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The role of the group in mindfulness-based interventions

Section A: What can research, professional practice literature and theory tell us about the role of the group in mindfulness-based interventions?

5496 (plus 20 additional words)

Section B: A grounded theory of the role of the group in mindfulness-based interventions

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Section C: Critical Appraisal

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Section D: Appendix of supporting material

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Summary of MRP Portfolio

Section A provides a critical review of literature pertinent to the role of the group in mindfulness-based interventions. The extant relevant empirical literature, consisting of 16 qualitative studies and two quantitative or mixed-methods studies, and professional practice literature, has been synthesized and critically assessed. Findings related to group experience in mindfulness-based interventions (MBIs) have been considered in light of existing theory drawn from the fields of psychoanalysis and psychotherapy, education and Buddhism. The implications for future research, theoretical understanding and clinical practice are discussed.

Section B presents a grounded theory of the role of the group in MBIs. The theory was developed from semi-structured interviews conducted with mindfulness students, teachers and trainers (N=12) exploring their experiences and views related to the MBI group format. Through analysis, three higher-order categories emerged from the data describing *stages of group experiences,* the *group-based tasks of the teacher,* and the *impact of the MBI group*. Findings were situated within existing group theory, facilitating differentiation between generic and MBI specific group factors. The implications for clinical practice, research and theory are discussed.

Section C provides a critical appraisal of, and reflections upon, the research as a whole. The clinical and future research implications raised in Section B are discussed in greater depth.

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Section A

Section B

Section A

What can research, professional practice literature and theory tell us about the role of the group in mindfulness-based interventions?

Dulcie Cormack

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Abstract

Mindfulness-based interventions (MBIs) are increasingly prevalent in healthcare settings: both Mindfulness-based Stress Reduction and Mindfulness-based Cognitive Therapy utilize a group format. To explore the potential impact of the group upon the experience of learning mindfulness, this review synthesizes and critiques the extant empirical and professional practice literature relevant to the group format in MBIs. This currently consists of 16 qualitative studies, two quantitative or mixed-methods studies, one meta-ethnography, two peer-review professional practice articles and two unpublished guidance documents. The review illustrates that the group in MBIs appears to have a positive impact on clinical outcomes, and enriches participants' learning experience through providing a sense of belonging and community experienced as normalizing and motivating. Group skills, grounded in the 'embodiment' of mindfulness, are viewed as a core competency in professional practice literature. The review situates the findings within a theoretical framework, drawing on aspects of psychoanalysis and psychotherapy, education and Buddhist theory. However, no one theory was entirely applicable and all had limitations. Therefore, this review identifies a gap in the theoretical literature pertaining to the role of the group in MBIs. Recommendations for further research and a discussion of the implications for clinical practice are provided.

Introduction

Mindfulness means paying attention, in a non-judgemental way, to all aspects of present moment experience (Kabat-Zinn, 1990). The first wave of mindfulness research explored the efficacy of mindfulness-based interventions (MBIs) (e.g. Baer, 2003). Later research investigated mechanisms such as attention, intention and attitude (Shapiro, Carlson, Astin & Freedman, 2006), self-compassion and cognitive reactivity (Kuyken et al., 2010), and neurocognition (Creswell, Way, Eisenberger & Lieberman, 2007). Drawing on the mindfulness ethos of taking the "spotlight of attention" (Williams, Duggan, Crane & Fennell, 2006, p.7) to explore all aspects of experience, this review turns towards a neglected component of MBIs: the group format.

This review critiques the relevant empirical research and professional practice literature and situates the findings within a theoretical framework. Remaining mindful of clinical implications, the limitations of existing research and theory are discussed and directions for future literature proposed. This is prefaced by an overview of the evidence base for MBIs, a brief discussion of their group format, and clarification of the review's objectives.

Overview of the evidence base of mindfulness-based interventions

In this review, MBIs are Mindfulness-based Cognitive Therapy (MBCT; Segal, Williams & Teasdale, 2002) and its predecessor Mindfulness-based Stress Reduction (MBSR; Kabat-Zinn, 1990). Research has demonstrated the efficacy of MBIs in recovery from, and coping with, a variety of physical and mental health difficulties (Baer, 2003; Grossman, Niemann, Schmidt &

Walach, 2004). Following randomized control trials (e.g. Teasdale et al., 2000; Kuyken et al., 2008) demonstrating its efficacy for recurrent depression, MBCT became a National Institute for Clinical Excellence recommended treatment (NICE, 2009a). Consequently, MBCT is increasingly offered within the NHS as a treatment for recurrent depression, in addition to being adapted and piloted for a range of other physical and mental health problems (Crane, Kuyken, Hastings, Rothwell & Williams, 2010).

Group MBIs defined

MBCT and MBSR utilize group formats and an eight-week curriculum, teaching participants to become more aware of bodily sensations, feelings and thoughts moment-by-moment, through meditation and discussion (teacher-led 'enquiry'). Through weekly group sessions and daily homework tasks, participants develop skills in nonjudgmental attention, and the capacity to enter a 'being' (rather than 'doing') mode (Segal et al., 2002). MBCT groups are generally homogenous, whereas MBSR groups tend to have greater heterogeneity. Structurally, MBI groups are closed, short-term, structured and psycho-educational (Yalom & Leszcz, 2005). However, the group's function lacks clarity. Segal et al. (2002) define MBIs as "psycho-educational"; other experienced clinicians argue that MBIs are not "group therapy", "psycho-education", or "classroom teaching" (McCown, Reibek & Micozzi, 2010, p.104). Yet "group therapy" has been defined as using groups "for prevention, guidance, counsel[l]ing and training" (Barlow, 2008, p.240), which, arguably, encompasses MBIs. These semantic debates illustrate the inherent difficulties of defining 'the group' in MBIs.

Group format rationale

There are a number of reasons why MBIs use a group approach. Firstly, Kabat-Zinn discussed bringing "traditional monastic teaching" to the intervention (1982, p.36), within which group learning based on discussion and collective meditation is central (Bluck, 2006). Although MBIs are secular, mindfulness comes from an Eastern, Buddhist tradition, where living together within mutually supportive, spiritual communities (*sangha*) is essential to enabling acceptance and understanding (Nhât Hanh, 2003). MBCT was closely modelled on MBSR, including its group format. Before MBCT, Segal et al. (2002) sought to develop a new, preventative group intervention, finding individual therapeutic (e.g. cognitive and interpersonal therapies) and pharmacological treatments to be insufficient in addressing recurrent depression. Segal et al. had witnessed Kabat-Zinn's successful large group MBSR classes and kept as close as possible to his format (J.M.G. Williams, personal communication, May 25, 2012).

Secondly, a group format is more cost-effective than individual therapies and Kabat-Zinn (1982) and Segal et al. (2002) cite this as central to offering a group format. Indeed, MCBT and MBSR are offered to groups of up to approximately 12 and 30 participants respectively at a time (Mental Health Foundation, 2010). A study of the cost-effectiveness of MBCT concludes that not only is MBCT more cost-effective than individual therapies, but probably more cost-effective than anti-depressant medication if calculated over a fifteen-month follow-up period (Kuyken et al., 2008). Moreover, a growing body of evidence suggests that group cognitive-behavioural therapy (CBT) interventions are comparable in efficacy to individual CBT in most client

groups (Morrison, 2001) and as a treatment for unipolar depression specifically (Oei & Dingle, 2008).

Finally, experienced clinicians consider the group setting integral to clinical efficacy. Kuyken states: "We know that people find being in a group helpful. They find it reassuring to meet people with similar problems and … to compare themselves with others. The social processes that happen in groups are part of the treatment" (Mental Health Foundation, 2010, p.36).

However, while much research has found group interventions to be as effective as individual approaches (Burlingame, 2010), other studies find individual approaches to have greater efficacy and lower drop-out rates (Cuijpers, van Straten & Warmerdam, 2008). Further, there have been challenges to uncritically promoting the view that 'group processes', such as developing cohesion between group members, are unproblematic and always lead to improved outcomes (Hornsey, Dwyer & Oei, 2007). Therefore, it is vital that the literature be critically examined, within the context of broader group theory, to ascertain whether the perceived benefits of the group format of MBIs are real.

Review objectives

In view of the scarcity of research explicitly considering the role of the group in MBIs, this review draws on both empirical literature and professional practice literature based on clinical experience to address the following questions:

1. What does existing literature tell us about the impact of the group context of MBIs upon individuals' experience of learning mindfulness?
2. How can the role of the group in MBIs be understood theoretically?
3. What are the clinical and research implications?

Review structure

This review firstly summarises and critiques the group-related findings of existing empirical research. Currently, the majority of the evidence base in this area is qualitative research, which has been evaluated according to Yardley's criteria (2000), with particular focus on their contribution to theoretical understanding. Next, the review evaluates the current professional practice literature. Empirical issues that arise are then situated within relevant theoretical frameworks, with the limitations of existing theory highlighted. Findings are then discussed *vis-à-vis* implications for clinical practice, theory and research.

Methodology

This review considers a range of literature, including empirical research, theoretical and mindfulness teacher-training literature. Therefore, in addition to broad reading on groups and on mindfulness, multiple searches of electronic databases were conducted to obtain peer-reviewed papers. Searches used combinations of the following terms, their synonyms and derivatives, in either title, abstract or keywords: "Mindfulness", "group", "qualitative" and "professional practice" (see Appendix 1 for further detail). Databases searched were the Cochrane Database of Systematic Reviews (2005–April 2012), Ovid Medline (1946–May 2012), PsycINFO (1806–May 2012) and Google Scholar.

Review

Overview of empirical research

A search of empirical literature found only one quantitative study (Imel, Baldwin, Bonus & MacCoon, 2008), and one mixed methodology study (Chambers, Foley, Galt, Ferguson & Clutton, 2012). Seventeen qualitative studies exploring aspects of MBI participants' experiences were located and read for relevance. Nine qualitative studies reported group-related findings. A recent meta-ethnography of qualitative MBI research was also located (Malpass et al., 2012).

Quantitative studies

The vast majority of quantitative studies measure specific clinical outcomes such as depression ratings, or mindfulness-specific qualities such as 'acceptance'. This review found no papers that measured group-related concepts such as cohesion. However, Imel et al. (2008) found a significant

correlation between group-level variance and improved outcomes in participants' levels of psychological distress. They calculated that 'group effect' accounted for 7% of the variance in outcome. They compare this to 5% of variance in psychotherapy treatment outcomes predicted by therapeutic alliance, concluding that "MBSR does not appear to simply be an individual intervention delivered in a group setting, but rather its methods and effects occur at the individual and group level" (2008, p.742). These findings can be considered valid and reliable, with a sufficient sample size (N=606 from 59 groups), and controlled for pre-treatment severity and teacher effects. However, the authors acknowledge that their analysis was not sufficiently powered to robustly detect teacher effects. Nevertheless, they indicate clearly that group effects have a significant impact on clinical outcomes in MBSR.

Chambers et al. (2012) incorporated questions about participants' preferred aspects of MBCT into their mixed methodology study. *'Being asked to do the course as part of a group'* was the second most popular of eight aspects of MBCT (84.6% rated this as 'liked', 15.4% rated as 'neutral'). *'Experiences that arose as a result of practicing mindfulness'* was most popular and *'Meditating'* third most popular. This indicates that MBI participants may value the group aspect at least as highly as practicing mindfulness meditation. However, in view of the small sample size (N=13) and the very specific population considered (men with advanced prostate cancer), this finding requires replication with larger and more diverse samples for firmer conclusions to be drawn.

Quantitative research summary

The reviewed studies indicate that the group is subjectively important to participants. Furthermore, it appears that the group impacts clinical outcomes: up to 7% of variance between group outcomes appears to be due to 'group effects'. However, there are insufficient quantitative studies at present to draw firmer conclusions.

Qualitative studies

The scarcity of quantitative data means that this review predominantly draws upon qualitative studies. Qualitative studies provide insights into the perceived role of the group because they explore complex and subjective inter-relational concepts (Willig, 2008). Searches found 17 relevant papers (Appendix 2), but as two of them drew on the same data, presenting near-identical findings, they have been treated as one study to give a total of 16.

Additionally, a recent meta-ethnography of qualitative research on MBIs (Malpass et al., 2012) was found, which synthesises qualitative studies published before 2010 regarding experiences of MBIs. It did not focus on group-related findings specifically and does not include six recent qualitative papers. Therefore, it does not overlap significantly with this review. However, their group-related findings have been synthesised below.

Overview of qualitative studies

The studies (N=16) described their methodologies as: interpretative phenomenological analysis (IPA; n=3); thematic analysis (n= 4); thematic analysis within IPA framework (n=1); grounded theory (GT; n=3); content analysis (n=2); GT and content analysis (n=1); GT with a "close-ended coding" approach (n=1); and a "framework approach" (n=1). Ten studies explored MBCT experiences, and the remainder MBSR. Sample sizes ranged from five to 30, with a mean of 13.9. The majority drew on specific adult clinical populations of participants with: bipolar disorder; a cardiac condition requiring rehabilitation; Parkinson's disease; chronic pain (n=2); and cancer (n=2). Five studies recruited adults or older adults with depression (plus anxiety, n=1); one included people with various physical or mental health problems; one recruited from the general public; one used a staff group of nurses; and one considered socio-economically deprived adolescents.

The studies' aims ranged in specificity. The majority (n=11) can be described as broadly exploring participants' MBI experiences in the context of their specific needs (e.g. exploring subjective perceptions of MBSR and meditation in the context of participants' cancer experience). The remainder were more specific in their aims, such as exploring participants' post-course practice, or exploring population-specific issues, such parent-child relationships. None of the studies gave exploring the group experience as their primary aim.

Of the sixteen studies, nine included findings related to the group experience. Eight of these were studies with a broad focus (Allen, Bromley, Kuyken & Sonnenberg, 2009; Chambers et al., 2012; Finucane & Mercer, 2006;

Fitzpatrick, Simpson & Smith, 2010; Griffiths, Camic & Hutton, 2009; Mackenzie, Carlson, Munoz & Speca, 2006; Mason & Hargreaves, 2001; Smith, Gragan & Senthinathan, 2007). Of the five studies with more specific aims, only one reported group-related findings (Langdon, Jones, Hutton & Holttum, 2011). This suggests that participants were more likely to discuss their experiences of the group if interview schedules had a broad focus. Another reason why the group may not have been highlighted in some studies was suggested by Mason and Hargreaves, who acknowledge taking an "implicitly individualist orientation [in their study] that may have relegated the role of group support and interpersonal process" (2001, p.209).

Malpass et al. (2012) presented a 'synthesis of patients' experiences of the therapeutic process in mindfulness'. 'Group processes' were found to play a key role in two of three broad phases of patient MBI experiences.

Key group-related themes

A number of recurrent themes emerged from the nine studies presenting group-related findings. Themes were developed through use of thematic analysis techniques (Braun & Clarke, 2006), whereby data was grouped according to recurrent patterns and named accordingly. The themes were predominantly positive, although some potential disadvantages also emerged, as follows:

The group provides a supportive and normalising environment

Sharing experiences and meeting others "in the same boat" (Chambers et al., 2012; Smith et al., 2007) normalized one's own experiences (Mason &

Hargreaves, 2001; Griffiths et al., 2009) and reduced stigma (Fitzpatrick et al., 2010; Allen et al., 2009). Consequently, participants felt less isolated (Finucane & Mercer, 2006; Allen et al., 2009). The studies frequently linked these experiences with participants' perceptions of the group as supportive. Malpass et al. (2012) recognize this as the second-order construct 'group process: reducing stigma'.

The group motivates and supports meditation practice

A number of studies reported participants finding the group helpful in developing and maintaining mindfulness practice through improved concentration (Griffiths et al., 2009) and motivation even if feeling personally discouraged, "for the groups' sake" (Finucane & Mercer, 2006), or feeling "accountable to the group" (Langdon et al., 2011). Indeed, several studies reported that participants desired follow-up groups to support ongoing practice and struggled to maintain practice without group support (Allen et al., 2009). Malpass et al. (2012) describe this within their second-order construct 'group process: aid to learning'.

The group provides a sense of belonging and community

A number of studies described participants' sense of belonging to the group, cohesion and "camaraderie" (e.g. Chambers et al., 2012) which for some participants was their main motivation for attending (Mackenzie et al., 2007). Fitzpatrick et al. (2010) found this particularly important amongst people with Parkinson's disease who may have experienced reduced social contact as a consequence of their illness. The group also provides a culture where mindfulness is valued, which supported ongoing practice (Langdon et al.,

2011). Mackenzie et al. (2007) observe that group cohesion in this context primarily develops through non-verbal shared experience, rather than talking.

The group supports the learning of mindfulness

Group members supported each other in a variety of ways, such as sharing coping strategies (Mackenzie et al., 2007) or different perspectives (Chambers et al., 2012). Griffiths et al. (2009) note an interesting interaction between developing awareness skills, commitment, and group experience, and suggest that commitment to practice is related to the process of developing awareness, and that commitment was influenced by the group experience. In particular, they suggest that whether or not the group develops an "attitude of perseverance and determination" (p.679) impacts upon individual commitment, and therefore, development of awareness. Thus, the group is perceived to play an important role in learning key mindfulness skills.

Challenges of being in a group

Some studies highlighted challenges the group context can pose. For example, a participant with a social anxiety-type presentation (Finucane & Mercer, 2006) reported feeling relieved that the course was relatively short. Nevertheless, he completed the MBCT course, apparently deciding that the benefits outweighed the challenges. Malpass et al. (2012) describe such experiences as a "difficult and uncertain space" in second-order construct 'heightened anxiety', though this construct was not well supported. Griffiths et al. (2009) report one participant experiencing group discussions as frustrating, finding them repetitive and purposeless.

Fitzpatrick et al. (2010) reported one participant, at an earlier stage of their degenerative illness than other group members, to have left the course after the first week. She reported not wishing to be on a course with other people with Parkinson's disease because "if I don't see it I haven't got it" (p.187). In contrast, Chambers et al. (2012) found that their participants valued being in a group with others at a more advanced stage of disease (prostate cancer), whilst simultaneously finding it challenging. Participants found it inspiring to see people cope with their more advanced condition, and this supported them to develop greater acceptance of future possibilities. The authors note their surprise at this finding, as they suggest a common consensus in group interventions is to screen for homogeneity of experience.

Critique of qualitative research

The quality of the nine studies reporting group-related themes has been assessed according to Yardley's criteria (2000), which considers sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. Yardley's criteria are particularly relevant as they allow for a range of qualitative methodologies, and pay specific attention to use of, and contribution to, theoretical knowledge.

The nine studies were predominantly found to display the characteristics of good qualitative research (Appendix 3). The weaker studies were those which employed mixed methodologies (Chambers et al., 2012; Smith et al., 2007), in part due to these studies having less space to describe their qualitative methodologies, thus displaying less transparency. The majority were found to pay insufficient attention to socio-cultural issues, such as participant age and

cultural background, which may have particular relevance to how the group is experienced. It was also noted that although some studies made valuable contributions to theory (Allen et al., 2009, Langdon et al., 2011; Mason & Hargreaves, 2001), none made theoretical links with group theory. Furthermore, the findings of the studies were not discussed in any depth and were predominantly presented unquestioningly as generic group effects. This was also true for Malpass et al.'s meta-ethnography (2012). Nevertheless, the findings reported above are judged to be sufficiently robust to merit further consideration within this review.

Qualitative research summary

Qualitative research broadly exploring MBI experiences consistently raises a number of benefits offered by the group environment; in particular, a sense of community and support, opportunities for learning from others, and motivation to maintain ongoing mindfulness practice. There is less clarity about the potential benefits and disadvantages of homogenous groups. However, the extent to which the reported benefits of the group context may be specific to, or in some way modified by, the MBI context, remains unclear, for none of the studies critiqued their group-based findings or considered them in light of broader group theory.

Mindfulness professional practice literature

The second source of literature used to explore the role of the group in MBIs is discussion papers, training and good practice guidance, predominantly aimed at mindfulness teachers and trainers. This has been reviewed due to the relative scarcity of relevant empirical research, and to encompass the views of

clinicians. This is an approach used by NICE, who draw on "expert consensus to make decisions when [empirical] evidence is poor or lacking" (2009b, p.16). Information has been synthesized from the following sources: two peer-reviewed professional practice papers (Crane et al., 2010; Crane, Kuyken, Williams, Hastings, Cooper & Fennel, 2011); the UK Mindfulness Trainers' Network's (2010) Good Practice Guidance; and the (unpublished) Mindfulness-Based Interventions Teaching Assessment Criteria (MBI-TAC; Crane, Soulsby, Kuyken, Williams & Eames, 2012).

Synthesis of professional practice literature

The Good Practice Guidance (2010) does not make group-specific recommendations, although it implies that group facilitation experience is beneficial. Crane et al. (2010; 2011) position group skills as a core skill for teachers. Their paper on training teachers to deliver MBIs (2010) states that there is an "emerging consensus on what teacher competence 'looks' like" (p. 85) and places skills in managing the group process as one of six domains of teacher competence and an advanced teaching skill. They also argue that all competencies should be embedded in the teacher's capacity "to teach everything *through* an embodiment of the qualities of mindfulness" (2011, p.5). Embodiment, which is the teacher's capacity to maintain and teach from a position of mindful awareness, is an enduring theme of professional practice literature.

In their 2012 paper, Crane and colleagues provide a fuller description of 'holding of the group learning environment' (MBI-TAC domain six, pp.36-39). They raise the importance of the teacher creating "safety" and a "learning

container"; of "using the group process to draw out universal themes"; and the need to sensitively manage the "inevitable vulnerabilities" which being in a group arouses. Parallels can be drawn here with McCown et al. (2010), currently the most comprehensive relevant text. McCown et al. delineate the teachers' responsibility for the 'stewardship' of the group into three components (freedom amongst participants; a sense of belonging; group resonance), which together create a "holding space in which participants can work" (2010, p.104).

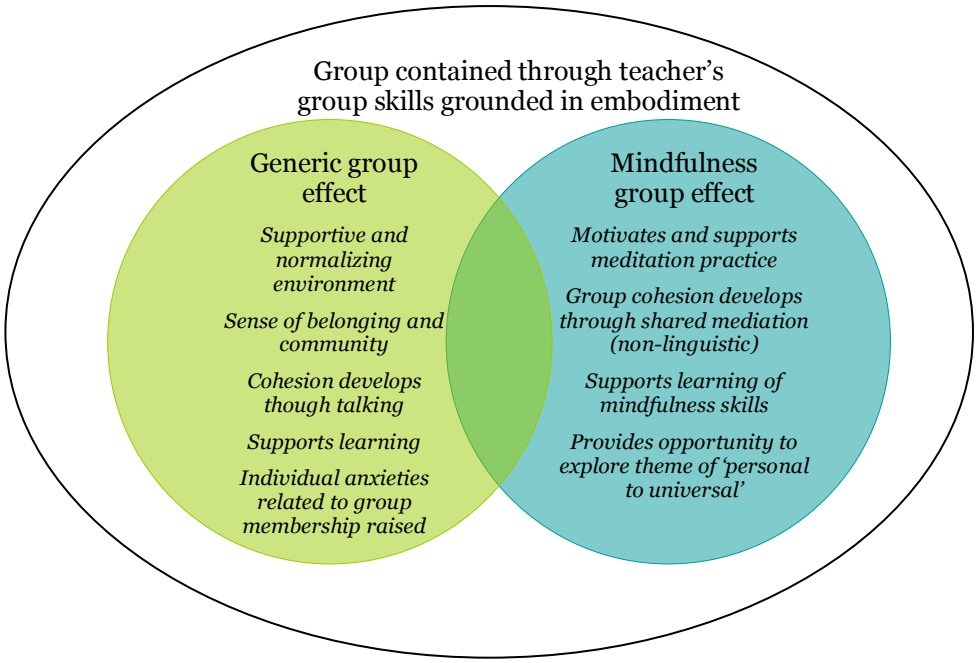
Critique of processional practice literature

These papers have a number of strengths. Firstly, they come from experienced mindfulness clinicians, drawing on many years of experience as teachers, trainers and researchers (Crane et al., 2010). Secondly, the views come from several UK training centres, drawing on the views of developers of MBSR in the USA, thus representing the views of the current leading names in both countries. Thirdly, their views correspond with those presented in key mindfulness texts (e.g. McCown et al., 2010). However, the papers also expose the lack of empirical evidence and theoretical understanding around the role of groups in MBIs. Although this is acknowledged to some extent, as Crane et al. (2010) advocate research on "teacher effects", the authors appear to perceive group effects as synonymous with teacher effects. Furthermore, despite utilising language reminiscent of a number of existing group theories, the authors have made no attempt to link their discussion with wider theory. Consequently, the professional practice literature creates the impression that the group is important but without saying why.

Summary of empirical and professional practice literature

This review's first aim was to discover what existing empirical research and mindfulness teacher-training literature tell us about the impact of the group context of MBIs upon individuals' experience of learning mindfulness. Empirical research offers convincing evidence that group factors influence individual outcomes in MBIs. The research reviewed has predominantly found the group to be benevolent: groups provide cohesion, support and motivation which participants' found helpful. Professional practice literature demonstrates that the group is considered a vital component of MBIs, with most attention paid to the teacher's role managing the group, emphasizing the importance of embodiment. However, existing literature has not begun to tease apart the difference between generic group effects, effects specific to mindfulness groups, or the overlap between them. Figure 1 presents a summary of empirical and professional practice group-related findings, suggesting effects that could be considered generic and those that appear specific to MBIs. However, the potential disadvantages of the group context of MBIs have yet to be considered. Furthermore, discussion of group effects has not been situated within any theoretical framework. The applicability of existing group theory has, therefore, been considered below.

Figure 1: Summary of the role of the group in MBIs presented in the empirical and professional practice literature



Situating the review within a theoretical framework

The review's second aim was to grasp how the role of the group in MBIs can be understood theoretically. Existing literature has not been situated within a theoretical framework, and therefore, the applicability and limitations of theory drawn from educational, psychodynamic and Buddhist spheres is appraised below.

Group development theories

Group development theories are widely applied in describing group behaviour (Johnson & Johnson, 2006). Such theories map out linear stages of group development and have been applied to multiple types of groups, such as learning and therapy groups. Tuckman's much-cited model of small group development (1965) conceptualizes changing group behaviour "in both social and task realms, across all group settings, over time" (1965, p.69). The group

begins by establishing its function and ground rules ('forming'), characterized by anxiety and dependence upon the facilitator. Next, the group enters a stage of intragroup conflict ('storming') as members attempt to maintain individuality within the group and resist group structure. Following this, cohesion develops ('norming') and group norms become established. This facilitates 'performing', where the group becomes most constructive. A fifth stage, 'adjourning', was added retrospectively (Tuckman & Jensen, 1977) to describe the group ending process.

A developmental group process is suggested in MBI professional practice literature, with reference to a 'storming' stage. The literature also provides examples of possible stages experienced by MBI participants. Arguably, 'adjourning' appears to occur as participants express fears about maintaining practice without group support, and the themes around belonging and cohesion are analogous to 'norming'.

However, without further research, stage theories should be applied with caution. Furthermore, it seems plausible that mindfulness, based on non-Western ideology, may not be an easy fit within this linear process. Indeed, the concept of 'performing', suggesting there is something to be achieved, is not congruent with mindfulness approaches.

Psychodynamic group processes

Some of the language and concepts utilized in MBI professional practice literature recall group psychoanalytic theory. Conceptually, parallels can be drawn between 'stewardship' in mindfulness groups (McCown et al., 2010) and the group analysts' responsibility for 'dynamic administration' (Barnes, Ernst & Hyde, 1999) in psychodynamic group therapy. Dynamic administration requires the fostering of group boundaries and structure, thereby creating a safe environment within which participants can explore individual psychological processes through group interaction.

Crane et al. (2012) make reference to the teacher's role in responding to participants' "digressions away from the core intention of the group". Arguably, this parallels psychoanalyst Wilfred Bion's theories of group (1961), which describe this process in terms of unconscious avoidance of the group's primary task (for example, a group struggling to perform the 'task' of being mindful might 'defend' against this by digressing).

However, the process of psychological change in mindfulness groups is conceptually distinct from psychoanalytic therapy groups. The process of change in psychoanalysis is through increasing conscious awareness of unconscious processes. The unconscious is not a concept that MBIs promote or utilize as a 'vehicle for change'. Instead, participants become more aware of all that is consciously available to them in the moment. Furthermore, 'change' per se is not the primary aim of MBIs.

The use of psychoanalytic language in MBI literature, therefore, may be due to the absence of a language of its own to describe group processes. However, without further detailed research into the group processes specific to MBIs, it is too early to draw conclusions on the utility of psychoanalytic group theory in this context.

Group therapeutic factors

Irving Yalom developed an enduring theory of eleven 'therapeutic factors' (Yalom & Leszcz, 2005) offered by the group that facilitate therapeutic change. Of these factors, the reviewed literature clearly suggests the presence of *universality, imitative behaviour* and *cohesiveness*.

The key group-related themes extracted from qualitative MBI research can be labelled 'The group provides a supportive and normalizing environment', and this label is practically synonymous with *universality*, often expressed as "we're all in the same boat" (Yalom & Leszcz, 2005, p. 6). *Imitative behaviour* is also evident, as participants described learning coping techniques from one another. Yalom and Leszcz state that "a cohesive group feels warmth and comfort in the group and a sense of being accepted and supported by other members" (2005, p. 55), an experience repeatedly described in qualitative research.

It is plausible that other therapeutic factors identified by Yalom may be present in MBIs, but without more in-depth research in this area, further discussion would be speculative.

Buddhist theories of sangha

The *sangha* refers to an interdependent Buddhist community that provides mutual support to live a mindful and spiritual life (Prebish & Keown, 2010). The ethos of the *sangha* has been described as a communitarian-based ethical system that nurtures acceptance and understanding through collective meditation and upholding a shared value system (Rich, 2007). Thích Nhât Hanh, a renowned Vietnamese Buddhist monk, states that "we can take refuge in the Sangha in order to succeed in our practice. There are many things that are very difficult for us to do on our own, but when we live together as a Sangha, they become easy and natural" (2003, p. 7).

This is pertinent to the description of participants' experience of the group as motivating and supporting meditation practice. Langdon et al.'s (2011) study in particular illustrated how participants found it harder to meditate without group membership.

Review summary

The review illustrates that the group in MBIs can have a positive impact on clinical outcomes (Imel et al., 2008). Qualitative literature suggests that the group enriches participants' learning experience, providing an experience of belonging and community that participants experience as normalizing and motivating. Mindfulness practitioners view group skills as a core competency. Professional practice literature advocates attending to group safety and boundaries through the embodiment of mindfulness. Existing literature has not situated group processes in MBIs within a theoretical framework. This review has found that aspects of group development theories, some of Yalom's

therapeutic factors and the Buddhist concept of *sangha* all provide tentative theoretical frameworks within which to view the role of the group in MBIs. Some key psychoanalytic ideas may also prove germane. However, without further investigation, the application of such frameworks must be tentative.

Discussion

It is evident that the role of the group in MBIs has not received sufficient attention, despite recurrently emerging as an important aspect of participants' mindfulness learning experience. Both empirical research and professional practice literature present group effects as generic to all groups. With the exception of Imel et al. (2008), quantitative research has overlooked MBI group effects. There are a number of plausible explanations for this.

Firstly, groups are frequently overlooked in clinical research. For example, Johnson (2008) found that research on clinical interventions frequently fails to report whether the treatment utilised group formats. Furthermore, in view of the complexity of interpersonal interactions within group settings, conducting research on group processes raises a number of methodological challenges (Burlingame, 2010).

Secondly, research seeking to understand the mechanisms of mindfulness has tended to adopt hypothetico-deductive methods, seeking to demonstrate the relationship between one factor and another. This review's findings suggest that mindfulness might be better conceptualised as a shared social practice and thus more fruitfully explored through social constructionist methodologies (Stanley, 2012a). The concept of *sangha* suggests that

mindfulness is a sense of connection with community: mindfulness is conceptualised as an interdependent, relational process. Therefore, a social reading of mindfulness is arguably more in line with its Buddhist roots than cognitive and neuropsychological perspectives, which conceptualise mindfulness as "an inner psychological construct, existing as an unobservable state or train, residing within the mind/body/brain" (Stanley, 2012b, p.2). This reflects the dominant discourses within Western healthcare systems more broadly, which tend to view mental illness as an individual, rather than social and cultural, problem (Rapley, Moncrieff & Dillon, 2011).

Implications

The review's final aim was to consider the theoretical, research and clinical implications of its findings.

Theoretical implications

The review has demonstrated that a rudimentary theoretical framework of the role of the group in MBIs can been drawn from multiple sources. However, no one theory is entirely applicable and all have limitations. Therefore, this review identifies a gap in the theoretical literature pertaining to the role of the group in MBIs.

Research implications

Research is needed to both support theoretical development, and to understand the relationship between the group and clinical outcomes in MBIs. As mindfulness becomes increasingly available as an individual therapy (Germer, Siegel & Fulton, 2005) or via teacher-led distance learning

approaches (as available via CMRP at Bangor University), opportunities for randomised control trials comparing formats become possible. As valid measurements of cohesion become available (Hornsey et al., 2012), it is also possible to explore the relationship between participants' sense of interconnectedness and other factors, such as teacher competence and clinical outcomes. It is equally important that researchers think in a more sophisticated way about the mechanisms of change that might be facilitated by groups. For example, meaningful explorations of the concept of cohesion in this context are needed, such as how cohesion might develop in silent group meditation. However, future research must avoid reductionism, and therefore, further qualitative approaches are advocated. Epistemologically, research aiming to explore the role of the group in mindfulness might be better served by critical psychological approaches, which are well suited to mapping emerging discourses of social experiences.

Clinical implications

The review has found the group to have a largely positive impact upon MBI participant experiences. However, the role of the group is not sufficiently understood, and thus teachers cannot be supported to utilize the format to maximum effect. This strengthens the case for further research aiming to develop deeper understanding and theory of the group in MBIs.

Limitations of review

There may be existing group theory which could be illuminating to MBIs but due to the breadth of this area it has not been possible to consider all theoretical possibilities.

Conclusion

This review has verified the predominantly positive impact of the group upon individual experiences of learning mindfulness and demonstrated that a number of existing theories drawn from a range of disciplines may account for various aspects of the role of the group in MBIs. However, closer attention to the specific mechanisms of the group in MBIs and the role of mindfulness as a social practice is required, to support theoretical development and improve clinical efficacy.

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Section B

A grounded theory of the role of the group in mindfulness-based interventions

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Abstract

Mindfulness-based intervention (MBIs) such as Mindfulness-based Stress Reduction and Mindfulness-based Cognitive Therapy utilise a group format. Experts in the field of mindfulness endorse the group as beneficial to participants and professional practice literature promotes the need for mindfulness teachers to develop competence in group skills. However, the role of the group in MBIs has been largely overlooked in empirical research to date and the utility of existing group theory in this area is unconvincing. The current study presents a grounded-theory of the role of the group in MBIs. The theory was developed from semi-structured interviews conducted with mindfulness students, teachers and trainers (N=12) exploring their experiences and views related to the MBI group format. Through analysis, three higher-order categories emerged from the data describing five *stages of group experiences,* four *group-based tasks* the teacher attended to from a position of 'embodiment', and *the impact of the MBI group*. Findings were situated within existing group theory, facilitating differentiation between generic and MBI specific group factors. The sense of connection developed through non-verbal group meditation, the multi-layered experience of normalization, and the grounding of the teacher's group-based responses in the embodiment of mindfulness, emerged as unique MBI group factors. The implications for clinical practice, research and theory are discussed.

Keywords: mindfulness; group processes; group development; grounded theory; teacher training.

Introduction

Mindfulness is the capacity to bring one's attention to all aspects of the present moment, and is a skill increasingly taught in healthcare and community settings (Baer 2003). This study explores the group format of mindfulness-based interventions, a part of the experience of learning mindfulness yet to receive full attention.

The most established mindfulness-based interventions (MBIs), Mindfulness-based Stress Reduction (MBSR; Kabat-Zinn 1982; 1990) and Mindfulness-based Cognitive Therapy (MBCT; Teasdale et al. 2000; Segal, Williams and Teasdale 2002) are delivered in a group format. Over the course of eight weekly group sessions, with daily individual homework tasks and practice, participants learn mindfulness through teacher-led meditations and discussion ('enquiry'). Mindfulness is the capacity to be more aware, and less judgemental, of one's bodily sensations, sounds, feelings and thoughts experienced in each moment. This has also been described as developing the capacity to enter a 'being', rather than 'doing' mode (Segal et al. 2002).

There has been an explosion of research into the use of mindfulness-based interventions in health care settings in recent years. A number of meta-analyses have found such approaches to be effective in alleviating the psychological symptoms of a range of physical and mental health problems both in clinical (e.g. Hofmann, Sawyer, Witt and Oh 2010; Bohlmeijer, Prenger, Taal and Cuijpers 2010; Ledesma and Kumano, 2009; Grossman, Niemann, Schmidt and Walach 2004) and non-clinical populations (e.g. Chiesa and Serretti 2009; Grossman et al. 2004). Consequently, MBCT is a

National Institute for Clinical Excellence recommended treatment for depression (NICE 2009), and utilised for a range of other physical and mental health conditions (Baer 2006).

There are a number of reasons for MBIs to utilize a group format. In developing MBSR, Jon Kabat-Zinn drew on "traditional monastic teaching" methods (1982 p.36) where mindful practices are taught and discussed in groups. Indeed, mindfulness has its origins in Buddhism and a long tradition of group meditation practice. MBCT was closely modeled on MBSR, including its group format, as it concurred with Segal et al.'s (2002) initial aim to develop a preventative intervention with the potential to meet maximum clinical need. MCBT and MBSR are delivered to groups of approximately 12 and 30 participants respectively at a time, thus offering better value for money than individual psychological therapies (Mental Health Foundation 2010). Indeed, Kuyken et al. (2008) found that not only is MBCT more cost-efficient than individual therapies, but it is highly probable that MBCT is more cost-effective than anti-depressant medication over a 15 month follow-up period.

Group settings are widely reported to provide a supportive and normalising environment that group members can experience as 'therapeutic' (Yalom and Leszcz 2005). Experienced mindfulness teachers recognize such therapeutic factors to be integral to the clinical efficacy of MBIs (Mental Health Foundation 2010). Empirical evidence provides some support for clinical opinion. A recent meta-ethnographic study synthesized the results of fourteen qualitative studies exploring people's experiences of mindfulness-based intervention, and found 'group processes' to play a key role in two out of three

broad phases of patients' experiences of the therapeutic process in mindfulness identified (Malpass et al. 2012). Additional qualitative studies have found further evidence of perceived group benefits. For example, one study found that MBI participants consider the group essential to supporting mindfulness practice, providing both motivation through a sense of accountability to others and a culture where mindfulness was valued (Langdon, Jones, Hutton and Holttum 2011). Other studies have described participants' appreciation of feeling a sense of belonging to the group, cohesion and camaraderie (Chambers, Foley, Galt, Ferguson and Clutton 2012) and of finding the group to be a normalizing and supportive environment (Griffiths, Camic and Hutton 2009). Currently, only one quantitative study (Imel, Baldwin, Bonus and MacCoon 2008) has attempted to explore the impact of the group on the clinical efficacy of MBIs. They found 7% of the variability in change in psychological symptoms to be accounted for by the group format and, therefore, hypothesise that "group cohesion may influence the process and outcome of treatment in MBSR" (2008, p.741). This study utilized a sufficient sample and controlled for pre-treatment severity. Thus their findings can be considered valid and reliable. However, replication of the findings is required if firmer conclusions regarding the impact of the group format on clinical outcomes are to be drawn.

The importance of developing group skills has been addressed in mindfulness teacher-training literature. The core principle of teaching mindfulness is acknowledged to be modelling a 'being' rather than 'doing' mode of mind to participants (Crane, Kuyken, Hastings, Rothwell and Williams 2010), and bringing this principle to managing group processes is advocated (McCown,

Reibek and Micozzi 2010). McCown et al. offer guidance on providing 'stewardship' of the group's "co-created mindfulness, [and] the inter-subjective resonance of the group" (2010 p. 109). Furthermore, Crane et al. state there is an "emerging consensus on what teacher competence 'looks' like" (2010 p. 85) and place skills in managing the group process as one of six domains of teacher competency.

However, research has also raised some challenges that the group format may present. For example, people with social anxiety-type presentations may struggle to participant in MBIs due to the group format (Finucane and Mercer 2006; Malpass et al. 2012) and people with degenerative illnesses may decide that the potential benefits of MBI participation do not outweigh the perceived disadvantages of participating alongside others at different stages of disease progression (Fitzpatrick, Simpson and Smith 2010).

Although the clinical opinion of mindfulness practitioners and existing research suggests that the group may be an active force upon the efficacy of MBIs, this is far from conclusive. To date, one quantitative study has explored this issue, and no qualitative study has made MBI participants' experience of the group their primary focus. Furthermore, existing studies have made no attempt to link their group-related findings with the theoretical literature on groups, developed original theory, or considered the clinical implications of their findings in relation to the group format. Thus, it is unclear whether there are aspects of the 'group processes' that may be unique to MBIs or whether the group effects are generic. Yet furthering our understanding in this area may support mindfulness teachers to maximise the benefits of the group, and be

alert to potential pitfalls. Indeed, mindfulness practitioners have defined 'group skills' as a core teacher competency, yet also acknowledge the need to better understand the mechanisms by which the group impacts upon the process of learning mindfulness (Crane et al. 2010; Crane, Kuyken, Williams, Hastings, Cooper and Fennel 2011). Existing group theory has been developed to account for learning groups (Jaques and Salmon 2007) or psychotherapy groups that aim to bring about psychological change (Barnes, Ernst and Hyde 1999). MBIs, arguably, fulfil both functions. Therefore, existing theory is not necessarily sufficient to understand the group experience and function in MBIs. New theory is needed, both to make links with existing group theory and to account for group processes which might be unique to MBIs.

Therefore, this research aimed to develop a theory of the role of the group in MBIs (i.e. MBCT and MBSR). Once the theory had been developed, its fit with existing group theory was critically assessed, facilitating differentiation between generic group experiences and processes unique to MBIs. These points are considered in the discussion. Following this, the implications of the grounded theory for future research and clinical practice are presented.

Methodology

As established above, this is a new area of research which aims to generate theory on the group processes specific to MBIs. Grounded theory (GT), which supports the generation of theory derived from the data, was selected as an appropriate methodology (Glaser and Strauss 1967). Epistemologically, the study took a critical realist perspective, seeking not to define an objective 'truth' of the role of group in MBIs, but to develop a theory transparently

situated within the context of the researcher and participants' co-created meaning. This position enabled consideration of how participants constructed their experience of learning mindfulness in a group through language whilst taking account of their 'real', or embodied, experience of being in a group (Stanley 2012a; 2012b).

Participants

Henceforth, participants have been referred to as 'students' if they took part in an MBI in a lay capacity; teachers and trainers are referred to collectively as 'clinicians'; and 'participants' refers to the full sample. There were twelve participants (N=12), of whom eight were female. They ranged in age from 27 to 67 years (mean = 45.6; median = 42) and were all ethnically white. To capture the experience of the group from multiple perspectives, six of the participants had attended an MBI (MCBT n=3; MBSR n=3) course as a participant within the previous 14 months (range of two to 14 months); two participants were mindfulness teachers; and four were both teachers and trainers of teachers (see Table 1). The trainers each continued to work as teachers of MBIs in addition to delivering post-graduate level mindfulness-teacher training. All teachers and trainers at least met the recommended criteria for 'basic teacher training' as outlined in Crane et al. (2010).

Table 1: Participant characteristics

Pseudonym	Role	Gender	Age	Time since: attending MBI course [a] becoming a teacher [b] becoming a trainer [c]
Adam	Student	M	42	4 months [a]
Brenda	Student	F	43	6 months [a]
Cathy	Teacher and trainer	F	62	10 years [b]; 4 years [c]
David	Teacher	M	43	4 years, 6 months [b]
Elizabeth	Teacher	F	43	3 years, 9 months [b]
Frances	Teacher and trainer	F	46	12 years [b]; 8 years [c]
Grant	Teacher and trainer	M	55	6 years [b]; 2 years [c]
Heather	Teacher and trainer	F	67	7 years [b]; 6 years [c]
Isabelle	Student	F	32	2 months [a]
James	Student	M	27	3 months [a]
Kate	Student	F	55	14 months [a]
Lucy	Student	F	32	11 months [a]

Procedure

Recruitment

A number of clinicians were approached by email, or in person at mindfulness conferences, and provided with information about the study (Appendix 4). The researcher requested that they pass the information on to colleagues and recent MBI course participants. This approach yielded sufficient interest in the study. From the pool of interested respondents, participants were recruited into the study according to theoretical sampling. Thus, students, teachers or trainers were recruited to best contribute to emerging theory development during the analysis process. Recruitment ended when the data appeared to reach theoretical saturation and no further categories emerged through analysis (Dey 1999).

Interviews

Participants completed a consent form (Appendix 5) and a demographic form (Appendix 6). Additionally, clinicians were invited to complete an optional background information form (Appendix 6) to ascertain whether they met the recommended professional development criteria outlined by Crane et al. (2010). All clinicians met the criteria. Following this, semi-structured interviews took place, lasting between 45 to 90 minutes. They were audio-recorded and later transcribed. Interviews took place in participants' homes (n=9), workplaces (n=2) or in a quiet café (n=1).

Interview schedule

The interview schedule (Appendix 7) explored participants' experiences of the group aspect of mindfulness courses, asking about their thoughts and feelings about being taught within or teaching the MBI group. Participants were encouraged to give examples of specific situations. The questions followed a temporal structure, asking about the beginnings, middles and endings of courses. Participants were also asked about the enquiry process and the experience of group meditation. Emergent themes from earlier interviews (e.g. 'safety') were explored in greater depth in subsequent interviews.

Data analysis

Following GT methods, data analysis began simultaneously with data collection, facilitating the refinement of later interviews around emerging theory (Bryant and Charmaz 2007). Substantive coding of data was employed, beginning with line-by-line open coding of interviews, accompanied by keeping 'memos' (i.e. theoretical notes of researcher's thoughts during coding

and on conceptual links between codes). As coding progressed, patterns developed through constant comparison between codes. Thus conceptual categories emerged and were further explored in subsequent interviews, facilitating the development of the emergent theory. No further theoretical insights emerged from the eleventh interviewee's data. However, a brief twelfth interview was conducted to confirm this. Thus, theoretical saturation seemed to have been achieved (Holton 2007).

One participant, Adam, can be described as a negative case (Morse 2007), with his data providing a contrast to the largely positive experiences of the other eleven participants. In view of this, Adam's data were analysed once the theory was already emerging. At this point, it became clear that many of the experiences he felt had been lacking in his MBI had emerged as important to other participants' more positive experiences.

Reflexivity

The researcher had completed an MBSR course several years prior to conducting this study, though as a one-to-one distance-learner rather than in a group format. However, she had experience of group meditation and mindful yoga. Thus, the researcher had experiential and theoretical knowledge of mindfulness and of group meditation, but no direct experience of an MBI group format. The researcher was alert to holding a positive view of the potential of group processes, and some basic knowledge of group theory (e.g. Yalom and Leszck 2005). Consequently, during data collection and analysis, disadvantages of the group setting were actively sought. Furthermore, the researcher strove to work inductively and to 'bracket' positive assumptions

and prior theoretical knowledge (Bryant and Charmaz 2007), to ensure that emerging theory was grounded in the study's data. For example, according to tradition grounded theory methods (Glaser and Strauss 1967), in depth exploration of group theory and a detailed literature review of relevant mindfulness research was conducted after analysis was complete to minimise the impact of existing ideas during analysis. Additionally, the researcher aimed to approach each interview and consequent data analysis from a position of mindful awareness to facilitate greater recognition of the potential influence of existing beliefs and knowledge upon interaction with new data.

Ethical considerations

The study obtained full ethical approval from Salomons (Canterbury Christ Church University) Ethics Panel (Appendix 8), and adhered to the British Psychological Society Code of Conduct (BPS 2006). Although the interviews did not include any questions likely to be of a sensitive nature, participants were advised not to take part in the study if they were currently experiencing high levels of psychological distress. Furthermore, the interview schedule was developed in consultation with a mental-health service user with MBI experience (via SAGE: the Salomons Advisory Group of Experts) to maximise the clarity and sensitivity of question phrasing. To protect the identity of the study's participants and any third parties discussed during interviews, all identifying information has been modified and pseudonyms used.

Quality Assurance Methods

Quality assurance was incorporated into the study's design in the form of participant triangulation, where data are collected from multiple sources (i.e. students, teachers *and* trainers) to incorporate the full range of perspectives on the phenomena of study. Further, the constant comparative method within GT enables cross-referencing between data to reduce bias towards one perspective. Quality assurance was also supported by ongoing discussions with the researcher's supervisor on reflexivity during data collection, analysis and reporting, and by specifically exploring data for disadvantages to counter potential bias towards the benefits of group membership. Finally, to ensure the study displays the characteristics of good qualitative research, the study sought to meet Yardley's (2000) criteria: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance.

Results

A grounded theory describing participants' experiences of MBI groups is presented below. Three higher-order categories, each encompassing a number of categories and sub-categories (see Table 2) evolved from the data, forming a theory describing the role of the group in MBIs. The higher-order categories are *stages of group experiences, group-based tasks of the teacher,* and *the impact of the MBI group*. The first two higher-order categories were closely interlinked with the tasks loosely corresponding to certain stages. For further detail of how categories developed through analysis, see Appendices 10-15. A diagram of the theory is presented in Figure 1. All participant sub-groups (i.e. students, teachers and trainers) contributed to each higher-order category. Where a participant sub-group was the dominant or sole contributor to a sub-

category, this has been made explicit by referring to 'students', for example, rather than 'participants'.

Table 2: Categories forming the grounded theory of the role of the group in MBIs

Higher-order category	Category	Sub-category
Stages of group experience	*Pre-course stage*	*Pre-course concerns*
		Pre-course hopes
	Orientation stage	*Nervousness and uncertainty*
		Impact of and on others
		Curiosity
	Spectrum stage	*Getting it*
		Struggling
		Developing cohesion
	Consolidation stage	*Consolidation of skills*
		Consolidation of group connection
	Ending stage	*Warmth*
		Sadness
		Concerns about continuing practice alone
Group-based tasks of the teacher	*Safety*	*Setting boundaries*
		Fear of exposure
		To talk or not to talk
		A leader who knows the territory
	Building the culture	*Facilitating connections*
		Managing communication
	Keeping on an even keel	*Equality*
		Group v. individual
	Letting others have a turn at the wheel	*Freer communication*
		Less guidance in meditations
	Embodiment	*Non-judgemental acceptance*
		Multi-layered attention
		Non-reactive observation
The impact of the MBI group	*The benefits of being on a shared journey*	*Sharing and magnifying positives*
		Learning from each other
		Normalising
		Comparisons
		Not alone
		Universality of human suffering
	The community of group meditation	*Connectedness*
		Motivation
		Energy of the group
		Hard to articulate
	In vivo *practice*	*Group experience provides material*
		Own judgements of others provide material

Higher-order category one: Stages of group experience

A clear picture emerged from participants of their experiences of the group unfolding across the eight-week course, which were categorised into five stages. Participants described this as a *"shared journey"*, despite individual differences:

> *"I looked forward to going and the next step on the journey. It did feel like a sort of journey that you were on with other people kind of in tandem, going along together at a different level of pace or whatever"* (Brenda, student).

Firstly, they described a 'pre-course stage', before meeting their group. This was characterised by hopes and concerns regarding joining the group, such as whether it would feel *"too big",* or whether they would feel able to contribute. Their hopes were to learn from others and to experience a *"collective effort to make yourself feel better"* (James, student). When participants met for the first time, they moved into an 'orientation stage'. This stage appeared to last until the third session and was defined by feelings amongst students of nervousness, uncertainty, concern about inhibiting each other in speaking, and also mutual curiosity:

> *"The beginning: lots of nervousness, lots of "is it alright, what's going on, am I safe, who are these other people, what's the teacher like, what am I allowed to say, am I going to be forced to do things I don't want to do?". All these questions".* (Grant, trainer).

Next there was the 'spectrum stage', incorporating contrasting experiences, ranging from *"getting it"* to *"struggling"*. Indeed, clinicians stated actively encouraging *"a full spectrum of responses"* (David, teacher) from students. Several clinicians linked this with the specific content of the course curriculum:

> *"The middle sessions, well, by session four some people are finding that it's been helpful so that's coming out, and some people are really struggling. And then you go into session five which is open[ing] up to difficulty and usually that's quite a heavy atmosphere in the group"* (David, teacher).

Brenda (student) described this as a *"dip"* when a *"lot of people seemed to be struggling and had hit a kind of point where they weren't quite sure if this actually was going to do any good"*. This was described by some participants as *"stormy"*. At the same time, participants described increasing *"cohesiveness", "safety"* and *"trust"* within the group.

The penultimate stage was the 'consolidation stage', occurring in the final weeks (weeks six-seven) and seeming to coincide with a day of largely silent mindfulness practice. Participants talked of the *"penny dropping"* and of an established cohesiveness amongst the group:

> "[The All Day is] *always a turning point in their practice but I began to see it as a real turning point in the group process as well … there*

> *was a real sense of connection and warmth and joy in week seven that hadn't been there* [before]*"* (Heather, trainer).

Finally, the group entered an 'ending stage', which participants described as characterised by *"warmth"*, *"camaraderie",* a *"deep connection"* between group members. Participants also described this stage as sad, as group members began to mourn the end of the course and the loss of the group, expressing the wish that that group could continue meeting, and fears they would struggle to continue practicing mindfulness alone. However, there was also a sense of being ready for the group to end.

Adam's experience paralleled that of other students at the pre-course and orientation stages. Thereafter, he often referred to the absence of components recognized by other participants within his own mindfulness course. He did not refer to his experience as a 'journey', shared or otherwise.

Higher-order category two: The group-based tasks of the teacher

Participants recognised the teachers' central task to be teaching mindfulness skills to students. However, they suggested that, to achieve this, teachers had to perform four key group-based tasks from a position of 'embodiment'. Thus, the group was presented by participants as having an important mediating role in the process of learning mindfulness. Additionally, clinicians recurrently portrayed the group as a boat steered by the teacher. The 'journey' of learning mindfulness was, therefore, conceptualised as enabled by the group:

> *"If you don't somehow launch this vessel that is the group at the beginning and then hold it through the whole things and manage that ending process, then actually people can't do the work they've come to do. It's kind of, it's central"* (Frances, trainer).

Firstly, participants felt teachers need to establish the 'safety' of the group for learning to take place. In particular, clinicians suggested that students could only learn mindfulness if they felt safe enough in the group to get in touch with their vulnerabilities through mindfulness practice. The main threat to safety was 'fear of exposure', in terms of whether students would have to speak more than they wanted to and/or become overwhelmed by emotions in group sessions. Participants proposed three ways in which safety was developed. They explained how teachers set clear boundaries (e.g. keeping to time, closed group membership, rules of group confidentiality), gave explicit permission for students 'to talk or not to talk', and they presented themselves as a confident leader who *"knows the territory"* (David, teacher).

Secondly, teachers 'build the culture' of the group by facilitating connections between group members and promoting a specific form of communication within the group. Students experienced minimal 'getting to know you' work in early sessions as beneficial to participating in small and large group work. Furthermore, it was clear that the nature of communication in mindfulness groups was perceived as unique, and something which took several sessions to understand. Participants defined the purpose and form of communication as *"not therapy"* or talking about *"your history", "social chit-chat",* or *"theorizing"*, but *"a space where you explore the immediacy of your*

experience" (Frances, trainer). Clinicians recognized their role in explicitly defining the nature of communication, particularly in early sessions.

Both simultaneously and subsequent to establishing the group culture, teachers performed the third task of 'keeping an even keel', the purpose of which was to maintain balance between group members in terms of their contributions and meeting the needs of individuals versus the group as a whole. Participants stated the importance of all group members having an equal right to talk and be heard: *"There was no particular extra time spent on anybody. We had all given and pulled an equal opportunity*" (Kate, student). Furthermore, participants expressed the view that individual contributions should be helpful to the group as a whole. Elizabeth (teacher) described this as the *"individual* [being] *in service of the group"*. Indeed, students noticed and appreciated teachers paying attention to the relevance of individual contributions during enquiry to the group as a whole:

> *"Where somebody's experience was valuable, I think* [the teacher]*'d explore it. When somebody had kind of extinguished the amount of value that could have been provided for themselves and others, I think she would gently move it on"* (James, student).

Following this, teachers performed their fourth task of allowing group members to 'take a turn at the wheel'. Participants noted needing to take a clear leadership role initially (*"at the helm"*: David, teacher), particularly in terms of managing communication. However, they suggested their role became less active as the course progresses and group members became more

skilled in using and talking about their mindfulness practice. Thus, clinicians noted allowing freer communication between group members and providing less guidance during mediation practices in the final week(s):

> *"You're training the other people on the boat as time goes on how to also steer the ship, and maybe later on they might take a turn at the wheel"* (Cathy, trainer).

Finally, it became clear that each of these tasks was perceived to be conducted from a position of 'embodiment'. Embodiment is the teacher's capacity to maintain and teach from a position of mindful awareness, thereby modeling the application of mindfulness to MBI participants. Indeed, Kate (student) described her teacher as someone who *"so evidently sort of embodied the benefits of living* [mindfully]*"* and talked of finding this an inspiration for maintaining her own practice. In particular, teachers appeared to embody mindfulness through bringing multi-layered attention, a non-judgemental attitude and a non-reactive, observing stance to the group. For example, one teacher talked about his surprise at positive feedback from other group members on his management of an extremely restless and challenging group member:

> *"A number of people in the feedback said "I was really impressed by how you and the other teacher managed the group" … I didn't feel like we handled it brilliantly, but [group members] seemed to be really impressed that we hadn't reacted, we hadn't lost her, we just held it and held her"* (Grant, trainer).

It appears that group members responded well to Grant's capacity to embody mindfulness: despite finding one group member particularly challenging, he maintained a non-reactive, accepting attitude towards her. Thus, it seems that embodiment enables teachers to 'do' the tasks of building and sustaining the group culture whilst maintaining a 'being' mode.

Again, Adam's experience offered a contrasting view of this. He talked of feeling that his own struggles to attend the course due to chronic pain were not met with an accepting, non-judgemental attitude:

> *"…it was always like "why weren't you here?". I don't know, it just wasn't done quite right, and made me feel slightly guilty and I just thought, "sod off!""* (Adam, student).

Higher-order category three: The impact of the MBI group

The final higher-order category to develop from the data was of the impact the group had upon individuals' experience of learning mindfulness. With the exception of Adam, participants' described a range of benefits they perceived the group to provide.

Firstly, participants described a number of benefits derived through talk. In MBIs, talk occurs predominantly during the enquiry process. Participants described how this facilitated a sense of belonging and connection, as group members felt less alone within their individual suffering. They talked of how supportive and motivating it was for group members to share in each other's

successes and inspire mutual hope for the benefits of maintaining mindfulness practice. Participants talked of individual positive experiences being *"magnified"* and/or *"transferred"* to the group and of learning from others, such as gaining practical tips, a new perspective or clarification. Some participants also talked of the impact of other people's negative experiences too: *"if you're struggling or other people are struggling, than can make the group more of a weight"* (Brenda, student). However, participants talked of the *"relief"* and *"reassurance"* derived from discovering that one's own struggle, be it with depression, the mind wandering, or the inability to motivate oneself, is normal and experienced by others. Participants also talked about group members making comparisons with one another, consequently perceiving their own position to be more manageable: *"I know that I have my faults, but I thought I'm so lucky not to be plagued by some of the thoughts that people have"* (James, student). However, James also raised that this may have inhibited him in speaking more in the group, though he was uncertain of his own appraisal in this regard. David (teacher) recalled a group member who had had the reverse experience of feeling her problems were greater than those of others in the group, resulting in her feeling *"alienated"*. However, David said this shifted as the course progressed and people shared more difficult experiences.

Secondly, participants described 'the community of group meditation', characterized by feelings of *"togetherness"* and *"solidarity"* and fostered through participants' non-verbal experiences in meditation. Participants tried to explain the feeling of meditating in a group, but struggled to do so (e.g. *"it's not something you can put into words")*. However, descriptions recurrently

offered were *"collective energy"*, *"warmth"*, *"calmness*" or *"tranquillity"* and *"connectedness"*. Participants evoked imagery from other cultures (such as sitting around a fire in Africa), described group meditation as a *"profound"* experience, and talked of feeling connected with something greater than the individual; a timeless *"shared human experience"*:

> *"It is a feeling that I can't explain other than it's this is what it's all about and this is how it's always been and whatever else changes in society and technology or whatever, humans being together and looking after each other and nurturing themselves and each other … it's just being about shared human experience, because what else is there?"* (Isabelle, student).

Participants felt that they were able to *"go deeper"* when meditating in a group compared to meditating alone, describing it as a *"richer experience"*. Participants also described group meditation as being easier than home practice for a number of practical reasons, such as better meditation equipment and fewer distractions.

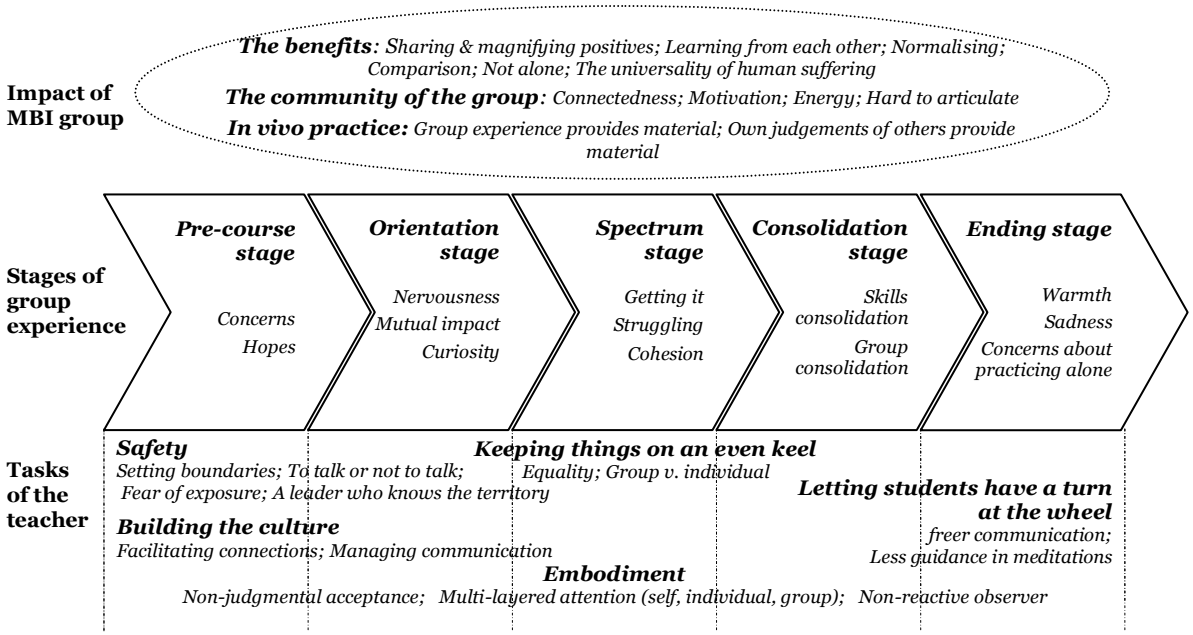
Thirdly, participants gave examples of ways in which the group provided them with opportunities to practice their mindfulness skills *"in vivo"*. For example, Frances (trainer) spoke about a course in which one member of the group had been very critical of the intervention and had frequently cut across other members of the group to say how unhelpful mindfulness was. She talked about how it seemed to her as if this person had provided the rest of the group with an opportunity to practice their skills in response to a 'live' difficulty.

Both Kate and James (students) gave examples of noticing their internal judgements of other people in the group during sessions and how this provided them with *in vivo* mindfulness practice.

Results summary

A grounded theory analysis of participants' data drawn from interviews exploring experiences of the group context in MBIs found three higher-order categories. This MBI group theory consists of five stages of MBI group experience, four specific group-based tasks for the teacher to attend to from a position of embodiment, and a number of ways in which the group impacted upon the process of learning mindfulness.

Figure 1: Diagram of grounded theory of group in MBIs



Discussion

The grounded theory of the role of the group in MBIs developed in this study is now situated within existing theory, drawn from educational, psychological and Buddhist perspectives. Such theory has been considered from a position of 'theoretical agnosticism' (Henwood and Pidgeon 2003), and thus their concepts are appraised for specific relevance to this study's grounded theory. Due to the breadth of potentially applicable literature, the theories presented as relevant to the grounded theory of the group in MBIs are considered provisional, rather than definitive. However, this discussion provides a foundation for situating MBI group experiences within an existing theoretical framework, differentiates between generic and novel MBI group factors, and clarifies aspects of the grounded theory which constitute original MBI-specific group factors (see Appendix 16).

The first higher-order category established the MBI group experience to progress through distinct stages with teachers' group-based tasks more or less relevant at certain stages. Comparison of this category with existing theories of group development has found Johnson and Johnson's sequential-state theory (2006) largely applicable to MBIs. Built upon Tuckman's much-cited 'forming', 'storming', 'norming', performing' and 'adjourning' model of small group development (Tuckman 1965; Tuckman and Jensen 1977), this seven-stage theory was developed to account for learning groups where the leader or facilitator takes an active role in directing the group process. In the MBI group grounded theory, the *orientation stage, getting it* and *developing cohesion* within the *spectrum stage,* the *consolidation* and *ending stages* correspond

with aspects of Johnson and Johnson's model (2006), as did the teacher's tasks of *building the culture,* establishing *safety,* and *keeping on an even keel.*

However, there were a number of ways in which Johnson and Johnson's model (2006) did not convincingly account for experiences reflected in the MBI group framework. Firstly, despite study participants referring to Tuckman's 'storming' stage ('rebelling and differentiating' stage in Johnson and Johnson 2006) this study's data did not suggest that group members are attempting to differentiate themselves from the group as a whole or rebel against the leader as described by existing stage-theories. The *struggle* described within the *spectrum stage* appeared related to the MBI course curriculum at the halfway point, which focuses on turning internally towards difficult experiences and developing acceptance towards them (Segal et al. 2002). Thus, rather than a 'storming' between participants or a leadership struggle, the 'storm' can be perceived as participants' internal battle initiated by the MBI course content.

Secondly, sequential-stage theories account for group processes once the group has formed in 'real', physical terms. However, the MBI framework describes a *pre-course stage*, at which group members are yet to meet but have already formed expectations. Some psychodynamic theories argue that 'the group' begins before it meets as individuals "have fantasies about the ground rules and expectations of limits on behaviour based on past experiences of what is acceptable" (Clarkson 1991, p. 38) that draw on the individual's "conscious, preconscious or unconscious" expectations of the group based on experiences of the family group. There was no evidence in this

study of participants drawing upon experiences from their family group or unconscious influences. However, such experiences are intangible and attempts to explore them were beyond the scope of this study.

Finally, Johnson and Johnson's model (2006) on the whole is incongruent with a mindfulness paradigm because it defines a group's stage based upon the productivity or output of group members. This could be viewed as a 'doing' mode and therefore it does not sit well with the 'being' mode advocated by mindfulness approaches. Furthermore, sequential-state theories generally trace group development through verbal interaction, yet sharing verbally is not a prerequisite in MBIs.

Some Buddhist, social constructionist and psychodynamic theories have been found applicable to the four group-based tasks attended to by teachers from a position of embodiment as described in the second higher-order category. Participants talked repeatedly about the unique nature of communication in MBIs and the need for guidance in learning how to talk within the enquiry process. This has been described in social constructionist psychology literature as 'Mindful-Talk': students learn how to demonstrate their understanding of mindfulness principles through their use of language, and talk itself becomes a form of mindfulness meditation (Cormack 2009). However, participants also stressed the importance of silence within their MBI experience, and of the right *not* to talk. The Buddhist concept of the non-self may be pertinent here: the idea that it is our attachment to our self as a 'real' entity that leads to our suffering, and letting go of the illusion of self (which might also be termed our identity or ego) frees us from this suffering (Epstein

1995). In social constructionist terms (Gergen and Hosking 2006) our self is constructed through language, and meditation enables the "softening and dissolving of Self" (p.15) by helping us to "break the spell of language as a map or picture of the real … to see the possibility that one's understandings are not demanded by "what there is," but are means of constructing it for some human purpose" (p.6). Arguably, therefore, the silence of meditation and the permission in MBIs *to talk or not to talk*, supports the relinquishing of a 'self' which is constructed through talk. The group format in MBIs may therefore provide an experience where participants can *be* with others without having to present or maintain a 'self'.

Within higher-order category two, discussion of safety, facilitating connections and setting boundaries is reminiscent of psychoanalytic group language describing the group analysts' responsibility for 'dynamic administration' (Barnes et al. 1999). Dynamic administration requires the fostering of group boundaries and structure, thereby creating a safe environment within which participants can explore individual psychological processes through interaction with the group. Furthermore, embodiment, found to underpin the teacher's delivery of group-based tasks, can be viewed as the MBI teacher's way of "shap[ing] group norms through … the example they set in their own group behaviour" (Yalom and Leszcz 2005, p. 125). Thus, embodiment can be seen as an adapted form of the psychodynamic concept of 'model-setting' to encourage the desired 'group culture'.

Many of the sub-categories described in *benefits of being on a shared journey* parallel Yalom's group psychotherapeutic factors of 'universality', 'imitative

behaviour' and 'cohesiveness' (Yalom and Leszcz 2005). For example, 'universality' is a sense of relief at learning you are not alone in experiencing your difficulties, thus one is normal and can be understood by others. The grounded theory sub-categories of *normalising*, *comparisons*, *not alone* and *universality of human suffering* can all be recognised in this description However, *normalising* in the context of MBIs appears to have an additional layer. Participants talked about how they learnt from others that their own internal experience (e.g. of the mind wandering, or of self criticism) is normal and experienced by others. For participants, the process of exploring struggles in enquiry and then meditating together with people who might be having these experiences *at that very moment*, seemed to bring an additional depth to people's experience of normalising.

The community of group meditation can be accounted for by the Buddhist concept of *sangha*. The *sangha* refers to an interdependent, Buddhist community that provides mutual support to live a mindful and spiritual life (Prebish and Keown 2010). Thích Nhât Hanh, a renowned Vietnamese Buddhist monk, states that:

> We can take refuge in the Sangha in order to succeed in our practice. There are many things that are very difficult for us to do on our own, but when we live together as a Sangha, they become easy and natural. We do them without growing tired or making a strenuous effort. The Sangha has a collective energy. Without this energy, the practice of individual transformation is not easy. (2003 p.7)

This provides a helpful framework for understanding participants' accounts of mindfulness meditation as supported by, and strengthened through, their connection with others in the group. This supports an alternative discourse of mindfulness as an interdependent, relational process. This definition of mindfulness contrasts with cognitive and neuropsychological perspectives, which conceptualise mindfulness as "an inner psychological construct, existing as an unobservable state or train, residing within the mind/body/brain" (Stanley 2012b p. 2).

Theory within the mindfulness literature appears to account for *in vivo* practice. McCown et al. (2010) state that the teacher is responsible for the 'stewardship' of the MBI group, part of which requires them to attend to the group *resonance*, by bringing participants' attention to what is happening for the entire group in the moment. Whilst this is reminiscent of psychoanalytic ideas around focusing on process rather than content in psychotherapy groups (Yalom and Leszcz 2005) participants in a MBI do not address such group processes verbally with another group member. Instead, they learn to notice this process occurring and practice maintaining a mindful internal response.

The unique role of the MBI group

A number of aspects of the MBI group grounded theory cannot be sufficiently accounted for by existing theory, or such theory requires significant adaptation. Therefore, the following aspect of the group experiences can be considered to be original to MBIs. Firstly, the *struggles* experienced by MBI students appear to be primarily due to specific course content, rather than processes between group members. Thus stage theories of group development

do not account for all aspects of the MBI group experience. Secondly, sequential-stage theories (e.g. Tuckman 1965; Johnson & Johnson 2006) rely too heavily on verbal interaction between group members for them to account sufficiently for MBIs non-verbal experiences. Indeed, the study suggests that the non-verbal experience of group meditation may provide a unique opportunity for MBI participants to experience *being* without having to construct, present and maintain a 'self' to others through language. Thirdly, the study has found the therapeutic group factor of 'normalising' (Yalom and Leszcz 2005) to have an additional depth in MBIs, as the possibility of normalising micro-processes of present-moment experiences is facilitated through the inquiry process and group mediation. Finally, the teacher's response to the group from a position of embodiment of mindfulness has been conceptualised as a form of modelling, but one specific and essential to MBIs.

Implications

Theoretical Implications

The study has demonstrated that a number of theories from the disciplines of education, psychoanalysis and psychotherapy, social constructionism and Buddhism can account for some aspects of the role of the group in MBIs. This is the first time that existing theory has been comprehensively explored in relation to empirical data on the role of the group in MBI, and demonstrates the need to maintain a broad and multi-disciplinary perspective in accounting for MBI experiences. Furthermore, the study has demonstrated that a number of these theories require adaptation to account for MBI specific issues, such as the non-verbal nature of meditation. It supports a relational model of mindfulness (Stanley 2012b), as the study's MBI group grounded theory

demonstrates the interdependent nature of MBIs as experienced by participants.

Research implications

This study is the first to explore the group aspect of MBIs in depth. It supports the view that the group plays an important role in facilitating the learning of mindfulness skills, through supporting practice, providing a mindfulness community and the possibility of *being* with others without reliance on language. However, robust quantitative research is now required to ascertain whether group formats may enhance clinical efficacy and whether group variables mediate outcome in the manner suggested. In view of the increase in options for self-study (e.g. www.bemindful.co.uk) or one-to-one study of mindfulness (e.g. as available via CMRP at Bangor University), randomized control trials comparing these different formats are advocated. Other issues that could be explored through further qualitative or quantitative research include group size and differences in group experience between MBCT and MBSR.

Clinical implications

Predominantly, participants in this study felt the group experiences had been positive and helpful. Therefore, the study supports the view that responding to the group from a position of embodied mindfulness should form an essential part of mindfulness teachers' training and continuing professional development. This supports work of Crane et al. (2010; 2011), who have written on teacher competencies and training processes in the UK. They have argued that, "it is widely supposed that the subtle inner qualities of the teacher

– their ability to be present with themselves and with participants with warmth, curiosity, care and compassion – facilitate change" (2010 p. 85) and call for research to ascertain the truth of this supposition. This study responds to this call, providing greater clarity on the role of the teacher and the implications for the group as a whole. The central role of embodiment in managing group experiences suggested by this study supports the view that mindfulness teachers need to have an established mindfulness practice (Crane et al. 2010; 2011). The study's findings also suggest that the full day of silent practice in MBIs supports the consolidation of mindfulness skills and group cohesion. Yet the full day is often presented as optional or omitted entirely from the MBI programme. This study suggests that it could be an important part of the programme and should be presented as such.

Limitations

The sample in this study was small, culturally homogenous and self-selected, with participants predominantly sharing positive experiences of the group and purporting to have an interest in group processes. Furthermore, the MBIs upon which participants' group experiences were drawn were 'primary-care' level interventions. Group experiences within more complex clinical settings may differ. Therefore, the findings have limited generalisability and research with more diverse, larger samples is needed.

Conclusion

This study asserts that the journey of learning mindfulness skills is a richer and more powerful experience when the journey is shared. The grounded theory of the role of the group in MBIs illustrates a range of benefits to participants, some of which can be described as generic group effects. However, the non-verbal experience of group meditation, the multi-layered experience of normalisation, and the grounding of the teachers' group-based responses in embodied mindfulness, are presented as unique MBI group factors that appear to have important consequences for the clinical efficacy of MBIs.

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Section C

Critical Appraisal

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A thesis submitted in partial fulfilment of the requirements of
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Overview

In this section of the Major Research Project, I provide a critical appraisal of my research, which was a grounded theory study of the role of the group in mindfulness-based interventions (MBIs). This appraisal is written in response to four questions and demonstrates my capacity to critique my research and to reflect upon the research competencies acquired in conducting it.

Question one: What research skills have you learnt and what research abilities have you developed from undertaking this project and what do you think you will need to learn further?

A project of this nature requires a number of research skills. During the process of conducting my study I have learnt and developed skills in generating feasible research ideas, writing initial proposals and ethical approval applications, conducting interviews, analyzing qualitative data, reviewing literature and writing up research to a publishable standard.

I found the early stages of the research most enjoyable. I like generating new ideas, discussing them with fellow trainees and with supervisors, and exploring relevant literature. I found the proposal and ethics process relatively straightforward, as I was able to visualize the research process in its entirety from fairly early on. I hope to further develop my capacity to generate potential research ideas and feasible research plans and proposals in my future career. However, on reflection, I would prefer to work in future as part

of a research team. Working predominantly as lone researcher, I struggled to maintain my initial enthusiasm throughout the research process.

Having developed the proposal and gained approval from the Salomons ethics board, I began recruitment. Following up on leads and arranging to meet with potential participants required good organizational and communication skills. I can envisage that recruitment for a larger study would need me to employ greater persistence and variety in my recruitment procedures.

My skills in conducting qualitative interviews developed significantly during the research process. For example, as various theoretical hypotheses began to emerge following early data analysis, I reflected with my supervisor upon how to test emerging theory in future interviews. We discussed the difference between *leading* a participant towards a theoretical hypothesis and *testing* a hypothesis in a more neutral manner. Consequently, I tested emerging theory in interviews with my participants by:

a) using participants' words in my questioning as much as possible rather than imposing my own language
b) employing an open and curious style to encourage discussion and difference in participant's responses
c) presenting my emerging ideas in a simple and concrete way to allow participant's to build on ideas using their own thoughts and experiences as much as possible rather than having to draw upon my frame of reference.

I found clinical skills useful in summarizing participants' responses to clarify and deepen understanding.

I feel my research skills developed most during the analysis stage. Before selecting grounded theory (GT; Glaser & Strauss, 1967) I had to learn about multiple possible qualitative methodologies to ensure my study's design was appropriate to my research questions. I selected grounded theory rather than interpretative phenomenological analysis (IPA), because it enabled me to draw on participants' direct 'lived experience' of the group (as would be the focus of an IPA study) whilst also capturing more theoretical and synthesized views from teachers and trainers (Bryant & Charmaz, 2007a). Furthermore, GT is well-suited to developing original theory, which was my primary research aim. Once data collection commenced, I began learning GT techniques in greater depth. This was challenging in terms of time management due to keeping up with the demands of transcribing and clinical training more broadly simultaneously. I reached a stage of 'self-conscious incompetence' (Cutcliffe, Butterworth & Proctor, 2001) by the time I needed to commence analysis, recognizing my lack of expertise in this area and how much there was to learn. However, I had to balance my feelings of incompetence with getting on and learning through doing. When I conduct qualitative research in future, I will feel better able to commence analysis, better equipped with grounded theory skills. Furthermore, I will be better able to set realistic deadlines for myself, as I can now make more accurate estimates of how long stages of data analysis might take.

In addition to more concrete research skills, I have engaged with more philosophical questions about the nature of knowledge and how meaning is formed and conceptualized within the research process (Bryant & Charmaz, 2007b). My personal leaning is towards social constructionist understandings of how meaning is made through language and cultural practices. However, I found it challenging to balance this view with the focus in mindfulness on the body and disengaging from more intellectual and constructed views of the world and self. I found Steven Stanley's work (2012) extremely helpful in making sense of some of these issues, and have ultimately occupied a critical realist position in my research, taking account for both the ways in which participants' constructed their experiences and made sense of them, whilst acknowledging that the experience of being alone is different to being within a group in a more 'real' sense. I still have much further learning to do in such epistemological debates, and envisage engaging in them throughout my career.

Question two: If you were able to do this project again, what would you do differently and why?

In view of the lack of existing research in this area and the intangible and complex nature of group interactions, I feel the methodology I selected was the most appropriate for the topic and my research aims. However, if I were to conduct the research again I would seek to recruit more participants who had a neutral or negative view of the group aspect of MBIs. With the exception of one participant ('Adam', student), my participants were keen to promote the group as a beneficial experience, which biased the study towards a positive

view of the group format. This may have been difficult to achieve, however, as clinicians who have elected to specialize in delivering MBIs are unlikely to feel negative or ambiguous towards the group aspect. Additionally, students who have had a negative experience of the MBI, due to the group format or other for reasons, may have been less likely to volunteer to participate in the research or respond to information about the study passed on through their MBI teacher.

If doing the research again, I would consider getting 'respondent validation' (Bloor, 1997). This involves taking one's findings back to the study participants for verification (Silverman, 2009). This may have facilitated some further clarification and consolidation of the ideas, and could have increased the robustness of my findings. However, I feel the model is sufficiently robust without this additional validation as I attempted to be thoughtful and systematic throughout the research process, and incorporated triangulation into the study's design. Triangulation of three perspectives (i.e. students, teachers, trainers) provided an important validation process (Bryant & Charmaz, 2007a). The three groups brought different views of the group processes: recent experiences of group membership as mindfulness students; experiences of managing groups as teachers; and a perspective from trainers of the group skills they impart to mindfulness teachers based on their own experience and more developed understanding. Furthermore, qualitative researchers must be cautious of making claims that their research presents definitive explanations and of using credibility checks such as respondent validation uncritically (Barbour & Barbour, 2003). I view my research findings

as one possible interpretation of the role of the group in MBIs and do not suggest that this is the end of the research process in this area.

Question three: Clinically, as a consequence of doing this study, would you do anything differently and why?

I am not currently trained to deliver MBIs, though I hope to undertake further training in this area in future. If I deliver or co-facilitate MBIs in future, I would pay attention to the stage of the group experience and the necessary group-based task required of me. I would maintain my own personal mindfulness practice and be alert to developing my own capacity to remain mindful (embodied) during the group, particularly at challenging moments. Furthermore, I would be clear with participants that verbal interaction is not a pre-requisite and would encourage attendance at the full day of silent practice.

Doing this research has also alerted me to how group interventions are often assumed to be beneficial without sufficient thought as to why. Conducting background research revealed multiple examples of studies reporting 'group effects' and 'cohesion' without consideration of what this really means and how group experiences might differ between groups, interventions and populations (e.g. Hornsey, Dwyer & Oei, 2007). Research on group interventions rarely measures any group factors, focusing instead on individual clinical outcomes (e.g. Johnson, 2008). Consequently, group skills are often viewed as generic, rather than as skills which might require refinement or significant adaptation in different circumstances. Therefore, I will continue to explore ways of researching 'group effects' in a more

meaningful way in my career, to developing expertise in understanding, delivering and training on group-based interventions.

It was evident from doing this research that some participants who had been 'students' on an MBI were keen for me to know that they had a professional interest in addition to a personal interest and didn't identify themselves as a 'mental health' clients. They were concerned about the extent of other people in the group's 'problems'. This illustrates how important it is for interventions to feel de-stigmatizing and for people to feel they can attend without being labeled as mentally ill. However, groups are often run, particularly within the NHS, for people with a specific diagnosis (e.g. MBCT for depression). This raises the kind of debates discussed by clinical psychologist Guy Holmes (2010) who runs psychological groups based on bringing people together through shared interests rather than shared problems or diagnoses. I will remain alert to this in running other groups, balancing transparency about the aims of intervention whilst remaining alert to how the aim can be framed in a positive and de-stigmatizing way (e.g. a 'learning to have better relationships' group rather than 'group for people with borderline personality disorder').

Question four: If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing that?

In view of my qualitative expertise, I would prefer to pursue a further study to expand upon the model I have proposed. I would be interested to do this by focusing on the non-verbal components of the theory, which emerged as

unique group factors in MBIs. However, this would raise a number of methodological challenges, as qualitative research relies upon participants verbalizing their experiences. I am as yet unclear about how such research might be designed, but will continue to explore theoretical literature to support my development in this area (e.g. Stanley, 2012a; 2012b; Gergen & Hosking, 2006).

It would also be hugely valuable to conduct a study comparing the experiences and outcomes of people who study mindfulness on their own (i.e. using a book and CDs or web-based learning), and people who study one-to-one with a mindfulness teacher. The most appropriate methodology would be a mixed-methods approach. Quantitatively, a randomized control trial (RCT) design could compare outcomes for the three conditions (i.e. group-based learning, self-study and one-to-one). To reduce the range of variables, the sample should be participants with a specific diagnosis and only one type of MBI utilized. In view of MBCT's increasing prevalence in the UK (Crane, Kuyken, Hastings, Rothwell & Williams, 2010), a study of MBCT for depression with would be most feasible and valuable. As prior research suggests that the group is important in motivating ongoing mindfulness practice (e.g. Langdon, Jones, Hutton & Holttum, 2011), a follow-up period measuring ongoing mindfulness practice and the implications of this for clinical outcomes is indicated. The qualitative part of the study could seek to explore subjective experiences of learning experiences according to condition. The grounded theory presented in Section B indicates that areas worthy of in-depth exploration would be: experiences of meditating alone or just with the teacher; the advantages or disadvantages of having the opportunity to explore one's individual internal

experience one-to-one with a teacher; and the experience of learning the principles and practice of mindfulness and motivating oneself to practice alone. Interviews with the participants in the group condition could also seek to validate the theory presented in Section B.

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Section D: Appendices of supporting material

Appendix 1: Literature search strategies

Databases searched:

- Cochrane Database of Systematic Reviews (2005 – April 2012)
- Ovid Medline (1946 – May 2012)
- PsycINFO (1806 – May 2012)
- Google Scholar (final search May 2012)

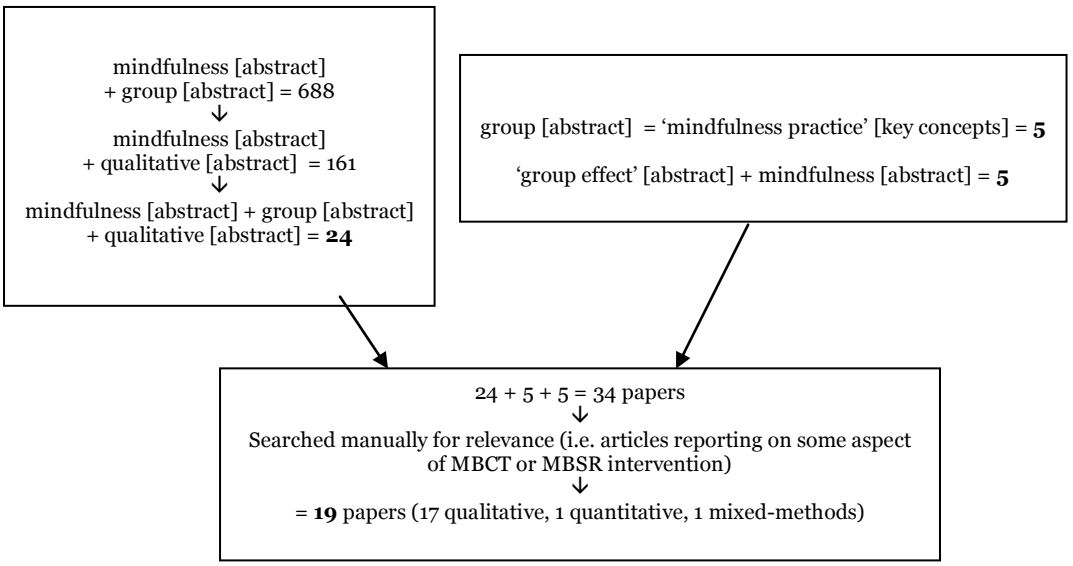
Search terms in either title, abstract, key words or key concepts:

mindfulness OR MBCT OR MBSR OR Mindfulness-based Cognitive Therapy OR Mindfulness-based Stress Reduction OR mindfulness practice	Combined with AND	qualitative OR qualitative studies OR grounded theory OR interpretative phenomenological analysis OR IPA OR thematic analysis OR interviews OR group effect OR group process* OR group dynamic* OR group therapy OR professional practice OR teacher training

Exclusion criteria:

- Articles about mindfulness other than those exploring MBCT or MBSR interventions specifically
- Dissertations
- Non peer-reviewed articles

Flow chart of example literature search:



Appendix 2: Summary table of reviewed articles (N=16)

Authors & Methodology	Sample	Study aim(s)	General findings	Findings related to group experience
Allen, Bromley, Kuyken & Sonnenberg (2009) UK Thematic analysis (semi-structured interviews)	N=20 MBCT People with recurrent depression from primary care	To explore "participants' reflections on what they found helpful, meaningful and difficult about MBCT as a relapse prevention program" (p. 413).[B]	The study presented four main themes: • *'Control';* which described participants' new and increased resources for taking control with regards to relapse prevention • *'Acceptance';* incorporating experiences of reduced stigma and relating differently to depressive thoughts • *'Relationships';* with self and others improved • *'Struggle';* which described aspects of MBCT participants found most challenging, including managing their own expectations and balancing acceptance and desire for things to be different	The theme of 'Acceptance' incorporated two subthemes, one of which was *de-stigmatization*. The experience of de-stigmatization was accredited to the group, which enabled people to feel less alone with their difficulties. This facilitated normalization. Participants also made comparisons between themselves and others in the group, which was reported as a helpful process. Both the 'Relationship' and 'Struggle themes mention group, though less substantially than 'Acceptance'. In 'Relationship', participants explained how the accepting culture of the group enabled them to open up to previously avoided emotional experiences. In 'struggle', participants' difficulty in continuing to practice mindfulness without the group was raised.
Bailie, Kuyken & Sonnenberg (2012) UK Thematic analysis (semi-structured interviews)	N=16 MBCT Parents with a history of depression	To explore whether MBCT had had an impact upon participants' relationships with their children.[S]	The study presenting a number of ways in which participants felt their emotional relationship with their children had altered positively since participating in an MBCT programme a year earlier. For example: • Parents felt they were less irritable and reactive • They noticed themselves to be more empathic and accepting towards their children • They felt more involved in their parenting role and more emotionally available to their children • They felt better able to recognise and address their own emotional needs	No group experience findings. However, the aim of the interviews was not especially conducive to eliciting data on the group.
Chadwick, Kaur, Swelam, Ross & Ellett (2011) UK Thematic analysis (semi-structured interviews)	N=12 MBCT Adults with a diagnosis of bipolar affective disorder	To explore participants' "experience of mindfulness practice in the context of living with, and managing bipolar disorder' (p. 279).[B]	The authors describe seven themes as emerging from their data. All themes described changes in participants' internal psychological processes, how they individually utilised mindfulness skills, and the impact of this on their mental health: • *'Focusing on what is present'* • *'Clearer awareness of mood state and mood change'* • *'Acceptance'* • *'Adapting mindfulness practice to different mood states'*	No group-related findings emerged from this study.

			• *'Reducing and stabilizing negative affect'* • *'Relating differently to negative thoughts'* • *'Reducing impact of mood states'*	
Chambers, Foley, Galt, Ferguson & Clutton (2012) Australia Mixed-methodology: Qualitative method of 'thematic analysis based in an interpretative phenomenological framework' (semi-structured interviews)	N=12 MBCT Men with advanced prostate cancer	The qualitative component of the study explored the participants' experiences of the MBCT group encompassing "personal views and feelings about: overall experience of the group, aspects of the group that were helpful or unhelpful, and experiences of being in a group with men at different levels of illness/symptoms" (p. 1187).[B]	The authors report four key themes: • *'Group identification'*: participants talked about finding it helpful to feel part of a group with the same diagnosis; • *'Acceptance of diversity'*: individual differences between group members were perceived to have enhanced their group experience; • *'Peer learning'*: participants described learning from other group members' questions, experiences, and perspectives; • *'Acceptance of disease progression'*: Participants described the challenges of being in a group with men with at more advanced stages of disease progression, but ultimately conclude this was a helpful experience as it facilitated acceptance.	All four themes relate to group experiences, and are presented as positive findings. The authors include an interesting discussion about their fourth theme, 'Acceptance of the disease progression'. They note their surprise at this finding, as a common consensus in support group settings is to screen for homogeneity of experience. However, participants' perceptions were that it was inspiring to see people cope with their more advanced condition, and supported acceptance of future possibilities. Additionally, the authors asked some evaluative questions about preferred aspects of the MBCT programme. 'Being asked to do the course as part of a group' was the second most 'liked' aspect of the programme. 'Experiences that arose as a result of practicing mindfulness' was the most liked aspect.
Finucane & Mercer (2006) UK Mixed methodology: Qualitative method of 'framework approach'. (semi-structured interviews)	N=13 MBCT Adults with recurrent depression and anxiety recruited within primary care	"To investigate the acceptability and effectiveness of MBCT in primary care for patients with a history of relapsing depression who had current symptoms of depression or depression and anxiety" (p. 2).[B]	The qualitative component of the study found four themes to emerge reflecting participants' experiences of MBCT: • *'Preconceptions, motivations and expectations':* Within this theme, participants talked about being motivated by having a long history of mental health problems, not wanting to take medication, and a belief in self-help. • *'Being in a group':* Participants talked about the importance of being in a group to normalise, not feel alone, and to share emotional experiences. Some found the group a motivating factor. One participant with social anxiety found the group experience difficult. • *'The course exercises':* This outlined different opinions in the group of various course components (e.g. body-scan, sitting meditations) and experiences of home practice. • *'Benefits and on-going practice':* This described differences between participants' practice three months after the course ended, and the benefits they felt had been sustained.	One of four themes in this study related to the group experiences. This was predominantly positive, although it also highlights that some individuals may particularly struggle with the group environment to the detriment of their well-being (i.e. people with social anxiety). The authors note in their discussion that they feel a follow-up group was "essential" (p. 14).

Fitzpatrick, Simpson & Smith (2010) UK Interpretative phenomenological analysis (IPA) (semi-structured interviews)	N=12 MBCT Adults with a diagnosis of Parkinson's disease	To explore the experiences of MBCT of people with Parkinson's disease.[B]	Four themes emerged in this study, each with descriptive titles: • *'Changing patterns of coping'* • *The role of mindfulness in consolidating existing coping skills in the context of loss: 'You have to be mindful with Parkinson's anyway'* • *Group support in the context of loss and a society that stigmatizes difference: 'It was like one big family kind of thing, because we all have something in common'* • *The dualism of experience between Parkinson's and mindful meditation: 'very calm and peaceful, yeah, you're sort of on a different level'*	One of four themes focused on the importance of the group context. The authors describe this as an "important part of the experience and benefit of the course" (p. 187) and note that participants appreciated sharing common experiences and developing a sense of belonging. However, they note that one participant left the group feeling her difficulties were not as bad as others in the group. The authors suggest this offers an example of "how important group factors might be in maintaining people's commitment to a course" (p. 187).
Frisvold, Lindquist & McAlpine (2012) USA Content analysis (semi-structured interviews)	N=20 MBSR Female nurses aged 45-55	The study aim was 'to determine the feasibility and potential efficacy of MSBR as a platform to reduce stress and improve health behaviour change efforts among female nurses at midlife" (p. 268). Interviews aimed to explore the participants perception of MBSR, specifically related to stress reduction and their personal and professional quality of life.[S]	Five themes, with largely self-explanatory headings, were described: • *'Strengthening of interpersonal communication through social support'* • *'Increased interpersonal awareness through becoming more mindful and reflective'* • *'A spiritual awakening'* • *'Stress reduction'* • *'Living life in balance'*	No direct mention of the group experience. However, participants talked about valuing having learnt active listening skills through the course. One participant appears to attribute this to being in the group ("we got really close as a group and we did a lot of communicating" (p. 272). Although the authors don't account for this benefit as a group effect, it could be viewed as such. Another reason for lack of group-related content may be that the questions asked at interviews aimed specifically to explore stress reduction and quality of life through questions such as "How has your life changed since you participated in the MBSR course" and "Do you respond to stress differently after taking the MBSR course" (p. 270). These would focus participants in a specific direction rather than at their experience of the course more broadly.
Griffiths, Camic & Hutton (2009) UK Interpretative phenomenological analysis (IPA) (semi-structured interviews)	N=6 MBCT Adults diagnosed with cardiac condition requiring rehabilitation	To explore participant experiences of taking part in an MBCT group which had been adapted for cardiac rehabilitation. The authors explored the experiences of the therapy, being in a group, and the daily impact of MBCT.[B]	The study describes five master themes: • *'Development of awareness',* including increased awareness of causes and triggers of stress, paying attention to thoughts, and incorporating mindfulness into daily life. • *'Within group experience',* which described participants' assessment of the group experience as normalising and enjoyable. However, some participants found group discussions 'frustrating'. • *'Relating to the material'* described participants'	One of the five themes focused on the benefits of the group experience. The authors also incorporate negative experiences of group enquiry within this, though it should be noted that frustrations were related to feeling unclear about the purpose of the intervention, and of the discussions being repetitive. This could, arguably, be better described as a structural or teacher-related factor than a group factor. The authors note an interesting interaction between the development of awareness, commitment, and group

			experiences of specific practices, such as body scans and meditation • *'Commitment'*. This theme incorporated views on the benefits and challenges of maintaining commitment to using mindfulness skills. • *"Acceptance as an outcome',* which noted that participants who seemed to develop a greater sense of acceptance had a more positive experience of MBCT.	experience: They suggest that commitment to practice is implicated in the process of developing awareness, and that commitment was influenced by the group experience. In particular they seem to suggest that whether or not the group develops an "attitude of perseverance and determination" (p. 679) has an impact on individual commitment, and therefore, development of awareness.
Hawtin & Sullivan (2011) UK Interpretative phenomenological analysis (focus group data)	N= 5 MBSR Adults diagnosed with psoriatic arthritis, fibromyalgia or rheumatoid arthritis (chronic pain)	To explore participants' experiences of mindfulness in relation to coping with pain and psychological well-being.[B]	Two themes were described: • *'Responding to pain';* in which participants describe using mindfulness techniques such as curiosity to manage pain differently. The difference between paying attention to an experience of pain and turning attention away is discussed. The authors acknowledge it was not always clear which approach participants used. • '*Psychological well-being'*: This demonstrated experiences participants had had before MBSR, such as depression and their accounts of using mindfulness to prevent further depression, or improving their quality of life in other ways (e.g. enjoying nature).	No mention of group experience. This could be partly due to participants having completed the MSBR programme six months earlier, or due to the focus group questions (which is not made explicit).
Kerr, Josyula & Littenberg (2011) USA Grounded theory with a "close-ended coding" approach (diary entries)	N=8 MBSR General public	To explore the participants' experiences of mindfulness, specifically exploring home-practice.[S]	The authors do not report themes or a model, but a series of observations: • They note that there were similarities and differences between diary entries. The main similarity was that participants' developed an "observing attitude towards their own experience" (p. 86) in later diary entries. • In later entries, participants noted more positive feelings. They describe this as "reperceiving", either with "less negative reactivity" or more "meta-awareness" (p. 86). • This increase in reperceiving often followed a period of "negative reactivity".	None of the study's findings related to the group experience. However, as with Monroe et al.'s study (2008) the data used came from diary entries specifically about experiences of home practice.
Kerrigan, Johnson, Stewart, Magyari, Hutton, Ellen &	N=10 MBSR "Urban youth":	Participants selected from a larger sample taking part in a study aiming to determine the "acceptability, feasibility	The authors outline three main themes. The third incorporates two inter-linked sections of the article: • *'External stressors and reactions to stressors prior to MBSR participation',* which described the participants' daily environment and the types	There was no mention of the group experience in this study, despite the interview schedule exploring the broad aim of "perceptions of and experiences with the MBSR programme" (p. 97).

Sibinga (2011) USA Content analysis (semi-structured interviews)	age range 13-19, socio-economically disadvantaged adolescents. Four participants had been diagnosed with HIV.	and potential domains of effect of MBSR" (p. 97) in the target population.[B]	of stressors they regularly encountered (e.g. verbal fighting amongst family members). Existing attempts to cope (e.g. "tuning it out") were highlighted. • *"Perceptions and experiences with mindfulness-based practices'*. Participants demonstrated an understanding of the principles of mindfulness and of the challenges of learning this skill. • *'Shifts in perspectives linked to mindfulness-based practices'* and *'Mindfulness and positive changes in relation to coping with daily stressors'*. Authors describe a range of 'shifts' and changes participants described. They offer two case studies to support this observation.	
Sibinga, Kerrigan, Stewart, Johnson, Magyari & Ellen (2011) USA Mixed methodology: Qualitative method of content analysis (semi-structured interviews)	N=10 MBSR 'Urban youth" aged 13-21, from predominantly socio-economically disadvantaged backgrounds. Five of the participants had been diagnosed with HIV.	To explore "acceptability and effects of participation in the MBSR programme" (p. 215).[B]	The study outlines almost identical themes to Kerrigan et al. (2011) above, for the two studies appear to use the same data. This study also notes the positive impact MBSR appears to have had upon interpersonal relationships, school achievement and physical health (including adherence to HIV medication regime).	No mention of the group experience. *[NB: Although the studies by Kerrigan* et al.*, and Sibinga* et al. *clearly draw on the same data, they have reported their studies slightly differently, such as the reported age range and number of participants diagnosed with HIV. The studies have, nevertheless, been presented as one study, rather than two separate studies].*
Langdon, Jones, Hutton & Holttum (2011) UK Grounded theory (semi-structured interviews)	N=13 MBCT Adults with a variety of mental and physical health conditions	To develop a theory of the factors which help or hinder people in maintaining formal mindfulness practice after MBCT participation.[S]	The authors found five higher-order categories: • Participants described mindfulness as a journey, and that having established a practice during MBCT they then moved into a *'Virtuous practice cycle",* supported by factors such as integrating mindfulness into everyday life. • Due to various challenges and obstacles, participants described a reduction in regular practice: *'slipping out of the cycle'*. • Factors such as finding resolve and overcoming obstacles helped participants with *'getting back to the cycle'* of regular practice	Of the five higher-order categories, two included group-related sub-themes. The *'course as a supportive space to set up practice'* and *'group as a support to practice'*, were subcategories in a higher-order category relating to maintaining practice *('virtuous cycle'*). The *'it's harder to practice without group support'* subcategory belonged to the *'slipping out'* of practice higher-order category. In their discussion, the authors note the role of group support in influencing individual norms and beliefs towards valuing mindfulness. They conclude by recommending that opportunities for ongoing group practice appear key in supporting ongoing practice.

			• Participants recognised *'positive beliefs about mindfulness'* and the *'influence of significant others'* to play important roles in their ongoing mindfulness practice.	
Mackenzie, Carlson, Munoz & Speca (2006) Canada Grounded theory (semi-structured interviews)	N=9 MBSR Cancer patients (adults)	To explore cancer patients' subjective experiences of MBSR and meditation in the context of their cancer experience.[B]	The authors found five major themes: • *'Opening to change',* which described how participants shifted their lifestyles and attitudes during and following MBSR • *'Self-control'*: participants felt more able to control their own behaviour and emotions in some domains and also more able to let go of trying to control areas in areas they could not affect. • *'Shared experience':* Participants talked about the community of the group, the importance of sharing their suffering, and learning from each other. • *'Personal growth':* Participants noted changes in their attitudes towards themselves, others and their illness, which they perceived to be positive. • 'Spirituality': Participants recognised a largely unexpected but welcome increase in their appreciation of "spiritual tools and resources" (p. 66).	One of five themes was specifically related to positive group experiences. This third theme of *'shared experience'* was noted to be very important to participants, and the "sense of community is what kept them coming week after week" (p. 66). The authors note that the strong sense of group cohesion described by the group is of particular interest in view of the MBSR format allowing "relatively little time [for] talking and sharing" (p. 67). NB: Participants were recruited through a weekly practice group they each chose to attend after completing the MBSR programme. This implies the sample was biased towards favouring group practice.
Mason & Hargreaves (2001) UK Grounded theory (semi-structured interviews)	N=7 MBCT Recruited via adult mental-health services following experiences of depression	Qualitative exploration of participants' accounts of an MBCT course for depression. [B]	The authors found nine main categories: • *Preconditions*: aspects of the self (e.g. coping styles) participants recognised underlay later difficulties • *Changes to health and well-being*: events participants recognised as causal to presenting difficulties • *Distress & depression:* descriptions of periods of distress and depression, with emphasis on cognitive patterns • *Context of course*: participants' perceptions of MCBT (e.g. "an alternative therapy"). • *Expectations of course*: participants expectations for potential outcomes ranged from low or few expectations to extremely high. • *Initial negative experiences*: describing initial struggles with MBCT • *'Coming to terms'*: this category, describing a	The subcategory of 'Group support and identification' (within the category 'coming to terms') describes participants' experience of the group as supportive, normalising of their own struggles, and facilitating discovery. The authors note that the group "offer[s] a safe place in which to learn skills, and benefit from others' experiences" (p. 207). The authors also offer a critique of their own model, "acknowled[ing] an implicitly individualist orientation that may have relegated the role of group support and interpersonal process" (p. 209). They note that the merits of group support werea raised by all participants, and thus could have merited a category in its own right. They conclude the group to be "essential" in helping individuals to come to terms with their difficulties.

			number of beneficial experiences, incorporated subcategories of *'Group support and identification', ' Discovery/'surprise", 'Relaxation', 'Skills',* and *'Accepting attitude'.* • '*Warning bells*': participants' developing capacity to note 'warning signs, and thus develop preventative strategies • *'Bringing it into everyday'*: how participants utilise mindfulness skills in daily life	
Monroe, Lynch, Greco, Tindle, & Weinern (2008) USA Grounded theory and content analysis (diary entries)	N=27 MBSR Adults with chronic back pain	"To identify themes that best described or commonly suggested participants' experience of applying mindfulness meditation to pain as well as to their daily lives" (p. 842), focusing specifically on home-practice.[S]	The authors identified six self-explanatory main themes (though only report the first four in any detail): • *'Experiencing pain reduction from mindfulness meditation'* • *'Improvement in attention skills resulting from mindfulness meditation'* • *'Improved sleep resulting from meditation'* • *'Achieving well-being'* • *'Well-being: Short-term effects'*	None of the study's findings related to the group experience. However, the data used came from diary entries which were written about experiences of home practice under the headings of 'amount of time spent meditating', 'Any benefits or problems with the meditation?' and a 'comments' section. Arguably, participants' attention was focused specifically on their home practice, and thus they were unlikely to comment on their experiences in the group.
Smith, Gragan & Senthinathan (2007) UK Mixed methodology: Qualitative method of thematic analysis (semi-structured interviews)	N=30 MBCT Older adults (aged 65+) with recurring depression	To explore the suitability of MBCT for older adults. Interviews asked about experiences before, following and one year after the course.[B]	The authors present a table of 17 main themes. These are not described in depth. Instead, the authors provide three case studies to illustrate the themes.	Of the 17 themes, two appear to relate to the group experience. Firstly, the authors comment by the theme of 'Helpfulness of mindfulness course/practice' that "working in a group is easier for most (alone easier for a few)" (p. 350). Secondly, they comment next to the theme 'Reduction of stigma' that this is partly enabled by "learning with others in the same boat" (p. 350). Furthermore, in one of their three case studies, they include quotes from a participant saying that "meeting others in the same boat" was helpful, and that "being in a group helped … when they say they are depressed it is nice I'm not the only one" (pp. 352-3). These experiences could be described as normalising and of not feeling alone in one's suffering.

[B] = Studies with the broad aim of participants' experiences of MBSR/MBCT courses in the context of their specific needs
[S] = Studies with specific aim related to the population in question or a specific aspect of mindfulness training

Appendix 3: Critique of qualitative papers reporting group-related findings (n=9)

Authors & Methodology	Sensitivity to context	Commitment and rigour	Transparency and coherence	Impact and important	Notes (incl. group-specific issues)
Allen, Bromley, Kuyken & Sonnenberg (2009) Thematic analysis (semi-structured interviews)	✓Ethical issues addressed ✓ Relevant background literature provided ✓ Relevant empirical research provided ✓ Situated within theoretical framework × Sensitivity to participants' sociocultural setting not in evidence	✓ Sample appropriate for qualitative purposes ✓ Inter-rating reliability provided	✓ Sufficient evidence of reflexivity ✓ Results and study as a whole coherently presented ✓ Interview schedule sufficiently transparent × Selection of interview for analysis (20 of full data set of 54) not sufficiently transparent ✓ Adequate use of quotes provides transparency	✓ Develops original theory on maintaining mindfulness practice ✓ Links with other relevant theory	× No linking with group theory
Chambers, Foley, Galt, Ferguson & Clutton (2012) Mixed-methodology: Qualitative method of 'thematic analysis based in an interpretative phenomenological framework' (semi-structured interviews)	✓Ethical issues addressed ✓ Relevant background literature provided ✓ Relevant empirical research provided × Not situated within theoretical framework × Sensitivity to participants' sociocultural setting not in evidence	✓ Sample appropriate for qualitative purposes × Insufficient justification for or explanation of qualitative methodology. ✓ Inter-rating reliability provided	✓ Adaptations to MBCT sufficiently transparent. × Facilitator's competence in delivering intervention not established × Interview schedule not sufficiently transparent × Insufficient evidence of reflexivity ✓ Results and study as a whole coherently presented ✓ Adequate use of quotes provides transparency	✓ Provides clinical insight with practical implications for utilising MBIs with population studied ✓Offers novel insight on homogenous v. heterogeneous groups. × Qualitative findings not situated within any theoretical framework	Mixed-methodology study. Critique is of qualitative aspect only. Some adaptations to MBCT programme for population (men with cancer) but followed MBCT 8-week structure. × No linking with group theory
Finucane & Mercer (2006) Mixed methodology: Qualitative method of 'framework approach'. (semi-structured interviews)	✓Ethical issues addressed ✓ Relevant background literature provided ✓ Relevant empirical research provided × Not situated within theoretical framework ✓ Sensitivity to participants' sociocultural setting not in evidence	✓ Sample appropriate for qualitative purposes ✓ Rigour in data collection × Methodology not sufficiently explained, thus not possible to assess rigour of analysis	✓ Results and study as a whole coherently presented, though results could been more succinct ✓ Adaptations to MBCT sufficiently transparent. ✓ Facilitator's competence in delivering intervention established ✓ Interview schedule sufficiently transparent (included in table) × Methodology not transparent ✓ Adequate use of quotes provides	✓ Provides clinical insight with practical implications for utilising MBIs with population studied × Qualitative findings not situated within any theoretical framework	Mixed-methodology study. Critique is of qualitative aspect only. Some adaptations to MBCT programme for population (patients with active depression – shortened some meditation practices) but followed MBCT 8-week structure.

			transparency		Good synthesis of quantitative and qualitative findings. × No linking with group theory
Fitzpatrick, Simpson & Smith (2010) Interpretative phenomenological analysis (IPA) (semi-structured interviews)	×Ethical issues insufficiently addressed ✓ Relevant background literature provided ✓ Relevant empirical research provided × Not situated within theoretical framework ✓ Sensitivity to participants' sociocultural setting not in evidence	✓ Sample appropriate ✓ Thoroughness and commitment demonstrated in data collection and analysis	✓ Sufficient reflexivity ✓ Interview schedule sufficiently transparent ✓ Results and study as a whole coherently presented, though results could been more succinct ✓ Transparency in procedure and analysis	✓ Provides clinical insight with practical implications for utilising MBIs with population studied ✓ Some linking with theory on coping strategies	× No linking with group theory
Griffiths, Camic & Hutton (2009) Interpretative phenomenological analysis (IPA) (semi-structured interviews)	✓Ethical issues addressed ✓ Situated within theoretical framework ✓ Relevant empirical research provided × Sensitivity to participants' sociocultural setting not in evidence	✓ Sample appropriate ✓ Thoroughness and commitment demonstrated in data collection and analysis	✓ Adaptations to MBCT sufficient transparent × Interview schedule not sufficiently transparent × Insufficient reflexivity ✓ Transparency in procedure and analysis	✓ Provides clinical insight with practical implications for utilising MBIs with population studied ✓ Links with theory related to internal cognitive processes	× No linking with group theory
Langdon, Jones, Hutton & Holttum (2011) Grounded theory (semi-structured interviews)	✓Ethical issues addressed ✓ Situated within theoretical framework ✓ Relevant background literature provided ✓ Relevant empirical research provided × Sensitivity to participants' sociocultural setting not in evidence	✓ Sample appropriate ✓ Thoroughness and commitment demonstrated in data collection and analysis	✓ Sufficient reflexivity ✓ Interview schedule sufficiently transparent ✓ Results and study as a whole coherently presented ✓ Transparency in procedure and analysis	✓ Develops original theory on maintaining mindfulness practice ✓ Links with other relevant theory	× No linking with group theory
Mackenzie, Carlson, Munoz & Speca (2006) Grounded theory (semi-structured interviews)	× Ethical issues not sufficiently addressed ✓ Situated within theoretical framework ✓ Relevant background literature provided ✓ Relevant empirical research provided	✓ Sample appropriate ✓ Thoroughness and commitment demonstrated in data collection and analysis	✓ Sufficient reflexivity ✓ Interview schedule sufficiently transparent ✓ Results and study as a whole coherently presented, though results could been more succinct ✓ Transparency in procedure and analysis	✓ Provides clinical insight with practical implications for utilising MBIs with population studied ✓ Some link with broader theory on mindfulness mechanisms	× No linking with group theory (only empirical literature)

	✓ Sensitivity to participants' sociocultural setting in evidence				
Mason & Hargreaves (2001) Grounded theory (semi-structured interviews)	× Ethical issues not sufficiently addressed ✓ Situated within theoretical framework ✓ Relevant background literature provided ✓ Relevant empirical research provided ✓ Sensitivity to participants' sociocultural setting in evidence	✓ Sample appropriate ✓ Thoroughness and commitment demonstrated in data collection and analysis	✓ Sufficient reflexivity × Interview schedule not sufficiently transparent ✓ Results and study as a whole coherently presented, though results could been more succinct ✓ Transparency in procedure and analysis	✓ Develops original theory on participants' experiences of MBCT ✓ Uses to test out other relevant theory (i.e. 'theoretical cognitive framework')	× No linking with group theory
Smith, Gragan & Senthinathan (2007) Mixed methodology: Qualitative method of thematic analysis (semi-structured interviews)	× Ethical issues not sufficiently addressed × Not situated within theoretical framework ✓ Relevant background literature provided ✓ Relevant empirical research provided × Sensitivity to participants' sociocultural setting not in evidence	✓ Sample appropriate × Lack of clarity around methodology (mix of content, thematic analysis and suggestion of grounded theory) ✓ Thoroughness and commitment demonstrated in data collection and analysis (large sample, multiple stages to analysis)	× Insufficient reflexivity × Interview schedule not sufficiently transparent × Results not transparently (authors presented three case studies rather than discussing thematic findings from full data set) ✓ Transparency in procedure and analysis	✓ Provides clinical insight with practical implications for utilising MBIs with population studied × No elaboration on importance of qualitative findings provided × No drawing on theory	× No linking with group theory

Appendix 4: Participant information sheet

January 18th 2011: Version 1.0

Information for participants

We would like to invite you to take part in a research study. Before you decide whether to take part, we would like you to understand why the research is being done and what it would involve for you.

Overview of the Study
This is a study exploring the role of the group aspect of Mindfulness-Based Interventions. For example, both Mindfulness-Based Stress Reduction (MBSR) and Mindfulness-Based Cognitive Therapy (MBCT) 8-week courses are usually delivered to a group, rather than to individuals. This study is interested in what impact this might have on participants' learning and how teachers go about managing the group. This issue will be explored via interviews with the researcher (Dulcie Cormack, Trainee Clinical Psychologist).

Who is organising research?
This study is being conducted by Dulcie Cormack, as part of doctoral level training in clinical psychology. It is being supervised by Dr. Michael Maltby and Dr. Fergal Jones at The Department of Applied Psychology, Canterbury Christ Church University.

Why have you been invited to take part?
You have been invited to take part in the study because:
a) You have participated in an MBSR or MBCT 8-week course within the last 2 years OR
b) You are a Mindfulness teacher currently running either MBSR or MBCT courses OR
c) You are a trainer of Mindfulness teachers

It is up to you to decide to join the study. If you agree to take part, the researcher (Dulcie) will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason.

What would happen if I took part in the study?
If you chose to take part in the study, Dulcie would contact you to arrange a time for an interview. This could take place by phone or in person at a mutually agreeable time and place. The interview would last between 30-60 minutes. The interview would be recorded. If you have been a participant of a mindfulness group, you would be asked questions in relation to what it was like being part of a group when you were learning mindfulness, in what ways this was helpful or not, and how you felt the teacher responded to the group. If you are a teacher, Dulcie would ask you about your experiences of managing groups, such as the skills you feel you use and how you feel the group might help or hinder participants' learning. If you are a trainer, Dulcie would ask you similar questions in addition to focussing on how you train teachers to manage groups. Dulcie will also ask teachers and trainers to reflect on their own experiences of group processes in the MBCT or MBSR course or courses in which they were themselves a participant.

You would also be asked to complete a short form, before the interview commences, to provide basic demographic information (age, gender and ethnicity), and mindfulness-related background (e.g. type of mindfulness course you participated in; relevant training and experience if you are a teacher or trainer).

The study does not aim to explore distressing experiences. However, if you foresee such questions causing you significant distress, we would advise you not to take part. Alternatively, you would be free to not answer questions during the interview without giving a reason if you chose to.

What happens after I have participated in the study?
After the interview, the researcher will transcribe the interview. Together with data from other study participants, your interview data will be analysed and used to develop a theory about the role of the group in learning mindfulness skills.

Will my contribution to the study be confidential?
Yes. The study will follow ethical and legal practice and all information about you will be handled in confidence. The researcher will record the interview and immediately after the interview is completed, transfer it onto a computer and password protect it, to be later transcribed and analysed. The original recording will then be deleted. The copied recording will be deleted when analysis is complete. There will be no personal information attached to the data, which will only be accessible to the researcher so that your confidentiality can be protected. When the research project is completed, the transcripts will be kept for up to 10 years, after which it will be destroyed. Your name, and the names of any other people you discuss during the interview, will be removed and replaced with pseudonyms. Any other identifying information (e.g. places) will also be removed. Your basic demographic information and relevant mindfulness-related background will be collected on a form, identifiable through a Participant Information Number known only to the researcher, and with no names or other identifiable information attached. The forms will be kept for up to 10 years, after which they will be destroyed.

However, if following the interview the researcher were to be concerned about a risk of harm to yourself or another person, it may be necessary for such information to be shared.

What if there is a problem?
Any complaint about the way you have been dealt with during the study will be addressed.

If you have a concern about any aspect of this study, you can contact me on 07980 055884 or d.cormack260@canterbury.ac.uk. I would do my best to answer your questions. If you remain unhappy and wish to complain formally, you can do this by contacting:

Professor Paul Camic
Research Director
The Department of Applied Psychology
Canterbury Christ Church University
Broomhill Road, Southborough,
Tunbridge Wells, Kent, TN3 0TG.

Email: paul.camic@canterbury.ac.uk
Telephone: 01892 507773

What will happen if I want to withdraw from the study?
You have the right to withdraw from the study without giving any reason. If you chose to withdraw from the study after the interview, the recording and any transcription of your interview will be destroyed at your request. However, we ask that you make such a request within 3 weeks of the interview as it would not be possible to extract your anonymised data from the analysis beyond this point.

What will happen to the results of the study?
The results of the study will be written up for publication in academic journals. They may also be presented at academic conferences.

Appendix 5: Informed consent form

Patient Identification Number:

CONSENT FORM

Title of Project: The role of group process in mindfulness-based interventions

Name of Researcher: Dulcie Cormack

1. I confirm that I have read and understand the information sheet dated January 18th 2011 (version 1.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I understand that my data will treated as confidential amongst the research team. However, if the researchers become aware of any risk to myself or others during the research, it may be necessary to pass such information to relevant third parties.

4. I agree to my anonymised data being reported in future reports for publication.

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

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

When completed: 1 for participant; 1 for researcher site file (original).

Appendix 6: Demographic form

Demographics form

To be completed by researcher:

Participant Identification Number:_____

To be completed by all research participants

I would describe myself as a…: (tick all that apply)			
☐ mindfulness 'student' (i.e. I have completed an 8-week Mindfulness course in within the previous 2 years) ☐ mindfulness teacher (i.e. I teach MBSR and/or MBSR 8-week courses) ☐ mindfulness trainer (i.e. I train MBSR and/or MBCT teachers)			
Gender	Age	Ethnicity	
☐ Male ☐ Female	_____ years	☐ Asian ☐ Asian British ☐ Black ☐ Black British ☐ Mixed ethnic group	☐ White ☐ Any other group (please specify) ……
Time since attending 8-week course		Type of course attended	
_____ months _____ years		☐ MBCT ☐ MBSR ☐ Don't know	

Additional section for teachers and trainers only

Time teaching mindfulness 8-week courses	**Time training mindfulness teachers**	**Approx. number of courses delivered (as lead or co-facilitator)**	**Approx. number of teacher training programmes delivered**
_____ months _____ years	_____ months _____ years	_____	_____

Type of course taught	Are your courses delivered for a specific client group or problem (e.g. anxiety, depression, carers, chronic pain)? Please specify:
☐ MBCT ☐ MBSR ☐ Both	....

Mindfulness teacher training / experience (tick all that apply) Adapted from Crane et al., 2010	**Optional section** Relevant background (tick all that apply)
☐ Have participated in a 3-7 day, part-silent, mindfulness retreat ☐ Have participated in 7-day mindfulness mediation retreat ☐ Engage in daily personal mindfulness practice ☐ Have knowledge of theory and research underpinning mindfulness approaches ☐ Have in-depth knowledge of the aims and structure of mindfulness-based programmes ☐ Continue to have opportunity to teach MBCT/MBSR courses/practice core skills under supervision ☐ Have ongoing, regular supervision with an experienced mindfulness-based teacher ☐ Have participated in a MBSR/MBCT teacher training programme(s) Please specify:.....	☐ Psychotherapist ☐ Cognitive therapist ☐ Behavioural therapist ☐ Group analyst ☐ Buddhist teacher ☐ Counsellor ☐ Clinical Psychologist ☐ Other health or well-being professional/role (please specify)..... ☐ Any other background information you think is relevant to your role as a mindfulness teacher/trainer (please specify) ....

Appendix 7: Interview schedules

a. Student (of MBSR or MBCT course)

I am interested in hearing about what it was like for you to learn mindfulness within a group of people.

1. Can you tell me about what it was like for you being in your particular mindfulness group (i.e. 8-week MBCT or MBSR course)? For example, was it helpful to be learning within the group? Were there difficulties?
2. Can you remember the first couple of weeks on the course? What were your thoughts about being in the group then?
3. And what happened next? Did your feelings/attitude towards the group change? How?
4. What was it like towards the end of the course? How did you feel about the group as you prepared to say goodbye?
5. How did you find doing the practices within a group?
6. What was it like for you to discuss your experiences within the group?
7. Can you describe how the teacher managed the group as a whole? For example:
    - Can you remember a time when the teacher had to attend to any difficulties within the group, such as someone being distressed? How did they respond to the individual and to the group as a whole?
    - Were there times when you thought the teacher responded well to someone in the group, or the group as a whole?
8. How did this group compare to other groups you have been in?

b. Teachers (NB: Also ask questions from 4a)

I am interested in hearing about your experiences of managing the group when teaching Mindfulness courses (i.e. 8-week MBCT or MBSR courses).

1. Can you tell about how you approach managing the group, using 'live' examples?
    a. Can you give any examples of when this has been a helpful approach?
    b. Can you give any examples of when this has been difficult to do?
2. Can you think about a recent course you have taught? How did you manage the first few sessions? What do you think about in terms of the group as a whole?
3. And during the middle of the course – what happened then? What did you do?
4. What was it like towards the end of the course?
5. In terms of modelling a 'being' mode, rather than a 'doing' mode, how do you manage group processes?
6. How does your experience and knowledge of running Mindfulness groups fit with your prior knowledge of managing groups?

7. Drawing on your experience, can you tell me a bit about how important you feel group processes are to participants' learning? Why?
8. Has your attitude to the role of group processes changed over time? How and why?

c. Trainers (NB: Also ask questions from 4a and 4b)

I am interested in hearing about your experiences of training Mindfulness teachers to manage group processes.

1. In your experience, how important do teachers in training feel attending to group processes is?
2. In your experience, how important do you feel attending to group processes is? Why? Please use 'live' examples if possible.
3. Has your attitude to the role of group processes changed over time? How and why?
4. Drawing on your experience, can you tell me a bit about how important you feel thinking about group processes is to teachers' learning? Why?
5. Teacher training is delivered in a group format. When teaching mindfulness teachers, do you model managing the group? How and why? Please use 'live' examples if possible.

Appendix 8: Ethical approval letter

This has been removed from the electronic copy.

Appendix 9: Summary of findings for participants and Salomons ethics panel

Dear study participants,

Between April 2011 and February 2012, you were kind enough to allow me to interview you as part of my research into the role of the group in mindfulness-based interventions (MBIs). I thoroughly enjoyed the discussions we had and appreciate how openly you spoke about your experiences and views. As promised, I am writing to let you know the outcome of the study. I aim to publish the full report in due course. Meanwhile, here is a brief summary of the results.

Study title: A grounded-theory of the role of the group in MBIs

Rationale for the study: Mindfulness-based interventions (MBIs) such as Mindfulness-based Stress Reduction and Mindfulness-based Cognitive Therapy utilise a group format. Experts in the field of mindfulness endorse the group as beneficial to participants and professional practice literature promotes the need for mindfulness teachers to develop competence in group skills. However, the role of the group in MBIs has been largely overlooked in research to date. Furthermore, there is no theory currently available to help understand how the group format might impact upon the experience of learning mindfulness in MBIs. Therefore, this study aimed to develop a theory of the role of the group in MBIs to support teacher training and the optimal delivery of MBIs.

The study's procedure: The theory was developed from semi-structured interviews conducted with six recent mindfulness students, two mindfulness teachers and four teacher-trainers. The twelve participants were interviewed about their experiences and views related to the MBI group format. Interviews were then transcribed and analysed. Analysis involved line-by-line coding of the data and constant comparison between emerging themes. Later interviews explored themes from earlier interviews in greater depth.

Overview of results: The study found most people to have experienced the group format as positive and supportive. The theory that developed presents a number of 'group stages', which describe how experiences of being in an MBI group change over the eight-week course. It also describes the ways the teacher manages the group and uses their own mindfulness skills to do this. Finally, the specific ways in which learning mindfulness as part of a group appears to be helpful are described. A minority of participants described negative experiences of the group format. It appeared that many of the group stages and some group-based skills of the teacher were lacking in their MBI experience.

Potential impact of the study
The findings provide, for the first time, a detailed description of how the MBI group experience unfolds. It also supports the view that the group format is generally beneficial. I also looked to existing theory about group-based interventions and have differentiated between group experiences which

appear to be unique to MBIs rather than generic group experiences. I hope the study will be useful to mindfulness teachers and trainers in providing a better understanding of how the group can support MBI participants to develop mindfulness.

Please do not hesitate to contact me if you would like any further information about the study. I am happy to send you a copy of the full report once the assessment process is complete and the report can be finalised.

My thanks again for your participation.

Yours sincerely,

Dulcie Cormack
Trainee Clinical Psychologist
Salomons at Canterbury Christ Church University

Cc: Salomons Research Ethics Panel

Appendix 10: Research diary extracts

Date	Diary Entry
14th November 2009	First teaching session on research on Friday. Reminded me I need to start thinking about my IRP! For my Salomons interview I did a presentation of doing a study exploring the efficacy of mindfulness for dementia caregivers. This was a bit overly ambitious (mixed methods and RCT) in design. Need to remind myself I'm not doing a PhD and scale things down! However, there was an aspect of the study which I would really like to do and could be more manageable. Thinking of looking into how mindfulness training for family carers of people with dementia impacts upon the quality of the relationship between the caregiver and the person with dementia. My thinking is that: • Mindfulness-based approaches could be really helpful for people who care for someone with dementia – increasing capacity to be in the moment with that person, rather than making demands of them to remember the recent past or make plans for the future • I am really interested in how the capacity to be mindful might impact on relationships – being together in the moment However, I can foresee that it would be difficult to capture the person with dementia's current experience of their relationship – my previous research post involved interviewing people with dementia and people often relied on their historic view on something (e.g. quality of life) as it was difficult to draw on recent experiences and make a new appraisal. Anyway, further thinking still needed.
21st December 2009	I am still thinking of developing my idea above and have a better idea now of who might be interested in providing internal and external supervision – have consequently contacted Fergal Jones. I'm going to meet with him and other trainees interested in doing mindfulness IRPS. Need to talk through the feasibility of the idea – I would need access to clinical populations, and a teacher running a suitable course, so could be logistically tricky. Will do some reading over Xmas on mindfulness and relationships, and revisit some stuff from my last job on interviewing people with dementia.
16th January 2010	Research Fair at Salomons last week. I am still holding the mindfulness and dementia idea in mind, but also really interested in the 'Ladder to the Moon' (LTTM) proposal presented at the fair. It is an intervention delivered by a theatre group in dementia care homes; through involving staff and residents with dementia in drama productions, the LTTM approach helps staff to see their residents in new lights, find out more about them, and feel more connected to them. It was very inspiring. I am going to set up a meeting with Paul Camic and speak more with the LTTM director. Main concerns though at this stage are that I am not clear how likely it is that a project like this would go ahead – sounds like there's a lot of co-ordinating to do, waiting for LTTM to secure funding etc. Can keep my other idea on the back burner.
5th February 2010	Meeting yesterday with Fergal about mindfulness study along with other trainees interested in mindfulness stuff. Would be great to link in with each other further down the line – sharing literature etc. But bit concerned about logistics of my idea – might be pretty hard to recruit, and to find a teacher who could run the group. Don't really want to have to set up the intervention specially, then research it, but there don't seem to be any mindfulness for dementia carer groups specifically I could tap into. Have got a contact of someone in Brighton who runs

	more generic mindfulness for carers though, so will get in touch with him and see how feasible it might be to research one of his groups (and whether many participants are caring for someone with dementia.
4th March 2010	Had a meeting with Paul Camic about the LTTM project. Whilst it is still a really inspiring project and I would love to hold out and go for it, I am starting to think that it doesn't sound 1. definite enough (might fall through) 2. Like LTTM might have requirements that don't really fit with my particular interests 3. Like negotiating with other trainees interested in the project might get a bit complicated – slicing up the project between us could be hard. However, we did all get excited about doing a special addition journal publication with all of our articles, and talked about how we could support each other in literature searching etc., so it could also be great. Have also had some good meetings with Fergal – I've been thinking about moving in a slightly different direction with mindfulness research. I've been doing some reading on group dynamics and starting thinking about the group dynamics in mindfulness groups. There doesn't seem to be much written about it, but wondering about how this might impact on the experience for people? So still juggling a few ideas/options.
9th March 2010	Had a meeting with a third year trainee who has done a Delphi study on mindfulness. Really like the sound of the methodology – would enable me to get an 'expert' view of the group in mindfulness. Current thinking is to do a focus group with teachers, to get their views on: • managing the group, • what 'dynamics' go on • how competent teachers feel in group skills • how relevant they think group dynamics are (do teachers see mindfulness as an individual experience and the group as irrelevant?) Then could develop findings into a questionnaire which I could send out to larger sample of teachers. Bit concerned about the time though, and whether this would really enable me to explore 'the group' sufficiently.
11th March 2010	I've explored some of these ideas with Michael Maltby – approached him as a possible supervisor as he is interested in mindfulness and a group analyst. However, he suggested Fergal could stay on as second supervisor if we go with this idea and a Delphi study, as Fergal is more familiar with this methodology. Also talked about a qualitative study, which would suit the exploration needed in the area of group processes in mindfulness. I feel pretty sure this is the way to go. Have had a few more meetings about LTTM but it seems to be getting more complicated by the minute. I feel I could be more autonomous with the mindfulness + groups idea, and also feel I could work well with Michael and Fergal's' supervision.
12th March 2010	Final decision made. Have let Paul and LTTM know I won't be involved with this project, and have confirmed that Michael and Fergal will be first and second supervisors on the mindfulness + groups study. Need to spend some time reading about different qualitative methodologies now and thinking more about what it is I want to get at through the project. I think my main area of interest, and preliminary literature searches aren't showing any existing studies looking at this, is how the group

	might help people in the process of learning mindfulness and what teachers can do to help with this. This would lend itself better to a study that recruits people who have been on courses as well as teachers (and trainers too – more experience? Could offer perspective on how 'group skills' are approached on training courses?). Library time.
6th May 2010	Had a meeting with Michael today. Was really useful to make some firmer decisions about research aims and methodology. Have decided to go with a qualitative study exploring the role of the group in mindfulness courses – there's nothing on this so qualitative seems most appropriate for first wave of research – focus on participants' experiences of the group and how teachers go about managing group. We were thinking about the different professional backgrounds of teachers – do people with a CBT background, for example, think very differently about the group to people who are Buddhist teachers too? I took along a draft timeline for the project – when to start recruitment etc. Priority now is to start reading about different qualitative methodologies to help inform design decisions. Feel good about this, as I really enjoy qualitative research.

Appendix 11: Example transcript and initial coding

This has been removed from the electronic copy.

Appendix 12: Early category development

Higher-order category	**Category**	**Sub-categories**
Skills of teacher	Building culture of group	Not therapy
		No chit chat
	Safety/Vulnerability	Unsure of rules
		Worries about being over-exposed
(role of teacher)		Teacher providing reassurance
	Individual v. group needs	Person who talks too much
		Person who doesn't talk
		Pacing not right for everyone
		Individual personalities emerging
(role of teacher)	Embodiment	Teachers' calmness/style
		Teachers' awareness of own vulnerability
Describing MBI group processes	Challenges	Stormy week 5
		Frustration
		Difference between expectation and experience
Describing MBI group processes	Togetherness	Warmth of group
Why group processes matter		Sad to leave group
		Going to miss each other
Why group processes matters	Benefits	Can focus more in meditation – go 'deeper'
		Connection with others – not alone
		Normalising
Safety	Group safety	Enables deeper exploration/risk taking
		Less safety=chance to explore difficulties posed by group
		Balancing safety and vulnerability for most fruitful learning experience

Appendix 13: Example memos to show category development

Emerging category:
Pre-course concerns

Memo

Participant (#2) remembers feeling nervous before the course and at first sessions. Is saying that nervousness wasn't about meeting new people (as might be the case at a social event) but about the unknown nature of the MBI-group interactions. Links this with risk of 'exposure'. What is the exposure she is worried about? This could be about being emotionally exposed, or 'put on the spot' to say things, or to be able to show you understand what mindfulness is/means?

Possible links with other categories

Linked with idea of exposure -'Safety' category?

Emerging category:
Safety/lack of safety

Memo

Lots of participants seem to raise the idea of feeling unsafe. Language used in describing what this means is the idea of feeling 'vulnerable', which gets linked with being 'exposed'. Exposure seems to be a fear at early points in the MBI. Later on in course, ideas about allowing yourself to feel vulnerable within the group (and in personal mindfulness practice) seems to be linked with how learning happens – that you need to feel safe enough in the group to allow yourself to experience internal vulnerabilities, and it is through allowing this that the learning happens. So a link being made between safety, and how safe the group feels (due to teacher's skill?) with feeling 'safe enough' to learn through exploring one's vulnerabilities. Some complex ideas here about 'safety' – feeling 'unsafe' is the group portrayed as unhelpful, but feeling 'vulnerable' in the group can sometimes be helpful.

Some teachers talk about their own vulnerabilities - #4 talks about how he wouldn't have allowed one person to join his group because she was perhaps too vulnerable as currently experiencing bereavement. But then acknowledges she got "load out of the course". He noted that other group members were able to support her, and felt this was a credit to them, but also to him for keeping the group 'safe' ("contained"). Makes me wonder whether 'screening' is about the teacher's capacity for holding safety (link with embodiment?)- i.e. the limits of the teacher's capacity to remain mindful and containing in the face of the most distressed participant's struggles, is how 'screening' is decided? Not sure about this. Will explore it more.

This also raises questions about whether clinicians see MBIs as 'preventative' interventions or interventions people can utilize whilst currently in distress.

Possible links with other categories

Links with stages of the group experiences? i.e. that feeling unsafe/vulnerable at the beginning is different to feeling

vulnerable later?

Links with tasks/skill of the teacher – their job to manage these parameters of safety

Emerging category:
Role of the teacher

Memo

Ideas keep coming up about how the teacher needs to be a confident leader, someone who portrays themselves as a leader. Students who have experienced their teacher as confident seemed to have had a better group experience. Participant #1 described his teacher as anxious, and it seemed as if he wasn't very confident in her – and he didn't have a good experience of the group. I don't want to overstate this, but it seems important. The idea of a confident leader fits with all the journeying metaphors – needing a guide or someone who "knows the territory" (#4, teacher). Implies the group will get lost if their leader isn't confident to lead, and finds a way to convey their confidence. Unclear how this fits with not being in a 'doing' mode, though. Perhaps teachers have to show confidence that they cannot 'do' in relation to things which happen in group, but they can remain mindful and 'in charge' and not get 'thrown off course'?

Possible links with other categories

Links with metaphors around journeys and boats

Emerging category:
Describing group process/Stages of group experience

Memo

As interviews progress, and I ask about early sessions, middle sessions, later sessions, endings, it is becoming clear that these are distinct. Time and again the same descriptions and experiences are being described to me. The 'journeying' metaphor gets used a lot too in discussion of the different stages. I have begun with calling this 'describing group processes', but I am not sure if this is a 'process' so much as their experience. Perhaps this is how I might be able to separate out the 'why group process matters' theme and the 'describing the group process'. The first is where people describe how it felt at different points during the course to be with a group [phenomenological experience?], the latter is when they give a function to their experience – what did it mean that in week three they felt more able to share their experiences of meditating with the group? What effect did hearing from other people have.

Possible links with other categories

Why group processes matter

Emerging category:
To talk or not to talk

Memo

Lots of discussion about people who talk a lot, or don't talk. I am sure there are people in the middle too! One teacher/trainer (#3) suggests that 'the talkers' talk because they can't "bear the silence" and "think they're doing everyone a favour". #2 defines herself as a 'talker' rather than 'non-talker' and confirms this – feels the silence is uncomfortable and is happy to fill it if no-one else talks. Teachers/trainers seem to be agreeing that if people are talking but not in a way that is helpful to others (i.e. usually not about their present moment experience) then they will stop them, interrupt, try to reframe what they are saying to make it about their current experience/experience of practicing mindfulness. Students noticed that this happens and value it. No-one said this was rude, or that 'talkers' should be allowed to talk as much as they like. In terms of 'not talking', student and teachers seem to be saying that not talking can be hard – as teachers they don't know whether the person is learning or struggling, they have nothing to go on. But they seem to use time between sessions (e.g. quick catch-up one-to-one at end) to explore this. Or look more for non-verbal clues to how someone is finding the course (e.g. #4). But consensus that not talking is OK – accepted. Perhaps this links with how teacher's style/skill is to be mindful in their response to the group? Accepting of whether people talk or don't talk, whilst helping any talk that is offered to maintain attention on present moment experience.

Possible links with other categories

Links with skills of teacher? Managing communication, managing indiv v. group? Maybe links with 'embodiment'.

Emerging category:
Embodiment

Memo

First idea for this came from trainer (#3) explaining how when she is in an 'enquiry' process with one member of a group, she is aware of becoming very focused in on this person and this discussion. She notices this makes her feel "energized", so is remaining aware of her own emotional and physical response in discussion. Then she says she has to deliberately broaden her attention out to the rest of the group – not forget about them. This made me think about the processes in mindfulness practice where you start by focusing on the breath, then the body, then sounds, then thoughts, then lead to being aware of all these things – so narrowing and broadening attention. The way teachers describe attending to the group is similar – focus on one person in group, focus on self, focus on whole group, focus on all these things at once. It's like a parallel process. I wonder if this is an advanced form of mindfulness – not only being mindful of the multiple levels of your own internal experience, but being aware of the multi-layered experience within the group.

Capacity to remain embodied also comes up when teachers talk about managing difficult moments in sessions For example, managing their own nervousness at early sessions, or managing irritation with

people who are challenging.

Possible links with other categories

Group skills as 'advanced skills'?

Emerging category:

Building a culture

Memo

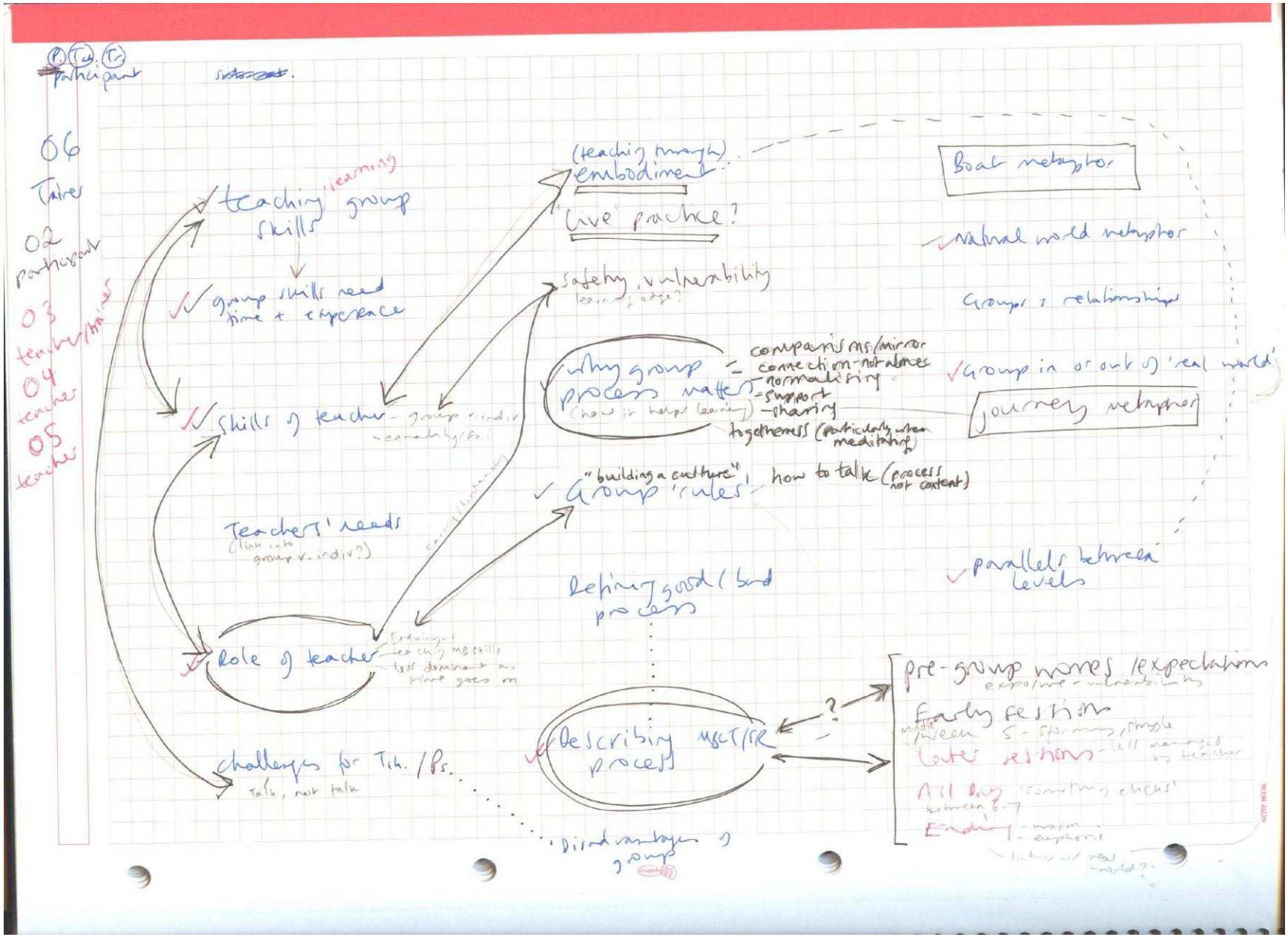
This started off as being about defining 'group rules' – as #1 and #2 talked about their uncertainty at the beginning about what was expected of them. But I am starting to feel that 'rules' is too restrictive a terms - #4 (teacher) talks about 'building a culture', in how he has to 'rein in' group members who don't communicate in the way he is trying to train them in – he gives an example of a man who was very 'theoretical' in how he talked – the man didn't seem to pick up on how he should have been talking so #4 had to speak to him one-to-one and explain more explicitly (#4 disclosed a disability which might account for some of the difficulty this man had in picking up on the group norms) how to talk – i.e. what's happening for you right now, describing on experiential level.

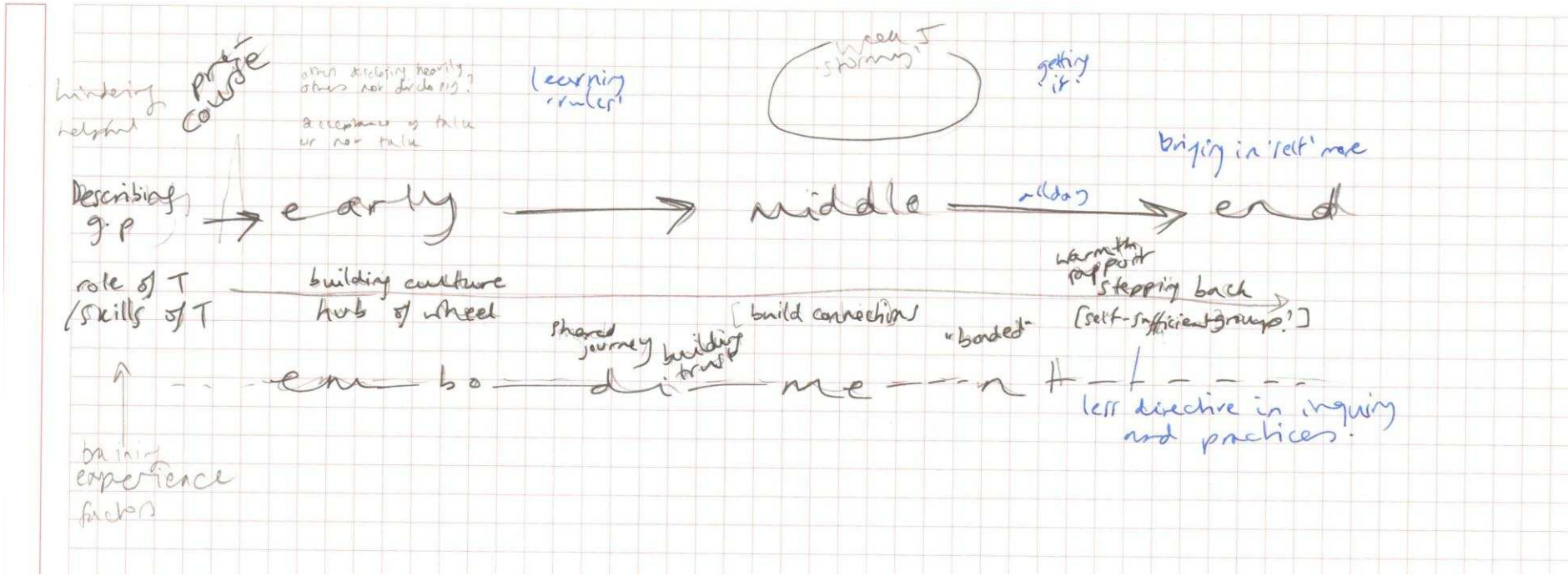
#1, who had negative experience of groups, says how people in his group have to monitor themselves in terms of whether they were talking too much or saying the 'right' things. Seems they didn't have much guidance on what was expected of them or how to talk, or what the 'culture' of their group was.

Possible links with other categories

#2 seems to be linking nervousness with idea of exposure so links with 'Safety' category?

Appendix 14: Category development diagrams




hindering
helpful
pre course
learning curve
getting it
bringing in 'self' more
Describing g.p
early
middle
end
role of T
/skills of T
building culture
hub of wheel
stepping back
[self-sufficient groups?]
shared journey
building trust
[build connections
"bonded"
embodiment
less directive in inquiry and practices
training experience factors

Appendix 15: Final categories and sub-categories with illustrative quotes

This has been removed from the electronic copy.

Appendix 16: Table comparing new grounded theory with existing group theory

Higher-order category	Category	Sub-category	Parallels with existing theory	Notes
Stages of group experience	*Pre-course stage*	*Pre-course concerns*	*Group imago (Clarkson, 1991)*	*Though no evidence from my data of family or unconscious influences, more concrete (e.g. previous yoga class)*
		Pre-course hopes		
	Orientation stage	*Nervousness and uncertainty*	*'defining and structuring procedures' (Johnson & Johnson, 2006)*	
		Impact of and on others		
		Curiosity		
	Spectrum stage	*Getting it*	*'conforming to procedures and getting acquainted' (Johnson & Johnson, 2006)*	
		Struggling		*'Storming' linked to MBI course content, and internal struggle, rather than inter-relational struggle.*
		Developing cohesion	*'Recognising mutuality and building trust' (Johnson & Johnson, 2006).*	
	Consolidation stage	*Consolidation of skills*	*'Committing to and taking ownership for the goals, procedures and other members' / 'Functioning maturely and productively' (Johnson & Johnson, 2006)*	
		Consolidation of group connection	*'Functioning maturely and productively' (Johnson & Johnson, 2006)*	*Maturity developed largely through non-verbal, silent day of meditation*
	Ending stage	*Warmth*	*'Terminating' (Johnson & Johnson, 2006)*	
		Sadness		
		Concerns about continuing practice alone		
Group-based tasks of the teacher	*Safety*	*Setting boundaries*	*Johnson & Johnson (2006) 'defining and structuring procedures" 'Creation and maintenance of group (Yalom, 2005).*	
		Fear of exposure	*Johnson & Johnson (2006) 'defining and structuring procedures'*	

		To talk or not to talk	*Johnson & Johnson (2006) 'defining and structuring procedures', 'Culture building' (Yalom, 2005)*	*Permission to not talk makes MBI group experience different/unique to therapy group experiences as 'issues' not worked through in verbal interaction.*
		A leader who knows the territory	*Johnson & Johnson (2006) 'defining and structuring procedures',*	
	Building the culture	*Facilitating connections*	*Dynamic administration (Barnes* et al*, 1999)*	
		Managing communication	*Cormack (2009)– mindful-talk*	*Though talking isn't necessary to developing group connections or learning skills*
	Keeping on an even keel	*Equality*	*'Recognising mutuality and building trust' (Johnson & Johnson, 2006)*	
		Group v. individual		
	Letting others have a turn at the wheel	*Freer communication*	*'Committing to and taking ownership for the goals, procedures and other members'/ 'Functioning maturely and productively' (Johnson & Johnson, 2006)*	
		Less guidance in meditations		
	Embodiment	*Non-judgemental acceptance*	*Building culture (Yalom, 2005) as 'model-setting participant').*	*Unique as modelling is mindfulness-specific*
		Multi-layered attention		
		Non-reactive observation		
The impact of the MBI group	*The benefits of being on a shared journey*	*Sharing and magnifying positives*	*Cohesiveness (Yalom, 2005)*	
		Learning from each other	*Imitative behaviour (Yalom, 2005)*	
		Normalising	*Universality (Yalom, 2005)*	*Extra-depth to* normalising *in MBI context*
		Comparisons		
		Not alone		
		universality of		

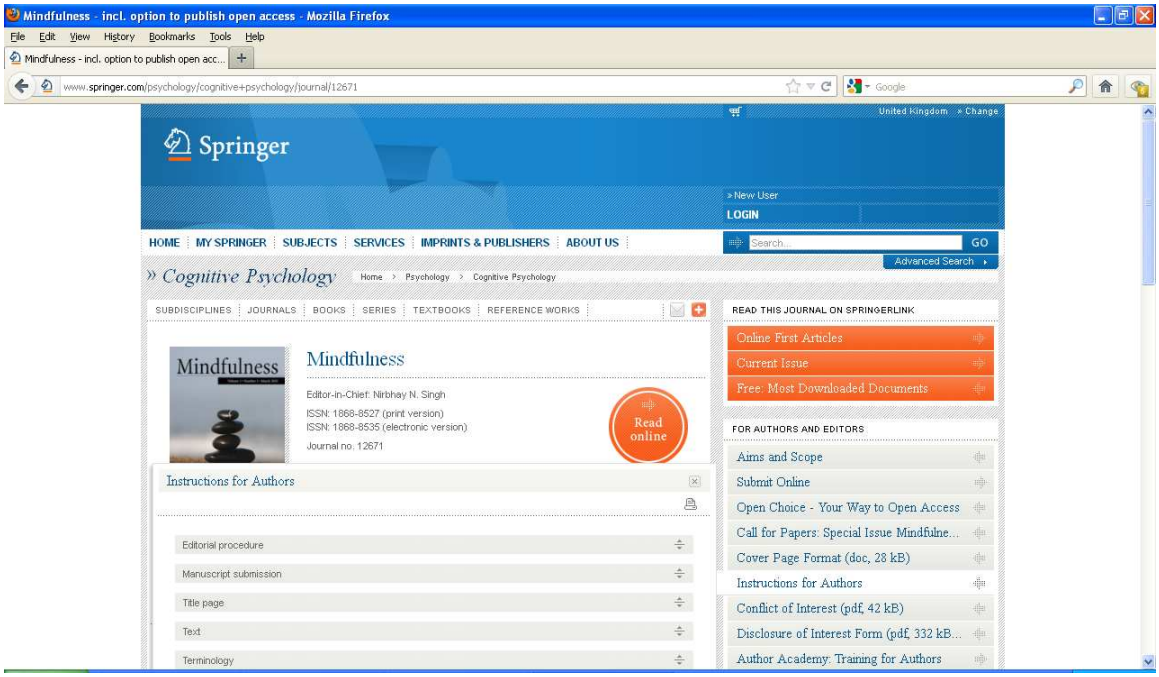
	human suffering		
The community of group meditation	*Connectedness*	*Buddhist* sangha	*Unique in western healthcare*
	Motivation		
	Energy of the group		
	Hard to articulate		
In vivo *practice*	*Group experience provides material*	*'process focus: the power source of the group' (Yalom, 2005)*	*But different in that group members respond to processes with comments outwardly*
	Own judgements of others provide material		

Appendix 17: Instructions for authors for *Mindfulness*

Section B has been formatted according the instructions for authors provided by *Mindfulness:*

http://www.springer.com/psychology/cognitive+psychology/journal/12671

Where guidance has not been provided by the journal and Springer, APA (American Psychological Association) referencing style has been employed.



Text Formatting

Manuscripts should be submitted in Word.

- Use a normal, plain font for text.
- Use italics for emphasis.
- Use the automatic page numbering function to number the pages.
- Do not use field functions.
- Use tab stops or other commands for indents, not the space bar.
- Use the table function, not spreadsheets, to make tables.
- Use the equation editor or MathType for equations.
- Save your file in docx format (Word 2007 or higher) or doc format (older Word versions).
- Word template (zip, 154 kB)

Manuscripts with mathematical content can also be submitted in LaTeX.

- LaTeX macro package (zip, 182 kB)

Headings

Please use no more than three levels of displayed headings.

Abbreviations

Abbreviations should be defined at first mention and used consistently thereafter.

Footnotes

Footnotes can be used to give additional information, which may include the citation of a reference included in the reference list. They should not consist solely of a reference citation, and

they should never include the bibliographic details of a reference. They should also not contain any figures or tables.
Footnotes to the text are numbered consecutively; those to tables should be indicated by superscript lower-case letters (or asterisks for significance values and other statistical data). Footnotes to the title or the authors of the article are not given reference symbols.
Always use footnotes instead of endnotes.

Acknowledgments

Acknowledgments of people, grants, funds, etc. should be placed in a separate section before the reference list. The names of funding organizations should be written in full.

Abstract

Please provide an abstract of 150 to 250 words. The abstract should not contain any undefined abbreviations or unspecified references.

Keywords

Please provide 4 to 6 keywords which can be used for indexing purposes.

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 and Smith 1998; Medvec et al. 1999).

Reference list

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. Do not use footnotes or endnotes as a substitute for a reference list.
Reference list entries should be alphabetized by the last names of the first author of each work.

- Journal article
  Harris, M., Karper, E., Stacks, G., Hoffman, D., DeNiro, R., Cruz, P., et al. (2001). Writing labs and the Hollywood connection. Journal of Film Writing, 44(3), 213–245.
- Article by DOI
  Slifka, M. K., & Whitton, J. L. (2000) Clinical implications of dysregulated cytokine production. Journal of Molecular Medicine, doi:10.1007/s001090000086
- Book
  Calfee, R. C., & Valencia, R. R. (1991). APA guide to preparing manuscripts for journal publication. Washington, DC: American Psychological Association.
- Book chapter
  O'Neil, J. M., & Egan, J. (1992). Men's and women's gender role journeys: Metaphor for healing, transition, and transformation. In B. R. Wainrib (Ed.), Gender issues across the life cycle (pp. 107–123). New York: Springer.
- Online document
  Abou-Allaban, Y., Dell, M. L., Greenberg, W., Lomax, J., Peteet, J., Torres, M., & Cowell, V. (2006). Religious/spiritual commitments and psychiatric practice. Resource document. American Psychiatric Association. http://www.psych.org/edu/other_res/lib_archives/archives/200604.pdf. Accessed 25 June 2007.

Journal names and book titles should be italicized.
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- EndNote style (zip, 3 kB)