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MINDFULNESS-BASED COGNITIVE THERAPY FOR PARTNERSHIPS

Section A: The interaction of the intimate-partnership and depressive relapse:

A literature review

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Section B: The process of engaging in mindfulness-based cognitive therapy as a partnership:

A grounded theory study

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SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

Declaration

Acknowledgements

Firstly, I would like to thank, the service-users and their partners who shared their experience of mindfulness-based cognitive therapy with me.

I would like to thank my supervisors, Dr Fergal Jones, Dr Sue Holttum, and Dr Kim Griffiths, for their guidance, support and expertise throughout this project. I would particularly like to thank Sue for sharing her knowledge of Grounded Theory with me and for her guidance during the process of analysis. I would like to thank Kim for welcoming me into a mindfulness-based cognitive therapy group, which was a valuable learning experience for me personally and also, facilitated my understanding of the experience that partnerships had engaged with. I would like to thank Fergal for his thorough feedback and guidance with writing-up this research project.

Finally, I would like to thank my partner, family, friends, and fellow trainees who have given me their support in a number of ways. I would particularly like to thank Charley Nineham for reading several drafts.

Summary of the MRP Portfolio

Section A: Summarises theory and research relevant to understanding the interaction between intimate-partnership and depressive relapse. Interpersonal theories of depression are introduced. Following this, extant empirical studies examining the effects of interpersonal processes on depressive relapse are critically evaluated. As these studies do not consider how depressive relapse might affect the intimate-partner over time, a separate body of literature examining the impact of depression on intimate-partners is reviewed. Limitations and gaps in the existing evidence-base are discussed, and areas for future research are outlined, such as studies to understand the bidirectional interaction and to explore alternative interventions that enable both partners to cope with relapses.

Section B: Presents a Grounded Theory study of the process of engaging in mindfulness-based cognitive therapy (MBCT), which is a relapse prevention strategy for depression, as an intimate-partnership. Twelve participants took part in a semi-structured interview about their experience of the MBCT course. These data were triangulated with sessional data from an MBCT course and facilitator validation. The proposed theory captured the ‘process of learning new mindfulness skills together’. While intimate-partnerships who engaged in an MBCT course seemed to learn similar mindfulness skills as in individual MBCT courses, learning as a partnership seemed to facilitate home practice, attendance and a sense of mutual support, which led to unique outcomes for the partnership and their sense of responsibility for each others’ wellbeing. Limitations and implications are discussed.

Section C: Provides a critical appraisal of the process of conducting this research study, including the researcher’s learning experience, implications for clinical practice and future research.

TABLE OF CONTENTS

Section A	Abstract	2
	Introduction	3
	Overview	3
	Depression	3
	Intimate-partnership	4
	 Theoretical context	 5
	Systemic theory	5
	Interactional theory	6
	Marital Discord Model	6
	Stress generation hypothesis	7
	Diathesis-stress attribution model of EE	8
	Summary and critique	9
	 Literature Review	 10
	Literature Search	10
	Prospective research studies	11
	Treatment studies	16
	Impact of depression on intimate-partners	21
	Summary of evidence for role of relationship in depressive relapse	23
	Future Directions	25
	References	26
 Section B	 Abstract	 2
	Introduction	3
	Rationale	6
	Method	8
	Participants	8
	Ethics approval	8
	Recruitment	8
	Data collection and analysis	10

	6
Quality Assurance Methods	11
Results	13
Overview of the model	13
Core category: Learning new mindfulness skills together	13
Category A: Context for engagement with learning mindfulness	15
Category B: Learning new mindfulness skills	17
Category C: Partnership influence of engagement with MBCT course	19
Category D: Influence of MBCT on the partnership	22
Category E: Group process	24
Category F: Outside influences on perceived change	25
Discussion	27
Partnership and practice	27
Valuing the group experience	29
Mindfulness as facilitating reconnection	30
Increased empathy as protecting from depressive relapse	30
Decentering	31
Limitations and future research	31
Implications for clinical practice	32
Conclusion	33
References	34
Section C	
1. What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?	2
2. If you were able to do this project again, what would you do differently and why?	4
3. As a consequence of doing this study, would you do anything differently in regard to making clinical recommendations or changing clinical practice, and why?	8
4. 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 it?	9

List of Tables

Section B	Table 1: Participants' characteristics	9
	Table 2: Learning new mindfulness skills together	15

List of Figures

Section A	Figure 1: Marital Discord Model of Depression	7
Section B	Figure 1: Learning new mindfulness skills together – a model of the process of engaging in MBCT as a partnership.	14
Section C	Figure 1: Original model	5
	Figure 2: Chosen model	6
	Figure 3: Merged model	7

Section D: Appendix of Supporting Material

- Appendix 1:** Section A Search Methodology
- Appendix 2:** Studies on intimate-partnership and depressive relapse
- Appendix 3:** Participants' demographic information
- Appendix 4:** Salomons Research Ethics Committee Approval
- Appendix 5:** Research Ethics Committee Approval
- Appendix 6:** R&D approval
- Appendix 7:** Participant Information Sheet
- Appendix 8:** Consent Form
- Appendix 9:** Interview Schedule
- Appendix 10:** Later Interview Schedule
- Appendix 11:** Substantial amendment to ethics
- Appendix 12:** Participant Information Sheet B
- Appendix 13:** Consent Form B
- Appendix 14:** Annual progress report to REC
- Appendix 15:** REC Annual approval
- Appendix 16:** Abridged research diary
- Appendix 17:** Example interview transcript
- Appendix 18:** Audit trail: Quotes, Initial codes, categories, subcategories
- Appendix 19:** Theoretical memos, diagramming, & initial model development
- Appendix 20:** Tables of initial NVivo codes
- Appendix 21:** Journal submission guidelines
- Appendix 22:** Summary of research for participants, research ethics committee, and R&D

MAJOR RESEARCH PROJECT

EMMA SMITH BSc (Hons) MSc

Section A: Literature Review

The interaction of the intimate-partnership and depressive relapse: A literature review

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Section A: PARTNERSHIPS AND DEPRESSIVE RELAPSE

Abstract

Research and clinical experience suggest that depression is often a relapsing problem that impacts on the sufferer's intimate-partner. This relationship appears to be bidirectional, whereby an intimate-partner's response may also influence the course of depression. Given that relapse is common, there is a question as to how the intimate-partnership and depressive relapse interact.

The current review draws on interpersonal theories of depression and relevant literature to explore this question. To assess the relationship of intimate-partnership variables with relapse, longitudinal studies which monitor relapse are considered, these fall into two types, prospective and treatment studies. Inclusion criteria were relaxed to identify studies focusing on the impact of depression on the intimate-partner.

Prospective studies suggest possible factors that may influence relapse, including expressed emotion (EE), perceived criticism (PC), relationship quality and intimate-partner support.

Treatment studies suggest that interventions for partnerships can reduce relapse, although the therapeutic mechanism is unclear. Intimate-partner studies suggest that living with a depressed person is linked to increased stress and depressive symptoms explained by the perceived burden of caregiving, among other variables.

Systemic couples theory provides a helpful framework for understanding these interacting processes within complex feedback systems. While its flexibility is helpful clinically, it is somewhat disprovable. Interactional theory appears more scientific in presenting testable theories, however, in doing this it may oversimplify complex processes. Further research is needed to understand the bidirectional interactions and to explore alternative interventions that enable both partners to cope with relapses.

Section A: PARTNERSHIPS AND DEPRESSIVE RELAPSE

Introduction

Overview

Depression is increasingly being understood as a recurring problem and researchers and clinicians are increasingly interested in understanding and preventing relapse (National Institute for Health and Clinical Excellence [NICE], 2009). Evidence suggests a bidirectional relationship between the intimate-partnership and depression, whereby intimate-partners are both affected by depression (Benazon & Coyne, 2000) and involved in the maintenance of depression and relapse (Joiner, Coyne & Blalock, 1999). Given that relapse is common, this raises the question of how the intimate-partnership and depressive relapse interact.

Following definitions of terms, this review focuses on how the relationship between the intimate-partner and depressive relapse has been conceptualised. The contribution of available research evidence in addressing this question is then evaluated. Implications for future research are discussed.

Depression

Major Depressive Disorder (MDD) is diagnosed using the Diagnostic and Statistical Manual of Mental Disorders ([DSM-IV-TR], American Psychiatric Association [APA], 2000) based on the presence of at least five of nine identified symptoms during a two-week period, not explained by bereavement, substance-use or medical conditions. One of the symptoms must be depressed mood for most of the day, nearly every day. Other symptoms include weight change, fatigue, feelings of worthlessness or inappropriate guilt, diminished ability to think, and suicidal thoughts (APA, 2000).

NICE (2009) outline the shift from thinking about depression as a time-limited disorder to acknowledging that incomplete remission and relapses are common. In

Section A: PARTNERSHIPS AND DEPRESSIVE RELAPSE

approximately sixty percent of cases, people have a relapse (Judd, 1997). This risk increases with each further relapse (Kupfer, 1991). In a systematic review of outcomes in depression, Hughes and Cohen (2009) found relapse rates of forty to eighty-five percent, with no significant differences pertaining to long-term anti-depressant medication. With regards to incomplete remission, a longitudinal study (n= 400) found that, on average, participants experienced some symptoms of depression in fifty-nine percent of weeks during 12-year follow-up (Judd et al., 1998). This is concerning considering that incomplete remission is potentially a risk factor for relapse (Paykel et al., 1995).

Intimate-partnership

As depression is often a recurring problem, it seems important to understand the factors which can influence recovery and relapse. Given the drive for greater carer and family involvement in service-user care (Department of Health [DoH], 2002), the impact of caring for a depressed partner (Benazon & Coyne, 2000; NICE, 2009), and the potential protective influence of intimate-partner relationships (cf. Mead, 2002; Whisman & Schonbrun, 2010), this review focuses on the interaction between the intimate-partnership and depressive relapse. The term intimate-partnership is used throughout this review so as not to exclude partners living as though married.

Section A: PARTNERSHIPS AND DEPRESSIVE RELAPSE

Theoretical context

To provide context to the review, it is important to outline theories of depression that attempt to explain the onset, maintenance and relapse of depression interpersonally. These were identified through key review papers and books (e.g. Joiner & Coyne, 1999). Evidence for the theories is briefly reviewed.

Systemic theory

Jones and Asen (2000) describe the systemic couples therapy approach to depression, based on various systemic family therapy models, including, 'post-Milan', strategic and structural concepts (Leff et al., 2003). The patient's depressive presentation is conceptualised interactionally, with symptoms located within their contexts and relationships. An intimate-partner's reaction to the depressive symptoms may maintain or intensify distress, eliciting a response from the patient, which generates a complex feedback system (Jones & Asen, 2000; Leff et al., 2003).

Jones and Asen provide an example to illustrate a systemic formulation of depression onset. Firstly, something places demands on the individual(s) to adjust, e.g. bereavement. Contextual, interpersonal and individual factors influence how the individual(s) manages these demands, sometimes leading to depressive symptoms. This places demands on the intimate-partner who may respond with acceptance, criticism or other reactions. Labelling and criticising negative behaviours may increase depression and lead to further critical responses from the intimate-partner. Similarly, encouraging a positive outlook may lead the depressed partner to feel misunderstood and alone, increasing depressive symptoms (Jones & Asen, 2000). Complex feedback systems can be helpful in understanding the onset, maintenance, recovery and relapse of depression and the impact on the intimate-partner.

Section A: PARTNERSHIPS AND DEPRESSIVE RELAPSE

Interactional theory

Coyne's interactional theory (1976; 1987) proposes "that depressed persons engage the environment in ways that lose support and elicit depressing feedback" (Joiner et al., 1999, p. 7). There are three key components: Depressed people are thought to engage their environment through excessive reassurance seeking (ERS), for example, seeking feedback about themselves and their relationship to alleviate social anxiety. The interpersonal behaviour associated with depression, including ERS, is thought to lead to rejection by intimate-partners, which increases depression. Depressive symptoms are thought to be contagious, causing stress and potentially depression in the intimate-partner. A number of these predictions are supported by research (Beach, Fincham, & Katz, 1998; Katz, Beach & Joiner, 1999; Starr & Davila, 2008), although mostly in non-clinical samples, and often the study designs are unable to determine cause and effect.

This theory considers the complex and bidirectional links between intimate-partnerships and depression, rather than presenting a formal interpersonal model of depression (Coyne, 1999). Coyne (1999) recommends exploring psychosocial factors promoting resiliency and vulnerability to depression, and developing a richer understanding of the changing characteristics and role of the intimate-partner.

Marital discord model

This model proposes that marital discord can lead to depression via increased relationship stress and reduced partner support as outlined in Figure 1 (Beach, Sandeen, & O'Leary, 1990). A number of studies provide support for this hypothesis (Beach et al., 1998; Hollist, Miller, Falceto, & Fernandes, 2007).

Section A: PARTNERSHIPS AND DEPRESSIVE RELAPSE

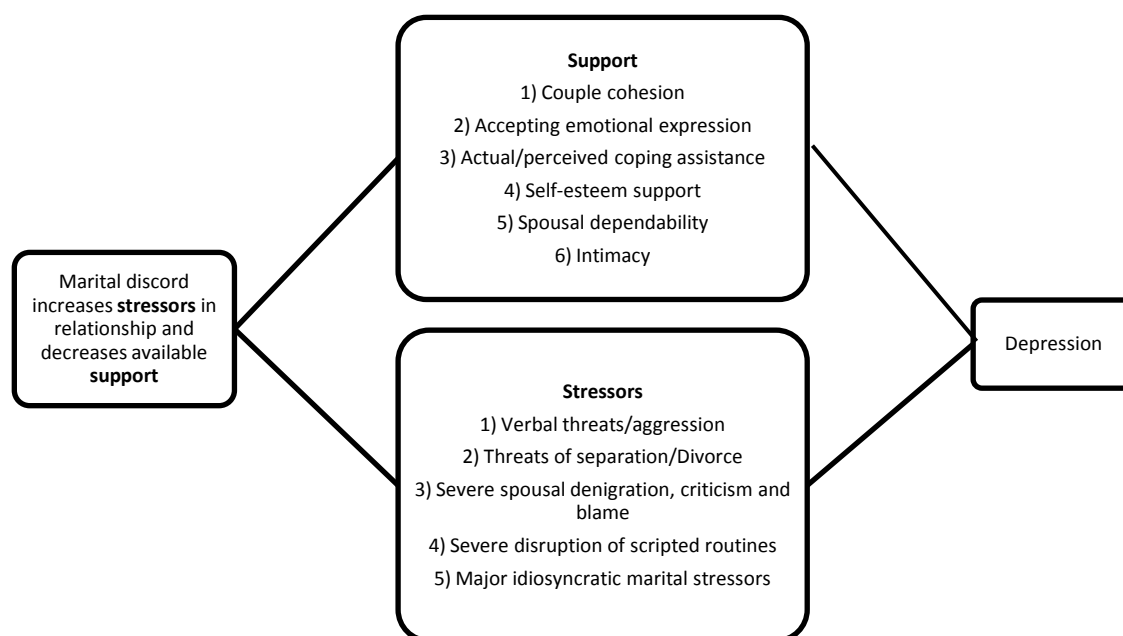


Figure 1. A marital discord model of depression (diagram taken from Beach, Sandeen, & O'Leary, 1990, p.54).

Integration with attachment theory (Anderson, Beach, & Kaslow, 1999) provides a way of explaining why marital discord does not always lead to depression, as it depends on the intimate-partner's attachment styles. However, this model is limited by only explaining depression where marital discord is a problem.

Stress generation hypothesis

Hammen (1991; 2003; 2006) proposes that depressed individuals may unintentionally behave in ways that generate stress, particularly interpersonal stress, triggering depressive onset and recurrence. Some evidence suggests that depressed people engage in more negative marital processes, negative support behaviour, poor role performance and that these behaviours generate interpersonal stress (Beach et al., 1998; Davila, Bradbury, Cochran, & Tochluk, 1997). There is less evidence for stress generation as causal in the onset of

Section A: PARTNERSHIPS AND DEPRESSIVE RELAPSE

depression, but the increased stress in the intimate-partnership is thought to lead to decreased support potentially explaining vulnerability to prolonged depression or future relapses.

Self-verification theory. Self-verification theory (Swann, 1983) can be located within stress generation as it proposes that people are driven to receive feedback matching how they view themselves for increased predictability and control. Giesler and Swann (1999) propose that an increase in negative affect activates negative self-views, causing people to seek negative feedback to match their self-view. If someone has low self-esteem their partner may provide negative feedback, which increases negative affect potentially leading to increased stress and depression (Katz & Beach, 1997). Self-verification theory proposes that remission occurs when the cycle is disrupted through social support or cognitive therapy (Giesler & Swann, 1999). Several studies provide support for this theory (Borelli & Prinstein, 2006; Haefel & Mathew, 2010; Joiner & Metalsky, 1995), although mostly in community samples. It offers hypotheses for understanding how an intimate-partner may contribute to depressive relapse within a cognitive framework e.g. following activation of negative affect.

Diathesis-stress attribution model of EE

The concept of Expressed Emotion (EE) is briefly outlined as it is a well-researched interpersonal variable in relation to relapse of mental health problems. It is potentially relevant to all the theories discussed above, but is located within a diathesis-stress model by leading researchers (Hooley, 1986; Hooley & Gotlib, 2000). EE refers to the emotional tone of family life. An environment of high EE, particularly criticism, hostility and over-involvement is thought to increase probability of relapse in families suffering with depression (Dallos & Draper, 2010). There is longitudinal research into these variables, which is discussed further in the main review.

Section A: PARTNERSHIPS AND DEPRESSIVE RELAPSE

Although EE is often measured in a single caregiver, it is a systemic construct in the sense that it represents the transactional patterns of the family (Miklowitz, 2004). A diathesis-stress conceptualisation of EE posits that certain personality traits or beliefs of the intimate-partner (e.g. internal locus of control) make them vulnerable to reacting actively to the patient's depressive symptoms to create change (Hooley, 2007). It is hypothesised that over time the interaction between an active approach to depression and the patient's failure to improve causes frustration and blaming, which can be captured using EE (Hooley, 2007).

Summary and critique

There is some overlap between these theories, such as an emphasis on the bidirectionality of intimate-partnerships and depression. Bringing this together into a systemic complex feedback system, the theories suggest that a depressed person may elicit negative responses from an intimate-partner, through seeking reassurance, self-verifying feedback and behaving in ways that generate stress. Subsequently, the beliefs of the intimate-partner, the quality of the relationship and environmental factors may influence how they respond. For example, they may experience stress and develop depressive symptoms themselves, which may be experienced as rejecting by the depressed person. Alternatively, they may respond actively in an attempt to improve the situation or encourage positivity, which may contribute to making the depressed person withdraw further. These theories suggest that over time this may lead to high EE interactions as the intimate-partner becomes frustrated that their attempts are not helping, which may be perceived as criticism by the depressed person. After recovery from depression, these interpersonal patterns might be easily triggered when the intimate-partnership faces another stressful situation or when one partner perceives the other as depressed, this might quickly escalate towards relapse.

Some empirical research explores these interactions, this is considered next.

Section A: PARTNERSHIPS AND DEPRESSIVE RELAPSE

Literature Review: Empirical research on the interaction between the intimate-partnership and depressive relapse

Literature Search

The NHS Evidence: Healthcare Databases Advanced Search tool was utilised to systematically search PsychINFO, MEDLINE and British Nursing Index. Evidence-based reviews, Web of Knowledge and Assia were searched directly. Three searches were undertaken to identify the relevant literature (Appendix 1). References and abstracts were read to extract studies pertaining to the bidirectional interaction of the intimate-partnership and depressive relapse (Appendix 2). The following key variables were combined:

- Depression/Depressive
- Relationship/Intimate-partner/Carer/Caregiver/Spouse
- Relapse/Recurrence/Recovery/Long-term outcome/follow-up
- Couple/Systemic/Marital Therapy/Psychoeducation

The following inclusion criteria were applied:

1. Studies with a relational measure OR an interpersonal intervention
2. Studies with a primary diagnosis of depression
3. Longitudinal studies with a measure of relapse, because this review is seeking to understand the interaction between intimate-partnership and relapse.
4. English language

This generated eighteen studies to review in addressing the question: nine prospective and nine treatment studies. This strategy generated no studies that considered the influence of depression on the intimate-partner. Therefore, the longitudinal requirement was relaxed and nine studies were identified pertaining to the impact on the intimate-partner.

Section A: PARTNERSHIPS AND DEPRESSIVE RELAPSE

Prospective research studies

A number of studies explore the role of EE and perceived criticism (PC) in depressive relapse. EE refers to the intimate-partner's expressed emotion and is typically measured using the Camberwell Family Interview or the Five Minute Speech Sample. PC refers to the level of criticism the depressed person feels from their intimate-partner, this is measured through a self-rating scale from 'not at all' to 'very critical indeed'.

Vaughn and Leff (1976) conducted a prospective study of thirty-two depressed inpatients in the UK. Relapse over 9-months post-discharge was related to the intimate-partner's criticism as measured by an abbreviated family interview (Brown & Rutter, 1966) post-admission to hospital. Sixty-seven percent of the 'critical' group relapsed in comparison to twenty-two percent of the 'non-critical' group, suggesting that intimate-partner criticism may influence relapse. The absence of standardised tools to measure relapse meant these results were potentially open to bias.

Hooley (1986) and Hooley and Teasdale (1989) improved on the methodology from the previous study using standardised measures in a UK study of thirty-nine depressed inpatients. EE, PC and relationship quality were measured post-admission. Twenty patients relapsed during follow-up. Hooley (1986) reported that patients with more critical partners had significantly higher relapse rates than less critical partners. In Hooley et al. (1989) patients who did not relapse had significantly higher marital satisfaction as did their partners. PC was the best predictor of relapse, contributing thirty-eight percent, further analysis suggested this was not confounded with illness severity.

The studies suggested that EE, PC and relationship quality were predictive of relapse. The only other significant predictor was previous psychiatric treatment. However, other

Section A: PARTNERSHIPS AND DEPRESSIVE RELAPSE

potentially relevant variables were not tested, such as, whether higher EE was related to greater depressive symptoms or intimate-partner burden, which may interact with relapse.

Kwon et al. (2006) replicated Hooley and Teasdale's (1989) study with twenty-seven outpatients in Korea. During the 11 month follow-up, five patients relapsed. PC was a predictor of relapse. PC was negatively correlated with emotional support from the intimate-partner, suggesting that the depressed person's ratings of PC were consistent with more objective measurement of the emotional support received.

Okasha et al. (1994) tested the role of EE and PC on depressive relapse in thirty-two Egyptian inpatients, twenty-two with unipolar depression. Fifty-six percent relapsed over a nine-month follow-up. PC predicted relapse using a modified PC scale. Family EE also predicted relapse but at the higher cut-off than previous studies of seven critical comments. It was harder to isolate the role of intimate-partner criticism in depressive relapse in this study as they interviewed other family members and included both unipolar and bipolar depression.

Research into EE also generated some inconsistent and null findings. Hinrichsen and Pollack (1997) explored EE in fifty-four depressed inpatients aged sixty or above and their intimate-partner (48%) or adult child (52%) in the USA. Participants with high EE adult children were more likely to relapse during one year follow-up, whereas those with high EE spouses were less likely. These results suggested that the link between EE and depressive relapse might not apply to older adults in very long-term partnerships. The authors hypothesised that in this context high EE might not be experienced as critical.

Hayhurst, Cooper, Paykel, Vearnals and Ramana (1997) found no relationship between intimate-partner criticism and relapse in a UK prospective study of thirty-nine depressed patients and their partners over 12-month follow-up. A related study found the only predictor of relapse was symptom level at remission (Paykel et al., 1995). However,

Section A: PARTNERSHIPS AND DEPRESSIVE RELAPSE

there were some indications that the intimate-partnership was an important variable in recovery. Intimate-partner criticism was measured at admission and remission, Hayhurst et al. grouped intimate-partners into those who were consistently critical or critical at admission only. Depressed patients with persistently critical intimate-partners had significantly more depressive symptoms at remission. The behaviours that were criticised were similar to those associated with caregiver burden (Benazon & Coyne, 2000), such as withdrawal, irritability, indecisiveness and socially undesirable behaviour. This study did not suggest that intimate-partner criticism impacted on relapse rates but points to a bidirectional interaction between ongoing depressive symptoms and criticism.

Kronmüller et al. (2008; 2011) addressed the limitations of short-term follow-up, by testing EE, PC and marital satisfaction with a 10 year follow-up. Participants were fifty depressed inpatients, in Germany. EE was measured pre-discharge from hospital. Fifty-seven per cent had one or more depressive relapse during ten years. No relationship was found between PC or EE and relapse (Kronmüller et al., 2008). Intimate-partner EE was a prognostic factor for the quality of the relationship ten years on (Kronmüller et al., 2011). The design of the study precluded testing the hypothesis that quality of relationship might predict relapse (Kronmüller et al., 2011).

The authors suggested that their findings challenged previous evidence that EE predicted depressive relapse (Butzlaff and Hooley, 1998). However, a significant limitation was not recording EE or whether the patient was with the same intimate-partner at follow-up, thus the possibility remains that EE in the new partnership predicted relapse. The authors suggested that EE and PC might be more influential in less severe depression, in contrast to Hooley and Teasdale's (1989) findings that the link between PC and relapse was unrelated to illness severity.

Section A: PARTNERSHIPS AND DEPRESSIVE RELAPSE

Backs-Dermott, Dobson and Jones' (2010) explored multiple psychosocial risk-factors that were theoretically linked to depressive relapse longitudinally. Forty-nine depressed women were followed up bi-weekly with telephone Beck Depression Inventory (BDI; Beck, Steer & Brown, 1996) screening for twelve-months after remission to monitor relapse. Twenty-nine relapsed during follow-up. Consistent with an interpersonal model of depression, relapse was predicted by social support, particularly from an intimate-partner, emotion- and avoidance-oriented coping and marked interpersonal difficulties. These factors predicted relapse versus stable recovery in 75.5% of participants, suggesting that interpersonal factors played a significant role in relapse for many people with depression.

The results were limited by high drop-out, which potentially biased the sample. The statistical approach could not show interaction between variables, for example, interpersonal difficulties may have been buffered by perceived social support from an intimate-partner as in Brown and Harris (1978). This represented a move away from the focus on PC and EE, but it would be valuable to replicate in a larger sample, incorporating measures of PC to compare this construct to broader interpersonal variables in predicting relapse.

Summary and critique. Most of the studies comprised small sample sizes (22-54 participants), the total number of participants from nine studies was 320. Follow-up periods ranged from 9 – 12 months, apart from Kronmüller et al. (2011) which measured at ten years. Despite limitations, six out of nine studies found a significant relationship between intimate-partner variables and relapse, including EE, perceived and expressed criticism and social support. In studies that did not find a significant relationship with relapse, the relevance of the intimate-partnership was not dismissed.

All studies defined relapse as meeting the criteria for depression as defined by a version of the DSM, some used the Frank et al. (1991) criteria or Research Diagnostic Criteria (RDC) to make decisions about relapse, some used the Present State Exam (PSE) to

Section A: PARTNERSHIPS AND DEPRESSIVE RELAPSE

guide their relapse interview. Baks-Dermott et al. (2010) was the only study monitoring relapse frequently, whereas most studies assessed at readmission or 9-12 month follow-up, which potentially resulted in lack of sensitivity to relapse. Some studies were strengthened by adding a self-report measure to assess severity of depression, such as the BDI or HRSD, or a structured measure of relapse, such as LIFE, but results from these were not reported in most articles. In dichotomising relapse as either present or not, a way of measuring interpersonal variables in relation to relapse can be provided, but understanding of how the intimate-partnership contributes to recovery from depression is limited.

In sum, there is a small body of research exploring interpersonal variables in depressive relapse longitudinally. While a number of studies confidently assert that EE and PC are significant predictors of relapse cross-culturally, arguably the findings are less clear and further research is needed to understand why these variables are sometimes important, for example, it may depend on depression severity or interaction with other interpersonal variables. There is also initial evidence that relationship quality and intimate-partner support influence relapse.

Section A: PARTNERSHIPS AND DEPRESSIVE RELAPSE

Treatment studies

Given the focus on understanding the interaction between intimate-partnership and depressive relapse, treatment studies that include the intimate-partner and measure relapse are relevant in addressing this question. Treatment studies fall into three broad categories: Marital therapy, systemic therapy, and family/caregiver psychoeducation. While there is substantial literature suggesting interpersonal interventions are at least as helpful as individual therapies for depression (Barbato & D'Avanzo, 2008; Gupta, Coyne & Beach, 2003; Henken, Huibers, Churchill, Restifo & Roelofs, 2009; von Sydow, Beher, Schweitzer and Retzlaff, 2010), longitudinal evidence is limited.

Marital therapy. The most researched intervention is marital therapy, there are different approaches under this umbrella, but they are connected by focusing on improving the marital relationship to address depression (Cordova & Gee, 2001; Gurman, 2002). Three studies were identified which measured longer-term outcomes.

In the USA, O'Leary and Beach (1990; Beach & O'Leary, 1992) compared behavioural marital therapy (BMT) in combination with Cognitive Therapy (CT) (n= 15), with CT alone (n= 15) or wait-list control (n= 15). Participants were diagnosed with MDD or Dysthymia, severity was measured by the BDI. Relationship functioning was measured by the DAS. Both treatment conditions led to significantly lower BDI. BMT led to higher marital satisfaction, which was maintained at 1 year follow-up. This did not relate to greater improvement in depression.

In another USA study, Jacobson, Fruzzetti, Dobson, Whisman and Hops (1991; 1993) explored whether behavioural couple therapy (BCT) (n= 20), or BCT in combination with cognitive behaviour therapy (n= 20) reduced depressive relapse in comparison to individual

Section A: PARTNERSHIPS AND DEPRESSIVE RELAPSE

CBT (n= 20) at 6- and 12-month follow-up. Patients were sixty depressed, married women, randomly allocated to condition.

There were no significant differences between relapse rates suggesting that couple interventions were not preferable to individual with regards to relapse, but the percentage of relapse was small (10-15%). Outcome was associated with husband facilitative behaviour at post-test and reduction in wife dysphoric behaviour from pre- to post- test. Wives of husbands who interacted positively at post-test were less likely to relapse. BCT was not effective in alleviating depression in non-discordant intimate-partnerships. This study design appeared to identify interpersonal factors related to depressive relapse and suggested the importance of facilitative interaction in recovery.

Bodenmann et al. (2008), in a Swiss multi-centre study, explored the effectiveness of coping-oriented couples therapy (COCT) (n= 20), in comparison to CBT (n= 20) and interpersonal psychotherapy (IPT) (n= 20) in depressive relapse. Participants were sixty couples with one depressed partner as assessed by the BDI and HRSD. All conditions showed similar improvement in depression over the following 18-months. COCT showed significant improvements in EE, not seen in CBT or IPT. This provided preliminary evidence for couple work offering a mediating effect on EE, but this requires replication.

In summary, while these studies were small which limits their generalisability, they do provide evidence that marital therapy may be as effective as individual therapy over fairly long-term follow-up. These results apply to discordant partnerships and therefore may not be applicable to all depression (Anderson et al., 1999). The authors suggest potential mechanisms for reduced depressive relapse including EE and facilitative behaviour, although this was correlational not causal. To better understand the interaction between the intimate-

Section A: PARTNERSHIPS AND DEPRESSIVE RELAPSE

partnership and depressive relapse more research is needed on the therapeutic mechanisms underlying change in marital therapy. This might enable more targeted treatments

Systemic couple therapy. Two studies of systemic therapy, based on systemic conceptualisations of depression, monitored long-term outcomes.

Leff et al. (2000) compared the efficacy of systemic couple therapy (n= 40) with antidepressant medication (n= 37) in a UK RCT. Participants had depression, assessed by the BDI, and were living with a critical partner. Couple therapy led to significantly better outcomes in depression at the end of treatment and 2-year follow-up. Relapse was not linked to EE, but hostility reduced in the couples group which may be a potential mediator of change.

Lemmens, Eisler, Buysse, Heene and Demyttenaere (2007; 2009) investigated the use of multifamily group therapy (MFGT) (n= 35), single systemic family therapy (SSFT) (n= 25) and treatment as usual (TAU) (n= 23). Participants were 83 inpatients in Belgium diagnosed with depression and their partners. Family interventions had better results at 3- and 15-month follow-up as measured by the BDI. MFGT had higher rates of treatment response (defined as 50% improvement on BDI) and more patients stopping medication than TAU. The improvements were potentially mediated by changes in partner's perception of subjective emotional health, which changed more quickly in MFGT and SSFT conditions. Changes in DAS were unreported.

In sum, systemic therapy is thought to shift the system leading to improvements in depression. Long-term outcomes might be linked to reduced hostility in the intimate-partnership, however, the absence of an active control limits the conclusions.

Section A: PARTNERSHIPS AND DEPRESSIVE RELAPSE

Family/ caregiver psychoeducation. Family psychoeducation interventions are based on a biopsychosocial or diathesis-stress model of depression assuming a biological vulnerability to depression (Lemmens et al., 2007), with the understanding that depression influences people around the patient (Benazon & Coyne, 2000). Psychoeducational intervention aims to adapt the psychosocial environment to protect from stressors and improve coping with depression (Luciano, Del Vecchio, Giacco, Malangone & Fiorillo, 2012). Research is scarce, four studies were identified that measured relapse.

Glick, Burti, Okonogi and Sacks (1994) and Spencer et al. (1988) reported on an inpatient individual psychoeducational family intervention (n=79) compared with TAU (n=89), randomly assigned in the USA. Participants were diagnosed with depression or schizophrenia. The treatment group fared better at 6- and 18-month follow-up: Patients had better attitudes towards medication, improved social functioning and their partners reported improved social contact.

In Italy, Fabbri, Fava, Rafanelli, and Tomba (2007) investigated the use of a family intervention with patients on antidepressant medication who experienced recurrent depression, compared with increasing medication and clinical care. Participants were twenty outpatients living with a partner. Those who received a family intervention based on the McMaster Model (n=10) were significantly less likely to relapse during one-year follow-up. There was no relational measure so the authors could not theorise interpersonally regarding lower relapse rates.

Shimazu et al. (2011) designed and evaluated a psychoeducational intervention for caregivers of people with depression using an RCT design, in Japan. Time to relapse was significantly longer in the intervention group (n=25) compared to TAU (n=32) over 9-month follow-up. EE was not predictive of reduced relapse, thus mechanism of change was unclear.

Section A: PARTNERSHIPS AND DEPRESSIVE RELAPSE

The authors hypothesised that caregivers were possibly more supportive following intervention, or less burdened, although evidence could not be provided.

Magliano (2009) and Fiorillo, Malangone and Del Vecchio (2011) addressed a criticism of the above studies, by using an active control condition. In the above studies, the treatment group received more time and input than the control group, which potentially accounted for the relapse reduction. An individual psychoeducational family intervention focusing on communication skills and problem-solving (n=22) was compared to informative sessions (n=22), randomly assigned. The treatment group showed improvements in social contacts and reduced family difficulties at 6- and 12-month follow-up.

In summary, the psychoeducational studies were small, which limits generalisability, but the reduction in relapse following intimate-partnership involvement is consistent with the possibility that the interpersonal environment is important. However, the limited use of relational measures means these studies contribute little to understanding the interaction with depressive relapse. There might be value in this kind of intervention, but other interventions could be considered as well which might be able to achieve more with regards to relapse.

In view of the limited attention given to bidirectionality within these studies, it seemed important to consider another body of research concerning the impact of depression on intimate-partners.

Section A: PARTNERSHIPS AND DEPRESSIVE RELAPSE

Impact of depression on intimate-partners

The literature is less well developed in this area, thus more relaxed inclusion criteria were applied. Seven quantitative and two qualitative studies focus on the impact of depression on intimate-partners, taking into account burden, burnout and depressive symptoms.

Benazon and Coyne (2000) found that the intimate-partner was more likely to be experiencing higher levels of depressive symptoms than the general population (Benazon & Coyne, 2000), often warranting psychiatric intervention (van Wijngaarden, Schene, & Koeter, 2004). This was attributed to the increased burdens of living with a depressed partner, particularly in response to the patient's feelings of worthlessness, worrying and lack of energy, and the partner's emotional strain and concerns about future relapse (Benazon & Coyne, 2000; Coyne, Kessler, Tal, Turnball, Wortman & Greden, 1987; van Wijngaarden, Schene, & Koeter, 2004). The intimate-partner's level of depression was statistically explained by self-reported caregiving stress (Jeglic et al., 2005). These researchers argued for interventions to support caregivers and enable them to respond to their intimate-partner in ways that avoided reinforcing depression (Jeglic et al., 2005).

Research into couples with one depressed partner suggested that about a quarter of caregivers experience a high level of burnout (Angermeyer, Bull, Bernert, Dietrich & Kopf, 2006). The burden of caring for a depressed partner appeared unchanged in the year post-discharge from hospital (Heru & Ryan, 2004). In a study of relatives of inpatients with depression (n=34) and schizophrenia (n=16), caregiver's burden, psychological symptoms and quality of life were best predicted by caregiver's expressed criticism, followed by patient's perceived resignation (Möller-Leimkühler & Jandl, 2011).

Section A: PARTNERSHIPS AND DEPRESSIVE RELAPSE

Two qualitative studies add further insight. In a thematic analysis, participants perceived that isolation made caring more stressful, alongside being uninvolved in service-user care (Highet, McNair, Davenport & Hickie, 2004). In an IPA study, participants perceived challenging aspects of the support process to be role adjustment and finding ways to help their depressed partner (Harris, Pistrang & Barker, 2006).

The above studies did not make cause and effect links and were limited in some cases by the mixed samples. However, this research provided insight into the other-side of the bidirectional relationship depicted in prospective studies of EE and PC with the suggestion that the intimate-partner's interaction style, for example, high expressed emotion, was potentially related to how much they were struggling with their partner's depression.

Section A: PARTNERSHIPS AND DEPRESSIVE RELAPSE

Summary of evidence for role of relationship in depressive relapse

The literature provides some insight into the interaction between the intimate-partnership and depressive relapse, and how this can be utilised to protect against relapse. Theoretical models drawing on systemic theory suggest that the onset, maintenance and relapse of depression can be understood interpersonally. These models highlight that the role of the intimate-partnership in depression is bidirectional or cyclical, rather than static. Research appears more one-sided either focusing on the influence of intimate-partnership variables on relapse or the impact of depression on intimate-partners.

Initial research focused on EE, PC and hostility, this generated mixed findings, but on balance these variables appeared to have a role in depressive relapse. These findings can be understood within the diathesis-stress attribution model of EE, which proposes that the intimate-partner might want to help but be predisposed to taking an active role, which over time may be experienced as critical, contributing to depressive relapse. This could similarly be framed as a complex feedback system within systemic couples theory.

More recently, prospective studies suggested that social support, relationship quality and couple's coping behaviour influence depressive relapse. These findings are supported by treatment studies suggesting that interventions addressing marital discord can reduce depressive relapse. At first sight these variables reflected the marital discord model, however, when considered in greater depth the findings from prospective studies are not consistent with the premise that marital discord preceded depression. Furthermore, the treatment studies do not provide evidence that changes in the intimate-partnership caused recovery. Thus the findings appear to favour systemic couples theory which can encompass concepts of support and couple's coping behaviour into a complex feedback system, it can

Section A: PARTNERSHIPS AND DEPRESSIVE RELAPSE

also formulate how the partner may feel burdened and need support for themselves within this system.

A strength of systemic theory appears to be its flexibility in that it can be clinically applied to make sense of these complex, interacting processes and present avenues for intervention. This flexibility may also be a limitation in that scientifically it is harder to use systemic theory to make predictions for research or to clearly refute it. In contrast, interactional theory appears scientifically stronger in presenting specific testable pathways, such as understanding the apparent relationship between patient depression and partner stress/depression as caused by contagion and excessive-reassurance seeking. This approach risks potentially oversimplifying complex, interacting processes.

Section A: PARTNERSHIPS AND DEPRESSIVE RELAPSE

Future directions

Given that depression can be a chronic, recurring problem, that appears to both influence and be influenced by the intimate-partnership, it seems important to further explore how the intimate-partnership can contribute to relapse and prevention. This could be explored using longitudinal research looking at a wider range of theoretically informed relational variables, which may be predictive of depressive relapse or remission, for example, facilitative behaviour. Better measurement of intimate-partnership variables and relapse is required to make causal links, for example, measuring EE, PC, caregiver burden and depressive symptoms pre-/post-discharge and at follow-up to analyse how they interact. This might enable greater understanding of the mixed findings in this area and have implications for services supporting partnerships to manage relapse together.

Some evidence suggests that interpersonal treatments may be effective long-term, at least as effective as individual therapy, but this is based on a few small studies. Furthermore, interventions were primarily tested in discordant intimate-partnerships, did not measure effect on intimate-partner stress or the mechanism of change, and on a practical note, are not widely available in the NHS. Thus it is important to continue researching interpersonal interventions for depressive relapse. Potential avenues include:

1. Developing the evidence-base for marital therapy in nondiscordant couples
2. Testing systemic couples therapy in comparison to an active control
3. Applying interventions with proven efficacy in relapse prevention to intimate-partnerships e.g. mindfulness-based cognitive therapy (Segal, Williams, & Teasdale, 2002).

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Running Head: SECTION B: MBCT AS A PARTNERSHIP

MAJOR RESEARCH PROJECT

EMMA SMITH BSc (Hons) MSc

Section B: Empirical Paper

The process of engaging in mindfulness-based cognitive therapy as a partnership:

A grounded theory study

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SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

Section B: MBCT AS A PARTNERSHIP

Abstract

Objectives: Mindfulness-based Cognitive Therapy (MBCT) has been evidenced as a relapse prevention strategy for depression. Depression often influences and is influenced by intimate-partnerships, thus it makes sense to include both individuals in interventions. This study aimed to develop a theory of the process of engaging in MBCT as a partnership.

Design: As there was no theory or research that could be directly applied to understanding the process of engaging in MBCT for depression, as a partnership, an exploratory grounded theory study seemed appropriate to generate rich data and a theory.

Methods: Twelve participants who had attended an MBCT course as a partnership were interviewed. These data were triangulated with sessional data from an MBCT course and facilitator validation. Analysis and interviews ran simultaneously, so that initial findings influenced subsequent data collection. Constant comparison of data and higher-level concepts facilitated generation of a theory grounded in the data.

Results: The proposed theory captured the ‘process of learning new mindfulness skills together’. The partnership’s rationale for pursuing MBCT together seemed to influence engagement with the course. Participants’ accounts suggested that learning mindfulness skills together led to shifts in the relationship and how they managed depression.

Conclusions: While intimate-partnerships who engaged in an MBCT course seemed to learn similar mindfulness skills as in individual MBCT courses, learning as a partnership seemed to facilitate home practice, attendance and a sense of mutual support, which led to unique outcomes for the partnership and their sense of responsibility for each others’ wellbeing. It may be helpful for course facilitators to consider inviting intimate-partners to attend where both partners are suffering, or there is a willing partnership.

Section B: MBCT AS A PARTNERSHIP

Introduction

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

Evidence and theory highlight how depression may be influenced by intimate-partner variables. 'Expressed Emotion' and 'Perceived Criticism' have found some support as predictors of relapse (Hooley, 1986; Hooley & Teasdale, 1989; Kwon et al., 2006; Okasha et al., 1994; Vaughn & Leff, 1976), although there have also been inconsistent findings (Hayshurst, Cooper, Paykel, Vearnals & Ramana, 1997; Hinrichsen and Pollack, 1997; Kronmüller et al., 2008; 2011). More recently, different psychosocial risk-factors for depressive relapse have been explored: Backs-Dermott, Dobson and Jones (2010) found that intimate-partner social support and coping predicted relapse. While the findings appear somewhat mixed, these interpersonal processes may play a role in relapse and could be helpfully addressed in relapse prevention interventions.

Depression also appears to influence the intimate-partner, causing stress and depressive symptoms (Benazon & Coyne, 2000; Coyne, Kessler, Tal, Turnball, Wortman & Greden, 1987; Jeglic et al., 2005; van Wijngaarden, Schene & Koeter, 2004). Within interpersonal theories of depression, intimate-partner burden may be conceptualised as part of a complex feedback system that influences the onset, maintenance and relapse of depressive

Section B: MBCT AS A PARTNERSHIP

symptoms (Jones & Asen, 2000). Interpersonal theories of depression suggest that processes such as excessive-reassurance seeking (Coyne, 1987) and negative-feedback seeking (Giesler & Swan, 1999) by the depressed person, marital discord (Beach, Sandeen, & O’Leary, 1990) and intimate-partner over-involvement (Hooley, 2007) may generate stress in both partners. These are hypothesised to lead to reduced support (Hammen, 1991; Joiner & Coyne, 1999), rejection (Coyne, 1987), expressed emotion and criticism (Hooley, 1986), which further impact upon depression and stress (Jones & Asen, 2000).

Considering depression affects both partners, and the potential for the intimate-partner to contribute to or protect against relapse, partnership interventions appear warranted. Marital therapy is the most researched conjoint intervention for depression, but the evidence is limited for relapse prevention (Bodenmann et al., 2008; Jacobson, Fruzzetti, Dobson, Whisman & Hops, 1993; O’Leary & Beach, 1990) and the mechanism of change is unclear. Furthermore, systemic (Jones & Asen, 2000) and interactional theories (Coyne, 1987) suggest that marital discord might not be a causal problem. The intimate-partner may want to help but being unaware of how to prevent relapse, they may unintentionally contribute to maintaining depression or feel stressed and in need of support for themselves (Benazon & Coyne, 2000). In these cases, different formulations and interventions are called for to engage the partner in relapse prevention.

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

Section B: MBCT AS A PARTNERSHIP

different way of relating to the interpersonal processes associated with stress and depressive relapse.

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

MBCT was developed based on the premise that relapses frequently occur in depression because exposure to negative events triggers sad mood and reactivates a depressive cycle. Through developing mindfulness skills, individuals can become aware of their mental processes and learn to intentionally step out of 'doing' mode into 'being' mode when negative thoughts are in the driving seat, preventing escalation (Kabat-Zinn, 1990), which appears akin to the skill of 'decentering' from cognitive processes (Sauer & Baer, 2010). This potential mechanism of change is supported by evidence that mindfulness is linked to reduced cognitive reactivity to sad mood (Raes, Dewulf, Van Heeringen & Williams, 2009). Developing these skills as an intimate-partnership may provide opportunities to improve interpersonal functioning (Carson et al., 2006) and potentially exit interpersonal processes such as, excessive-reassurance seeking and self-verifying feedback cycles which are thought to influence depressive relapse.

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

Section B: MBCT AS A PARTNERSHIP

(Neff, 2009; Neff & Pommier, 2012). However, individual mindfulness only predicts individual outcome, thus it is suggested that for mindfulness training to be effective for both partners, they need to engage together (Barnes et al., 2007; Eubanks Gambrel & Keeling, 2010).

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

Rationale

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

The present research study aimed to address this gap by developing a theory of the process of engaging in MBCT as a partnership. As this presented a new, previously uninvestigated clinical intervention, a qualitative study seemed suitable. Grounded theory

Section B: MBCT AS A PARTNERSHIP

(GT; Glaser & Strauss, 1967) was selected because it can explore social processes over time and be used to generate a theory, with practical implications, grounded in the rich experiences of participants. This was conducted from a critical realist philosophical position, assuming real events occur, but are coloured by an individual's social and cultural experiences (Corbin & Strauss, 2008). It was hoped that developing a theory of the process of engaging in MBCT as a partnership may lead to developing this intervention further. Practical implications for when partnership involvement may be helpful or unhelpful will be considered.

Section B: MBCT AS A PARTNERSHIP

Method

Context

A clinical psychologist and family therapist, who had trained as MBCT facilitators, were offering MBCT to service-users with a history of depression within a secondary care adult mental health setting. Following service-user feedback that it would have been helpful to have shared the group with a partner, they initiated MBCT groups for partnerships. Service-users referred to MBCT by healthcare professionals were offered the choice of attending a group for individuals or partnerships. The partnership group was often favoured where the service-user had a partner who was also suffering from stress or depression, or where they had a supportive partner who wanted to help. Participants were recruited from three cohorts of MBCT for partnerships. Six participants were interviewed from Cohort 1 and three from Cohort 2. There were seven group members in Cohort 3, all group members consented to participate and three met for an interview after the group had finished.

Participants

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

Participants attended one of three MBCT courses run for service-users with a history of depression and their partners. They had been referred by health professionals and had chosen to attend a partnership group. Courses adhered to the 8-week MBCT programme

Section B: MBCT AS A PARTNERSHIP

(Segal et al., 2002), with minor adjustments for partnerships, for example, completing the automatic thoughts questionnaire and warning signals exercise together to facilitate increased understanding of signs of relapse.

Table 1.

Participant characteristics.

Pseudonym	Gender	Reason for attending	Months since finished
Bill*	M	Depression	9
Linda	F	Partner	9
Rachel*	F	Depression	9
William	M	Partner	9
Belinda*	F	Depression	12
Rose	F	Personal stress	12
Tom*	M	Depression	12
Sam	M	Anxiety/ depression	4
Janine*	F	Depression	4
Jeff*	M	Depression	1
Jane	F	Partner	1
Claire*	F	Depression	2
Eric	M	Depression	#
Rowena*	F	Depression	#
Ken	M	Depression	#
Kelly*	F	Depression	#

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

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

Section B: MBCT AS A PARTNERSHIP

Ethics approval

Ethical approval was obtained from the Brighton-East Research Ethics Committee (Appendix 5) and relevant Research and Development department (Appendix 6). Ethical approval was obtained for a substantial amendment to enable the researcher to attend Cohort 3 as a participant-observer and to use this audio-recorded data in the analysis (Appendix 11). Written, informed consent was provided by all participants. The British Psychological Society Code of Conduct (BPS, 2006) was followed.

Recruitment

Participants were recruited via a clinical psychologist, who distributed information sheets and consent forms during the MBCT course. The researcher telephoned consenting group members to discuss the research and nine participants attended a subsequent interview. Members of Cohort 3 consented to the group being observed and audio-recorded, and their data being included. Further interviews were arranged with three participants from Cohort 3.

Data collection and analysis

An interview schedule (Appendix 9) was developed with the research supervisors, this included two MBCT-trained clinical psychologists and a senior researcher with mindfulness experience. The interview aimed to explore the process of engaging in MBCT with an intimate-partner. Initial topics included: expectations of MBCT with regards to depression; experience of engaging in the course and home practice as a partnership; and the perceived impact, if any, of MBCT on depression, life, and intimate-partnership. A service-user coordinator, with experience of mindfulness, was consulted, to highlight implicit assumptions and improve questions.

Section B: MBCT AS A PARTNERSHIP

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

Nine interviews were conducted from Cohort 1 and 2. In line with the GT principles, data analysis ran concurrently with data collection, after every 1-3 interviews transcription, coding and comparison took place, informing future interviews. Extensive microanalysis was used in analysing the first interview to ‘break into the data’ and sensitise the researcher to different interpretations. Line-by-line coding was used for the first four interviews to break the interviews into chunks of raw data. ‘Constant comparison’ (Glaser & Strauss, 1967) was made between chunks of data for similarity and differences, facilitating the development of properties and dimensions within data. Memo writing and diagramming were used concurrently to begin conceptual development and elucidate possible relationships between concepts (Appendix 19).

Once initial categories were formed, questions and hypotheses arose around how partnerships engaged in the sessions together. Following the GT principles of ‘theoretical sampling’ this led to researcher attendance of Cohort 3 as a participant-observer. Sessions were audio-recorded for analysis using focussed coding, while remaining open to new categories, comparing to interview data and writing memos. By this point a theory was emerging and the interview schedule was amended to test (Appendix 10).

Final interviews involved more confirmatory questions whereby participants were asked to reflect on experiences relevant to emergent categories. For example, “Some people

Section B: MBCT AS A PARTNERSHIP

have talked about approaching depression as a ‘partnership’ since engaging in MBCT together; I wondered if you could tell me whether this is relevant to your experience?”

Three participants were selected from Cohort 3 to test the model. Claire was selected because her partner had not attended the course, which provided the opportunity to test the hypothesis that certain outcomes were linked to engaging together. These data enriched the model and no new concepts arose.

Interviews were conducted in NHS community mental health centres. Interviews lasted between 40 and 90 minutes (mean: 68 minutes).

Quality Assurance Methods

Elliott, Fischer and Rennie’s (1999), Elliot and Lazenbatt (2004) and Yardley’s (2000) guidelines for qualitative research were considered to ensure quality control. Through personal experience of mindfulness practice, personally participating in Cohort 3 and collaborating with supervisors who were experienced in mindfulness this facilitated sensitivity to the context that was being explored. Particularly helpful, was having sensitivity to exploring novel aspects of engaging in mindfulness as an intimate-partnership.

Commitment, rigour, transparency and coherence were achieved through line-by-line coding, constantly moving back and forth between the data and emerging concepts, checking out hypotheses with participants and presenting the model grounded in data, audited by a GT consultant. Triangulation of interview data, Cohort 3 session data and MBCT facilitator validation added further coherence. A reflective diary was used to facilitate ‘owning one’s perspective’ and supervision aided reflection on how this influenced the data.

Section B: MBCT AS A PARTNERSHIP

Although a small step, this research has theoretical impact and importance as it may provide an initial conceptualisation of how intimate-partnerships engage in and use MBCT, which is important to explore if this approach is to be applied further in the NHS.

Results

Overview of the model

The model presented below (Figure 1) illustrates the process of engaging in MBCT as a partnership, categories and subcategories are presented in Table 2 and in the text these are presented in bold. At the top of the model, contextual factors that influenced engagement with the course are outlined. These led into partnership influence on engagement with the course, which is in a reciprocal relationship with learning new mindfulness skills. The interaction of these processes is linked to unique outcomes outlined in the influence of MBCT on the partnership. There is also an arrow in the opposite direction to highlight that these outcomes (e.g. reduced worry) seemed to reinforce the practice of mindfulness skills. A more tentative process is represented for those who did not fully engage with learning mindfulness skills, which seemed to lead to ‘valuing the group process’ in the absence of other changes detailed in the influence of MBCT on the partnership. The level of commitment and engagement with mindfulness seemed to influence the group process which is also positioned as impacting on the learning of mindfulness skills.

Core category: Learning new mindfulness skills together

The core category linking all the data together is the process of learning new mindfulness skills together. Several participants talked about engaging in mindfulness as a process of learning new skills together, for example, ‘... *you can share that and learn something new between you*’ (Bill). Learning new mindfulness skills connected the data from before, during and after the MBCT course. For example, the partnerships’ expectations before the group influenced how they engaged with learning new skills together and in turn learning new skills together seemed to influence the partnership and how they coped with depression.

Section B: MBCT AS A PARTNERSHIP

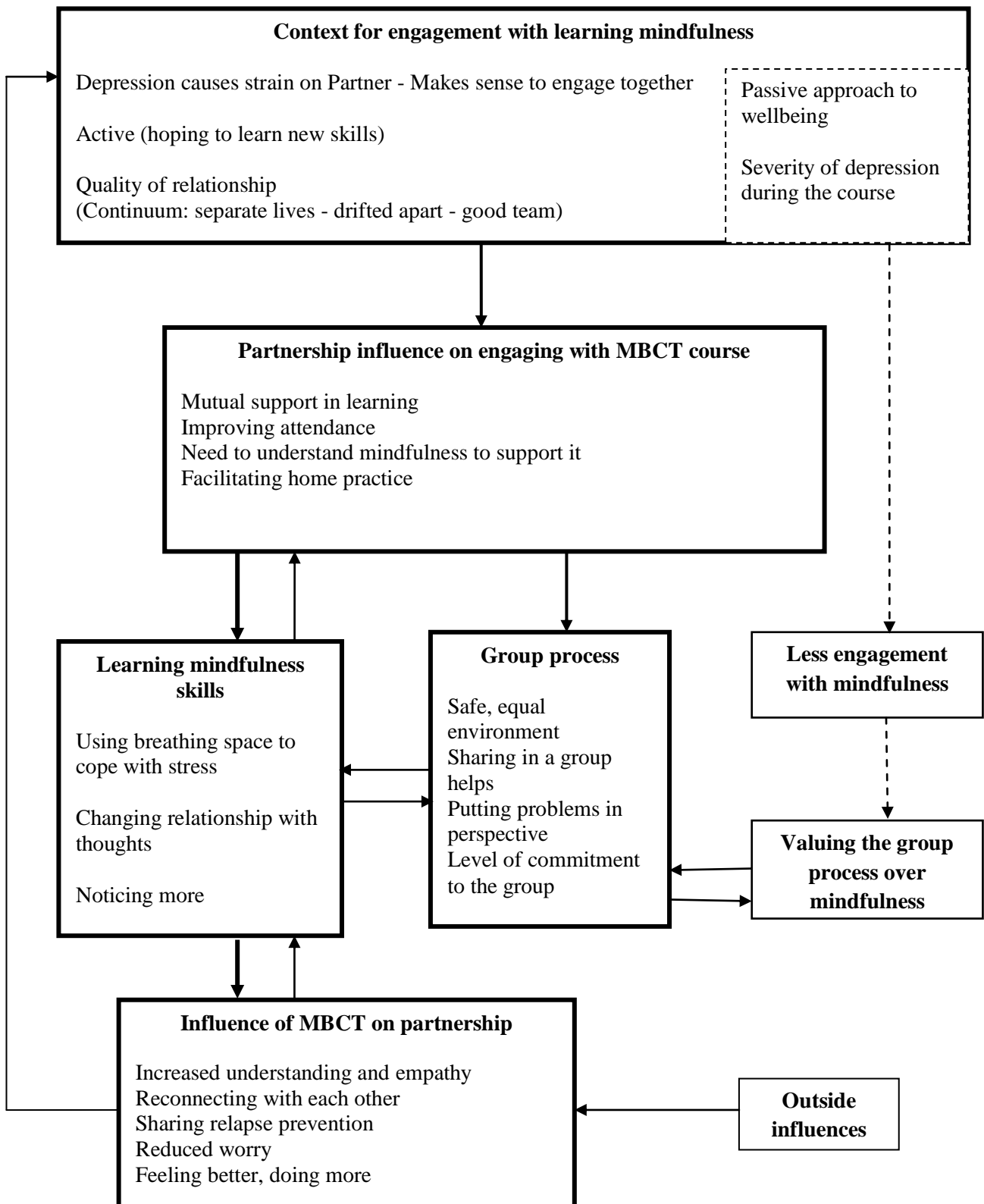


Figure 1. Learning new mindfulness skills together – a model of the process of engaging in MBCT as a partnership.

Section B: MBCT AS A PARTNERSHIP

Table 2.

Learning new mindfulness skills together

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

Category A: Context for engagement with learning mindfulness

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

Section B: MBCT AS A PARTNERSHIP

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

Most intimate-partnerships were **hoping to learn new skills** to enable them to cope with depression and interpersonal strain, *'I was hoping, which I think I did, is learn some things that could help me deal with um, everyday life' (Bill)*. These subcategories represented pre-group experiences and expectations that partnerships took with them into the course, which appeared to facilitate engagement.

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

There were several potential reasons for this, found in the data, although these have been presented tentatively because there was evidence from only two service-users. There appeared to be a passive rather than active approach to the MBCT course, for example, *'it can't do any harm' (Rachel)* and a perceived lack of control over wellbeing, for example, *'maybe it's just my time to be better' (Rachel)*. This has been labelled **passive approach to wellbeing**, as mindfulness requires an active approach to looking after yourself, for example, regular practice and looking for warning signs. Another factor that seemed to play a role was the **severity of depression** during the course, for example, *'I couldn't ever see myself going back to normal' (Belinda)*, and *'I still wasn't properly well' (Rachel)*, which may have

Section B: MBCT AS A PARTNERSHIP

hindered engagement with mindfulness, ‘... *relaxation, I find that really difficult, especially the 40 minutes lying and thoughts just going to dark memories*’ (Belinda).

These participants did not report the same perceived changes as other partnerships, although they reported **valuing the group process**, ‘*nice to know that somebody else was suffering a bit like you*’ (Rachel). This process, which is returned to in Category E, represented a minority of participants’ experiences. It was hypothesised that this was related to severity of depression and holding a more passive view of wellbeing.

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

Category B: Learning new mindfulness skills

Participants reported several skills learned through the MBCT course, which were linked to positive changes. These processes temporally spanned during and after the course and seemed to both influence and be influenced by the partnership processes.

Using the breathing space to cope with stress. Learning to use the breathing space was described as a radically different way of coping with stress, ‘*If these thoughts come into my mind of a night time, I think breathing exercises [...] whereas before I’d be awake half the night.*’ (Rose). Examples were provided of this skill being used at work, home, with daily stress and in relationships. In partnerships who practised together, both partners reported benefitting from the breathing space:

Section B: MBCT AS A PARTNERSHIP

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

Changing relationship with thoughts. This subcategory refers to *‘talking about thoughts not being facts that really opened my mind’ (Rose)*, MBCT appeared to help people to step back from thoughts to *‘see the wood for the trees’ (Bill)*. In describing what she took from learning that ‘thoughts are not facts’, this quote highlighted how powerful it can be to learn these skills as an intimate-partnership and apply them to understanding relational patterns, *‘I think because Jeff is very quiet I think [...] I’ve done something wrong [...] and that manifests and rots in your head’ (Jane)*.

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

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

‘Noticing more’. Participants reported noticing more about themselves and their worlds through engaging in mindfulness practice and living in the present. This was positioned as a different way of being that facilitated improved self-care and a gentle approach to painful experiences.

Section B: MBCT AS A PARTNERSHIP

'... when you do the full body scan you suddenly realise, oh there's, that feels a little bit, that you didn't even realise,[...] because you actually [...] rather than thinking about 101 things... taking a bit more notice of yourself' (Bill).

Paying attention in a different way was experienced as self-broadening and it was felt that mindfulness practices *'enriched the day'* (Sam).

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

Noticing more also included learning to face physical and emotional pain. There was a process of noticing the tendency to *'shut it out'* (Claire) and avoid facing pain, which was described as *'autopilot'*. Mindfulness presented a different way of being with pain that people were experimenting with, *'I think one thing I'm learning in this is that you have to face things, like the dance in the film [MBCT DVD shown in session 5]'* (Claire). In directing attention towards physical pain, some people noticed a *'bit of relief'* (Rowena).

Category C: Partnership influence on engagement with MBCT course

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

Mutual support for learning new skills. It appeared that engaging in the course together often facilitated increased *'commitment'* to the *'joint project'* (Sam) of learning new skills and feelings of mutual or *'collegic support'* (Sam).

'... because there was two of us doing it together [...] it did improve your commitment to it actually, because you were trying to look at a mutual support for each other to do things.' (Sam).

Mutual support was positioned as facilitating the learning of mindfulness skills

Section B: MBCT AS A PARTNERSHIP

through increased commitment and investment in the MBCT course. In turn, engaging together appeared to lead to positive shifts in the partnership, further discussed in Category D.

Attendance improved. Participants reported *'we enjoyed coming together'* (Rachel) and felt this facilitated attendance, which could be difficult when depressed and anxious, *'I don't know that she would've gone to [...] every meeting if she had been on her own'* (William).

For individuals who were highly motivated, this was not felt to make much of a difference, but for those who were still struggling with low mood and anxiety, attending as a partnership seemed to make it much easier and more enjoyable to attend:

'We walked up here to the group, so that was a good thing [...] in a way that was therapy in itself [...] to actually walk up here with Cody, I hadn't been out on my own for nearly a year' (Belinda).

These data were validated by the MBCT course facilitator who noted that the partnership group is better attended than the individuals' group.

It was hypothesised that the drop-out rates and attendance may be better in the partnership group because *'discussion still goes on at home'* (Tom), which may help to overcome initial scepticism, *'I was a very sceptical person 8 weeks ago'* (Eric). Another important factor seemed to be mutual support and increased commitment because both partners had an interest in finding ways to cope with stress.

Need to understand mindfulness to support it. It was widely reported that mindfulness was not something you could easily explain to your partner, *'... if I tried to go home and sort of say to Linda, OK what we did today [...] it would be so [...] diluted that she wouldn't get anything out of it'* (Bill). Consequently, it seemed that the partnership benefits might not have

Section B: MBCT AS A PARTNERSHIP

been gained if only one partner had done the MBCT course. Furthermore, numerous partnerships implied that not being involved might have exacerbated the divide between them and led to resentment, which might have negatively impacted on the individual's practice and wellbeing, for example, *"I understand what she's doing so there's no sense of resentment or discontent about her going off to do something like that."* (Sam).

Partnership influence on home practice. There was a continuum of influence from **commitment to practising together**, *'if you're on your own, you tend to say, ah I'll do that later and whatever [...] whereas if you've got a partner, you can sort of remind each other and encourage each other to do, to take time out you know'* (Linda), to **mentoring**, where the partner took on an active role of supporting and encouraging, *'I did have to be prompted, you know if I could get away with not doing it, I would... William would be reminding me "you haven't listened to your tape today"'* (Rachel), through to partnerships who **chose to practice separately**, *'we did them separately. I'm trying to think why; I think we just maybe found different periods of time during the day where we were free'* (Sam).

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

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

Category D: Influence of MBCT on the partnership

Within the time frame of the model, these influences were positioned as the perceived consequences of engaging in the group together. This followed on from exploring how the

Section B: MBCT AS A PARTNERSHIP

partnership influenced engagement with the course. Participants reported various changes and improvements that they linked to engaging in the MBCT course together, including direct changes in the interpersonal relationship and individual changes, which impacted on the relationship.

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

The data suggested that these effects were not solely due to learning mindfulness skills, but through the interaction of learning mindfulness skills together. This was supported by an interview with Claire, (whose partner was not available to attend the sessions), because while she fully engaged with learning mindfulness skills, she did not note any interpersonal changes, even when directly asked about the relationship.

Reconnecting with each other. Through doing the MBCT course together, the intimate-partnerships felt they engaged in different conversations that felt like *‘really communicating’* (Bill) in a way they had not for a while. Many people described that the process *‘brought us closer’* (Jeff) or that their relationship was ‘stronger, I mean we were a strong couple anyway, but I think our foundations were shaken’ (Rose). This was particularly important for partnerships where depression had caused stress for both partners.

Sharing relapse prevention. It could be hypothesised that any kind of partnership intervention might lead to ‘reconnecting’. However, MBCT seemed to add something on top of the fact that they attended in partnership, it seemed to provide a shared resource that the partnership could turn to in times of stress. This was also referred to as *‘skilling the carer’* in that *‘it gave the person who was well, like a tool to be able to use it to encourage their*

Section B: MBCT AS A PARTNERSHIP

partner to participate and do things' (Sam). This process seemed to transform 'depression' and 'stress' into something that can be shared by the partnership, '... this is another thing that you can work on together[...] she probably feels more comfortable in the fact that she can help me in that' (Bill).

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

'... this has been quite a positive thing [MBCT course] and it's made us perhaps, uh, understand the fact that I'm not just on my own with, when I do get down [...] you're going to have a bit better support and in that knowledge I suppose it gives you more courage to carry on and do something a bit different' (Bill).

There was a process of recognising how isolated you can become when feeling low or anxious and finding that it helped to do more and reconnect with people, 'I was becoming quite insular, as I said last week and I couldn't be bothered to do things. Whereas this past week, well you know I went to lunch with my friend last week and that was really nice and that was quite a big thing for me.' (Claire).

Reduced worry. This was reported by both the 'service-user', '*it's really all come together now, I think that's due to the mindfulness course again because I think because I'm more settled and I don't worry' (Tom)* and by 'partners', '*yeh he doesn't seem worried about anything like that at all, his attitude towards people has changed, I think he can really see things as they are' (Linda).* This could be connected to mindfulness skills of changing relationship with thoughts and living in the present and was experienced as a dramatic

Section B: MBCT AS A PARTNERSHIP

change, for example, *'I used to famously say, if I had nothing to worry about, I was worried'* (Tom).

Category E: Group Process

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

Learning in a safe, equal environment. It seemed an important foundation for sharing and learning that the group was a safe space. This was experienced as a positive part of the MBCT course, *'It was brilliant because it was non-judgemental, you didn't know which one had the depression and which wasn't, it was fabulous.'* (Rose). This equality applied to the roles of participants and facilitators in the group, which enabled normalising of the challenges that arose in learning mindfulness, *'... in discussion it suddenly dawned on me that [the facilitators] were saying that their brains did the same so I suddenly felt a bit more relaxed about it.'* (Sam).

Sharing helps. Sharing experiences with other partnerships who had gone through similar challenges was experienced as helpful for both the 'service-user', *'that was nice to know that somebody else was suffering a bit like you'* (Rachel), and the 'partner', *'I think one of the good things about the groups is that you can talk to people who are going through exactly the same situation as yourself and I think that is a huge benefit'* (Linda).

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

Section B: MBCT AS A PARTNERSHIP

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

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

Category F: Outside influences on perceived change

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

Coming to a time in our lives where we can focus on ourselves. For some, it was difficult to untangle the different factors that may have influenced change, although mindfulness was positioned as an important factor, *'I think it's possibly not just the course, I think it's everything. I think the course has been a part of the jigsaw'* (Jane) *'an important part'* (Jeff). Some participants noted that they had more time for each other since retiring, or since their

Section B: MBCT AS A PARTNERSHIP

children had grown up they *'haven't got the distractions of children'* (Bill) and in that context they felt *'It just suited us both being there, at that time of life'* (Jeff). Thus, the partnership's context appeared to impact on how much they engaged with the MBCT course and the impact it had on them.

Section B: MBCT AS A PARTNERSHIP

Discussion

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

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

Partnership and practice

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

Section B: MBCT AS A PARTNERSHIP

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

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

Validating participant data, MBCT course facilitators noted that partnership groups showed better attendance and engagement with home practice than individual groups. Research has related amount of home practice to improvements in mindfulness, symptoms and wellbeing (Carmody & Baer, 2008; Orzech, Shapiro, Brown & McKay, 2009). Small scale studies have suggested that, among other variables, lack of group support (Finucane & Mercer, 2006), motivation (Gross et al., 2004), and negative views of others may hinder practice (Langdon, Jones & Hutton, 2011). The present model suggests that engaging together may facilitate greater engagement with home practice, potentially because it addresses some of these hindering factors.

Section B: MBCT AS A PARTNERSHIP

Valuing the group experience

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

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

Section B: MBCT AS A PARTNERSHIP

Mindfulness as facilitating reconnection

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

Increased empathy as protecting from depressive relapse

Qualities of empathy and mindfulness have been linked in research (Wachs & Cordova, 2007). The current model suggests a process of increased empathy and understanding through engaging in the course together. It was hypothesised that this was facilitated through developing a more self-compassionate approach to self and other, which was directly applied to the intimate-partner because of the context of engaging in mindfulness together. Preliminary evidence indicated that this process did not apply to participating individually. This theory requires further testing, but is consistent with literature suggesting that interpersonal changes are not derived through individual mindfulness (Barnes et al., 2007; Eubanks Gambrel & Keeling, 2010). It could be hypothesised that increased empathy and compassion might protect against depression in the longer-term, as theoretically it appears to be the antithesis of high expressed-emotion, and improving the interpersonal relationship may protect against depression (Beach et al., 1990). This requires testing longitudinally, and would likely depend on whether partnerships continue with practice.

Section B: MBCT AS A PARTNERSHIP

Decentering

The model depicts a process of learning different ways to cope with stress, such as using the breathing space to switch out of autopilot and letting go of worries. This may be consistent with decentering as a mechanism of change in mindfulness (Sauer & Baer, 2010). Additionally, engaging as an intimate-partnership appeared to be related to unique outcomes not identified in previous literature, notably, ‘sharing relapse prevention’, which is linked to both partners having mindfulness and decentering skills to draw on when stress arises.

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

Limitations and future research

In view of the small sample size, this model was tentative and findings should be treated with caution. The participants were all White-British and came from a metropolitan area, which limits the transferability of the findings to different cultures. Furthermore, in view of the partially self-selected sample, it was not clear whether the theory would apply to discordant partnerships or partnerships who left the MBCT course early, who arguably had more ambivalent feelings about the course. Similarly, it was not entirely clear why some

Section B: MBCT AS A PARTNERSHIP

people did not fully engage in learning mindfulness skills due to the small subset that followed this journey these categories were not saturated and required further testing.

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

Implications for clinical practice

Partnerships reported enjoying attending the MBCT course together and felt a sense of mutual support for learning new skills that facilitated commitment to the course. In view of the numerous positive experiences and absence of negative experiences, it seems valuable to recommend that healthcare practitioners consider providing partnership groups. This might be a useful way to engage partners in service-user care in line with policy (DoH, 2002).

The data suggests value in considering in assessment for MBCT whether individuals hold an active or passive view of how much control they have over their well-being, and severity of depressive symptoms. Furthermore, it would be important to check that both partners feel partnership attendance would be helpful, and to involve the partnership as equals.

Some partnerships directly applied mindfulness skills to their relationship. This might have reflected differences in need. However, those who were able to apply mindfulness in the context of the intimate-partnership appeared to value this, for example, letting go of anger

Section B: MBCT AS A PARTNERSHIP

pertaining to a partner's depression and increasing empathy. Integrating systemic and mindfulness theory in light of these findings, it could be suggested that turning mindful awareness towards the relationship context potentially enables stepping out of complex feedback systems that may provoke depressive relapse and caregiver burden. It might be beneficial to consider this more explicitly in the MBCT course for partnerships, to encourage partnerships to think about how they can apply mindfulness skills together.

Conclusion

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

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MAJOR RESEARCH PROJECT

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Section C: Critical Appraisal

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SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

Overview

This paper provided a critical appraisal of a grounded theory (GT) study of the process of engaging in Mindfulness-based cognitive therapy (MBCT) as a partnership. It is guided by four questions, which are addressed in turn.

1. What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?

Prior to clinical training, I completed an MSc on the relationship between stability of self concept, attachment security and paranoia in young female offenders. This involved designing a quantitative research study, recruiting participants to complete a series of questionnaires, then analysing the results using quantitative methods (e.g. factor analysis, regression). While this was helpful in developing my quantitative research skills, I felt that the data lacked richness and I was therefore drawn to explore a qualitative methodology for my doctoral research project.

Through immersing myself in qualitative research, I have developed skills in devising interview schedules, undertaking research interviews, and using grounded theory methodology to analyse data and inform future interviews. I have experimented with using computer software (NVivo) and compared this to more traditional approaches. I found NVivo was useful in pointing towards codes that had lots of evidence and those that were less saturated. This helped to make me aware of areas I needed to explore in future interviews. However, theoretical development would have been challenging in the absence of hand-written data analysis. I really valued diagramming as a method for understanding the links between codes (Appendix 19).

Section C

I have reflected on the different ethical issues apparent in small-scale qualitative research and on a practical level, gained skills in navigating the NHS research ethics committee and research and development procedures which will be useful during my career. Working with small sample sizes in qualitative methodology presented different ethical issues to working with larger populations in quantitative research. I became aware during the write-up that participants could potentially identify each other through the participant characteristics table. I protected anonymity by removing participants' ages and cohort number. Another ethical issue was assessing how far to explore areas of interest in research interviews. For example, one participant I interviewed was giving fairly surface level answers and I found myself wanting to follow up open questions to try to make sense of her experience. However, I was also aware of not wanting to push her beyond her comfort zone for the purposes of the research. When I asked her how she had found the interview, she stated that she had felt concerned that it would trigger difficult emotions, but actually it had been gentle and fine. Her reflections provided an explanation for her not wanting to go too deep and I was reassured that I had made the right choice to respect the boundaries of what she was willing to discuss. In later interviews, I was able to follow up on leads with participants who were more willing to talk about difficulties. Engaging with this project has enabled me to critically reflect on ethical issues and make ethical decisions in research.

I feel I have grown in my ability to be a reflexive researcher. Through engaging in GT analysis, I approached the data in a number of different ways (e.g. microanalysis), which sensitised me to the numerous possibilities for interpretation, which in turn influenced the construction of a theory. A central part of the process was keeping an open-mind, looking at my own assumptions through questioning, constant comparison, memo-writing, diagrams, and stepping back from my preconceptions through keeping a research diary and consultation

Section C

with my GT supervisor. I think this helped me to think critically about my position and the research, and facilitated ‘owning one’s perspective’.

In the future, I would be keen to continue developing qualitative research skills in GT and other qualitative methods. I am also interested in combining quantitative and qualitative methods, for example, I feel it might have been helpful to compare the qualitative model to quantitative data to see how it fits with the proposed theory. I have valued learning about the critical realist position, which would be a suitable position to take in mixed-method research.

2. If you were able to do this project again, what would you do differently and why?

On balance, while this project was a small step and requires further exploration, it has been useful in understanding the process of engaging in MBCT as a partnership, which will hopefully inspire healthcare providers to consider offering this intervention or to continue researching in this area. I would have liked to meet with participants who had pursued an MBCT course as a partnership in more diverse settings, for example, non-metropolitan areas, or with people from a different class, race or ethnic background to see whether different codes arose or whether the model applied to different contexts. However, I am not aware of other locations where MBCT for partnerships is being offered at present.

I considered using an alternative methodology, such as interpretive phenomenological analysis or narrative analysis, to explore partnerships’ experience of doing mindfulness together. However, seeing as there was not a theory to understand this process, this would have remained a gap in the research, so I feel GT was the best choice of methodology.

Section C

Model development and respondent validation

It would have been valuable to meet with participants prior to final write-up to discuss the different possible representations of the process of engaging in MBCT as a partnership. The initial model arose quite naturally from bringing participants' data together into an overview (Figure 1); I liked the way Figure 1. highlighted that learning mindfulness skills was framed by learning as a partnership and in turn by the group process, which felt consistent with participants' accounts of the process. However, when I consulted peers and supervisors, I received feedback that it was difficult to know where to start with this model. I experimented with other ways of representing the process and decided on a model that I felt presented the same process more clearly (Figure 2).

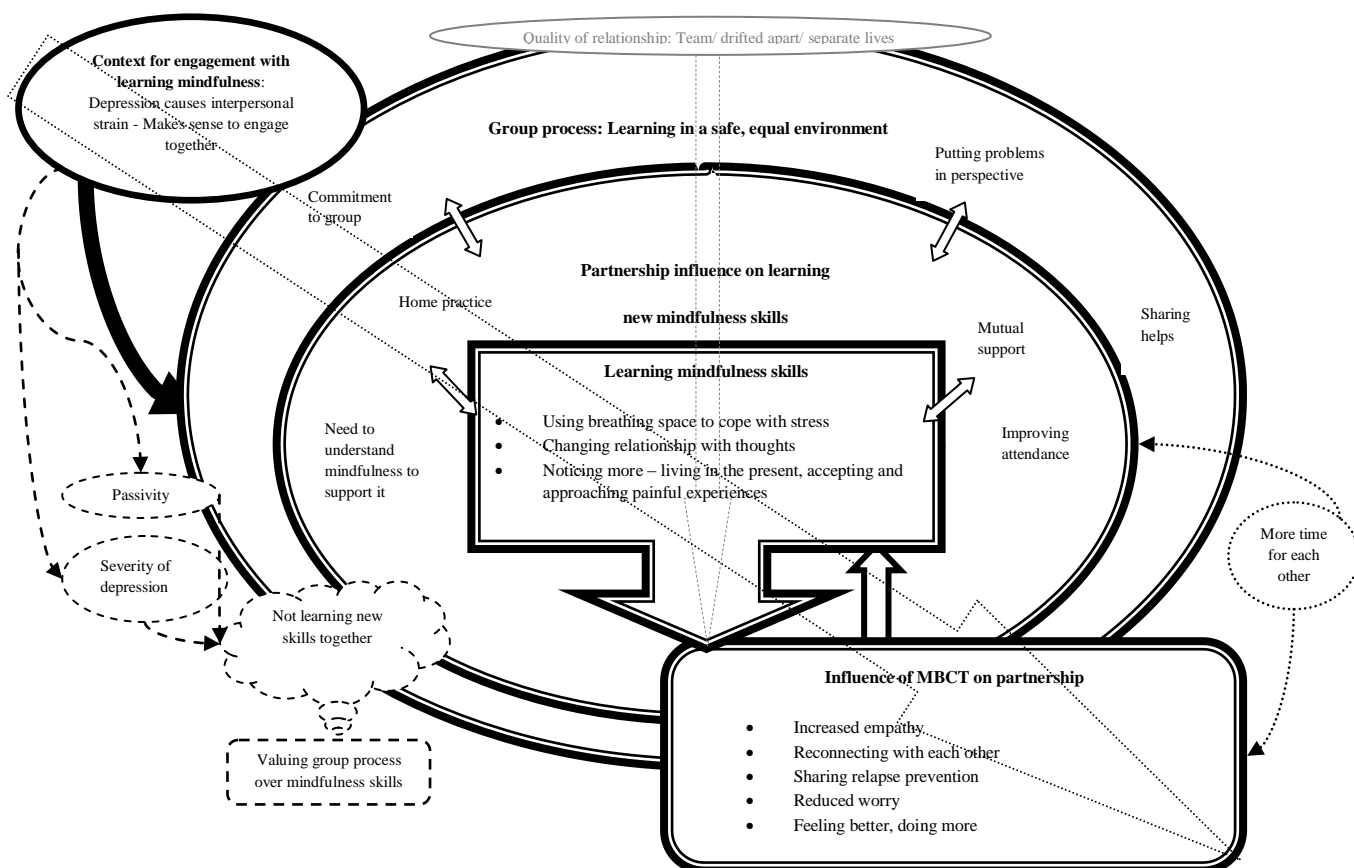


Figure 1. Original model

Section C

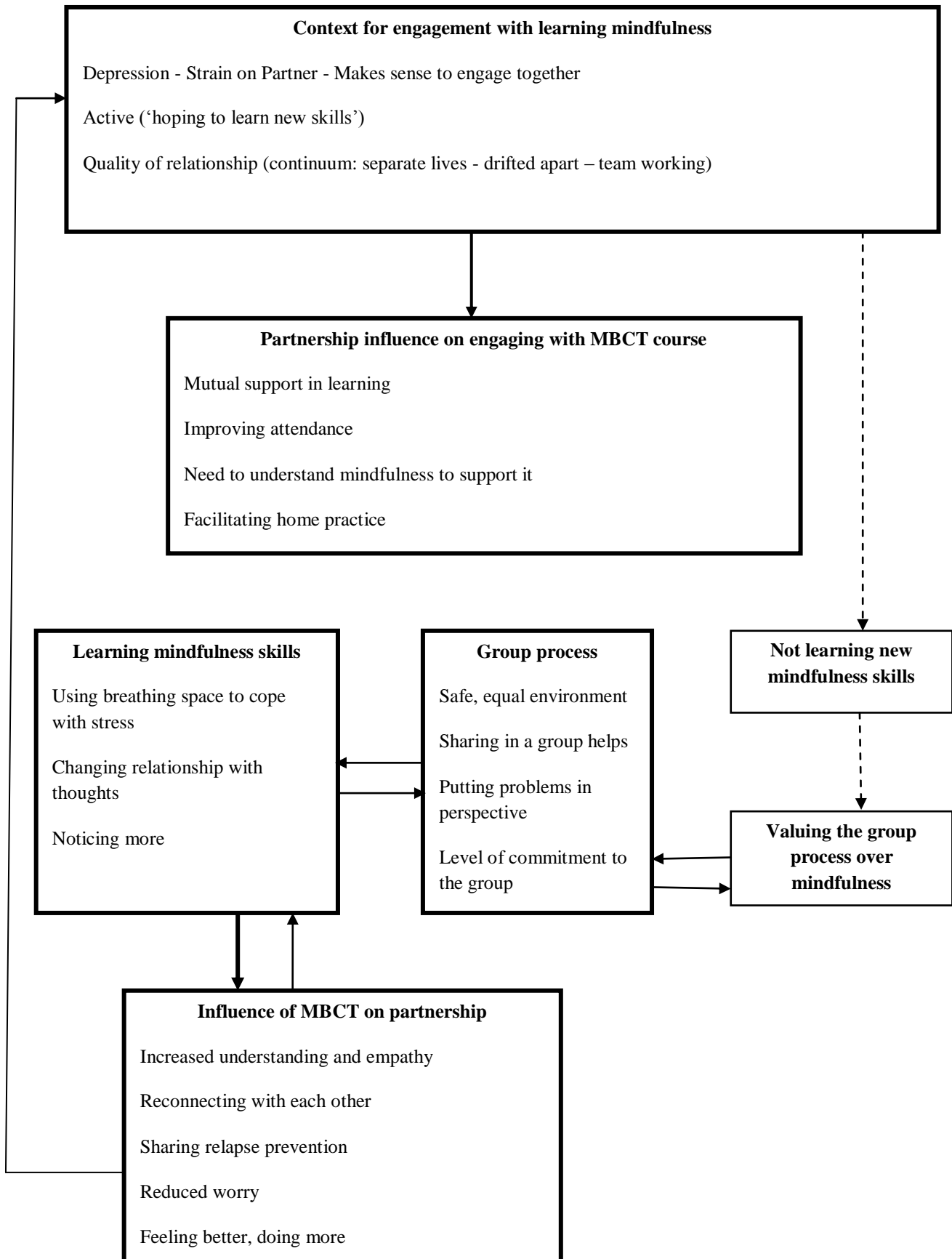


Figure 2. Chosen model

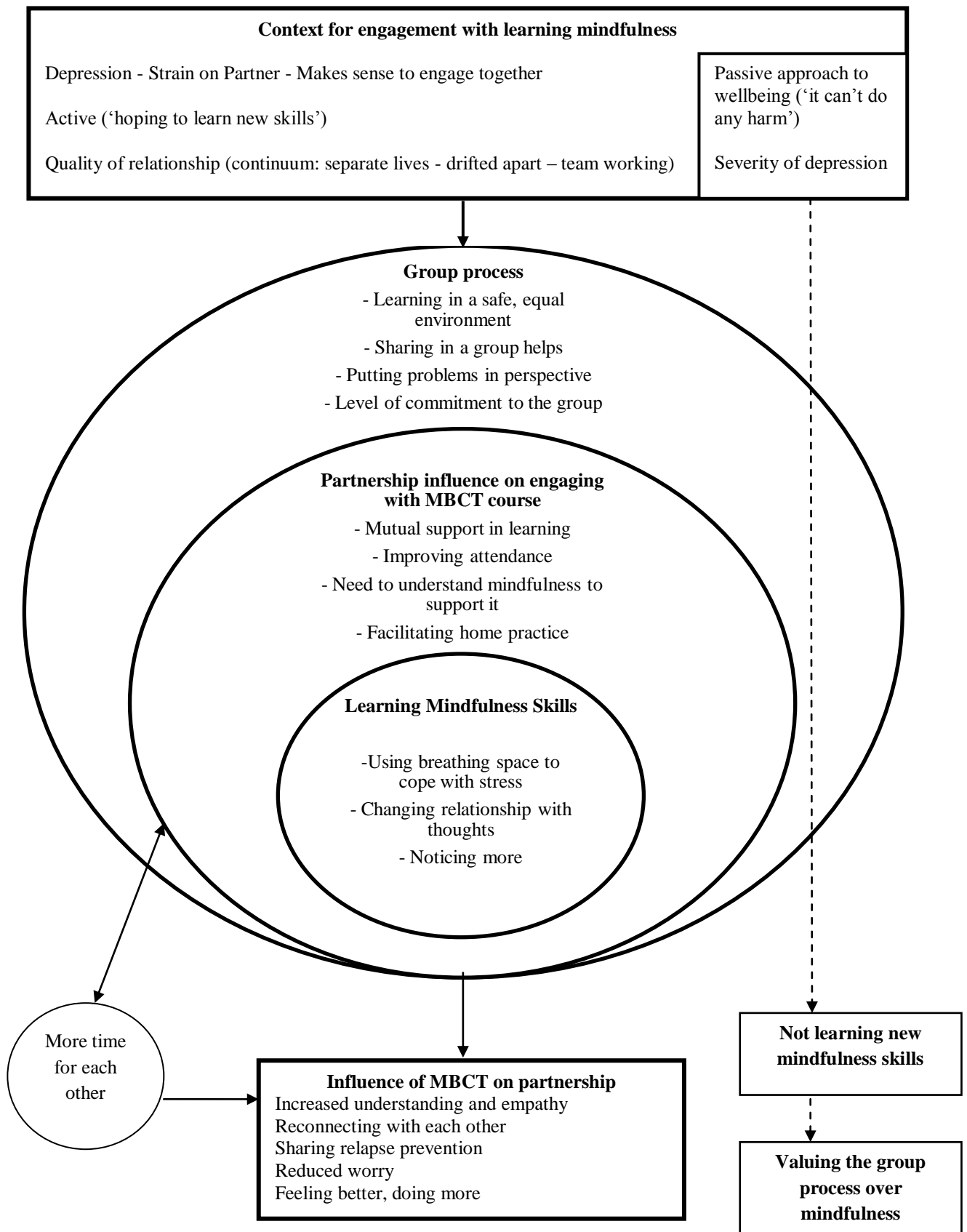


Figure 3. Merged model

Section C

Towards the deadline, I also reconsidered ways of merging the best parts of each model (Figure 3). By this point, I had already sent out requests for respondent validation, so I did not want to make further changes until I heard back from this. Unfortunately, there was not enough time to organise a focus group to discuss which model most helpfully captured participants' experiences of engaging in MBCT as a partnership, which I felt would have been beneficial. This is something I plan to do prior to submission to a journal article. It was an interesting learning process to explore the different ways the theory could be presented, which again made me reflect on my role in the construction of the theory. I would value the opportunity to further debate this with the participants whose accounts contributed to the theory.

3. As a consequence of doing this study, would you do anything differently in regard to making clinical recommendations or changing clinical practice, and why?

I would like to train as an MBCT facilitator in the future as I feel this approach can be helpful to many people. I would be keen to invite partnerships to attend MBCT course where both partners were willing because this seems to be a useful way to involve the partner in mental health care and provide them with a way of coping with stress.

Through engaging in this research, I would be more mindful of assessing the individual's/partnerships' severity of depression at the time of starting the group and make them aware of how challenging it can be when severely depressed. I would also emphasise that people need to make an active choice to engage with the course and that it requires a high degree of commitment and perseverance. These factors seem particularly important considering the impact the group process appeared to have on participants' learning. In groups where everyone was willing to learn and committed to the group, the participants

Section C

reported that sharing with others helped and that this facilitated putting problems in perspective. However, in groups where there was inconsistency in attendance due to participants struggling with severe symptoms of depression, this impacted on the rest of the group. Thus, I would pay more attention to the group composition in my future practice.

4. 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 it?

Through clinical practice and undertaking this research project, I have become very interested in understanding the mechanisms of change in therapy, particularly MBCT. The current model suggested that engaging in the process of learning mindfulness as a partnership led to positive outcomes for most partnerships. The model and theoretical synthesis suggested potential mechanisms of change, such as using the breathing space to cope with stress, changing relationship with thoughts, increased self and other compassion, reconnecting as a partnership and sharing relapse prevention. Initially, I would be interested to pursue further qualitative research to develop aspects of the theory, such as whether it applies to different settings or non-completers.

Following this, I would be interested to explore some of these potential mechanisms of change quantitatively, as participants often struggled to pinpoint what caused the changes they noticed. I would use questionnaires to measure variables that have been identified as potential mechanisms of change, such as, self-compassion, decentering, expressed emotion and dyadic coping before and after the course, and analyse whether there has been significant change using t-tests. In larger samples, regression analysis could test which variables best predict outcome for depression. It would be valuable to compare outcome for depression and mechanism of change between an individuals' and partnership group, to better understand the process and to measure whether involving an intimate-partner protects against relapse.

MAJOR RESEARCH PROJECT

EMMA SMITH BSc (Hons) MSc

Section D:

Appendix of supporting material

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church
University for the degree of Doctor of Clinical Psychology

JULY 2012

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

Appendix 1: Section A Search Methodology

Literature Search for Treatment Studies

Search terms used for depression	depression OR depressive OR depressed OR mood disorder OR affective disorder OR psychiatric illness		
Search terms used for family intervention	"family psychoeducation" "family intervention" "family treatment" "psychosocial interventions" "psychoeducation"	"systemic therapy" "family therapy" "systemic couple therapy"	"marital therapy" "couple therapy"
Database searched	Number of studies identified (>9month follow-up)		
Psychinfo	181 (3)	427 (2)	204 (3)
Assia	33 (2)	39 (0)	26 (3)
Web of Knowledge	73 (1)	47 (1)	40 (4)
EBM Review - Cochrane	158 (4)	30 (1)	20 (3)
Total	8		
Reference searching	1		
Total included in review	9 (Psychoeducation (4), Systemic (2), Marital Therapy (3))		

Inclusion criteria:

- Diagnosis of Major Depression or Dysthymia
- Intervention is a couple based treatment for depression.
- Participants aged 18 – 65 years old.

Exclusion criteria:

- Primary focus on bipolar disorder, psychosis, personality disorder, eating disorder, substance misuse or post-partum depression.
- Does not provide a measure long-term outcome or relapse. The aim of this review was to look at the connection between the intimate-partner relationship and depressive relapse, so only studies that measure long-term outcome (>9 months) were considered.
- Case studies.
- Not available in English.

Section D

Literature Review for Prospective studies

Search terms used for depression	depression OR depressive OR depressed OR mood disorder OR affective disorder OR psychiatric illness	
Search terms used for intimate partner	carer or caregiver or care-giver or marriage or married or marital or partnership or partner or couple or couples or spouse or spousal or family or familial or supportive other or social support or relationship	
Search terms used for relapse	Relapse OR recovery OR long term outcome OR recurrence OR longitudinal OR follow-up	
Databases searched	Number of studies identified	Number of studies identified as relevant
Psychinfo	95 (in abstract) 1 in (title)	4
Assia	298 (in abstract)	14
Web of Knowledge	152 (in title)	10
British Nursing Index	0	0
Ovid Medline	96	2
EBM Review - Cochrane	248 (abstract)	6
Total		36 De-duplicated: 24
Reference searching		4
Total number of prospective studies included in review		9

Section D

Inclusion criteria

- Diagnosis of Major Depression or Dysthymia.
- Pertaining to the role of the intimate partner in depressive relapse or recovery.
- Participants aged over 18 years old.

Exclusion criteria

- Not English language.
- Primary focus on bipolar disorder, psychosis, personality disorder, eating disorder, substance misuse, with a focus on depression as a secondary problem.
- More generally about social support, marital status or considering the role of divorce/separation in depression, without a specific consideration of the intimate partner relationship.
- Primary focus on intimate partner violence, because this is a different level of marital discord.
- Studies on the impact of medication on recovery.
- No measure of relapse or long-term outcome in depression.

Section D

Literature review for Impact on Caregivers

Search terms used for depression	depression OR depressive OR depressed OR mood disorder OR affective disorder OR psychiatric illness	
Search terms used for intimate partner	carer OR carers OR caregivers OR caregiver OR marriage OR married OR partnership OR couple	
NOT	geriatric OR Alzheimer's OR dementia OR elderly OR stroke OR Parkinson OR physical illness OR children OR child OR adolescent OR adolescents OR cancer OR palliative care OR spinal cord injury OR traumatic brain injury OR schizophrenia OR psychosis	
Databases searched	Number of studies identified	Number of studies identified as relevant
Psychinfo	160	3
Assia	33	3
Web of Knowledge	692 (refined to 258)	5
British Nursing Index	62	0
Ovid Medline	83	4
EBM Review - Cochrane central register of controlled trials and all Ovid EBM review resources	0	0
Reference searching	3	3
Total		9

Inclusion criteria

- Diagnosis of Major Depression or Dysthymia.
- Pertaining to the impact of caring for an intimate-partner with depression.
- Participants aged over 18 years old.

Exclusion criteria

- Not English language.
- Primary focus on dementia, physical illness, bipolar disorder, psychosis, personality disorder, eating disorder, substance misuse, with a focus on depression as a secondary problem.
- Primary focus on intimate partner violence, because this is a different level of marital discord.

Section D

Appendix 2: Studies on intimate-partnership and depressive relapse**Prospective studies**

Study (year), country	Inclusion criteria, participants, assignment	Assessments	Main results	Follow-up
Backs-Dermott et al (2010), Canada	Female community aged 18-65 years Major Depression using SCID, BDI-II	Multidimensional scale of perceived social support (MSPSS) Bi-weekly telephone contact to monitor for depressive relapse. Frank et al (1991) criteria for relapse.	Of 49, 20 remained in stable remission, 29 relapsed before 12 month follow-up. Social support, emotion/ avoidance coping combined to predict depressive relapse.	12 month follow-up from the time the participant achieved remission from major depression
Hayhurst, et al (1997), UK	39 depressed patients and their partners. Major Depression using Clinical Interview for Depression (Paykel, 1985) Hamilton Rating Scale for Depression (1967).	Patients' PC 10-point scale 'not at all critical' to 'very critical indeed' (Hooley & Teasdale, 1989) Marital adjustment scale from 1 ('excellent') to 7 ('marriage on the point of breaking down') (Paykel et al, 1996) Camberwell Family Interview (CFI; Vaughn & Leff, 1976b) Interviews coded for no. critical comments, no. positive remarks and ratings of warmth, hostility and emotional over-involvement.	Criticism when patients were most depressed predicted neither remission nor subsequent relapse. Patients who fully recovered, with or without later relapse, had partners who were consistently uncritical, or critical only at presentation. Patients with residual symptoms during remission had more persistently critical partners.	12 month follow-up from the time the participant achieved remission from major depression
Hinrichsen & Pollack (1997), USA	adult children (52%) or spouses (48%) of 54 elderly inpatients (age >60) Major depression using SADS	LIFE. Five Minute Speech Sample (FMSS).	In adult children, high EE predicted higher relapse. In spouses, high EE predicted lower relapse.	1 year follow-up, measures recovery vs. Relapse.

Section D

Hooley & Teasdale (1989), UK	39 inpatients, who met RDC for Major depression using The Beck Depression Inventory (BDI; Beck et al, 1961)	Partners were interviewed 2-3 weeks after admission using the CFI Dyadic Adjustment Scale (DAS; Spanier, 1976). Patients PC 10-point likert scales.	In Hooley et al (1986) patients with more critical partners had a higher relapse rate. In Hooley et al. (1989) patients who did not relapse had higher marital satisfaction as did their partners. Patients who relapsed rated their partners as more critical than those who did not. Perceived criticism was not related to expressed criticism or illness severity, it contributed 38%.	Relapse assessed at 3 and 9 months
Kronmuller et al (2011) and Kronmuller et al (2008), Germany	50 consecutively admitted inpatients with depression, diagnosed with Major Depression by the SCID, and their spouses	Terman item (Terman, 1938) to assess marital satisfaction. Five minute speech sample to assess EE. Perceived criticism index (Hooley & Teasdale, 1989) Relapse defined by DSM and Frank et al criteria. Longitudinal interval follow-up information (LIFE)	Over half had 1 or more recurrence during 10 years. Spousal EE was a prognostic factor for relationship quality 10 years on. Relationship did not predict relapse, but recurrence predicted marital satisfaction.	10 years
Kwon et al (2006), Korea	27 married female outpatients discharged from hospital. Recovered at the start of the study. Diagnosed with Major Depression using SADS and BDI.	PC (Perceived Criticism) PC-E (PC—Expanded Scale) Inventory) DAS-D (Dysfunctional Attitudes Scale—Dependency) GDS (General Marital Dissatisfaction Scale) Interview—investigator based Marital relationship (SESS)	Perceived criticism by spouse was a predictor of depressive relapse. This reflected actual negative characteristics of the marital relationship as well as the depressed person's high dependence on the relationship. 5/27 relapsed, none of participants with low PC relapsed.	11 month follow-up
Okasha et al (1994), Egypt	32 depressed patients and their spouses. Diagnosed with depression or bipolar disorder.	Camberwell Family Interview.	56% relapsed. Family criticism predicted relapse, but at a higher cut-off of 7. PC did predict relapse.	9 month follow-up
Vaughn & Leff (1976), UK	30 depressed patients, 37 with schizophrenia	Expressed emotion with adjusted cut-off of 2 critical comments for depressed patients. Camberwell Family Interview	Depressed patients relapse was related to relative's criticism, even more than the schizophrenia group. 67% in 2+ critical comment group relapsed.	9 month post discharge

Section D

Marital Therapy

Study (year), country	Type of intervention (n) and assignment of cases	Inclusion criteria	Assessments	Main results	Follow-up
Bodenmann et al (2008), Swiss multi-centre study	RCT Comparison of 3 interventions, Coping Oriented Couples Therapy (COCT) (20) vs CBT (20) vs IPT (20), random assignment.	Non-maritally distressed couples with 1 depressed partner. In a relationship for > 1 year. BDI > 18. Diagnosed using the SCID-I.	BDI and Hamilton Rating Scale for Depression. Close stable relationship for > 1 year. Partnership questionnaire to assess marital quality. Dyadic coping inventory. Five minute speech sample (FMSS).	Shows clinical recovery and improvement for each condition. BDI > 11 classed as relapse, among those who recovered during treatment, fewer relapsed in the COCT condition, though this was not significant. COCT condition showed significant improvements on expressed emotion, not seen in CBT or IPT. Preliminary evidence for a mediating effect of EE in COCT on relapse and not in CBT or IPT.	pre- and post-test questionnaire with follow-up at 6, 12 and 18 months. Measured relapse rates.
Jacobson et al (1993), USA	Behavioural Couples Therapy (20) vs BCT in combination with CBT(20) vs CBT (20), random assignment	Married, depressed outpatient women. Primary diagnosis of Major depression.	BDI < 10 was cut off for recovery. LIFE observation coding system measured Facilitative, aversive and dysphoric interaction behaviour (Hops et al, 1987; Hops et al, 1990). Data from 15-min conflict interaction pre- and post-therapy	Low relapse rates across all treatment conditions. Husband facilitative behaviour was related to reduced relapse in the year following treatment.	6 and 12 month follow-up, measure relapse rates in those who recovered. CT 15% relapsed, BCT 10% and combined 10% relapsed, nonsig.
O'Leary & Beach (1990), (1992), USA	Behavioural marital therapy (BMT) with Cognitive Therapy (CT)(15) vs. CT alone (15) vs. Wait-list control (15)	Diagnosis of major depression or dysthymia	BDI , Dyadic Adjustment Scale	Both treatment conditions led to significantly lower BDI. No significant difference in impact on depressive symptomology, but BMT led to higher marital satisfaction.	1 year follow-up

Section D

Systemic studies

Study (year), country	Type of intervention (n) and assignment of cases	Inclusion criteria	Assessments	Main results	Follow-up
Leff et al (2000), Jones & Asen (2000), London	RCT of antidepressant drugs (37) vs. couple therapy (systemic) (40) vs CBT (11)	The subjects were 88 people meeting criteria for depression living with a critical partner.	BDI > 11, Hamilton Depression Rating Scale. Partners assessed with BDI and Camberwell Family Interview. Included if 2 critical comments.	CBT arm was excluded because 8 out of 11 patients dropped out. Drop-outs were 56.8% from drug treatment and 15% from couple therapy. Subjects' depression improved in both groups, but couple therapy showed a significant advantage, according to the Beck Depression Inventory, both at the end of treatment and after a second year off treatment. EE not related to change, but hostility reduced in the couples group, which might be linked to change.	2 year follow-up, measured relapse
Lemmens, Eisler, Buysse, Heene, and Demyttenaere (2009), Belgium.	Investigated the use of multifamily group therapy (MFGT) (35), single systemic family therapy (25) and treatment as usual (23).	Participants were 83 inpatients with a diagnosis of depression and their partners. Cohabiting for at least 1 year.	Mini International Neuropsychiatric Interview, Dutch version 5.0.0. (sections A to O), Hamilton Rating Scale for Depression. Beck Depression Inventory (BDI), both they and their partners filled in the Dyadic Adjustment Scale (DAS), a rating of the subjective emotional health (SEH) of their partner rated on a 4-point Likert scale (1 = poor, 2 = not very good, 3 = quite good, 4 = very good). The BDI and the SEH were re-administered in month 3 (after session 6) and month 15.	Family interventions had better results at 3 month follow-up, at 15 month follow-up, those in the MFGT condition showed significantly better results. 49% MFGT, 24% SFT and 9% medication responded to treatment. MFGT and SFT had higher rates of patients no longer using antidepressant medication. Partners were significantly more likely to notice the improvements in the emotional health of the patient early on compared to those in the treatment as usual condition.	They measured 15 months FU, did not measure relapse rates.

Section D

Psychoeducation studies

Study (year), country	Type of intervention (n) and assignment of cases	Inclusion criteria	Assessments	Main results	Follow-up
Spencer et al. (1988), Glick et al. (1985)USA	Inpatient individual psychoeducational family intervention (79) plus Treatment as usual (TAU) (89), random assignment.	Admission in psychiatric ward. Diagnosis of depression or schizophrenia	At discharge, 6 months and 18 months	Treatment group: better attitude toward medication, improved social functioning, improvement of relative's social contacts of their relatives	18 months
Shimazu et al. (2011), Japan.	Individual psychoeducational family intervention, focus on problem-solving and coping skills (25), plus TAU (32), random assignment.	Relatives living with patient with a diagnosis of depression, for at least 3 months.	Baseline and 9 months	Treatment group: significant reduction in pateint's rates of relapse. No reduction in expressed emotion.	9 months
Magliano (2009), Italy and Fiorillo et al. (2011), Italy	Individual psychoeducational family intervention, focus on communication skills and problem-solving (22), plus informative sessions (22), random assignment.	One or more depressive episode within the past 2 years. No psychiatric admission in the past month. Living with a family member, who does not have a major physical or psychiatric problem	Baseline, 6 and 12 months	Treatment group: reduction in personal and family difficulties, improvement in social contacts.	12 months
Fabbri et al. (2007), Italy	family intervention with patients on antidepressant medication who continued to experience recurrent depression (10) compared to increasing medication and clinical care (10)	Relapse of depression while taking antidepressants. 3 or more episodes of depression. Living with a partner.	baseline, 12 weeks, assessed by psychologist using change version of Paykel's clinical Interview for depression (CID).	Those who received a family intervention based on the McMaster Model were significantly less likely to relapse during 1-year follow-up than those who received increased medication.	1 year follow-up, relapse measured

Section D

Impact on caregiver studies

Study, (date), year, country, N	Design	Main results
Benazon and Coyne (2000), USA, 79 couples	Examined the depressed mood and specific burdens experienced by spouses living with depressed patients. Regression analyses. Measures of depressed mood and burden.	Found that the intimate-partner is more likely to be experiencing higher levels of depressive symptoms than the general population. Spouse's depressed mood was explained by specific burdens and gender.
Coyne, Kessler, Tal, Turnball, Wortman & Greden, (1987), USA, 49 adults	Comparison of spouses of service-users who were currently depressed vs. Those who were not. Factor loading and regression analyses. Measures of subjective and objective burden and psychological distress.	Results showed the increased burdens of living with a currently depressed partner, particularly in response to the patient's feelings of worthlessness, worrying and lack of energy, and the partner's emotional strain and concerns about future relapse
Jeglic et al., (2005), USA, 31 married couples	Tested the hypothesis that subjective levels of caregiver stress mediate the relationship between patient's and spouse's depressive symptoms. Regression analyses. Measures of depressive symptoms, caregiving stress and burden.	The intimate-partner's level of depression was statistically explained by self-reported caregiving stress.
van Wijngaarden, Schene, & Koeter, (2004), the Netherlands, 260 spouses of depressed patients	Tested the caregiving consequences of spouses of depressed patients. Measures of involvement, ways of coping, social support, depression.	Spouses of patients with depression reported higher level of depressive symptoms, often warranting psychiatric intervention
Angermeyer, Bull, Bernert, Dietrich & Kopf, (2006), Germany, 133 partners and 128 professionals	Comparison of partners and professional carers of people with depression and schizophrenia. Regression analyses. Maslach Burnout Inventory.	There was no significant difference in burnout of partners and professionals. About a quarter of caregivers experience a high level of burnout.
Heru & Ryan, (2004), USA, 39 caregivers of patients with mood disorders	Comparison of caregivers of bipolar and unipolar depression. T-tests. Caregivers completed measures of family functioning, strain, burden, patients level of functioning, at enrolment and 1 year follow-up.	The burden of caring for a depressed partner appears unchanged in the year post-discharge from hospital. Whereas the burden of caring for a partner with bipolar improves after a year.
Möller-Leimkühler & Jandl, (2011), Germany, 16 schizophrenia, 34 depression caregivers.	Evaluation of prognostic value of expressed emotion and perceived criticism on caregiver stress at 3 year follow-up. Measures of caregiver burden, well-being, quality of life, psychological symptoms. Regression analyses.	Caregiver's burden, psychological symptoms and quality of life were best predicted by caregiver's expressed criticism, followed by patient's perceived resignation
Highet, McNair, Davenport & Hickie, (2004), Australia, 37 carers of depressed patients	Qualitative, thematic analysis	Participants perceived that isolation made caring more stressful, alongside being uninvolved in service-user care
Harris, Pistrang & Barker, (2006), UK, nine couples	Qualitative, IPA	Participants perceived challenging aspects of the support process to be role adjustment and finding ways to help their depressed partner

Section D

Appendix 3: Participants' demographic information

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Section D

Appendix 4: Salomons Research Ethics Committee Approval

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Section D

Appendix 5: Research Ethics Committee Approval

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Appendix 6: R&D approval

Appendix 7: Participant Information Sheet



Salomons Clinical Psychology Programme
Department of Applied Psychology,
Broomhill Road, Tunbridge Wells, Kent, TN3 0TG.

PARTICIPANT INFORMATION SHEET (Version 2: 20/10/2010; 10/H1107/62)

Title of Project: Developing a theory of the process of engaging in an Mindfulness-Based Cognitive Therapy course as a ‘partnership’

A research study is being undertaken as part of a Doctorate in Clinical Psychology, sponsored by the Department of Applied Psychology at Canterbury Christ Church University (CCCU). The researchers are Emma Smith (Trainee Clinical Psychologist), Dr Fergal Jones (Senior Lecturer), Dr Kim Griffiths (Chartered Clinical Psychologist) and Dr Sue Holttum (Senior Lecturer in Research).

You are being invited to take part in a research study. Before you decide whether to take part please read the following information and if you have any questions that are not addressed here, please do not hesitate to ask me. Contact details are at the end of the information sheet.

Why is this research happening?

Some people who have attended the Mindfulness-Based Cognitive Therapy (MBCT) groups in the past have said they would have liked their partner to join. As such, Oxleas NHS Trust is now offering MBCT groups for individuals plus a selected ‘partner’. We will use the term ‘partner’ to mean any supportive-other, friend, family member or carer, and the term ‘partnership’ in a similar way.

Delivering an MBCT group to ‘partnerships’ is quite a new idea; as such this study is going to look at people’s experience of attending the group as a ‘partnership’. Although mindfulness has been around for a long time, it is only recently becoming common in NHS settings. So far, there is a lot of research to suggest MBCT is effective, but less research on why it is effective for people e.g. what the process is? We hope this research will contribute to the why question, by helping us to better understand the process of engaging in an MBCT group as a ‘partnership’. From this we may also be able to think about how to deliver useful groups for partners in the future.

Why have I been asked to take part in this study?

You have been asked to participate in this study because you have undertaken an MBCT course for partners, or you might be on the waiting list for the next group. The study is open to both partners attending the group, as we are interested in both of your experiences.

What will you be required to do?

Participants in this study will be invited to meet individually with the researcher, Emma Smith, to engage in an interview about their experience of the MBCT course and mindfulness

Section D

practice. The interview will take place at Bexleyheath Centre, or an NHS location convenient for you, and your travel expenses can be reimbursed up to £10. The interview will last about 45 – 60 minutes. During the interview I will ask you questions about your experience of attending the MBCT course and practising mindfulness with a partner. It may be that you have not continued practising and I will be interested to hear about these experiences too. I will record the interview, so that afterwards I can write down what had been said and then think about this. The recording will be kept confidential (see below) and be stored in a secure place.

There are few risks to people from taking part in interviews; however, the interviews might touch on difficult issues, for example, if you felt distressed by certain parts of the course. You will not have to talk about anything you do not feel comfortable talking about. There will be time at the end of the interview to review your experience of the interview and think about possible sources of support if required.

If you choose to take part in this research, we will send a letter to your GP to let them know. We will also ask the clinicians involved in your care to review your medical records to provide some demographic information and contact details.

Confidentiality

All data and personal information will be stored securely within CCCU premises in accordance with the Data Protection Act 1998 and the University's own data protection requirements. Data can only be accessed by the research team, the regulatory authorities and the NHS Trust. When the audio-recordings are typed up, all identifying information will be changed to protect anonymity. Similarly, if the research study is published at a later stage, all your personal information will be changed so you will not be identifiable.

The only occasion on which I might have to share something you said (e.g. by speaking with a GP) would be if you told me something that suggested there was a risk of harm to yourself or another person. In such circumstances, I will try to discuss the way forward with you first.

How can I find out about the results?

It is planned that the results will be fed back to Oxleas NHS Trust Research & Development Department, and submitted for publication at a later date.

You will be invited to attend a meeting to discuss the results and if you wish we can send you a copy of the report when it is completed.

Deciding whether to participate

Please take your time deciding whether you wish to participate. It is completely up to you whether you decide to take part and your decision will not affect the treatment you receive in the NHS. Should you decide to participate, you will be free to withdraw at any time without having to give a reason. If you have any questions or concerns about the nature, procedures or requirements for participation do not hesitate to contact me.

What should I do if I want to make a complaint?

There are many options available to you if you are unhappy about something or wish to make a complaint. You can speak to a member of the research team in person, by email or telephone. Alternatively you could go to your GP.

Any questions?

Section D

Please contact Emma Smith on e.l.smith25@canterbury.ac.uk or 01892 507673, or via Dr Kim Griffiths at the Bexleyheath Centre on 02083019400.

Appendix 8: Consent Form



Salomons Clinical Psychology Programme
 Department of Applied Psychology
 Broomhill Road
 Tunbridge Wells, Kent, TN3 0TG.

CONSENT FORM (Version 2: 20/10/2010; 10/H1107/62)

Title of Project: **Developing a theory of the process of engaging in a Mindfulness-Based Cognitive Therapy group as a ‘partnership’**

Please read the following statements and initial in the box to show your agreement.

1. I have read and understood the participant information sheet for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without my health care or legal rights being affected.
3. I agree that researchers can contact the clinicians and GPs involved in my care.
4. I agree that the clinicians involved in my care can review my medical records and provide personal information to the researchers, such as contact information and demographic information.
5. I understand that my personally identifiable research data will be kept confidential within the research team.
6. I understand that confidentiality may be broken if the researchers are concerned that there may be significant risk of harm to myself or others.
7. I agree that my medical records and research data collected during the study may be looked at by individuals from the research team, sponsor, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in the research. I give permission for these individuals to have access to my records.
8. I agree that the research can be audio recorded and that anonymised quotes of what I say can be used in reports and publications about the research.
9. I agree to take part in the study.
10. Would you like a copy of the final report?

Yes/No

 Name of Participant

 Date

 Signature

Section D

Name of Person taking consent
(if different from researcher)

Date

Signature

Researcher

Date

Signature

Name of research team: Emma Smith (Trainee Clinical Psychologist), Dr Kim Griffiths (Chartered Clinical Psychologist), Dr Fergal Jones (Senior Lecturer), Dr Sue Holttum (Senior Lecturer in Research)

Contact details: Salomons Clinical Psychology Programme, Department of Applied Psychology, Broomhill Road, Tunbridge Wells, Kent, TN3 0TG. Tel: 01892 507673, Email: e.l.smith25@canterbury.ac.uk

Copies: 1 for participant, 1 for researcher

Appendix 9: Interview schedule

Interview Schedule (Version 5: 13/04/2011; 10/H1107/62)

Initial Questions aimed at helping to reconnect with the experience

1. As best as you can remember, how long is it since you did the MBCT group?
2. How many sessions did you do?
3. Sometimes the questions will be referring to the person you did the group with. How would you like me to refer to the partner you did the group with?
4. How did you hear about the group?
5. Why did you choose to attend? What spurred you to attend the group?
6. What was it like being asked to bring a partner along? Or being asked by your partner to come?
7. Remembering back to how things were before you started the group, if it feels OK to say would you mind saying something brief about the sort of difficulties and challenges you and your partner were having around the time you started the group?

Intermediate Questions

Before questions

1. What were your thoughts about starting the group?
2. What were your hopes, expectations or concerns about attending the group? Prompt: with your partner?

During questions

3. Tell me about your experience of the MBCT group with your partner or carer...
4. What are your main memories of the group? What do you remember about what happened in the group?

Potential prompts:

Section D

- And how about in relation to doing the group with a partner?
 - Anything you would add that was particular to doing the group as a ‘partnership’?
5. Can you think of anything from the group that seemed helpful at the time?
 6. Can you think of anything that seemed unhelpful?
 7. Can you tell me about any positives about doing the group together?
 8. Can you tell me about any difficulties about doing the group together?
 9. If I need a little more information, I may ask... Now I’m just going to ask you to tell me about your experience of some areas in a little more depth, again with a particular focus on any thoughts about doing the group as a ‘partnership’

Potential prompts:

For each of these prompts, I’ll be asking about their experience with a particular emphasis on doing it with their partner.

- Tell me about your experience of the... with your partner
- Mindfulness practice?
- Body Scan?
- Walking and movement meditation?
- Sitting Meditation?
- CBT?
- Home practice?
- Group discussions?
- Attending?
- Being in a group? With other partnerships?
- Working as a partnership in a group?
- The facilitators?
- Follow-up sessions?

Section D

After questions

10. Tell me about any changes in your life since finishing the MBCT group...
11. Have you noticed any changes in your life since finishing the group? Any changes in yourself? Your partner? Your relationship? Since attending the MBCT group? Were these positive or negative changes?
12. I would be very interested to hear about your sense of what might have caused these changes...

Possible prompts

- If you have noticed any changes, what do you think they are related to?
 - What makes you think they may be related to the MBCT group?
 - Can you think of any other explanations for the changes? E.g. have you had any other therapy? Major life events? Change in medication?
13. I'm interested in any ideas you have about what might be different about doing the group with a partner rather than alone. What benefits and difficulties do you think came from doing the group together rather than alone?
 14. What thoughts do you have on how the group might have been different if you had undertaken it alone?

Ending Questions

1. After having this experience what would you say to a friend who was considering undertaking the MBCT course with a partner?
2. Is there anything else you think I should know to better understand your experience of engaging in the MBCT course as a partnership?
3. Is there anything you would like to ask me?
4. How have you found the interview today?

Section D

5. If you don't mind saying, is there anything I could have done differently that might have helped the interview today?

Information sheet

Name	
Age	
Gender	
Ethnicity	
Length of time since finishing the course?	
Reasons for attending? E.g. the difficulties that you or your partner were experiencing.	
Have you ever done anything like mindfulness before?	Yes/No

Appendix 10: Later Interview ScheduleInterview Schedule (Version 9: 3/05/2012; 10/H1107/62)

Initial questions

8. Remembering back to how things were before you started the group, if it feels OK to say would you mind saying something brief about the sort of difficulties and challenges you and your partner were having around the time you started the group?
9. How would you refer to the difficulties that brought you to the group? E.g. depression, life stress?
10. Just briefly, what was your understanding of depression at the time?
11. Had you heard of the idea of recovery and relapse prevention? What did you think recovery or relapse prevention was about? E.g. did you have ideas about how you could keep yourself/ each other well?
12. Some people have talked about how depression impacts on their partner and relationship. How were you managing this prior to the group? What expectations did you have of your partner before starting the course? E.g. how would you like them to respond when you're feeling low? How did they?
13. And could you say a little about how your relationship was before you started the group? How do you think this might have influenced your engagement in the course? E.g. being a very close couple vs. being more separate?
14. How do you refer to the MBCT course? And your partner? Just so, I know what language to use when asking questions.

During questions

15. What sticks out most for you, thinking back to your experience of the MBCT course?

Section D

16. People take different things away from the course, what were the key skills or ideas that you learned that you have taken away from the course? (E.g. switching off autopilot, changing relationship with thoughts, noticing more, approaching pain & distress)
17. Can you think of anything from the group that seemed helpful at the time?
18. Can you think of anything that seemed unhelpful?
19. How did sharing the experience with your partner influence your engagement with the course?
20. Some people have talked about getting more out of MBCT because of a sense of “mutual support” with their partner, there seemed to be two parts to this that I wanted to check out with you. Did you notice mutual support in learning new skills together; can you think of any examples? Secondly, did you feel a mutual support in trying to deal with stress together, any examples? How do you think this was related to the kind of couple you are/ the MBCT course? How did it impact on your experience of the group? How did this influence how you manage stress together?
21. Other people have appreciated having someone to joke about the course with, because it can seem a bit strange, did you notice this? Do you think this helped you continue to attend or separated you from the course? How?
22. People have described engaging with the home practice in different ways. Did you tend to practice together or not? (Was this more of a mentoring relationship or a commitment to practice together/ separately?) Why do you think you chose to practice together/ separately? How did this influence your learning? Does this reflect ways you have worked together in the past?
23. Some people have commented that sharing with others (i.e. in the group) was a useful part of the process. What, if anything, did you get out of this? E.g. a sense of putting

Section D

things in perspective or normalising the experience of depression? How about a feeling of helping others or feeling like you are all ‘in it together’?

After questions

24. Have you noticed any changes in your life since finishing the group? Any changes in yourself? Your partner? Your relationship? How you support your partner? Were these positive or negative changes?
25. I would be very interested to hear about your sense of what might have caused any changes you have noticed e.g. MBCT or other life events?
26. Some people have talked about approaching depression as a ‘partnership’ since engaging in MBCT together (as opposed to feeling quite alone in depression). I wondered if you could tell me whether this is relevant to your experience. Can you give me an example? What do you think facilitated this change? Has your perspective on depression changed at all?
27. Have you changed your views on what keeps you well? Or how you can support each other with stress? Is this a shared understanding of what helps?
28. Some people have talked about feeling like they have a shared resource in mindfulness that they can turn to keep depression at bay... How would you know if you had a shared resource? E.g. some people have talked about suggesting their partner practices when stressed or having a shared language when facing difficulties together.
29. Some people have talked about doing more and feeling better since the MBCT course, I wonder if you have noticed this and if so, what you put it down to?
30. Some people felt doing the course together had strengthened their relationship and linked this to increased empathy and understanding of each other, does this resonate with you at all? Any ideas why or why not? What caused it?

Section D

31. I'm interested in any ideas you have about what might be different about doing the group with a partner rather than alone. What benefits and difficulties do you think came from doing the group together rather than alone?
32. What thoughts do you have on how the group might have been different if you had undertaken it alone?

Ending Questions

6. Is there anything else you think I should know to better understand your experience of engaging in the MBCT course as a partnership?
7. Is there anything you would like to ask me?
8. How have you found the interview today? If you don't mind saying, is there anything I could have done differently that might have helped the interview today?

Section D

Appendix 11: Substantial amendment to ethics

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Appendix 12: Participant Information Sheet B

PARTICIPANT INFORMATION SHEET B (Version 1: 18/07/2011; 10/H1107/62)

Title of Project: Developing a theory of the process of engaging in an Mindfulness-Based Cognitive Therapy course as a ‘partnership’

A research study is being undertaken as part of a Doctorate in Clinical Psychology, sponsored by the Department of Applied Psychology at Canterbury Christ Church University (CCCU). The researchers are Emma Smith (Trainee Clinical Psychologist), Dr Fergal Jones (Senior Lecturer), Dr Kim Griffiths (Chartered Clinical Psychologist) and Dr Sue Holttum (Senior Lecturer in Research).

You are being invited to take part in a research study. Before you decide whether to take part please read the following information and if you have any questions that are not addressed here, please do not hesitate to ask me. Contact details are at the end of the information sheet.

Why is this research happening?

Some people who have attended the Mindfulness-Based Cognitive Therapy (MBCT) groups in the past have said they would have liked their partner to join. As such, Oxleas NHS Trust is now offering MBCT groups for individuals plus a selected ‘partner’. We will use the term ‘partner’ to mean any supportive-other, friend, family member or carer, and the term ‘partnership’ in a similar way.

Delivering an MBCT group to ‘partnerships’ is quite a new idea; as such this study is going to look at people’s experience of attending the group as a ‘partnership’. Although mindfulness has been around for a long time, it is only recently becoming common in NHS settings. So far, there is a lot of research to suggest MBCT is effective, but less research on why it is effective for people e.g. what the process is? We hope this research will contribute to the why question, by helping us to better understand the process of engaging in an MBCT group as a ‘partnership’. From this we may also be able to think about how to deliver useful groups for partners in the future.

Why have I been asked to take part in this study?

You have been asked to participate in this study because you are going to be taking part in the next MBCT course for partners. The study is open to both partners attending the group, as we are interested in both of your experiences.

What will you be required to do?

You are being asked to agree to me (Emma Smith) sitting in the MBCT course sessions as an observer so that I can gain experience of how they run to help with this research. I will take notes in the sessions and audio-record them so that afterwards I can write down what has been said and then think about this. I will use this data alongside interview data to understand the process of engaging in the group as a ‘partnership’. The recordings will be kept confidential (see below) and be stored in a secure place.

If you choose to take part in this research, we will also ask the clinicians involved in your care to review your medical records to provide some demographic information and contact details.

Section D

You have three options in terms of taking part, firstly to consent to Emma Smith observing the group, secondly, to consent to Emma Smith observing the group and agree to the things you say and do being included in the research, and thirdly, to consent to neither, and the observation will not go ahead.

At a later date you may be asked to take part in an interview, again this is up to you and you will be give more information at the time.

Confidentiality

All data and personal information will be stored securely within CCCU premises in accordance with the Data Protection Act 1998 and the University's own data protection requirements. Data can only be accessed by the research team, the regulatory authorities and the NHS Trust. When the audio-recordings are typed up, all identifying information will be changed to protect anonymity. Similarly, if the research study is published at a later stage, all your personal information will be changed so you will not identifiable.

The only occasion on which I might have to share something you said (e.g. by speaking with a GP) would be if you told me something that suggested there was a risk of harm to yourself or another person. In such circumstances, I will try to discuss the way forward with you first.

How can I find out about the results?

It is planned that the results will be fed back to Oxleas NHS Trust Research & Development Department, and submitted for publication at a later date.

You will be invited to attend a meeting to discuss the results and if you wish we can send you a copy of the report when it is completed.

Deciding whether to participate

Please take your time deciding whether you wish to participate. It is completely up to you whether you decide to take part and your decision will not affect the treatment you receive in the NHS. Should you decide to participate, you will be free to withdraw at any time without having to give a reason. If you have any questions or concerns about the nature, procedures or requirements for participation do not hesitate to contact me.

What should I do if I want to make a complaint?

There are many options available to you if you are unhappy about something or wish to make a complaint. You can speak to a member of the research team in person, by email or telephone. Alternatively you could go to your GP.

Any questions?

Please contact Emma Smith on e.l.smith25@canterbury.ac.uk or 01892 507673, or via Dr Kim Griffiths at the Bexleyheath Centre on 02083019400.

Appendix 13: Consent Form B

CONSENT FORM B (Version 1: 18/07/2011; 10/H1107/62)

Title of Project: **Developing a theory of the process of engaging in a Mindfulness-Based Cognitive Therapy (MBCT) group as a ‘partnership’**

Please read the following statements and initial in the box to show your agreement. Each section is optional, you can agree to some and not others.

1. I have read and understood the participant information sheet for this study and have had the opportunity to ask questions.

2. I agree to Emma Smith observing some of the sessions of the MBCT course.

3. I agree to my data being included in the analysis, for example, anonymised quotes of what I say may be used in reports and publications about the research.

4. I agree that the clinicians involved in my care can review my medical records and provide personal information to the researchers, such as contact information and demographic information.

5. I understand that my personally identifiable research data will be kept confidential within the research team.

6. I understand that confidentiality may be broken if the researchers are concerned that there may be significant risk of harm to myself or others.

7. I agree that my medical records and research data collected during the study may be looked at by individuals from the research team, sponsor, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in the research. I give permission for these individuals to have access to my records.

8. I agree that the MBCT course sessions can be audio recorded.

9. I understand that my participation in the research is voluntary and that I am free to withdraw at any time, without my health care or legal rights being affected.

10. Would you like a copy of the final report?

Yes/No

Name of Participant

Date

Signature

Name of Person taking consent
(if different from researcher)

Date

Signature

Section D

Researcher

Date

Signature

Name of research team: Emma Smith (Trainee Clinical Psychologist), Dr Kim Griffiths (Chartered Clinical Psychologist), Dr Fergal Jones (Senior Lecturer), Dr Sue Holttum (Senior Lecturer in Research)

Contact details: Salomons Clinical Psychology Programme, Department of Applied Psychology, Broomhill Road, Tunbridge Wells, Kent, TN3 0TG. Tel: 01892 507673, Email: e.l.smith25@canterbury.ac.uk

Copies: 1 for participant, 1 for researcher

Section D

Appendix 14: Annual progress report to REC

This has been removed from the electronic copy

Appendix 15: REC annual approval

Section D

Appendix 16: Abridged research diary

I have presented excerpts from my research diary, replacing participant's pseudonyms with ** to maintain confidentiality.

January 2010

Following the research fair, I am really drawn to research ideas around mindfulness, this is something I have come across before at yoga classes and when I was travelling in Thailand, and have been using on my adult placement and it really appeals to me.

March 2010

Meetings with supervisors and development of the research idea

June 2010

I had my MRP review today, got some useful feedback to think about with my supervisors to develop the research idea.

September 2010

I've been reading about mindfulness and thought it might be useful to record some of the expectations and thoughts I have mindfulness and MBCT.

Having read about 'being' and 'doing' modes, I'm wondering whether a theme that might arise through my interviews might be around MBCT shifting partnerships from 'doing' mode to 'being' mode. Or provide awareness of these different modes and therefore help them step out of 'autopilot' together. Perhaps this will influence the quality of their relationship and communication, if they have the ability to move into 'being' mode together. This seems very similar to Shapiro's 'reperceiving' model of mindfulness.

I've read a lot of evidence that suggests MBCT and MBSR courses have beneficial effects on people, so I'm expecting that this course will benefit the partnerships in some way. What ways? Perhaps increasing acceptance and compassion for themselves and each other.

I have read a bit about mindfulness and acceptance in relationships, and it seems to be a beneficial state for couples to utilise in relationships. I haven't found anything yet in terms of theory about why mindfulness might foster healthy relationships, or how this might be judged. But I have wondered if it could be understood in Teasdale et al.'s theory of 'being' and 'doing' modes, or Shapiro's model of re-perceiving? I wonder if there's a difference between people who are naturally 'mindful' and those who engage in mindfulness training?

I've just performed a literature search on the NHS advanced search and combining mindfulness and MBSR, MBCT for title and abstract, in PSYCHINFO, produced 1985 articles, I'm curious to see how many there will be when I am finished.

April 2010

I had a really interesting first interview, ** was so passionate about MBCT and the effects it has had on his life and his relationship, for example, feeling like they are 'in it together' now, rather than being alone in depression.

Section D

I was quite nervous about the first interview, I noticed that I did not stick to the interview schedule, rather I followed ** in the topics he brought up. I think this was useful, because quite early on he started talking about all the good things that had happened since finishing the MBCT course and that meant we could explore how those changes had come about and try to make links. For example, he felt that it was due to a lot of different things, such as coming to a time in their lives where they could focus on themselves a bit more, because children are independent etc. But he really positioned being able to see clearly or 'see the wood for the trees' as the central to the changes in his life which was really interesting.

I'm thinking it will be really important to take a look at the questions I asked and how I could have followed them up better to get more information to inform my next interview, but I feel like we got a lot of interesting data through our conversation.

May 2011

I noticed myself feeling a bit frustrated while transcribing the interview for participant **. She talks a lot at first about things 'not being a problem', such as attending the MBCT group with her partner. Looking back, I'm not sure I really understood what she means by this, I wish I had asked her at the time. It feels a bit odd to me, because I wasn't asking if it was a problem... has she assumed that I thought it might be a problem from something I said? Or has she got ideas about what I'm looking for that I'm not aware of?

Looking over my reflections on the interview, I noted that she did seem quite closed and was talking at quite a superficial level, at the end of the interview she revealed that she was worried about the interview digging up feelings and upsetting her, so perhaps she was not going too deep to protect herself?

** raised an interesting point that she felt embarrassed about doing the practices with her partner, in the interview I was trying to explore with her what it was that felt embarrassing, and she kept saying 'it's just not my kind of thing', which left me feeling a bit stuck.

In analysing P3's interview, I am noticing myself feeling quite frustrated by her answers to my questions, I'm critical of her lack of engagement with and understanding of the course. It doesn't feel like she has really tried to use the course, which is backed up by what her partner says about her almost rebelling against what was asked of her.

Why is this bringing up frustration in me? Because I hold the value that I should always try my best at things and that love and approval are conditional on achievement and trying your best?

I am trying to bring mindful awareness to my analysis, for example, noticing this frustration and stepping back from it, but I find myself judging others, and then judging my critical stance, for example, I would like to be able to take a more accepting, non-judgemental approach to this data, noticing my reactions and letting them go, showing some compassion towards myself and this participant. I am noticing that I think she should have tried harder and got more out of the course, but perhaps that's not what she wanted or could do, and allowing in the possibility that that too could be ok.

July 2011

Having analysed 5 interviews I feel like I'm getting a good idea of kinds of things people bring to the MBCT course, e.g. there tends to be a feeling that depression impacts on both partners and their relationship, so it makes sense to engage together, because they both want

Section D

to learn ways of coping with this kind of stress. Also the kinds of changes people describe through learning mindfulness skills as a partnership e.g. worrying less, having mindfulness as a resource they can turn to together in times of stress and increased closeness and intimacy. However, the processes that seem less clearly elucidated (or saturated) seem to be a sense of how people get from A to B. The participants I've met seem less able to pinpoint what actually helped to make those changes, or how to connect what happened in the course to what they've noticed is different.

Having discussed this with my supervisors, I planned to observe the next group as a participant-observer in hope of fleshing out this part of the process and being able to remind participants where they struggle to remember. Plan to make a substantial amendment to ethics and hopefully observe an MBCT group for partnerships around November.

October 2011

I've completed nine interviews now and have no more potential participants to interview, unfortunately, have not been able to meet anyone who dropped out of the course early which would have provided a different perspective. I'm a little nervous about getting enough participants, just hoping the next MBCT group will start soon. In the meantime, my data has been getting a bit out of hand so I'm using NVivo to organise it and starting work on section A. I've also been meeting with Sue and moving forward with my analysis through using diagrams to bring the data together.

December 2011

I have been analysing the interview from ** today using NVivo and found myself worrying about the progress of my project. This is in the context of spending a lot of time working on section A lately now that I'm engaging in interviews and data analysis again, I'm starting to worry that my Section A and data don't fit together very well. I think the anxiety trigger was reading the feedback from the examiners of the MRPs because I worried about the theory in my project.

My Section A is a review of what we know about relapse prevention in depression, specifically the role of intimate partners in relapse prevention. I refer to interpersonal theories of depression to provide theoretical accounts of the role of intimate partners in depression. I critically review the evidence for the intimate partner's role in relapse, summarising what we know about partner and relationship characteristics that lead to relapse or prevent relapse. e.g. perceived criticism, expressed emotion, conflict-avoidance coping etc.

This feels relevant to consider as a Section A because my study is looking at MBCT, which is a relapse prevention strategy for depression, and it is being delivered to intimate-partnerships. But a lot of the concepts that come up in Section A are not coming up in my data analysis, is that OK?

I have looked at some past MRPs to think through how to frame mine and to see if I am on the right track and it seems that my approach is not uncommon, so I feel a bit reassured to carry on.

January 2012

I attended the introductory session for the MBCT group today, I felt a bit uncomfortable and awkward as it was a bit of a tense and anxious group. I explained my role in the group as a participant-observer and explained that there was no pressure to be involved in the research. I

Section D

provided participant information sheets and consent forms for people to take away and have a think about whether they were happy to me to sit in on the group and use their audio-recorded data as part of the research. I invited people to call or email if they had any questions.

Talking with Kim and Marcus afterwards, it seemed that it was not normal for session zero to be so tense and they were not sure how it would unfold. I wondered if people might have been more anxious because of the research.

February 2012

I attended the second MBCT group today as a participant-observer, fortunately there was a much warmer feeling to the group today, and people seemed more at ease. It was really good to see Kim and Marcus in action, they were very warm and transparent and inviting of questions, while encouraging everyone to keep an open mind and see how the course unfolds. I could really see why the participants I interviewed reported that they felt like equals in the group, as it is not important whether someone is a service-user or a partner, and they created a really safe space to learn mindfulness skills.

I was surprised to see ** had attended alone, she explained that her partner could not make the session and probably would not be able to attend the rest of the course. I felt she was very brave to have come to the group alone considering that everyone else was there as a partnership and I wondered whether she would manage to stay in the group.

I felt quite emotional at the end of the session when ** became tearful during the poem (the one about, if I had my time over) and I wondered whether she might get as much out of the group as her partner who was the 'referred' person.

March 2012

Coming to the end of the 8-week course, I feel really glad that I had the opportunity to observe the group, as I have learned a lot more about MBCT clinically, e.g. how it is used with a small clinical group is very different to my experience in a large group of students/staff.

A couple of things that really stuck out for me, were the focus on relapse prevention and looking out for warning signs and how using mindfulness can lead to a different relationship with difficulties. This was particularly interesting in this group, where both partners in 3 of the partnerships had some experience of depression. This got me thinking about the most helpful theories for understanding these relationships where both partners have depression e.g. systemic, psychodynamic, marital discord theory, stress generation, attachment theory, cognitive theories or mindfulness theories such as 'cognitive reactivity'.

There were similarities to my previous experiences, in that some people really 'got it' while others really struggled to get their head around it and I wondered what the preconditions were for these different paths.

April 2012

Meeting with ** and ** was a really different experience to previous interviews, I felt we could jump straight into it because we were familiar with each other from the course. Having a preliminary model, I was able to use this interview to test out hypotheses from the model. For example, does the quality of relationship prior to the course influence reported outcomes. They were an interesting case because they had very much engaged as a partnership and

Section D

noticed feeling closer following the course (in line with the model) but they reported that in the years prior to the course they had 'drifted apart'. This provided further evidence that different kinds of relationship are related to similar consequences.

May 2012

I was really interested to meet ** for an interview to see how the emerging model of 'learning new skills together' applied to her experience, considering she had attended the course alone. She was one of the group members who 'got it' straight away and I could see from her questions and involvement in the course that she had really thrown herself into it and got quite a lot out of it in return. Interesting she reported all the same kinds of things with regards to the process of learning mindfulness skills and applying them in daily life e.g. using breathing space to cope with stress, changing relationship with thoughts, and pain, noticing more, and feeling better, doing more. However, even when directly asked about any impacts on her relationship, she did not notice any changes reflective of the partnership processes in the model. I really probed because I noticed her answers fitting really well with the model and wondered if my bias was coming across, but listening back to the interview the questions were in no way leading. It was really satisfying to get some evidence that the process people engage in as a partnership seems to lead to unique outcomes not evident when you engage as an individual.

End of May 2012

I met with Sue and Kim to finalise the preliminary model. We talked about how best to present the alternative pathway within the model and the write-up, that is for participants who did not follow the dominant pathway of 'learning new mindfulness skills together'. We talked quite a lot about the concept of 'passivity' towards depression and the MBCT course, which represented a key difference between the participants who valued the group process over mindfulness. While I worried that this sounded a bit critical, we struggled to find a better way to frame this approach to the course. This part of the model was a bit more tentative, because only 2 participants clearly followed it, and 1 seemed to straddle the two pathways, not wholly belonging to either.

The rest of the categories seemed quite well saturated and I'm quite happy with how the model fits together.

June 2012

I've been writing up section B and sent a draft to my supervisors for feedback. Both section A and B are a bit over the word limit, so I think I'm going to have a big job cutting them down but it is coming together.

Section D

Appendix 17: Example interview transcript

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Section D

Appendix 18: Audit trail: Quotes, Initial Codes, Categories and Sub-categories

Core Category: Learning new skills together		
<p><i>"... you can share that and learn something new between you" (Bill)</i></p> <p><i>"We were... both learning something new, and we've never learned anything together before"</i> (Belinda)</p> <p><i>"I think because they was two of us doing it together.... it did improve your commitment to it actually, because you were trying to look at a mutual support for each other to do things." (Sam)</i></p> <p><i>"to actually do the exercises together, and you can talk about them" (Rose)</i></p> <p><i>"if doing it together means you will do it then that's what I'll do. But I also found in my daily work... I would take 3 or 4 minutes just to reassess and do a 3 minute breathing space... I've approached things in different ways because of it, um so yes I think it's something that everybody can, time allowing slot into their lives." (Jane)</i></p>		
Subcategories	Initial and focused codes	Quotes
Category A. Interpersonal context of depression		
25. Depression causes strain on partnership	Strain	P2/L60 <i>"like everyone, every now and again it gets a bit on top of you, because you do feel, god when is this going to end and get back to normal, I think that's probably normal to feel like that really"</i>
	Both suffering because of my depression	P5/L311 <i>"We were both living in this horrible hell, and you know, I was, it was down to me"</i>
	Living with depression is a trial	P6/L169 <i>"I was in turmoil as well, I mean I just, every day was a real trial for me, because I couldn't see any improvement in Tom whatsoever"</i>
	Partner's ill health	P9/L7 <i>"As Sam will probably tell you, he's had quite a few long periods of mental ill health that have been quite a strain on me"</i>

Section D

	causes burden Fear for future	P6/L284 <i>“everything was frightening and I used to think, I couldn’t see the future cause I thought... and listening to the other people as well, because a lot of them are long term depression, cause we used to talk outside first”</i>
26. Makes sense to engage as a partnership	Depression affects us both so involving partners is good Wanting to involve partner because they suffer too	P1/L84 <i>“it’s [depression] something that affects the family you know, your partners, or your children, and all that lot, so umm, you know, I thought it [MBCT for partnerships] was a, just a really good idea”</i> P2/ L71-72 <i>“yes I think that is why it is quite important for the partners to be included because the strains on the partners can be probably as bad as the person going through it themselves”</i> P3/ L167 <i>“I was keen for William to come because um, I wanted him to be part of it to, because he’d had a really difficult 2 or 3 years with me naturally, you know it’s hard living with someone who is depressed”</i>
27. Hope to learn new skills	Expectations Hoping to learn ways to cope Open minded Hopeful	P1/L198 <i>“being a new sort of technique and that, um I was hoping, which I think I did, is learn some things that could help me deal with um, everyday life as it were (I: right) better, um, you know, um, so I was hoping, I was anticipating, learning some more techniques as it were”</i> P8/L63 <i>“I’ve heard people sing its praises a little bit, so I was... fairly open-minded and looking forward to it.”</i>
28. Passive approach to wellbeing and mindfulness	Passivity Valuing group over mindfulness	P3/L14 <i>“we thought oh well it can’t do any harm, so that’s what I thought of it anyway, and [P4] he’ll go anywhere or do anything”</i> P3/L66 <i>“I didn’t find the sort of, not meditation exactly, but I didn’t find that was very helpful, but I did try...but it wasn’t really for me”</i> P3/L123 <i>“Body scan ah yes, no I didn’t, it wasn’t really my thing, I just enjoyed being in the group and doing it, but I didn’t find it, “ah that was brilliant” I didn’t have that”</i>

Section D

	<p>Passive engagement with mindfulness</p> <p>Prioritising other activities</p> <p>Limited home practice</p>	<p>P2/L216 <i>"I think really, mainly, just people sharing their experiences is the main thing, I mean I did like the relaxation, but I found the talking and the exercises and just sort of discussing things, better"</i></p> <p>P4/L266 <i>"Yeah, she wasn't sure, erm, with the things that she was asked to do, erm, exercises and listen to the music and things like that, erm, she would do it, but wasn't sure whether it was actually helping it or not. But she did it because she was asked to."</i></p> <p>P4/L468 <i>"coming along to the meetings, I think she realised, oh I... I can do this. I can do this myself! Erm, and she would listen to the CDs and do the exercises but erm, then she would say, oh no no. I do that later, no I've got to go and do something now, I've got to go, I want to go out to the shops, or something like that."</i></p> <p>P5/L202 <i>'we didn't always do the homework we'd skip bits of it'</i></p> <p>P4/L446 <i>'Erm, and she would listen to the CDs and do the exercises but erm, then she would say, oh no no. I do that later, no I've got to go and do something now, I've got to go, I want to go out to the shops, or something like that.'</i></p> <p>P3/L163 <i>'I'm sure there are other people that would get more from it than me if they could do the body scan'</i></p>
29. Severity of depression	<p>Hopelessness during the group</p> <p>Still struggling</p> <p>Difficulty approaching distress</p>	<p>P5/L112 <i>'I couldn't ever see myself going back to normal'</i></p> <p>P3/L37 <i>'I still wasn't properly well, I'm still not now properly well'</i></p> <p>P5/L118 <i>'relaxation, I find that really difficult, especially the 40 minutes laying and thoughts just going to dark memories' (Belinda).</i></p>
30. Quality of relationship	<p>Partner as a carer</p> <p>Working as a team</p>	<p>P1/L71 <i>"she's technically a carer I suppose"</i></p> <p>P1/L467 <i>"we don't try to pull in different direction because we know that working together makes the job that much easier, you know helping each other in"</i></p>

Section D

	<p>Strong relationship</p> <p>Balance each other</p> <p>Drifted apart with depression</p> <p>Separate lives</p>	<p><i>many... so we've always tried to do that"</i></p> <p>P1/L705 <i>"we've always worked as a team"</i></p> <p>P2/L85 <i>"we've got quite a strong relationship and I'm quite easy going, so it's never got to anything like tension between us two apart from obviously tension in as much as you feel a bit depressed yourself probably"</i></p> <p>P3/L13 <i>"we've got a very very rock solid marriage, it's wonderful"</i></p> <p>P7/L254 <i>"we're really devoted to each other"</i></p> <p>P2/L234 <i>"we've got quite a strong relationship and um, I'm probably quite a calming influence on Bill because I'm quite a placid, even-tempered person, whereas he's always been kind of up and down"</i></p> <p>P11/L46 <i>"we were tip-toeing round each other"</i></p> <p>P10/L149 <i>"I suppose over the years we've drifted apart for one reason or another. I'm not one for talking anyway, so we would just sit there in the evening and not talk to each other and that sort of thing"</i></p> <p>P9/L312 <i>"we still do our own thing"</i></p> <p>P10/L409 <i>"we're sort of the same people but different, the same sort of backgrounds and age that sort of thing, we've had the hardships in life but we're totally the opposite in the things we like"</i></p>
Category B. Learning mindfulness skills		
31. Using breathing space to cope with stress	Breaking vicious cycle with breathing space	<p>P1/L385 <i>"...I'd been through a period like that before when I was sort of, I'd lie awake tossing and turning until about 3 o'clock in the morning and that you know, um or I'd end of getting up and going and sitting downstairs until 5 o'clock or something like that and then sleeping late, um, um I thought well I don't want to get into that sort of, because it gets into a bit of a vicious circle um, so I find myself in bed then making myself relax and actually doing maybe some breathing exercises or some um, you know like the body scan and, um and just sort of lying there and actually making myself relax"</i></p> <p>P6/L14 <i>"I'm very very positive now, and I can deal with those emotions. I mean if I, if these thoughts</i></p>

Section D

	<p>Coping with interpersonal stress using breathing space</p> <p>Switching off from stress using breathing</p> <p>Learning to switch off autopilot by staying in the present</p> <p>Learning to live in the moment</p>	<p>come into my mind of a night time, I think breathing exercises, three minute breathing exercises and it goes and I go off to sleep, and it's brilliant. Whereas before I'd be awake half the night. And they would still be there in the morning."</p> <p>P9/L76 "I mean I use it at work as well when I've got, when I'm being particularly harassed by one individual, um you know I get myself into a flap and I think what am I meant to do, is the first response, and I think oh I'll do the 3 minute breathing space and see how you feel and I like that."</p> <p>MBCT session 5/P12/L148 "last week, I had a bad situation going on indoors and I took myself off got in my car and sat in my car, didn't go anywhere, because it was a bit heated indoors and I did the breathing space and... it made me feel less tense, less agitated, less angry and just sort of able to carry on"</p> <p>P10/L25 "I suppose the thing we both get out of it, we've both said it, is the breathing technique, um so, when I feel in times of trouble or stress, I just sort of try to switch off and breath and you said that as well, when you're on the counter at work."</p> <p>MBCT session 6.5/P12/L103 "I could feel my throat getting tight you know that sort of thing, so I was trying to do that hour glass and it wasn't easy and I just tried to stick with it and normally what I do, I go straight into autopilot. I can't do this, I can't do that, I can't think about this, got to focus on what we can do, but I am trying not to do that, I'm trying to stay 'now'."</p> <p>P7/L136 "for me, it was once I cracked the living in the moment and not worrying about everything, it's a lot easier"</p> <p>P6/ L340 "Live in the moment, this is the day, not yesterday, yes you, certain things you got to look forward to and you've got to plan, but primarily just live in that bit."</p>
32. Changing relationship with thoughts (letting	Feeling I'd do something wrong	P11/L168 "one thing that I took out of it that the week he wrote on the board, incorrectly, 'thoughts are facts' ... I think because Jeff is very quiet I think sometimes I then get it into my head, I've done

Section D

<p>go/standing back from thoughts/re cognising thoughts are not facts)</p>	<p>Recognising thoughts are not facts</p> <p>Sharing thoughts might help</p> <p>He's thinking people don't want to see him because he's low</p> <p>Ruminating on negative thoughts</p> <p>Letting go of past</p> <p>More control over thoughts</p> <p>Standing back from unhelpful thoughts</p>	<p><i>something wrong... and that manifests and rots in your head. That then causes this vicious circle, that we've had weeks where we've not spoken because I'm stubborn, you're quiet and then sometimes it just, one little trigger and it will all come out, so I think, I'm hoping that you will talk to me more because it helps. It helps you because it's not all bottled up in your head and it helps me because I need to understand you and what makes you tick you know."</i></p> <p>P2/L151 <i>"I think the course really reconfirmed to him a lot of things, and his attitude changed a lot towards life in general and sort of, people, and he didn't think people were thinking bad, you know trying, because it is very easy to do that, oh they don't want to see me because I'm like this... and there's probably nothing like that at all, you're just reading things into something that's not there"</i></p> <p>P6/L337 <i>"Well it was just the thoughts, you know that go through your mind, yes what if he does it again, I won't let him do that to me again, and just thinking over and over again you know and coming back to... this time last year he was doing this, it was just compounding it really, not letting it go, and the mindfulness thing, just let it go, it's gone."</i></p> <p>P6/L433 <i>"I don't spend hours at the bedroom window now or I get a thought and it preoccupies my mind for ages and ages, it can go just like that. Yes the thoughts come in, but I can tell them to go. I: Yeh. P: whereas before I'd think aw and it would be there"</i></p> <p>P9/L292 <i>"I do recognise what thought processes are the ones that make me unwell, or not make me unwell... with having done the mindfulness that makes me stand back a bit more, and think I want to rescue myself from this I don't want to go on like this."</i></p>
<p>33. Noticing more</p>	<p>Noticing nature</p> <p>Mindfulness practice as enriching</p>	<p>P9/L280 <i>"I notice things a lot more, particularly in the outdoor world, the bird sounds and tree's growing, things like that that you realise you never really stop and look and consider when everything's sort of very rushed."</i></p> <p>P7/L15 <i>"it was surprising what you noticed, like all</i></p>

Section D

	<p>the group, I noticed the birds singing outside and someone noticed the clock ticking and all sorts of <i>things like that</i></p> <p>P1/L373 <i>“when you do the full body scan you suddenly realise, oh there’s, that feels a little bit, that you didn’t even realise, you know because you actually are taking more notice of actually what, rather than thinking about 101 things... taking a bit more notice of yourself”</i></p> <p>MBCT session 3/P10/L142 <i>“that physical lifting I had for a good experience out in the snow, couple of people had some black gloves on, the snow was falling, but it was falling as the crystal rather than as the lumps of snow, a crystal was forming on the glove and I’d never seen, obviously I’d seen pictures but I’d never seen that falling before, and it was just amazing, I just felt myself become taller”</i></p> <p>MBCT session 6.5/P12/L34 <i>“I think one thing I’m learning in this is that you have to face things, like the dance in the film.”</i></p> <p>MBCT session 5/P12/L158 <i>“yes because normally I do switch off with everything, anything unpleasant that’s thrown at me in life, I tend to shut it out and think about something pleasant.”</i></p> <p>MBCT session 7/P14/L125 <i>“I have found this meditation is actually helping with the pain. Especially, I said to [facilitator], I can feel a bit of relief in my left leg, when we were meditating then I actually felt my lower back was glowing. But not pain, usually I’m in a lot of pain, but it wasn’t the pain I was focusing on it was more of a glow. So for me I think that helps. And I find it a lot easier now, you were saying you find it difficult to switch off today, I’m the opposite the more I do it the more I’m suddenly able to switch off.”</i></p>	
	<p>Noticing body</p> <p>Noticing nature and growing taller</p> <p>Facing pain</p> <p>Tendency to shut out pain</p> <p>Focusing on pain in meditation</p> <p>Noticing times without pain</p>	
Category C. Partnership influence on engagement with MBCT course		
34. Mutual support for learning new skills	Share learning	P1/L456 <i>“the basic thing is that you can share it I think, you can share that and learn something new between you”.</i>

Section D

	<p>Mutual support for project</p> <p>Share exercises</p> <p>Sharing leads to own learning</p>	<p>P5/L443 <i>“we were both learning something, both learning something new, and we’ve never learned anything together before”</i></p> <p>P8/ L231 <i>“because they was two of us doing it together there was more.... it did improve your commitment to it actually, because you were trying to look at a mutual support for each other to do things. Especially, I found it so much more for my wife, I don’t know if she found the fact that I was doing it any benefit to her? But it’s certainly the case; the fact that she was doing it encouraged me... I felt encouraged because she was doing it and even if sometimes, maybe just reminding me, it was more that it was a joint project, effort”</i></p> <p>P6/L531 <i>“to actually do the exercises together and you can talk about them, because you go away.”</i></p> <p>P11/L310 <i>“if doing it together means you will do it then that’s what I’ll do. But I also found in my daily work, because of the staffing levels I would be out in the staff room on my own on lunch breaks, I would take 3 or 4 minutes just to reassess and do a 3 minute breathing space or whatever and there are times where I’ve done the things or approached things in different ways because of it, um so yes I think it’s something that everybody can, time allowing slot into their lives.”</i></p>
35. Improving attendance	<p>Improving attendance</p> <p>Enjoyable</p> <p>Discussion continues at home</p> <p>Overcoming</p>	<p>P4/L551 <i>“Yeah, I don’t think, really, P3 would have enjoyed it and I don’t know that she would’ve gone to everyone, every meeting if she had been on her own”</i></p> <p>P5/L317 <i>“We walked up here to the group, so that was a good thing... so in a way that was therapy in itself... to actually walk up here with Cody, I hadn’t been out on my own for nearly a year”</i></p> <p>P3/L199 <i>“we enjoyed coming together”</i></p> <p>P7/L203 <i>‘discussion still goes on at home’</i></p> <p>P14/L <i>‘I was a very sceptical person 8 weeks ago’</i></p> <p>P10/L <i>‘the first one, you said bear with us and you’ll</i></p>

Section D

	scepticism together	understand it, and now I sort of understand'
36. Need to do mindfulness to support it	<p>Seems crazy to an outsider</p> <p>I wouldn't have supported it</p> <p>Understanding alleviates resentment</p> <p>Can't convey spirit of mindfulness</p>	<p>P11/L268 <i>"I think it would have been hard if he'd done it on his own, because if P10 had come home and said to me, right I'm going to sit here and... I'd have thought, right you need to get back to that counsellor love, you've gone crazy."</i></p> <p>P11/L363 <i>"yes if you'd have come on your own, and said you have to do an hour of this, I'd have slammed and banged about in the kitchen going why am I doing this while you're sitting around having a nice time lying on the floor... I'm not saying I would have, but if I hadn't have understood why you were doing it, I'd have thought you'd really flipped"</i></p> <p>P8/L226 <i>"I understand what she's doing so there's no sense of resentment or discontent about her going off to do something like that."</i></p> <p>P6/L654 <i>"I don't think it would have worked [doing MBCT separately], because I don't think the other person would have been experiencing what you were experiencing, how would they feel when you think right I've got to do my relaxation thing, I've got to lay down here, so you've got to be quiet or go away or go out, um no I think experiencing it together is better"</i></p> <p>P1/L694 <i>"I think it would be watered down (I: yeh) if I tried to go home and sort of say to P2, OK what we did today, is we did this and you know, you sat there and it would be so watered down and diluted that she wouldn't get anything out of it"</i></p>
37. Facilitating home practice	<p>Mentoring</p> <p>Pushing partner</p>	<p>P2/ L446 <i>"after a while, you're doing things just automatically that, he's not reading into something that's not there and he doesn't think this that someone's avoiding him..., he still needs a little push sometimes"</i></p> <p>P2/L486 <i>"I can you know remind him sometimes (I: yeh) although I don't have to remind him that often now, I think he's seeing it for himself, I try not to push him too much because I don't want to be nagging him about things"</i></p>

Section D

		<i>now, I suppose we're semi-retired really, Sam's retired, we still do our own thing. Yes I can't, I was thinking about that before coming, but I, that's just the way we are in a way"</i>
	<p>Adapting practice to meet needs</p> <p>We relaxed in other ways</p> <p>Choosing shorter practices</p> <p>Valuing the variety</p>	<p>P2/L347 <i>"I don't think me and Bill did a lot of um, breathing exercises when we were at home, but we relaxed in other ways, we talked about it and I think that was more beneficial"</i></p> <p>P8/L116 <i>"The 40 minute body scan just too long, so I adopted the, didn't, the 20 minute mindfulness. Um, also I cheated a little bit, basically you're supposed to do it sitting up, but because I fidgeted too much, I did it lying down, I at least used to go and lie down on the floor so you know you are prone if you lay on a bed to drop to sleep, so um, that's what I did, during the practice."</i></p> <p>P9/L223 <i>"But that's the good thing about it, you know, you can, I know that when we're doing the course we do certain practices every week and obviously it's useful to follow what the course is telling you to do, but other than that you've got a lot of different things to choose from which appeals to me"</i></p>
Category D. Influence of MBCT on the partnership		
38. Increased understanding and empathy	<p>Understanding that partner suffers</p> <p>Less alone</p> <p>Understanding SU experience</p> <p>Partner can understand through hearing others' experiences</p>	<p>P1/L233 <i>"it's [MBCT course] really brought it to light to me, how... she suffers with it as I do, if I go down, she's going to suffer... that's really brought it more home to me... I'm not actually alone in this"</i></p> <p>P11/L46 <i>"we were tip-toeing round each other really weren't we (P10: yes), so in some respects that's what I've gained from the course, a little bit of understanding and a little bit of somewhere I can come to listen to what has been going on"</i></p> <p>P3/L212 <i>"it helps him to understand a bit more because he understands what the other couples say and think um, so yes it was helpful to have him with me, I think it was much more positive and good for us that perhaps me having completed one of these course on my own"</i></p>

Section D

	Increased sympathy	P8/L231 <i>"I've developed a more sympathetic attitude. That may be of course because of just having done something together to try and make things better for ourselves"</i>
39. Reconnecting with each other	Sharing and understanding brings you closer	P2/L442 <i>"because it does make you closer, because you are talking about things and you are helping, and he knows I understand it and um, and he's not worried to tell me things, I just feel like the whole conversation about all of it is quite good."</i>
	Really communicating	P10/L580 <i>"I think it's brought us together a bit, it's the understanding part, yes I've opened in the meetings in a way I might not have done at home"</i>
	Reconnecting over poem	P1/L313 <i>"having a little bit more time to talk about things sometimes, as I say, you know, after a long time a relationship can get very sort of routine and you find yourself not actually really communicating a lot, um, apart from day to day thing you know... but you're not actually communicating um, what you really want... what your real dreams and ambitions are and what you expect out of life and that"</i>
	Strengthened following challenge	P10/L428 <i>"I think it was the first poem, about the lady saying, if I had the time again, that was quite moving and I know strung a chord with Jane and it did with me as well. You know we were young when we had our first child and it's only the last 8 years when Jane's been back to work and they've been at secondary school that we've had a chance to find things for us and then, I feel guilty because I've had to step down and reduce the money that we're now losing that. P11/L433 but I don't want you to feel guilty"</i>
	Letting go of anger	P6/L580 <i>"I think it's stronger, I mean we were a strong couple anyway, but I think our foundations were shaken, mine more than P7, because P7 was adamant. But mine were shaken."</i>
	Learning about each	P6/L334 <i>"that was what the mindfulness did, because I did let it go. I: really. P: I did let it go because I just thought you're just making yourself more angry and you're not letting it go because you're just holding it there, and you're making it worse than it is."</i>
		P7/L203 <i>"we've had loads of discussions about it, I</i>

Section D

	<p>other</p> <p>Consolidated a new phase in relationship</p> <p>Reassuring to share improvement in mental health</p>	<p><i>think that's part of the fact that you're both there together, P6 asks something, I found out something the other week that I never knew about P6... I say what I need to say and because the discussion still goes on at home and plus there were other people in the group as well and its all the different things you pick up from them yeh"</i></p> <p>P8/L236 <i>"I don't think it had a major impact on our relationship... because our children have grown up now we are able to do more things together on our own and in some senses the actual course consolidated that a little bit, that we were doing something together."</i></p> <p>P9/L121 <i>"we did talk a little bit more. We have talked about how each of us is when not well, but it kind of made us talk about that again kind of thing and how we both felt, what assessment we would give of our own mental health at the time, so that was reassuring in a way for him because he was saying that he was still feeling very well. You know I knew he was, or thought he was, but it was nice to have that reinforced by having that topic of conversation raised."</i></p>
40. Sharing relapse prevention	<p>Proactively working on depression together</p> <p>Monitoring triggers together</p> <p>Watching for relapse indicators feels manageable</p>	<p>P1/L470 <i>"this is another thing that you can work together... she probably feels more comfortable in the fact that she can help me in that"</i></p> <p>P1/L493 <i>"we've always tried to do things together and we've always tried and this has really brought us into a way of being able to deal with this problem, um, in a way that we can deal with it together"</i></p> <p>P11/L179 <i>"one of the weeks was looking out for trigger points and warning signals and I think I'm over sensitive. I'm thinking, why aren't you going to cadets tonight, why aren't you doing this tonight? That a trigger point that you're not going out. Why don't you want your dinner tonight, the fact that he's probably stuffed himself all afternoon, you know it's that sort of thing. So I think it's made me possibly over sensitive to things, but maybe that's, for a little while, not a bad thing. He can then turn round to me and say, because this, rather than me not say anything and just churn around in your head."</i></p> <p>P6/L289 <i>"I thought aw my goodness, you know, I</i></p>

Section D

	<p>Sharing in fear of relapse</p> <p>Shared resource to turn to</p>	<p>thought it was a one off thing you know but as <i>[clinical psychologist] say's it's recognising when you are beginning to become unwell... and living in the moment and picking up on those thoughts and how you feel, and I can cope, I can cope with those, yes.</i>"</p> <p>P8/L231 <i>"my wife is very fearful that I'll have another break down. I have had three or four over the past couple of decades so she's um, sort of urges me to think about these sorts of things."</i></p> <p>P9/L121 <i>"there's that tool there that we can perhaps use that might be helpful. If and when he sort of relapses, so that's quite reassuring, it's definitely reassuring in terms of my mental health and I think we can perhaps stop things getting too awful with him, with him we haven't tried it so much, so we can't be 100% sure, but it is something obviously that we would turn to."</i></p>
41. Reduced worry	<p>Positive effects of mindfulness</p> <p>Reduced worry</p> <p>Seeing more clearly</p> <p>Making changes because of reduced worry</p>	<p>P7/L193 <i>"it's really all come together now, I think that's due to the mindfulness course again because I think because I'm more settled and I don't worry"</i></p> <p>P2/L204 <i>"yeh he doesn't seem worried about anything like that at all, his attitude towards people has changed, I think he can really see things as they are"</i></p> <p>P1/L136 <i>"being able to look at things um, perhaps a bit more logically, a bit more clearer than emotionally, if you know what I mean, because you know, when you're suffering like that, your, its emotions that are clouding I think, like your decisions... you can't look at things, um, well clinically if you like, logically, (I: Mm) you can't really put things into real perspective because your emotions are clouding everything, you know, your worry about this and your concerns about that, um, and I think its enabled me to be a bit calmer, to perhaps detach myself a little bit from the emotional side of it a bit more and look at things in a clearer light... you know because your whole techniques, it's just all calming, you know it's very calming and very sort of relaxing (I: Yeh) and you know, you do forget your worries, your cares and woes, you know, you do forget that"</i></p> <p>P1/L305 <i>"that's probably given me the strength to do that [change career], in changing me way of thinking"</i></p>

Section D

		<i>about stuff, and I think that's... probably the most positive thing that, as well as being a bit more sort of relaxed"</i>
42. Feeling better, doing more	Positive effects of mindfulness	P5/L452 <i>"I must have felt more positive because I actually booked the acupuncture session, I knew I needed something and I was willing to try, I booked it before the end of the MBCT course. So I have been, something must have clicked in to make me book it"</i>
	Positive cycle	MBCT session 7/P10/L136 <i>"umm, I do feel better, I suppose I've been back to work now for what five weeks or something like that. So that's given me an aim, something else to do rather than just sitting at home, festering really. I didn't really have the urge to do anything"</i>
		MBCT session 8/P12/L72 <i>"I've had a good week as well, yeh, really positive. I was becoming quite insular, as I said last week and I couldn't be bothered to do things. Whereas this past week, well you know I went to lunch with my friend last week and that was really nice and that was quite a big thing for me."</i>
		P1/L <i>'... this has been quite a positive thing [MBCT course] and it's made us perhaps, uh, understand the fact that I'm not just on my own with, when I do get down[...] you're going to have a bit better support and in that knowledge I suppose it gives you more courage to carry on and do something a bit different'</i>
Category F. Group process		
43. Learning in a safe, equal environment	Everyone's equal in the group	P6/L152 <i>"It was brilliant because it was non-judgemental, you didn't know which one had the depression and which wasn't, it was fabulous."</i>
	We all face challenges	P8/L283 <i>"it's not a direct like you're the carer this is what you do, and you're the patient, this is what you do, everybody's equal in the sense of their participation"</i>
	Normalising	P8/L102 <i>"in discussion it suddenly dawned on me that [clinical psychologist] and [family therapist] were saying that their brains did the same so I suddenly felt a bit more relaxed about it. Because I had this notion that you should be able to narrowly</i>

Section D

	Equality	<p>focus everything down and stay there, but of course <i>you don't.</i>"</p> <p>P7/L23 <i>"what I liked was the, instead of [facilitators] obviously asking, they sort of laid the groundwork, and there was eight of us, we were the, you'd ask what you wanted to ask not what you was asked"</i></p>
44. Sharing with others in a group helps	<p>Normalising</p> <p>Sharing helps understanding</p> <p>Feeling less isolated</p> <p>Sharing a journey</p>	<p>P2/L96 <i>"I think one of the good things about the groups is that you can talk to people who are going through exactly the same situation as yourself"</i></p> <p>P2/L475 <i>"you always think that it's not happening to anyone else, it's just you and is this normal or not, and you've got people confirming to you, yes it is normal, and they go through this whole cycle and you can really see how it's happening and why it spirals out of control"</i></p> <p>P3/L203 <i>"having the other people there... that was nice to know that somebody else was suffering a bit like you were"</i></p> <p>P11/L276 <i>"I'd listen to someone saying exactly the same as I was feeling and I'm thinking thank goodness what I'm going through isn't isolated. Other people are thinking exactly the same. It was like after the first week of the MBCT course"</i></p> <p>P8/L369 <i>"by the people coming forward with their experiences and um, which may not, sometimes they reflected with you that you had maybe a similar feeling but even just listening to other people... it felt as though, and it sounds daft but you were all on a journey"</i></p>
45. Putting problems in perspective	<p>Feeling fortunate</p> <p>Putting suffering in perspective</p>	<p>P1/L223 <i>"I thought to myself although I've suffered a long time, I haven't been that far, you know, and I just felt quite lucky actually that I hadn't been that bad"</i></p> <p>P2/L180 <i>"hearing about other people, and sometimes you realise you're not such a bad off at all, because you always think when you're going through these things that, it's all on me, it's happening to me and everything, but when you listen to people you realise, one of the guys, he'd been in hospital, you know P1"</i></p>

Section D

	<p>Seeing improvement in myself</p> <p>Recognising abilities</p>	<p><i>hasn't been in hospital or anything like that."</i></p> <p>P9/L137 <i>"Well I think seeing that other people, I mean I was very well when I was doing the course, seeing people who weren't at all well I suppose it helped me to measure the changes in me"</i></p> <p>P4/L493 <i>"it made her realise that she could do things... more than she thought she could... you could almost see it running through her mind, oh I don't have to do that."</i></p>
46. Commitment of group members	<p>Positive experience of commitment to the group</p> <p>Drop-out broke the group</p> <p>Frustration that others were unwilling</p>	<p>P6/L <i>'it was so good that all the people came to every session... because we were all getting so much from it'</i></p> <p>P8/L69 <i>'it sort of broke the group'</i></p> <p>P8/L81 <i>'if you're poorly, I do realise how at times how tough it can be'</i></p> <p>P9/L102 <i>'refusal to suspend disbelief'</i></p> <p>P9/L95 <i>'her mind was closed'</i></p> <p>P9/L107 <i>'I think we felt like the only couple who were positive really about what was going on' (Janine).</i></p>
47. Valuing the group process over mindfulness		<p>P3/ L83 <i>'I enjoy that, I was keen to hear what other people had to say',</i></p> <p>P3/L123 <i>"Body scan ah yes, no I didn't, it wasn't really my thing, I just enjoyed being in the group and doing it, but I didn't find it, "ah that was brilliant" I didn't have that"</i></p> <p>P4/L493 <i>'... it made her realise that she could do things. And we, you know, often spoke about things that we'd done, or hadn't done, couldn't do, couldn't do. And I think Rachel began to realise that she was able to do more than she thought she could.'</i></p>
Category F: Outside influences on perceived change		
48. Coming to a time in our lives when we	We haven't got the distractions of children anymore	<p>P1/L657 <i>'haven't got the distractions of children and starting out in life and mortgages and things like that'</i></p> <p>P10/11/ L582 <i>'I think it's possibly not just the course,</i></p>

Section D

Appendix 19: Theoretical memos, diagramming & initial model development

The memos and diagrams presented below were selected to demonstrate the progress of my thinking about the emergent theory.

Following interviews and initial coding, I mapped out the initial codes in diagram form to make links between the codes. This was an initial step in making sense of the process of engaging in MBCT together. I started to see that there were processes pertaining to learning mindfulness, to engaging as a partnership and to being part of a group and this generated questions about how these processes interact.

P1 & P2

They are a very strong couple who see themselves as a team and learning mindfulness means that depression is another thing in their lives that they can approach as a team. I wondered whether a similar process would apply to partnerships with different kinds of relationships, or who are more independent?



P3 & P4

P3 & P4 were similar to the P1 & P2 in the sense that they were a very close and committed partnership and were keen to engage together. However, they had a very different process of engaging with the course, this seemed to be related to a different approach to wellbeing and the MBCT as a route to wellbeing. The service-user assumed a passive approach towards

Section D

MBCT, seeing it as something to 'lean on' rather than something to 'learn', and her partner also took a fairly passive approach of being there if she needed him, rather than an active supporter. This was dramatically different to the P1 & P2 who saw mindfulness as a skill they could learn to deal with depression together. While P2 did not engage with mindfulness as much as her partner, she did assume an active approach to supporting him with stepping back from his unhelpful thinking and encouraging engagement with the course. This makes me think that having a close relationship is not sufficient for full engagement with the partnership MBCT course, there may need to be a fairly active approach to learning new skills too.



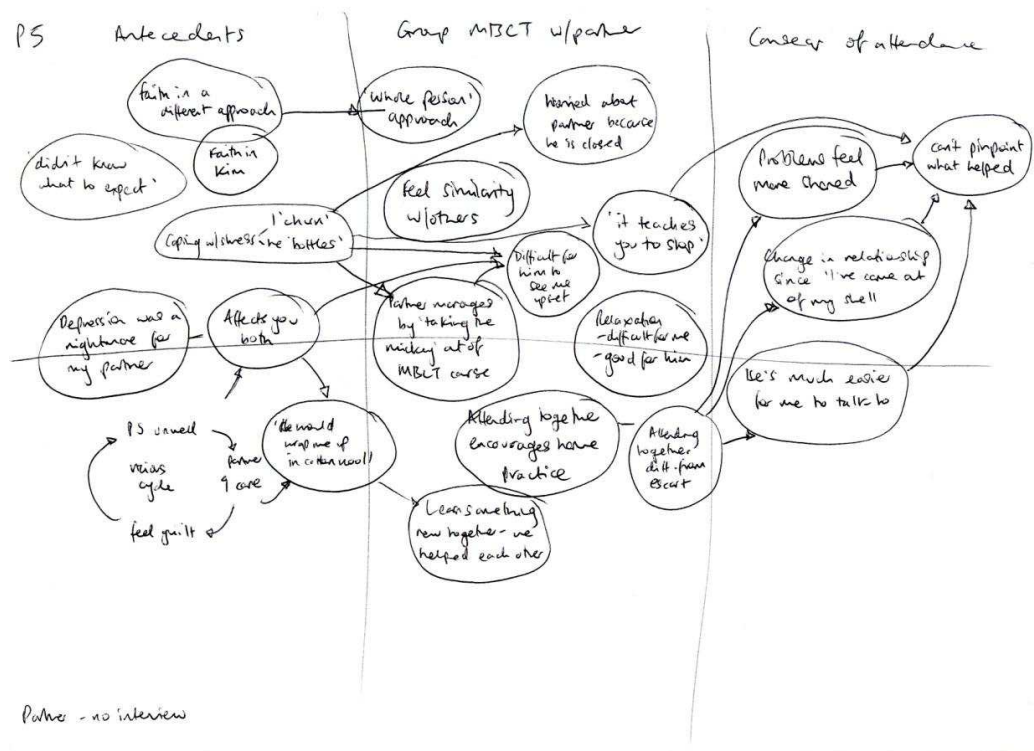
P5

P5 struggled to pinpoint what had helped with her recovery, which seemed recent and fragile, she had been very depressed during the MBCT course and at times this seemed to make it more difficult to engage. For example, during mindfulness practices, her mind would turn to 'dark thoughts' and in view of being new to mindfulness, she probably did not have the skills to decenter from these thoughts, which would have made the practice more challenging. P5 did not make links between mindfulness practice her feeling better/doing more in the way that P1 was able to. Similarly to P3 this seemed to be linked to practising less, but in P5's case this seemed more to do with being severely depressed than taking a passive approach to her wellbeing.

There was a clear process emerging of feeling a rationale for engaging together, because depression affects both partners, valuing doing the group together and feeling that they both

Section D

benefited from this process, because a) the partner has more understanding of what the service-user is going through and b) because problems feel more shared. This process was consistent across all participants so far, even though learning mindfulness was more absent from P3, P4, & P5. This seems to be related to doing less home practice (which appears to be influenced by severity of depression, passivity and possibly medication?) and means participants are less able to engage in conversations about what facilitated the perceived changes.



P6 & P7

These interviews provided an interesting insight into potential cross-sections between partnership processes and mindfulness processes. Similar to P1 there was a process of learning to step back from unhelpful thought processes, use the breathing space to cope with stress (e.g. rumination that leads to insomnia), living in the present and linking this specifically to reconnecting with partner and developing a stronger relationship after difficulties (e.g. partner's suicide attempt). Additionally, P6 directly applied mindfulness skills to the anger and fear she felt within her relationship following her partner's mental health problems. She described a process of letting go and feeling that she had learned skills that meant she would deal with it differently if he were to relapse. As a partnership they had a change of priorities and experienced a shift towards 'living in the moment'. They had a shared language and set of skills they could use and encourage each other to use in times of stress. In this sense, the partner was not only there to support the learning of new skills, but

Section D

actually found a way of healing the partnership and developing strength to move forward, which present an interaction of partnership and mindfulness processes.



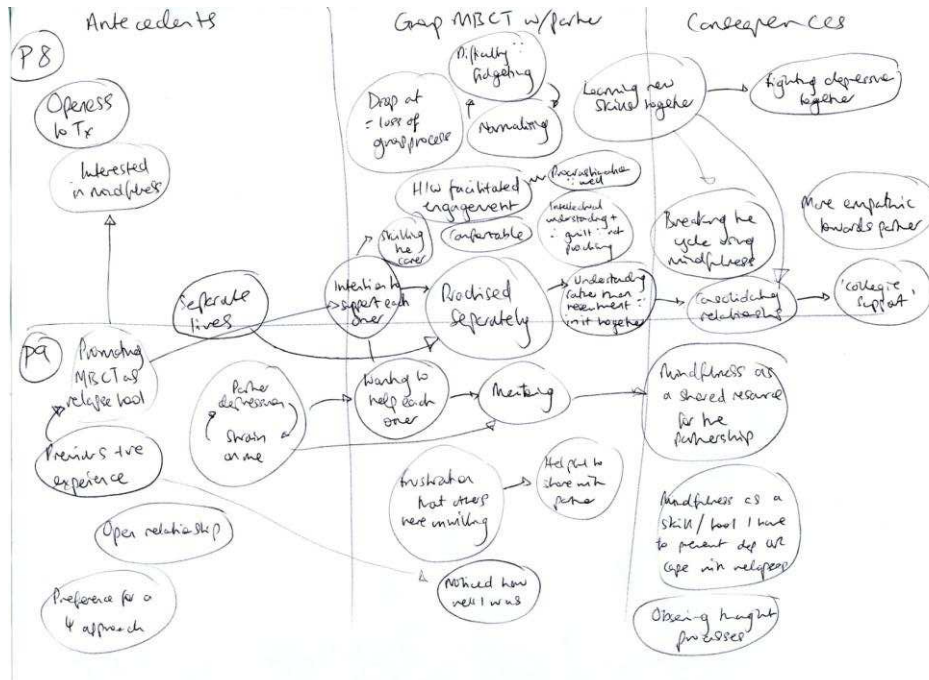
P8 & P9

Following focused coding of interviews with participants 8 and 9, the codes were mapped out similarly to previous partnerships. This partnership was interesting as it was the first partnership that engaged in home practice separately. Therefore, I was hypothesising about what antecedents may have influenced their decision to practice separately and in turn how practising separately may have influenced the reported consequences of engaging in MBCT together.

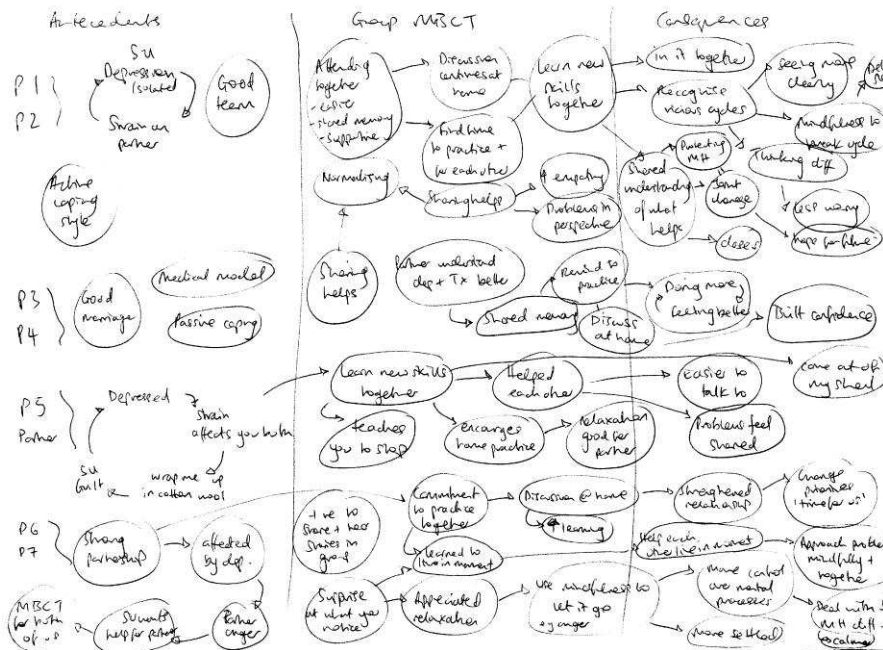
The decision to practice separately seemed to be related to these partners leading fairly independent, separate lives, although they were a stable partnership, it was not convenient to practice together. Despite this they both reported appreciating that the discussion continued at home, and P9 had engaged in an individual's course before, so she was able to provide mentoring to P8 to support his engagement with home practice.

Across all partnerships there was a stable, long-term relationship. Although there were differences in the quality of the relationship, none of the partnerships presented themselves as experiencing marital distress. These differences did not appear to lead to distinct outcomes, for example, both P1 and P8 experienced an increased empathy towards their partner's suffering through engaging in the course together.

Section D



Summary codes and theoretical links for partnership interviews and MBCT group sessions



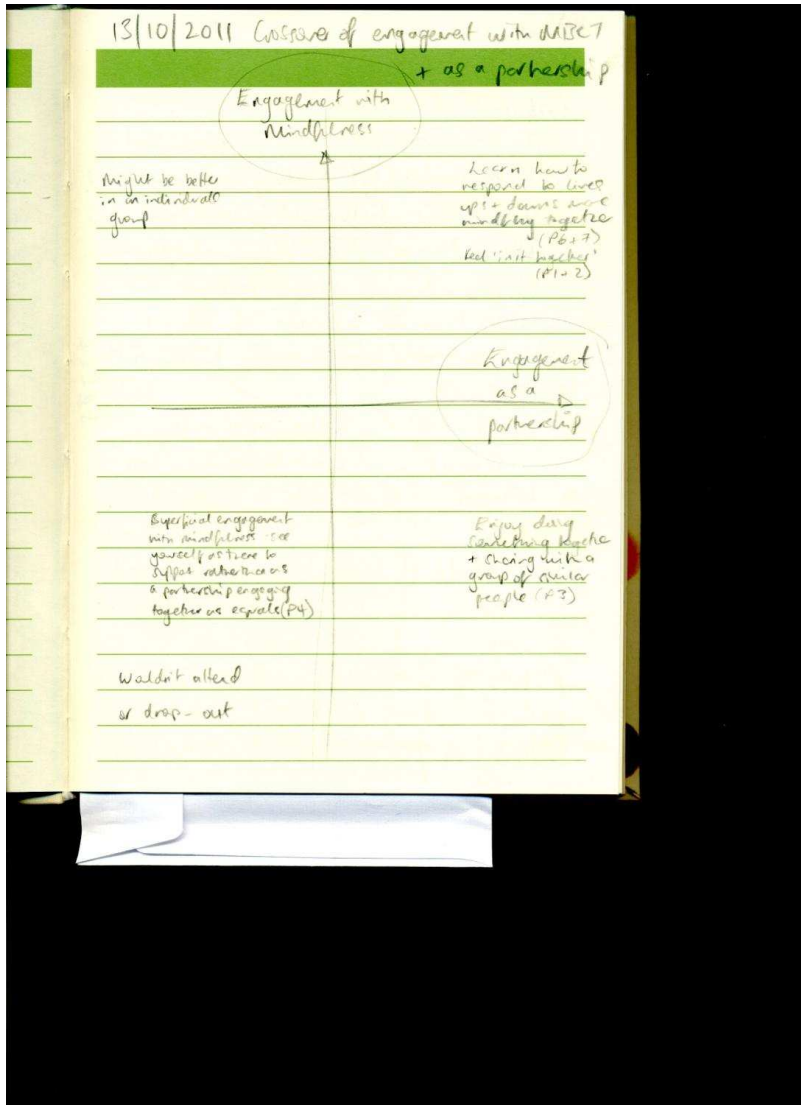
Section D



13.10.2011

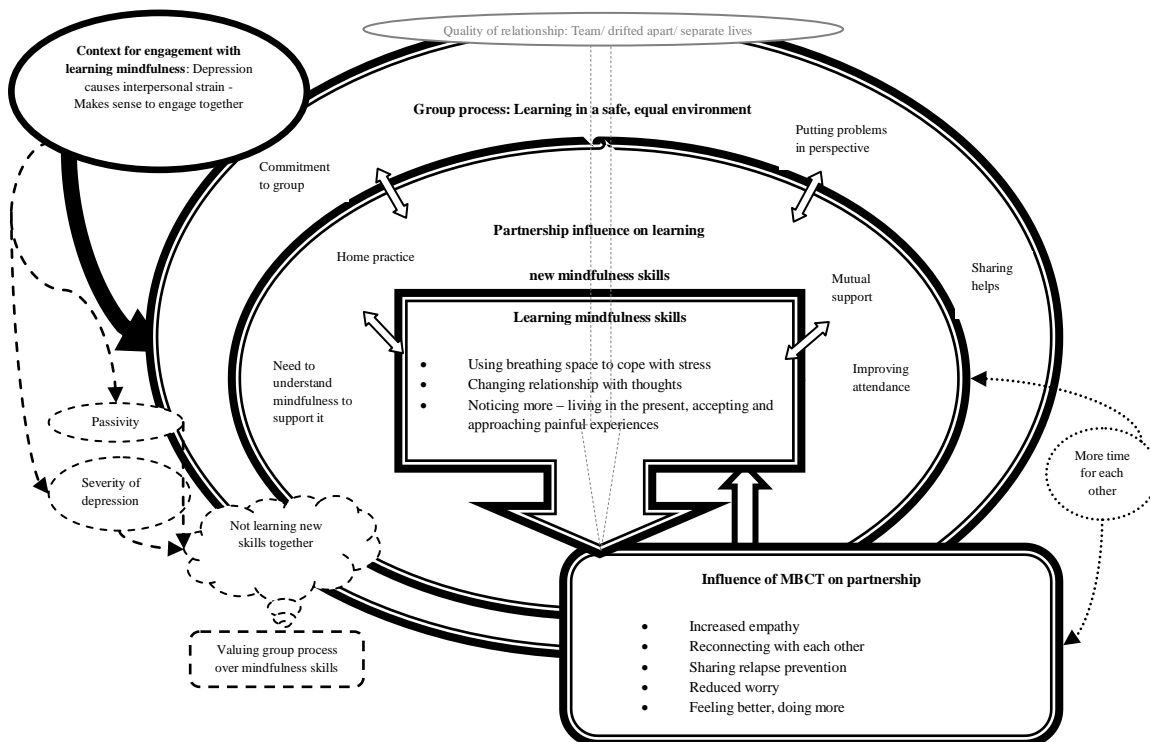
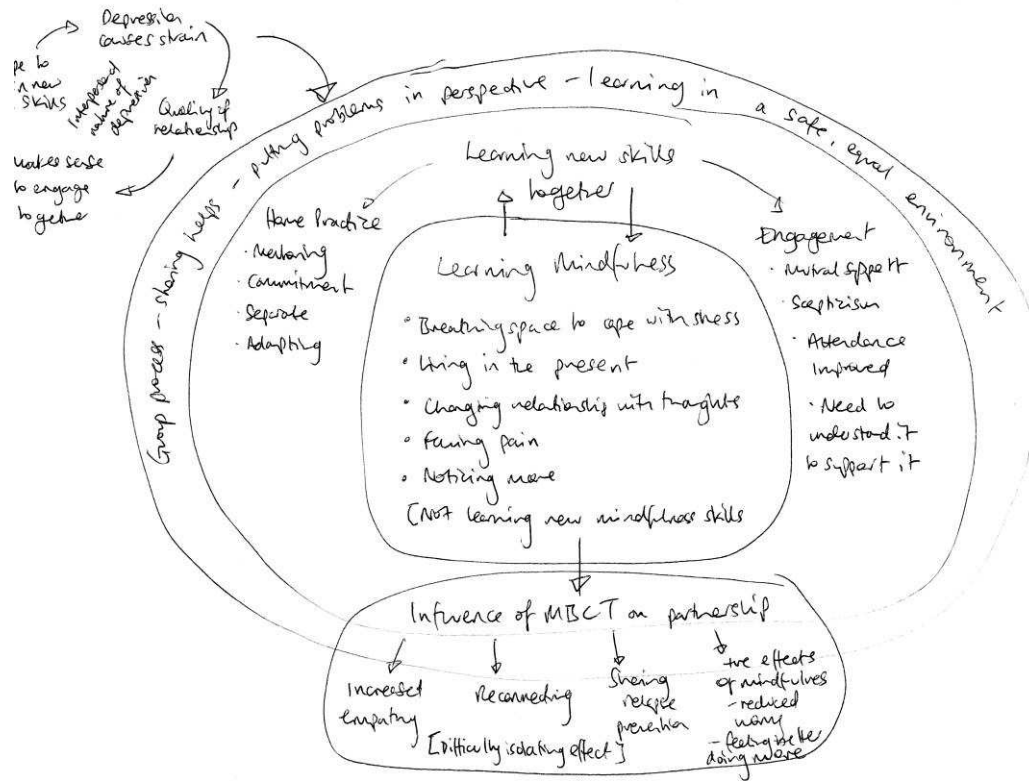
Engagement with mindfulness and engagement as a partnership seem to interact, they don't seem to be completely separate. I wonder whether they might be helpfully represented on a continuum, with different outcomes dependent on where the partnership is with regards to their engagement with mindfulness and their engagement as a partnership. For example, P3 & P4 were engaged with the group as a partnership and enjoyed attending together, but they did not really engage with the mindfulness, thus the outcome was that they felt better for sharing with the group and seeing some similarity with others, but they were no further forward with regards to using mindfulness to cope with stress. On the other hand, P8 & P9 were very engaged with mindfulness, and fairly engaged as a partnership, so they came out feeling they had a shared resource in mindfulness which they could turn to in times of stress. P8 in particular noticed increased empathy with his partner and a sense of 'collegic support'. This might also provide a way of understanding why some partnerships drop out early on, or refuse the intervention, if they are low on both.

Section D



Initial model development

Section D



Section D

After receiving feedback that it was difficult to know where to start with this model, I tried different ways of presenting the process more clearly, here is an early draft that was subsequently revised for the final Section B.

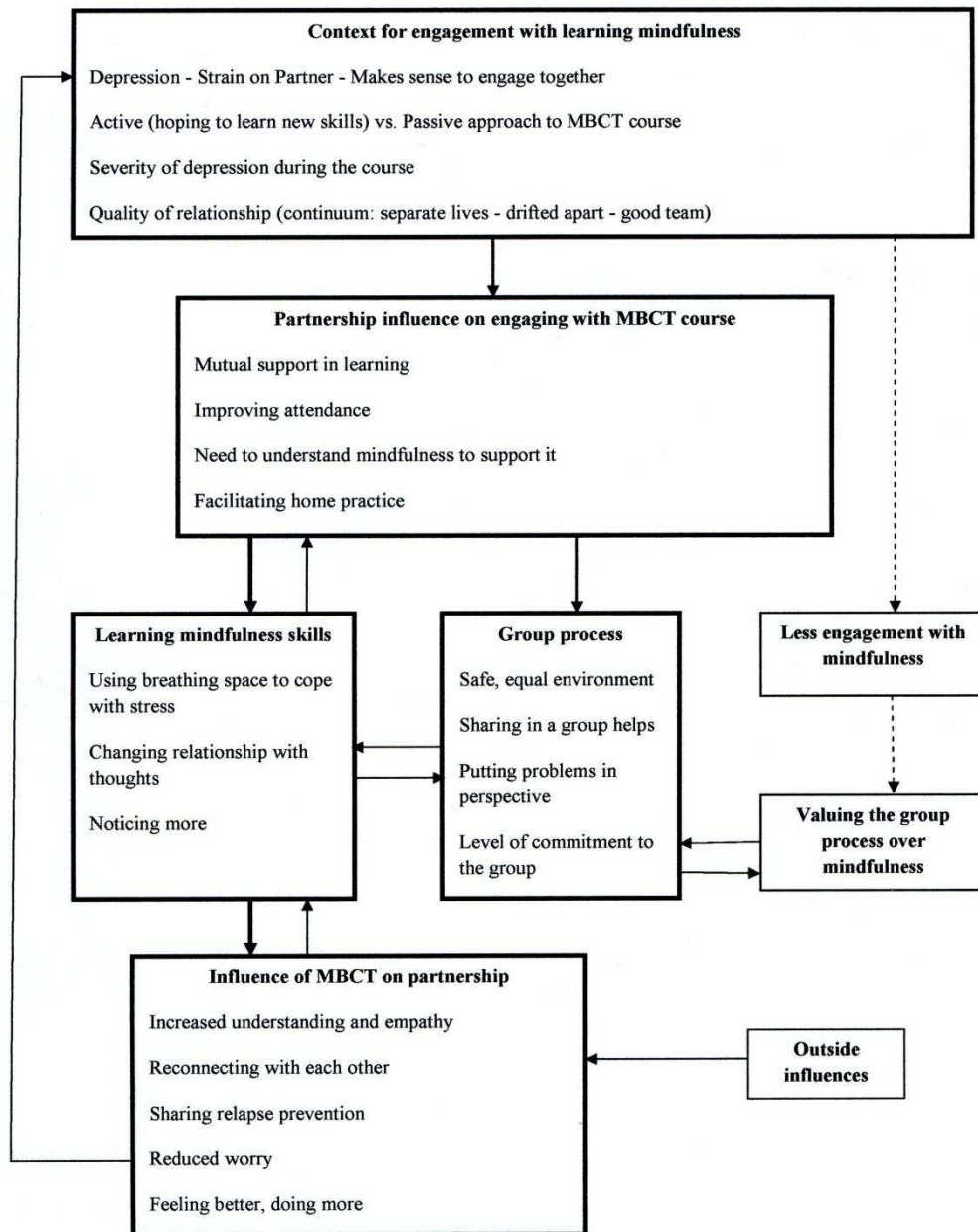


Figure 1. Learning new mindfulness skills together – a model of the process of engaging in MBCT as a partnership.

Section D

Appendix 20: Tables of initial NVivo codes

I used NVivo through the mid-stages of data analysis to organise my data. I have exported the main overview tables of initial code and categories and the number of sources and references for each. Some columns have been deleted because of space limitations.

Mindfulness processes

Codes/ Initial categories	Sources	References	Created On	Modified On
Using mindfulness to cope with difficulties	7	54	15/11/2011 12:28	09/01/2012 17:12
Using breathing space to cope with stress	7	33	09/01/2012 16:59	11/07/2012 15:39
Changing relationship with thoughts	5	21	09/01/2012 16:52	06/05/2012 13:53
Factors that affected home practice	10	46	15/11/2011 11:46	09/01/2012 16:53
Adapting practice to needs	5	11	09/01/2012 17:14	06/05/2012 13:00
Passive engagement	3	9	09/01/2012 17:22	09/01/2012 17:25
I would have done more if I were unwell	1	8	15/11/2011 11:50	15/11/2011 14:13
Guilt about not doing enough HW	1	5	15/11/2011 11:48	15/11/2011 12:51
Mindfulness practice can be hard but willing to give it a go	1	3	13/12/2011 19:32	09/01/2012 17:24
Distraction during mindfulness practice	1	2	15/11/2011 11:34	09/01/2012 17:24
Difficulty approaching distress	2	2	09/01/2012 17:17	09/01/2012 17:25
Struggle to get into the body scan	1	1	15/11/2011 16:27	09/01/2012 17:24
Procrastination interferes with practice	1	1	15/11/2011 11:44	09/01/2012 17:24
Less practice since returning to work full time	1	1	06/05/2012 12:46	06/05/2012 12:46
Choosing to relax in other ways	1	1	06/05/2012 15:09	06/05/2012 15:09
Feeling better, doing more	6	16	12/12/2011 14:42	09/01/2012 16:53
Having courage to take steps to bring about a different future	3	5	12/12/2011 09:57	03/05/2012 17:38
Hope for future	2	2	03/05/2012 17:38	03/05/2012 17:38
Opening up has helped recovery	1	1	06/05/2012 13:11	06/05/2012 13:11
Reduced worry	3	13	09/01/2012 15:55	09/01/2012 16:53
Mindfulness practice as enriching	5	8	15/11/2011	09/01/2012

Section D

			14:13	15:56
Noticing more	3	4	05/12/2011 14:31	09/01/2012 16:04
Appreciating relaxation	1	1	15/11/2011 16:00	09/01/2012 16:04
Whole person approach	1	1	07/01/2012 15:54	09/01/2012 16:04
New understanding of physical symptoms	1	1	06/05/2012 13:08	06/05/2012 13:08

Partnership processes

Code/Initial categories	Sources	References	Created	Modified
The role of the partner in course engagement	11	138	12/12/2011 17:50	06/05/2012 13:29
Home practice	10	55	12/12/2011 18:00	15/12/2011 17:14
Mentoring	8	31	15/12/2011 17:04	06/05/2012 15:16
Commitment to practising together	5	16	13/12/2011 19:39	09/01/2012 10:35
Choosing to practice separately	3	8	15/11/2011 11:37	09/01/2012 10:35
Attendance	8	42	12/12/2011 18:01	15/12/2011 17:14
More enjoyable engaging as a partnership	6	20	15/12/2011 17:26	09/01/2012 15:19
Comfortable sharing with partner	4	10	12/12/2011 18:03	09/01/2012 12:14
Partner reduces barriers to attendance	1	7	09/01/2012 12:20	09/01/2012 12:20
Worrying about partner	2	5	12/12/2011 18:07	09/01/2012 12:14
Mutual support	10	41	12/12/2011 18:14	15/12/2011 17:23
Learning new skills	6	28	15/12/2011 16:29	09/01/2012 10:27
Sharing relapse prevention	7	13	12/12/2011 10:25	06/05/2012 13:27
Interpersonal nature of depression	8	75	12/12/2011 17:33	09/01/2012 15:31
Depression causes strain on partner	5	29	09/01/2012 12:40	06/05/2012 13:56
Empathy for partner's suffering	6	17	09/01/2012	06/05/2012

Section D

			12:45	13:02
Partner needs therapy	5	10	12/12/2011 17:44	06/05/2012 13:59
Partner responses influence course of depression	3	9	09/01/2012 12:54	06/05/2012 13:09
Partner apprehension for future	2	5	09/01/2012 12:51	09/01/2012 14:54
Depression brings re-evaluation and growth	2	3	09/01/2012 14:29	09/01/2012 14:30
Anger at partner's depression	2	2	06/05/2012 15:14	06/05/2012 15:26
Impact of MBCT course on the relationship	9	62	12/12/2011 18:26	09/01/2012 12:54
Increased understanding and empathy	6	27	06/05/2012 15:30	06/05/2012 15:32
Reconnecting	8	22	06/05/2012 15:32	06/05/2012 15:32
Mindfulness as a shared resource for the partnership	4	12	09/01/2012 14:18	09/01/2012 15:28
we're a couple that talk to each other about everything, so it didn't really cast an awful lot of new light on the situation	1	1	05/12/2011 14:40	09/01/2012 14:49
Quality of the relationship	6	23	12/12/2011 18:20	09/01/2012 12:54
Strong, close relationship	4	14	09/01/2012 14:59	09/01/2012 15:00
we were tip-toeing round each other really weren't we	1	4	06/05/2012 13:04	06/05/2012 13:10
Absence of marital discord	1	3	15/11/2011 11:07	09/01/2012 15:00
Coming to a time when we can focus on ourselves more	1	2	12/12/2011 10:54	09/01/2012 15:00

Group Processes

Codes/Initial categories	Sources	References	Created	Modified
Sharing with others	10	33	12/12/2011 18:54	12/12/2011 18:56
It helps to share with people who are going through the same thing	6	18	12/12/2011 12:38	09/01/2012 17:57
Group discussions were normalising	3	8	15/11/2011 16:28	06/05/2012 15:04
Putting problems in perspective through hearing others' stories	4	7	12/12/2011 09:38	09/01/2012 17:29
Drop-out broke the group	5	22	15/11/2011 11:14	12/12/2011 19:00

Section D

Frustration that others were unwilling	2	10	09/01/2012 17:42	09/01/2012 17:44
Commitment to group because we were getting so much out of it	3	3	09/01/2012 17:44	09/01/2012 17:44
Empowering learning process	3	14	15/11/2011 15:59	23/01/2012 14:09
everybody's equal in the sense of their participation	3	6	15/11/2011 12:44	09/01/2012 17:30
Facilitators normalised and modelled mindfulness	2	4	23/01/2012 14:08	23/01/2012 14:08
Helped partner to recognise depression	1	2	13/12/2011 19:17	23/01/2012 14:08
Illness influenced attendance	2	6	15/11/2011 11:28	12/12/2011 19:01
I still wasn't properly well	1	2	12/12/2011 14:08	12/12/2011 14:11
In recovery during the MBCT course	1	2	15/11/2011 11:09	15/11/2011 11:09

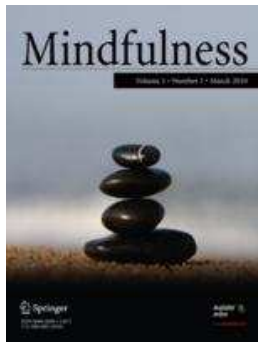
MBCT group sessions

Codes/Initial categories	Sources	References	Created	Modified
Using mindfulness to cope	7	31	11/04/2012 18:36	03/05/2012 16:21
Using breathing space to cope with stress	4	8	03/05/2012 16:59	03/05/2012 17:20
Noticing times without pain	4	6	03/05/2012 17:20	07/05/2012 12:08
Choosing body scan because it's holding	3	4	03/05/2012 17:01	03/05/2012 17:20
Going with the flow	3	4	03/05/2012 17:12	03/05/2012 17:20
Turning point, I'm trying to keep bringing myself back to the now	2	4	11/04/2012 13:07	03/05/2012 17:12
Mindfulness sends problems a bit further away	1	5	11/04/2012 13:13	03/05/2012 17:20
Noticing mood influences thoughts	6	11	11/04/2012 18:39	03/05/2012 16:28
Thinking changes with mood and pain	5	8	03/05/2012 16:52	03/05/2012 16:52
Body tenses when I bring difficulties to mind	1	2	11/04/2012 12:58	03/05/2012 16:52
Thought are not facts really influenced me	1	1	03/05/2012 16:09	03/05/2012 16:52
Learning to approach pain & distress	5	19	11/04/2012	03/05/2012

Section D

			18:32	16:21
with practice it is easier to get into the zone	2	2	11/04/2012 11:52	03/05/2012 16:35
Overcoming scepticism	2	8	03/05/2012 14:45	06/05/2012 15:08
Mindfulness as medicine	1	1	03/05/2012 15:09	03/05/2012 17:01
Learning to face pain	2	6	03/05/2012 16:34	03/05/2012 17:01
Allowing thoughts rather than shutting them out	1	3	11/04/2012 12:34	03/05/2012 16:35
Previous	5	8	11/04/2012 18:52	03/05/2012 16:21
I'm a worrier	2	2	11/04/2012 12:43	11/04/2012 12:59
Wanting a different solution to medication	2	2	11/04/2012 12:48	11/04/2012 13:16
I cannot switch off	1	2	11/04/2012 12:06	11/04/2012 12:07
I didn't realise how depressed I was	1	1	11/04/2012 12:03	11/04/2012 12:03
I noticed I do not know my face	1	1	11/04/2012 12:06	11/04/2012 12:06
Relational empathy	3	6	11/04/2012 18:53	03/05/2012 16:21
Understanding partner's pain	3	4	03/05/2012 16:47	03/05/2012 16:47
Noticing similarity in partnership	2	2	11/04/2012 13:19	03/05/2012 16:47
Noticing improvement	3	16	03/05/2012 16:17	03/05/2012 16:22
Recognising pleasant experiences	2	6	03/05/2012 17:17	03/05/2012 17:31
Feeling better, doing more	2	8	03/05/2012 17:31	03/05/2012 17:31
Thinking more about wellbeing	1	2	03/05/2012 15:05	03/05/2012 17:31

Appendix 21: Journal submission guidelines



Mindfulness

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Instructions for Authors

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- A blinded manuscript without any author names and affiliations in the text or on the title page. Self-identifying citations and references in the article text should be avoided.

Section D

- A separate title page, containing title, all author names, affiliations, and the contact information of the corresponding author. Any acknowledgements, disclosures, or funding information should also be included on this page.

Manuscript submission

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Submission of a manuscript implies: that the work described has not been published before; that it is not under consideration for publication anywhere else; that its publication has been approved by all co-authors, if any, as well as by the responsible authorities – tacitly or explicitly – at the institute where the work has been carried out. The publisher will not be held legally responsible should there be any claims for compensation.

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Authors should submit their manuscripts online. Electronic submission substantially reduces the editorial processing and reviewing times and shortens overall publication times. Please follow the hyperlink “Submit online” on the right and upload all of your manuscript files following the instructions given on the screen.

Title page

Title Page

The title page should include:

- The name(s) of the author(s)
- A concise and informative title
- The affiliation(s) and address(es) of the author(s)
- The e-mail address, telephone and fax numbers of the corresponding author

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.

Section D

Text

Text Formatting

Manuscripts should be submitted in Word.

- Use a normal, plain font (e.g., 10-point Times Roman) 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.

Terminology

- Please always use internationally accepted signs and symbols for units (SI units).

Section D

Scientific style

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Bold for vectors, tensors, and matrices.

References

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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

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- 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.

Section D

- 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.

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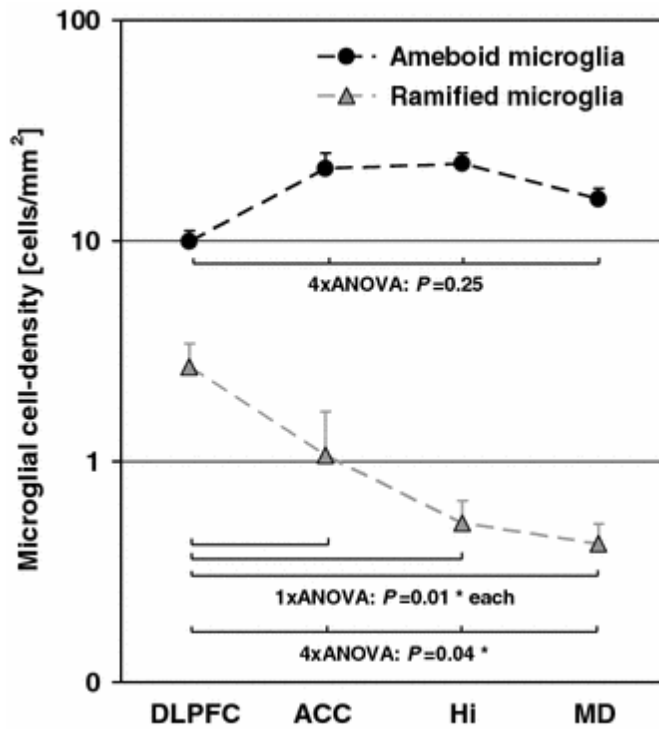
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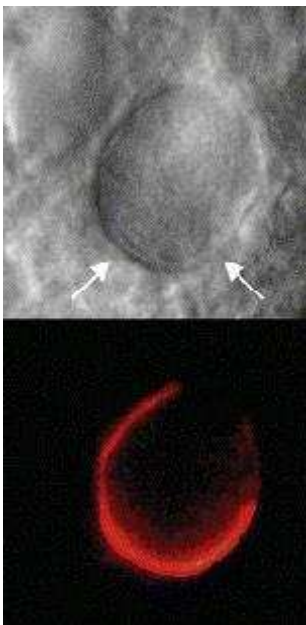
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Section D



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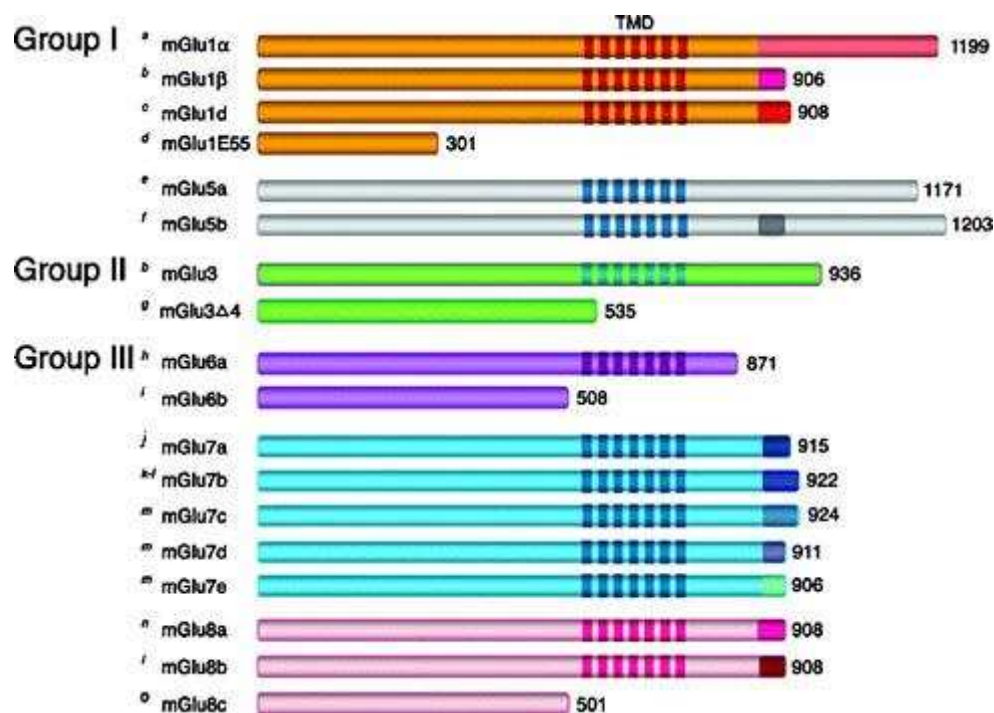


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Section D

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Section D

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Section D

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Section D

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Section D

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Appendix 22: Summary of research for participants, ethics committee and R&D

Salomons Campus at Tunbridge Wells

Date: 2nd July 2012

REC reference number: 10/H1107/62

Study Title: Developing a theory of the process of engaging in a Mindfulness-based Cognitive Therapy (MBCT) group as a 'partnership' (e.g. service-user with a supportive-other) in a clinical setting.

Dear [chair of REC/ R&D manager],

I am writing to inform you that the above titled research project has now been completed. The research was conducted as originally intended and the research objectives were achieved.

Summary of research

Objectives: Mindfulness-based Cognitive Therapy (MBCT) has been evidenced as a relapse prevention strategy for depression. Depression often influences and is influenced by intimate-partnerships, thus it makes sense to include them in interventions. Although clinicians and researchers have put forward a rationale for using mindfulness within family/couples therapy (Cohen-Katz, 2004; Eubanks Gambrel & Keeling, 2010; Quintiliani, 2010), there has been no research into the use of MBCT for partnerships with depression. While there is existing theory that provides some ideas about engaging in MBCT as a partnership, these ideas have not been tested, so it is unclear whether they would apply.

Section D

The present research study aimed to address this gap by developing a theory of the process of engaging in MBCT as a partnership. As this presented a new clinical intervention that has not been previously investigated, a qualitative study seemed suitable. Grounded theory (GT; Glaser & Strauss, 1967) was selected because it can explore social processes over time and be used to generate a theory, with practical implications, grounded in the rich experiences of participants.

Methods: Twelve participants who had attended an MBCT course as a partnership were interviewed. These data were triangulated with sessional data from an MBCT course and facilitator validation. Analysis and interviews ran simultaneously, so that initial findings influenced subsequent data collection. Constant comparison of data and higher-level concepts facilitated generation of a theory grounded in the data.

Results: The proposed theory captured the ‘process of learning new mindfulness skills together’. The partnership’s rationale for pursuing MBCT together seemed to influence engagement with the course. In turn, participants’ accounts suggest that learning mindfulness skills together led to shifts in the interpersonal relationship and how they managed depression. The categories and subcategories are outlined below.

A. Context for engagement with learning mindfulness: The partnerships’ experience of depression impacting on their interpersonal environment and expectations for the group influenced engagement with the course. More specifically the following factors appeared to influence engagement.

1. Depression causes strain on partner
2. Makes sense to engage as a partnership
3. Active vs. Passive approach to course
4. Severity of depression
5. Quality of relationship

B. Learning mindfulness skills: Most service-users and their partners reported learning new mindfulness skills and linking these to positive changes in their ability to cope, more specifically, the following skills were valued.

1. Using breathing space to cope with stress
2. Changing relationship with thoughts
3. Noticing more

Section D

C. Partnership influence of engaging with the MBCT course: Engaging in MBCT as a partnership appeared to facilitate the learning of new skills in the following ways.

1. Mutual support for learning new skills
2. Improving attendance
3. Need to understand mindfulness to support it
4. Facilitating home practice: The partnerships influence on home practice represented a continuum from commitment to practising together, to mentoring, through the practising separately, which influenced the learning of new skills.

D. Influence of MBCT on the partnership: The interaction of learning new mindfulness skills within the partnership appeared to lead to unique outcomes for the individual and the partnership. More specifically, the following changes were noted.

1. Increased empathy and understanding
2. Reconnecting with each other
3. Sharing relapse prevention
4. Feeling better, doing more
5. Reduced worry

E. Group Process: Participants reported that the group process impacted on what they got out of the group, in most cases this is captured by items 1-3. However, these items interacted with items 4 and 5, for example, when the level of commitment to the group was lower, the other processes were to some extent lost. Also, when participants valued the group process over learning mindfulness, this was connected with a more passive approach to the course and they did not describe so many of the changes outlined in Category D.

1. Learning in a safe, equal environment
2. Sharing in a group helps
3. Putting problems in perspective
4. Level of commitment to the group
5. Valuing the group process over mindfulness

F. Outside influences: Participants connected the changes they had noticed to outside influences, such as coming to a time in their lives when they can focus on themselves more.

Section D

Conclusions: The theory of ‘learning new mindfulness skills together’ represented a preliminary theory of the interacting processes involved in engaging with MBCT as a partnership. Intimate-partnerships who engaged in the MBCT course seemed to learn and value similar mindfulness skills to those learned in individual MBCT courses. Learning as a partnership seemed to facilitate home practice, attendance and a sense of mutual support, which led to unique outcomes for the partnership, such as increased empathy, reconnecting, and a shared approach to relapse prevention. This provides a new synthesis across a range of interpersonal and mindfulness theories to offer a tentative new theory with unique elements.

Implications: It may be helpful for course facilitators to consider inviting intimate-partners to attend where both partners are suffering, or there is a willing intimate-partnership. It might be worth considering in assessment for MBCT whether individuals hold an active or passive view of how much control they have over their well-being, and whether they are experiencing severe depressive symptoms or are currently well. Furthermore, it seemed important to involve the partnership as equals.

Limitations and future research: Given the small sample size, further qualitative and quantitative research should be undertaken to refine aspects of the theory and test hypotheses pertaining to intimate-partnership and mindfulness processes in depressive relapse.

Arrangements for publication/dissemination

It is intended that findings will be submitted for publication in a peer-reviewed journal, namely, Mindfulness. At a service level, findings will be disseminated to staff within the service at the focus of this study.

Feedback to participants

A brief summary of findings will be provided to all research participants, who will be invited to a feedback session.

Yours sincerely,

Section D

Emma Smith

Chief Investigator/ Trainee Clinical Psychologist,

Canterbury Christ Church University