A Grounded Theory Exploration of the Impact of Mindfulness Based Cognitive Therapy (MBCT) on Conceptualisation of and Relationship with Selfhood

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Main Research Project

A Grounded Theory Exploration of the Impact of Mindfulness Based Cognitive Therapy (MBCT) on Conceptualisation of and Relationship with Selfhood

Sunil Nandha

Supervised by:
Professor Paul Chadwick
Dr Janet Wingrove
Abstract

The Buddhist philosophy from which mindfulness-based approaches originate proposes a system of understanding whereby inherent suffering stems from attachment to a rigid and unchanging concept of self. Though this notion of selfhood is afforded centrality within such traditions, as well as having been a predominant concern in the history of theoretical psychology, our modern research interests and clinical applications have seemingly preferred to focus on operationalisable constructs, such is their relative amenity to empirical study, whilst at the same time, an interest in the clinical application of mindfulness is abound.

As such - and with MBCT as currently the most evidenced of mindfulness-centred clinical protocols - we consider the extent to which the benefits apparent may pertain directly to, and be more clearly understood in terms of, this broader theme of change in conceptualisation of and relationship with self, commensurate in particular with the key Buddhist tenets of Dukkha, Anicca and Anatta (inherent suffering, transience of forms, and non-self). Our motivation is to explore the context within which well-researched content-based mechanisms of change in MBCT (e.g. cognitive reactivity and self-compassion) may operate.

Explorative interviews investigating processes of change experienced were conducted with 21 subjects; comprising current MBCT patients, previous MBCT patients, and Clinical Psychologists in Training, with a Grounded Theory methodology employed in data collection, abstraction, and integration of theory. Findings indicate a dynamic three-phase process of change; capturing the accounts of individuals firstly in gaining insights into “how I am constructed and controlled”, secondly in “getting to know my experience”, and finally in “knowing myself differently”. The constituent categories of these central concepts (which make up our explanatory scheme) are described and illustrated in detail.

Our findings and interpretations are suggestive that MBCT does indeed promote change in conceptualisation of, and relationship with selfhood, potentially through processes seemingly well aligned with the Three Marks of Existence outlined in Buddhist philosophies. Implications, both theoretical; regards the prominence of context versus content in psychological literature, and clinical; with respect to the issue of working therapeutically - and more explicitly - with selfhood, or personhood, are considered. Links are made with existing research into known change mechanisms in MBCT, as well with prominent clinical models, in particular CBT, ACT and PBCT. Finally, wider structural inferences and potential future research are suggested.
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The Sufi master, Uwais, was asked: “How do you feel?” He said: “Like one who has risen in the morning and does not know whether he will be dead in the evening.” The other man said: “But this is the situation of all men.” Uwais said: “Yes, but how many of them feel it?” (Quoted in Teasdale & Barnard, 1993)

CHAPTER 1: Mindfulness

1.1. Philosophical origins of mindfulness

The term mindfulness is derived from the Pali word “sati”, meaning to remember, though as a facet of consciousness it is considered to relate to a broader sense of “presence of mind” (Bodhi, 2000), or perhaps the function of presence of mind in “remembering what is otherwise too easily forgotten: the present moment” – the preferred definition of Analayo (2003). Although a significant history of contemplative traditions are apparent within most major world religions, mindfulness is perhaps most fundamentally embedded in Theravada and Vipassana schools of Buddhist thought, existing within “complex and highly developed sets of philosophical, cultural and spiritual practices” (Delmonte, 1989), as a holistic system of thought and behaviour, and one fostering “an alert participation in the on-going process of living” (Gunaratana, 2002), that is neither “religious nor esoteric in nature” (Grossman et al., 2004).

Within these traditions the mindful philosophy is considered to offer an account of suffering as stemming from dissatisfaction with the current state, for example a desire to acquire what is not present, or to remove what is, predominantly the concept of distress or suffering itself (Ekman et al., 2005). In conceptualizing this ceaseless struggle as futile in the context of suffering as intrinsic to the human condition, Buddhist philosophies advocate a mindful transcendence of the struggle, a commitment to “being with” (Kumar, 2003), or “suffering with” (compassion) in a state of awareness characterised by non-attachment (Epstein, 1998).

The most fundamental cause of suffering is attachment to the idea that there is a self that is fixed and somehow unchanged by conditions. As such, the Buddhist system of thought provides a framework within which to find contentment by virtue of embodying the essential tragedy of the human condition, that we are unavoidably finite and constantly changing. Taken a little further, even that perceived to be concrete, extant, yet finite, which can be valued, attached to, adorned and so on, ultimately represents a persistent illusion, and one that is equally dissatisfactory (Collins, 1982). The Buddha’s wisdom was principally presented “a solution to a
problem” (Kane, 2009), and the problem was “Dukkha”; the fundamental problem of life. Commonly thought of as “suffering”, Dukkha more broadly pertains to “lack”, and according to Loy (2000) it represents our most profound and unthinkable intuition that we are not real.

“Our most troublesome repression is not sexual wishes, nor even death fears, but awareness of non-self – the intuition that ‘I am not real’ – which we become conscious of as a sense of lack infecting our empty core. It is the deep feeling we all have that ‘something is wrong with me’, that something is missing” (Loy, 2000)

Processing in the mindful state is a practice illustrative of this “lack” (Dukkha), in opening one’s mind to the impermanence (Anicca) of formations, and providing a gateway for insight into no-self (Anatta). Together, these concepts represent the ‘Three Marks of Existence’ in Buddhist thought, theoretical notions encompassed by mindfulness practice - “bare attention” (Gunaratana, 2002), or “lucid awareness” (Das, 1997) - aimed at facilitating the transcendent position of non-attachment, and as such addressing and easing the fundamental pain of Dukkha.

Whilst these time-honoured tenets can generally co-exist with the prevailing ideas of a particular philosophical or scientific era (Imamura, 1998), the perspective offered here can often become neutered or diluted as a result (see Dimidjian & Linehan, 2003). Whilst a mindful standpoint has clearly been adopted with some enthusiasm within clinical psychology, and a Buddhist one perhaps less so, it is suggested that a more root-to-branch acknowledgement of these ideas within healthcare and Western science may contribute a “provocative dialogue leading to re-examination of some of the most entrenched paradigms governing our culture” (Verhoeven, 1998).

1.2. Self as a central concept in mindfulness traditions

“Emptiness appears first as the dark side of our attempts to create a separate and self-sufficient self…Buddhism as the most psychological of the worlds religions and the most spiritual of the world’s psychologies, authenticates a feeling that psychotherapy endeavours, unsuccessfully, to eradicate.” (Epstein, 1998)

As discussed, mindfulness traditions hold our fears and insecurities around selfhood close to their core (Harvey, 1995). Whilst a prevailing theme in predominantly individualistic, Enlightenment and post-Enlightenment era Western thinking is to value the pervasive and enduring nature of the individual as objectively extant and distinct (see Descartes, 1641), selfhood – and particularly the concept of Anatta – is central to a Buddhist understanding.

Anatta, or “no-self”, is a counter-point to the notion that an indivisible, consistent and enduring “T” can be boundaryed from the world, maintained and protected from suffering. Despite the
seemingly nihilistic leaning here (as has been a popular interpretation over time, for example see Burton, 2001), Anatta is not arguing that there is no self, simply that the self that exists is changing and conditioned by inner and outer experience. It is thus perhaps more accurately, and moderately, considered to be a statement pertaining to a form of impermanence (Anicca) in relation to selfhood, rather than one implicating absolute absence (French, 2006). Buddhist attitudes towards the self emphasise the extent to which our interactions with the world, or way of being, is driven by an “ego clinging attitude” (French, 2006), manipulating our navigation and appraisal of environments in service of satisfying the self. By means of mindfulness practice, and when we are confronted with the illusory nature of this construct, we come to see the self – ourselves – as transient, and characterised fundamentally by what is termed in the Theravadan tradition as “momentariness” (Brown, 1999).

The concept of Anatta offers a self-referent framework for Buddhist practice and underpins the philosophy as a whole (French, 2006). In Buddhism, Anatta is viewed as a meditational device to guide our journey toward liberation, the implication being that a mindful analysis or observation of myself as both conditioned and transient, renders the constituents of that “self” equally impermanent (for example pain, desire, happiness etc.), with the same ultimately being applicable for “other” – my environment, my world (Gethin, 2001). Selfhood is the fundamental concept in Buddhist philosophy – a self-creating construct that subsequently serves to place an illusory fog around our world, through which experience is then filtered (as in the cognitive model, e.g. Beck 1979), and in recognising this fixed self as illusory, the problem of Dukkha – as is attributable to the finite nature of life – also changes in tone; in non-attachment to self, one achieves acknowledgement - but non-attachment to - suffering itself.

1.3. Self as central in the history of Western psychology

In consideration of the place held by selfhood in the history of Western psychology our focus will inevitably be post-Enlightenment perspectives, and interestingly, this is where the first fundamental point of overlap would appear to be. As described above, the self in Buddhist thought represents an immediate and accessible opportunity for knowledge and insight, which subsequently translates to other; the observed transience of self-states becomes appreciated as a universal transience (Gethin, 2001).

Similarly, the logical positivism of Enlightenment era thinking is typified by the Cartesian method of doubt, experiment and discovery (Descartes, 1641), and is also one – like in mindful traditions - where the self (Descartes having doubted all around him) became the most crucial unit of analysis. However, whereas early Buddhist teachings focused on the sense of “lack” relating to felt, unified, boundaried selfhood, Descartes concluded that cognition was evidence of his existence, and the paradigm, appearing to adopt this principle of “from self to other”,
concluded that “other” must also exist, ready to be effectively investigated. As a consequence, self was somewhat torn from other, with the assumption being that “because we experience, we exist as distinct from that experience” (Kane, 2009).

Later, the conceptualisation of James (1890) characterised self as “a source of permanence beneath the constantly shifting set of experiences that constitute conscious life” (Farb et al., 2007), and psychology has (until very recently) proceeded with this model of pervasive selfhood, with properties in its own right (e.g. the cognitive model; Beck 1967), though the construct of selfhood perhaps has had a more central role in the formation of our theoretical understanding than is often credited within modern clinical psychology, or at least in psychology as a discipline more broadly.

In truth, some suggest that concepts of self are unclear in both Western and Eastern philosophies, with the often spiritual leaning of Buddhist traditions countered by a Western paradigm that “tends to reduce the concept to metaphors for neurophysiological processes” (Guenther, 1997). Despite this divergence, there is also a notable “conceptual kinship” between the notion of mindfulness, and various therapeutic modalities (Brown, Ryan & Creswell, 2007), for instance humanistic (Rogers, 1961) and Gestalt (Perls, 1973) approaches that seek to emphasise the value of authentic immediate experience, and how it relates to the functioning or well-being of the self. Furthermore, there exists a historical acknowledgement among the majority of therapeutic schools that integrated awareness of i) phenomenological experience and ii) aspects of the self are crucial (Brown, Ryan & Creswell, 2007), from Freudian psychoanalysis to modern cognitive-behavioural methods (Teasdale, 1999). In linking this shared ground back to the work of James (1890), the contemporary emphasis on decentering (Segal, Williams & Teasdale, 2002), or contextual self (Fletcher & Hayes, 2006) is perhaps analogous to James’ (1890) “Me”, the more distant appraiser of the agent “I” in the process of self-consciousness.

Nevertheless, and despite conveying messages around the value of bringing moment-to-moment experience to bear, contemporary psychological approaches (at least in terms of clinical application) would appear to stop short of explicitly promoting the (Buddhist) implications of this model for our notions of fixed selfhood (e.g. Crossley, 2011). This is inevitably difficult. For example, how can we move towards an appreciation of Anatta within contemporary psychological approaches, when we so heavily rely upon an enduring and objective impression of self as our unit of intervention? A unit that holds within it “thing-like properties” that also represent our therapeutic units of change (Sass and Parnas 2003).
Brown, Ryan and Creswell (2007) consider the idea that although Buddhist teachings offer a comprehensive account of the nature of mindfulness, these perspectives have not been mirrored within modern research psychology - a manifest trend despite the commonplace use of the term “self”, or “selfhood”, which we neglect in regards to theoretical investigation (Crossley 2011), yet “implicitly rely on as a psychological construct”. Inevitably we are primarily concerned with symptom alleviation within clinical psychology, as distinct from the more overarching, more “self-amenable”, problem of Dukkha (inherent suffering) described previously, and as such we employ a biopsychosocial model congruent with our diagnosis driven interest (Beutler, 2000), but one that “does not ground itself in selfhood” (Crossley, 2011). Despite the conceptual overlap discussed above with respect to historical psychological theory, the predominant paradigm currently in operation is one where Buddhist notions of self are difficult to integrate more fully; such is the “primacy of the ego, or constructed self, as the appropriate guiding force” (Brown, Ryan & Creswell, 2007).

The extent to which this construct pervades our thinking leaves it embedded in our view of reality (Leary, 2004), meaning that whilst the principles and techniques of mindfulness are coherent and usable, the philosophical implications – at least those pertaining to the nature of self, or no-self – are perhaps uncomfortable, or incongruent - “if we abstract all the particular details of experience we are not left with a constant, individual self, but a blank, a nothing” (Gethin, 1998). Experimental psychology is well suited to this process of abstraction, of deconstruction and reduction too, whilst the resultant “blank” is perhaps dubious in its therapeutic value, and more difficult to view as an important concept in contemporary clinical practice. At the same time, the blank is difficult to put aside, for life is unavoidably a “limit situation” (discussed in more detail later) defined by an associated existential crisis that provides a context in our search for transcendence (Ghaemi, 2007; see also Becker, 1973 on Terror Management Theory and the problem of mortality for Western perspectives). As we will come to discuss, content fits better than context within experimental research (Verschuren, 2001), and the self as a central component in our research and practice would appear to have been sidelined accordingly.

Overall, this opening chapter has described the philosophical origins of mindfulness practice, as well as touching on the changing emphasis on selfhood within modern psychology over time. Ultimately, it would appear that whilst the principle concern of Buddhism - Dukkha, or “lack” - holds a central place for selfhood and the implications of its illusory nature, the focus for psychology as a discipline is instead the understanding and alleviation of specific distress, and this within a experimental paradigm with refinement, delineation and reduction of concepts at
its core. Perhaps for these reasons, some of the most influential principles in Buddhist philosophy—Anatta, Anicca and Dukkha as guides and inferences of mindful awareness—are marginalised in our clinical applications, despite the interest and value placed on mindfulness practice itself.

CHAPTER 2: The Conceptualised Self

"One may certainly admire man as a mighty genius of construction, who succeeds in piling an infinitely complicated dome of concepts upon an unstable foundation, and, as it were, on running water. Of course, in order to be supported by such a foundation, his construction must be like one constructed of spiders' webs: delicate enough to be carried along by the waves, strong enough not to be blown apart by every wind.” (Nietzsche, 1873)

2.1. The making of a permanent, partless and crystallised self

The idea of the conceptualised self—Dennett’s “selfplex” (1991)—is not only rigid and fostering of attachment, but also distorts experience in such a way that we make interpretations in order to maintain it. In exploring the creation of this structure, our attitudes towards the self-other distinction, as well as the role of language (and our relationship to the content of language), is crucial. Again, there exists a long history in modern psychology of recognising the process by which one’s self is consolidated, predominantly as part of a complex social matrix within which our self-conscious activities are manifested. Crucially, human behaviour cannot be reduced to discrete mechanisms (Mead, 1934), but is instead driven by active self-awareness, and recognition of oneself from a societal perspective. From the symbolic interactionist viewpoint, it is this social ingratiations of ourselves with others that facilitates self-consciousness or self-awareness (Jones, 1964), an attribute attainable solely through “intersubjective relations” (Husserl, 1952), making awareness of self a product rather than a precondition of interaction (Coser, 1971).

Essentially, appreciation of self, or “I”, as separate and distinct arises from sophisticated symbol use within the social act of communication (Mead 1913). Once this is achieved, the imaginations of subjects “stand for the entire act” (Meltzer, 1972), hence through communication, language, and significant symbols, we are efficiently able to inform others of our intentions (Blumer 1966), thus creating a cognitive mechanism via which our “self” is consciously appreciated from an external viewpoint, whilst simultaneously being objectified in one’s own mind as the prevailing possessor of intent. We become “objects of our own reflection” (Coser, 1971; see also Buss 1980 on reflexive self-consciousness).
“...There is a tight loop between consciousness and self-relevant cognition, such that attention to stimuli continually feeds cognitive operations that associate those stimuli, directly or indirectly through related stimuli, to the self, and more specifically, to thought-generated accounts about the self—self-representations, the self-concept, or more simply, ‘Me’. ” (Brown, Ryan & Creswell 2007)

More recent developments in contextual psychological approaches (see Fletcher & Hayes 2006) have developed a model of understanding the construction of a conceptualised self, in the form of Relational Frame Theory (RFT; Hayes, Barnes-Holmes & Roche, 2001). RFT is a central thesis in the Acceptance and Commitment Therapy (ACT) approach, and posits that humans have the ability to make symbolic inferences and generalise words and concepts in terms of how they relate to behaviour, afterward expanding this stimulus equivalence into the more general case – for instance we learn to relate events arbitrarily and in an enormous number of ways (Ramnero & Torneke, 2008). We build up a repertoire of relational frames, and are subsequently able to demonstrate a wide range of behaviours based on limited trained frames (Barnes et al., 1997), meaning that perception and interpretation are coloured by beliefs and prejudices not pertaining to direct experiential evidence (Niemiec, Brown and Ryan, 2006).

Essentially, we attribute learned relational frames to “I”, which become what “I” know (to be true) about the world or myself (Ramnero & Torneke, 2008). Hayes, Strosahl & Wilson (1999) claim that the vast majority of our knowledge is verbally dependent and linguistically bound, though it serves the vital function of enabling us to label both experience (of self and other) with characteristics and attributes that can become reinforced over time. A means of categorizing and organizing instances and environments (Padesky 1994) that are otherwise context-less and chaotic respectively.

"We call a person "honest," and then we ask "why has he behaved so honestly today?" Our usual answer is, "on account of his honesty."
Honesty! We know nothing whatsoever about an essential quality called "honesty"; but we do know of countless individualized and consequently unequal actions which we equate by omitting the aspects in which they are unequal and which we now designate as "honest" actions.” (Nietzsche, 1873)

As such, a linguistic concept, like “honesty”, “self” or “I”, with no intrinsic properties of permanence, consistency or concreteness, becomes unified, enduring and highly influential. Cognition and language are the processes by which we create, symbolise and maintain “self” within our contexts (Roepstorff, 2007; see also Maturana & Varela, 1980), whilst at the same time being guided by this creation itself – a separate “disengaged subject” able to objectify experience (Crossley, 2010).
“Thoughts are seen to produce artificial constructs, one of which is the sense of a partless or permanent self.” (French, 2006)

2.2. Suffering as attachment to conceptualised self, core beliefs and schema

“The perception of ourselves as subjects of particular experience is brought about by feeling that the experience which one is having is mine… We may speak of a pre-reflective self-awareness whenever we are directly, non-inferentially, or non-reflectively conscious of our own occurring thoughts, perceptions, feelings, or pains; these appear always in a first person mode of presentation that immediately reveals them as our own; that is, it entails a built-in self-reference” (Sass & Parnas, 2003)

Inconsistent, traumatic and neglectful early life experiences inevitably increase vulnerability to significant psychological distress in later life (Fava & Kendler, 2000), whilst personality traits such as neuroticism or perfectionism, and negative self/other/world beliefs in particular (Beck, 1979), also heighten risk in the context of stressful life events. Fundamentally, these constitute experiences that become attributed and attached to the “I”, owned by the conceptualised self (Padesky, 1994). Hamilton (2000) recommends that we attend “carefully and deliberately” to the process by which we recruit and construct past and present experience within the present moment, for there is an abiding tendency to believe that we are this fixed amalgamation of experiences to date, to be limited by, and to act in line with (e.g. Young, Klosko & Weishaar, 2003).

Padesky (1994) highlights the destructive impact of tightly held core beliefs and self-schema in maintaining chronic psychiatric problems including depression, anxiety and personality disorders. In relation to cognitive therapy, schemas are defined as an organism’s mechanism for “screening, coding and evaluating stimuli”, with the result of guiding our capacity to “categorise and interpret experiences in a meaningful way” (Beck, 1967). More functionally, this filter system contributes “specific rules that govern information processing and behaviour” (Beck et al., 1990), for example “I am vulnerable so I have to…” and as such we can begin to appreciate the network of experiences and beliefs that we come to identify with, and that inadvertently obstruct our mindful access to the present moment (Fletcher & Hayes, 2006; Ramnero & Torneke, 2008).

The problem with mindless guidance at the hands of “I” (Teasdale, 1999), or “ego-invested preconceived notions” (Hodgins & Knee, 2002), is that we are compelled to behave in accordance with a repertoire pertaining to the past, rendering us stuck in a self-fulfilling mindset moulded by previous experience that we continue to be fearful of (Langer, 2000). We boundary, constrict and limit ourselves by virtue of self-belief. We are conceptually entangled within rigid, conceptually constructed views of self, other and world (Padesky, 1994), and we suffer as a
consequence of an attachment to our own interpretations and self-descriptions (Fletcher & Hayes, 2006).

“A picture held us captive. And we could not get outside it, for it lay in our language and language seemed to repeat it to us inexorably.”
(Wittgenstein, 1951)

Segal, Williams & Teasdale (2002) describe the concern that concepts such as negative automatic thoughts and core beliefs are experienced and processed, psychologically, as objectively real rather than incidental mental events. For instance “I am bad”, rather than the metacognitive position “I have a belief that I am bad” (Padesky, 1994). Sass and Parnas (2003) term them “thing like objects in causal interaction”, regarding the maladaptive perception of beliefs and judgments as parts of the self, as opposed to of experience (French, 2006). The very idea “I am vulnerable” is the attaching of a particular instance of vulnerability to the ‘I’ (making it “mine”), whereby the individual now owns it – and no longer does it belong to the system in which it was created. The “I” is then equipped to radiate vulnerability outward (primarily through affect and behaviour) and receive vulnerability back (generally in the form of cognitive distortion; see Padesky, 1994).

As we have discussed, the conceptualised self then dictates what is possible in the future – for instance “I am vulnerable so I can’t do...” (this continues to be linguistically bound; see Hayes & Smith, 2005) – a powerful and influential concept, made up of our beliefs, fears, insecurities and doubts, but ultimately one that lends to the objectification of an "arbitrary and constructed" narrative (Williams et al., 2007). Attachment to this construct entails that my current self is bound by experiences grounded in my past (Hayes, Strosahl & Wilson, 1999). Despite these experiences perhaps now being out-dated, invalid and out of context, they have become abstract and diffuse concepts like “worthlessness” and “vulnerability” rather than particular instances in which manifestations of these traits were elicited by a general system. They become the “thing like properties” of “I” described by Sass and Parnas (2003) rather than of the system, whilst our unhinging attachment to this “I” - and subsequent identification with its congealed concepts - is theorised within Buddhist scholarship to be the source of our psychological distress (Gethin, 2001).

A shift in such a conceptualisation would aim to bring about understanding of self as complex, contradictory and changing (Chadwick, 2006), and we shall come on to discuss the potential therapeutic role of insight here, whereby negative self-beliefs are seen as a part of the momentary, transient self - so part of the self, rather than the self. The difficulty here is the extent to which self-concept maintains, promotes and endorses itself so successfully, as is described in the way that core beliefs and schema are conceptualised within cognitive models,
for example (Beck, 1979). We ultimately develop a deep-seated attachment to the perception of self, and self-beliefs more specifically, perhaps owing predominantly to the fear of their loss (e.g. Loy, 2000), in linking back to chapter one.

"Most people come into therapy wanting to defend their particular conceptualised self, even if it is loathsome." (Hayes, Strosahl & Wilson, 1999)

2.3. A transient, diffuse self, and the role of insight

“Only by forgetting that he himself is an artistically creating subject, does man live with any repose, security, and consistency. If but for an instant he could escape from the prison walls of this faith, his ‘self-consciousness’ would be immediately destroyed” (Nietzsche, 1873)

As discussed, mindfulness comes from the Buddhist tradition that characterises selfhood by its essential emptiness, and illusory nature of our rigid and fixed conceptualisations (Hamilton, 2000), with no amount of protection or adornment sufficient in addressing this ultimate pain, and attempted escape from or avoidance of this existential problem serving only to maintain suffering (Hayes, Strosahl & Wilson, 1999). In having conceptualised and attached to a fixed and unchanging self, we fail to see the true nature of self-experience – its inherent momentariness (Brown, 1999), and it is suggested that insight into this momentariness loosens our attachment to maladaptive self-beliefs (see the role of “decentering” as a mechanism in traditional cognitive therapy also; Teasdale, Segal & Williams, 1995), thus potentially heightening one’s appreciation of a parted, transient and contextual self.

The notion of a “Dialogical Self” has its roots in James’ distinction between “I” and “Me” but also in Bakhtin’s (1973) theory of the “Polyphonic Self” – a “multiplicity of voices in a polyphonic novel”. If we have ever-changing selfhood or multiple selves (I-positions), then the self can be seen as existing within “a highly dynamic field of criss-cross dialogical relationships among possible positions, subjected to influence from all sides” (Hermans & Kempen, 1993), as part of a matrix (French, 2006) perhaps, rather than as a “self-relevant, self-determining, individual agent” (Taylor, 2007).

To facilitate flexible, reflexive and dynamic interactions in and with the world, the self needs to have insight into its own nature as being all of these things – complex, contradictory and changing (Chadwick, 2006) – whilst cognitive, behavioural, and experiential rigidity subsequently become the foundations of dysfunctional living (Hayes & Smith 2005). Where key depressive symptom of hopelessness can stem from a view of oneself as “flawed”, “bad” and “unchangeable” – or “who I am” - a global and stable phenomenology, metacognitive insight into the nature of selfhood as complex, contradictory and changing has been found to loosen the
bind of such global and stable self-attributions, thus contributing to a quite different process of knowing oneself (Fletcher & Hayes, 2006).

As well as relating to a mindful process of insight into the essential nature of selfhood, there is also the issue of insight into (and potential liberation from) within-self processes of conflict (Koole, Dijksterhuis & van Knippenberg, 2001), which exist between explicit goals and beliefs (Emmons & King, 1988), as well as on implicit levels (Baumann & Kuhl, 2005). In this respect, we may choose to view ourselves as contexts, or vessels, within which inevitable conflicts arise and dissipate, with the experiential meditative insight being that one can “observe the private war, without being in the private war” (Hayes, Strosahl & Wilson, 1999), or indeed becoming the private war. Crucially, as a function of this realisation we are without attachment to either self or experience, and resultantly free from the suffering associated with fixed and unchanging selfhood, theoretically removed from concerns around identity and self-esteem in particular (Brown & Ryan, 2003).

Importantly, we may also make a distinction here between i) self-reflection and ii) insight, whereby the former is a process by which self-consciousness (and therefore judgement) arises – echoing the “I” – “Me” dialogue (James, 1890), whereas insight is more closely aligned with understanding and acceptance. Fittingly, whilst the type of “internal state awareness” (moment-to-moment) advocated by mindful traditions has been experimentally associated with greater well-being, “self-reflectiveness” is found to be dysfunctional (Brown, Ryan & Cresswell, 2007), a hypothesis consistent with theories of social processing in anxiety disorders (e.g. processing of self as a social object; Clark, 2001).

2.4. Problem specific approaches and suffering

"We need to do more than collect a recipe book of psychological procedures, we need to understand human suffering and how best to treat it”. (Hayes, Strosahl & Wilson, 1999)

To take depression as an example of dissatisfaction with life, and with self, even in the context of the most effective treatments (both psychological and pharmacological) a substantial percentage of clients do not respond (Hollon et al., 2005), and of those who do, a significant proportion relapse (Segal, Williams & Teasdale, 2002). A similar pattern emerges with respect to the majority of anxiety disorders (Twohig et al., 2005), and the message more broadly would seemingly be that once manifestation of distress becomes chronic, disorder specific cognitive-behavioural interventions begin to lose their efficacy (e.g. Young, Klosko & Weishaar, 2003) – as once again they pertain to the problem of symptomology, rather than the more fundamental
problem of Dukkha. According to Hayes, Strosahl & Wilson (1999), this represents an important message in terms of the way we treat people.

"The key difference between Western and Buddhist psychology is that while Western ego based psychology views the development of a healthy sense of self integrated into society as a final outcome of treatment, this is only a starting point for further development”. (Kornfield, 2009)

The merits of disorder-driven interventions focused on symptom alleviation are clear, and inevitably this philosophy has been hugely influential in the modern prominence of psychological theory and applications. The approaches derived are empirically grounded, operationalisable and amenable to dissemination, as well as being testable (Norcross, Beutler & Levant, 2006). However, they exist (crudely speaking) within a paradigm that fails to authenticate suffering (Epstein, 1998), and serves to address observable manifestations, rather than core dilemmas of selfhood (Rosch, 2007). Hayes, Strosahl and Wilson (1999) describe the way in which aspects of cognitive therapy may serve simply to replace dysfunctional rules or “tracks” with societally adaptive alternatives (see for example Padesky, 1994) – an approach that is in part ill-advised as it continues to promote rule based living, which in turn feeds into the selfhood or “I” of an individual, guiding their behaviour in a world that is appraised in such a way that reinforces and maintains behavioural and cognitive rigidity. Perhaps a more adaptive rigidity, but nonetheless a rigidity that is vulnerable to the frailties and pitfalls of rigidity itself.

An interesting account and explanation of the shortcomings of such an approach is suggested by Ghaemi (2007), who in distilling the writings of Karl Jaspers on existentialism in psychiatry identified the ideas of i) limit situations and ii) transcendence, both of which appear to be important in a consideration of why it is that “common-sense strategies, when applied to subjective experience, all too often become traps” (Hayes, 2007). “Limit situations” correspond to existential crises stemming from an awareness of mortality that pervades human life, while “transcendence” relates to the concept of freedom as a central aspect of existence – impossible to encompass within scientific understanding or rationalist systems of thought (Ghaemi, 2007). Our human comprehension and acceptance of these ideas would seem to exist outside of the tendency - or possibility - for reductionism and operationalisation (Kabat-Zinn, 2003), and in essence, they represent problems of the human condition, and fundamental ones that exist both concurrently with, and independently of, the disorders that problem specific models seek to address. The overlap, at least within the Buddhist tradition, might be that both are rooted in the same processes of attachment to fixed self (Forman et al., 2007).

Whilst suffering is recognised as an inherent part of life, this view has rarely been appreciated by mainstream psychology, which seeks primarily to “fix” a “problem” (Hayes, Strosahl &
Wilson, 1999), thus inadvertently marginalising people during their transient periods of distress and feasibly making reintegration more difficult - “fighting a problem can itself create a problem” (Hayes, 2007). Relational Frame Theory (as previously described) offers an account of human suffering as created by “entanglement with the cognitive networks made possible by language” (Fletcher and Hayes, 2006), and Hayes, Follette and Linehan (2004) contrast this to the way in which “whilst CBT deals with thoughts by aiming to dispute, change and restructure their content”, third wave approaches focus on process and context oriented variables (psychological flexibility or the conceptualised self in ACT for example), and as such provide a more comfortable conceptual framework within which intrinsic suffering can sit, and be authenticated or validated (Forman et al., 2007).

2.5. Content and context in mindfulness

There would appear to be two primary threads of investigation relevant to mindfulness, firstly what we might term “content” focused, and secondly “context” based. Content can be seen to encompass the majority of modern psychological investigation of mindfulness, and relates to studies exploring demonstrable and empirically measurable change; for example in attention, concentration or indeed levels of mindfulness itself (Segal, Williams & Teasdale, 2002). Context on the other hand might be thought of as the impact of mindfulness on more subjective experiential qualities, for example one’s relationship to self, to existence, or to the core problems of life outlined by Buddhist philosophies; those which are seen by these philosophies to be important constructs in the context of Dukkha.

“The current popularity of this topic [mindfulness] among researchers and clinicians is somewhat incongruous. Mindfulness is fundamentally a quality of consciousness, and except among intrepid bands of philosophically oriented psychologists and cognitive scientists, consciousness has received relatively little attention in psychological scholarship, research and clinical practice.” (Brown, Ryan & Cresswell, 2007)

Nevertheless, our predominantly content driven analysis of mindfulness has proceeded at pace over recent years (Keng, Smoski & Robins, 2011), looking (primarily through self-report questionnaire measures) at dispositional (Baer et al., 2006) and momentary mindfulness (Lau et al., 2006), as well as effects on cognitive reactivity and self-compassion (Kuyken et al., 2008), attention (e.g. Jha et al., 2007), concentration (e.g. Bogels et al., 2006), self-control (e.g. Singh et al., 2003), emotion regulation (e.g. Chambers et al., 2009), pain (Kabat-Zinn, 1982) and sleep disturbance (Shapiro et al., 2003) as well as other operationalisable outcomes and more general well-being (Germer, 2005). This type of evidence is closely tied to clinical practice, and has clear implications for therapeutic methods. Psychological research over the past decade or so has been fairly prolific in delineating, defining and better understanding components of
mindfulness (Kabat-Zinn, 2003), with the intention of integrating the approach within both more established, and novel treatment protocols (Segal, Williams & Teasdale, 2002), and with considerable success.

However, a tendency for over-operationalisation, or reduction, is perhaps in danger of leaving mindfulness "plugged into a behaviourist paradigm with the aim of driving desirable change” (Kabat-Zinn, 2003), and whilst there need not necessarily be an explicitly spiritual or Buddhist leaning in our application – in recognition of mindfulness as a universal faculty (Kabat-Zinn, 1990) – some suggest that absolute separation from philosophical roots leads to Western clients receiving a relatively insipid or neutered version (Dimidjian & Linehan, 2003), and one that is subsequently less able to promote fundamental change through application of mindfulness as a quality of consciousness.

2.6. Mindfulness and potential impact on selfhood

Lykins and Baer (2009) found significant differences between meditators and non-meditators for rumination, levels of mindfulness, fear and avoidance of emotional states, and increased behavioural regulation, whilst Gratz and Roemer (2004) concluded that mindfulness facilitates the ability to behave adaptively in the context of distress; results generally commensurate with the rationale for contextual clinical approaches (Segal, Williams & Teasdale, 2002; Hayes, Strosahl & Wilson, 1999). Though these analyses make little mention of implications for Dukkha, and less so again Anatta, it would appear that even predominantly content focused exploration of mindfulness might pertain necessarily to selfhood (Malpass et al., 2011), which represents a more holistic, global and perhaps experimentally underused construct (Crossley 2011), as discussed.

"In its widest sense a man's Self is the sum total of all that he can call his, not only his body and his psychic powers, but his clothes and his wife and children, his ancestors and friends, his reputation and works, his lands and horses, and yacht and bank-account. What makes all these things part of a man's Self is that they give him the same emotions. If they wax and prosper, he feels triumphant; if they dwindle and die away, he feels cast down, - not necessarily in the same degree for each thing, but in much the same way for all. What determines the boundary between self and not-self is one's emotional attitude about an object or thought. The things, people, or thoughts, with which one identifies, are quite literally part of Me, so long as what happens to them is experienced as something happening to me” (James, 1890).

The key processes of decentering (as discussed by Teasdale, Segal & Williams, 1995) would appear to facilitate a view of thoughts (and experience more generally) as independent mental events without necessary objective implications for “truth” or reality per se (Segal et al., 2002).
Fletcher and Hayes (2006) write that the meditative fostering of a “transcendent sense of self” should ultimately promote “a shift from identifying with the conceptualised self”, as such leaving us less prone to identifying with the waxes and wanes of that which makes up, or has made up, this self (e.g. James, 1890; quoted above). We look to change experience, by virtue of bringing attention to it (Segal, Williams & Teasdale, 1999), and in the mindfulness tradition, we can alter self simply by attending to it through a different process, and perhaps “other” through awareness of events and occurrences as “phenomena…rather than as objects of a conceptually constructed world” (Olendzki, 2005).

Indeed, more subjective outcomes such as compassion for self, outward empathy and increased ecological understanding have been described (see Brown, Ryan & Cresswell, 2007), with empathy towards others (Beitel, Ferrer & Cecero, 2005) particularly interesting in that it seemingly relates to a mindful blurring of the self-other boundary central in the Buddhist tradition – for example defining self with respect to the contributory matrix (French, 2006), and in doing so overcoming some of the problems associated with absolute individuality (Lancaster, 1997), perhaps relating again to the limit-situation of our own mortality.

Brown, Ryan & Cresswell (2007) discuss potential implications for insight and non-attachment with regards to mindfulness practice (two variables closely aligned with the interests of mindful traditions), and whilst the focus on insight is seemingly well accounted for through discussion of decentering and metacognitive positions in modern clinical psychology (Teasdale, 2001 for example), our understanding around the concept of non-attachment continues to feel distinct from that within Buddhism. Whilst non-attachment to emotional, cognitive or physical states is well recognised (Ekman et al., 2005; Kabat-Zinn, 1990), the philosophical implications here – Anatta - are less prominent in the discipline.

In summary, this chapter has described the creation, attachment to, and influence of the conceptualised self, as well as the potential impact of mindfulness in this regard. As well as content focused change, there is seemingly a place also for the idea that patients develop new experiences of self, illness in the context of self, insight into self, and non-attachment (see Malpass et al., 2011; Brown, Ryan & Cresswell, 2007). Whilst we shall go on to discuss the modern clinical use of mindfulness in more detail, questions emerging at this point would appear to be three-fold: i) Are fundamental self-related changes promoted by current clinical protocols (that primarily, or explicitly, favour content focused variables), ii) does self-related change - in line with the Buddhist tradition of understanding suffering - occur within these interventions, and iii) if so, how is this change accounted for, measured or recognised?
CHAPTER 3: Clinical Applications of Mindfulness

3.1. Transdiagnostic approaches, clinical applications and experimental evidence

“Buddhism and psychotherapy should coexist and interpenetrate quite easily.” (Imamura, 1998)

A third wave of contextual psychotherapies have created more natural home for mindfulness within clinical settings (e.g. Hayes, Strosahl & Wilson, 1999), whilst interest in Buddhist principles and philosophies more generally has also seen significant growth as a consequence (Barinaga, 2003). As has been discussed, there exist large areas of conceptual overlap, with some suggesting that psychology’s “self” is essentially a secularised soul (Williams, 2000), or that psychotherapy is itself a “secular spirituality” that increasingly promotes a transcendental (decentered, perhaps) stance (Symington, 1994), as such encouraging clients to respond more directly to reality, as opposed to by order of the conceptualised self (Hodgins & Knee, 2002).

“We do not merely live in the world, we live in the world as we view it, construct it, or interpret it.” (Hayes, Strosahl & Wilson, 1999)

This process of construction and interpretation is the ground upon which many recent applications of mindfulness would appear to operate (Segal, Williams & Teasdale, 2002; Hayes, Strosahl & Wilson, 1999), and generally by means of integrating mindfulness as a tool, or technique, into a formulated intervention that may also comprise more traditional cognitive, behavioural, systemic or analytic methods (Hayes, Follette & Linehan, 2004). As such, there is considerable variability in application (Dimidjian & Linehan, 2003) - both theoretically and operationally - in the use of mindfulness as a method of self-regulation, acceptance and affect regulation in Dialectical Behaviour Therapy (DBT; Linehan & Dimeff, 2001), of primarily metacognition in Mindfulness Based-Cognitive Therapy (MBCT; Segal, Williams & Teasdale, 2002), of diffusion and acceptance in Acceptance and Commitment Therapy (ACT; Hayes, Strosahl & Wilson, 1999), and commonly as an applied coping strategy within cognitive-behavioural approaches to anxiety disorders (e.g. Barlow, 2000). In general, mindfulness approaches have been integrated with existing knowledge relating to specific clinical problems and diagnoses – for example individuals with Bipolar Disorder (Ball, Corry & Mitchell, 2007) - and dependent on the need of particular populations, within which each of the approaches mentioned has sought to develop growing evidence bases (Brown, Ryan & Cresswell, 2007).

Despite impressive efficacy findings and good face validity of mindfulness-based approaches generally (Hoffman et al., 2010), the mechanisms of change at hand are generally not well understood (Malinowski, 2009). Although specific variables as discussed have been cited as influential, each can be seen to account for only a small proportion of variance, whilst more
abstract units of interest such as “cognitive flexibility” (Moore & Malinowski 2008), or “psychological flexibility” (ACT; Hayes, Strosahl & Wilson, 1999) are inevitably more difficult to pin down. Overall, Hoffman et al. (2010) in reviewing 39 articles to have investigated Mindfulness Based Approaches (MBAs) concluded that:

“Mindfulness based therapy approaches improve symptoms of anxiety and depression across a relatively wide range of severity, and may be due to therapeutic mechanisms that are not disorder specific but instead target processes of relevance across disorders.”

In our continued analysis of the role, effectiveness and mechanisms of mindfulness within clinical practice - and with the initial questions laid out in Chapter 2.6 in mind – we will now focus more explicitly on Mindfulness Based Cognitive Therapy (MBCT; Segal, Williams & Teasdale, 2002), which will hereon form a subject for the majority of this thesis. MBCT has been selected for this purpose in consideration of its strong position within currently recommended psychological approaches to relapse prevention in major depression (National Institute of Health and Clinical Excellence, 2009; NICE), with chronic depression being identified as perhaps the psychiatric disorder most explicitly characterised by enduring and fixed attachment to negative self-concept. MBCT has the most reliable and extensive evidence base among mindfulness interventions (Dimidjian & Davis, 2009), and uses meditation as its most prominent technique, where other approaches – such as ACT and DBT for instance - are inclined to integrate it within a more diverse framework of methods.

"Amongst empirically supported mindfulness based treatments, the most intensive meditation training is provided by MBCT." (Lykins and Baer, 2009)

As such, MBCT offers a more specific arena in which to explore our questions regarding the extent to which clinical applications of mindfulness promote the changes in selfhood (conceptualisations of, and relationship to), that are identified as fundamental processes in attaining enduring psychological well-being within Buddhist philosophy.

3.2. MBCT, evidence and mechanisms of change

Mindfulness Based Cognitive Therapy (MBCT) comprises eight weekly sessions each of two hours, which take place in a group format. The method is based on an earlier program devised by Kabat-Zinn (1982) – Mindfulness Based Stress Reduction (MBSR) – focused on employing mindfulness practices and Buddhist philosophical principles around acceptance in managing chronic pain, as well as associated low mood and anxiety. During MBCT, patients are guided in developing enhanced awareness of cognitive, emotional and physical states through a variety of
meditations, from lengthy 40-minute “body scans”, to brief “breathing spaces”, as well as being encouraged to maintain their own personal practice (Segal, Williams & Teasdale, 2002).

“The theoretical premise of MBCT is that depressive relapse is associated with the reinstatement of negative modes of thinking and feeling that contribute to depressive relapse and recurrence.” (Lau, Segal and Williams, 2004)

Essentially, this pertains to reactivation of negative concepts that have remained housed, and relatively dormant, within the self during periods of remission, subsequently able to perpetuate a further depressive episode, or relapse. Results of the first MBCT randomised controlled trials (RCTs) – targeting patients in remission - showed a reduction in relapse rates from 66% to 38% at one-year post intervention (Segal, Williams & Teasdale, 2002), whilst the program was found to have no demonstrable effect on clients who had experienced two previous episodes. Two RCTs suggest that MBCT produces favourable results when compared with treatment as usual (TAU), in primary care (Ma & Teasdale, 2004; Teasdale et al., 2000), whilst a further trial showed that MBCT was equal to maintenance antidepressant medication (mADM) in terms of relapse (47% versus 60%), but produced significantly better outcome in terms of self-reported and observer-rated depressive symptoms at 15-month follow-up (Kuyken et al., 2008).

“MBCT focuses on creating change through increasing metacognitive awareness and present moment, non-judgmental awareness of negative thoughts and feelings in at-risk populations.” (Segal, Williams & Teasdale, 2002)

In terms of known mechanisms of change in MBCT, Kuyken et al. (2010) present data suggestive of a link between improved outcome and greater reported levels of self-compassion; claiming that independent of shifts in depression severity, increases in mindfulness and self compassion (measured through self-report questionnaire) accounted for less severe later depressive episodes. More specifically, self-compassion is credited with “attenuating the toxic relationship” between post-treatment cognitive reactivity and depression outcome (Kuyken et al., 2010). The role of self-compassion here would appear to be especially promising, being that as a concept at least, it links fairly directly to the philosophy of mindful traditions. Moreover, Kuyken et al. (2010) also propose that self-compassion as relates to a broader process common to MBAs may be operating here – one of enhanced capacity and willingness to meet distress with “empathy, equanimity and patience”, and with less room for self-judgement, self-attack and blame - “the fuel for depressive thinking”. These findings would seem to be consistent with the importance of self-compassion suggested elsewhere (outside of MBCT), with Lykins & Baer (2009) reporting a moderate effect size for meditators versus non-meditators with respect to pre-post change.
A growing body of theory, practice and experimental research has contributed to MBCT being acknowledged by NICE (2009) as recommended for people who are currently well but have experienced three or more previous episodes of depression. Nevertheless, the process of refinement and investigation inevitably continues, and clearly there is much yet to be understood in relation to the mechanisms by which MBCT is able to reduce relapse in depression. Although large trials (Kuyken et al., 2010; Ma & Teasdale, 2004; Segal, Williams & Teasdale, 2002) have proven valuable in exploring the role of constructs such as cognitive reactivity and self-compassion, the question of whether, and to what extent, MBCT promotes the key areas of insight and understanding relevant to Buddhism (e.g. Anatta, Anicca and Dukkha), in terms of essential change regarding relationship with self, remain.

3.3. Depression, relapse and dissatisfaction with the self

Although the aims of this thesis are to explore the impact of mindfulness on selfhood quite broadly, owing to the role of dissatisfaction with self in depression (Padesky, 1994), and the centrality of the disorder in clinical practice, theory, and research relating to MBCT, it is important to consider chronic and recurrent depression both in terms of its conceptual and theoretical nature, but also with respect to the sampling of this study.

Depression, as mentioned previously, is a disorder characterised by dissatisfaction with the self, distorted self-concept, and enduring identification with negatively held beliefs and attitudes around self-worth, self-perception and self-image, in addition to decreased activation and often self-punitive impulses (Beck & Alford, 2009). Indeed, the majority of our modern psychological understanding of core beliefs and negative self-schema as knowable constructs can be seen to originate with Beck’s (1967) writing, clinical work and formulation around major depression within the cognitive model, and in terms of formal diagnosis, five or more symptoms relating to those areas mentioned by Beck & Alford (2009) must be endorsed, as is stipulated by the American Psychological Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 2000).

Despite treatment of first episode (often reactive) depression being fairly successful through problem specific approaches as discussed, it is estimated that at least half of people who receive psychological treatments continue to be depressed at one year follow up (Holon et al., 2005; Simon et al., 2002), whilst around 10% are found to suffer from a chronic or enduring depressive condition (Kessler et al., 2003). Indeed, within this latter sample it is suggested that risk of subsequent episodes increases with each episode passed (Segal, Williams & Teasdale, 2002), such is the automaticity in reactivation of maladaptive and depressogenic thinking styles (Lau, Segal & Williams, 2004). The UK point prevalence of depression is said to be around 2.6% (Singleton et al., 2001), with a slightly higher rate in females than males (2.8% versus
2.3%, Waraich et al., 2004), whilst patients experiencing their first episode before the age of 20 are considered most at risk of a chronic and persistent presentation (Mitchell & Subramaniam, 2005).

We can therefore recognise major depression as an at times pervasive demonstration of dissatisfaction with self (Bockting, Spinhoven & Huivers, 2010), but one that stems from an intense attachment to and identification with conceptualised self (as well as rigidly conceptualised views of “other”), which is by no means the preserve of clinical populations (Hayes, Strosahl & Wilson, 1999). As such, in our investigation of the role of mindfulness meditation in addressing or working with these constructs, our sample of MBCT participants would ideally comprise both clinical and non-clinical groups. It is suggested that both would inevitably relate to a degree of attachment to conceptualised self, though perhaps to differing degrees if this construct were seen as a continuum, with the clinical sample likely to have had a more significant history of identification with what might be thought of as entrenched core beliefs (Beck, 1979), or highly influential self-schema (Young, Klosko & Weishaar, 2003).

“By seeking close guidance from the centuries-old meaning of mindfulness that is exhaustively described in the scholarly literature, the task of separating essential and nonessential ingredients will be simplified considerably.” (Brown, Ryan & Cresswell, 2007)

In summary, and in conclusion of this chapter, it is relationship to self (and therefore also dissatisfaction with self) that we are interested in here, and particularly the potential translation and transmission of an alternative view of selfhood (as outlined in Buddhist scholarship) through the most popular and efficacious modern clinical application of mindfulness (MBCT), in both clinical and non-clinical samples. It is suggested that a changing view of, relationship to, and conceptualisation of selfhood (that pertains directly to Anatta, Anicca and Dukkha both intellectually and experientially), would represent the most effective method of relapse prevention in those with a history of major depression, as well as an effective preventative measure in non-clinical groups. Our investigation is one that concerns the extent to which this broad and important shift is apparent following MBCT, and may account for a portion of its success to date in reducing depressive relapse.

**CHAPTER 4: Investigating a Broader Mechanism of Change**

4.1. Qualitative methods in investigating selfhood

In exploring this change, which relates predominantly to context rather than content, we seek to investigate within-self relationships that perhaps do not fit comfortably with a purely quantitative method of enquiry. Although empirical tools inevitably have their considerable
value, in the field of self-exploration Rosch (2007) makes the point that many scales – of mindfulness, compassion, awareness etc. – “seem to be measuring a construct of more versus less pathology”, and thus contribute to a tendency toward increasing reductionism in the understanding of psychological distress (Dimidjian & Linehan, 2003), where causal explanatory truths are rare (Frosh, 1997). Although our target group will be those who have completed MBCT - an arena in which quantitative questionnaire based methodology is popular - the intensive meditation training provided means that there is perhaps scope to investigate a degree of self-liberation through mindfulness (as suggested by Shapiro, 1992), and to consider the prospect that these on-going and lifelong processes have been set in motion.

“Qualitative research allows for a holistic and systematic window into the lived experiences of phenomena being investigated.” (Kazdin, 1998)

If causal truths are unlikely in the humanities, then the goal of the qualitative researcher becomes a “meaning imbued narrative truth” (Frosh, 1997), observing, commenting on, and describing the meaning that arises from exploration of human experience in context – aimed at “deep and textured understanding”, rather than the operationalisation or delineation of existing constructs (Pidgeon & Henwood, 1997).

Once again, if our interest is in the extent to which MBCT brings about changes in relationship with, perception of, and attachment to conceptualised self, it is important to explore how this is reflected in the narratives of the individuals who take part, and the way in which they feel, relate to, or describe this change. We are necessarily looking at variables pertaining to i) process and ii) context with regards to the potentially irreducible concept of “self”, “I” or “me”; for example metacognitive change in how participants understand self, as opposed to shifts in units of change within self-concept – for example self-esteem. For these reasons, our investigation is amenable primarily to qualitative interview based study, allowing the researcher to place an emphasis on the accounts, stories and narratives of those who are experiencing change, and thus favouring or facilitating the idiosyncratic and nuanced expression of that change, rather than capturing felt change as it is commensurate with predefined measurement tools (Fassinger, 2005).

4.2. Grounded Theory (GT), sampling and rationale for exploration

“We should seek to understand meditation’s original purpose as a self-liberating strategy…to enhance qualities such as compassion, understanding, and wisdom.” (Shapiro et al., 2002)

Frosh (1997) describes the self-knowledge attainable through present moment insight and experience as “transformative”, and this study aims to explore this notion through the use of
Grounded Theory methodology. Grounded Theory (GT) aims to “generate or discover a theory” (Glaser & Strauss, 1967), by means of investigating underlying processes at hand, and is strongly influenced by the symbolic interactionist perspective previously described – whereby meaning arises out of social and communicative process, and does not exist independently in a positivist reality (Charmaz, 2000). As will be described in more detail going forward, GT seeks to employ a number of techniques in deriving this meaning, these (common to all schools of GT) being: simultaneous collection and analysis of data, creation of analytic codes and categories, outlining of basic social processes, inductive construction and abstraction of categories, theoretical sampling and the integration of categories into a theoretical framework (Charmaz, 1995). These methods typically proceed from the point of explorative open interviews, allowing for themes to be “embedded in narrative descriptions” (Strauss & Corbin, 1990).

In employing this method of study, independent (as far as possible) from preconception, we seek to develop an account of self-related change following MBCT, with a particular interest in the extent to which participants’ descriptions entail, or allude to, shifts in relationship with self consistent with that advocated in the Buddhist origins of mindfulness – pertaining broadly to an understanding characterised and influenced by notions of Anatta, Anicca and Dukkha – thus investigating a broader mechanism of change, and one that is amenable to study through qualitative methodology.

As described in 3.1, our analysis will target participants who have completed the eight-week MBCT course. We might reasonably consider this program to be the current home of mindfulness in terms of direct clinical application, and therefore it presents an important arena in which to explore the presence or absence of self-related shifts outlined. Two more considerations are important at this stage: Firstly, we have touched upon the issue of ensuring that our sampling will include both clinical and non-clinical participants – the rationale here being that whilst MBCT is a specifically designed program devised and recommended for people suffering from chronic and recurrent major depression (our clinical sample), mindfulness – and the changes in relationship to self suggested, as well as the Buddhist perspective on attachment to conceptualised self - makes no such clear distinction between “patients” and “non-patients” (Kabat-Zinn, 1994).

As such we seek equally to explore change in people who do not have a history of depression, but who nonetheless live in a society dominated by the concept of “I”, and who will inevitably subscribe to direction as governed by the conceptualised self to some extent (our non-clinical sample). Secondly, the literature on mindfulness emphasises the importance of continued practice as a means to metacognitive insight. Where with many psychological interventions, it
would be expected that the level of change manifest immediately post-treatment might be subject to a process of decay over time, as is commonly true of problem specific approaches such as CBT, as well as pharmacological interventions (e.g. Hollon et al., 2005). And indeed, there is evidence of relapse into depression in the MBCT studies reviewed above. On the other hand, where mindfulness practice continues, it could be argued that profound change in selfhood might emerge after initial exposure to mindfulness though an 8 week programme. For these reasons, it remains important for our sampling to include interviews of participants both immediately after MBCT completion, and one year post-completion, in both clinical and non-clinical groups.

In summary, a Grounded Theory methodology will be employed in addressing the research question of the extent to, and process by, which Mindfulness Based Cognitive Therapy (MBCT) promotes metacognitive insight into the nature of selfhood as an illusory and self-fulfilling construct, consistent with teachings offered by its Buddhist roots, and particularly with respect to notions of Anatta, Anicca and Dukkha – therefore a contextual, transient and abstract conceptualisation self that holds a place for inherent suffering, and one that would theoretically represent effective protection against depressive relapse.
Methodology

5.1. Introduction and Grounded Theory (GT)

“Qualitative study can help us to understand a situation that might otherwise be enigmatic or confusing.” (Eisner, 1991)

5.1.1. A Grounded Theory approach

As described within the introduction section, GT provides an open and explorative method with which to investigate a phenomenon, potentially free from “conjecture and preconception” in coming to understand underlying processes of interest that may not be amenable to empirical methods (Glaser, 1978). Broadly speaking, the positivist assumption that our world is made up of observable and measurable facts is placed under question (Glesne & Peshkin, 1992), nevertheless there exist essential components in ensuring rigor and quality within the process, and this section will in part be used to demonstrate the fidelity of our study to relevant principles.

Reichertz (2007) describes GT as being a synthesis of inductive and abductive methodology. *Inductive* in that we begin with individual cases and units of analysis before abstracting and extrapolating concepts from this point, and *abductive* in that we remain open to theoretical possibility; examining potential descriptions and explanations, before ultimately arriving at the most plausible. Crucially, the factor elevating GT above a purely descriptive account is the willingness and ability of the researcher to take - and adequately represent – the conceptual and analytic leaps that form a theory (Birks & Mills, 2011).

Charmaz (2000) identifies three key areas – amongst a range of others to be described in more detail within this chapter – that are characteristic of GT, particularly in terms of achieving this integration of inductive and abductive: i) Identifying a core category, ii) theoretical saturation of categories, and iii) a “accumulated bank” of memos in charting the analytic process.

5.1.2. Reflexivity and owning our perspective

The research team comprised three people. The first author (SN) was responsible for data collection, analysis, and producing a final report, whilst supervisors (PC and JW) provided theoretical advice, recommendations and assistance at every stage, as well as reviewing the final thesis at various degrees of completion. PC was involved in quality assurance measures relating to the interview process, as well as contributing to the key process of theoretical integration during concurrent data collection and analysis.
SN has taken part in an MBCT training course, and has practised predominantly concentration meditation for around ten years, finding that a constructionist, relativist and pluralistic position most accurately represents his current worldview. The second author (PC) has several years of meditation experience, as well as being influential as both researcher and clinician in the application and theoretical integration of mindfulness approaches and philosophies within clinical practice. Third author (JW) is an experienced meditator, clinician and facilitator of MBCT groups, as well having a considerable background in the clinical application and teaching of Acceptance and Commitment Therapy (ACT). Both co-authors thus have extensive personal and professional experience of mindfulness, as well as interest in its modern applications and philosophical origins.

5.1.3. Reliability and validity in Grounded Theory

In empirical research reliability essentially pertains to stability of repeated measurement, stability of measurement over time, and stability of measurement within a given period (Kirk & Miller 1986), whilst validity is a function of how “truthful” results are (Joppe, 2000), or perhaps the extent to which research measures what it intends to (Golafshani, 2003). However, in the qualitative arena, and within GT in particular, the tone of what is meant by reliability and validity is altered slightly.

In terms of reliability, whilst empirical demonstrations are not possible, Lincoln & Guba (1985) state that terms pertaining to the same basic construct are influential and important in GT - for instance credibility, neutrality, confirmability, consistency, dependability, applicability and transferability - in that they relate to the central concept of “quality”. With respect to validity, Golafshani (2003) suggests that in the absence of the clarity existing within quantitative study, researchers often select their own criteria and terminology, for example equating validity with such notions as “quality”, “rigor” and “trustworthiness” (e.g. Stenbacka, 2001). As such, we will attempt to place a premium on these ideas throughout.

5.2. Ethical Considerations and Approval

The study has been approved by the South East London Research Ethics Committee 4 (approval reference code: 11/L0/0072), and also the Kings College London Research and Development Office (approval reference code: R&D2011/057).
5.3. Sampling in Grounded Theory

5.3.1. Purposive and theoretical sampling

There are two key types of sampling employed in GT research; purposive and theoretical. Purposive sampling describes the process by which a group is selected on the basis of a priori knowledge regarding the question, and may typically relate to a decision around which participants form subjects for initial interviews (Curtis et al., 2000). Theoretical sampling on the other hand, relates to the method of selecting samples according to their relevance with respect to emerging theory (a function of concurrent collection and analysis of data); allowing for theory generation to be grounded in the data (Strauss & Corbin, 1990). Further considerations outlined by Curtis et al. (2000) are that i) sampling should be relevant to the conceptual framework employed, the sample should ii) be likely to generate a rich depth of information, iii) contribute to the generalisability of findings, iv) be able to produce believable and reliable examples, and v) the sampling strategy must be both ethical and feasible.

With these points in mind, our sampling incorporated a mixture of these methods – with a purposive strategy initially identifying Clinical Psychologists in Training (who had completed the eight-week MBCT course) – as a starting point for investigation. Inevitably, we also had the intention that current clinical MBCT clients would be interviewed, and as such this may also be regarded as purposive, based as it is on our interest in mechanisms of change within clinical applications of mindfulness. Theoretical sampling was used in diverting from these initial ideas where appropriate, for example in being guided by emergent ideas around change processes being budding, in their infancy, or reliant on continued practice, and subsequently choosing to sample both trainees and patients one year on from their participation in the course.

5.3.2. Saturation

Birks and Mills (2011) suggest that the qualitative researcher continuously works toward theoretical saturation, with data collection complete at the point where we feel able and confident in building a “comprehensive and convincing theory” (Morse, 1995). Essentially, saturation can be said to have occurred when new data no longer contributes properties or dimensions to a category, with the goal being that a saturated category is both “conceptually abstract yet substantively grounded” (Birks & Mills, 2011). Our sample – of trainee psychologists and MBCT patients, current and one year on – comprised 21 participants, at which point (with respect to the criteria described here) it was felt that the abstract categories contributing to our theoretical integration and model of understanding had been saturated, meaning that data collection came to an end. Moreover, a similar process of evaluation was undertaken in decisions regarding moving from one sample to another – whereby interviewing within a single group proceeded to the point where new concepts ceased to emerge with
5.4. Participants

*Figure 1: A table detailing demographic information in situating the sample*

<table>
<thead>
<tr>
<th>Participants</th>
<th>ID, Age and Gender</th>
<th>Ethnicity</th>
<th>Occupational Status</th>
<th>Marital Status and Children</th>
<th>Diagnosis*</th>
<th>Previous mindfulness</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trainee Psychologists Following MBCT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) 26, M</td>
<td>British</td>
<td>Employed</td>
<td>Single</td>
<td>n/a</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>(2) 29, F</td>
<td>Iranian</td>
<td>Employed</td>
<td>Married</td>
<td>n/a</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>(3) 33, F</td>
<td>Australian</td>
<td>Employed</td>
<td>Single</td>
<td>n/a</td>
<td>Eight-week mindfulness course two years previously</td>
<td></td>
</tr>
<tr>
<td>(4) 29, F</td>
<td>American</td>
<td>Employed</td>
<td>Single</td>
<td>n/a</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>(5) 27, M</td>
<td>Italian</td>
<td>Employed</td>
<td>Single</td>
<td>n/a</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>(6) 25, M</td>
<td>Irish</td>
<td>Employed</td>
<td>Single</td>
<td>n/a</td>
<td>Intermittent practice over one year</td>
<td></td>
</tr>
<tr>
<td>(7) 32, M</td>
<td>English</td>
<td>Employed</td>
<td>Single</td>
<td>n/a</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>(8) 27, F</td>
<td>Employed</td>
<td>Single</td>
<td>n/a</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Trainee Psychologists One year post-MBCT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(9) 26, F</td>
<td>English</td>
<td>Employed</td>
<td>Single</td>
<td>n/a</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>(10) 32, F</td>
<td>Czech</td>
<td>Employed</td>
<td>Married and mother of two</td>
<td>n/a</td>
<td>One year of home practice mindfulness</td>
<td></td>
</tr>
<tr>
<td>(11) 36, F</td>
<td>English</td>
<td>Employed</td>
<td>Married and mother of one</td>
<td>n/a</td>
<td>One year of practice within clinical setting</td>
<td></td>
</tr>
<tr>
<td>(12) 30, F</td>
<td>English</td>
<td>Employed</td>
<td>Single</td>
<td>n/a</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>Patients: One year post-MBCT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(13) 31, F</td>
<td>English</td>
<td>Employed</td>
<td>Married</td>
<td>Recurrent MDD** (remission); GAD***</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>(14) 51, F</td>
<td>German</td>
<td>Self-employed</td>
<td>Single</td>
<td>Recurrent MDD (R*); GAD; Chronic pain</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>(15) 54, F</td>
<td>English</td>
<td>Employed</td>
<td>Married and mother of two</td>
<td>Recurrent MDD (R); Social Anxiety</td>
<td>Some experience through church</td>
<td></td>
</tr>
<tr>
<td>(16) 38, F</td>
<td>Chinese</td>
<td>Employed</td>
<td>Single</td>
<td>Recurrent MDD (R)</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>Patients: Following MBCT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(17) 54, M</td>
<td>English</td>
<td>Voluntary Employment</td>
<td>Divorced</td>
<td>Recurrent MDD (PR*)</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>(18) 47, M</td>
<td>Spanish</td>
<td>Self-employed</td>
<td>Single</td>
<td>Recurrent MDD (PR); Mixed anxiety and depression</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>(19) 36, F</td>
<td>English</td>
<td>Employed</td>
<td>Married</td>
<td>Recurrent MDD (R)</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>(20) 40, F</td>
<td>English</td>
<td>Unemployed</td>
<td>Married and mother of two</td>
<td>Chronic Dysthymia</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>(21) 46, F</td>
<td>English</td>
<td>Employed</td>
<td>Married and</td>
<td>Recurrent</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>
5.4.1. Clinical Psychologists in Training: Immediately following MBCT

The first sample selected were eight Clinical Psychologists in Training in their second year of study at the Institute of Psychiatry, all of whom had taken part in the eight-week MBCT course. 20 trainees were emailed requesting their participation (the full cohort), and were seen in the order in which they replied. Five of these participants had no previous formal experience of mindfulness, whilst one trainee had attended an independent group, and another had been intermittently practising through drop-in sessions for approximately one year. All trainees had a basic understanding of the theoretical and clinical applications of mindfulness in relation to their work; they had attended the full eight sessions and committed to varying degrees of home practice. Trainees were aged between 25 and 33, and three were male, with five female. Seven of the eight trainees were white, and of those, four were British, one Australian, one Italian, one Irish and one German, whilst another trainee was of Iranian heritage. Interviews were conducted within six weeks of the group ending.

5.4.2. Clinical Psychologists in Training: One-year post-MBCT

The second sample invited for interview was four third year Clinical Psychologists in Training at the Institute of Psychiatry. Participants in this group had completed the eight-week MBCT group one year previously. Participants were selected who had continued to practice mindfulness during the intervening time, to some degree, and again the full cohort were approached via email and interviewed by order of response to this request. Despite three of the four having no formal experience of mindfulness prior to MBCT, these trainees were again familiar with the principles and applications of mindfulness through their work, and had all attended for the entirety of the course. The sample – all female - were aged between 26 and 36, whilst three were white British, and one Czech.

5.4.3. Patient sample one: One-year post-MBCT

The third sample group, again selected theoretically on the basis it would be important to consider the experiences of those participating in mindfulness some time on from the group, were former MBCT patients who continued to practice mindfulness both at home, and more formally as part of a Buddhist Centre drop-in group, where meditation was guided by their initial facilitator and co-author of this research (JW). A total of four subjects from this monthly group volunteered for interview. All were female, ages ranged from 31 to 54, and regards ethnicity, two were white British, one German and one Chinese. Three were in full-time
employment, and one part-time. All four of these subjects had a history of major depression (three or more previous episodes), whilst one lady had a comorbid diagnosis of Generalised Anxiety Disorder (GAD) as well as a history of Panic Disorder, and another suffered from chronic back pain.

5.4.4. Patient sample two: Immediately following MBCT

The final distinct group sampled were current patients referred to Southwark IAPT service, and comprised five participants from two MBCT groups, where the study had been presented at the orientation session (recruitment details described in the procedure section; 2.7). Made up of two males and three females, the ages ranged from 36 to 54, whilst two were in full-time paid employment, one self-employed, one in voluntary work and one unemployed. In terms of ethnic background four were white British and one Spanish. At the time of starting four had diagnoses of recurrent Major Depressive Disorder (MDD), and two of mixed anxiety and depression. Four of the five had been in partial remission from depressive symptomatology, with one in full remission. One participant had a diagnosis of Chronic Dysthymia. All interviews were conducted within four weeks of patients completing the MBCT program.

5.4.5. Total sample characteristics

The total sample consisted of 21 participants; six male and 15 female, whose ages ranged from 26 to 54; with an average age of 35.6 years. Of these, eight had previous diagnoses of recurrent Major Depressive Disorder (MDD), having experienced three or more episodes, with two in partial and six in full remission at time of interview. Regards comorbidity, the sample included two historical cases of mixed anxiety and depression (both in partial remission), one of Generalised Anxiety Disorder (GAD) and Panic Disorder, and one of chronic pain. Of the 21, 16 were in paid employment, two self-employed, one in voluntary work and two unemployed, whilst five people interviewed had a degree of previous mindfulness experience.

5.4.6. MBCT Inclusion/exclusion criteria, and a self-selecting sample

All participants from the patient sample (current and one-year post) had been accepted for Mindfulness Based Cognitive Therapy (MBCT) as coordinated by Southwark IAPT service, and facilitated by a co-author of this report (JW). The inclusion and exclusion criteria were based on those stipulated by NICE (2009) with respect to MBCT. Regards inclusion, that is to say that these participants will be people - who at the time of referral – had a diagnosis of Major Depressive Disorder (MDD) in full or partial remission according to the DSM-IV-TR (American Psychological Association, 2000), aged over 18 and with a history of three or more episodes. In terms of exclusion criteria, patients who were currently depressed, or had co-morbid diagnoses of substance dependence, organic brain damage, current or past psychosis, bipolar disorder, persistent antisocial behaviour, persistent self-injury requiring clinical
management and/or therapy, and formal concurrent psychotherapy do not qualify for MBCT (NICE, 2009). A caveat here is that Southwark IAPT do allow for patients who continue to experience mild to moderate depressive symptoms, as is consistent with emerging research on the efficacy of MBCT in these populations (e.g. Barnhofer et al., 2009). All groups sampled from were facilitated by fully trained MBCT therapists.

As will be described in more detail during the Procedure section, our sample was essentially self-selecting, in that generally speaking each person interviewed (within the patient groups) had chosen to take part after having found MBCT beneficial, and having - in most cases - evidently developed a sense of enthusiasm and regard for the approach and philosophy more broadly. As a result, we clearly have a sample of participants for whom the method was a relative success, and are without the perspectives of those who did not consider the course to be valuable. Nevertheless, and despite this trend being worthy of mention, considering that our interest is in the process by which change occurs, rather than whether or not it is apparent, this issue is not viewed as a particular constraint. That is, our rationale for investigation does not preclude the worth of a sample made up of people who either continue longer-term practice post MBCT, or who feel sufficiently positive post MBCT to participate in a qualitative research study. In terms of selection, participant information did not discourage people who had felt little or no subjective benefit or MBCT.

5.5. Interviews

5.5.1. Interviewing in qualitative research

Interviewing in GT and in qualitative research more broadly views the subject as expert, and typically proceeds along the lines of Rogers’ (1961) humanistic and non-directive approach; aimed at “valorising the respondent’s private experiences, narratives, opinions, beliefs and attitudes” (Brinkmann, 2007). Fontana and Frey (2005) talk of “empathic interviewing”, again touching on a Rogerian theme of unconditional positive regard, whereby interactions are characterised by warmth, curiosity and respect. Qualitative interviews generally unfold through the process of Socratic questioning (Brinkmann, 2007); an open-ended style focused on exploring possibilities, achieving clarity of response and bringing about an account with richness and depth. As such, Rogerian principles of style and Socratic techniques around questioning formed the foundation for interviewing in this research.

5.5.2. Interview schedule

As is characteristic of Grounded Theory (GT), interviews were conducted in a relatively open semi-structured format (devised by SN and PC), incorporating a schedule to provide framework,
whilst also retaining the flexibility to explore unique threads generated by participants, thus allowing the researcher to be responsive (Legard, Keegan & Ward, 2003) to “stories, opinions and concerns that emerge” (Mason & Hargreaves, 2001). In keeping with GT methodology, the explorative interview was modified with respect to emerging themes from concurrent analysis (Corbin & Strauss, 2008), meaning that whilst core questions remained, the researcher would investigate particular elements of an interviewee’s response in more depth depending on the relevance of that material in terms of on-going theory development.

The central question for semi-structured interview was “What, if anything, have you learnt about yourself through mindfulness?” whilst a sub-question “In what ways, if at all, has mindfulness changed how you see yourself?” was used to encourage further or more detailed response. Phrasing was also altered slightly to explore the subjects’ perceptions of dynamic or changing selfhood; for instance, “what type of person do you consider yourself to be, and how if at all, has that changed through mindfulness?” or, “people have many types of beliefs about themselves...what beliefs do you hold about yourself, and how have they changed through mindfulness?” A further topic for investigation (relevant to patient samples) was the way in which concepts of depression or anxiety were contained within subjects’ selfhood, or perception of self. Additional sub-questions would therefore target this more explicitly, for example “how, if at all, has mindfulness changed the way that you see depression”, or “what does anxiety mean to you now?”

In keeping with exploratory interview, Socratic dialogue and frequent summary statements were aimed at following the subjects’ idiosyncratic experience, whilst prompts, probes and clarifying questions were used for richness where necessary, and to encourage continued disclosure, perhaps in the face of initial surface level response; for instance “that’s interesting, could you tell me a little more about that?” or “what do you mean by that?” Finally, participants were asked for any additional comments they felt were important to add, and on average the interviews were approximately one hour in length.

Practical or technical adaptations were made resulting from methodological issues arising, for example the addition of a more neutral opening question – “Could you start by telling me what you thought of MBCT and mindfulness in general?” – after the first two interviews, with the rationale of easing interviewees into the process more gradually. This would typically elicit a breadth of response - from issues pertaining to selfhood and self-concept (especially meaningful regards this research), to discussion around practicalities of group attendance (less pertinent) – and these themes would be developed/explored, or sidelined, accordingly; again with respect to simultaneous analysis where possible. Where interviewee responses became tangential, the researcher preferred not to interrupt or redirect forcefully, but instead to summarise with particular emphasis on the most salient point made; perhaps asking for elaboration or
clarification, for example: “[summary]…and I was particularly struck by what you said in relation to…could you tell me a little more about that?” Quality control measures for the interview process are described in section 2.11, and an example transcript can be seen in appendix 1.

5.6. Procedure

Our procedure was fundamentally consistent across groups sampled, with differences existing only in the method by which participants were invited to take part, and with respect to the addition of questions about the concepts of “depression” and “anxiety” - and how they are held - for those participants with current or previous diagnoses (as detailed above). Clinical Psychologists in Training were approached via group email for involvement in an interview to explore their experience of mindfulness, with respondents subsequently being sent information and consent sheets (see appendix 2).

The first patient sample - who completed MBCT one year previously, and had continued to attend regular mindfulness drop-in sessions – were approached through the primary researcher’s attendance at one of these meetings, where the study was presented, and information sheets provided for those who requested them. Interested attendees subsequently made email contact with the researcher to arrange a suitable time for interview. Finally, the current patient sample was introduced to the research as presented by the primary researcher at a routine initial MBCT orientation session (facilitated by JW), and those willing to take part gave consent to be contacted regarding interview on finishing the group.

On attending the interview, each participant gave written consent (as described below, 2.7.1), and was given the opportunity to ask questions before beginning. Following interview, participants were thanked for their contributions, offered the chance to ask further questions or make additional comments, and compensated for their time. Lastly, participants were asked whether they would like to receive a summary of the final report. On one occasion, following discussion between members of the research team (SN and PC), we elected to contact a participant for further exploration of a theme within their interview; and this was achieved by means of a short telephone interview.

Though the above provides a summary of the main procedure for recruitment and interview, participants were also involved in the secondary process of respondent validation; which forms an important component of ensuring quality and rigor in qualitative research (see 2.11.4). With regards analysis, interviews were transcribed and coded by the chief investigator (SN), who also took primary responsibility for theory development, though these processes were contributed to in various ways, for example through theoretical and exploratory discussion (PC and JW),
checking of transcripts and interview style (PC; see 2.11.1), and the co-rating of a transcript by someone independent of the research team (see 2.11.2).

5.6.1. Informed consent

Each participant was given an information sheet detailing the project, as well as being required to complete a consent form confirming that they had i) had the opportunity to consider the proposal and ask questions, ii) had any questions answered satisfactorily, iii) understood that their involvement was voluntary and could be terminated at any point they wished, iv) understood that having taken part in an interview, a selection of anonymised quotations may appear in the final report, v) felt that the study had been fully and honestly explained, and vi) agreed to take part.

5.6.2. Recording, data confidentiality and transcription

All interviews were taped onto a secure digital recorder (as consented to), and kept in a locked cabinet in the Psychology department where our sessions were conducted. Tapes were transcribed by SN, and then saved as password protected text files, in addition to having been fully anonymised; meaning that by the point of contact with another member of the research team there would be no remaining personally identifiable information. Following transcription, the original audiotapes were deleted.

5.7. Key Processes in Grounded Theory

Corbin and Strauss (1990) identify the key canons and procedures of Grounded Theory that contribute to a methodologically sound and scientifically rigorous approach, which at once retains exploratory and procedural flexibility. A number of these guidelines are used as a structure to illustrate our process of data collection, analysis and exploration.

5.7.1. Data collection and analysis are interrelated processes

“Data collection and analysis occur concurrently, and form a dynamic relationship whereby carrying them out systematically and sequentially expands the researcher’s potential to generate and capture potentially relevant aspects as they emerge.”

As suggested, after the first two trainee participants were interviewed, interviews and analysis—initial coding, memoing and theoretical discussion - were conducted simultaneously. From this point onwards, interviews continued through the various groups sampled, whilst at the same time our analysis moved towards greater integration and levels of conceptual abstraction. Importantly, time was allocated between interviews (generally conducted in couples), thus
allowing for concurrent analysis to contribute to the next phase of data collection.

5.7.2. Concepts are the basic units of analysis

“The theorist analyses the raw data, and in comparing incidents and grouping like phenomena, they create concepts at a level of abstraction from the transcript, which form our basic units.”

Whilst the interview transcripts might be regarded as the equivalent of a raw data set in empirical research, the grouping of phenomena within that data set allowed for the formation of more abstract units – codes or categories - that draw together likeness across participants, and mean that we were able to work towards a more generalizable theoretical account.

5.7.3. Categories must be developed and interrelated

“Like concepts are grouped to form categories at a further level of abstraction, and that provides the means by which a theory can become integrated.”

Having developed codes at a level of conceptual abstraction from the data, we then grouped them into categories that both describe the content of codes held within, and add a further analytic step through the process of relating categories together (perhaps in terms of order within a multiphase process), or potentially through recognising any dissimilarity or incongruence – allowing the researcher to delineate and define them more clearly as part of an integrated theory.

5.7.4. Sampling in GT proceeds on theoretical grounds

“Sampling proceeds on theoretical grounds and in terms of concepts, their properties, dimensions and variations.”

Following on from initial purposive sampling, we observed the relevance of exploring this process one year on and thus interviewed previous trainees, following this with a patient sample one year after MBCT, and a current MBCT group when it was seemingly of theoretical importance to take our initial ideas and investigate them in a clinical context, within which mindfulness has become an increasingly popular and highly valued approach. This was particularly the case as trainee samples had alluded to processes of change regarding such areas as beliefs about the self, for example, which might be considered to hold significant weight with respect to depression and anxiety.

5.7.5. Analysis makes use of constant comparisons

“In comparing incidents and phenomena, we are better placed to achieve greater precision in the way that they are grouped.”
In the process of coding and categorization, it was pertinent to ask questions of the data such as “how are these units similar and how are they different”, and to compare codes and categories with each other, asking ourselves what each is describing or saying, and why that sets it apart as a unique phenomenon in relation to others within our analysis. Inevitably, at times this process led to the collapsing of two or more units to make one, or for example the relegation of a category to become the subcategory of another. For example, the categories “adopting a more existential perspective” and “recognising my higher values” were merged into one having been seen as pertaining to the same fundamental principle, which was eventually conceptualised as a subcategory of the primary category “acknowledging that I am only human”.

5.7.6. Process must be built into theory

“This can involve breaking a phenomenon down into stages, phases or steps. A method of acknowledging the fluctuating nature of patterns and accounting for variability in how these patterns manifest.”

It was important that our findings represented an attempt at illustrating process (over time), rather than simply describing a certain state described by interviewees. As such, and as is the case in GT, our final result, grounded theory, or “scheme”, is an account of a dynamic change process. As suggested by Corbin and Strauss (1990), the observed phenomenon will be presented primarily in terms of a non-linear series of phases.

5.7.7. Hypotheses about relationships among categories are developed

“Hypotheses arising about relationships between categories are taken back to the field and checked or revised as appropriate.”

This notion relates directly to the concurrent process of data analysis and collection previously mentioned, meaning that emerging ideas have the opportunity to be tested in the context of further interviews. For instance, themes arising from initial trainee interviews – perhaps relating to processes of change in perception of self following MBCT, such as “feeling a sense of control over who I am and what I do” – could be refined, added to, or restructured dependent on their congruence when explored later on. Category relationships emergent from early interviews may not have encapsulated the perspective of later participants as comprehensively, and as such the theoretical link - or working hypothesis - would be developed in order to account for this variability.

5.7.8. Grounded theorists need not work alone

“The process of testing concepts and relationships with colleagues and engaging in interactions that provide new insight and increased theoretical sensitivity.”
Co-working in the theoretical integration and conceptualisation stages formed a fundamental part of the movement from data to theory. As is the philosophy of a GT approach, it is through the process of interaction and discussion that our meaning arises, and whilst there is a level of interpretation that exists purely between the interviewer and interviewee (Jarvinen, 2000), discussion with supervisors was essential. Indeed, as is discussed in 2.10, it became important to keep detailed memos of ideas arising during and immediately after supervision meetings; to ensure that important material in charting progress could be represented in the final report.

5.8. Data analysis and theory generation

Birks & Mills (2011) differentiate between low, medium and high level concepts in the process of data collection and analysis, and the following section will describe the process of this study in generating conceptually abstract theory, which is at once grounded in more basic units, and with the above principles outlined by Strauss and Corbin (1990) in mind.

5.8.1. Initial coding

The initial coding was open, with all elements included, and followed the style advocated by Charmaz (2006) whereby code names were presented as verbs – or “gerunds”, with the suffix “…ing” – to convey a sense of development or process; for example “thinking about the mindfulness session during my week”. The first interviews were coded line-by-line, at which point there was little conceptual abstraction, and the primary aim was to account for as much of the detail appearing within a transcript as possible. The qualitative research program Nvivo (version 9) was used to facilitate this process throughout the study.

5.8.2. Focused coding

Once codes began to re-occur between transcripts, we were able to get a closer feel for ideas that are consistent and relevant across participants, and that might therefore be related to a more generalizable theory or process. Once the researcher begins to gain a level of “conceptual control”, line-by-line coding is redundant (Birks & Mills, 2011), and analysis becomes more focused. As such, the coding process no longer incorporates areas that do not pertain to a broader emerging understanding of participants’ experience; for instance material around practicalities of MBCT attendance, or initial scepticism of the approach were initially coded, and subsequently sidelined, or omitted.

5.8.3 Category and subcategory formation

From the initial coding processes, we move towards a stage where observations have been isolated somewhat, and incidences have been separated and boundaried; one incident having
been classified as meaningfully distinct from another. From this point we are able to begin the process of grouping codes that “pertain to the same phenomena” (Birks & Mills, 2011) – for instance recognising the two ideas “seeing that who I am is constantly changing” and “realising that who I am cannot be pinned down” as falling under the broader theme of “feeling less defined”. As such we progress towards abstracted theory. When we speak of categories, the same processes of comparing one against another are relevant in ensuring that each is increasingly well defined and discrete (depending on the stage of data collection and analysis). Both categories and their subcategories should have properties that are identifiable in the data, whilst we continued to write frequent memos in theorising the relation of one category to another, as well as how each relates to original units – thus grounding our abstraction. This process is also thought of as intermediate coding, whereby the data is brought together again, having rather been “fractured” by the initial coding process (Birks & Mills, 2011).

5.8.4. Category refinement and delineation

Inevitably, this process occurs simultaneously with further data collection (where our analytic assumptions continue to be tested), and with focused/selective coding of these on-going interviews. As a result, our categories continue to become more refined, and through continued exploration there may come a point where they require modification – this may include the splitting of one category into two, the collapsing of categories (as described in 2.7.5), or the relegation of a category to become the subcategory of another – for example, after continued analysis it was felt that the categories i) “coming to conceptualise my own selfhood and who I am” and ii) “arriving at a more flexible idea of who I am, now and over time” were describing processes that were distinct, yet similar and related to the extent that (ii) was better positioned as secondary to (i), rather than as a primary category in its own right.

5.8.5. Identifying a core category

In having explored codes and their relationships at increasing levels of analysis and abstraction, we now began to appreciate in more detail the narratives that were emerging from participants’ accounts, and Strauss and Corbin (1998) suggest the identification of a “core category”, or “central phenomenon” to encompass these key messages; providing a “well fitting story” that can be expressed either as a category label or illustrative sentence. Their advice here is for the researcher(s) to ask themselves: i) What is the main issue or problem with which these people seem to be grappling? ii) What keeps striking me over and over? iii) What keeps coming through, although it might not be said directly? In considering these questions, the core category of “knowing myself differently” was identified, as will be discussed and elaborated more thoroughly in Chapter 3.
5.8.6. Concept and “scheme” formation

Having identified and investigated codes, categories and subcategories, we moved towards greater conceptual abstraction again. This time in grouping like-categories (pertaining to similar processes of change) to form higher level “concepts”. Of these, there were three, fitting together in forming an explanatory scheme to encompass the narratives of individuals taking part. The three-phase scheme is dynamic and non-linear, existing at a theoretical level beyond the units of analysis below, and aims to say something broader and more generalizable about the change experiences described, whilst at the same time pertaining to categories and codes beneath. Again, as in previous stages of exploration, these analytic steps are tested at the interview stage (which by this point is reaching its close), meaning that we can continue to adjust the means of representing our units, both basic and abstract. The ethos here continues to be that theory has explanatory power (at the highest possible conceptual level), yet remains grounded (Charmaz, 2006).

5.8.7. Diagramming

Diagramming is a method discussed by Birks and Mills (2011) as facilitating a flexible visual representation of the development process. It allows for conceptual links to be made, relationships to be more clearly understood, and for these to be represented in a way that adds to what can be achieved in words alone. Diagramming (though important throughout) was used primarily at the stage where categories were fairly well established, and our intention was to get to grips with the way in which they corresponded to, and existed around, the emerging scheme. An example of this can be seen in appendix 3, where the three-phase scheme is central, and labelled post-it notes represent surrounding categories. This was found to be especially helpful in memo writing, particular in terms of more fully integrating the constituent parts of our theory, identifying gaps, and in working towards synthesis, whilst a final version of the diagram is presented in our findings section.

5.8.8. Synthesis and a grounded theory

Finally, and similar in some ways to the process of having elected a core category, we ask ourselves what is being said by the theory as a whole. We seek to account - in as concise a way as possible – for the story, or change, that our data is describing, and ultimately reach the point of an overarching theoretical statement, though this is by no means a necessary component of GT, which in many cases may stop short (Birks & Mills, 2011). As mentioned, our progress to the point of such a statement, as well as a suggested grounded theory, will be described within Chapter 3.
5.9. Charting the Process of Grounded Theory

5.9.1. The importance of memoing

Strauss and Corbin (1990) identify writing theoretical memos as integral in moving from basic units of data to more generalizable and conceptual statements about relationships and processes.

“A system by which to keep track of categories, properties, hypotheses, conceptual relationships and generative questions arising from analysis.”

Theoretical memos were used in various ways as a method of establishing links and relationships, integrating theory and capturing the thought process involved in GT analysis. Most often these were made in an electronic document, but also in a diary, and consisted of both written notes and diagrams. Perhaps the most important stage of memoing was in theorising relationships between categories, and between concepts - and as described in our discussion of diagraming - allows for conceptual relationships as well as areas of relative incoherence, to be visualized, and written about. This - and memoing more broadly - was found to be a crucial tool in seeing what was missing, answering questions, generating additional questions, and ultimately in the development of a theory. Finally, with data collection and analysis complete, memos continued to be vital in the production of this report, in making continued theoretical links, placing the work in a wider context, and considering implications.

5.9.2. Storyline method

Construction of a “storyline” is recognised as an important part of theoretical integration within GT, and essentially represents a “descriptive narrative about the central phenomenon of the study” (Corbin, 1990). The narrative should be a conceptually abstract guide to the theory at hand, with Birks and Mills (2011) identifying key considerations in achieving this; i) theory must take precedence, and ii) allow for variation, whilst also iii) limiting gaps, iv) describing evidence that is grounded, and using an v) appropriate style. As such, following collection, analysis and integration of data into a theory, a narrative storyline method was used as one method of illustrating findings (see results section; 3.1.1).

5.10. Quality Assurance

5.10.1. Semi-structured interview

There were two methods used to ensure the quality of our interview process. Firstly, the primary supervisor (PC) – who has considerable experience in conducting explorative interviews for qualitative research - reviewed one interview from each sample group; four in total. There was
particular attention paid here to style, openness, the use of Socratic questioning, and non-directiveness; so ensuring that the participants’ stories were allowed to unfold without being led or heavily guided by the interviewer. Secondly, it was considered appropriate that a third party from outside of the research team would be involved in the quality assurance process, and as such an independent clinician and researcher – with extensive mindfulness experience and no affiliation to this project – was asked to take part in an interview, and give feedback on interview content and process. This person is a leading proponent of mindfulness-based approaches (predominantly in health psychology) within South London and Maudsley (SLaM), as well as being a facilitator of MBCT groups for the trust. These dual processes meant that quality control methods regarding the interview process were both post-hoc and in-vivo; allowing us to be confident that the techniques and schedule used were of an appropriate standard.

5.10.2. Independent checks of coding and categorisation

A fellow Clinical Psychologist in Training - who did not take part in the study, and who has experience of data analysis within qualitative research - coded one interview from the first sample, without prior instruction other than a basic explanation of the study. They were subsequently asked to group their codes into categories; with each label summarizing the content held within, but at a further level of abstraction. In addition, they reviewed codes produced by the primary researcher, and matched those existing codes to emergent categories. These two processes were then discussed between SN and the independent rater in order to explore similarities and differences, thus allowing for refinement, clarity and increased understanding with respect to coding and categorisation; and to investigate the links, relationships and interpretations that had been made up to this point. As described above, these methods also provided helpful material for memoing and charting theory development.

5.10.3. Respondent validation

Respondent validation in qualitative research is the process by which emergent themes, ideas and hypotheses are presented back into the field from where they originate; essentially representing a mechanism for ensuring that the assumptions, interpretations, theoretical abstraction, and “analytical leaps” (Birks & Mills, 2011) remain congruent with the subjects’ experience. Although it is inevitably difficult to ensure that the entirety of our eventual scheme is commensurate with each participant’s description, it is hoped at the respondent validation stage that individual experience will fit within the context of a theory that may in addition encompass elements they do not endorse fully, but that are required in accounting for the experiences of others sampled.

On completion of our analysis and theoretical integration, a summary of findings was sent to all
participants sampled (see appendix 4), and interviewees were given the opportunity to provide feedback and thoughts based around the following three questions: i) Do you feel that the scheme makes sense? ii) Does the scheme appear to fit with your experience? iii) Is there anything that you feel is missing? The responses received, and the extent to which participants felt that our abstraction and interpretation are true to their experiences, are detailed in section 6.8 of our findings.
This chapter will present our findings; first detailing a primary “scheme” consisting of three phases, before describing a grounded theory. Subsequently, each phase of the scheme will be addressed in turn, with an analysis and exploration of the conceptual categories and sub-categories housed within, and illustrative quotes being used to demonstrate the fidelity of our understanding to the perspectives of those interviewed, in telling the story emergent from data collection. An integrative diagram is presented, in addition to the process of respondent validation for our findings.

6.1. Scheme

The scheme above describes a dynamic process by which a person – through mindfulness – gains insight into themselves as having been constructed and controlled (phase 1) through beliefs held in relation to themselves and their role in the world. This often rigid, inflexible and self-fulfilling understanding can at times exist almost independently of contingencies within the “real world”, and as such, a commitment to being with present moment experience (phase 2) – as it is, and without the struggle for control of our experience - having begun to appreciate attachment to the self as constructed and controlling, allows for a connection with myself and my world (as opposed to with the cognitive contents of my mind) whereby our tightly held self-beliefs are recognised as increasingly invalid and impotent. Finally, the partial dissolution of such concrete selfhood allows for a qualitatively different relationship to, and more flexible appreciation of self (core category; phase 3); whereby the individual is able to adopt a broader perspective on self and life, recognise themselves as active participants in conceptualizing their self concept, and know themselves in a way that enables self-compassion, allows for complexity and uncertainty, and facilitates a sense of agency and worth. Essentially, we seek to present a
dynamic process of change, broadly from left to right, though not in a linear respect, and instead such that for example the value of knowing myself differently (3) contributes further insight into the extent to which I am and have been constructed (1), as well as providing a mindset and self-conceptualisation amenable to continued engagement with immediate experience (2).

6.2. Grounded Theory

Experiencing a new sense of empowerment and clarity over who I am and what I do as a process of having let go of the need to control myself, and my environment. Recognition of transience, and an acceptance of suffering that I need not take absolute responsibility for, as well as the freedom that this ultimately brings, from the responsibility of always acting in line with my conceptualised self.

6.3. Summary of categories and sub-categories

Figure 2: A table summarizing the primary scheme areas, categories and sub-categories

<table>
<thead>
<tr>
<th>Realising how I am constructed and controlled</th>
</tr>
</thead>
<tbody>
<tr>
<td>C: Seeing clearly who I think I am</td>
</tr>
<tr>
<td>SC: Considering patterns in the way I think, feel and react</td>
</tr>
<tr>
<td>SC: Beginning to see how ideas about myself are constructed</td>
</tr>
<tr>
<td>C: Seeing how I define and limit myself</td>
</tr>
<tr>
<td>C: Questioning self-beliefs and breaking out of those labels</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Getting to know my experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>C: Rediscovering myself and my world</td>
</tr>
<tr>
<td>SC: Appreciating moment-to-moment experience, transience and impermanence</td>
</tr>
<tr>
<td>SC: Observing that I am guided by sensations, almost like “puppet strings”</td>
</tr>
<tr>
<td>C: Engaging with the world as it is</td>
</tr>
<tr>
<td>C: Exploring the freedom I have and practising new ways of responding</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Knowing myself differently</th>
</tr>
</thead>
<tbody>
<tr>
<td>C: Feeling less defined</td>
</tr>
<tr>
<td>C: Coming to conceptualise my own selfhood and who I am</td>
</tr>
<tr>
<td>SC: Arriving at a more flexible idea of who I am, now and over time</td>
</tr>
<tr>
<td>SC: Knowing that I am more than my thoughts and behaviour</td>
</tr>
<tr>
<td>C: Treating myself with compassion</td>
</tr>
<tr>
<td>C: Acknowledging that I am only human</td>
</tr>
<tr>
<td>SC: Adopting a more existential perspective and recognising my higher values</td>
</tr>
</tbody>
</table>

C= Primary category; SC= Sub-category

6.4. Realising how I am constructed and controlled

This broader scheme concept is emergent from the categories and subcategories described below, and in addressing each, we shall outline the process by which a person moves towards an
insight characterised by realisation that they are constructed of, and controlled by, components of self-concept, that may potentially exist without merit.

6.4.1. C: Seeing clearly who I think I am

“It was amazing, you know, this insight that you get into how you actually are.” (Pp. 14)

This category was initially defined as a function of such codes as “realising we’re always giving ourselves labels” and “gaining a different type of insight into myself”, and in part accounts for the extent to which one is able to develop an understanding of the influential self-beliefs that otherwise function unconsciously, yet dictate our interactions with ourselves and our world.

“I guess I’ve spent a lot of my adult life thinking I’m a bad person…and I’m not sure I even knew I thought that before…” (Pp. 19)

A feature of this category is the progression that people describe from the unconditional acceptance of (or resignation to) elements of negative self-concept, to an acknowledgement that these are beliefs that I hold about myself, rather than myself per se, and that it is these self-beliefs – who I think I am – which are governing my attitudes to and relationship with self.

“You kind of have an idea of the person that you are, and that kind of acts itself out in loads of different situations.” (Pp. 6)

The importance of this idea would appear to be the extent to which it offers individuals a clarity, or quality of perception in viewing the self as they have considered themselves to be, and thus provides a foundation for change by bringing into view highly influential and potentially destructive self-beliefs that may have long since been operating implicitly. It is only by first seeing who I think I am, that one can move towards a different understanding of who I indeed am, or would like to be.

6.4.1.1. SC: Considering patterns in the way I think, feel and react

“Sometimes I really want to do what I have always done…’cause that’s how I have always been.” (Pp. 13)

Here, interviewees were seen to describe a relatively consistent process of attachment and reaction in the face of self-beliefs, based perhaps on “how I have always been” and what I have always considered myself to be. There is an awareness of behavioural predictability and familiarity as a consequence of self-view, and an acknowledgement of well-worn tendencies relating to low mood, but also anxiety and catastrophisation.
“With this health anxiety…I am little bit scared of it and in the past I kind of think that I’ll have the worst case scenario of anything and instead of thinking it’s a few panic attacks I was terrified I’d end up locked away somewhere and have schizophrenia!” (Pp. 13)

Finally, within this theme we observed the beginnings of a process by which individuals are able to consider that their responses, actions and affective states - though governed by beliefs around identity, self-worth or vulnerability - become automatic, and a function of the beliefs themselves, rather than a reflection of “who I am”.

“I guess I wonder about how much of it is me and how much is the animal brain just responding” (Pp. 6)

Overall, these ideas are conceptualised as a sub-category of “Seeing clearly who I think I am” (3.3.1), for it is through identifying these consistencies and typical repertoires of thought, feeling and behaviour (as has been in the past) that we can discover in more detail this person that I always thought I was.

**6.4.1.2. SC: Beginning to see how ideas about myself are constructed**

A further subcategory of 3.3.1 is the process of seeing moment-to-moment how beliefs about the self are constructed and created, through our experience, and predominantly in a way that entails an inevitability around who we are, having been mindlessly and passively created by experience that exists outside of our awareness. Here, interviewees discussed how we “project” into the world with ideas regarding self-concept, and how the world in turn confirms, or appears to confirm, our beliefs – crystalizing these ideas –and contributing to the maintenance of self-knowledge guided by who I think I am. This sub-category in part details insight into the ongoing process of self-making.

“Most of the time we’re watching the screen…and we’re not aware of what else is going on, and I guess one of the things for me is that mindfulness is about turning around and seeing the projector, and seeing that actually that is what’s happening…you’re just projecting something that you hope is something that reflects reality…and when you’re not being mindful you’re just engrossed and enraptured, and you didn’t question it.” (Pp. 1)

Furthermore, this theme deals with the experience of participants who were able to consider the role of “other” (as opposed to self) in the construction of self-concept, whereby there appears an increased understanding of how messages – or “labels” - received throughout our lives become internalized; feeling as though they are simply who I am and must be, rather than a construct based on experience.
“Labels stick and people want them to stay like that, and it’s easy for them to keep saying, ‘that’s who you are’ and actually that’s not who I am, or that’s just how you perceive me to be…but it’s not who I am”. (Pp. 20)

Essentially, this sub-category describes the development of people’s thinking around how their self-concept and self-beliefs have been constructed and maintained over time, through both internal and external processes.

6.4.2. C: Seeing how I define and limit myself

Our second primary category within the initial scheme phase details the experience of participants – having gained a degree of insight into the nature of their self-beliefs – of appreciating the extent to which these beliefs (and unthinking identification with them) imparts constraints and limits on what is possible - that is, they gain insight into the living constructed self. The category is emergent from such codes as “noticing how much my labels guide me” and “realising that I tend to live in the future”, thus accounting for how a fixed and passive experience of selfhood imposes conditions for our relationship with both self and other.

The predominant ideas here are around the boundaries instilled by self-doubt, and a tendency to be so riddled with insecurity that our thinking and being become dominated (and limited) by past oriented regret and rumination, or future focused anxiety.

“I suppose and I think I if I look back…I think I’ve been frightened quite a lot through life, by stupid things by really silly things as in you know my capabilities as an actress, and I think I always doubted myself as an actress, and I never used to live in the moment…which is what you need (pause) and so I’m always looking far too far ahead and I’m always looking back…so I’m either regretting something I’ve done, or thinking about something I can’t control in the future.” (Pp. 13)

When describing experiences consistent with this area, there was understandably a sense of regret in many participants’ accounts, in that through mindful appreciation and insight into the way that attitudes and beliefs have governed their lives, there emerges a growing acknowledgement of what had been missed, or filtered for so long, through the pressures to succeed, prove oneself, or be anywhere other than the present moment.

“It highlighted how much time I have spent in the past or the future and missed out on the present, and you know when you’ve got two young boys that makes me feel quite sad…you know I’ve probably spent time, you know, with them when I’m not with them at all…” (Pp. 20)

Ultimately, this would appear to be a crucial part of the process in moving towards a different conceptualisation of self, whilst the themes of regret and realisation (based on an
acknowledgement of one’s typical and longstanding way of being) are perhaps inevitable associates to the insight described in previous categories.

6.4.3. C: Questioning self-beliefs and breaking out of those labels

This category seeks to describe the process by which having gained an insight into the nature and influence of tightly held self-beliefs, participants find that they are more likely to question the components of their conceptualisation; thus beginning the process of breaking away from its rigidity, and in doing so freeing themselves from the absolute hold of self-belief in terms of attitudes towards oneself and the environment.

“I don’t believe any of it anymore, I don’t believe I’m a failure.” (Pp. 14)

The most fundamental shift apparent is one whereby people feel able to distance from beliefs that would previously govern their thinking, and this can seemingly take the form either of the attitude towards self becoming redundant and undermined through an altered perspective, or indeed a more conscious rejection of (accepted) self-knowledge, that one can now see as an artificial construct.

“I say to myself, ‘I’m gonna shake this label off’, you know ‘I reject this label’, it’s almost like peeling the Velcro off.” (Pp. 20)

There is also a theme within this category of alluding to the implications of this distancing, in that participants describe a sense that once we are able to question our beliefs, and recognise that they need not always be a constituent part of us, we are freer, less constrained, and more able to function without their interference or maladaptive guidance.

“It’s just given me freedom to respond in a different way and to break out of those patterns and to break out of those labels like being shy or, or kind of um…reassurance-seeking or something.” (Pp. 16)

Overall, the process of breaking away from elements of our self-knowledge represents the final stage of recognising that I am constructed and controlled, in that the questioning of what we once took to be the truth (however upsetting or painful) entails – or provides a foundation for - the rejection of, or distancing from, that which is discovered to be unfounded.

6.5. Getting to know my experience

This second scheme category details the accounts described by participants, of coming increasingly into contact with present moment experience, and the associated realisations,
observations and insights possible as a result. This domain was emergent from the categories and subcategories outlined below.

6.5.1. C: Rediscovering myself and my world

Having begun to establish distance and freedom from a fixed conceptualisation of who they are as people, participants described a subsequent sense of adopting refreshed perspectives in their exploration of themselves and their world, with codes such as “feeling more involved in my own life” and “noticing what is happening in my body” influential here. Interviewees described a tendency to have previously been caught up in their representations to such an extent that present experience was sidelined, and as such this category is the first that ascribes primarily to phase two of our scheme: Getting to know my experience.

“You have more of an idea of what’s happening in your body, and the breathing for example, like I was actually afraid of my own breath, and I was like “oh my God I actually breathe!”” (Pp. 14)

In being freer of the hold of self-concept, participants were able to demonstrate an attitude toward experience that no longer pertained necessarily to their own insecurities and self-doubts, meaning that both private and external experience could be discovered – and accepted - as it is, with a diminished need for struggle in the face of it.

“You know everyone I suppose has their inner demons, and I think, well, which I had overanalysed…now it’s like simply accepting that, that it’s fine, don’t need to fight anything” (Pp. 18)

Furthermore, there was a significant focus here on the discovery of, and attitude towards, one’s own emotional experience, which previously was subject to avoidance, invalidation or rejection. As such this category accounts for the impact of mindfulness in allowing us to more effectively know, feel and appreciate our current experience, fully and genuinely; rediscovering myself and what it is like to be me, in moments of contentment and suffering alike.

“When I’m doing something I like really making the most out of it…that’s definitely mindfulness, um…yeh but also in bad things actually, when I do, like I cry or if I feel in pain, sometimes it does help. I don’t know why…maybe you live the pain more, like deeper, I don’t know how to say…but, maybe it’s part of life, more authentic, so you feel more like, more alive or more human, like you are experiencing any type of experience you can and feeling totally and completely…” (Pp. 2)
6.5.1.1. SC: Appreciating moment-to-moment experience, transience and impermanence

This subcategory is conceptualised as being held within “Rediscovering myself and my world” (3.5.1). Contributed to by codes such as “being here now without focusing on what will happen next”, the thrust here is one of feeling able and willing to recognise moment-to-moment experience as transient, and the increasing comfort described by participants not only in tolerating painful moments, but in being with my experience regardless of what form it may take, and in affording oneself the space to do so.

“I found it very freeing just to sit there and…be aware…of…my body in space, sounds, I mean I might sit down and be listening to things in the background…and even to say ‘today I enjoyed a brie and grape baguette’, and being able to say that, and taking more time, and just making that space.” (Pp. 19)

In appreciating the impermanent nature of our experience – as a virtue of mindfulness practice – participants were increasingly able to generalise this perceptual stance with regards their own emotional states; acknowledging that just as one can engage non-judgmentally with (transient) pleasant or neutral stimuli, equally we can recognise and accept aversive experience in the knowledge that it will pass, and is not a fixed part of me.

“I thought ‘okay this is just a panic attack this will go’…and I can accept ‘okay I’m panicking now and it will pass’, or ‘I’m sad now and this will pass, other people are sad, today I’m sad, tomorrow I may not be…”’ (Pp. 14)

Essentially, we account here for the tendency reported by participants to develop capacities for engaging fully with immediate experience without absolute attachment to it. In conceptualizing oneself as apart from - or more than - these experiences, interviewees were able to detach from the struggle against private experience; appreciating instead its inherent value, if only we are open to it, rather than being numbed or blinded by pre-existing beliefs, which pollute our engagement with the here and now.

“It makes you aware, that’s the key thing, aware that it is worth it, even feeling bad, even feeling bad is worth it, so don’t fight against that…it’s feeling either way, it’s not emptiness…” (Pp. 18)

6.5.1.2. SC: Observing that I am guided by sensations, almost like “puppet strings”

A further sub-category of “Rediscovering myself and my world”, and one that leads on from one’s connecting with moment-to-moment experience, is a theme reported by participants whereby on-going mindful observation of our experiencing allows an appreciation of the extent
to which we are guided by sensations, often mindlessly following, but now with a growing acknowledgement of the process involved, and subsequently a broader awareness that also entails a greater level of choice with respect to what I am able to do, or how this experience may contribute to my self-concept. In acknowledging the influence that sensory drives have over our behaviour and interactions with the world (through mindful observation), there was a tendency for participants to again describe a novel insight into who they are; one that in some cases contributes to the undermining of elaborate and deep-seated self-beliefs that otherwise characterise identity.

“I wonder, ‘does this thing that I’m doing have inherent purpose, or is it just an extension or modification of basic drives?’…Food, sex, companionship etc. so once you catch yourself you realise you’re just…I don’t know…living out basic drives that you’ve built a drama around…” (Pp. 6)

Equally, participants spoke of a weight being alleviated from experience once we recognise our position as simply vessels for varieties of transient sensory experience; again an insight - or conceptualisation of being - that rests upon the central theme of getting to know my experience, and one that inevitably has implications for what interviewees mean when they talk about “I” or “me”.

“I think one of the things I’ve enjoyed, coming from mindfulness, is that, is kind of like no matter what happens – good or bad – it all boils down to this sensation that you’re feeling, you know…there is nothing in your life that you’ll experience that won’t be just a different combination of these physical things…so that’s comforting.” (Pp. 6)

6.5.2. C: Engaging with the world as it is

From arriving at realisations around the self, and appreciating the nature of moment-to-moment experience in a purer sense, participants described instances of having applied this understanding in being better placed to engage and interact with the world as it is; truly living, rather than formulaically proceeding as a function of our pre-existing notions about ourselves, others and the world. Such codes as “seeing pleasure in the smaller things in life” were important here.

“Live every moment as the last, um…appreciating the little things, that’s what life is made, of little things…like the whole of your self, your mind and your body you are completely…living it, it’s more …grounded.” (Pp. 18)

Participants described a sense that following mindfulness they were more able to base engagement with the world upon their experiential observations; of happiness, contentment,
pain or suffering for example, rather than operating within the world as seen through the lens of persistent self-beliefs. Most fundamentally, engaging with the world was no longer so heavily subject to a filter process, owing greatly to the insight into self discussed above.

“Once you become aware you realise it’s not actually what’s going on out there outside your head, it’s inside, and it’s irrelevant, you should actually…you can actually proceed as it’s not the case.” (Pp. 1)

As a result, this category also accounts for the beginnings of a gradual (and partial) dissolution of the boundary between self and other, allowing interviewees to feel part of their world as an imbedded experiencer, rather than separate and detached agent.

6.5.3. C: Exploring the freedom I have and practising new ways of responding

Participants spoke of a freedom with which they were able to respond having come to the realisation - based on mindful observation of immediate experience – that they were no longer unbreakably tied to the cognitive patterns and behavioural repertoires dictated by rigid self-concept. Influential contributory codes here were “avoiding confrontation with my anxieties and self-doubts”, “feeling that it is safe to try new and different things”, for example.

“It’s like ’oh what a miracle’ like suddenly you think ‘I don’t actually have to be in that place and I don’t actually have to run around in that’” (Pp. 15)

The implication here, is that this category accounts for the experience of participants in feeling that whilst we are inevitably subject to guidance at the hands of beliefs and sensations, we also have an increasingly appreciable degree of choice in selecting our response (particularly if our awareness of contingencies within ourselves and the environment is broad and mindful in tone), ultimately meaning that we develop a growing sense of choice and control over who we are as people.

“So mindfulness gives…it feels like it gives us a choice over something, but I suppose it’s difficult because the level of choice that we have over who we are is something that I suppose…we don’t always consider.” (Pp. 18)

No longer did participants regard themselves simply to be passive products of experiences now and to date. Instead, we are able to address situations encountered, adopt a mindful standpoint, and make decisions with a certain clarity of thought; with this being represented as wilful and measured response, as opposed to that governed by who I think I am, what I should be, or what I cannot do, for example.
“Actually being in the moment…and if it is important now then do it, and if it isn’t then…being able to decide…so I think actually its made me a little bit more assertive…so in terms of being shy it has kind of given me the space to respond a little bit more” (Pp. 14)

Overall, this category details the intrinsic value found by participants in connecting with immediate experience, and allowing themselves to be in the world more freely, more flexibly, and ultimately in accordance with measured decisions (around response in particular) that increasingly stem from mindful awareness.

6.6. Knowing myself differently (core category)

The third and final scheme area also represents the core category of this thesis, meaning that the findings and understanding derived (to this point, and beyond) predominantly relate around this central concept of participants coming to know themselves differently, and with a tone characterised by openness, flexibility, compassion, realism and increasing agency. This broad core category was emergent from the more specific categories and subcategories detailed below.

6.6.1. C: Feeling less defined

This category describes the accounts of participants who - having experienced insight into selfhood and connection with the present moment - report a theme of feeling less defined, less boundaried by self-beliefs, and with an increasingly malleable conceptualisation of who they are what they are able to do.

“Sometimes now I feel a bit watery, like being asked like ‘how do you see yourself’ and its like ‘well it depends on the context.’” (Pp. 6)

Whereas previously there may have been a sense that traits or behaviours were the definition of “who I am as a person”, context now becomes a highly influential variable, with responses, patterns and behaviours now viewed as a product of choice in our interactions with an environment, rather than an inevitable unravelling of “who I am”.

“Just because you know, you’re always sociable and reliable, that’s a thing that makes you feel comfortable, but it doesn’t define you because even if you’re reliable sometimes you can’t be [always] …so it doesn’t mean that you are fixed in that.” (Pp. 8)

In feeling less defined, participants are increasingly able to appreciate that the things we do cannot alone account for the people that we are; a conceptualisation characterised by a diffuseness that was seldom previously credited in the way that life was lived. Interviewees were able to reflect on the process of experiencing without attaching that experience crudely to
self-concept, meaning that the phenomenon of “feeling less defined” is seemingly maintained as a function of how experience is processed.

“If I become health anxious or worry about something and acknowledge that it’s a process that can be noticed but seen as something that’s outside of who I am, or outside my kind of core if you like, it doesn’t have to be unitary or who I am…its okay to see that as something I’m observing, but something that is kind of distanced from how I perceive myself.” (Pp. 5)

6.6.2. C: Coming to conceptualise my own selfhood and who I am

In having adopted a more abstract perspective on selfhood – and one that is not so strictly governed by identification with past experience - participants described a feeling of choice with regards to defining themselves and who they are as people. Crucially, this would appear to pertain especially to attitudes around what aspects of experience individuals make a decision to identify with, or attach to more emphatically; therefore a conceptualisation guided by what the individual would like from life, rather than driven by insecurity.

“I guess it’s again all about choice, like I guess you can use it to choose what you want to hold onto and what you want to be.” (Pp. 21)

In a movement away from passivity and inevitability with regards who I am (based on what has happened to me, and what I do), it appears that self can now be infused with messages emanating from my conscious wishes; thus enabling a degree of control over who I am – and offering the opportunity to become a more active participant in creating myself.

“I suppose mindfulness has given me something to do, or practise, which allows me to be more in control of who I am really.” (Pp. 2)

In developing a picture of selfhood that affords room for our values, choices, and the full spectrum of transient experiential states, we progress towards a conceptualisation amenable to such principles as kindness, compassion, empathy and warmth – both with respect to self and other – and is seemingly therefore self-maintaining, or experienced by participants as a more sustainable and lighter perspective.

6.6.2.1. SC: Arriving at a more flexible idea of who I am, now and over time

In having come to experience a sense of control yet openness relating to identity and self-concept, participants also reported an ongoing appreciation of the flexibility and relative complexity of this altered conceptualisation, both now and over time. For example, this may be demonstrated in acknowledging that an individual houses various “selves”, observing how frequently beliefs and attitudes can change, or seeing that who I am now is not “me” forever.
Whereas there was previously a pressure for consistency of selfhood, an acceptance of its ever-changing nature now more emphatically characterised interviewees’ accounts.

“There is the thing is that I can accept that I can’t be the same person always, and no woman is, no one is…and so it has changed my attitude.” (Pp. 14)

Furthermore, and in terms of ideas pertaining perhaps to negative elements of longstanding self-concept, there is a realisation that even these core aspects can be subject to change - such is the relevance and import of the developing our understanding of selfhood as a state of flux. Inevitably however, this is also recognised as a lengthy and on-going process.

“You just become more flexible about yourself as a person and I think…whereas before I had a belief that you have a personality and it doesn’t change and that actually the core you can’t really change, but actually that made me feel that you can change but that actually it’s just a really long-term process.” (Pp. 6)

Overall, this subcategory of “coming to conceptualise my own selfhood and who I am” captures the experience of participants both in accepting themselves as changing, complex, and at times inconsistent, and in recognising the potential for future change where beliefs are particularly persistent and deep seated.

“I’m just more, in a good way, more unstructured, more malleable, not having such a fixed view, knowing that there'll be certain personality traits in me, but they’re changing…it’s a moveable feast!” (Pp. 19)

6.6.2.2. SC: Knowing that I am more than my thoughts and behaviour

A further subcategory here relates to the process by which participants described coming to understand and observe that they are more than simply an amalgamation of thoughts, feelings and behaviours, existing instead at a level beyond that which is most outwardly, or superficially apparent. In having gained a degree of insight into themselves as constructed and controlled, and in experiencing the richness of transient present moment experience, interviewees were increasingly able to reflect on the distinction between “me”, and the things that I think, feel or do.

“If you define yourself by something and that thing isn’t going well then you feel a failure, but if you, if you, not detach from it, but take that step back and think, one “its okay to make a mistake”, two, “this isn’t all of me, and the way I respond isn’t all of me.” (Pp. 1)
In achieving this position of decentered awareness and a broader more contextual notion of selfhood, participants seemingly began to appreciate an identity whereby “I” is conceptualised as an observer of experience, rather than being defined by our actions in responding to that experience, or indeed experience itself.

“Like imagining your thoughts as though they are actors on the stage…you are the stage, there whatever happens.” (Pp. 18)

The implications of the awareness captured within this sub-category are also important, in that by virtue of recognising oneself as conceptually distinct from the details of my experience (a wider notion of self), participants were able to describe an acknowledgement, in turn, that the details of one’s experience are no longer a controlling factor in who I am, or choose to be.

“Anxiety is less in control of me and I am more in control of her.” (Pp. 21)

6.6.3. C: Treating myself with compassion

With the feeling reported by participants that they exist apart from their actions, thoughts, strengths and flaws alike, interviewees were subsequently likely to endorse a notion around changed – or changing – attitude and relationship towards self; and crucially one where kindness and compassion towards this broader, contextual and more diffuse “me”, is not only more comfortable, but also a more natural and fitting stance.

“I think you’re kinder perhaps, more gentler and maybe more compassionate towards yourself...or at least gives you that choice to be more compassionate with yourself and in that respect has a more positive effect on how you generally feel, um...on a day to day basis, but perhaps on a more underlying level as well.” (Pp. 5)

In adopting a compassionate mindset towards oneself, participants also spoke of its protective nature in terms of well-being; for example being able to greet oneself with respect for who I am (as a person), rather than castigating myself for failures, inabilities or deficits; a compassionate acceptance of the self, thus removing the imperative to live by standards dictated either by others, or by our own self-beliefs founded upon insecurity and self-doubt.

“In the training you’re accepting that things are as they are...so you also come to accept that ‘I am okay as I am, and I don’t have to change, for anybody’...and that's acceptable and that’s okay, and I don’t think I ever thought that for a long time...” (Pp. 21)

Finally, in the context of self-compassion, whilst the more significant impact reported here was an inward proclivity to demonstrate kindness and forgiveness (particularly in instances where
we may previously have been prone to self-chastisement), this capacity – once established towards the self – has implications for our treatment of others; therefore alluding to a more generalizable or fundamental shift with regards compassion.

“I’d start being kinder to myself, and more forgiving, then I was able to be more forgiving of others too.” (Pp. 20)

6.6.4. C: Acknowledging that I am only human

This category aims to capture the experience of participants in arriving at a gradual realisation that many of their previous modes of being were unsustainable; with insight into myself and connection with immediate experience having contributed to the acknowledgement that “I am only human”, and as such I deserve and warrant the compassion, forgiveness, acceptance and tolerance that for many years I was reticent to afford myself.

“I think, ‘okay you cannot do everything and nobody can anyway, but you lived as if you could’.” (Pp. 18)

The process of having recognised myself in a more realistic sense, as well as assimilating a more grounded perspective on life into this conceptualisation, was likely to aid interviewees in their progression towards a differing appreciation of their responsibilities in the world, or accountability for that which is out of any individual’s control.

“You know I always had that problem - feeling myself responsible for the good and the evil of the world, but you know, now I know that I’m just responsible for my bit.” (Pp. 18)

Overall, in acknowledging and accepting the human limits of responsibility and capability, participants were able to reflect again on the implications of these insights for what gives life - and their lives - meaning. In describing a recognition that life was more than a set of duties, responsibilities and challenges, and that in being only human we have unavoidable frailties, participants spoke of a continued freedom with which to find meaning and enjoyment, no longer feeling bound by our unreachable standards.

“That was the real wake up you know, it’s like ‘for God’s sake what have you been doing?’ This is what is there each day and just even enjoying the brightness of today and rather than running off, just thinking ‘well okay it might not be the best thing ever or the best thing anyone’s ever done but actually is what…’, you know, nobody’s gonna write that on your coffin!” (Pp. 19)
6.6.4.1. SC: Adopting a more existential perspective and recognising my higher values

“I think it helps you to slow down and focus on the…things that are actually important.” (Pp. 7)

In having conceptualised the self – and myself – as more abstract, grounded and malleable than had previously been credited, and in recognising with compassion the freedom that each individual can potentially enjoy, participants demonstrated movement towards a more existential perspective on life, often characterised by thoughtfulness and introspection in relation to who we are, and even the nature of reality itself.

“You start thinking ‘if everything is just a thought there’s no reality in this world…there’s no rules, there’s nothing certain…if it’s just thoughts you’re no one…if it’s just thoughts whatever you think it’s not necessarily true’, then…who are you, kind of, yeh…who are you?” (Pp. 2)

This standpoint, despite perhaps being considered disconcerting, or unnerving in some respect, was recognised by interviewees as helping to make room for what is most important to an individual. If we are not tied to an objective reality, and if the world does not necessarily entail or demand certain behaviours, traits, or successes, lives were experienced as more open, broader, and with space to be filled with whatever one might choose to make of their finite time. In continuing to be in touch with moment-to-moment being, mindfulness was recognised by interviewees as in part a means of managing those elements of experience that otherwise represent obstacles to what we have now identified as higher goals.

“I want to be happy and achieve my career, settle down and all that sort of stuff, but some things like my mood and emotions and things might get in the way of those things, and so I think that’s where mindfulness can be really good, and I can use it maybe to kind of let go of that stuff that can get in the way of that other stuff…like my bigger goals.” (Pp. 17)

As a subcategory of 3.6.4 (acknowledging that I am only human) and with an on-going recognition of an individual’s susceptibility to being governed and dictated to by the constructs that we create - this theme accounts for participants acknowledgment of the “only human” tendency to be vulnerable to living automatically, whilst equally employing a philosophy and practise of mindfulness in pursuing deeper values, which can be all too easily forgotten.

“If you’re acting more mindfully you’re more likely to act in accordance with your values and not drifting into things where you’re just carried along by a stream…” (Pp. 4)
Overall, this category represents interviewees’ descriptions of gradual advancement from a life governed by rigid attachment to controlling and unquestioned self-beliefs, to one characterised more emphatically and consistently by freedom and choice.

6.7. Integrative diagram

Figure 2: An integrative diagram displaying the interrelatedness of categories and sub-categories around the three primary scheme domains. Whilst each category predominantly pertains to a single scheme area (as discussed above), the representation below shows that this is not absolute, and instead illustrates a fairly dynamic set of relationships between categories existing within and across scheme domains.

6.8. Respondent validation

On completion of our analysis and theoretical integration, the primary scheme (3.1) as well as an elaborated version of the explanatory storyline (3.1.1) were presented back to participants, who were asked to give feedback pertaining to the extent to which our results i) make sense, ii) accurately represent their experience, and iii) are considered to be missing important factors. The following is a selection of responses received, with a full account of all respondent validation feedback available in appendix 5.

6.8.1. Does the understanding that we have come to make sense?

“Yes, it completely makes sense and I particularly agree with the idea that this is a circular process, maybe with an “unclear” starting point, at least in my experience.” (Pp. 2)
“Yes this all makes sense to me.” (Pp. 6)

“I thought the report was easy to understand and very clear to the points we discussed!” (Pp. 16)

“As someone who participated in your research and who also practices mindfulness, the model makes sense.” (Pp. 5)

“Each process seems to make sense in its own right; however, the process did not necessarily follow a sequential order for me.” (Pp. 4)

“I think your slides summarise the process very well.” (Pp. 14)

“I can say that yes it makes complete sense.” (Pp. 21)

6.8.2. Does our understanding fit with your experience?

“I think it’s really caught it, especially also the fact that its not necessarily a fixed linear progression but that you can move between stages.” (Pp. 21)

“This does fit with my experience. Once I take a detached stance to my experiences in the moment I see that I am much more than the sum total of my experiences.” (Pp. 6)

“All three stages of the Mindfulness exercises are spot on, it's taught me to see & enjoy the present without the shadow of the past and what's coming in the future!” (Pp. 16)

“Yes, it fits with my experience. However, I think I particularly started with stage 2 by noticing my thoughts, feelings, needs etc. (‘everyday’ thoughts – like automatic thoughts etc.), then moving to knowing myself as a person (stage 3) and then finally realising that I also have thoughts on how I think I am.” (Pp. 2)

“I can only speak for myself and for me it was pretty much the “classic” case of stage 1 > stage 2 > stage 3.” (Pp. 14)

“I was able to locate different parts of my own experience in each of the phases.” (Pp. 4)

“Yes, particularly seeing thoughts and emotions as states rather than as reality, and being more aware of self-criticism etc. It’s not so much that it’s made me think I’m more than that but more that it’s made me feel less defined by those things, and that things are constantly changing.” (Pp. 8)

6.8.3. Is there anything that you feel is missing?

“I don’t feel that there is anything missing, as it is a flexible model, which acknowledges that trajectories may be different for different people.” (Pp. 4)

“I felt everything we discussed are in the report and I can't see anything missing from the report!” (Pp. 16)
“I don’t think there are bits missing, but perhaps there could be arrows from stage three to stage one, as this would make it more of a circular process.” (Pp. 2)
4.1. Summary of findings

As discussed above, our findings provide a representation of the story that participants told regarding processes of change relating to conceptualisation of, and relationship with, selfhood following mindfulness. Our model captures a dynamic movement from recognising and seeing more clearly the aspects of concrete self that have been influential components of distress, connecting with immediate experience, and arriving at a more abstract and flexible understanding of who we are as people. In analysis of the implications, conclusions and links that can be drawn from our findings, we can relate to a grounded theory around freedom from responsibility to rigidly held self-knowledge, and consider the place of our observations – that suffering (more broadly than but inclusive of our traditional views around diagnosis and pathology) has a cause, and that cause is fixed and concrete identification with the conceptualised self – with respect to both theoretical literature (e.g. Buddhist philosophy and the self as an important concept in the history of psychology), and current clinical applications of mindfulness (in particular Cognitive Behavioural Therapy, Acceptance and Commitment Therapy and Person-Based Cognitive Therapy). Overall, we shall seek to position this understanding of change - in relationship to and identification with self - as a fundamental mechanism for MBCT, within the broader field.

4.2. Reflections on respondent validation

Following from the respondent validation feedback received we are able to feel comfortable in stating that our scheme and explanatory theory faithfully illustrate the experiences of those involved, and as such, that the transition from unchanging and oppressive self, to a conceptualisation characterised by freedom, choice, abstraction and diffuseness, is an appropriate and meaningful way to reference the benefit arising from MBCT. In total, 12 of 21 interviewees contributed their thoughts (comprising seven trainees, two mindfulness drop-in clients and three current MBCT patients), with all feeling that the model made sense and fit with their experience, providing that the scheme is interpreted as intended, that is; dynamic, reflexive, and potentially with a variable starting point. Relatedly, though no specific additions were recommended, one participant suggested a more explicit link from stage three back to stage one; emphasizing the on-going and dynamic nature of exploration, discovery and change.
4.3. Ideas around Buddhism

In the introduction section we laid out an understanding of the role of self and self-concept as envisioned by time-honoured Buddhist philosophies, in particular the proposal of an entangled relationship between self, suffering and impermanence (or Anatta, Anicca and Dukkha; the three marks of existence). During section 2.6 we asked the questions i) are fundamental self-related changes promoted by current clinical protocols, ii) does self-related change - in line with the Buddhist tradition of understanding suffering - occur within these interventions, and iii) if so, how is this change accounted for, measured or recognised? Following from our findings, we can answer affirmatively with respect to i and ii (relating to MBCT), and with regards iii, we may suggest that the current study, in its qualitative analysis and consideration of first person perspectives – without necessitating that these conform to questionnaire based methodology – provides an effective method of conceptualising and reporting the processes involved, which remain otherwise difficult to capture. As such; we may now consider in more detail the relevance of Buddhist thought and ancient narratives around suffering, to current clinical practice and approaches to intervention.

To state the overlap most concisely, we may say that there exists a central role for the concept of suffering more broadly than is often credited within diagnostically driven models, and that it is through a seemingly transdiagnostic approach of reconceptualising one’s own perception of self, that we create the context within which distress can be managed, tolerated and eased, irrespective of its symptomatic form. Our analysis explored the experiences of those without diagnosis, as well as those suffering from depression, pain and a range of anxiety disorders, and found a tight kinship with the understanding of suffering outlined in Buddhist attitudes towards the difficulty of attachment to conceptualised self. Specifically, we can relate this understanding to the Three Marks of Existence identified in Buddhist thought, and say with some confidence that MBCT does promote the key areas of insight and understanding associated.

4.3.1. Dukkha

Our findings would appear to fit with a more central place for the concept of Dukkha, or suffering, whereby an accepting attitude towards experience, without the demonstration of self-blame, absolves us from direct attachment to, and identification with, the contents of that suffering; instead allowing us to appreciate and acknowledge distress as inevitable, unavoidable and inherent, as opposed to a reflection of one’s own personhood.
4.3.2. Anicca

The essential impermanence of forms as discussed in Buddhist literature is echoed in the understanding and process of change described by interviewees, whereby an ability and willingness to experience states - recognised as transient, and distinct from who we are - is seemingly protective. The dedicated and intensive practice of mindfulness within MBCT - and the resulting moment-to-moment observing of experience - appears to give participants crucial insight into this central truth; though a truth that is often hidden in our unthinking interpretation of the world and ourselves, dominated as this is by pervasive and enduring self-knowledge.

4.3.3. Anatta

Whilst the notion of Anicca perhaps becomes intuitive only with direct mindful awareness (e.g. Marlatt et al., 2004), ideas around Anatta, or non-self, can feasibly be considered an implication or realisation founded on this observation. The reports of participants in experiencing a more diffuse, changing and flexible model of selfhood parallel concepts of Anatta; meaning that self, or “I”, is no longer unitary and fixed. Indeed, the interrelatedness of these constructs can be seen in the phenomenon whereby once suffering is accepted as inherent, yet transient, it no longer represents or reflects an unchanging deficit of “mine”; instead being seen as a constituent part of experience, that neither defines me, nor finds me responsible. As such we can identify the key shifts outlined within our scheme, in the principles discussed and valued as fundamental within an ancient philosophy.

“The deep recognition of these three marks of existence is said to result in a radical wrenching of one's cognitive system. Seeing the transitory and ultimately less than fully satisfying nature of sensory pleasures, as well as the illusory nature of our usual egoic identification, undermines egocentric motivation, thus enhancing renunciation and equanimity.” (Walsh, 1983)

Considering the overlap found here with respect to crucial aspects of change reported, we may suggest that any approach or theoretical attempt to formulate human distress – whether pathological or not – is likely to pertain to these areas, for they appear to be saying something intrinsic about what it is to be human, therefore providing a framework within which to view not only our understanding of the change processes occurring in MBCT, but perhaps also our conceptualisations of psychological distress, pathology and disorder more broadly.

4.4. Clinical and non-clinical samples: The imperative of Dukkha

The recognition of this Buddhist understanding – in its appreciation and formulation of inherent suffering, as opposed to pathology or disorder - has implications that are universal, rather than
applicable only in relation to specific patient populations. As such; our analysis was of both clinical and non-clinical samples, and although there is no systematic attempt to segregate these groups in terms of our theoretical conceptualisation of experienced change, one particular observation of difference that may be worthy of further reflection was the tendency for our clinical sample to speak more forcefully regarding an emerging sense of freedom. We may therefore hypothesise that the more overwhelmingly one’s suffering is experienced, the greater the imperative of Dukkha, and subsequently the more emphatically our understanding of the change process outlined (which fundamentally ascribes to suffering generally, without the distinction of clinical versus non-clinical) will be informed by a sense of freedom from what previously was. Nevertheless, the overall similarity of experience across groups sampled is testament to the universality of suffering as arising from attachment to conceptualised self.

4.5. Links to existing MBCT research: Content and context

In a degree of contrast with much of the existing empirical research into mechanisms of change in MBCT (as discussed in the introduction section), we propose a more fundamental underlying shift, as described. Whilst researchers have identified constructs that we may conceptualise as components of this broader shift (e.g. Kuyken et al., 2010), our understanding of change (in accordance with principles of Dukkha, Anicca and Anatta), may provide an essential backdrop atop which more specific cognitive, affective and behavioural changes occur; for example relating to cognitive reactivity and self-compassion as identified as influential by Kuyken et al., (2010), and which are nonetheless accounted for in our scheme, within phase two (cognitive reactivity) and phase three (self-compassion).

Therefore, we may hypothesise that important development at the level of content (as investigated empirically), are reflective of fundamental changes at the level of context; perhaps symptomatic of the change at hand, rather than the change itself. In illustrating this point, we might consider the construct of self-compassion in more detail. Our understanding would suggest that the promotion of self-compassion alone – in the absence of more underlying shifts in relationship to and identification with conceptualised self – would be relatively futile, the rationale here being that it is the context (self recognised as process) which entails an increasingly compassionate inward stance; making it feasible and intuitive. Without this simultaneous and dynamic process of change occurring regards selfhood (and perhaps one’s attitude towards negative self-schema in particular) the assimilation of a compassionate self-perspective (into a fixed idea of self), is likely to be regarded by clients as counter-intuitive, or perhaps superficial – so distant would it be from our traditionally insecurity-driven model of, and relationship with, ourselves.
“We should speak of a contextual psychology in which experiential worlds and intersubjective fields are seen to mutually constitute one another. Unlike Cartesian isolated minds, experiential worlds—as they form and evolve within a nexus of living, relational systems—are recognized as being exquisitely context-sensitive and context-dependent.” (Jacobs, 2002)

As such, we can consider the explanatory scheme proposed in this research as fully compliant and well-fitting with respect to established (predominantly content-based) explorations of mechanisms of change in MBCT, only that we suggest—and point towards with our findings—a broader, fundamental, and necessarily underlying shift—in accordance with principles outlined in the Buddhist philosophical origin of mindfulness—which exist as a framework for the more specific change processes identified elsewhere, regards reducible concepts amenable to empirical review.

4.6. Links with Cognitive Behavioural Therapy (CBT)

As discussed in section 2.2, traditional Beckian CBT places a premium on the concepts of core-beliefs and schema, which essentially represent influential elements of self-knowledge. Whilst the route to cognitive restructuring is the gradual questioning of these constructs, and an increasingly popular approach within third-wave therapies is to modify our relationship to such experience (Harris, 2009), it would appear—in interpretation of our findings—that MBCT essentially achieves both; that is, a questioning and restructuring of one’s self-knowledge, but functioning through a process of mindful observation and realisation that beliefs are unfounded, and indeed in some respects that the very nature of our understanding around responsibility to this self-knowledge is a persistent falsity. As described in our grounded theory (section 3.2), freedom from responsibility to conceptualised self inevitably entails a freedom from responsibility to the contents of that model of selfhood, and therefore the constructs implicated in CBT (schemas, core beliefs and dysfunctional assumptions for example) are highly prominent.

The parallels with traditional CBT are significant, particularly with regards to the aim of impacting the effect of constructs such as “failure”, or “worthlessness” for example, that interviewees were increasingly able to see as beliefs, rather than unending truths. Our scheme would seemingly also overlap with the principles of a primarily cognitive understanding around the maintenance of these self-beliefs, and whilst CBT models implicate a modification of thinking errors, or cognitive distortions (Beck & Alford, 2009)–occurring as we see self, world and future through the lens of self-knowledge—an alternative mindfulness-driven approach would be to alter the lens itself—the observer, or experiencer—rather than taking a corrective
approach to one’s thinking. Our scheme, and the perspectives offered by participants would appear to support an increasingly widely accepted hypothesis (e.g. Hayes, Strosahl & Wilson, 1999) whereby cognitive restructuring – and the subsequent impact upon distortions (for example lesser tendency for jumping to conclusions, personalization or catastrophisation as discussed by interviewees) – is a consequence of a changing relationship with, and experience of, selfhood.

The essential effect here is that the link between our core beliefs or schema, and our *behaviour* within the world is severed; meaning that these beliefs are no longer all that we are, their hold – and that of concrete conceptualisations of selfhood - is loosened. In achieving this shift, as is accounted for by the findings of this research - and also recognised by those authors emphasizing the role of decentering, for example, as an influential variable and mechanism of change in cognitive therapy (e.g. Segal, Williams & Teasdale, 2002), which again highlights the potential importance of a level of abstraction when viewing the contents of self – it would appear that the dominance of self-beliefs is undermined. Crucially however, a key difference here (as illustrated in phase three of our scheme) is the emphasis placed by subjects on the importance of maintaining a diffuseness of selfhood, rather than replacing maladaptive rules or beliefs, with more functional equivalents (see for example Padesky, 1994; schema change processes). As such, it is the ability of interviewees – both clinical and non-clinical – to tolerate the inherent uncertainty, impermanence, and flexibility of life-states that seemingly allows one to adopt a model of selfhood theoretically devoid of concretely held assumptions, whether positive or negative.

Finally, with regards more specific relation of our findings to CBT – and with the proviso in mind that cognitive restructuring may be an implicit and secondary process - rather than necessarily the primary target for intervention (Jacobson et al., 2001) - we may seek to establish the ground shared by the explanatory scheme of this research and the concepts of dysfunctional assumptions or life rules in cognitive therapy, which might provide the most suitable theoretical analogy. For instance, in consideration of the assumption “*if I get too close to people they will hurt me*”, within Beckian CBT the first therapeutic step may be to recognise that the rule exists, and has existed for some time. Secondly we might seek to recognise the rule in action - perhaps by acknowledging the temptation or inclination to behave in a certain way, or noticing the negative automatic thoughts generated – when one is faced with the potential for intimacy. Finally, the rule might be updated with a more adaptive or circumspect alternative, and one that requires testing and practice (Padesky, 1994). As such, we can find considerable parallel here with our model; where the acknowledgement, awareness of, and ultimate revision of self-knowledge and relationship with self-concept, are paramount.
Essentially (and despite significant similarity) in being problem specific - and in addressing particular distress as defined by patterns of symptomatology, as opposed to the broad and inherent continuum of distress identified within Buddhist thought - there are questions arising around the extent to which traditional CBT engenders a depth of change (e.g. Silverman, 1999) such as that reported by our interviewees with respect to their perception, modes of being in the world, and relation to self. Where CBT fosters the development of techniques to manage distress, mindfulness approaches and the philosophy they entail seemingly alter the very context of personhood within which symptoms present, and as such, MBCT would appear to provide an intervention whereby our key mechanism of change is the process of self, itself, as opposed to a modification of its constituent parts.

4.7. Overlap with Acceptance and Commitment Therapy (ACT)

The understanding emergent from our explorative process seemingly has close ties to the perspective adopted by leading theorists within Acceptance and Commitment Therapy (ACT) (e.g. Hayes, Strosahl & Wilson, 1999). The ACT “hexaflex” identifies i) acceptance, ii) cognitive diffusion, iii) contact with the present moment, iv) self as context, v) values, and vi) committed action, as six key processes, whereby an individual is able to manage and tolerate their experience in the service of living a life guided by values (Harris, 2009). Our explanatory scheme, in addition to several of the categories outlined, would appear to have a natural affiliation with the ACT approach, which might in part be attributed to a similar recognition of suffering and distress as normal, inherent and inevitable parts of life. The ACT emphasis on ending the struggle against experience (Harris, 2009) and instead mindfully embracing its varied forms, chimes with the reports of MBCT participants detailed in our findings. Interestingly, although MBCT seeks no explicit focus on values (a predominant feature of ACT interventions) the frequency with which interviewees referenced the theme of values-based action is suggestive that a mindful undermining of one’s previous modes of being opens up space for this perspective, whereby the primary (and explicit) focus on values within ACT can perhaps be seen to proceed implicitly – though as a function of mindfulness – in MBCT.

A further point of comparison exists with regards to interviewees’ descriptions of scheme stage one; “realising how I am constructed and controlled”, in which messages of criticism from self and other congeal to make concepts, or create realities that are then unthinkingly observed, and guide our interactions with the world. Similarly, the theoretical underpinnings of ACT heavily reference Relational Frame Theory (RFT), which describes the uniquely human propensity to make symbolic inferences and generalise words and concepts outside of the context from which they originate, thus facilitating our making of unhelpful generalizations (Barnes et al., 1997), perhaps most damagingly with respect to enduring and maladaptive conceptualisations of
unchanging self – or the “conceptualised self” both here, and in ACT. The “word” (here core-beliefs, schema, self-knowledge) stands for much more than the object or instance it describes (as discussed by Wittgenstein, 1953; language games). Similarly, whilst language guides all that we do and all that we know, it is the concrete relationship to the terms used to describe ourselves and our world – and the treatment of these words (e.g. crystalised concepts of “reliability”, “worthlessness”, or “failure” etc.) as if they exist as “thing like” part of us (see Sass & Parnas, 2003), or objectively in the world - that brings about the attachment to an amalgamation of such concepts; the conceptualised self.

“Concepts that have proven useful in ordering things easily achieve such authority over us that we forget their earthly origins and accept them as unalterable givens.” (Einstein, 1916)

It is the linguistically dominated human tendency to create rigid self-concept – “cognitive fusion” in ACT terms setting the scene for a later process of “realising how I am constructed and controlled” within our understanding – that lays the foundation for inflexibility of self, and subsequently distress. As such RFT would appear to deliver a framework influential in ACT, but also one befitting of our explanatory scheme, and therefore an illustration of how the truths of Dukkha, Anicca and Anatta come to be sidelined in everyday life. This kinship with ACT is perhaps not a surprise, as Hayes (2012, unpublished) has stated a feeling that whilst our understanding of mechanisms of change in ACT and MBCT is in its relative infancy, they are likely to be “dancing on the same floor”, more specifically – in reference to the findings of this research – what would appear to be the floor of Buddhist thought and its Three Marks of Existence.

4.8. Links with Person Based Cognitive Therapy (PBCT)

Person Based Cognitive Therapy (PBCT; Chadwick 2006) is a model of working with distress whereby an individual’s personhood is not only recognised as a concept worthy of attention, but also elevated to centrality within the understanding. The fundamental acknowledgement here is that suffering arises not from objectively distressogenic stimuli, but instead via a process by which meaning is constructed in relation to that stimulus, but also as a function of person-based contingencies. As the lens of self in turn drives the understanding and explanations we arrive at when faced with experience, the “self” becomes a crucial construct in exploration of this meaning-creating. PBCT addresses not only psychotic experience, but also “unconditional schema” and metacognitive beliefs about the self (Chadwick, 2006), creating both a significant overlap with principles of traditional cognitive therapy, and also an acknowledgement of the power of self-beliefs within an approach that subsequently recognizes personhood (and change
in relationship with personhood) as an important consideration when working with these phenomena.

"We all operate in a world of appearances, with a mind that has to simplify a bewildering array of sensory stimuli into a subjectively manageable and coherent flow of experience." (Chadwick, 2006)

The model adopts a Kantian perspective on reality whereby we cannot say anything about the world as it necessarily is. However, in this “world of appearances” (Chadwick, 2006), it is the process of appearance-making (in relation to, and as guided by the self) that we are predominantly interested in, and as such, approaches that steer away from a logical positivist view (and instead value meaning-making), will place a greater emphasis on selfhood, i.e. that shared by PBCT and the present research. The implications here are that in working with distress we must address the processes of appearance - and attachment to appearance - from which suffering emanates, therefore establishing a more predominant role for selfhood in our therapeutic interventions.

In relating this perspective more closely to our findings, it would appear that mindfulness (and MBCT more specifically in this case) offers individuals a degree of choice and freedom in the process by which the “bewildering array of sensory stimuli” at hand is experienced. If the thrust of PBCT is guided by a recognition that “perception gives coherence and meaning to sensations” (Chadwick, 2006), then the mindful reconfiguration of perception – involving (as discussed in our findings) a removal of elements of self-knowledge that pollute this perception – is a method with which to change our experiences in the world, common to both PBCT and the understanding described here.

In addition, and in thinking more specifically about overlaps in the conceptualisation of selfhood in this research and within PBCT, Chadwick (2006) discusses the value of an explicit focus on selfhood - the recognition of self as a worthy construct for intervention - for example through two-chair work described in more detail later. Rather than adopting a reductionist attitude that might favour empirical study (such as that evident in the enormous variety of potential mechanisms identified by traditional cognitive therapies, see McCracken & Gutierrez-Martinez, 2011; Wicksell, Olsson & Hayes, 2010), PBCT seeks to develop an understanding of “symbolic self” as a function of the Zone of Proximal Development (ZPD; Vygotsky, 1978) and through the “radically collaborative” therapeutic relationship. That is, there emerges a conceptualisation of self, not defined by a person’s history, characteristics and experiences alone, but a broader notion, and specifically one that accounts for what is possible between people. Therefore, a conceptualisation appreciating the extent to which self is a process. This “complex, contradictory and changing” self (Chadwick, 2006) is embedded within
environments – representing an understanding that shares significant similarity with the dynamic model outlined in our findings, and provides the context within which experience is interpreted.

Having established an inclination to work directly with concepts of personhood, PBCT seeks in part to “relinquish constructs that fix and narrow the self” – again identifying an aim that appears to have been well represented in the experiences of participants here following from MBCT. Whilst the process of this occurrence can equally be found throughout our three phase scheme, Chadwick (2006) also suggests that what ultimately fixes the self is that it quite intuitively takes on “the appearance of an entity, object or product” – again the persistent illusion that is seemingly impacted during MBCT, with interviewees reporting increasing insight into a changing and complex selfhood that cannot be pinned down – primarily through mindfulness meditation also favoured in PBCT. Moreover, the conceptual similarities between PBCT and our emergent understanding can also be closely aligned with the key Buddhist tenets described above; for example the principles of Dukkha, Anicca and Anatta whereby a rejection of suffering (versus acceptance), a perception of permanence (versus appreciation of transience), and the identification with enduring and unchanging selfhood (versus recognition of symbolic self as process), are all seemingly addressed in both MBCT and PBCT.

A final point of consideration in placing our findings in the context of PBCT is an exploration of the experiential route identified in addressing selfhood. Whilst a person-based approach is endorsed in all aspects (such is the emphasis on Rogerian principles of alliance and regard), it is perhaps in the use of “two-chair work” that the approach most explicitly places selfhood at the centre of the intervention; thus a philosophy of clinical practice that would appear to be strongly supported by the findings of this research. Chadwick (2006) identifies negative self-schemata (NSS) as perhaps the most “compelling and distressing” aspect of the process of self, whilst there is inevitably similar importance placed on a person’s strengths, capabilities and positive self-attitudes (positive self-schemata; PSS). Two-chair work proceeds towards a re-experiencing of self whereby NSS are experienced as “part of the self, not the self”, whilst PSS are explored and consolidated.

As with our understanding around MBCT, the movement towards a different quality of selfhood is seemingly heavily reliant upon an experiential component within therapy - perhaps the freedom to see for oneself that our unthinking perspectives on “who we are” may be unfounded. The purpose here is to achieve a better integrated, more complex and sophisticated conceptualisation of self, whereby our perceptions of personhood are nuanced, flexible, and appreciated – intellectually and experientially – as “complex, contradictory and changing”. A model of self that would appear akin to the third phase of our understanding; knowing myself
differently, suggesting again that where suffering is experienced in such a way as to cause significant emotional distress and functional impairment, fundamental change with regards to relationship to, and identification with “I”, represents a preferable alternative to predominantly symptom focused interventions, and seemingly one with the three marks of Buddhist existence at its theoretical and experiential core.

In sum, the overarching principles outlined by Chadwick (2006) in relation to PBCT are that i) self is a process, ii) we work with self-schemata, and iii) self-acceptance is a fundamental goal. In this light, the present research can identify a significant similarity of position, in that our model of the change following MBCT highlights the impact of self-beliefs, and promotes self-acceptance within the eventual context of having appreciated an increasingly diffuse selfhood; and one that exists as a process, rather than an “entity, object or product”.

4.9. Explicit self focus in therapy and a guiding framework

As illustrated above, self is perhaps an inevitable focus of therapeutic interventions, whether inadvertently, or more consciously. Whilst PBCT can be regarded a notable proponent of this approach, a more general and sustained emphasis on notions of selfhood as a source of significant, meaningful, and underlying change within clinical applications of psychology is a trend emergent to differing degrees in third-wave interventions. In line with the findings of this research as presented, a willingness to consider selfhood – and particularly the phenomenology of self – a viable, important, and explicit variable in therapy is advocated, thus constituting the continuation of a theoretical departure from what Grossman (2008) describes as “enormous reductionism”, and perhaps more specifically, the tendency for mindfulness to be “plugged into a behaviourist paradigm with the aim of driving desirable change” (Kabat-Zinn, 2003).

Our next step may be to suggest a coherent overarching framework for explicit self-focus in our therapeutic approaches, informed by the scheme presented. As such we propose that interventions may be amenable to a dynamic and flexible three-stage process (perhaps regardless of modality and specificity of approach, at least within the cognitive-behavioural field), whereby the initial phase is directed at heightened insight into what we think we know about the self, and how this is influential; a secondary process is one of experiential contact with aspects of the self (e.g. chair-work) and world (e.g. mindful awareness of immediate moment-to-moment contingencies) that may have been sidelined; and thirdly, a reconceptualization of who we are and how we might perceive the world. This is hypothesised to be a model of insight, experience, reconfiguration and action, commensurate with the Buddhist understanding detailed above.
In recognising this three-phase process of addressing context as central, there may nevertheless be significant alterations regarding content, or indeed change in terms of the intricacies through which this fundamental shift in context is achieved. For instance, and again as outlined in PBCT, the third phase (reconceptualization or more sophisticated integration of self) may be particularly distressing or troublesome where NSS are especially potent and dominant, meaning that experiential components may take a more influential role at this stage - with “clear conceptual aims” (Chadwick, 2006) - yet still ultimately in service of altering one’s relationship to and conceptualisations of self. As such, our framework provides a broad structure for the phases of change at hand, but with requisite flexibility in allowing for the idiosyncrasies of therapeutic interventions in targeting more specific distress. Even where this is the case however, stemming from the findings of this research (and particularly the regard afforded to a Buddhist understanding of suffering) we advocate an explicit focus on the concept of selfhood, thus allowing for an on-going appreciation of content modification as a function of our working within the context of personhood.

4.10. Continued mindfulness, and outside influences

A further point worthy of discussion is the extent to which interviewees here, and theorists more widely (e.g. Segal, Williams & Teasdale, 2002) recognise the centrality of on-going mindfulness practice in maintaining the insights and understanding emergent from MBCT, and mindfulness-based approaches more generally. Why is this single instance of insight (albeit in this case drawn out over an eight-week program) not sufficient? In addressing this issue it seems appropriate to again reference a Relational Frame Theory (RFT) perspective on the gradual construction and crystallization of conceptualised self; that is, to consider how the persistence of our human tendency to make a “category error” (as described by Chadwick, 2006) in regarding self to be unitary and unchanging is driven in part by linguistic traps that imply the possession of traits, the attribution of qualities, or the apportion of blame; for example in stating “I did this”, or “the fault was mine”, and hence unthinkingly discounting the role of context. Thus, although mindfulness grounds us in a more immediate reality, we continue to be exposed – both internally and externally – to influential cues for the consolidation of self-concept.

As such, mindfulness perhaps represents a practice and philosophy relevant irrespective of one’s present situation, not only when we are confronted with significant distress, but also – and perhaps even most predominantly – in the prevention of distress, to some degree via the acknowledgement and acceptance of suffering as an intrinsic constituent part of what it is to be human. The experiential contact that mindfulness (and MBCT more specifically) offers with this perspective is crucial, being as it is that we live in a world that is often loathe to reinforce
messages around acceptance, compassion and equanimity; and as such these basic, time-honoured and enduring truths are easily forgotten.

“In the West you have bigger homes, yet smaller families; you have endless conveniences, yet you never seem to have any time; you can travel anywhere in the world, yet you don’t bother to cross the road to meet your neighbours.” (Dalai Lama, 2006)

The increasing popularity of mindfulness meditation within our culture is in many ways at odds with predominantly individualistic and consumerist societal trends, which might be considered so dominantly driven by the influence of mass media that the consumer capitalist interest enjoys a conceptual monopoly on what it is to live a meaningful life. Within this cultural context – and in reflecting on the associated pressures for success, accumulation and recognition (as identified by our participants), continued mindfulness practice can perhaps be considered an important antidote.

4.11. Limitations

Inevitably there exist limitations in terms of the research presented, and here, we may seek to take a reflexive approach in reflecting on the areas of our explorative process that could perhaps be modified, should the study be repeated. Firstly, although our sample size of 21 is relatively large in the context of a Grounded Theory methodology (Marshall, 1996) – and perhaps more pertinently we feel that the point of saturation for categories was reached – it remains helpful to retain a degree of caution with respect to generalisability. Nevertheless, the methodology does neither seek nor confer generalization of findings or theory – rather, it generates a psychological theory, which might subsequently be used in further research, and in assessing relevance to wider groups.

Furthermore, we remain conscious that within Grounded Theory, an explanatory scheme does not necessarily fit any one person’s experience in its entirety, but rather represents an understanding, informed by and developed with respect to, meaningful aspects of all participants’ mindfulness experience. Feedback received at the respondent validation phase was enthusiastic, supportive, and confirmatory with regards our model, and is evidence that the methodology has yielded valid findings.

In terms of our participants, we must concede that Trainee Clinical Psychologists are indeed a select subset, and one (as a group) that may relate and respond differently when compared with either the wider population, or a clinical sample. However, in terms of knowledge – theoretical, clinical and experiential – around MBCT, we can state that none of these individuals had
received more than one three-hour workshop on the applications of mindfulness at the time of starting the program. As such, we can recommend that their status as Trainee Psychologists does not necessarily infer a depth of knowledge to impact profoundly on group experience, and more specifically, on their experience of the change processes at hand. Indeed – and as discussed – there exists a striking similarity between the change-perspectives offered across our samples.

Moreover, neither do we claim that our interviewing of Trainee Psychologists need pertain solely to an understanding of clinical populations, as has formed the predominant focus in our discussion of findings. There is a trend for both MBCT and (its theoretical predecessor) MBSR to have been researched within trainee populations, for example suggesting positive findings in relation to the impact of i) MBSR on a sample of medical students (Rosenzweig et al., 2003; reduced “mood disturbance” and “psychological distress”), and ii) MBCT on a group of Trainee Counselling Psychologists (Collard, Avny & Boniwell, 2009; increased mindfulness and subjective well-being). This would appear to lend further support for our own implication (stated elsewhere in this chapter) that mindfulness-based approaches have significant import with respect to well-being in non-clinical samples - especially perhaps with those training in healthcare professions – and as such justifying our sampling methodology.

A final point regards our sample relates to our interviewing of patients who continued to demonstrate clinical symptoms, thus constituting a slight departure from more restrictive sampling strategies employed within large-scale trials (e.g. Kuyken et al., 2008). Nonetheless, recent demonstrations of the effectiveness of MBCT in patients with chronic depression (see Barnhofer et al., 2009) point towards the value of a more inclusive approach, and as such, we can consider our sampling – comparably non-selective, predominantly driven by accessibility, and from within an inner London borough – to contribute meaningfully to the validity of our approach as a whole.

Lastly, it is impossible to ignore the potential influence of the researcher’s (and supervisors’) own philosophical positions on the understanding arrived at. Although a conscious attitude of openness, neutrality and transparency was adopted throughout, we inevitably cannot remove ourselves entirely from our worldview, and as such we must acknowledge the extent to which one’s own perspective is influential in the process of abstraction in generating conceptual theory from data. Nevertheless, we can reasonably consider this phenomenon to be a facet of Grounded Theory research, and qualitative methodology more broadly (Mehra, 2002). There is conceivably a degree of meaning created between interviewer and interviewee, which cannot exist without assumptions and beliefs being triggered in both parties (Wimpenny, 2000), and as such we recognise this as a potential limitation, whilst also acknowledging it as perhaps an
unavoidable feature (or by-product) of the richness and depth of understanding emergent from qualitative study.

4.12. Implications and future research

4.12.1. Content and context

In having presented and discussed the findings of this study, we shall now point towards the implications for, and areas of, future research stemming from the understanding emergent here. Most broadly, we should perhaps comment again on the status of context as an increasingly central concept, but also its relation to more widely investigated content based change. Despite the relative ease of fit that content – primarily symptomatology and self-report measure based study – enjoys with respect to large scale randomised controlled trials, we run the risk of reduction to the extent that “what it is to be human” becomes carved up into the tiniest components, each explaining a similarly tiny proportion of variance regards meaningful change (e.g. Scheff, 2003). Instead, approaches such as ACT (with its broader construct of “psychological flexibility”), and PBCT (with its commitment to addressing personhood) represent methods of conceptualizing distress with context (of selfhood) at their core.

Whilst self may be less amenable to empirical study, it would appear to be a fundamental process, and perhaps one to be more wholeheartedly embraced within both clinical and research domains. Though our aim may ultimately be to reduce and protect against observable and measurable distress, it is seemingly a more complex understanding of the context of selfhood – within which this distress occurs, and is maintained – that would be most fruitful. In achieving this measurable (content-based) aim more successfully and consistently (for example in terms of relapse prevention in depression, as is the primary focus for MBCT), our findings point towards the value of making self more knowable, and thus pursuing research interests that seek to shed light upon how our interventions impact upon phenomenology, or “what it’s like to be” (Nagel, 1974), therefore content, but as it exists within our context of selfhood.

The underlying shift described above, in fitting with previous empirical research into mechanisms of MBCT as discussed, demonstrates the role of context as the backdrop for specific content-based change, though it may also be worthwhile to investigate the extent to which contextual shifts can occur without an impact on symptomatology, or indeed vice versa. In doing so we may be in a position to understand with greater clarity the relationship that conceptualisations of self have with the observable and measurable aspects of a person’s presentation; thus potentially widening the scope for a more explicitly personhood-centred philosophy within clinical applications. Essentially, our findings here suggest a shift in
relationship with, attachment to, and conceptualisation of self following MBCT, though future research may be able to demonstrate the extent to which this shift is necessary, sufficient, or on the other hand perhaps even relatively impotent, in bringing about clinical improvements as they are more traditionally evaluated. Either way, through means that do not shy away from addressing the admittedly elusive and abstract notion of self.

In emphasising this matter, and in pointing towards more specific areas for additional research, we may formulate a method with which to investigate a relationship between the underlying self-related change demonstrated here, and the empirically observed constructs found to be influential elsewhere in the propensity for MBCT to prevent depressive relapse. For example, the replication of findings around self-compassion and cognitive reactivity indicates that they are seemingly robust constructs in this regard, though what relationship do these content-focused mechanisms have with the context-focused understanding presented in this research? To explore this issue, it may be interesting to conduct explorative interviews with a subsection of participants taking part in randomised, controlled and empirical trials, in investigating the extent to which there is a association between i) the degree of endorsement for our explanatory scheme, and ii) positive change regards “known” change mechanisms. If our understanding here is thought to be necessary regards to the manifestation of content-based measurable change, we might hypothesise a positive correlation between i) shift in attachment to and relationship with self, and ii) empirical measures of self-compassion, or cognitive reactivity, for example (and as highlighted by Kuyken et al. 2010). This type of research would inevitably be helpful in elucidating the interplay of content and context with respect to MBCT.

4.12.2. The structure of MBCT programs

Furthermore, although many of these insights and self-developments appear to be experientially driven, as supported here regards MBCT (as well as in ACT and PBCT), there continues to be a question around potentially crucial intellectual components of such discovery - perhaps relating to the constructed nature of reality, for example – that seem (at least to some degree) implicit. Nonetheless, as has been described in some detail, MBCT has its roots in a wealth of literary and scholarly tradition relating to introspection and contemplation, and considering the apparent role of these principles in bringing about the change – intellectually speaking – in our findings, it may be possible to explore the effectiveness of a more discursive, philosophical or educative aspect within MBCT, or as an adjunct to the eight-week program. This is not to diminish the importance of the unique intensity of meditation practice offered (Lykins & Baer, 2009), but to consider potential advancements in the approach.
In expanding on this theme, it may be noted that participants alluded to a sense of discovery occurring within the interview itself, and indeed that the respondent validation summary represented a valuable tool in this continued process by which implicit change is seemingly brought to conscious attention, and embellished as a result (see appendix 5; participant 16). Again, this would appear to link with the Vygotskian component advocated in our discussion of PBCT, whereby a process of “radical collaboration” (within the Rogerian context of regard) can engender insight and understanding achieved through reflection on experience; an understanding perhaps elusive to the individual working alone. Subsequently, we might suggest that there exists a degree of change represented within our scheme, which is created by the opportunity to reflect openly during interview. In fact - and given the depth of insight and benefit described – a more widely available opportunity to engage in such collaborative reflection within the MBCT program may facilitate the occurrence of important self-related shifts that do perhaps not emerge otherwise, though this hypothesis is admittedly speculative.

4.12.3. Mindfulness, non-clinical samples and public health

To continue, it is perhaps worth commenting in more detail at this stage on the relative similarity in change described by clinical and non-clinical samples. As such, and consistent with the perspective advocated in mindful traditions, our societal tendency to address suffering at the point - or after - it becomes overwhelming, disabling and unmanageable (as is established diagnostically) should perhaps not preclude a commitment to the wider endorsement of mindfulness in non-clinical samples, as a philosophy and practice with which to experience inherent suffering. The intention here might be that dysfunctional styles of attachment to, identification with, and conceptualisation of selfhood (as described in our non-clinical sample) exist along a continuum, with our crude classifications of patient versus non-patient borne out of clinical necessity rather than objectivity.

Although the idea of preventative measures in this regard is possibly a public health concern, rather than an explicitly clinical one, a drive to increase the prominence of a more grounded and protective method of relating to our world - and ourselves - through mindfulness, would surely be worthy of implementation amongst schools and youth community groups. However, owing to the impossibility of an idealistic all-inclusive approach, it may nevertheless be feasible for access to be more widely available – perhaps through primary care – for those identified by professionals as being for some reason suitable, or vulnerable; thus in some respects mirroring (with the targeting of mindfulness) the concept of an At Risk Mental State (ARMS) within Early Intervention models of psychosis.
Finally, and in summary, we present findings from 21 participants for whom MBCT provoked fundamental changes in how they understand and relate to their sense of self. Our explanatory understanding both complements and extends existing empirical research showing changes in self-compassion (and cognitive reactivity) following MBCT, and is indicative that interventions such as MBCT have succeeded in assimilating mindfulness into western healthcare without sacrificing its historical emphasis on self-related change as an essential mechanism in alleviating suffering.


Mehr, B. (2002). Bias in qualitative research: Voices from an online classroom. The Qualitative Report, 7(1).


I: Could you start by telling me about your experience of MBCT and mindfulness in general?

P: Um...I was um...I wasn’t apprehensive, I was optimistic that it would offer something and um...you know, I’ve read a bit about mindfulness, a few books in the past, and just something that really, you know, touched me in some way and I think when I went to my GP to find out about some support and that was on offer I was really, pleased about that, um...however getting on, when I started the training it was really interesting that one of the main things was to drop all of your expectations, you know, and um...once you start...you know...having those expectations and they're not being met or anything, or all that, you know, like “I’m not getting this right” and it was like you know, that’s not what’s its about, that was kind of like, it took a bit of time once we started doing the practise to really relax into it ‘cause I think I did have hopes and expectations and um...but it made sense that the more you battle with those, the less it would work...

I: And what kind of expectations did you have, and were they similar to what you found?

P: Um...I guess I didn’t really know, I mean yeh I’d read what mindfulness was but it was actually, kind of not understanding...“well how is it going to work?” And not really understanding early on that “okay I’m here listening to a CD and doing some practise and being told to accept that thought and not push it away”. and it was like “okay I’m doing that” but how do you know then its working and actually...I think after a few weeks for me I started to feel some changes...in that...I, you know I suppose listening to the CD and doing the work, a lot of the language is about acceptance, being kind to yourself, focusing on the present, and I found myself quite early on driving along and...you know I could see myself going into that “oh got to do this, should’ve done that” and it was like “okay I’m going to do this”, and some of it just started to happen just naturally where I’m driving along and I just focus on things around me rather than going into that mental list of beating yourself up...like “you haven’t done this yet, or you haven’t...” you know, um...and, so yeh I think I would start to feel a few ripples but it was more, very small to start with it was just about me going about my daily business, and those moments tended to be when I was on my own, where um...nobody was really interacting with me or having an impact on me and I was just driving along and it was more about me and my mind...I think I started to find it a bit more challenging when other people...not interfere...that’s the wrong word, but when I was interacting with other people, because I think...you know, I could have these thoughts about “I should be doing this or that” but then I could focus on something else like my breathing...whereas I think when it was with someone else if I’d had an interaction that hadn’t gone well, then I’d still be thinking “oh they’re thinking that about me”, and then you have that to deal with, and so that, um...I found it harder then “cause it was like telling myself “okay think about this and breathe about that” but when I’d have a slightly negative, in my own mind, interaction with someone else, that would be bigger to deal with and to relate to mindfully, cos I would find it harder to be kind to myself in that situation, and I think that’s the whole reason why really I wanted to go for the therapy and the mindfulness in the first place, because of um...how much I can kind of, um, internalize other peoples reactions to me, or in situations and start being negative in myself, cos its like “not only have I got evidence but I’m also now taking their evidence” and so its like, so its harder...

I: And so you felt that you were quite vulnerable to the judgement of other people, or the perceived judgement of other people...

P: Yes, and so that, the mindfulness took a while to work into that area, and it was easier when it was just me you know, on my own really...’cause those areas I find more challenging in my life anyway...

I: And you mentioned that it took longer to have an impact on that area; did it impact that area at all?

P: Yes, um yes, I think...it started to ripple into other areas of my life...I’m a mother of two young boys and ‘cause they have been my work, really, I gave up work and had my sons and did some studying myself in between, but I gave up work really and my full time work then has largely been in looking after my two sons, um...that’s had...the challenges that have come with that is that I do beat myself up when things go wrong, and things happen a lot with children where they don’t behave the way you expect them to or want them to, or they’re unpredictable, or you can’t control for that, and so...that caused me some anxieties, and so, whilst I love it, when things don’t go right in my life
generally I get stressed, and so young boys, you know…fighting, squabbling, you know, knocking the cereal on the floor, you know just things that young boys do really…but caused me anxiety ‘cause you know “its not supposed to be like that, you know”.

I: Do you mean sort of criticism of yourself there?

P: Um, yeh I think a bit of both…self-criticism but also, yeh if you criticise yourself you can do the same to other people, so I would have high standards I suppose, and so I guess for example, if my youngest would refuse to put his shoes on in the morning and then make his older brother late for school, you know things like that would cause me a lot of stress, you know I’d get cross with them and then I’d beat myself up you know, and so the mindfulness gradually started to work into that area too ‘cause I’d start being kinder to myself, and more forgiving, then I was able to be more forgiving of others too, you know, not that they were kind of committing any crimes! Um, I’m not thinking about things in such a negative way…

I: And I guess that leads us onto, I mean, what was it about the mindfulness that allowed you to do that and to be kinder with yourself?

P: Um, I think the practise, you know that kind of “just keep reminding yourself, you know that’s a thought, just acknowledge and accept the thought and then come back to the breathing” and as I say you know initially it was hard to see how that would, you know, impact on you, and you cant really put your finger on it but it just does, and as I say I would generally kind of beat myself up and be really my worst critic, and it’s just sort of…”I’m getting it wrong and my minds wandering, I’m not breathing, um just wandering off…”

I: “This is just another thing that I’m getting wrong…”

P: Yeh absolutely, and after a while it was just like “well that’s okay, it's okay for your mind to wander, that’s what minds do”, you know repeating the mantras on some of the CDs and just reminding yourself to be kind to yourself and “I’m going to focus on my breath”, and so I was gradually able to do that in areas of my life, instead of so “here go the boys fighting again” or “my son isn’t getting ready”, I was just becoming more…just, more okay about those situations or not beating myself up and getting cross with them and myself…

I: And so you almost cut short the whole spiral…

P: Yes and I just started to feel much calmer, more inner calm than I’ve ever felt for a long time…

I: And you mentioned this tendency to beat yourself and up and be quite self-critical, did you know that that’s what you were doing before?

P: Oh yes…

I: So you’ve…

P: Oh yeh I’ve analysed myself for years. I actually trained as a counselor so you know, I’ve kind of, not wanting to sound big headed, so I do have a certain level of awareness and I have certain a certain amount of therapy, and so I can recognise when I’m doing it but I could never seem to stop myself and that’s why I wanted to come onto the mindfulness course cos I don’t think at the time I did start the course was hugely depressed or anxious, things were quite manageable in some ways, but I still felt despite that that I wanted to do it because that’s the tendency, that’s the default position, beating myself up if things don’t feel right, you know, and if things just start not going how I want them too, I would get stressed about that, and so…you know I wanted something to kind of help with that…

I: And with your background and experience, is there anything that you’ve learned about yourself through mindfulness?

P: It did make me realise how unkind to myself I’d been…definitely…um, and so yeh it did…you know, I kind of know I beat myself up but it was that kind of thinking that well “everybody beats themselves up” and actually “no not everybody does”, and so no it did…it did um…also um…in trying
to bring yourself back to the present it highlighted how much time I have spent in the past or the future and missed out on the present, and you know when you’ve got two young boys that makes me feel quite sad…you know I’ve probably spent time, you know, with them when I’m not with them at all…you know physically, but in my mind I should be doing this and that, and you know, “just be in the moment with your two lovely boys”, so it did highlight how much I wasn’t in the present before and you know I’m not always all the time, and it'll take years to keep cultivating this new way of being and it kind of highlighted that more than anything…

I: And I guess it’s a tendency that we all have to be in the future and past, and is there anything about mindfulness that helps you to focus on what you’re doing now, or what’s more important to you rather than this list of stuff as you mentioned at the start?

P: Its hard to put into words in a way, I think, um… it was just very subtle, you know, um…I suppose doing the whole breathing thing and the CDs and the meditation, it did just…as I say I felt calmer, it felt that…”it doesn’t matter if all these things aren’t ticked off the list”, you know, “there are only so many hours in the day, others things crop up”…and it kind of like again, “cause you’re training yourself to be kinder to yourself too, I was able to just think “it doesn’t matter, that doesn’t matter…”

I: And before all those things felt more important or…?

P: Yeh the kind of everyday anxieties that we have…

I: Yeh it kind of felt more…more well “that’s got to be done and if its not then you’ve failed” whereas now I’m thinking “oh well I didn’t do that so never mind, giving myself a break, and not beating myself up…”

I: And you mentioned inner calm, could you tell me a bit more about that?

P: Just not getting as wound up about things…I mean I still do, its not like a magic wand, its just like you know, not responding in the same way, not reacting as extremely to things when they haven’t gone right and therefore feeling less stressed and calmer…

I: I guess the interesting thing is that those things do seem really important and you can get caught up in the idea that “I have to” or “should” and what it is it that gives you the separation from that?

P: Um, I don’t know, that’s quite a, I’m not quite sure how to answer that…Its difficult to put into words as you said…and I’m not sure exactly what you mean…

I: Um, for example for myself at times, it’s easy at times to feel that there are inescapable obligations, or things that I “must” do…and that that comes in a way to define you…

P: Yes so like I’m defined by my job or that I’m a mum…um, I kind of know what you mean now but hard to put into words, um… I suppose um…I suppose some of it relates back to that whole failure thing, like, you know if you define yourself by something and that thing isn’t going well then you feel a failure, but if you, if you, not detach from it, but take that step back and think, one “its okay to make a mistake”, two, “this isn’t all of me, and the way I respond isn’t all of me”, and being kinder to myself in that way I suppose…and before I might have…when I’m being harsh to myself and something’s not gone right I suppose I catastrophise and that would then impact my perception of me and the situation…so if I’ve failed at something then I’m a failure at everything, and then there’s a negative spiral associated with that…do you know what I mean?

I: And yeh, it actually reminds me of what you said at the beginning about if an interaction with someone has gone badly, that idea of it clouding who you see yourself as and how you think of yourself… and so how do you see yourself now, if its not all this stuff you do, and not necessarily your interactions with others and so on, what is it that’s you?

P: I think, I do feel, as I say I feel kinder to myself, and um…I suppose I…before, I have been grappling with the idea that I’m a mum and I trained to be something before and I haven’t got there yet, and yeh…so feeling…um…feeling bad about that, feeling that…um…I should have been juggling both
things and I wasn’t and always feeling pulled in two directions and feeling I don’t want to work ‘cause I want to be a mum, but the feeling that “you should be ‘cause everyone does it” and feeling guilty too about not working…um…and now having the opportunity to work because my sons in school…grass is greener kind of thing…I think I was being really harsh on myself ‘cause yeh I did feel guilt when I wasn’t working cos I didn’t want to, but I felt there was pressure for me to go and work, but I lost my dad too a few years ago which knocked me off track…and you know, despite that I would still be laying it on…but I wouldn’t think “you finished training and then you had a son and then he went to school and then your father died”, I’d be like “everyone else's career is off the ground” and now I’m able to look at it like “well you made these decisions that you’re happy with and you wouldn’t change that, and you had a hard times”

I: And is it the kindness aspect, that allows you to do that, or…
P: Yeh, yes…

I: And in doing that are there still times when the old doubts creep in?

P: It’s there, still there, and I suppose the mindfulness, its not kind of like a cure, its more like a way of being, and so I think to…to kind of feel that you’ve…changed dramatically over a short period of time is unrealistic and its quite subtle but, um…I think the more you practise it the more you can keep being kind to yourself, you can keep acknowledging the thoughts rather than letting them stick too much, and I think that’s what I’m doing, and yes I have those self-doubt’s but through the practise and doing the short ones too, the three minute ones, and acknowledging the thoughts and just saying “bye” rather than it sticking is all helping…and all the negative thoughts do still appear but they’re not causing me to spiral anymore…in the depth that they were ‘cause I’m able to be kinder to myself, or meditate or do something to keep on top of it…

I: And you mentioned, before the spiral getting into full flow, to stop that process happening…now has that had any impact on the beliefs that you hold about yourself, has mindfulness had any impact on those self-beliefs or I guess the way that you hold those beliefs about yourself?

P: Um…I think yes, but again its again early days, I think…I’ve spent a lot of…a lot of my adult life thinking I’m a bad person…and…um…finding evidence for that…and…some of that often kind of what other people have said or done, and…you know, I suppose if you have those self doubts and you find evidence somewhere else that kind of confirms it…and I’ve battled with that a lot and I suppose I don’t think I’m such a bad person as I did, you know I might not um…have always pleased someone or something but does that make you a bad person…and some of it isn’t always what other people say, its my own comparisons that haven’t always been helpful…so like “why aren’t I like that?” or “why don’t I react in that way?” you know that kind of thing, and…”why I cant I be stronger”, and “why do I always get upset?”, so I think one I’m not thinking I’m as bad, and two I’m not comparing as much…

I: So almost two stages, perhaps in not having the tendency to compare or to criticise…perhaps impacts that more abstract belief that “I’m a bad person” as you describe, and what did you mean by that when you thought it…

P: Bad?

I: Yeh…

P: Um, let me think, it’s just a word I’ve got used to using in my mind I think…

I: And it can be really powerful I guess can’t it…just as that…

P: Yeh I don’t know why or when it stuck, um…but…well, you know without digging into my whole past, I am one of three siblings, and I kind of grew up when I was older, not as a child, and as I got older and had adult conversations with my parents, things would be retold, “oh well you know you were difficult or you were this” and so the labels have kind of been internalized. And I kind of like, I don’t think the person saying them probably even meant anything by it, or would have even thought that they could have had such an impact…but for some reason I’m very sensitive and they did, and so…I um…just and I think I compared myself to my sister who was very um…gentle and…um
compliant and never any trouble and I was more…um…more of a risk taker, more um…pushing the
boundaries with my parents and more challenging to them, and instead of them saying “you were more
challenging cos you knew what you wanted”, it was more like “oh you were difficult, and your older
sister wasn’t”…and so…

I: And you talked about how those labels can be internalized, and when did you get to the stage when
you thought “well this is a label, this a belief about myself…?”

P: Well I didn’t hear it really as a child…I can’t really remember that ever being said when I was
young, but, I don’t know…I just um…I suppose after lots of, well some therapy, I’m aware that um,
you know my behaviors at times may have been more attention seeking, but I’m aware that they would
have been for a reason, but I think its difficult cos you can start to be kinder to myself, and kind of say
well yes, I say to myself “I’m gonna shake this label off” you know “I reject this label”, its almost like
peeling the Velcro off, but sometimes the people around you don’t change…they still stick the label on
you, you know…

I: And that’s, it almost, its often something that’s not really accounted for, and its sounds like your
saying an individual can go through a process of change, but those around…

P: Well families, its beneficial for everyone to have their role and their label and…“you’re the gentle
one, and you’re the troublesome one, and you’re like this or that”… and these labels stick and people
want them to stay like that and that, and its easy for them to keep saying “that’s who you are” and
actually that’s not who I am, or that’s just how you perceive me to be…but its not who I am, and you
know I think, you know I turned 40 last year, and last summer, you know, I felt this big (makes
gesture) when I went to see my mum ‘cause she said something that made me feel like a small child
again, and you know I’m 40 and “stop implying that I’m whatever when I’m not, I’m an adult, I have a
family”, and you know um…that kind of thing, over the years, of “we wouldn’t expect anything else of
you” and those comments would just really penetrate me and be like a knife, and would really set me
back…

I: Its the same idea of labeling isn’t it, that someone’s has labeled you and it has become your own
label, and you mentioned you can’t just rip it off or shake it off, and what do you feel the role of
mindfulness is in making some change in that, or the quite rigid beliefs that you might have held about
yourself?

P: Yeh, I think its…partly, or a lot to do with compassion, you know and I suppose that’s at the core of
it with the stuff from the Buddhist kind of philosophy of mindfulness meditation based on compassion,
and I think that, I suppose, the more kind you can be to yourself, the less you’re going to be
internalizing other peoples negative views of you, you can say “okay that’s your opinion”…I'm being
kind to myself…

I: And what gives you that assuredness? Even, as you said, someone quite sensitive to other people’s
opinions, what gives you that safety and the assuredness to do that? Because I guess someone could
have said to you in therapy “well you just need to be kinder to yourself”…what do you feel it is that
makes people believe that?

P: Really interesting… I don’t know, you know. I know you have to believe it from within yourself,
and I’ve spent years people saying “you’re not like this”, or “don’t think that, you’re not useless”, but
you go away thinking…you know, you don’t believe it, and its got to come from within…I don’t know,
I, I don’t know…its hard to say how breathing and this kind of meditation jump over to that result of
being kinder to yourself, but I suppose um…a combination of the approach I suppose, that kind of
giving yourself…I suppose in doing the meditation you’re being kind to yourself already I suppose,
and in giving yourself that half an hour everyday where you try and, you know, become present and not
go into the negative thoughts and I suppose just the act of doing it is being kind ‘cause you’re allowing
yourself that space that you otherwise don’t have, and always rushing around you don’t just stop…your
mind races…

I: And in doing that I guess you know that’s time when you won’t be ticking things off the list and to
afford yourself that as you say is compassion itself…
P: And the whole...like the language on the CDs and the whole kind of um...cos what you’re doing when your doing it is...one, you’re allowing yourself that time, which is kind, two, you’re trying to accept the thoughts as they arise instead of denting them or pushing them away, so again you’re not fighting with them, you’re just letting them be, which is such a different way to experience them, and three, you’re then also saying “its okay to have a negative thought”, rather than fighting it and then coming back to the breathing, and as you...just kind of bringing yourself back to somewhere else and then you gradually start to accept that “okay that meditation practise didn’t go how I wanted, but that’s okay”...and so its like you’re gradually telling yourself that things are okay as they are and it is, and if things are okay as they are, and as it is, then you are okay as you are, and as it is, you know...so it’s a subtle shift but I think that’s it actually, in the training you’re accepting that things are as they are and you can’t change it, so you also come to accept that “I am okay as I am, and I don’t have to change, for anybody”...and that's acceptable and that’s okay...and I don’t think I ever thought that for a long time...

I: Which is really related to something you said at the start, that its very tempting to want to have control over everything, and I guess one of the things about mindfulness practise, that everything is always constantly changing, and perhaps as you say its accepting that “its okay as it is” that frees you from the battle I suppose, and you put that really nicely. And just finally I guess, the idea that rooted beliefs can be shaken slightly as you talked about, what kind of things are they replaced by in terms of what makes you who you are?

P: Um, so the labels I think, grew up with or...

I: Yeh so if they shift slightly or there’s more space, what are they replaced by...if its not these things that others have told you, then what are you able to be, or how do you think of yourself?

P: Yeh, well I suppose instead of thinking like “I’m a bad person cos so and so didn’t like that about your behaviour in growing up...so and so got angry at that or this and that makes you bad”, suppose I’m more able to think, “okay well we’re all unique and I’m only human and its okay to make mistakes”, um...and just that awareness of comparing yourself to others is so unhealthy, and with that in mind I think I’m more able to think “well you’re only human, you’re not a bad person you’re only human...”

I: And I guess you also mentioned that anything you do, as you mentioned earlier, or any kind of characteristic you have, is just part of you, um...and often other people can see you as only that, whereas its just as aspect of you, and I wonder whether, how do you see that idea of there being different bits of you as you talked about?

P: Well I’ve been aware of that for quite some time having done some study, but I didn’t really...it was that kind of “I’ve got the knowledge but its not how I feel”...I’m aware we’re configurations and we’re dynamic, or angry, or we’re this or that, or fun or jealous, but a lot of the time the types of labels that come up would be the more negative like ones...

I: And really interesting how you mention that you can know all that stuff, and I guess its easy to get into that trap of knowing something, and loads about yourself, but it not connecting with how you feel about yourself...

P: And yeh that’s why I wanted to do the course ‘cause I have read a lot of self help books, and just therapy books, and I read them and I go “yeh, I can relate to that and that, blah blah blah” and I’d go away and carry on those behaviours and those beliefs...I suppose it depends on the type of person you are, maybe it doesn’t work for all, but...kind of like, I like to have something more tangible, so doing the meditations and experiencing it...um...there’s something more about that that’s just really special...

I: Thank you so much, is there anything else you’d like to add?

P: No, I don’t think so, other than to say that actually it’s I think the most important thing I’ve ever done to help myself.
I: One thing you mentioned that I thought was really interesting was this idea that you are now more than just the negative elements of yourself, and I wondered whether you might be able to tell me a little more about that?

P: Well, I suppose really I mean that yeh, its that I was always before kind of like a glass half empty kind of person…and now I suppose I’m more able to see the positive parts, and that I’m not necessarily all negative either, like that stuff about being a bad person, you know, like…I don’t know…it’s very easy to start believing all that stuff about yourself you know, things that you’re told as a child and you internalize that but it’s a long process really I guess…and what it means I think is that I’m able to be kinder to myself at times when I can’t manage everything the way that I’d like to be able to…and also you know, kinder to other people, and I think about the boys again as we talked about before, you know, just an example, but how I can be kinder to them also if they’ve done something wrong because I’m also being kinder to myself…but the difficulty I suppose is that its always been my default position to be fairly self-critical and when certain things have been said to you in the past it becomes part of you and you kind of think “well if they said that then it must be true”…and mindfulness certainly kind of helps with that in that the compassionate part of me is a little easier to find…

I: That’s really interesting, “the compassionate part of me” being easier to find, what do you mean by that?

P: Well…I suppose, I guess even though you have these quite negative thoughts about yourself…and beliefs…you know on some level I suppose that you’re a good person cause everyone’s a good person and no one can be born bad and all that, but like I said my default position has always been to be critical, so in a way…in the past it hasn’t really mattered that I’ve had that compassionate part, cause its so dominated…you know, its always there cause I’m a caring person…I really think…but its not really been at the fore of who I am…I don’t know, does that make sense? And with the mindfulness I suppose it helps me to bring that in…it sort of helps with my long-term tendencies, which definitely are to tap in to that critical rather than compassionate part…if you see what I mean?

I: Yes absolutely, that makes a lot of sense…almost as if its been much more difficult for that compassionate part of you to grow and be given space…

P: Yeh…and I think to some extent that’s happening now…but still it can be really easy to become critical again and yeh so its definitely something that I need to carry on with and practise…and I think that idea of it being a part of me, the compassionate and kind part…you know, I guess its like there are some times when that part is kind of less available, so for example if I’m really really stressed out, or not maybe unavailable, you know, but certainly a bit more of a struggle to find…

I: Yeh, and actually those ideas around being kinder and more compassionate with yourself, I wondered what that feels like, that process? How does it actually feel to be doing that? Does it feel authentic and genuine at that moment?

P: Um…I can do, but also at the same time it can be a bit of a struggle…you know, just again…it’s not something that I’ve been used to for most of my life and so you know, my default again being critical, so it can be an effort sometimes…you know but that’s cause its such early days with it…and actually one thing I really notice is that the more I’m doing the mindfulness practise the less of a struggle it is and so I really do know that this is something that its important for me to keep up with…and a little more difficult at the moment because I’m actually working more that I did at that time when I was doing the group and so…you know, just finding the time again can be…but yeh that kindness and that compassion its not something that comes entirely naturally to me, but its definitely something that is coming more and more naturally…the more and more I remind myself of those messages, and the more the I don’t get caught in those thoughts I have about myself and what I should have done…

I: Yeh, and it certainly sounds like this is something you’re continuing to put a lot of dedication into, and I’m pleased to hear that it is beginning to feel more natural, that process of being kinder to yourself…and I wondered what that felt like…perhaps how that feels in your body?

P: Um…I think…you know…it makes me feel a lot lighter, when it clicks it’s a weight off…I mean its harder at some times than others…but it calms me, the tension goes from my stomach cause I’m
reminded that it’s okay, and I’m only human, and yeh I’m worrying, but that’s alright too…sometimes that’s what my mind does…and also you know this thing about my labels, things people have told me in the past…you know…these things feel really…they feel so true but they’re not, and so when I can be kind to myself I feel the pressure off, cos I realise that it’s something that I can do…and it makes me feel, yeh, I think it makes me feel a lot calmer…

I: And, I wonder, what part of you is it that is able to give that kindness or compassion?

P: Well its that compassionate side, that is getting better at coming out I suppose, but it still has to be forced at times and I’m hoping that, like I said…it will become something more natural, and maybe even something more automatic, but I know I need to keep up with the practise and also just give it time too I suppose, you know it’s a long thing I guess and I’m still only just, you know…

I: Absolutely, I think that’s a really important, and just finally…you know, it sounds like you’re almost accumulating and practising instances of when you’re more compassionate side being able to grow and be influential…I wonder does that impact your view of those labels that came from your childhood?

P: Yeh I think it does really, yeh actually, cause you know those things were really stuck in childhood, and later to cause, well…but you know…it’s definitely a work in progress and its important to keep on thinking about that I think…and keep these messages in my head, cause you know, even this conversation now just refreshes things and you get clarity and yeh…so definitely a work in progress but I guess like I said that kindness if I’m able to show it to myself takes the pressure off, makes me feel lighter…and whether or not it will ever happen I would like I guess there to be…or I suppose I’m working towards something where that’s a more natural part of me and maybe something that just happens…

I: Thank you.
Appendix 2: Information and consent sheet

Does Mindfulness Based Cognitive Therapy Change How We Think about Ourselves?

We would like to invite you to take part in a research project that forms part of a Doctorate in Clinical Psychology qualification. This document is designed to give you some information about the study, detailing what we hope to achieve, why we believe the research to be important, and what your involvement, should you wish to take part, would entail. You are welcome to take your time in coming to a decision, and please do not hesitate to contact us with any queries, or to request further information.

What is the Purpose of Our Study?
In the past ten years or so much of the focus of clinicians and researchers in the field of depression has been on trying to develop new ways of protecting against relapse. The most successful program in doing this has been Mindfulness Based Cognitive Therapy (MBCT), which combines aspects of Cognitive Behavioural Therapy with meditation training. MBCT has been shown in clinical trials to significantly reduce relapse rates.

What we really want to know is more about how it works. There has been some research into what makes MBCT successful, showing for example that it can increase self-compassion, or make people better at spotting mood changes early. Whilst we agree that these changes are very important, we also have a particular interest in possible wider changes in how people see themselves.

One of the reasons for this is that the ancient traditions from which mindfulness approaches come have a significant focus on how meditation influences a person’s sense of self. The more we can understand about how MBCT works, the more we can refine it and improve its effectiveness.

Why Have I Been Chosen?
You have been chosen because you have been referred and accepted to take part in Mindfulness Based Cognitive Therapy, a group for people who have a history of experiencing relapse in depression.

Do I Have to Take Part?
Absolutely not, the decision regarding whether or not to take part is entirely yours. We would also like to make it clear that should you choose not to be involved, this decision will in no way impact upon your membership of the MBCT group, or your care either now or in the future.
**What Will Happen to Me if I Take Part?**

If you choose to take part in the study we request that you bring the consent form to your first MBCT session, where you will be given two questionnaires to complete prior to start of session two. In total, these measures should take no more than 20 minutes to fill in. This process will be repeated after the eighth and final MBCT session. Following this, you will be invited to take part in an interview to explore your experience of MBCT, which will last approximately one hour and take place at the Institute of Psychiatry. Having completed the questionnaires you are in no way obliged to be involved in the interview phase, which should be conducted within six weeks of your last MBCT group. Information about payment for your involvement is detailed below.

**Expenses and Payments**

Participants who complete the questionnaire measures will receive £10, whilst those who also take part in the interview will be paid a further £20 for their involvement. The two questionnaire measures should take no more than a combined 20 minutes to complete, and the interview will take no more than one hour.

**What Are the Possible Disadvantages, Risks or Side-Effects of Taking Part?**

This study will ask participants to complete two questionnaires before and after the MBCT group, and also take part in an interview relating to your experiences. As such, no apparent health risks are associated. However, if at any point the questionnaires or interview lead to feelings of discomfort or distress, you are free to withdraw as described above, and you are also welcome to contact the Chief Investigator (Mr. Sunil Nandha) or the supervisors (Professor Paul Chadwick and Dr. Janet Wingrove) to discuss these issues further, if you so wish.

**What Are the Possible Benefits of Taking Part?**

We hope that participants who choose to take part in the semi-structured interview process will value the opportunity to reflect on and consolidate their experience and learning during the MBCT programme. In this respect, we hope that the interview will complement your involvement in the MBCT course, which will by that point have come to an end.

**What Will Happen if I Do Not Want to Carry On With The Study?**

If you do choose to take part, but then change your mind during the process, you are free to withdraw at any point and without giving a reason. In this event, any information that you may already have provided will not be used, unless consent has been given.

If you decide to complete the pen and paper tasks but would prefer not to be interviewed then your involvement in the study will come to an end once the post-MBCT measures are filled in after the last session. The full aims and objectives of the study will then be explained to you and you will have the opportunity to ask any questions at this point. You will also receive a copy of the final report.

**What if there is a Problem?**

If at any point during your involvement in the study you experience concerns about aspects of our study you are welcome to contact the researchers, Mr. Sunil Nandha, Professor Paul Chadwick and Dr. Janet Wingrove. If you remain dissatisfied and wish to make a formal complaint, this can be done through the NHS Complaints Procedure (please see contact details below.

Compensation for harm arising from accidental injury as a result of your participation in our research will be covered by the Institute of Psychiatry, Kings College London.
Will my Taking Part in the Study be Kept Confidential?
All data collected during the course of our research will be kept strictly confidential, and any information you provide will have your name and other personal details removed so that no individual can be recognised. All questionnaires will be stored in a locked filing cabinet accessible only to the researchers, and interview recordings will be stored on a secure password protected memory stick.

What Will Happen to the Data Collected For this Study?
The anonymous data will be analysed at the Institute of Psychiatry, Kings College London. The questionnaire data will be coded and the interviews will be transcribed and interpreted in the eventual aim of producing a final report. In this report we may wish to include direct quotations from people who have taken part, and where this is the case a pseudonym will be used.

What Will Happen to the Results of this Study?
The research project should be complete by May 2011, and if possible our findings will be published. If you choose to take part, you will receive a written summary of the final report. None of the individual questionnaires will be published, and no individual will be identifiable.

Who Has Reviewed the Study?
This study has been approved by the South East London Research Ethics Committee 4 (approval reference 11/L0/0072), and also the Kings College London Research and Development Office (approval reference R&D2011/057).

Contact Details
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We wish to thank you for taking the time to read this information sheet, and if you have any queries please do not hesitate to contact us.
Research Project:
Does Mindfulness Based Cognitive Therapy Change How We Think about Ourselves?

Chief Investigator:
Mr. Sunil Nandha (Clinical Psychologist in Training, Institute of Psychiatry)

Co-Investigators:
Professor Paul Chadwick (Professor of Clinical Psychology, Institute of Psychiatry) and Dr. Janet Wingrove (Clinical Director, Southwark Psychological Therapies Service).

Please read the following statements and then initial the box on the right.

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

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

3. I understand that relevant sections of my medical notes and data collected during the study may be looked at by the named researchers from the Institute of Psychiatry where this is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

4. I understand that should I take part in the interview phase, a selection of my quotations may be used in the final research report, though these will be anonymised and will not be identifiable as mine.

5. I have had the opportunity to ask questions. The researcher has explained the project and has answered any questions honestly and fully.

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

Name of Participant:    Date:   Signed:
………………………………….  ……………..  …………………..

Name of Person Taking Consent:    Date:   Signed:
………………………………….  ……………..  …………………..
Appendix 3: Photographic example of “diagramming” in Grounded Theory
Our Emerging Theory

Phase 1

Realising How I am Constructed and Controlled

Getting to Know My Experience

Knowing Myself Differently

Phase 2

Phase 3
What do we mean by this?

The diagram above illustrates some of the ideas that have come out of our interviews. We've tried to take the common elements from what people have talked about, and put them together in making a model of the kind of change that seems to take place through mindfulness.

**Stage 1: Realising How I am Constructed and Controlled**

Having started meditating, it seems that the first stage of change seems to be in seeing more clearly “who I think I am”. In doing so people begin to notice some of the ways that they have been defining themselves in the past—often quite concretely—and as a result limiting themselves. Often these very strong ideas we have about ourselves seem to have a big impact on how we react emotionally and also how we behave. It seems that people come to get a better grasp of ideas that they have always had about themselves, which are often things we were never even aware of before.

**Stage 2: Getting to Know my Experience**

Following from stage one, it seems that people have noticed a tendency to be more mindful in everyday life too. For example being “in the moment” rather than always thinking about the past or future. It seems here that rather than our experience being guided by what we think we are, we are more able to pay attention to what is actually there—both in our minds and in the world around us. In doing so, it appears that we can start to notice the chains of events that lead us to act and react in certain ways—whether they are thoughts, desires, urges, and emotions etc. In observing these mindfully, it seems that we have more control over what we do and what we believe. We can start to practice new ways of responding, new ways of being, and a different way to think about who we are.

**Stage 3: Knowing Myself Differently**

Having come to see some of the ideas about us that had been getting in the way, and in using mindfulness to notice how our behaviour is guided and getting more in touch with ourselves and with the world, it seems that people then feel less defined, less stuck, and with a more flexible idea of who they are and what they can do. Part of this seems to be finding it easier to treat yourself with compassion or respect, while people have also talked about being more able to recognise the things in life that are most important to them. Overall, there seems to be a sense that people are better placed to decide who they are and who they would like to be no longer so defined by strict ideas about who they used to be, or who they should be. The key idea here might be that what I am cannot be defined by my thoughts or my behaviour, as I'm something more than that.

From what people have told us it seems that this is a process stages 1-3 that does not necessarily have a strict order. It seems that a person might move from one stage to the next and then back again, for example getting to know their experience and starting to treat themselves differently (stages 2 and 3), yet still becoming more aware of the beliefs they used to build about themselves (stage 1). Because of this, although the change following mindfulness would seem to be a process that moves from left to right generally speaking, this seems to be something that happens in quite a complex way and over some time.

We would greatly appreciate your feedback on our understanding so far, and if you would like to take part in this stage of the research please reply via email to the following three questions:

1. Does it make sense?
2. Does it fit with your experience?
3. Is there anything important that seems to be missing?
Appendix 5: Responses to the respondent validation phase

Participant 1:

“Yes, this does make sense to me, I like the ways it’s a simple way of explaining something that’s actually quite complicated!

It fits pretty well with my experience, especially how it dynamic as you said, and that you can keep going back to the first two phases as I think that’s something that’s really important in my experience.

Can’t think of anything missing - I think you’ve covered it!”

Participant 2:

“Yes, it completely makes sense and I particularly agree with the idea that this is a circular process, with an ‘unclear’ starting point, at least in my experience.

Yes, it fits with my experience. However, I think I particularly started with stage 2 by noticing my thoughts, feelings, needs etc. (‘everyday’ thoughts – like automatic thoughts etc.), then moving to knowing myself as a person (stage 3) and then finally realising that I also have thoughts on how I think I am...the stories I have about myself, my worries, my weaknesses and the limits I set to myself, and how these are also thoughts and not necessarily the truth, so back to stage 2 and then 3 (what to do about these thoughts), in a sort of cycle. I guess, through mindfulness this could change from a vicious to a virtuous cycle. Oh, anyway, it’s beneficial to be aware of this cycle happening, in the moment.

I don’t think there are bits missing. Perhaps arrows from stage 3 to 1? To make it as a circle?”

Participant 4:

“Each process seems to make sense in their own right; however, the process did not necessarily follow a sequential order for me. Given where I was psychologically and emotionally at the beginning of practicing mindfulness, I think it was easier for me to start at Phase 2, whereby I needed to spend some time making contact with what I was experiencing at the time and realising that for awhile I had been pushing this experience away. This led on to further exploration around Phase 1, where I was able to reflect more on how my past experience and situation was impacting on how I was engaging with the world at present. For me, these Phases were somewhat more protracted than Phase 3, which I felt really was the end point of finding my way through Phase 1 and 2. By the end, I felt in more contact with myself in the ‘now’ rather hanging on to rigid and inflexible ideas of who I am, was or will be. This has allowed me to have a more compassionate approach towards myself day to day, as in turn re-focus my priorities. I don’t feel that there is anything missing, as it is a flexible model, which acknowledges that trajectories may be different for different people. I was able to locate different parts of my own experience in each of the Phases.”

Participant 5:

“I have answered all 3 together but some daylight between the 3 questions should be clear. Please let me know if you need me to separate the responses out- this would not be a problem at all.

As someone who participated in your research and who also practices mindfulness, the model makes sense. Phase one appears to be a sound way of representing a mindful awareness. As you write, this is not just the start of mindful practice but an ongoing part of practice, which fits with my own experience. It is interesting that the results show that people learn how they have been defining themselves (phase 1) as well as being more mindful of everyday life (phase 2). My experience is that a mindful awareness helps me notice the thoughts (helpful and unhelpful) that I might act on daily which include fairly surface level
ideas and perhaps occasionally those which are more emotionally entrenched representations of who I believe I am. I suppose that people define themselves at different levels/depths and so this fits well with your model. That is, to highlight that mindful awareness assists people notice aspects of themselves at different emotional levels/depths thus representing the true complexity of the self. My experience is that the noticing of everyday life comes before noticing deeper aspects of the self. Your model accounts for this because you acknowledge that the phases are not linear or strict in their order of experience. My own experience is one of phase 2 before phase 1. With reference to phase 3 I would say that mindfulness better places me to notice things the way they are, without a need for change or difference. If I think of who I would like to be then I would be likely to experience this as outside the philosophy or practice of my mindfulness and at the same time it is something to be noticed. Mindfulness practice helps me simply be, less influenced by thoughts or behaviour, and therefore as you have found, more flexible and less influenced by what has happened or by what I may anticipate.”

Participant 6:

“Yes this all makes sense to me.

This does fit with my experience. Once I take a detached stance to my experiences in the moment I see that I am much more than the sum total of my experiences. I see it as different experiences stepping onto the spotlight of consciousness and I can taking a curious stance toward whatever character has just taken centre stage because I’m just an audience member. By taking such a detached stance, as though observing a play, it has allowed me choose my course of action in that moment independently of any thoughts and beliefs that I am aware of, which are really just experiences and not “me”. It has also allowed me some freedom from certain self-limiting beliefs of which I had previously been unaware but had been implicitly treating like facts. This has then led on to more flexibility in which I can act in line with the sort of person I would like to be, i.e., choosing my course of action in life in the broader sense.

Sometimes taking a detached stance strips experiences of their context and their “affordances” and I end up seeing everyday objects with more salience, like a new-born would. But this doesn’t happen very often.”

Participant 8:

“Does it make sense?

Yes it does

Does it fit with your experience?

Yes, particularly seeing thoughts and emotions as states rather than as reality, and being more aware of self-criticism etc. It’s not so much that it’s made me think I’m more than that but more that it’s made me feel less defined by those things, and that things are constantly changing.

Is there anything important that seems to be missing?

No I don’t think so”

Participant 14:

“Nice to hear from you again, hope you're well.

I think your slides summarise the process very well. I can only speak for myself and for me it was pretty much the ‘classic’ case of stage 1 > stage 2 > stage 3.

I do still very much enjoy my mindfulness practice and have noticed an improvement in my mental and physical health.
Good luck for your further work.”

Participant 16:

“Thank you for giving me the opportunity to share my thoughts and experiences I had with the Mindfulness group exercises! I thought the report was easy to understand and very clear to the points we discussed! All three stages of the Mindfulness exercises are spot on, it’s taught me to see & enjoy the present without the shadow of the past and what’s coming in the future! I felt everything we discussed are in the report and I can’t see anything missing from the report!

It was very nice to share my experiences with you as I hope the Mindfulness groups will continue to get funding and help others with the up-sets I experienced, enabling them to see the light at the end of the tunnel like it has to me!

Thank you for sending this to me, now I can read it every now & again to recap of what I went through and not to fall back into the dark hole again!”

Participant 18:

“I hope you are well. It was really nice to meet you for the interview, and thank you for sending me the results from your project, its very interesting to read and I'm glad I had the chance to be part of this! Here are my answers to your questions:

1) I understand what is meant by this and yes it makes sense and is quite simple and easy to follow in your diagram

2) The way you've explained it is a good fit with what I got from mindfulness, and I think sometimes that all the bits of the diagram actually happen at the same time, but its nice to have them written out separately so

3) I don't think there is anything that I would like to add.

Thanks again, and I hope everything goes well with the rest of your work.”

Participant 19:

“It is nice to hear from you again, and thank you for the email that you sent me. I am still doing the mindfulness, and it is really helping with my music I think. I told you about this in the interview and now I am being mindful all the time when I improvise so I don't miss anything in the moment - I hope it shows when I play! Your diagram does make sense, and I really like the part about how I can know myself differently. I think its still me so differently is a nice way of saying it. I wish you good luck with the rest of your project and I can say that there is nothing that you have missed in explaining things from when we did the interview. I will keep this with me and read sometimes as it is a good way of reminding myself of how important this is for me.

Thank you.”

Participant 21:

“Thanks very much for sending through the results of your research. I can say that yes it makes complete sense and does fit exactly with my experience - I think its really caught it, especially also the fact that its not necessarily a fixed linear progression but that you can move between stages. The last stage also implies that we can move outside our notions of ourselves and operate differently in the world.

A concrete example for me is that I have set up recently a poetry writing workshop and am able to undertake planning and delivering it with far greater degree of anxiety and more enjoyment because I can see my previous patterns and to an extent let them go so that anxiety does not overwhelm me, nor my desire for perfection! Its good enough and because
I am relaxed it is working really well! Its such a joy to feel able to be in the world differently - its not that it has gone away but that I have a tool bag to deal with it and when the anxiety comes I can, much better, manage it.

Good luck with the research and if I can be of any further help I am happy for you to be in touch.”
Service Evaluation Project

An Evaluation of Client Satisfaction with Psychology Reports

Developmental Neuropsychiatry Team, Michael Rutter Centre for Children and Young People

Supervised by:
Dr Maxine Sinclair
Abstract

This audit sought to investigate the quality of psychology reports produced by the Neurodevelopmental Psychiatry Team at the Michael Rutter Centre, as perceived by carers of children and young people seen for assessment. Our predominant focus was on the extent to which reports were considered comprehensible, valuable, and appropriate in terms of style, material and length, as well as whether or not advice and recommendations were feasible in terms of implementation. Furthermore, three specific areas of potential modification were explored: the integration of psychology and psychiatry reports, the inclusion of a “child friendly” version, and the placing of our assessment summary.

A postal method was employed, and a novel questionnaire measure developed; incorporating a total of 14 items in addition to requesting qualitative written response, from a sample size of N=20. Results are quantitatively presented in terms of satisfaction scores, and qualitatively with regards to themes emerging from carers’ additional comments.

Overall, the audit found 89.5% of feedback to be either “positive” or “relatively positive”, whilst particular encouragement was found for the development of child friendly reports, though dependent on the client’s age and other characteristics. Other themes emerging emphasised the value of support in implementing recommendations, the importance of feedback consultation meetings, and the role of effective administration in facilitating communication between service users and clinicians. Both service related and clinical implications are considered and summarised.
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1. Introduction

1.1. Neurodevelopmental disorders: ADHD

ADHD is one of the most commonly diagnosed childhood psychiatric disorders, with prevalence rates generally estimated at 3-5% (Hinshaw, 1994). ADHD is defined in diagnostic terms as being characterised by pervasive and functionally impairing i) inattention, ii) hyperactivity, and iii) impulsivity, generally split into sub-lists: a) inattention and b) hyperactivity/impulsivity according to DSM-IV (APA, 1994), though the often culture-bound subjectivity sometimes associated with diagnostic classification means that prevalence estimates have been as low as 1% (Bird, 2002) and as high as 20% (Faraone et al., 2003) in school aged children (see also Polanczyk et al., 2007 for systematic review).

ADHD is highly comorbid with a range of associated difficulties, encompassing mood disorders, conduct, oppositionality, interpersonal effectiveness and educational achievement (Fredman, 2001) - as well as other cognitive difficulties relating in particular to language and executive function - meaning that diagnosis, treatment and long term management becomes a societal public health concern as well as a requirement for the affected individual (Milberger et al., 1995). Though the term ADHD is a commonly used and widely recognised in the UK, it does not appear in the World Health Organisation’s classificatory system, with the ICD-10 equivalent diagnosis being Hyperkinetic Disorder (HKD, F.90).

1.1.2. Assessment in ADHD

An assessment for ADHD is generally triggered in the event that a child presents with marked behavioural inattention, hyperactivity and impulsivity, and/or demonstrates otherwise unaccounted for academic underachievement or behavioural problems. Assessment requires information to be gained from parents/guardians and the child’s school (preferably a classroom teacher or teaching assistant that knows the child well) regarding the manifestation of core symptoms across settings, as well as data regarding onset age, duration and level of functional impairment (American Academy of Paediatrics, 2000), as well as from the child themselves. Diagnosis of ADHD is dependent on the child meeting criteria outlined in the DSM-IV (1994), or ICD-10. As discussed above, the DSM-IV identifies three ADHD subtypes – i) inattentive, ii) hyperactive-impulsive and iii) combined, whilst symptoms must be present in two or more settings, as well as having a detrimental impact on functioning. A final criterion here is that symptoms must be considered inconsistent with the child’s developmental age. Crucially, in cases where behavioural symptoms of ADHD are present, but the child shows no evidence of
impaired functioning, there are no grounds for diagnosis (American Academy of Paediatrics, 2000).

In terms of direct child evaluation, psychometric assessment broadly investigates general cognitive ability, achievement, memory, language, and executive function, thus allowing clinicians to determine the extent to which behaviour can be considered out of keeping with the child’s developmental age. The Wechsler Intelligence Scale for Children (WISC-IV) is a method of measuring general intelligence and later interpreting findings for consistency with expected ADHD score profiles, whilst the Wechsler Individual Achievement Test (WIAT-II) gives measures of real-world performance. Accordingly, the clinician will look for ability-attainment discrepancies, as well as exploring whether or not performance appears to be a function of the need for sustained attention on a task, for example. Overall the worth of neuropsychological assessment – in addition to the psychometric information produced - is that it offers the clinician an opportunity to observe the child’s styles of interaction, problem solving and learning.

In the present service, the assessment process typically takes place over a single day, and provides the developmental context within which to understand the behavioural phenotype demonstrated by the child. If we consider this in terms of diagnostic axis, cognitive assessment offers a developmental context (axis III), within which our clinical problem, or behavioural presentation (axis I) can be more fully and accurately interpreted. Further, and consistent with the National Service Framework (NSF) for children, it contributes to a holistic profile of the child; revealing strengths to potentially be built upon as well as difficulties that form the focus of change.

1.1.3. Intervention in ADHD

Interventions in ADHD typically take multimodal form, with a premium placed on recognising the importance of education (and the maximisation of potential educational achievement) as a particularly influential protective factor. In this context, the worth of cognitive assessment can be recognised both in terms of its utility in identifying treatment factors pertaining to health and education, but also as an outcome measure with which to assess effectiveness.

A comprehensive intervention for ADHD would encompass psychological and behavioural treatment as well as the prescription of psychostimulant medication, though initially these approaches were likely to exist relatively independently (Jensen et al., 2001). In 1997 the NIMH sponsored a multimodal treatment study of children with ADHD (Hinshaw et al., 1997), with the aim of ascertaining which interventions, or combinations of interventions were most
efficacious in the long-term management of ADHD. The trial found that long term combination treatments – e.g. methylphenidate plus psychosocial behaviour therapy – as well as medication management alone, were more successful in reducing symptomology than psychological/behavioural approaches as stand alone interventions. There was no significant difference between the medication management and combined groups (Hinshaw et al., 2007).

To continue, symptom reduction being understandably impotent if it does not produce meaningful functional change; there were additional variables such as anxiety experienced, academic performance, oppositionality, parent child relations and social skills that are either implicitly or explicitly targeted by the psychological/behavioural components of combined treatments. Where the need for diagnosis is a reflection of distress and impairment rather than symptomology per se, the MTA trial (Hinshaw et al., 1997) demonstrated that this impairment is perhaps most effectively addressed from a multimodal perspective. Furthermore, the study also found greater client satisfaction in the combined group – 71% versus 32% in the medication only arm. Resultantly, extensive behavioural/psychological recommendations are now commonplace alongside psychostimulant use, a key consideration subsequently being the extent to which these changes can realistically and consistently be implemented at home and at school (Plizka, 2003).

In terms of treatment targets, despite ADHD symptomology being primary, there are inevitably secondary targets that equate more readily to general well-being. For example Klykylo & Kay (2005) discuss the extent to which intelligence, good rapport, improved working habits and perceived competence in extra-curricular activities are protective in terms of the social and educational impairment associated with ADHD, and with this in mind, the advice and recommendations stemming from neuropsychological assessment can be productive in facilitating the child’s broader progression with respect to these factors.

In terms of NICE guidance, the distinction is made between school aged children and young people experiencing moderate ADHD and impairment, and those with severe symptomology. In the moderate population, drug treatment is not recommended as first line, with parental education and individual CBT/social skills training preferred, particularly for adolescents, as well as more holistic behavioural adaptation across settings. Pharmacological interventions are considered appropriate first line treatments in the more severe sample, or in cases where behavioural approaches have been unsuccessful.
1.2. Client satisfaction

Pascoe (1983) defines client satisfaction as the “recipients reaction to the context, process, and result of their service experience”, and this is considered an important and influential variable in predicting treatment outcome, premature termination and acceptability of new programs and service recommendations (Chao et al., 2004), as well as assessing client views of both psychological services and administrative procedures. As discussed in relation to the MTA trial (Hinshaw et al., 1997), many authors have suggested that client satisfaction be given greater significance in the evaluation of clinical practice (Heppner et al., 2001), and also a broader significance – encompassing clinical contact of course, but also the wider service context such as administrative staff and so on, as is discussed later in the present report. Eklund & Hansson (2001) state that clinicians should be concerned with the “overall atmosphere” of mental health settings, whilst a more specific target would be canvassing views on the format, technique and effects of treatment received, as the most subjective measure of outcome (Eyberg, 1993).

Despite symptom reduction being the most traditional measure of efficacy, we cannot always assume that there is absolute correlation between symptom change and well-being, or diminished impairment. Certainly, the relationship may not be causal, and as such it can be important to reconsider our clinical targets, or at least adopt a broader perspective on change. As is illustrated in the MTA study (Hinshaw et al., 1997), additional variables are crucial in analysis of ADHD treatment/assessment, and particularly in the context of the increasing need to demonstrate clinical effectiveness, client satisfaction becomes a vital component of outcome assessment (Plante, Crouchman and Diaz, 1995), and perhaps at least on a par with our more traditional methods of evaluation (Ware et al., 1983). Either way, client satisfaction appears to be both “a stand alone construct and a component of treatment quality” (Heidegger et al., 2006).

An accurate measure of consumer satisfaction also forms an integral part of developing strategies for service improvement (Gill & White, 2008), as well as performance monitoring, quality control and facilitating broader policy change (Aharony & Strasser, 1993). Where service improvement is concerned, an emphasis on changes being “consumer led” (Boyer et al., 2006) fits with the prevailing ethos of the patient rights movement (Williams, 1994), whereby the perspectives of those who’s views may differ from individuals employed in clinical and service management positions are adequately accounted for and represented. With respect to child and adolescent provisions, the parent/guardian standpoint may represent the best route to utilising consumer opinion, especially considering the role they have in terms of the child’s attendance, motivation, compliance and implementation of recommendations, and within the context of the aforementioned potential for satisfaction mediating intervention and outcome (Pendleton & Hasler, 1983).
However, it would be equally foolhardy to assume that client satisfaction equates absolutely to outcome or change, and research into how these variables correlate has typically found moderate effects sizes (e.g. Brestan et al., 1999). An interesting aside to this finding was that the key link appears to exist between satisfaction and degree of change, rather than satisfaction and an arbitrary level of symptomology (even where this may constitute less “disorder”), which would seem to make sense.

1.2.1. Measuring satisfaction

Perhaps the most widely used method of service evaluation and client satisfaction is through the use of self-report questionnaires, and the various factors that impact upon satisfaction mean that multifactorial measures are required. However, the majority of research into the area is focused on satisfaction with longer-term treatment, whereas our concern is that with assessment, and a relatively specific and specialist assessment at that. The differences here, and our decision to create a novel and service specific measure are discussed in more detail later. In broad terms, Brestan (1999) states that overall satisfaction can be a function of that with i) degree of change, ii) assessment procedures and iii) the clinician, and thus the analysis of this study would pertain to all three, but perhaps most prominently points ii and iii.

Generally, satisfaction is measured using generic tools – for instance the Therapy Attitude Inventory (TAI) (Brestan et al., 1999), or the Client Satisfaction Questionnaire (Larsen et al., 1979). In addition, satisfaction can be a property measured at different levels of conceptual analysis, as described by Fawcett (1991), whereby the distinction is made between macro and micro. Macro analysis concerns the view of treatment as a whole, whereas micro analysis investigates individual treatment elements such as intake, report produced, communication of material etc., the implication being that a balance of the two is vital for holistic evaluation, and evaluation – particularly in combined treatments – where the overall judgement does not obscure micro level successes or failures within (Kazdin, 1996).

1.3. Report writing and communication of complex psychological/psychiatric material

Groth-Marnat & Horvarth (2005) describe psychological report writing as a process of “interpreting the referral question, test selection, case conceptualisation, theoretical orientation, interview, interpretation of test scores, integrating sources of information, prioritising the most salient aspects, and selection of the best means of presentation”. Within this process there are inevitably controversies, and here we will focus primarily on those associated with client perceived acceptability.
Regarding report length, Donders (2001) found the average psychological report to be between five and seven single spaced pages, though one study found evaluations to be between one and 54 pages (Horvarth et al., 2000). Though some authors emphasise the importance of succinct presentations with immediately recognisable implications (Stout & Cook, 1999), others advocate, or at least appreciate the worth of, detailed accounts of patient history, behavioural observations, full description of test results and thorough recommendations, and overall the sense is that clinicians should be aware of the rationale for various report lengths, and also have the flexibility to decide what is required in individual cases (Groth-Marnat & Horvarth, 2005).

In terms of readability Brenner (2003) identifies this as a problem area within psychological assessment, particularly where clients, parents and school staff are concerned, and use of jargon was found to be the most frequent complaint in previous satisfaction studies (Harvey, 1997), with this being attributed to clinician training that prioritises test scores above more subjective measures and overall context. Specifically in terms of assessment feedback report readability, Pope (1992) emphasises the importance of using language that is clear, and relating the data to examples particular to the client for ease of understanding.

Inclusion of test scores is a further consideration particularly pertinent to the current report, and a topic of much debate (Akerman, 2006). Freides (1993) mentions the importance of including scores, in that they allow criticism of the clinician’s interpretations, and also objective comparison at a date of reassessment. However, Groth-Marnat & Horvarth (2005) discuss the pitfalls, for instance the misinterpretation of scores by non-professionals, but also the importance that individual scores exist within the context of behavioural and emotional information that was available to the assessing clinician at the time.

Overall, Groth-Marnat & Horvarth (2005) recommend a thorough and integrated report wherever possible, whereby results are framed with appropriate consideration of the assessment context, the client’s background and the referral question, this subsequently representing an accessible reminder of assessment findings for the client, and their parents/guardians (Lewak & Hogan, 2003).

1.4. Service-user involvement in psychology

Client satisfaction research and the use of its findings in modifying provision represent an important part of the umbrella term “service user involvement” (SUI) in healthcare (Thornicroft & Tansella, 2005). SUI is increasingly becoming a central part of mental health service evaluation (Chamberlain, 2005), and with respect to the present study, the recent emphasis on SUI in clinical practice (Hart et al., 2005) and treatment monitoring (Lehmann, 2005) are
particularly relevant, as is the focus of Thornicroft and Tansella (1999) on effectiveness, accessibility and comprehensiveness regarding client contact and communication. The overriding principle is that those whom mental health provision is designed to serve, and who have the alternative perspective of being recipients of care, can offer “distinctive insights into the long-term effects” of treatment (Rose et al., 2003), and insights that should be maximized in terms of their contribution and influence over service development.

2. The Service Issue: Motivation for Audit

The present project is designed to investigate client satisfaction with the service provided by the Developmental Neuropsychiatry Team at the Michael Rutter Centre for Children and Young People. The team delivers comprehensive assessment reports detailing reason for referral, background, developmental history, parental and educational perspectives, psychometric outcomes and behavioural observations in producing rationale for diagnosis as well as recommendations for management and intervention. As discussed above, the nature of assessment is a complex task, usually undertaken over a relatively short period of time, and one where the resulting assessment information and implications must be communicated concisely, understandably and sensitively to professionals and lay people alike. For reasons discussed, the client’s perspective on the assessment process and its implications is of paramount concern, and broadly speaking the particular motivation for this audit is to explore the extent to which recipients are satisfied with the care that was delivered, and particularly their views on the final report disseminated.

In this regard, and considering the extent of influence that parental views potentially have on the efficacy of child and adolescent interventions (Pendleton & Hasler, 1983), as well as the imperative being with carers to implement behavioural recommendations in particular, it was deemed appropriate that our investigation would solely target the views of parents/guardians, and their perspective. Furthermore, the assessment report produced at present was thought to be beyond the level of understanding for the vast majority of children seen within the service, though for this reason the possibility of creating child-friendly versions forms a part of our study.

A further motivation for audit was the recognition of ADHD as being a disorder where - perhaps more than many others - psychology and psychiatry come together, yet still hold rather distinct philosophical principles – particularly with regard to ideas around symptom reduction versus functional impairment, perhaps. Where preferred intervention is routinely a combination of the medical and the psychological/behavioural - as illustrated in the MTA trial (Hinshaw et
al., 1997) - the task of our service is to present these perspectives to service users as a single coherent vision, at once understandable, acceptable and meaningful. Once again, the way in which information is communicated via assessment reports is a crucial factor in this process.

3. Aims and Objectives

With respect to the distinction made between macro and micro analysis (Fawcett, 1991), our objective was to achieve a balance of the two – looking at carer satisfaction with feedback reports at a general level, but also with respect to specific elements – for example the potential inclusion of a child friendly report, report length, implementation of recommendations etc. Our objective as a service was to canvass the views of those who use the service, with the eventual aim of using this information in guiding the development of how future assessment feedback reports are produced and disseminated.

Despite the availability of generic satisfaction questionnaires as discussed, a further aim was to design a novel measure to take into account idiosyncratic concerns of this particular National and Specialist service, and in doing so to incorporate items that have been previously highlighted in one way or another – either by managers, clinicians or service users – as being areas for possible improvement. Certainly, the feedback report represents a lasting and influential document in a child’s care both now and in the future, and whilst our reports have a traditional structure and tone that has been in place for some time, we recognise the importance of investigating it’s acceptability and effectiveness in the eyes of service users.

More specifically, our objective was to investigate the acceptability of the present report format with a range of questions, but also to explore views on potential changes that have been in mind – for example i) the integration of psychology and psychiatry reports, ii) the inclusion of a child friendly report and iii) structural change in terms of the report summary being presented first.

4. Methodology

4.1. Design

The present evaluation was a cross-sectional questionnaire based study using mixed methods. Data is primarily quantitative – relating to responses on a four-point scale, whilst participants were offered the opportunity to provide written qualitative feedback in more general terms.
4.2. The Neurodevelopmental Psychiatry Team, Michael Rutter Centre

The Neuropsychiatry Clinic provides a service of comprehensive neuropsychological assessment and recommendations for intervention, often targeted at individuals, families, schools and social contexts. The aim of the service is to administer, trial and develop methods of assessment and intervention, primarily in ADHD but also Autism Spectrum Disorders. Our service aims to meet the needs of young people below the age of 18, who have either a suspected or diagnosed neuropsychiatric disorder, commonly experiencing symptoms of inattention, impulsivity and overactivity. This National and Specialist service primarily accepts national referrals, often in cases where a second opinion is required, and commonly with the aim of disseminating treatment advice and recommendations back to Tier 3 CAMHS.

4.3. Population

The current sample was recruited from a series of outpatients seen for assessment between January 2009 and January 2011, all of which were aged between 4 and 17 years. Parents/guardians of children and young people referred to the service were sent questionnaires and letters requesting their participation. This period of time was selected as it was felt that those clients seen by the service more than two years previously may have difficulty in recalling their experience, and in addition, the current report format had been in place for approximately this length of time. Furthermore, in the period between March and July 2011, the questionnaire was sent out to families of newly referred children alongside the feedback report, in an effort to maximise the sample size.

4.4. Sample

An initial 80 questionnaires were sent out, of which 12 were returned. Following a reminder letter, a further four were received, and this combined with four completed questionnaires from currently referred children made an eventual sample size of 20 participants. Owing to an anonymous response system, we are unable to be specific regarding sample demographics of those whose data is included in the present report. The postal questionnaire method was used with the intention of providing a means by which to gather objective and subjective information relating to feedback reports, and issues around this method – specifically with respect to response rates – are addressed in the discussion section.

4.5. Measures

As mentioned, the rationale for creating a novel measure was to account for areas of investigation pertaining to the needs of this particular service. The questionnaire consists of items that have been suggested as areas for consideration by managers, clinicians and service
users in the past – commonly on an individual basis – and thus a tool made up of these elements allows us to give service users a voice in deciding whether or not these recommendations are adopted as a matter of course for feedback reports received by future clients. In addition it is hoped that once created, the questionnaire can be re-employed within the service at a later date to monitor satisfaction relating to changes made as a result of this evaluation, as is recommended in terms of audit cycle.

The questionnaire consists of 13 items to be rated on a four point scale, and broadly speaking, these items can be subdivided into two categories: i) quality control and monitoring and ii) feedback report development. As such 10 items (questions 1-8, 10 and 13) relate to client satisfaction with the feedback and reports as they received following assessment, investigating issues such as length, comprehensibility, accuracy etc., and three items (questions 9, 11 and 12) relate to topics that have been highlighted as potential areas for change, either by clinicians or service users on an individual basis. Finally, we decided to include an open ended written section allowing the opportunity to raise issues not explored in the questionnaire, as well as incorporating space for additional comments under each question. A final questionnaire sample and cover letter can be seen in Appendix 1.

4.6. Ethical approval

Ethical approval for the study was granted by the South London and Maudsley (SLaM) CAMHS Clinical Governance Committee on 27th September 2010, details of which are available in appendix 2.

4.7. Procedure

Having discussed the service issue within the Neurodevelopmental Team, the decision was made to engage in service user involvement through measuring client satisfaction with psychology feedback reports. In choosing that this effort should be one of both evaluating current practice and looking towards report modification, the key points for investigation were formulated, and a questionnaire constructed as discussed.

This material was then sent out to a database of Neurodevelopmental Team referrals from the past two years, each of which was invited to complete the measure and return in a freepost envelope. Six weeks later, a reminder letter was sent to the same families (appendix 3). Having received 16 responses, we were keen to reach a sample of 20, and therefore began to include the questionnaire and cover letter with feedback reports for current families.
Data was then collated into a single database and grouped by question in order to produce the descriptive statistics to follow. The qualitative responses were arranged according to relevant themes, and are presented as such in the results section, whilst full quotations can be found in appendix 4.

5. Results

5.1. Descriptive statistics

The quantitative questionnaire results are presented below in two ways. Firstly there is a question-by-question breakdown of responses for each item, along with additional comments provided. Secondly, the answers as a whole are collated and presented in terms of the proportion of positive versus negative feedback, thus again taking into consideration principles of macro and micro analysis (Fawcett, 1991). A completed questionnaire sample can be seen in appendix 1.

For each of the 13 questions a table illustrates the frequency of answers on a four-point scale, from one – “not at all” to four – “absolutely”, whilst two represents “to some extent”, and three “mostly”. Figures reported are percentages of responses.

**Question 1:**  *Was the report as a whole understandable?*

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Additional comments

- “The psychometric sections required some explanation”
- “Everything was clearly explained in the feedback session”
- “The commentary and advice was understandable”

Overall 55% of respondents considered the report as a whole to be “absolutely” understandable, while a further 40% rated “mostly” and 5% “to some extent”. Additional comments indicate that the psychometric section perhaps requires the most explanation (specifically suggested by 4/20 respondents), but it would appear that broadly speaking the report is accessible and comprehensible for clients, particularly in the context of having had a formal feedback session where difficult concepts can be discussed and explained in person.
Question 2: *Were there any specific parts of the report that were particularly difficult to understand?*

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<td>50%</td>
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**Additional comments**

- “Whenever I was unsure the clinician took time and explained in more detail or in layman’s terms”
- “Sum of scaled scores to composite scores conversion was difficult to understand”
- “Some of the results were a bit complicated and took some time to understand. Maybe this bit could have been a bit simpler”

In terms of comprehensibility of specific parts of the report, although 50% of respondents felt that this was not an issue, a further 45% stated that “to some extent” certain elements were difficult to understand, with 5% rating this question as “mostly”. Once again, the additional comments highlight the importance of the routine face-to-face feedback consultation, and with regards to particular areas of our report, the psychometric section was again highlighted as “complicated” and “difficult to understand” – with one client mentioning the conversion of scaled scores to composite figures.

Question 3: *Did you feel that the language used in the report was appropriate, and free enough of medical and psychological jargon?*

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<td>0%</td>
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**Additional comments**

- “I understand that sometimes medical and psychological jargon has to be used, but it was broken down by the clinician and explained.”
- “Again, the results bit was tricky at first.”

With respect to the use of medical and psychological language, whilst 35% of respondents did not feel that this was an issue, 55% rated the report as “mostly” appropriate, and 10% as appropriate “to some extent”. Additional comments again highlight topics raised earlier – firstly the value of feedback consultation when working with complex concepts, and secondly the terms in which psychometric results are presented.
Question 4:  *Were the results of the psychometric test explained in a way that made sense?*

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Additional comments

- “I found it a little difficult to understand the written report although most of the report was explained to us during the last consultation.”
- “I had to read the report several times to understand the psychometric tests. For example it might be useful to know practically what the block design is at it was referred to several times.”

Having already been highlighted as a key consideration in previous questionnaire items, 25% of parents/guardians rated the psychometric results as having been explained in a way that made sense, with 55% choosing “mostly” and a further 20% “to some extent”. Although a consultation meeting was again raised as important, a further point in terms of additional comments was that scores may have been more meaningful had carers known what each subtest entails, and also that the report had to be read “several times” in relation to this section.

Question 5:  *Were the recommendations provided useful?*

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<td>5%</td>
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Additional comments

None received.

In relation to the worth of recommendations provided, 60% of carers rated them as “absolutely” being useful, with 10%, 15% and 5% finding them “mostly”, “to some extent” and “not at all” useful respectively. As there were no additional comments offered here, it is difficult to ascertain the reasons for the combined 25% of respondents who answered “not at all” and “to some extent”. For instance, this could be a result of recommendations deemed inappropriate on the one hand, or appropriate but difficult to implement on the other.
**Question 6:** Have you implemented any of the recommendations suggested in our report?

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<td>5%</td>
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Additional comments

- “I have but school have not yet, but I know my daughter has got a statement coming and they will have to take on board what you have said.”
- “The recommendations enable us to support my daughter and teach her new ways of approaching her difficulties. It gave her the chance to achieve and continues to do so.”
- “It’s very soon after the report was received but we will still be implementing it.”

Following from question 6, the issue of implementation is a crucial consequence of our reports, and here 55% of respondents had “absolutely” been able to implement at least one suggestion, with a combined 40% for “to some extent” and “mostly” and finally 5% for “not at all”. In terms of additional comments, positive feedback detailed the way in which our recommendations allow children to achieve within the context of their difficulties, though one carer highlighted difficulties in making changes across settings – identifying school in particular.

**Question 7:** Was the report too short?

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<td>95%</td>
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Additional comments

None received.

Overall, 95% of parents/guardians did not feel that the report was too short, with 5% rating “to some extent”. Considering the comprehensiveness of reports produced – typically of around 15 pages - this was an unsurprising finding.

**Question 8:** Was the report too long?

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Additional comments

- “I think it was adequate for the current situation.”
- “Was reasonable to the extent of the problem”

In terms of the report being too long, 80% felt that this was “not at all” the case, with the remaining 20% answering “to some extent”. Additional comments detailed above suggest that in the context of the particular issues at hand, the length of report disseminated was “reasonable” and “adequate”.

**Question 9:** Would you have preferred the summary section to be at the beginning of the report, rather than towards the end?

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Additional comments

- “Doesn’t matter either way - we read it all the way through”
75% of recipients did not feel that the summary section should be placed at the beginning of the report, whilst 5% thought this “to some extent”, 10% “mostly” and 10% “absolutely”. This was considered an important consideration considering the ease of understanding implications within a shorter period of time, though there would appear to be a degree of ambivalence here on the part of clients, who as one parent stated in the additional comments are understandably likely to read the entire report anyway.

**Question 10:** Did you feel that the report you received was a fair and accurate assessment of your child’s difficulties?

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Additional comments

- “It made the things that were difficult to understand make sense. It helped us to understand what we need to do to help, in order to make everything better for us as a family as well as for my daughter.”
- “I do believe X does have some sort of cyclical mood disorder so in a sense I disagree with the assessment given”
- “They got some details in the report wrong”
Although the majority of respondents - 70% - considered the report to be “absolutely” a fair and accurate representation, a further 30% believed this to be the case only “to some extent” or mostly”. In cases where the report was seen as a reliable and valid reflection of difficulty, additional comments mention discuss the value in aiding understanding, and the resultant implications for positive action, though other carers were inclined to disagree with diagnostic conclusions, or find errors in report details.

**Question 11:** *Would you rather that the medical and psychological reports were integrated into one single report?*

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**Additional comments**

- “I think it was easier to read and understand when they are separated, as the two reports are different but correlated.”
- “No, separate reports are helpful as not all agencies need to know personal history of the family.”
- “Yes. Because self-injurious behaviour is linked in my son's case with a gastric disorder”
- “No preference”

We have discussed the extent of co-working between psychology and psychiatry within the Neurodevelopmental Team previously in this report, and with regards to the potential for integrating the currently separate reports produced by these disciplines, 40% of clients did not feel that this would be preferable, whilst another 50% felt that it would be “to some extent” or “mostly”. Finally, 10% of respondents were of the opinion that a combined report would “absolutely” be beneficial. In the additional comments, parents/guardians highlighted the advantages of having distinct reports – stating that this makes the information easier to read and understand, and also that separate reports allow for only certain information to be sent to agencies who need not necessarily receive all the assessment information. Once again, it would appear however that in certain circumstances – perhaps particularly where behavioural difficulties are explicitly caused by medical complaints – an integrated report would be welcomed.
Question 12: *Do you feel that you would like to receive an adapted version of the report for your child?*

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Additional comments

- “Depending on what an adapted version is.”
- “My daughter was in secondary school when assessed. I think sometimes it might help for her to have a report to relate to.”
- “I am struggling to explain the report to my son in a way he’ll understand, so an adapted version would be really helpful.”
- “X was too young”

Whilst 45% of carers would “not at all” have liked to have received a child-friendly version of the report, 10% would have appreciated this “to some extent”, and the remaining 40% would “absolutely” found this beneficial. In terms of the additional comments made, one parent described “struggling to explain the report” to her son, whilst another felt that for her daughter of secondary school age a specially designed version would be helpful to “relate to”. The results appear to be somewhat divided (45% “not at all” versus 40% “absolutely”), and in the light of one carer’s comment that her child was “too young” to warrant their own version, one wonders whether those parents advocating the receipt of adapted reports are more predominantly those with children in the higher age bracket seen in clinic.

Question 13: *Did our report meet your expectations of the kind of feedback that our service would provide?*

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Additional comments

- “Everything, to have a service that was and still is supportive of her needs is fantastic - the therapy through to medication has allowed my daughter to see and have a future, which I think she thought at one time was not possible.”
- “In some ways, it would be helpful to be able to read the report prior to the feedback session, to be able to digest it. I had loads of questions the day after!”

Overall, 55% of respondents found our service to provide feedback that met their expectations, whilst a further 40% found this to be the case “mostly”. The final 5% stated that expectations
were “not at all” met. In the additional comments, one parent was enthusiastic regarding the new perspective offered on her daughter’s future, whilst another, relating again to the importance of the feedback consultation, suggested that receiving the report prior to this meeting would allow time for specific questions – which may be difficult to formulate in the consultation context – to be asked.

5.1.1. Summary of quantitative feedback

*Figure 1* (below) illustrates the proportions of positive versus negative questionnaire responses. For example in positively phrased question such as “was the report as a whole understandable?” 4 would represent a “positive” response, 3 “relatively positive”, 2 “relatively negative”, and 1 “negative”, with the scoring reversed for negatively phrased questions. This section omits data from questions 9, 11 and 12 as these items pertain to issues of preference rather than quality/acceptability.

![Pie Chart Key: 1= “Positive”, 2= “Relatively Positive, 3= “Relatively Negative”, 4= “Negative”](image)

As is demonstrated above, 58% of responses received were clearly positive, with a further 31.5% relatively positive. 9% were relatively negative, with 1.5% clearly negative. Overall, 89.5% of quantitative questionnaire answers relating to the feedback reports were either positive or relatively positive.

5.2. Qualitative themes

**Question 14:** *Finally, we would appreciate if you could use the space below to make any further comments regarding the quality of our reports, pertaining to any of the questions above, or indeed anything that we have not mentioned. We are also happy to receive your suggestions and*
Each participant was invited to offer their written views, and these responses are detailed fully in Appendix 4. Below is a summary of the perspectives offered, subdivided into relevant themes.

**Implementing recommendations in an educational setting**

The implementation of suggestions by other agencies - particular education authorities – was an issue raised in comments 1, 2 and 5; one carer saying that recommendations had been “ignored or reinterpreted” (1) by the LEA, and again this links to the importance of instigating change across settings, and also the extent to which expert recommendations are ideally stated in specific and clear terms, so as to avoid the risk of misinterpretation. However, another parent/guardian wrote of how the LEA had been receptive in “taking on board” (2) suggestions, and was thankful that their child’s need for a statement had been recognised as a result.

**Implementing recommendations at home**

One carer (13) found that although the recommendations were sensible and appropriate, they had been “difficult to make a reality”, and again this alludes to a potential divide between theoretical worth and practical usefulness. This particular respondent suggests that a longer term follow up session would be helpful in terms of monitoring the implementation of change, as well as an opportunity to seek further advice around this issue.

**The psychometric report of results**

Following on from responses offered within the main body of the questionnaire, some concerns regarding the psychometric presentation were mirrored in qualitative feedback. One respondent makes the point that “carers do not always understand the language” (3), whilst this was echoed by another carer who found difficulty in interpreting elements of “medical jargon” (9). Both of these respondents make a suggestion for future reports whereby the neuropsychological test results are discussed “point by point” (3 and 9), rather than in a single “verbal explanation” (9).

**Feedback consultation meetings**

As discussed in relation to the questionnaire responses as a whole, the value of face-to-face feedback consultation meetings was recognised by many carers, though qualitative feedback identified two respondents (8 and 9) who highlight possible changes in format, at least in specific circumstances. One parent describes how her son was “perplexed” at the consultation,
and would have preferred him not to be present as she had been left feeling “unable to comment fully” (8), whilst another repeated a point made earlier whereby receipt of the report beforehand would give parents time to formulate questions that often come to mind the day after (9).

**Administrative and communicative issues**

One carer (10) had the unfortunate experience of contacting the service to confirm a follow-up session for her 16 year old child and being told that the service only caters for the needs of those below that age, understandably finding this fairly frustrating, whilst another parent describes a catalogue of administrative complaints (12) relating to phone messages and report delays in particular, before concluding that “admin needs a massive shake up”. This again relates to literature discussed earlier in terms of taking a holistic view of services, and regarding this response (12), despite stating that the “assessment was great”, it is clear to see the detrimental impact that disturbance elsewhere in the process can cause.

**Other: diagnostic disagreement and report errors**

There are two other relatively specific complaints made with regards to diagnostic disagreement (7), and report errors (11). One carer felt that our assessment had likely produced an incorrect diagnosis, whilst another noted that the report contained the incorrect child’s name. Despite the obvious distress associated, it would appear that these issues are particular to the extent that they inevitably become difficult to discuss or address within the context of a wider evaluation of service. Nevertheless they represent an important reminder of occasions where service users have voiced marked dissatisfaction with elements of their care.

**Positive feedback**

Respondents offered a range of positive feedback relating to the care they received in their contact with the Neurodevelopmental team, regarding various aspects such as the nature of the feedback reports (3, 9, 11 and 15), support offered (6 and 11), the assessment itself (12), information for other professional agencies (5), recommendations made (13) and aid in gaining an educational statement (2).

**6. Discussion**

**6.1. Summary of findings**

**Current report format satisfaction**

Overall, the findings above suggest that the current structure, format and content of the psychology feedback report is broadly speaking acceptable, useful and understandable in the
eyes of parents/guardians, with 89.5% of questionnaire feedback either positive or relatively positive. Nevertheless, there inevitably exist areas for potential improvement, one in particular being the communication of psychometric test results – which questionnaire and written feedback indicates as a topic of difficulty for some.

Despite previous concerns regarding the length of reports, 80% of respondents did not consider this to be an issue, though there were a section of participants who felt that psychological and medical jargon could have been minimised – 65% answering either “to some extent” or “mostly” when asked if the report was appropriately free of such terminology. In addition, 90% of carers felt that the report constituted a fair and accurate representation either “absolutely” or “mostly”.

In terms of usefulness and implementation of recommendations made, although again the majority of carers reported having been successful in this regard, 20% had been only “to some extent” and 5% “not at all”. Written responses here alluded to some difficulty in achieving and maintaining these modifications, particularly when attempting to do so across home and educational settings, and one suggestion was that a longer-term follow up might be valuable in terms of troubleshooting, although the nature of this National and Specialist team entails that the longer term facilitation of change a task is traditionally and understandably undertaken by local services.

**Views on potential modifications**

Regarding the routine production of a child friendly report and whether carers would value this, opinion was fairly divided (45% “absolutely” and 40% “not at all”), though an important consideration here can be made in the light of written responses. One parent in favour spoke of how her secondary school age daughter would have appreciated such a point of reference, whereas another, not in favour, commented that her son was “too young”. In terms of future development in this respect, the child’s age may be the deciding factor.

In terms of whether or not to integrate psychology and psychiatry assessments into a single feedback report, only 20% of respondents were either “mostly” or “absolutely” in favour of this potential change, citing ease of understanding as a reason for retaining the current format, as well as the notion that separate reports allow greater flexibility in terms of specific areas of communication with agencies who need not necessarily receive full medical and psychological detail.

Finally, regarding the issue of whether recipients felt that the summary section should open the report, 75% of respondents answered that this would “not at all” have been their preference, and
although 10% responded “absolutely”, the results understandably make it difficult to advocate routine change of format here.

**Other**
Written feedback produced important insights both in elaborating on questionnaire items, and in identifying issues that had not been raised. Of those issues not discussed in a) and b), the importance of effective administration/communication and also the value of in-person feedback consultations were highlighted.

6.2. Clinical implications and recommendations

**Child-friendly report**
It would appear from our findings that a child friendly version of the psychology report would be welcomed by a large portion of carers, though not all, whilst there is some indication that parents/guardians of adolescents rather than younger children were more likely to be in favour. In an attempt to meet the needs of those who would find this valuable, a recommendation would be to offer the option of a child friendly report at assessment, and allow families to make this decision. Furthermore, it may be prudent to develop different styles of adaptation; for example predominantly picture-based for the younger age group, and perhaps simply worded written summaries for older children and adolescents, though considering vast differences in ability, understanding and functioning, age alone may not be a sufficient variable.

**Integration of reports**
Although this was seen as a preference for a small group of respondents, the majority felt that the existing format of separate psychology and psychiatry reports carried valuable benefits relating to ease of understanding and communication of information with other agencies. Resultantly, it would be recommended that the current format be retained.

**Placing of the report summary**
Again, despite a percentage of carers choosing that having the summary at the beginning would be an advantage, the majority did not advocate this. Therefore it is recommended that the present structure and order of contents remain unchanged.

**Report length**
Despite previous concerns regarding report length, our findings demonstrate that within this particular National and Specialist context carers appreciate the comprehensive nature of feedback. Accordingly, the recommendation here is that reports continue to value thoroughness
over brevity, though whilst keeping in mind the principles of flexibility and succinctness where possible, as is discussed by Groth-Marnat & Horvath (2005).

**Presentation of psychometric results**

Presentation and ease of understanding regarding psychometric results represented the main area of concern highlighted by parents/guardians. It would appear that the concepts involved are often somewhat confusing for families, particularly some time after the very helpful face-to-face feedback consultation. As a result, two carers suggested that results be explained “point-by-point” in an effort to break down more abstract sections of text. An additional suggestion was that the report contain some description of what each neuropsychological subtest practically entails, thus making the figures more accessible. As such, it is recommended that each report now incorporate a generic appendix detailing subtest descriptions and examples.

**Support in implementing recommendations**

A prominent theme for carers was a difficulty in implementing recommendations at home and at school. In educational settings, it would appear that the importance of making specific and consistent changes might not always be appreciated, whilst one parent identified misinterpretation and reinterpretation as obstacles where other agencies are concerned. As a result, it is proposed that all recommendations should be operationalized as far as possible – broken into precise steps where they can be - and with the avoidance of ambiguity in terms of language used.

Regarding the task of implementing change at home, it has been suggested that despite the immediate usefulness and sense of our recommendations, they can be difficult to keep in place over longer periods of time. Despite this not being the case for all respondents, it is recommended that where possible, and in cases where it is deemed appropriate – perhaps owing to particularly complex family circumstances – a longer term follow up session is offered to monitor progress and facilitate troubleshooting.

**Feedback consultation meetings**

Several respondents highlighted these consultations as a crucial feature of their time with the service, at once being a source of comfort and reassurance, and a method of making the report itself more accessible. Stemming from our findings however, recommendations for the future would be that carers are given an explicit choice regarding whether or not their child attends this meeting, and that the report be available for review before the feedback date. Alternatively, and where it is felt necessary that the young person be present at the consultation, it is recommended that the parent/guardian be offered the opportunity to speak to clinicians without having the child in attendance.
6.3. Service implications and recommendations

On-going emphasis on client satisfaction
With regards to the important interplay of consumer choice and client satisfaction, it is recommended that any changes made as a result of this report be once again evaluated in terms of satisfaction, and directions for further investigation are discussed later in this report. In doing so, the service must continually be mindful of the dual tasks of meeting specific needs, whilst also producing generic report and feedback standards, meaning that individual preferences inevitably cannot always be accounted for.

The importance of effective administration
The impact of effective administration on clients’ perspective of services is perhaps an undervalued component, and certainly one that was not explicitly recognised a priori in this evaluation. This perhaps links to the literature discussed previously on taking a more holistic view of service efficacy (Chao & Metcalfe, 2004), and as administration within the team was in a period of transition during the course of this study, it is recommended that future audit incorporate this broader view of contact with our service pertaining not only to the clinical domain.

Difficulties in deciding upon report style/standards
With carers discussing the receipt of reports by schools, education authorities, other agencies, and parents/guardians themselves, clearly we have a complex task of producing a single document in balancing the differing requirements and expectations associated. Perhaps as a result, our approach has traditionally been to be as thorough and inclusive as possible with information, and this would appear to be an effective strategy in meeting the needs of all concerned. Overall then, it is recommended that this focus on exhaustive assessment feedback proceed, but again with the caveat that room for flexibility is retained.

6.4. Methodological criticisms

Measuring child satisfaction
There are various methodological limitations to our approach, firstly that we do not include a measure of satisfaction completed by children. Although this is inevitably difficult when assessing the quality of our written reports, future service research may choose to look at how children experienced the assessment day, as well as evaluating changes made as a result of this project, particularly where children and young people are specifically targeted – for example their satisfaction with child-friendly reports, should these be produced. Without this consideration, we may be in danger of the type of error discussed by Shapiro et al. (1997), where it is irrationally presumed that young people cannot contribute meaningful data.
**Sample size and generalisability**

In addition, we also have a fairly small sample size meaning that our data, and the conclusions drawn may not necessarily be representative of the general feeling among all carers, thus impacting generalizability (Armstrong et al., 1992). The overall return rate of 16/80 (including responses following reminder letter, but not data received from present referrals) equates to 20%, which is similar to the 25.4% found in an RCT aimed at investigating postal survey response rates (Harrison & Cock, 2004), though they report that there is no agreed standard for expected response, dependant as rates are on questionnaire length, topic etc.

**Questionnaire design and service-user involvement**

Finally, in line with the principles of service user involvement (Thornicroft & Tansella, 2005), it may have been beneficial to include the views of carers more explicitly in the questionnaire development phase. Although the final measure incorporated perspectives mentioned by parents on an individual basis – for example the placing of the summary section and the comprehensibility of psychometric results – a more systematic emphasis on sharing this task would represent the important goal of involving service users at different levels of the evaluation process (Thornicroft & Tansella, 2005). This method of contextualising our data may also have been helpful in terms of addressing perhaps the key difficulty in designing a novel measure – that there exists no normative data or point of comparison, though it is hoped that elements of the questionnaire can be used in repeat audit, with the present results representing a baseline.

**6.5. Feedback to service**

The findings, recommendations, and areas of further investigation produced by the present service evaluation study were fed back to the Neurodevelopmental Psychiatry Team, as was the report itself.

**6.6. Areas for further audit**

It would be important to evaluate the impact of changes made as a result of this investigation on future client satisfaction, for example to explore reaction to the production of child-friendly reports. In doing so the service may also be able to address some of the methodological issues raised, in for example assessing the satisfaction of young people who receive these new reports.

As discussed, one of the key difficulties the service faces is in producing a single feedback report that meets the various needs of families, referrers, educational services and others. Subsequently, the satisfaction of other agencies with our report represents an important area to evaluate, and in addition to canvassing the views of referrers, the findings of this audit would

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suggest that - with implementation of recommendations across settings a particular concern –
efficacy may be improved were we to have more information from schools regarding
perceptions of our feedback.

Though there are specific areas for further audit above, more general recommendations for
investigation based on this study would be to take an increasingly holistic view where possible,
for example in exploring satisfaction with the service as a whole, including points of contact
such as administration, and also to liaise with service users more comprehensively, in both the
planning and execution phases of service related research.
7. References


Appendix 1: Sample Response Questionnaire

**PSYCHOLOGY REPORT FEEDBACK QUESTIONNAIRE**

Underneath each question is a choice of four possible responses, followed by space for further comments. Please circle the option that you feel is most appropriate, and then feel free to make any additional comments.

1. Was the report as a whole understandable?

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Comments: Everything was clearly explained in the feedback session.

2. Were there any specific parts of the report that were particularly difficult to understand?

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Comments: Anything I was unsure about the clinician took some and explained in more detail in layman's terms.

3. Did you feel that the language used in the report was appropriate, and free enough of medical and psychological jargon?

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Comments: I understood that sometimes medical and psychological jargon has to be used, but it was broken down by the clinician and explained.
4. Were the results of the psychometric tests explained in a way that made sense?

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Comments:

5. Were the recommendations provided useful?

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Comments:

6. Have you implemented any of the recommendations suggested in our report?

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Comments: the recommendations enabled us to support my daughter’s new ways of approaching her difficulties. It gave her the chance to achieve what continues to do so.

7. Was the report too short?

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Comments:
8. Was the report too long?

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Comments:

9. Would you have preferred for the summary section to have been at the beginning of the report, rather than towards the end?

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Comments:

10. Did you feel that the report you received was a fair and accurate assessment of your child’s difficulties?

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Comments: It made the things that were difficult to understand make sense. Helped us to understand what we had to do to help in order to make everything better for us as a family, as well as my daughter.

11. Would you rather that the medical and psychological reports were integrated into one single report?

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Comments: No - separate reports are helpful. Not all agencies need to know personal history of the family.
12. Do you feel that you would like to receive an adapted version of the report for your child?

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Comments: My daughter was in secondary school when assessed. I think sometimes it might help for her to have a report to relate too.

13. Did our report meet your expectations of the kind of feedback that our service would provide?

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Comments: Everything, to have a service that was and still is supportive of her needs is fantastic. The therapy through to medication has enable my daughter to see and have a future, which I think she thought at one time was not possible.

14. Finally, we would appreciate if you could use the space below to make any further comments regarding the quality of our reports, pertaining to any of the questions above, or indeed anything that we have not mentioned. We are also happy to receive your suggestions and recommendations if you have any ideas about how our feedback reports could be improved.

Just to say Thank you!! All reports were sent, I was kept in the loop with school and you have been very supportive to her needs!
Appendix 2: Details of Ethical Approval

Dear Sunil & Maxine,

Please find attached a copy of your approved Evaluating the Extent to which Psychological Reports are Accessible and Understandable to the Families of Service Users in the Developmental Neuropsychiatry Team Project Proposal Form (PPF), this will also be uploaded onto our intranet site. Your data collection can now begin.

Also attached is a blank template for the audit report. Once the report is finalised and approved, can you please send me a copy of the final report.

If you require anything further, please do not hesitate in contacting me.

Best wishes for the audit

Charlotte

Charlotte Connolly
CAMHS Clinical Governance Project Officer
South London and Maudsley NHS Foundation Trust
CAMHS | Michael Rutter Centre | De Crespigny Park | London | SE5 8AZ
Telephone: 020 3228 2693 Internal: 82693 Mobile: 07800770844
http://sites.intranet.slam.nhs.uk/camhs/Clinical_Audit/default.aspx

020 3228 6000 The switchboard number for SLaM
Mental health matters - Click if you care
South London and Maudsley NHS Foundation Trust (SLaM) provides mental health and substance misuse services for people living in the London Boroughs of Croydon, Lambeth, Southwark and Lewisham. In addition, the Trust provides substance misuse services for people in the London Boroughs of Bexley, Greenwich and Bromley, as well as specialist services to people from across the UK.
Appendix 3: Reminder Letter

Dear Parent/Caregiver,

I am writing to request your help in the evaluation of our service. We the Developmental Neuropsychiatry Team (Michael Rutter Centre) are currently auditing the quality of the feedback reports that we provide service users and their families after the assessment is complete, and as you have been part of our service quite recently, we would very much appreciate your contribution.

We sent out questionnaires before Christmas and are hoping that you may be able to find the time to complete the form and return it to us. We understand that Christmas is a busy time with lots of post, so if you would like to return the questionnaire but are not able to find it then please contact me and I am happy to send you another copy.

Once again, we would be extremely grateful for your contribution in helping us to provide the best possible service to future service users.

Please do not hesitate to contact me at sunil.nandha@slam.nhs.uk, or on 07751959650 if you have any questions.

Yours sincerely,

Sunil Nandha
Clinical Psychologist in Training
Appendix 4: Qualitative Written Responses

“The only comments that I have are already stated but I feel that this is very important, as we had to fight VERY hard to gain appropriate education for our daughter. The recommendations made were ignored or reinterpreted by the LEA and by the tribunal service so her statement is not useful now. Luckily she gets this support anyway as she is in an excellent school but wouldn't have got this otherwise.”

“I would like to thank the Maudsley hospital and the people who have seen my daughter as after this the education department has taken the advice on board and agreed that my daughter does need a statement so thank you for helping me get the right help for my daughter and being so understanding with her when we had an appointment. Thank you.”

“Overall the reports were very informative and well constructed, especially the initial assessment report. My only recommendation would be about the psychometric report as I feel that it should be explained point by point because carers do not always understand the language.”

“Assessment was in three parts - psychiatric, psychological, school visit. The first two were completed in March and the school visit did not happen until July, so the final report was delayed.”

“The report allowed us to provide other interested professional organisations with the evidence they need to make their own decisions.”

“Just to say thank you! All reports were sent, I was kept in the loop with school and you have been very supportive to her needs.”

“I still don’t entirely agree with the assessment - I suspect my son's initial diagnosis could still be incorrect.”

“I would have appreciated if x had not been present at the feedback meeting. He was there and utterly perplexed by the talk about Asperger’s as he was only aware he had been assessed for OCD. I didn’t feel able to comment fully on aspects of the assessment and diagnosis that I was unsure of. I was not expecting the Asperger’s diagnosis and would have liked the opportunity to comment freely and ask more questions than I could with him there.”

“The language was very clear in the reports, however in the psychometric tests I found a little of medical jargon that was difficult to understand. I would have liked the verbal explanation of them to be point by point rather than an overall summary. Also, like I said before getting the report before feedback session would have been good”

“I was recently contacted regarding a follow up appointment then when I called to confirm said appointment I was told that X was too old, and that the cut-off point for these follow-ups was 16. It seems that certain people in the service who are working with these children don't read the reports properly themselves, and they should listen more carefully to the patients and get the reports right in the first place. They actually need more help after 16 years of age!”

“Just one unfortunate thing - the report had the wrong name in it from the middle onwards. I guess it had been copied and pasted but I wasn’t sure if his past referred to my child or this other child. Overall, I think the feedback, report and support we have been given has been excellent.”
“We felt that everything was great apart from the admin and communication side of things. 1) No one passed on messages, 2) We have still only received a draft copy of the report, 3) other agencies have not received anything at all, 4) this is after almost 5 months and several phone calls. Admin needs a massive shake up. Assessment was great - you got X down too a T.”

“I think that the recommendations that were made make very good sense but we have found them difficult to make them a reality. We really appreciate the service that was provided, but it would be great if there could be some kind of follow up that could have helped us to make the changes at home that we talked about at the time.”

“Thank you all for the help you gave us.”

“We thought the report was very good and informative. X's needs are complex and difficult to understand and deal with but we hope now to deal with it more constructively and to have the best effort possible.”