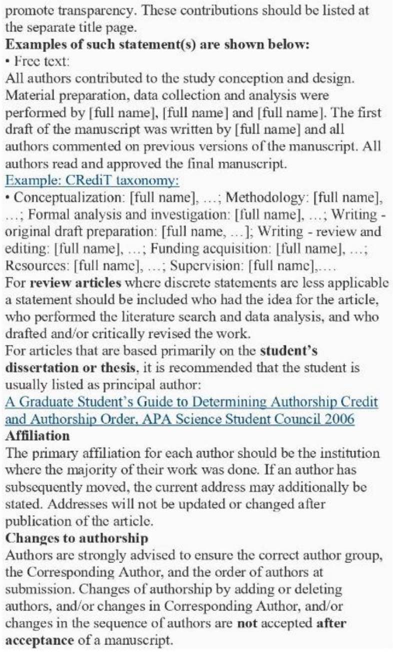

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All authors contributed to the study conception and design. Material preparation, data collection and analysis were performed by [full name], [full name] and [full name]. The first draft of the manuscript was written by [full name] and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

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- Conceptualization: [full name], …; Methodology: [full name], …; Formal analysis and investigation: [full name], …; Writing - original draft preparation: [full name, …]; Writing - review and editing: [full name], …; Funding acquisition: [full name], …; Resources: [full name], …; Supervision: [full name],…

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For articles that are based primarily on the **student's dissertation or thesis**, it is recommended that the student is usually listed as principal author:

A Graduate Student's Guide to Determining Authorship Credit and Authorship Order, APA Science Student Council 2006

Affiliation

The primary affiliation for each author should be the institution where the majority of their work was done. If an author has subsequently moved, the current address may additionally be stated. Addresses will not be updated or changed after publication of the article.

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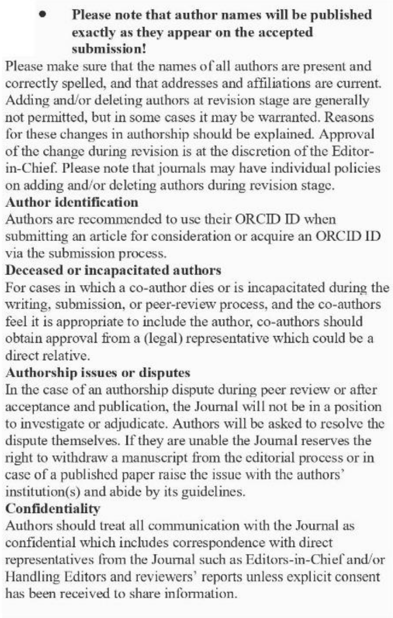
Authors are strongly advised to ensure the correct author group, the Corresponding Author, and the order of authors at submission. Changes of authorship by adding or deleting authors, and/or changes in Corresponding Author, and/or changes in the sequence of authors are **not** accepted **after acceptance** of a manuscript.



- **Please note that author names will be published exactly as they appear on the accepted submission!**

Please make sure that the names of all authors are present and correctly spelled, and that addresses and affiliations are current. Adding and/or deleting authors at revision stage are generally not permitted, but in some cases it may be warranted. Reasons for these changes in authorship should be explained. Approval of the change during revision is at the discretion of the Editor-in-Chief. Please note that journals may have individual policies on adding and/or deleting authors during revision stage.

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In the case of an authorship dispute during peer review or after acceptance and publication, the Journal will not be in a position to investigate or adjudicate. Authors will be asked to resolve the dispute themselves. If they are unable the Journal reserves the right to withdraw a manuscript from the editorial process or in case of a published paper raise the issue with the authors' institution(s) and abide by its guidelines.

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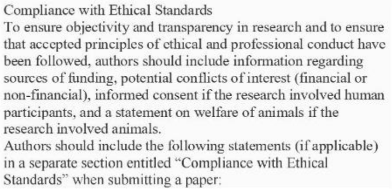
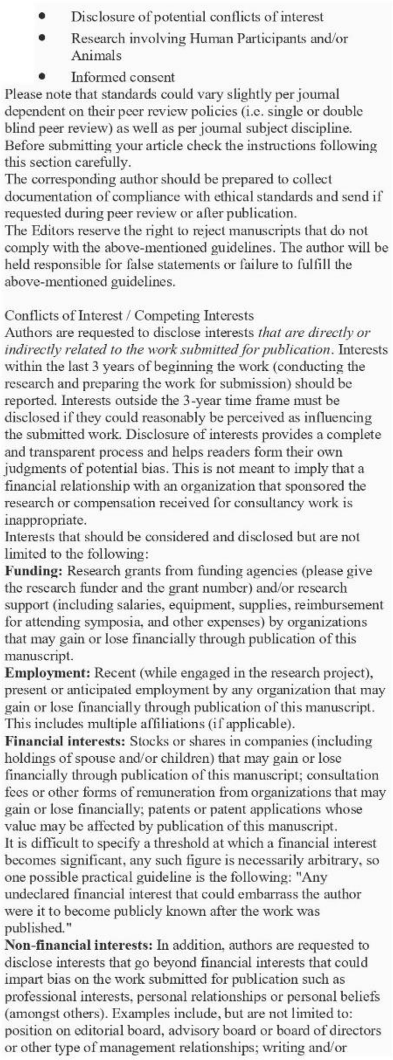


Compliance with Ethical Standards

To ensure objectivity and transparency in research and to ensure that accepted principles of ethical and professional conduct have been followed, authors should include information regarding sources of funding, potential conflicts of interest (financial or non-financial), informed consent if the research involved human participants, and a statement on welfare of animals if the research involved animals.

Authors should include the following statements (if applicable) in a separate section entitled "Compliance with Ethical Standards" when submitting a paper:



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Please note that standards could vary slightly per journal dependent on their peer review policies (i.e. single or double blind peer review) as well as per journal subject discipline. Before submitting your article check the instructions following this section carefully.

The corresponding author should be prepared to collect documentation of compliance with ethical standards and send if requested during peer review or after publication.

The Editors reserve the right to reject manuscripts that do not comply with the above-mentioned guidelines. The author will be held responsible for false statements or failure to fulfill the above-mentioned guidelines.

Conflicts of Interest / Competing Interests

Authors are requested to disclose interests *that are directly or indirectly related to the work submitted for publication*. Interests within the last 3 years of beginning the work (conducting the research and preparing the work for submission) should be reported. Interests outside the 3-year time frame must be disclosed if they could reasonably be perceived as influencing the submitted work. Disclosure of interests provides a complete and transparent process and helps readers form their own judgments of potential bias. This is not meant to imply that a financial relationship with an organization that sponsored the research or compensation received for consultancy work is inappropriate.

Interests that should be considered and disclosed but are not limited to the following:

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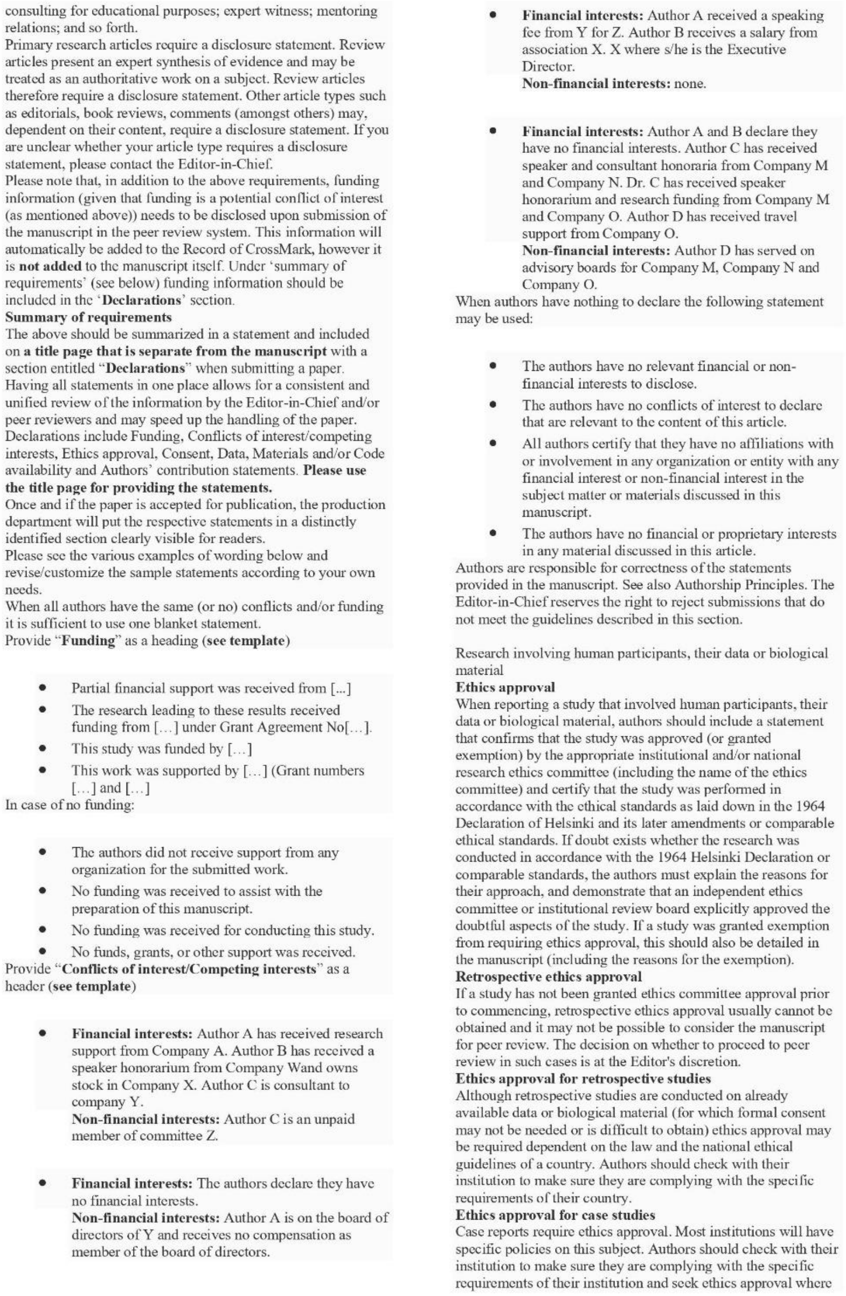
It is difficult to specify a threshold at which a financial interest becomes significant, any such figure is necessarily arbitrary, so one possible practical guideline is the following: "Any undeclared financial interest that could embarrass the author were it to become publicly known after the work was published."

Non-financial interests: In addition, authors are requested to disclose interests that go beyond financial interests that could impart bias on the work submitted for publication such as professional interests, personal relationships or personal beliefs (amongst others). Examples include, but are not limited to: position on editorial board, advisory board or board of directors or other type of management relationships; writing and/or



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- Partial financial support was received from [...]
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- This study was funded by […]
- This work was supported by […] (Grant numbers […] and […]

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- No funding was received for conducting this study.
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  Non-financial interests: Author A is on the board of directors of Y and receives no compensation as member of the board of directors.

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Research involving human participants, their data or biological material

Ethics approval

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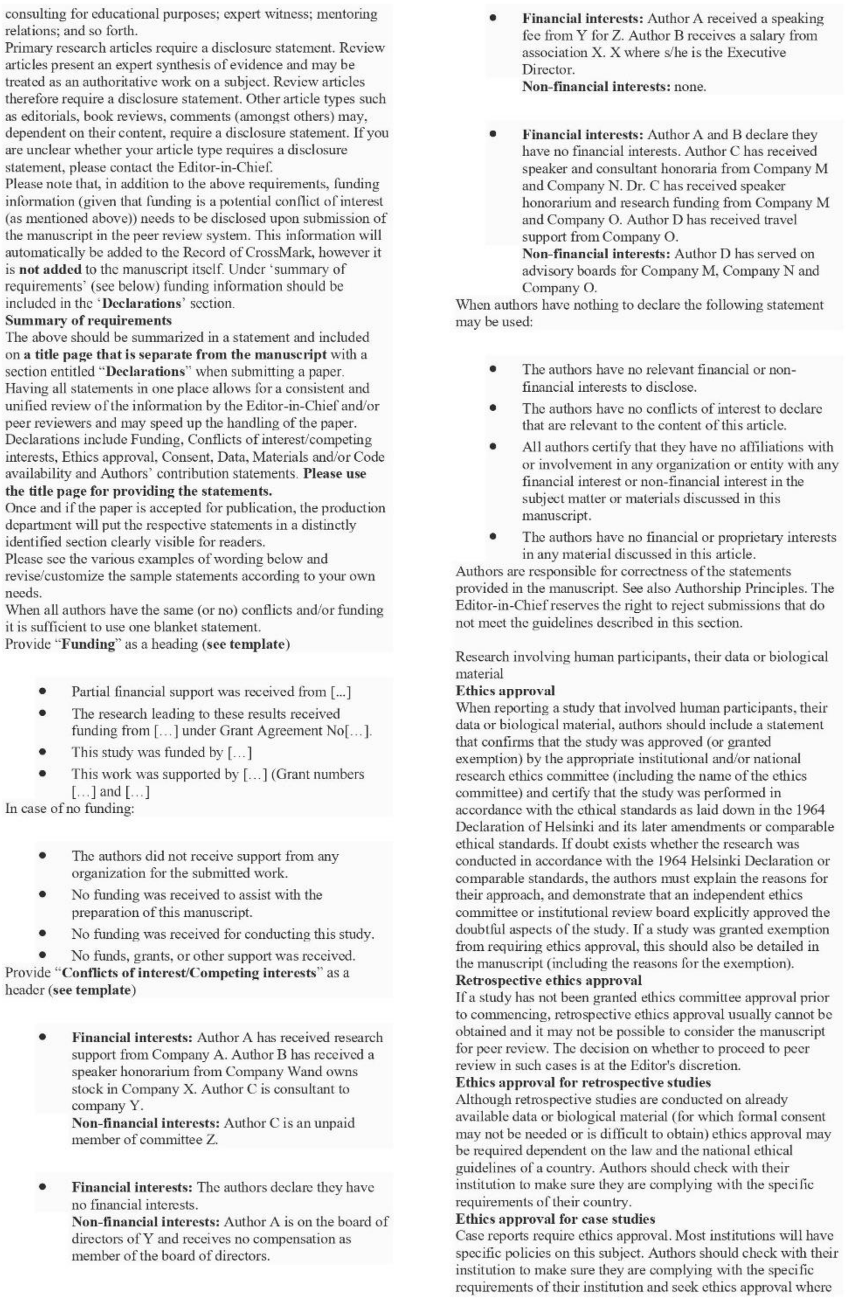
Ethics approval for case studies

Case reports require ethics approval. Most institutions will have specific policies on this subject. Authors should check with their institution to make sure they are complying with the specific requirements of their institution and seek ethics approval where



consulting for educational purposes; expert witness; mentoring relations; and so forth.

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- All authors certify that they have no affiliations with or involvement in any organization or entity with any financial interest or non-financial interest in the subject matter or materials discussed in this manuscript.
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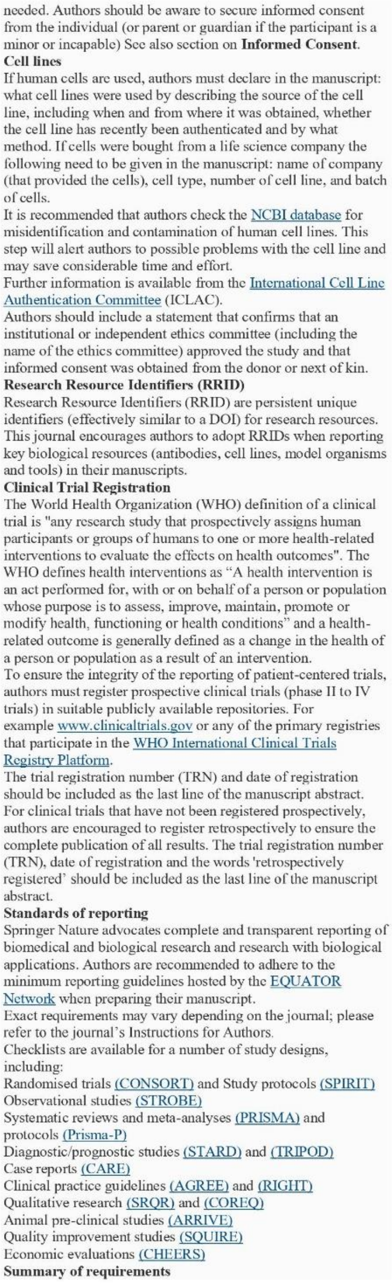

needed. Authors should be aware to secure informed consent from the individual (or parent or guardian if the participant is a minor or incapable) See also section on **Informed Consent**.

Cell lines

If human cells are used, authors must declare in the manuscript: what cell lines were used by describing the source of the cell line, including when and from where it was obtained, whether the cell line has recently been authenticated and by what method. If cells were bought from a life science company the following need to be given in the manuscript: name of company (that provided the cells), cell type, number of cell line, and batch of cells.

It is recommended that authors check the NCBI database for misidentification and contamination of human cell lines. This step will alert authors to possible problems with the cell line and may save considerable time and effort.

Further information is available from the International Cell Line Authentication Committee (ICLAC).

Authors should include a statement that confirms that an institutional or independent ethics committee (including the name of the ethics committee) approved the study and that informed consent was obtained from the donor or next of kin.

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Clinical Trial Registration

The World Health Organization (WHO) definition of a clinical trial is "any research study that prospectively assigns human participants or groups of humans to one or more health-related interventions to evaluate the effects on health outcomes". The WHO defines health interventions as "A health intervention is an act performed for, with or on behalf of a person or population whose purpose is to assess, improve, maintain, promote or modify health, functioning or health conditions" and a health-related outcome is generally defined as a change in the health of a person or population as a result of an intervention.

To ensure the integrity of the reporting of patient-centered trials, authors must register prospective clinical trials (phase II to IV trials) in suitable publicly available repositories. For example www.clinicaltrials.gov or any of the primary registries that participate in the WHO International Clinical Trials Registry Platform.

The trial registration number (TRN) and date of registration should be included as the last line of the manuscript abstract.

For clinical trials that have not been registered prospectively, authors are encouraged to register retrospectively to ensure the complete publication of all results. The trial registration number (TRN), date of registration and the words 'retrospectively registered' should be included as the last line of the manuscript abstract.

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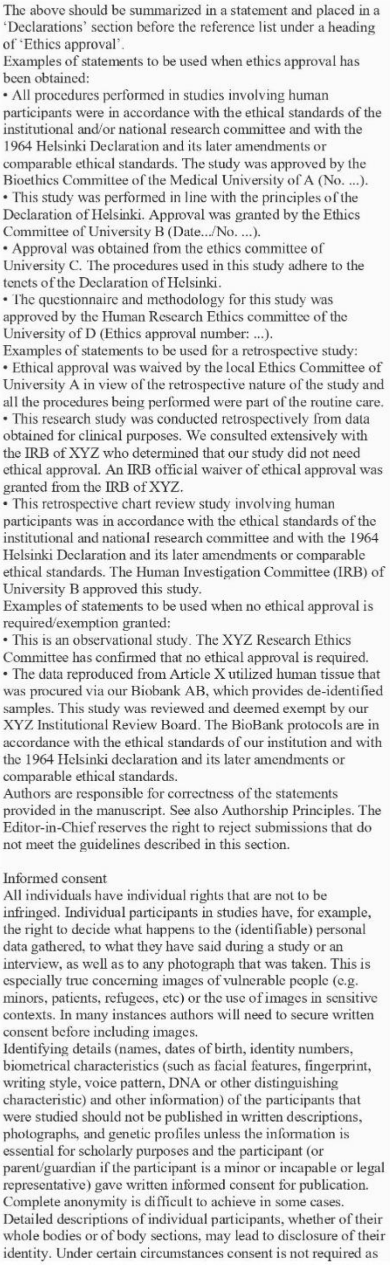
Observational studies (STROBE)
Systematic reviews and meta-analyses (PRISMA) and protocols (Prisma-P)
Diagnostic/prognostic studies (STARD) and (TRIPOD)
Case reports (CARE)
Clinical practice guidelines (AGREE) and (RIGHT)
Qualitative research (SRQR) and (COREQ)
Animal pre-clinical studies (ARRIVE)
Quality improvement studies (SQUIRE)
Economic evaluations (CHEERS)

Summary of requirements



The above should be summarized in a statement and placed in a 'Declarations' section before the reference list under a heading of 'Ethics approval'.

Examples of statements to be used when ethics approval has been obtained:

- All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. The study was approved by the Bioethics Committee of the Medical University of A (No. ...).
- This study was performed in line with the principles of the Declaration of Helsinki. Approval was granted by the Ethics Committee of University B (Date.../No. ...).
- Approval was obtained from the ethics committee of University C. The procedures used in this study adhere to the tenets of the Declaration of Helsinki.
- The questionnaire and methodology for this study was approved by the Human Research Ethics committee of the University of D (Ethics approval number: ...).

Examples of statements to be used for a retrospective study:

- Ethical approval was waived by the local Ethics Committee of University A in view of the retrospective nature of the study and all the procedures being performed were part of the routine care.
- This research study was conducted retrospectively from data obtained for clinical purposes. We consulted extensively with the IRB of XYZ who determined that our study did not need ethical approval. An IRB official waiver of ethical approval was granted from the IRB of XYZ.
- This retrospective chart review study involving human participants was in accordance with the ethical standards of the institutional and national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. The Human Investigation Committee (IRB) of University B approved this study.

Examples of statements to be used when no ethical approval is required/exemption granted:

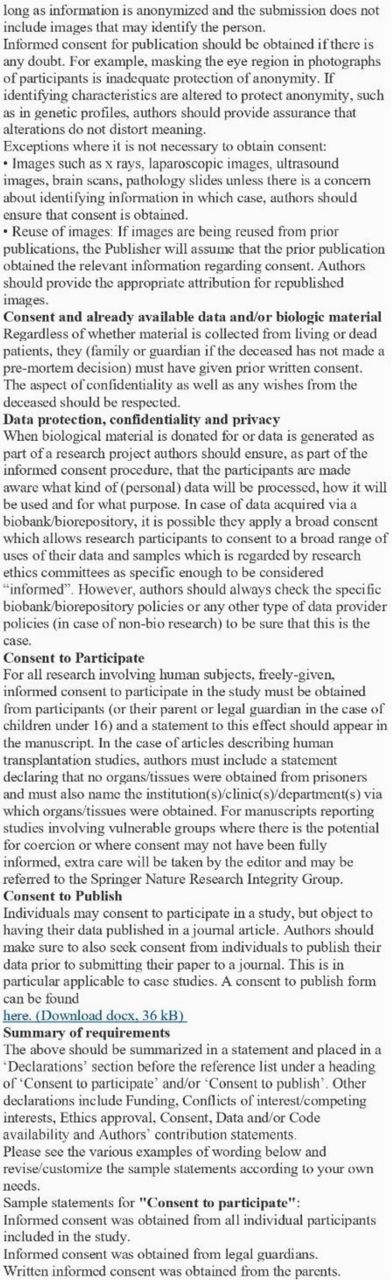
- This is an observational study. The XYZ Research Ethics Committee has confirmed that no ethical approval is required.
- The data reproduced from Article X utilized human tissue that was procured via our Biobank AB, which provides de-identified samples. This study was reviewed and deemed exempt by our XYZ Institutional Review Board. The BioBank protocols are in accordance with the ethical standards of our institution and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Authors are responsible for correctness of the statements provided in the manuscript. See also Authorship Principles. The Editor-in-Chief reserves the right to reject submissions that do not meet the guidelines described in this section.

Informed consent

All individuals have individual rights that are not to be infringed. Individual participants in studies have, for example, the right to decide what happens to the (identifiable) personal data gathered, to what they have said during a study or an interview, as well as to any photograph that was taken. This is especially true concerning images of vulnerable people (e.g. minors, patients, refugees, etc) or the use of images in sensitive contexts. In many instances authors will need to secure written consent before including images.

Identifying details (names, dates of birth, identity numbers, biometrical characteristics (such as facial features, fingerprint, writing style, voice pattern, DNA or other distinguishing characteristic) and other information) of the participants that were studied should not be published in written descriptions, photographs, and genetic profiles unless the information is essential for scholarly purposes and the participant (or parent/guardian if the participant is a minor or incapable or legal representative) gave written informed consent for publication. Complete anonymity is difficult to achieve in some cases. Detailed descriptions of individual participants, whether of their whole bodies or of body sections, may lead to disclosure of their identity. Under certain circumstances consent is not required as



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Informed consent for publication should be obtained if there is any doubt. For example, masking the eye region in photographs of participants is inadequate protection of anonymity. If identifying characteristics are altered to protect anonymity, such as in genetic profiles, authors should provide assurance that alterations do not distort meaning.

Exceptions where it is not necessary to obtain consent:

- Images such as x rays, laparoscopic images, ultrasound images, brain scans, pathology slides unless there is a concern about identifying information in which case, authors should ensure that consent is obtained.
- Reuse of images: If images are being reused from prior publications, the Publisher will assume that the prior publication obtained the relevant information regarding consent. Authors should provide the appropriate attribution for republished images.

Consent and already available data and/or biologic material

Regardless of whether material is collected from living or dead patients, they (family or guardian if the deceased has not made a pre-mortem decision) must have given prior written consent. The aspect of confidentiality as well as any wishes from the deceased should be respected.

Data protection, confidentiality and privacy

When biological material is donated for or data is generated as part of a research project authors should ensure, as part of the informed consent procedure, that the participants are made aware what kind of (personal) data will be processed, how it will be used and for what purpose. In case of data acquired via a biobank/biorepository, it is possible they apply a broad consent which allows research participants to consent to a broad range of uses of their data and samples which is regarded by research ethics committees as specific enough to be considered "informed". However, authors should always check the specific biobank/biorepository policies or any other type of data provider policies (in case of non-bio research) to be sure that this is the case.

Consent to Participate

For all research involving human subjects, freely-given, informed consent to participate in the study must be obtained from participants (or their parent or legal guardian in the case of children under 16) and a statement to this effect should appear in the manuscript. In the case of articles describing human transplantation studies, authors must include a statement declaring that no organs/tissues were obtained from prisoners and must also name the institution(s)/clinic(s)/department(s) via which organs/tissues were obtained. For manuscripts reporting studies involving vulnerable groups where there is the potential for coercion or where consent may not have been fully informed, extra care will be taken by the editor and may be referred to the Springer Nature Research Integrity Group.

Consent to Publish

Individuals may consent to participate in a study, but object to having their data published in a journal article. Authors should make sure to also seek consent from individuals to publish their data prior to submitting their paper to a journal. This is in particular applicable to case studies. A consent to publish form can be found

here. (Download docx, 36 kB)

Summary of requirements

The above should be summarized in a statement and placed in a 'Declarations' section before the reference list under a heading of 'Consent to participate' and/or 'Consent to publish'. Other declarations include Funding, Conflicts of interest/competing interests, Ethics approval, Consent, Data and/or Code availability and Authors' contribution statements.

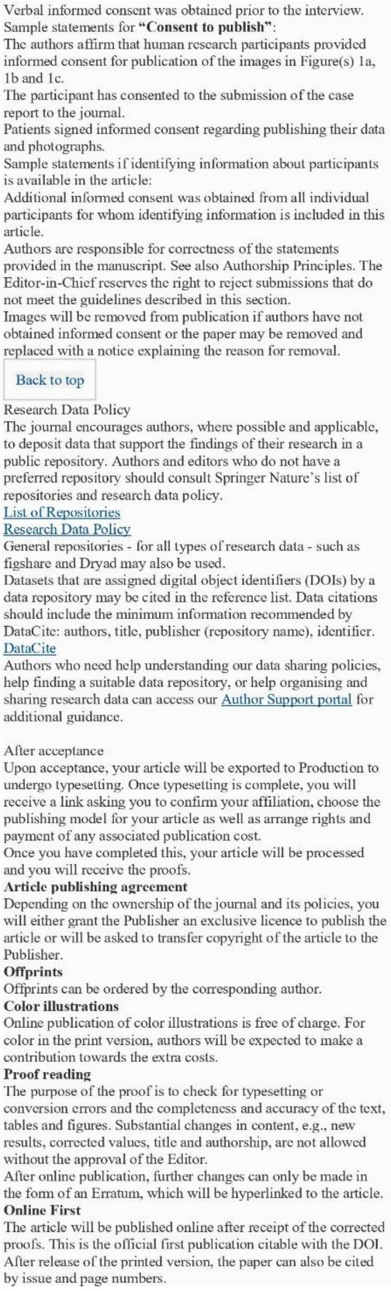
Please see the various examples of wording below and revise/customize the sample statements according to your own needs.

Sample statements for **"Consent to participate"**:

Informed consent was obtained from all individual participants included in the study.

Informed consent was obtained from legal guardians.

Written informed consent was obtained from the parents.



Verbal informed consent was obtained prior to the interview.

Sample statements for **"Consent to publish"**:

The authors affirm that human research participants provided informed consent for publication of the images in Figure(s) 1a, 1b and 1c.

The participant has consented to the submission of the case report to the journal.

Patients signed informed consent regarding publishing their data and photographs.

Sample statements if identifying information about participants is available in the article:

Additional informed consent was obtained from all individual participants for whom identifying information is included in this article.

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Images will be removed from publication if authors have not obtained informed consent or the paper may be removed and replaced with a notice explaining the reason for removal.

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List of Repositories

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Datasets that are assigned digital object identifiers (DOIs) by a data repository may be cited in the reference list. Data citations should include the minimum information recommended by DataCite: authors, title, publisher (repository name), identifier.

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Authors who need help understanding our data sharing policies, help finding a suitable data repository, or help organising and sharing research data can access our Author Support portal for additional guidance.

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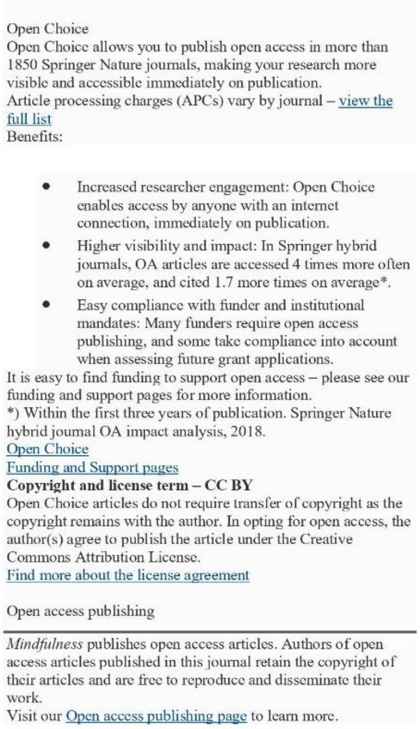

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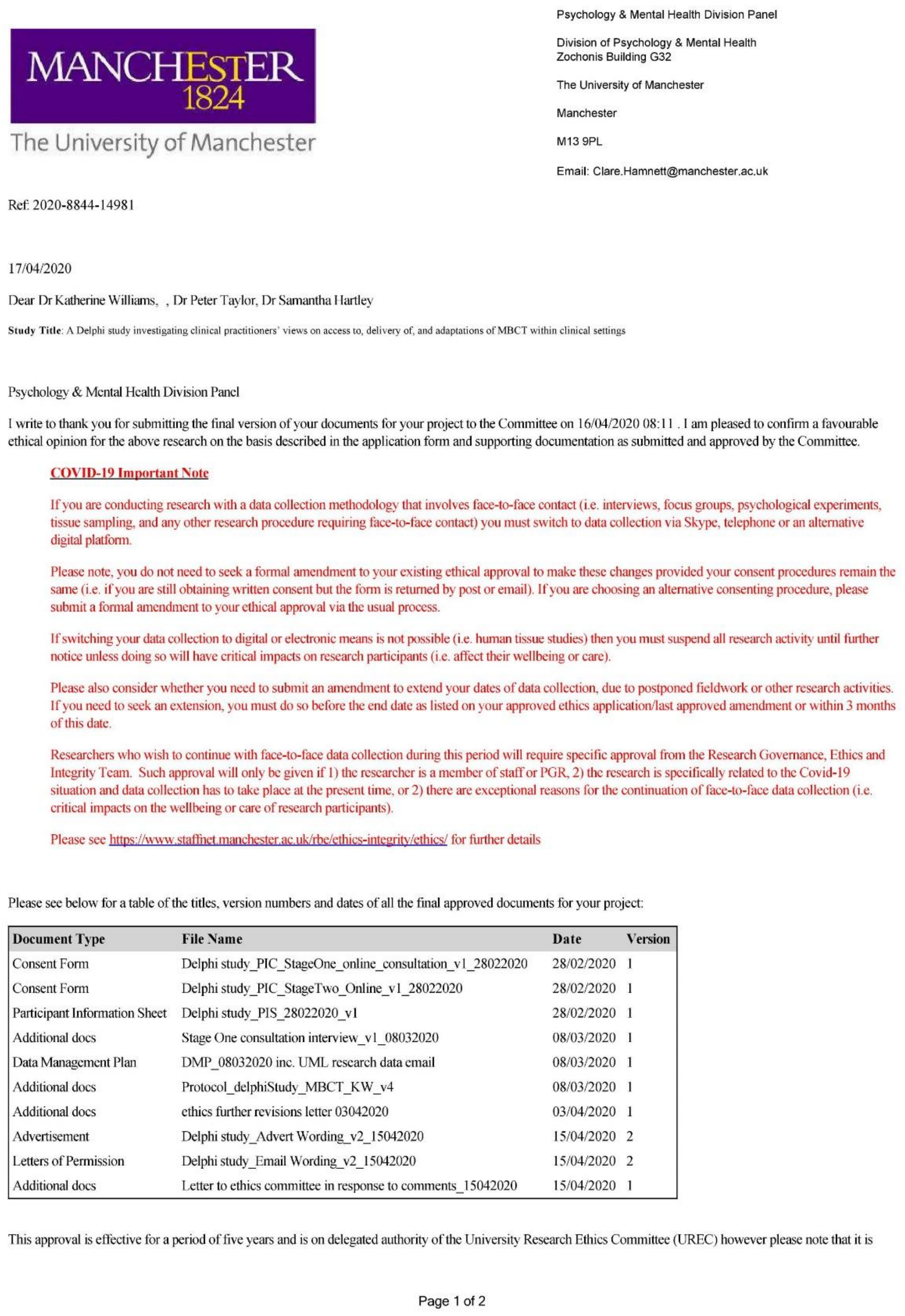
Appendix Eight. Paper Three. Ethical Approval



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Ref: 2020-8844-14981

17/04/2020

Dear Dr Katherine Williams, , Dr Peter Taylor, Dr Samantha Hartley

Study Title: A Delphi study investigating clinical practitioners' views on access to, delivery of, and adaptations of MBCT within clinical settings

Psychology & Mental Health Division Panel

I write to thank you for submitting the final version of your documents for your project to the Committee on 16/04/2020 08:11 . I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form and supporting documentation as submitted and approved by the Committee.

COVID-19 Important Note

If you are conducting research with a data collection methodology that involves face-to-face contact (i.e. interviews, focus groups, psychological experiments, tissue sampling, and any other research procedure requiring face-to-face contact) you must switch to data collection via Skype, telephone or an alternative digital platform.

Please note, you do not need to seek a formal amendment to your existing ethical approval to make these changes provided your consent procedures remain the same (i.e. if you are still obtaining written consent but the form is returned by post or email). If you are choosing an alternative consenting procedure, please submit a formal amendment to your ethical approval via the usual process.

If switching your data collection to digital or electronic means is not possible (i.e. human tissue studies) then you must suspend all research activity until further notice unless doing so will have critical impacts on research participants (i.e. affect their wellbeing or care).

Please also consider whether you need to submit an amendment to extend your dates of data collection, due to postponed fieldwork or other research activities. If you need to seek an extension, you must do so before the end date as listed on your approved ethics application/last approved amendment or within 3 months of this date.

Researchers who wish to continue with face-to-face data collection during this period will require specific approval from the Research Governance, Ethics and Integrity Team. Such approval will only be given if 1) the researcher is a member of staff or PGR, 2) the research is specifically related to the Covid-19 situation and data collection has to take place at the present time, or 2) there are exceptional reasons for the continuation of face-to-face data collection (i.e. critical impacts on the wellbeing or care of research participants).

Please see https://www.staffnet.manchester.ac.uk/rbe/ethics-integrity/ethics/ for further details

Please see below for a table of the titles, version numbers and dates of all the final approved documents for your project:

Document Type	File Name	Date	Version
Consent Form	Delphi study_PIC_StageOne_online_consultation_v1_28022020	28/02/2020	1
Consent Form	Delphi study_PIC_StageTwo_Online_v1_28022020	28/02/2020	1
Participant Information Sheet	Delphi study_PIS_28022020_v1	28/02/2020	1
Additional docs	Stage One consultation interview_v1_08032020	08/03/2020	1
Data Management Plan	DMP_08032020 inc. UML research data email	08/03/2020	1
Additional docs	Protocol_delphiStudy_MBCT_KW_v4	08/03/2020	1
Additional docs	ethics further revisions letter 03042020	03/04/2020	1
Advertisement	Delphi study_Advert Wording_v2_15042020	15/04/2020	2
Letters of Permission	Delphi study_Email Wording_v2_15042020	15/04/2020	2
Additional docs	Letter to ethics committee in response to comments_15042020	15/04/2020	1

This approval is effective for a period of five years and is on delegated authority of the University Research Ethics Committee (UREC) however please note that it is

Page 1 of 2

only valid for the specifications of the research project as outlined in the approved documentation set. If the project continues beyond the 5 year period or if you wish to propose any changes to the methodology or any other specifics within the project an application to seek an amendment must be submitted for review. Failure to do so could invalidate the insurance and constitute research misconduct.

You are reminded that, in accordance with University policy, any data carrying personal identifiers must be encrypted when not held on a secure university computer or kept securely as a hard copy in a location which is accessible only to those involved with the research.

For those undertaking research requiring a DBS Certificate: As you have now completed your ethical application if required a colleague at the University of Manchester will be in touch for you to undertake a DBS check. Please note that you do not have DBS approval until you have received a DBS Certificate completed by the University of Manchester, or you are an MA Teach First student who holds a DBS certificate for your current teaching role.

Reporting Requirements:

You are required to report to us the following:

1. Amendments: Guidance on what constitutes an amendment
2. Amendments: How to submit an amendment in the ERM system
3. Ethics Breaches and adverse events
4. Data breaches

We wish you every success with the research.

Yours sincerely,

Dr Jane Senior

Psychology & Mental Health Division Panel

Appendix Nine. Paper Four. Example of a Reflective Log.

There are different ways to engage in a reflective log. Braun and Clarke (2013) discuss the guidance for a reflective log, including functional (acknowledging the impact of the research design and materials on the results) and personal reflexivity (acknowledging the researcher's assumptions, views, and how these shape interpretations). For example, this can include introspection reflexivity (applying self-understanding when making interpretations), intersubjective reflexivity (the impact of the researcher in relation to the participant), mutual collaboration (acknowledgement of participants as collaborators in the research process; Trainor & Bundon, 2020).

Below is an excerpt from my reflective log maintained during coding and theme generation in **Paper Two**.

"When I was transcribing the data, it felt like there were just a few "themes" emerging. But when I started to code individual transcripts and develop "codes", it dawned on me just how many individual, subtle, nuanced codes there are, which may fit under broader themes, but may not. There's actually a lot of rich data here. I think I had a similar feeling when I was collecting the data as it felt like people were saying largely similar things at the time but on reflection, when coding, I realised that people were saying so much in the individual interviews! There were so many more subtleties and intricacies than I realised".

"I am in coding overload! There feels like so much data to code and I'm only on the post-MBCT data. There are so many different thoughts, reflections, comments, and small pieces of data that it's overwhelming to imagine developing themes from this and ensuring that individual voices still come through in the end report. I am also trying to stay aware of what I call the individual codes and I am trying to label them with the participant's words, being careful not to add my interpretation on top".