"To me, it's like a little box of tricks":

breaking the depressive interlock as a programme participant in

Mindfulness Based Cognitive Therapy (MBCT)

Abstract

Objectives. Mindfulness meditation practices have become increasingly popular in clinical therapies, changing patterns of depressogenic thinking for individuals who experience consecutive episodes of depression. We were interested in finding out how Mindfulness Based Cognitive Therapy (MBCT) worked for programme participants by focussing on how meditative practices changed their relationships to their thoughts.

Design. Data for the study came from six semi-structured research interviews carried out with individuals who had taken part in an 8 week MBCT programme

Methods. We used Interpretative Phenomenological Analysis (IPA) to analyse the experiential accounts.

Results. We report on two superordinate themes – *Engaging the Neutral Mind* (with subordinate themes 'breaking the paralysis of worry' and 'choosing to think differently') and *Experiencing the Neutral Mind* (with subordinate themes of 'reflection on previous thinking styles' and 'becoming psychologically self-reliant').

Conclusions. Themes from the present study offer support to the assertion that mindfulness meditation helps facilitate a different mode of meta-cognitive processing with which to handle depression-related cognitions.

Practitioner Points

- Participants reported that they experienced an enhanced capacity to differentiate between their thought processes, experiencing an ability to tolerate some more uncomfortable thoughts and experiencing a/more choice in how to respond to thoughts
- Participants recognised that ruminating over negative thoughts was related to depressive states and experienced a shift in meta-cognitive processes that actively challenged depressogenic cognitions
- Participants became more psychologically self-reliant and therapeutically independent following MBCT
- Integrating mindfulness based practices in therapy may be a mediating factor in sustaining psychological wellbeing and may help clients develop self-compassion
- Future research looks to examining exit cases to understand elements of MBCT which are experienced as less successful by clients

INTRODUCTION

Understanding ways of working with depression and developing evidence based relapse prevention strategies eases the burden of disability for individuals with complex mental health needs (Moussavi et al., 2007). Mindfulness meditation practices were first integrated into clinical practice by the work of Kabat-Zinn (1990) as mindfulness-based stress reduction (MBSR) (Kabat-Zinn, Massion, Kristeller, & Peterson, 1992). Subsequently, Segal, Williams & Teasdale (2002) developed Mindfulness Based Cognitive Therapy (MBCT), a clinical programme aimed at individuals who experienced recurrent depression. The MBCT approach asserts that individuals who have experienced several episodes of major depression differ from their never depressed counterparts in patterns of thinking that are activated by depressed mood (Teasdale, Segal, & Williams, 1995). Dysphoric mood is more likely to activate patterns of depressogenic thinking, leading to escalating cycles of ruminative cognitive-affective processing, which in turn causes further episodes of depression (Ingram, Miranda, & Segal, 1998; Segal, Gemar, & Williams, 1999; Teasdale, 1988, 1997). Solomon et al. (2000) notes that the risks of further episodes of depression are increased with each consecutive episode and each episode of major depression requires less provocation by stressful life events (Kendler, Karkowski, & Prescott, 1999; Lewinsohn, Allen, Seeley, & Gotlib, 1999).

Using a combination of cognitive therapy and mindfulness practice, MBCT programmes were designed to break the constellation of negative thoughts, feelings and physical sensations by providing new experiences for the mind and body and creating an alternative relationship to negative thought patterns for programme participants (Segal et al. 2002). Programme participants commit to eight weekly 2 hour sessions

with one hour per day allotted to a meditative homework assignment (for example, the body scan, moment-to-moment awareness, mindfulness of the breath and body, mindful walking, three minute breathing space, mindful stretching and yoga, sitting meditation). Cognitive therapy elements of MBCT facilitates dis-identification from negative automatic thoughts, uses activity scheduling to focus on mastery and pleasure, delivers psycho-education regarding negative automatic thoughts and produces relapse prevention plans (Williams, Teasdale, & Kabat-Zinn, 2007). Through meditation, programme participants learn how to respond to negative thoughts in ways that enable disengagement from depressive cycles thus freeing the mind for positive reinforcement (Teasdale, 1999).

Evaluating the impact of MBCT

Controlled clinical trials have shown that MBCT is effective in reducing relapse rates in populations experiencing three or more episodes of major depression (Ma & Teasdale, 2004; Teasdale et al., 2000). Subsequent studies found support for MBCT as an intervention for treatment-resistant depressed individuals in acute phases of depression (Kenny & Williams, 2007), for individuals experiencing acute depression and anxiety (Finucane & Mercer, 2006; Kim et al., 2009), for children with symptoms of depression and anxiety (Lee, Semple, Rosa, & Miller, 2008), for psychiatric outpatient populations with a history of recurrent major depressive disorder (Kingston, Dooley, Bates, Lawlor, & Malone, 2007) and for individuals displaying recurrent suicidal behaviour (Williams, Duggan, Crane, & Fennell, 2006).

While the UK National Institute for Health and Care Excellence (NICE) stipulates that people with depression should be offered MBCT if they have experienced three or

more previous episodes of depression and are at significant risk of relapse (NICE, 2009) [c.f. Geschwind, Peeters, Huibers, van Os & Wichers, 2012], understanding what mindfulness is and how it works for individuals still remains somewhat under-researched. Mindfulness has been predominantly researched within the post-positivist paradigm using quantitative scales and inventories (Baer, Smith & Allen, 2004; Lau, et al., 2006; Walach, et al., 2006) but quantification of the experience of mindfulness may be problematic for several reasons. Firstly, mindfulness, as a psychological term, varies with the use of different scales – ranging from a 'curiosity of thought processes' to a 'lack of attentiveness to daily activities' (Grossman, 2008). Secondly, scales were developed and validated using student populations with little or no experience of meditative practice (Brown & Ryan, 2003). Understanding what 'mindfulness' is still remains a conceptual challenge, and from a phenomenological perspective, the specific processes underlying the experience of how cognitions change for individuals in MBCT remains unclear.

Understanding mindfulness phenomenologically

A study by Allen, Bromley, Kuyken, & Sonnenberg (2009) provided qualitative accounts of the experience of undertaking MBCT and found that there was an increase in control over depressive relapse, de-stigmatisation of depression and improved relationships with others. Other qualitative studies have focussed on the acceptability of MBCT for different clinical populations including those experiencing psychosis (Abba, Chadwick, & Stevenson, 2008) and acute depression (Mason & Hargreaves, 2001). However, there has been little research carried out on how individuals actively respond to MBCT in relation to meta-cognitive experiences and how individuals gain mastery over their thought processes.

Aims of the present study

Regular mindfulness practice has been hypothesised to impact directly on a number of cognitive behavioural mediators of psychopathology, including self-criticism, rumination, stress reactivity and experiential avoidance - factors recognised as underlying and maintaining anxiety and depression (Arch & Craske, 2006). We were interested in how MBCT worked for participants, specifically how mindfulness based practices changed participants' relationships with their thoughts. This would help us determine the role of meta-cognitions and help us understand the relationship between the practice of mindfulness and dis-engagement with the 'depressive interlock'.

METHODS

Sample

Six participants were recruited from a local UK National Health Service (NHS) Trust, which facilitates MBCT courses through an out-patient clinic. Participants had initially been screened by the direct care team at the NHS Trust, conforming to the DSM-IV criteria of diagnosis for depression on at least three occasions. Participants had been required to attend all MBCT sessions[1] and engage in meditative practice between sessions. Participants were also required to have completed the full MBCT programme a minimum of three months prior to the interview taking place. Participants who currently practiced yoga or meditation more than twice a week were excluded because these practices significantly overlap and feature as a component of the MBCT programme (Teasdale et al., 2000).

Participants came from three different MBCT groups: three participants were from a group that ended three months prior to the research interview, two participants were from a group that ended six months prior to the research interview and one participant was from a group that ended twelve months prior to the research interview. The five female participants and one male participant were aged between 41 – 60 years old. One participant described her/himself as Black and all other participants were of White British origin. All participants had experienced three or more episodes of depression prior to the MBCT course. The majority of participants reported that each episode of depression had lasted for a number of years while one participant described the typical length of an episode as approximately one year.

[1] In accordance with the MBCT course protocol (Segal, et al., 2002), participants had met weekly for two-hour group sessions led by the instructors over a period of eight weeks. Homework was given each week, with daily meditation practice six days a week of at least 45 minutes per day. Each participant received a Compact Disc (CD) with the standard meditative practices in the programme recorded by their instructor.

Data Collection

The second author attended booster sessions[2] following the 8 week MBCT treatment programme to recruit participants[3] and following a research briefing to each group, participant information sheets were circulated, giving the second author's contact details. Semi-structured research interviews (lasting between forty and sixty minutes) were then carried out on local research premises between May-July 2010. Participants were debriefed by the second author, discussing their experience of the research interview with a verbal check for depression. None of the participants reported that they were currently depressed. The research interviews were then transcribed by the second author and the data anonymised with pseudonyms allocated. Ethical approval was gained from The University of East London Ethics Committee, the National Health Service (NHS) Regional Ethics Committee and the Research and Development Unit of the hospital where the MBCT programme had been delivered (NHS Health Research Authority, 2013).

Interpretative Phenomenological Analysis (IPA)

We used Interpretative Phenomenological Analysis (IPA) to analyse the participants' experience of meditative practices. IPA's three key philosophical tenets of phenomenology, hermeneutics and ideography lend itself well to the to the study's aims in gathering accounts that are embodied, situated and meaningful (Reid, Flowers

[2] Booster sessions are held four times per year and are open to clients who have finished the MBCT programme. The session involves a meditation, inquiry into meditation, a discussion of how practice has been maintained and obstacles encountered in meditation.

[3] On average, about 20 individuals attended each booster session and the second author attended three booster sessions. Eight individuals initially came forward to participate in the research but two of these individuals refused to carry out the research interview at the agreed location.

& Larkin, 2005; Smith, Flowers, & Larkin, 2009). Notably, entering the life world of participants' meditative practices engages the 'double hermeneutic' whereby the researcher interprets the interpretations of the participants, so recognizing that the experience is never fully directly accessible to the researcher (Thorne, Reimer, Kirkham & O'Flynn-Magee, 2004; Willig, 2013). While Smith (2011, p. 10) describes IPA as providing "a chain of connection between embodied experience, talk about that experience and a participant's making sense of.. that experience", recent perspectives on IPA have highlighted its misapplication and lack of social and cultural embeddedness as an analytical technique (Chamberlain, 2011; Hefferon & Gil-Rodriguez, 2011; Todorova, 2011). Subsequently, we contextualised the accounts during the analytic stages, adopting a critical realist epistemological position and used the 'persons-in-context' approach (after Larkin, Watts & Cliffton, 2006). Participants' lived experiences were then specific to local socio-political conditions and were temporally specific.

Data Analysis

Several discussions had already occurred between the first and second authors following a global preliminary analysis by the second author over the content of the transcripts. The first author immersed herself in the transcripts and read and re-read the transcripts, listening to the stories that the participants were presenting and focused on understanding participants' relationships to their thoughts. Preliminary themes were produced alongside each transcript and then matched within and across the set of transcripts (Smith, et al., 2009; Smith, Jarman &Osborn, 1999). Sub-themes were listed and the research process was paused by the first author for a number of weeks to contemplate the analysis. The first author returned to the transcripts and

tested the transcript extracts against the sub-themes. Sub-themes were then organised into super-ordinate themes and a validation exercise confirmed the identification of two super-ordinate themes presented in the final analysis.

Reflexivity and 'bracketing'

IPA recognises that the analysis is influenced by the researcher's own framework and views of the world, and while both the first and second author had initially engaged in intense debates and conversations about mindfulness, meditation and its relation to Buddhism, this was not significant for the data analysis. Conversely, the first author was impacted by two absences – an unsettling perception of the absence of cognitive psychology expertise during the analytic period and, in understanding mindfulness as a micro-phenomenon [sic], the absence of political and cultural markers in IPA. The first 'troubling' perspective during analysis was responded to by challenging the idea that 'only an academic cognitive psychologist could accurately understand participants' cognitive processes' and we pulled back into the fundamentals of IPA. We were interested in the *account of the lived experience* and that the *individual participant is the expert of that experience*.

The absence of social and political markers in IPA became problematic, especially when engaging in critical realist epistemologies. To remedy this, the first author created a set of phenomenological case[4] accounts (see Appendix 1) to support and connect the analysis up for us as researchers - and for you, as our audience of readers. The research interviews had focussed specifically on the experience of meditative

[4] 'Case' is used in the ideographic sense rather than in the pathological sense of 'caseness'

practice during and between MBCT sessions but depth of detail emerged from participants' accounts because of the semi-structured approach adopted and the research interview skills of the second author. Hence, we created accounts of participants' current life conditions as well as their mental health histories that could be related back to meditative practices. We could also then locate their psycho-biographies within a particular time and space continuum – the summer of 2010, two years after the Global Financial Crisis of 2007-8 (International Monetary Fund, 2011). Therapeutic delivery was located within the UK IAPT (Improving Access to Psychological Therapies) framework (Layard et al., 2006). The phenomenological case accounts and the temporal location of the research interviews are presented to help contextualise the analysis in the results section.

RESULTS

Two superordinate themes were produced from the analysis – *engaging the neutral mind* and *experiencing the neutral mind* (see Table 1). The term 'the neutral mind' is one that was evident and named in participants' accounts at various points during the research interviews. 'The neutral mind' describes how thinking content was previously negative and downwardly cyclical compared to a mindset which is now more balanced and productive for participants. Participants described this state as 'neutral' - *not* an absence of threatening thoughts but a set of thought processes that they could now manage and negotiate around and away from. Participants also became more accepting, measured and philosophical about their thought patterns, believing them to be sometimes positive, sometimes negative. Some participants had more insight into how this process worked compared to other participants but this was not an over-riding concern for any of the participants. The neutral mind was firstly engaged – or developed – and then the neutral mind was consciously experienced – this was both a *process* and an *outcome* for individuals involved in the MBCT programme.

Engaging the neutral mind

The first theme, *Engaging the Neutral Mind*, illustrates the process by which participants become conscious of rumination and then find that they are able to break these destructive thought cycles following meditative practices. Participants become active in handling their thoughts and are able to then choose and better manage their thought patterns. The process of engaging the neutral mind focussed on two subordinate themes – *breaking the paralysis of worry* and *choosing to think differently*.

Breaking the paralysis of worry

Participants developed insight into the ability to recognise destructive or non-adaptive thought patterns as a result of the MBCT programme and *breaking the paralysis of worry* forms the first part of the decision making process in managing 'errant' thoughts. Previous thought patterns are challenged and anxieties begin to fragment for participants. Jennifer and Claire remind us of the deeply dysprohic and spiralling effects of rumination:

> Jennifer: Feeling low - it becomes so difficult to stop it that you become paralysed by worry, literally… You're thinking 'I don't wanna do this because that's gonna be the outcome'. What it [meditation] does, is it stops escalating. Stops automatic thoughts going round and round and round and round… That means you have the ability to be in the present that you can switch the past or switch the future off.

Jennifer identifies her low mood as a result of her paralysing and previously inescapable thought processes. Meditative practice stops the process and provides the space to recalculate and reassess Jennifer's tensions in relation to her past/future dichotomy. The impasse is broken and Jennifer becomes agentic in managing her thought processes. Claire experienced similar lows and describes a downward trajectory that she had once found difficult to extricate herself from:

> Claire: Even though I'm still going through stressful periods but not that mad kind of dip down into a big black hole really. And I think once I went in there, it just takes a long, long time to come back up again. You're just down there. It's stopped that from happening. It's a kind of miracle really!

While Claire acknowledges that there are still situations which she finds difficult to deal with, the cycle has been broken and she has moved away from the debilitation of depressive thought patterns. The release from those thoughts and feelings is life changing and in some way, the process of breaking that paralysis does not have to be

logically or fully understood by Claire. In engaging the neutral mind, the underlying processes do not have to be fully transparent for participants.

Maggie clearly describes how she experiences the previous lack of control over thought patterns and how she now pauses, breaks the cycle and appraises their threat:

> Maggie: [My thoughts are] like when kids spiral out of control, and the mum just gets hold of them and stops them! You sort of literally get a hold of yourself and stop. Just think right sit down, take three deep breaths - think about it. Is it really that bad?

Similarly, Joe is acutely conscious of his rumination over daily life issues which had previously left him unable to function in an adequate manner despite the fact that the triggers were, admittedly, micro-elements of his social beingness:

> Joe: Well the ruminating is something I couldn't control before and a small problem or idea would just get bigger and bigger. I couldn't stop thinking and it just got worse and worse and worse. I would catastrophise so much that in the end I couldn't handle it… Something small, something somebody said, or a letter coming through the door, or a telephone ringing.. I'd start thinking and imagining things all the time until I couldn't handle it anymore... But with the meditation I could put it into perspective more and stop it snowballing and getting out of control

Joe had developed an ability and an acknowledgement in understanding the magnifying effect of simple triggers and was able to restrain the process though enhanced meta-cognitions as a result of meditative practices. Maggie and Joe present pragmatic yet nurturing accounts of their insight to recognise non-adaptive thought patterns.

Choosing to think differently

Having become aware of the negative cycle of thoughts and becoming able to break their hold, participants begin to actively manage their thoughts processes as a result of

the MBCT programme. Participants develop an awareness of their thoughts being processed, bringing them to consciousness and proactively dealing with their content. Participants also note the qualitative difference in their thought processes compared to pre-MBCT. The accounts from Joe and Maggie illustrate a clear and pragmatic approach to understanding the cognitive processes that help them to think in a different manner:

> Joe: In some way the rumination would stop. Either by observing the thought and as they say on the tapes - 'to gently escort the thought back to your breathing' or whatever you're doing at the time. I would do that sometimes, if it was in a sitting meditation I could examine the thought in more detail and it'd go away completely or it didn't quite seem so bad.

Joe becomes conscious of his meta-cognitions through the calmness and stillness of meditative exercises, and although he is unable to explain or understand the process whereby this can occur, stays with the process and knows that this has worked for him. This is somewhat similar to Claire's experience in breaking the paralysis of worry as outlined above. Maggie too returns to her breathing to centre herself away from chaotic thought patterns and shows how she had previously perceived her conscious experiences:

> Maggie: when I was in a state I would react straight away. And now, I don't. I just think okay, take five you know. Walk away, take a breath, have a think, come back.

The pausing, stillness and return to a feeling of equilibrium illustrate where Maggie has come from and where she is now in being able to control her thought processes and reactions to her environment. Claire describes in more detail how she detaches herself from the negative thought process when feeling challenged:

> Claire: if I'm getting stressed or thinking negative thoughts I think okay, 'that's kind of fine maybe that's kind of normal, everybody's got these ups and

> downs'. I think it just stops me from really going with these negative thoughts and falling down… The meditation makes you aware that these are negative thoughts that come up in your head and not to attach yourself with them too closely and not get involved with them too much. And I suppose get carried away with them.

Claire neutralises the impact of the negative thoughts through comparison and processes of normalisation. Thoughts are acknowledged in a rationalised manner and Claire moves away from them as she understands that they are not productive for her. The impact that 'choosing to think differently' has on participants' quality of life is also evident in Susie's account:

> Susie: it's become such a reflex.. switching into the objective frame of mind... It's taking a mental step back from my own mental state and thinking, this comes, this goes. it's no big deal. Whereas before when I started having the very strong physical symptoms I would go into my GP's and say 'I cannot live with this!', and now I am living with it!

Susie has developed the ability to think differently and it has become naturalised into the lived experience of her thought processes, experiencing it as an automatic response and as a neutral, calm and unthreatening consciousness. Thoughts are now experienced as transient, not escalating and not catastrophic - neutral. Moreover, Susie's thought processes are controllable. In this case, Susie wants to thoroughly understand those processes:

> Susie: Today I had a thought, it went through my mind, I had the reaction but I couldn't identify its passage. I knew that something had whizzed through and I thought 'shit what was that? Why am I now shaking and pouring with sweat?' What is it, I just couldn't get it back… A quote that I read – 'thoughts flickering like lizards through the masonry of my mind'. I thought 'that is exactly what I experienced my mind feels like a semi collapsed Greek temple sort of rather beautiful in parts, rather massive in a certain amount of disarray but not total disarray', and then thoughts flickering like lizards is exactly the sort of serration that I have. My feeling is that I want to catch the lizard like that (*catches it with hand*) and sometimes I get it, sometimes I don't.

Susie seeks to identify and understand her thoughts and uses sophisticated imagery to explain the neutral set position that she connects with. Susie has linked the thought to the sensation it produces for her and we see a drive for understanding of the thought's location and a drive to seek its resolution. Susie meets the challenge while at the same time acknowledging the acceptance of partial existential failure and partial existential success in choosing to think in a different way in the last sentence of the quotation.

Experiencing the neutral mind

The second superordinate theme, *Experiencing the Neutral Mind*, was the outcome of the cognitive processes involved in the first theme. Participants experienced a deeper understanding of the process of the neutral mind and drew in and incorporated the changes in thinking as a product of meditation. The rewards of changed thinking patterns brought forward the realisation of a new psychological skill set and some participants felt more psychologically independent. Again, this second superordinate theme, also had two related subordinate themes – *reflection on previous thinking styles* and *becoming psychologically self-reliant*.

Reflection on previous thinking styles

Participants re-assessed present thoughts compared to their previous mind set, noting that their previous thinking had not been productive and that alternative ways of thinking made them freer to live the life that they wanted to. Jennifer tells us that the MBCT programme made her pause and consider how the impact of one style of thinking can improve her tendency to be anxious:

> Jennifer: If somebody else doesn't come along and said well there's a different way to be thinking, it just becomes a mode of how you function and until it gets to the point that it's taken over your life.

Jennifer's mode of thinking was challenged and she realised the impact in choosing one thinking mode over another and comments on the consummate nature of that choice on her life experience. Maggie, similarly, realises that she is able to actively manage events and situations which she had previously found demoralising:

> Maggie: before I was kind of afraid and before if someone gave me something I'd think I've got to do it straight away 'cos they'll dislike me or shout at me and now I just think: is that a reasonable request? Does that need to be done now? Can it be done later? So it's made me more competent. It's brought back my confidence.

Not only is Maggie able to reflect upon requests made to her but realises that in doing so, she gains more control over the process, building confidence and validating her work skills, abilities and presence. This is particularly significant for Maggie given her work history and concerns over her relationship with several managers. While Jennifer and Maggie provide us with pragmatic accounts, Claire and Susie use humour to distance themselves from their previous thinking styles by noting the irrationality and fabrication of such thought processes:

> Claire: If I start thinking negatively, I laugh at myself sometimes. Cos I think.. it's all in the mind!

Claire allows herself to locate the cause, gives herself permission to accept her negative thoughts and her fallibilities and put these aside while Susie frames her previous thought processes as less threatening and now sees the absurdity of their content:

> Susie: [The meditation] had an impact on everything, absolutely everything, what it's done is in a way develop my sense of humour about my own extremes [of thinking]… There's been a very big change. It's actually very difficult to put it

> into words. I suppose the best way of summing it up would be that I cease to take myself so seriously!

Claire and Susie move away from cognitive distortions and towards a neutral experience of thought processes. Previous debilitating distortions are now bound in humour and have been re-framed and distanced. Framing their previous thinking using humour has a calming effect – positions are re-calculated and a different perspective on the thought processes is adopted. In parallel, both participants begin to accept their own fallibilities without stereotype, without judgement, without stigma and almost with compassion.

Becoming psychologically self-reliant

Participants became aware that their MBCT group experience and meditative practices led to forward movement in their psychological lives. Participants named this as acquiring a skill or having a psychological tool and this evolved into feeling psychologically self-reliant. Although Donna struggled with controlling her thoughts and practising the meditations inside and outside the MBCT group, she was aware of the benefits that practice brought:

> Donna: It's given me the tools for the future - I know that some people meditate through all their lives and still don't feel like they've got it right but you can't expect that in eight weeks. Because you have to do it every day and practice it...I think now I've got ground for it.

More sustained effects were seen by Maggie who tells us of her daily struggle in maintaining patience with her environmental stressors and how she has come to see meditation as something which is solid and useful. Again, Maggie, like Donna describes MBCT as a tool:

> Maggie: You give them a CD (twenty quid but!) you got the tools that you can use at any time... when you're going on in the day and just thinking grrr.. and you do a little bit of self meditation. It's sunk in somewhere and it's something that you can recall, something you can rely on.

Maggie and Donna realise that they have developed a key skill which gives them confidence in how they approach their particular life challenges and begin to feel safer and more secure in having the ability to control their thought processes. The skill is integrated into the individual's life space and the individual is released from debilitating anxieties:

> Susie: I still have quite strong physical anxieties at some point every day. Because of the mindfulness practice, I can almost disregard them. I use the techniques I've learned in the mindfulness practice but I cease to dread them because I know I have this tool.

Becoming psychologically self-reliant is an active process and Susie comes to realise that she can separate herself from the threat of becoming anxious again. Similarly, Jennifer provides a pragmatic account of how she manages her anxiety about being late for the research interview:

> Jennifer: I can't say wholeheartedly that it's solved all my problems! But I think what it does is like give you tools to use if you feel you're a bit overwhelmed... when I thought I was gonna be a bit late to meet you I phoned up. Before [MBCT] I wouldn't have phoned. I would have just sat and worried about it. [Interviewer: yeah] And that's all right! I feel good; you feel good; and we're happy!

For Jennifer, we interpret this as her nirvana as she has successfully negotiated her lateness, her anxiety and as a result of the MBCT programme, developed agency in managing the outcome for the benefit of herself and others. Jennifer has developed a belief in the method, a belief in the skill of mindfulness and experiences the positive outcome of her practice – knowingly, insightfully and in front of a MBCT practitioner.

For Claire, this became more significant as she recalls her dependence on health professionals and/or health interventions:

> Claire: For years I've always been trying to grasp onto something that would help me, like homeopathy. I'm always relying on other people to give me potions or to do the acupuncture. And I just feel after this course that to me it's like a little box of tricks... I don't need to rely on anybody else out there for this... I don't need to rely on the doctor to get tablets to mess me up even more. So I feel it's kind of my set of skills that I can use at any time and I think this is something that I have that will help me in the future.

Claire displays the psychological self-reliance as evident in other accounts but points to a socio-therapeutic context that had re-enforced dependencies and limited her success of self-care. Having experienced MBCT, Claire takes a stance and rejects both traditional and non-traditional interventions. By enabling participants to self-manage and self-regulate thought processes through meditative practices, participants gain a psychological self-reliance that boosts the ability, *and their belief in that ability*, to break through their depressive interlock.

DISCUSSION

The transforming potential of meditation was clear in most participants' accounts in that how they now responded to their thoughts was fundamental for better mental health experiences. Following mindfulness meditative practice, participants spoke of stepping into a neutral mindset, being able to detach from negative thought patterns and view challenging situations more pragmatically and rationally. Participants developed a capacity to disengage from negative cycles of thought and rumination which had predicated depressive states. There was an effortful acceptance of negative thought processes as a result of meditation and this, combined with greater choices in their behavioural responses became empowering for participants as they believed that they became more psychologically self-reliant and therapeutically independent.

The mindful client

The shift in meta-cognitions reported by participants can be viewed in the context of overcoming Teasdale's (1999) 'depressive interlock'. Participants became aware that rumination was a predictor to depressive states and that increases in their meta-cognitive awareness reduced depressive rumination (Beck, 1995; Ingram et al., 1998; Segal et al., 2002). Anxiety and depressive related cognitions were inhibited by bringing awareness to the present moment and individuals became aware of their ruminative thought processes (Roemer & Orsillo, 2002). Experiencing thoughts as events and not realities allowed participants to re-set goals and form better meta-cognitive strategies that generated more adaptive thinking styles (Wells, 2000). Hayes (2002) argues that a *mindful response* contextualises the self so that its' functions can be channelled more flexibly toward a choice of cognitive or behavioural engagement that support personal wellbeing. Participants reported feeling more psychologically

empowered and this reflects findings from Allen et al. (2009) with a shift from feeling helpless to being in control over mood states following MBCT. Through reflection on thinking styles, participants became more self-accepting. Given that individuals with depression or anxiety disorders find it difficult to experience self-compassion (Gilbert & Procter, 2006: Pauley & McPherson, 2010), including meditative exercises involving the development of self-compassion as an adjunct to existing MBCT meditative exercises may aid well-being effects and help sustain recovery from depressive episodes. Transformations in meta-cognitive processes can be experienced as a mediating factor for psychological wellbeing.

Persisting with mindfulness

Regular daily practice of mindfulness is one of the most essential aspects of the programme. Indeed, the degree to which an individual feels competent to carry out meditative practice is influenced by beliefs about the particular task, the relevance of homework to the therapy goals and information about how it has helped others in a similar situation (Kazantzis & Lampropoulos, 2002). One participant (Donna) was unable to sustain meditative practices long enough for substantive change. MBCT encourages individual routines but responsibility for tailoring assignments rests with the client. Hence, difficulties in sustaining practice in mindful meditation will affect MBCT's clinical efficacy. Consequently, clinical developments in MBCT may wish to explore less successful cases as well as considering going beyond mindfulness and use meta-cognitive guidance, free association tasks, metaphors and rumination postponement experiments from meta-cognitive therapy to support individuals in distress (Fisher & Wells, 2009).

Limitations

Three limitations are documented in relation to the study's focus and sample population. Firstly, the research we have presented documented participants' *experience* of the changes from meditation in relation to their thought processes from a meta-cognitive perspective – and so, we cannot report findings as *theoretical* cognitive processes. However, there is scope for aiding meta-theory generation in relation to our findings - for example, the addition of Kazantis, Dean, Ronan and L'Abate's 2005 Integrated Theoretical Foundations Model to Teasdale's 1999 Interactive Cognitive Subsystems Model and Wells' 2000 Self-Regulatory Executive Function Model may be useful for the production of meta-theory.

Secondly, programme participants also received CBT interventions, written material involving the concept of mindfulness as well as taking part in discussions with other group members. Hence it is difficult to ascertain whether the reported positive outcomes are specific to meditative practice, other elements of MBCT or exposure to different therapies before entering the MBCT programme. By definition, MBCT clients have recurrent depression, so it is likely that these individuals may be long(er) term service users and have experienced other therapeutic services in the IAPT model. In this light, we can look towards assessing comparative efficacies of psychotherapeutic interventions using network meta-analyses (Barth et al., 2013) and/or examine the plausibility criteria for analysing cases in relation to therapy outcome (Elliott, 2002; Kazdin, 1986; McLeod, 2003). Here, we argue that participants described plausible links to MBCT.

Thirdly, participants were approached and recruited through booster sessions and so this population sample may be predisposed to engage more fully with mindfulness practices (c.f. Donna). Additionally, exit cases were not included in the sample and indeed, existing studies have thus far excluded such individuals from the analysis of treatment effectiveness. Drop-out rates for MBCT interventions range from 8% (Ma & Teasdale, 2004) to 13% (Godfrin & van Heeringen, 2010) and analysing the experience of people who have chosen to leave the MBCT course prior to its completion will become key given the effectiveness of MBCT reported here and elsewhere.

Future directions for clinical theory and research

Considering the success of mindfulness based interventions as a tool to combat [recurrent] depression, therapists using mindfulness interventions should explore meta-cognitive aspects of the intervention as well as including meditative practices which develop self-compassion for clients. In terms of developing phenomenological based researches, it may be worthwhile documenting how the language of MBCT enters/develops in the narratives of individuals who experience this particular therapy in relation to sustaining MBCT practice.

We can also expand our knowledge base of the effectiveness of meditation practice in MBCT through studying exit cases. The subsequent challenge for theory will be to account for changes in meta-cognitive awareness using pre- and post-testing using test measures that are valid and reliable to the phenomenon under study. Theoretical advances surrounding mindfulness as a psychological concept need to ascertain and understand its essences – is mindfulness a state of mind, a trait, a particular type of mental processing or cultivation of specific meta-cognitive processes?

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Table 1

Superordinate and Subordinate Themes

Superordinate Theme	Subordinate Themes
Engaging the neutral mind	Breaking the paralysis of worry
	Choosing to think differently
Experiencing the neutral mind	Reflection on previous thinking styles
	Becoming psychologically self-reliant