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**A qualitative study examining the experiences of healthcare  
staff 12 months after their completion of an 8-week  
Mindfulness Based Stress Reduction course**

**and**

**Clinical Research Portfolio**

**Volume I**

**(Volume II bound separately)**

**Ross Kennedy Turner**

**Institute of Health and Wellbeing  
University of Glasgow**

**July 2013**

*Submitted in partial fulfillment of the requirements for the degree of  
Doctorate in Clinical Psychology (DClinPsy)*



University  
of Glasgow

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# **CHAPTER ONE: SYSTEMATIC REVIEW**

## **A systematic review of educational and psychological stress management interventions for burnout in staff who work in mental health settings**

Ross Kennedy Turner

*Submitted in partial fulfilment of the requirements for the degree of  
Doctorate in Clinical Psychology (DClinPsy)*

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of Health Psychology (See Appendix 1.1).*

## **ABSTRACT**

**Objective:** Developing interventions to reduce levels of burnout in staff who work in mental health settings is important due to the major health problems it can lead to in those who suffer from it and the potential impact it can have on patient care and service delivery at an organisational level. This review identifies, synthesises and discusses the key findings from studies published between 2000 and 2013, which have attempted to implement interventions to reduce or protect against the symptoms of burnout in staff who work in mental health settings.

**Methods:** A systematic literature search was carried out using Embase, Medline, CINAHL, Health Source, PsycArticles, PsycInfo and Psychology and Behavioural Sciences to identify relevant studies. Articles were then screened against inclusion criteria.

**Results:** Eleven studies met the inclusion criteria. One was rated as being of 'high' quality, two of 'moderate' quality, four of 'low' quality and four of 'poor' quality. Seven studies related to educational interventions designed to decrease burnout through the training or teaching of new skills and four related to psychological interventions designed to decrease burnout through psychotherapeutic methods such as mindfulness. All interventions were delivered in a group context.

**Conclusions:** Educational methods were found to be more effective at reducing levels of burnout, although this may be due to the greater amount of research in this area. Psychological methods of reducing burnout show some promise. Overall, a deficit in scientific rigour in the majority of studies limits generalisability. Burnout continues to be a significant problem for staff working in mental health settings and further research into interventions designed to reduce burnout is unlikely to have an impact on policymaking and practice unless it is of good quality.



## INTRODUCTION

Burnout resulting from occupational stress within the healthcare profession is a major health problem for the individuals who suffer from it and a factor that impacts on the effectiveness of the organisations they are a part of (Marine, et al., 2006; van Wyk, et al., 2010; Fagin, et al., 1996; Melchior, et al., 1997; Sullivan, 1993). Burnout is most often defined as a work related mental health impairment comprising of three dimensions: emotional exhaustion (feelings of being overextended and exhausted by the emotional demands of one's work), depersonalisation/cynicism (characterised by a detached and cynical approach to other people in the context of work) and reduced personal accomplishment/efficacy (the self-evaluated feeling that one is no longer effective in one's work) (Maslach, et al., 1996). Burnout is frequently reported amongst healthcare workers with over 40% of nurses reporting general occupational burnout, 28% of physicians endorsing two out of three aspects of burnout and up to 60% of psychologists describing times when they have practiced despite viewing themselves as distressed to the point of clinical ineffectiveness (Bruce, et al., 2005; Pope, et al., 1987; Vahey, et al., 2004). Physical problems that have been associated with burnout include: fatigue, insomnia, carcinogenesis, diabetes and premature ageing (Miller, et al., 1988; Spickard, et al., 2002). Burnout has also been associated with decreased patient satisfaction, a reduction in clinician attention and concentration, detracting from decision making skills, reduced ability to communicate effectively and a reduction in the ability to convey empathy and establish meaningful relationships with patients, ultimately effecting patient recovery times (Beddoe and Murphy, 2004; Enochs and Etzbach, 2004; Skosnick, et al., 2000). The cost of burnout in terms of economic impact is also high as shown by rates of absenteeism and staff turnover (Jacobsen, et al., 1996; Raiger, 2005).

There have been a number of recent systematic reviews examining the effectiveness of interventions aimed at reducing or protecting against burnout

in a range of healthcare workers including nurses, physicians, nursing students, social workers and direct care staff (Mimura and Griffiths, 2003; Marine, et al., 2006; Van Wyk, et al., 2010; Awa, et al., 2010). The overall conclusions from these systematic reviews highlight the poor quality of the studies that have been carried out and that there is little consensus regarding the most effective type of intervention to reduce or protect against burnout. A potential disadvantage of considering healthcare staff who work in a vast range of settings as a homogenous population is that the unique aspects of the different settings they work in are not considered as moderators of the effect of the intervention. These factors may influence the implementation or the focus of interventions.

A population that may be particularly likely to respond differently to interventions designed to reduce or protect against burnout or that may require more tailored approaches are staff who work in mental health settings. For example, Maslach et al. (2001) note that the development of burnout is linked to sources of job stress such as interacting with violent patients, which is more likely when working with patients with mental health problems compared to working with patients in general healthcare (Moore and Cooper, 1996). Furthermore, Moore and Cooper (1996) highlight that staff who work in mental health settings are required to cope with additional levels of stress given that the nature of their work is often to deal with distressed individuals for sustained periods of time and that this can exacerbate experiences of stress and strain.

In comparison to those relating to the general healthcare population there have been considerably fewer reviews that focus specifically on how to reduce or protect against burnout within the mental health staff population. Edwards and Burnard (2003) conducted a systematic review of the moderators of stress and stress management interventions for mental health nurses working in a range of settings. They found 8 studies that attempted to reduce burnout levels by implementing interventions based on relaxation

techniques, training in behavioural techniques, stress management workshops and training in therapeutic skills. The authors concluded that the interventions they reviewed appeared to be largely effective in terms of reducing levels of burnout, however due to wide variations in methodological rigour, low sample sizes and considerable heterogeneity in terms of the type of intervention implemented it was difficult to generalise the results. A more recent systematic review by Cahill, et al. (2004) examined the extent, aetiology and consequences of poor staff morale in inpatient mental health services and attempted to identify the clinical effectiveness and cost effectiveness of strategies to improve morale. In terms of strategies to improve morale they found that educational interventions such as skills enhancement, mentoring and supervision delivered in individual or group formats may be beneficial although they note that much of the research in this area comes from specialist settings (i.e. forensic secure units) and so may not be directly generalisable to the other settings such as community mental health teams or inpatient mental health units.

#### *Rationale for this review*

Edwards and Burnard (2003) investigated the effectiveness of occupational stress management programmes specifically for those individuals working in mental health settings and Cahill, et al. (2004) specified their population more stringently, including only studies which used mental health professionals who worked in inpatient settings. Edwards and Burnard (2003) searched for studies up until 2000 (they do not provide the month in 2000 in which they began their search) and Cahill, et al. (2004) searched for studies up until July 2003. Therefore, to the author's knowledge, there has been no systematic review of the literature regarding the effectiveness of stress management interventions for staff who working in mental health settings since 2000.

Cahill, et al. (2004) specify a helpful method of grouping the most common types of interventions and the most common methods of delivery in order to

organise the results of their systematic review. They classify the type of intervention as 'educational' (involving some kind of training or teaching e.g. communication skills training), 'psychological' (involving some kind of psychotherapeutic component e.g. counselling or stress management courses) or 'environmental/structural' (involving modifications to the external environment (e.g. changes in ward design) or organisational structures (e.g. the introduction of flexitime)). Mode of delivery is classified as 'individual intervention' (targeted at the level of the individual, e.g. counselling), 'group intervention' (e.g. workshops) or 'organisational intervention' (changes to the setting or physical environment, creation of multidisciplinary teams).

Given that Edwards and Burnard (2003) found no environmental/structural interventions in their systematic review and in order to keep the number of studies included in this systematic review to a manageable level environmental/structural interventions were excluded and interventions delivered at an organisational level were also excluded. Consequently, the following review will only aim to include all educationally and psychologically focussed interventions and all interventions delivered at a group and individual level published between 2000 (inclusive) and 2013.

In summary, this review aims to:

- Identify, synthesise and discuss the key findings from studies examining educational or psychological stress management interventions to reduce burnout for staff working in mental health settings from 2000 (inclusive) to 2013.
- Consider the quality of the identified studies.
- Determine which educational or psychological stress management interventions are most effective in the identified studies.

## **METHOD**

### **Search strategy**

The following databases were used to identify studies: OVID; EMBASE and EBSCO; MEDLINE, CINAHL (Cumulative Index to Nursing and Allied Health Literature), Health Source, PsyArticles, PsychInfo and Psychology and Behavioural Sciences. These databases were searched using the following search string:

("mental health nurs\*" OR "psychiatric nurs\*" OR "mental health professiona\*" OR "mental health staff" OR "mental health personnel" OR "community mental health team\*")

AND

("burnout" OR "stress" OR "job satisfaction" OR "coping")

The searches were limited to:

Published between the 1<sup>st</sup> of January 2000 and the 29<sup>th</sup> of March 2013, language (English), research subjects (human), age (adults (18+)). Endnote X4 for Macintosh and Windows (2010) was used to store and manage the results of the database searches.

Hand searches were also carried out on reference lists of the selected papers.

An expert in the field of occupational stress was contacted (Dr Jo Lloyd, Programme Director, MSc Occupational Psychology, Goldsmiths, University of London), who reviewed the list of included papers and certified them as representative of the area under investigation.

### **Inclusion and exclusion criteria**

The title and/or abstract of each paper identified from the search was screened for suitability according to the inclusion and exclusion criteria. The full text paper was obtained when suitability could not be determined from review of the title or the abstract alone.

*Inclusion criteria:*

**Population:** All staff working with patients within a mental health setting – e.g. primary care mental health team, community mental health team or inpatient psychiatric unit.

**Intervention:** All educational and psychological interventions delivered at an individual or group level designed to reduce or protect against burnout.

**Outcomes:** Studies must use a standardised measure of burnout or a proxy measure of this such as a standardised measure of stress or psychological wellbeing.

The reason that the outcome measure was not limited to a specific burnout measure (e.g. the Maslach Burnout Inventory) was because during the preliminary stages of the systematic review it was identified that it was relatively common for studies to use more general measures of psychological distress such as the General Health Questionnaire as proxy measures of burnout. These less direct measures of the concept of “burnout” were still deemed relevant to include given they were still being used to indirectly measure stress which leads to burnout.

**Design:** Due to the paucity of available research in this area, no papers were excluded on the grounds of quality. This meant the design of studies could include: Randomised Controlled Trials (RCTs), controlled and uncontrolled pre/post test designs and descriptive designs.

*Exclusion criteria:*

**Population:** Any study in which staff who did not work in mental health settings were the subjects and any study where it was not possible to separate out staff who worked in mental health settings and staff who did not e.g. general health care staff.

**Intervention:** Any environmental/structural intervention or any intervention delivered at an organisational level was excluded.

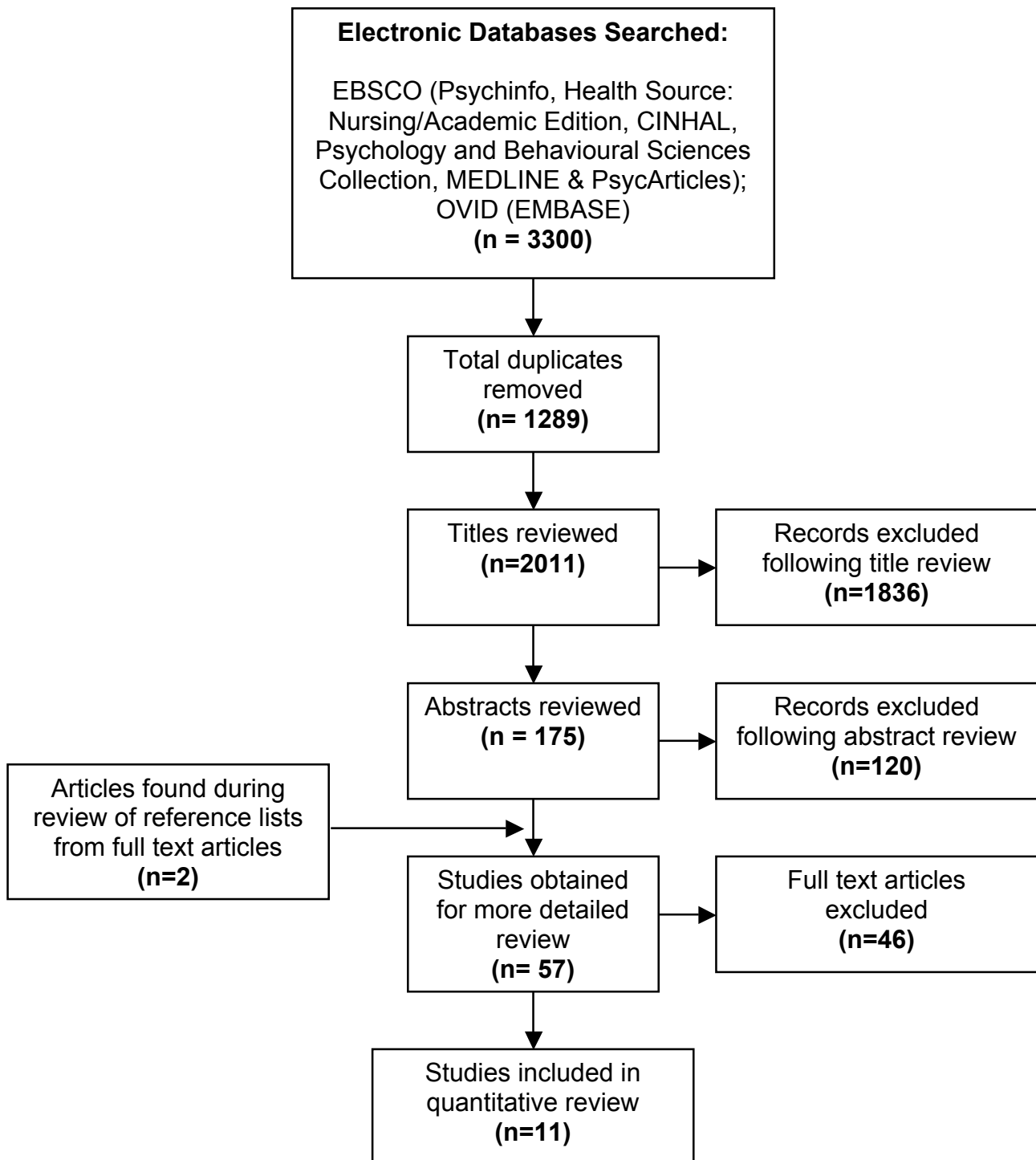
**Outcomes:** Studies that did not use a standardised measure of burnout or a standardised proxy measure of burnout such as a measure of stress or psychological wellbeing.

**Design:** Any type of fully qualitative design (this allowed for the inclusion of papers that used mixed methods providing they met the inclusion criteria). Case studies, reviews, unpublished dissertations, conference abstracts, newspaper articles or book chapters.

**General:** Full text not published in English. Published before 1<sup>st</sup> of January 2000.

The computerised search returned 3,300 results, which was reduced to 2,011 studies once duplicates were removed. These were examined according to the inclusion and exclusion criteria. 1,836 were rejected on the basis of title alone. 175 abstracts were reviewed from which the full text was obtained for 55 of these. 2 studies were identified from hand searching of the reference lists of the included studies, the full text of these 2 studies was also obtained resulting in a total of 57 full text articles. The final number of studies found to be eligible for inclusion in the review was 11. The study selection process is summarised in Figure 1.

**Figure 1:** Flow Diagram of selection process





## **Quality rating and data extraction**

The 11 studies that met the full inclusion criteria were rated by the author using a quality rating form (see Appendix 1.2) developed by the author following consultation with the Scottish Intercollegiate Guidelines Network – Annex C (2008) and the Critical Appraisal Skills Programme (2004) resources. The reason the author developed their own quality rating form based on these established rating frameworks is because the included studies varied widely in terms of methodology and neither the SIGN or CASP guidelines provided parameters wide enough to capture the range of methodologies used in the 11 included studies.

The quality rating form (see Appendix 1.2) contained 18 items, covering the areas of methodology, participants, measures, confounding factors and statistical analysis. The items were scored a '2' (indicating an area had been well covered), a '1' (indicating an area was adequately addressed but not fully addressed) or a '0' (indicating an area was not addressed or poorly addressed) and a number of items were rated either '1' or '0' indicating 'yes' or 'no' respectively.

Section 3.1 of the quality rating form states that "A standardised measure of burnout (2 points) or a proxy measure of burnout such as a standardised measure of stress or psychological wellbeing has been used (1 point)". Studies that used a direct measure of burnout received a score of 2/2 ("two out of two") on this item; studies that used a proxy measure received 1 /2 ("one out of two") on this item.

A final score was then summed to determine the overall quality of the study and this final score was converted into a percentage which was used to categorise the quality of the study as: 'High' ( $\geq 75\%$ ); 'Moderate' (60-74%); 'Low' (50 - 59%) or 'Poor' ( $\leq 49\%$ ).

One researcher (RT) rated all the included papers and a second researcher, a Doctorate of Clinical Psychology Trainee who was independent of the study, rated the 11 papers. The rate of agreement between the researchers was 93% and disagreement was resolved by discussion resulting in 100% agreement.

## **Data synthesis**

Due to the heterogeneous nature of the papers identified, meta-analysis was not possible. To summarise and synthesise the data from the included studies a narrative synthesis approach is taken in line with Popay, et al. (2005) who suggest summarising the main findings of each included study, exploring the relationships within and between studies, exploring whether any observed effects were consistent across different studies and describing any possible reasons for inconsistencies. Finally, an assessment of the strength of the evidence is provided in addition to the facilitators or barriers to implementation and a discussion of the generalisability of the studies.

The author developed a data extraction protocol (Appendix 1.2) that was used to gather the relevant data for inclusion in the systematic review for each study. The quality ratings and key characteristics of the included studies are presented in Table 1.

If effect sizes were not presented in the original studies they have been calculated, where possible, by the author using the established formulae below (Cohen, 1992):

$$d = \frac{M_{group1} - M_{group2}}{SD_{pooled}}$$

The pooled standard deviation was calculated using the formula:

$$SD_{pooled} = \sqrt{\frac{\sigma_{group1}^2 + \sigma_{group2}^2}{2}}$$

Using Cohen's (1992) convention, an effect size of 0.2 is described as 'small', 0.5 is 'medium' and an effect size of 0.8 is deemed 'large'.

**Table 1:** Summary of included studies.

Study	Quality rating	Sample (profession, n)	Country	Outcome measure	Setting	Design	Effect size (Cohen's d). <u>d</u> =calculated by author.	Intervention	Main findings (p<0.05)* (p<0.01)** NS (Non Significant).
Redhead, et al. (2011)	High	Exp group: N=22 (Qualified nurses n=12, unqualified nursing staff n= 10)  Control group: N=20 (Qualified nurses n= 9, unqualified nursing staff n=11)	UK	MBI	Low secure mental health unit	RCT	Qualified staff:  MBI: EE: d = 0.09 DP: d = 1.19 PA: d = 0.56  Unqualified staff:  MBI: EE: d = 0.54 DP: d = 0.055 PA: d = 0.41	Psychosocial Intervention training.  Qualified staff - 16 half-day sessions delivered over 8 months.  Unqualified staff – 8 half-day sessions.  All sessions supplemented by group supervision.	Outcomes for Qualified staff:  Sig decrease in DP*, NS difference in EE and PA (exp vs. control group)  Outcomes for unqualified staff:  NS difference in any subscale of MBI (exp vs. control group).
Ewers, et al. (2002)	Moderate	Forensic Mental Health nurses, 20. Exp group (n=10), control group (n=10)	UK	MBI	Medium Secure psychiatric unit	Controlled Quasi-exp (pretest/ post-test)	Not reported.	20 days of Psychological Intervention Training vs. Waiting list control	Sig decrease in EE* and DP*, sig increase in PA*.

Doyle, et al. (2007)	Moderate	Exp group: N=14 (Nursing n= 9, non-nursing = 5)  Control group: N=12 (Nursing n= 7, non-nursing n= 5)	UK	MBI	Medium secure unit	Controlled quasi-exp (pretest/post-test)	Not reported.	16 weekly 3-hour sessions of Psychosocial Intervention training.	Sig increase in PA in exp group*.  NS changes in EE and DP.
Salyers, et al. (2011)	Low	Mental health staff (n=74)	USA	MBI	Community mental health team.	Uncontrolled Quasi-exp (pretest/post-test)	MBI: EE: d= .65 DP: d= .43 PA: d= .12	Day workshop (6hrs) to improve awareness of burnout prevention principles and experiential exercises.	Sig decrease in EE** and DP**. NS change in PA.
DeZoysa, et al. (2012)	Low	n=10 (no demographic detail provided)	UK	GHQ-12	Mental Health trust and research institute.	Long term follow up (18 months after baseline) to a quasi-exp uncontrolled study.	Not reported.	8 week MBCT programme "modified for healthy individuals" because the group was not a clinical one .2 hour sessions. 2 Follow up sessions also provided.	NS changes in psychological wellbeing as measured by the GHQ-12 after 18 months.

Chen, et al. (2010)	Low	59 Psychiatric nurses. Exp group (n=26), control group (n=33).	China	IWS - Chinese version.	Participants from 3 Psychiatric hospitals.	Controlled Quasi-exp (pretest/post-test)	Not reported.	Potentiality education programme – 4 x 3.5 hour lectures on potentiality	Job satisfaction scores, task requirements and organizational policy scores significantly higher in exp group*.
Perseius, et al. (2007)	Low	n= 22 (2 physicians, 3 psychologists, 8 nurses, 8 mental care assistants one occupational therapist).	Sweden	MBI – GS	Adult and child psychiatry clinics	Uncontrolled Quasi-exp. (Pretest/post t-test)  MBI-GS measures taken at Baseline (before participants began treating patients with Dialectical Behaviour Therapy (DBT) and then at 6, 12 and 18 months after the participants began	MBI-GS: Baseline vs 18 months: Exhaustion: $\underline{d} = -0.01$ Cynicism: $\underline{d} = 0.09$ Personal efficacy: $\underline{d} = -0.15$	Aim was to investigate how starting to use DBT affected psychiatric professionals occupational stress levels.  6 months of DBT training with no patient treatment – baseline measure taken during this period.  Next phase was an 18-month period of supervised DBT treatment	Exhaustion and Cynicism sub scales of the MBI-GS showed a slight trend towards increasing mean scores between baseline and 6 mo. At 18 months exhaustion returned to baseline levels and cynicism levels were below baseline levels.  All NS results.

						treating patients using DBT.		with patients Participants received 3 hours of group supervision per week, 111hrs of theory, 51hrs of method and mindfulness training workshops and 153hrs of supervision in the teams or individually over the 18-month period.	
Scarnera, et al. (2009)	Poor	Mental health staff (n=25). Direct care staff (n=14, "group 1"), managers (n=11, "group 2")	Italy	MBI (Italian version)	Psychiatric inpatient and residential community providing therapeutic/ rehabilitative services.	Uncontrolled Quasi-exp (pretest/ post-test & follow up)	Not reported.	Group 1 and 2 were given different initial sessions. Group 1 was given a workshop aiming to achieve cognitive restructuring of the their attitudes towards severe mental illness with the	NS change in EE at post-intervention or 18 months.  Sig decrease in DP at post-intervention*, still significant at 18 months*.  Sig decrease in PA post-intervention *, NS at 18 months.

								<p>aim of re-defining dissonant emotions. Group 2 was given a workshop around task planning, leadership style, supporting staff.</p> <p>An additional 5 workshops (3-5hrs in length) were then given to both groups simultaneously focusing on assertiveness training.</p>	
Sharkey and Sharples, (2003)	Poor	Psychiatrists, occupational therapists, social workers (n=27)	UK	OSI, Health related work pressure scale (adapted from NSI)	Inpatient unit and community mental health team.	Uncontrolled Quasi-exp (pretest/post-test)	Not reported.	<p>A learning pack on risk management was developed.</p> <p>The learning pack comprised of six sections</p>	<p>OSI – General decrease in many sources of stress, sig decrease in ‘factors intrinsic to job’* and ‘managerial role’*.</p> <p>Sig decreases in the following items of the NSI – fluctuations in</p>



	<p>each of which had a corresponding group workshop facilitated by mental health trainers.</p> <p>Group workshops had a minimum of 4 weeks between them and lasted approximately 2.5 hours.</p> <p>Article reports on the impact that the learning pack had on team members' stress - specifically work related stress.</p>	<p>workload*,difficulty in dealing with aggressive people*, difficult patients*, involvement in life and death situations* and dealing with relatives* .</p>
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Brady, et al. (2012)	Poor	Staff members (n=16). (Psychiatric nurses (n=7), social workers (n=3), mental health technologists (n=3), psychiatrists (n=1), recreational therapists (n=1), health unit coordinators (n=1))	USA	MBI for human services, MHPSS	Acute psychiatric unit	Uncontrolled Quasi-exp (pretest/post-test)	MBI: EE: $\underline{d} = 0.51$ DP: $\underline{d} = 0.24$ PA: $\underline{d} = -0.3$	Group Mindfulness Based Stress Reduction (MBSR) - 1 hour per week for 4 weeks.	NS difference in any MBI subscale.  MHPSS significantly lower after intervention**.
Berry, et al. (2012)	Poor	n= 13. Registered mental health nurse (n=7), support worker (n=6).	UK	MBI.	Low secure psychiatric unit.	Uncontrolled Quasi-exp (pretest/post-test)	MBI: EE: $\underline{d} = -0.36$ DP: $\underline{d} = -0.30$ PA: $\underline{d} = -0.14$	A 3-hour workshop focussed on increasing staff awareness of psychological factors that maintain challenging behavior in patients.	Sig increase in EE post intervention*.  NS changes in PA and DP after intervention.

Key: EE – Emotional exhaustion, DP – Depersonalisation, PA – Personal Accomplishment (MBI Measure)  
Exp – Experimental, MBI - Maslach Burnout Inventory, MBI-GS – Maslach Burnout Inventory General Survey, GHQ-12 – General Health Questionnaire-12, MBCT – Mindfulness Based Cognitive Therapy, OSI - Occupational Stress Indicator, IWS – Index of Work satisfaction, MHPSS - Mental Health Professionals Stress Scale, NSI – Nurse Stress Index.

## RESULTS

### *Sample characteristics – job roles*

The 11 reviewed studies included a total of 334 participants. Seven of the 11 studies (Ewers, et al., 2002; Chen, et al., 2010; Brady, et al., 2012; Perseius, et al., 2007; Berry, et al., 2012; Doyle, et al., 2007; Redhead, et al., 2011) provided sufficient data on job titles to make it possible to calculate the number of participants employed in distinct job categories. These 7 studies had a combined participant total of 198.

Of these 198 participants, 138 were classified as various types of “nurse”, e.g “Forensic Mental Health Nurse” (n=20) (Ewers, et al., 2002), “Psychiatric Nurse” (n=66) (Chen, et al., 2010, Brady, et al., 2012), “Nurse” (n=8) (Perseius, et al., 2007), “Qualified Mental Health Worker – Nurse” (n=16) (Doyle, et al., 2007), “Qualified Nursing staff” and (n=21) (Redhead, et al., 2011) and “Registered Mental Health Nurse” (n=7) (Berry, et al., 2012).

Other distinct professions (n=60) included “Qualified Mental Health worker – non-nursing” (n=10) (Doyle, et al., 2007), “Unqualified nursing staff” (n=21) (Redhead, et al., 2011) and “Support worker” (n=6) Berry, et al. (2012). Perseius, et al. (2007) and Brady, et al. (2012) used participants employed in a large range of distinct job roles including “Social Worker” (n=3), “Mental Health Technologist” (n=3), “Psychiatrist” (n=1), “Recreational therapists” (n=1), “Health unit coordinator” (n=1), “Physician” (n=2), “Psychologists” (n=3), “Mental Care assistant” (n=8) and “Occupational Therapist” (n=1).

The data from these 7 studies is summarised in Table 2.

**Table 2:** *Proportion of Job roles held by participants.*

Job Title	Proportion of 7 studies that provided this information. %, (n).
<b>Variation on “Nurse”.</b>	69.7 (138)
<b>Other professions</b>	30.3 (60)
<b>Total</b>	<b>100 (198)</b>

The remaining 4 studies (Scarnera, et al., 2009; Salyers, et al., 2011; Sharkey and Sharples, 2003; DeZoysa, et al., 2012) included a total of 136 participants and who were classed as “Mental Health staff” (Scarnera, et al., 2009; Salyers, et al., 2011) or comprising of psychiatrists, occupational therapists and social workers (Sharkey and Sharples, 2003). DeZoysa, et al. (2012) provided no information on the job characteristics of the 10 participants in their study.

In summary, in those studies that provided sufficient information to ascertain the individual job roles included in their samples the majority (69.7%, n=138) were employed as various types of “nurse”. Just over 30% of the participants (n=60) were employed in other roles distinct from nursing although still in the field of mental health. Therefore, stress reduction interventions appear to be being offered to a range of mental health professionals.

### *Settings*

Six of the 11 studies were carried out in inpatient settings (Ewers, et al., 2002; Chen, et al., 2010; Brady, et al., 2012; Doyle, et al., 2007; Redhead, et al., 2011; Berry, et al., 2012), 2 studies were conducted in a community mental health setting (Salyers, et al., 2011; Perseius, et al., 2007) and 2 were conducted with mental health professionals who worked both in community and inpatient settings (Scarnera, et al., 2009; Sharkey and Sharples, 2003). The participants in the study by DeZoysa, et al. (2012) were gathered from a mental health trust and research institute. Dr DeZoysa was contacted to

ascertain the remit of these participants and the author was informed that all participants would have had clinical contact with patients in a variety of settings.

### *Outcome measures*

The most common tool to measure the construct of burnout is the Maslach Burnout Inventory (MBI) (Maslach et al., 1996). The MBI is a 22-item measure designed to assess three aspects of burnout: emotional exhaustion (EE, nine items), depersonalization (DP, five items) and personal accomplishment (PA, eight items). Each item is scored on a seven-point scale measuring frequency (ranging from 'None' to 'Every day'). Maslach, et al. (1996) argue that the three dimensions within the MBI are best viewed as continuous variables ranging from low to moderate to high degrees of experienced feeling as opposed to being labelled dichotomously as present or absent.

Six of the included studies used the MBI (Maslach, et al., 1996) as a measure of burnout (Ewers, et al., 2002; Salyers, et al. 2011; Doyle, et al., 2007; Redhead, et al., 2011; Berry, et al., 2012; Brady, et al., 2012). Brady, et al., 2012) used both the MBI and a proxy measure of burnout, The Mental Health Professionals Stress Scale (Cushway, et al., 1996) which provides a measure of overall stress. One study (Scarnera, et al., 2009) used the Italian version of the MBI (Sirigatti and Stefanile, 1993). An alternate version of the MBI (the MBI-General Survey, Maslach, et al., 1996) was used in one study (Perseus, et al., 2007). The MBI-GS contains 16 items with 5 items relating "Exhaustion", 5 concerning "Cynicism" and 6 concerning "Personal Efficacy". Perseus, et al., (2007) note that their reason for using the MBI-GS over the original MBI (Maslach, et al., 1996) was because the MBI-GS measures burnout more generally compared to the MBI which has been noted to have a narrow focus on industries regarding human services employees. Given the MBI-GS is a relatively recently developed instrument it has less evidence

supporting its reliability and validity than the original MBI and the comparability with the original MBI is limited.

The remaining 3 studies used a proxy measure of burnout as defined in the inclusion criteria of this systematic review. Chen, et al. (2010) used the Index of Work Satisfaction (Chinese version), IWS (Slavitt, et al., 1978). The IWS is a 48-item scale which includes six components of job satisfaction including pay, professional status, interactions, task requirements, autonomy and organisational policy. DeZoysa, et al. (2012) used the General Health Questionnaire - 12 (GHQ-12, Goldberg and Willaims, 1988) to measure psychological wellbeing which aims to evaluate changes in perceived psychological functioning. Sharkey and Sharples (2003) used the Occupational Stress Indicator (Cooper, et al., 1988), which comprises of a biographical questionnaire and six subscales relating to work based stress. Sharkey and Sharples, 2003 also used an adapted version of the Nurse Stress Index (NSI) (Harris, 1989) which is a 30 item self report method of identifying sources of stress in senior nurses, it includes six subscales relating to various aspects of work related pressure specific to nursing, the authors note that only two subscales were administered - the 'managing the workload' and 'dealing with patients and relatives' subscale.

#### *Methodological quality of the included studies*

The methodological quality of the studies varied across the 11 studies from 14 to 24 out of a possible score of 29 (Median: 15, IQR: 4) as measured by the rating tool (see Appendix 1.2). This highlights that the majority of studies were of 'low' or 'poor' quality. A summary of the quality ratings for all the included studies is presented in Table 3 (see Appendix 1.3 for a matrix of the quality rating scores of the included studies.).

**Table 3:** *Quality rating of studies included in the systematic review.*

<b>Study</b>	<b>Total out of 29</b>	<b>% Rating</b>	<b>Overall Rating</b>
Redhead et al. (2011)	24	82	High
Ewers et al. (2002)	20	68	Moderate
Doyle et al. (2007)	18	62	Moderate
Salyers et al. (2011)	17	58	Low
DeZoysa et al. (2012)	15	51	Low
Chen et al. (2010)	15	51	Low
Perseius et al. (2007)	15	51	Low
Scarnera et al. (2009)	14	48	Poor
Sharkey and Sharples (2003)	14	48	Poor
Brady et al. (2012)	14	48	Poor
Berry et al. (2012)	14	48	Poor

All 11 studies addressed a clearly focussed question or hypothesis. The vast majority of studies (n=10) also detailed in sufficient detail what their objectives were, the procedures they used and the way in which their intervention was implemented. Chen, et al. (2010) was an exception, as they had slightly unclear objectives and there was little information provided regarding the details of the intervention they evaluated.

In terms of research design, one study employed a RCT (Randomised Controlled Trial) design (Redhead, et al., 2011). The remaining 10 studies employed a quasi-experimental designs, with 3 employing a controlled pre/post test design (Ewers, et al., 2002; Chen, et al., 2010; Doyle, et al., 2007) and 7 employing an uncontrolled pre/post test design (Scarnera, et al., 2009; Brady, et al., 2012; Salyers, et al., 2011; Sharkey and Sharples, 2003; Perseius, et al., 2007; Berry, et al., 2012; DeZoysa, et al., 2012).

In terms of recruitment, most of the studies used convenience sampling to gather participants. This reflects the overall pragmatic nature of the included studies in that most studies appeared to be designed in order to fit with the demands of a busy work place and fit in with participants' already busy work schedules. Inclusion and exclusion criteria were poorly reported with only

three studies explicitly reporting this (Redhead, et al., 2011; Ewers, et al., 2002; DeZoysa, et al., 2012). Only one study (Salyers, et al., 2011) completed an intention to treat analysis for participants who dropped out during the trial.

In terms of the statistical analyses the majority of the studies (n=8) used t-tests to compare pre and post intervention mean scores on their chosen measure of burnout or proxy measure of burnout. One study (Chen, et al., 2010) used an Analysis of covariance (ANCOVA) with a sufficient sample size of 59, although provided no power calculation. The remaining two studies (DeZoysa, et al., 2012; Scarnera, et al., 2009) used Analysis of Variance (ANOVA) tests to analyse their data, neither of these studies had particularly large sample sizes from which to carry out an ANOVA test, with Scarnera, et al. (2009) using 25 participants and DeZoysa, et al. (2012) using only 10 participants. Neither study noted whether they had carried out a power calculation to ascertain the optimum number of participants needed to detect any significant differences between the group means and so therefore these may not have been an appropriate statistical test to use.

Effect sizes were reported for only two studies (Redhead, et al., 2011; Salyers, et al., 2011) however it was possible to calculate effect sizes for an additional three studies (Brady, et al., 2012; Perseius, et al., 2007; Berry, et al., 2012).

Follow up data was gathered in 3 out of the 11 studies (Scarnera, et al., 2009; Perseius, et al., 2007; DeZoysa, et al., 2012), each of these studies followed up the participants 18 months after the original intervention.

### **Effects on levels of burnout following intervention**

As discussed in the introduction, this review included studies that employed an educational or psychological intervention to reduce levels of burnout in mental health staff. As defined by Cahill, et al. (2004) an 'educational'



intervention involves training or teaching e.g. communication skills training and a 'psychological' intervention involves a psychotherapeutic component e.g. counselling or a stress management course. All interventions were delivered in a group format in terms of its 'mode of delivery' (as defined by Cahill, et al., 2004), no interventions were delivered at an individual (one-to-one) level.

Below, the individual studies are split into those that examined the effect of educational interventions and those that examined the effect of psychological interventions. The studies are then discussed in terms of their strengths, methodological limitations and effect on measures of burnout.

### **Educational interventions**

Educational methods for reducing burnout are hypothesised to address skills deficits that may undermine the performance of staff in mental health settings and contribute to their perception of their jobs as stressful (Cahill, et al., 2004). Five different types of educational interventions were used in the studies included in this review: Psychosocial Interventions Training (PSI), Dialectical Behaviour Therapy (DBT), training in managing challenging behaviour, training in risk management and training in increasing 'potentiality'.

#### *Training in Psychosocial Interventions*

Three of the studies included in this review evaluated the effectiveness of training staff in Psychosocial Interventions (PSI) to affect levels of burnout. PSI training programmes aim to reduce the amount of stress that service users and caregivers are exposed to by improving quality of life in service users experiencing psychotic symptoms (Mairs and Bradshaw, 2005). Ewers, et al. (2002) note that staff working in a mental health setting may have difficulty understanding the 'bizarre' or 'disturbed' behaviour exhibited by some patients with mental health problems and that they may not be fully

trained to cope adequately with this. PSI training has been shown to result in increased knowledge regarding mental health problems, improved attitudes towards service users and increased confidence in practice (Lam, et al., 2003; Forrest, et al., 2004). PSI training is hypothesised to increase resistance to burnout by helping those who undertake it to understand their patients' presentation and provide them with skills to intervene therapeutically, thereby raising their feelings of self-efficacy which may in turn reduce their stress levels and increase wellbeing (Ewers, et al., 2002).

Ewers, et al. (2002) provided 20 days of PSI training over 6 months to forensic mental health nurses within a medium secure unit. This included educational components and training in specific interventions such as how to treat hallucinations and delusions. Compared to the waiting list control group, the staff (n=10) who had been provided with PSI training showed a significant decrease in EE (Emotional Exhaustion) and DP (Depersonalisation) and a significant increase in PA (Personal Accomplishment) as measured by the MBI 6 months after the beginning of the PSI training. The authors propose the decreases in burnout symptoms were related to the development of new knowledge and skills as well as the modification of dysfunctional attitudes towards patients. The relatively specialised participant group and small sample size make generalisation of these findings difficult and the lack of any follow up period also means that it is not possible to say if these effects were sustained.

Doyle, et al. (2007) provided 16 weekly 3-hour sessions of PSI training (described as a total of 8 days) to qualified mental health workers (nursing (n=9) and non-nursing (n=5)) working in a medium-secure unit. The MBI was used to measure levels of burnout in staff at baseline and after the intervention. Compared to the waiting list control group, the staff who had undertaken the PSI training (n=14) showed a decrease in EE and DP, however these differences were non-significant when compared to the control group. PA was significantly higher in the experimental group compared to the

control group after the intervention, suggesting that PSI training led to an increased self of efficacy amongst the participants.

Redhead, et al. (2011) provided two levels of PSI training; one for qualified nursing staff (n=12) lasting 8 months and consisting of 16 half-day sessions (totalling 8 days) and the other for unqualified nursing staff (n=10) who were provided with 8 half-day sessions (totalling 4 days). All sessions were supplemented with group supervision. Burnout was measured with the MBI. Compared to the waiting list control group the qualified nursing staff who had undertaken the PSI training showed a reduction in EE and DP and an increase in PA, however only the DP score was significant and the effect size was large ( $d=1.19$ ). Compared to the waiting list control, the unqualified nursing staff who had been provided with the PSI training showed no significant change in any subscale of burnout as measured by the MBI, however, the effect sizes for the EE, DP and PA subdomains of the MBI are between small and medium in size (0.54, 0.055 and 0.41 respectively). This suggests that there was some level of effect from the intervention and that that sample size may have been too small to detect this difference. This study represents the only RCT in this review and despite its small sample size, results suggest that qualified nursing staff were able to experience some change in terms of feeling more connected to those they work with as evidenced by the significant change in DP and large effect size. The lack of follow up data is a limitation of this study.

### *Training in DBT*

Dialectical Behaviour Therapy (DBT) is a type of psychotherapy which involves components of Cognitive Behavioural Therapy (CBT) and mindfulness. It has a particular focus on helping the patient balance the difficult relationship between acceptance and change (Linehan, 1993). The potential for therapist burnout is highlighted in the treatment manual for DBT and Perseius, et al. (2007) investigated if starting to use DBT had an impact on the experience of

stress and levels of burnout among mental health professionals working with patients who self-harm, i.e. they examined if learning to use DBT has the indirect consequence of reducing levels of burnout.

Perseius, et al. (2007) provided Dialectical Behaviour Therapy (DBT) training to a group of mental health professionals (n=22) over a 24 month period. The first 6 months of the training in DBT involved no patient contact (baseline measure were taken at this time), the following 18 months involved the participants using DBT to treat patients. In total the participants received 111 hours of theory, 51 hours of method and mindfulness training workshops and 153 hours of supervision. The MBI-General Survey was used to measure any changes in burnout level amongst participants and effect sizes were calculated between the baseline and 18 month period. Exhaustion and Cynicism sub-scales of the MBI-GS showed a slight trend towards increasing mean scores between baseline and 6 months. At 18 months the Exhaustion subscale ( $d = -0.01$ ) returned to baseline levels and the Cynicism subscale ( $d = 0.09$ ) was below baseline, although not significantly. The authors note that their small sample size may have meant that the MBI-GS was not sensitive enough to detect any differences and that there was also a large reorganisation of services going on in the setting where the participants worked at the time of the study which may have influenced the results.

#### *Training in managing challenging behaviour*

Berry, et al. (2012) conducted a 3-hour workshop facilitated by a clinical psychologist with mental health nurses (n=7) and support workers (n=6) in a low-secure psychiatric unit. The workshop focussed on increasing staff awareness of the psychological factors that maintain challenging behaviour. Burnout was measured using the MBI, which was administered before the workshop and re-administered within one month after it. There were no significant changes in DP ( $d = -0.3$ ) or PA ( $d = -0.14$ ) after the intervention. There was a significant *increase* in EE ( $d = -0.36$ ) after the workshop. The lack

of any significant findings and the increase in EE is likely to be due to the very brief nature of the intervention. The small sample size and lack of control group make it difficult to draw conclusions from this study.

### *Training in risk management*

Sharkey and Sharples, (2003) provided training on risk management to a range of mental health staff (nurses, psychiatrists, occupational therapists, psychologists and social workers, n=27). They note that assessing and managing risk within mental health settings is a stressful process and aimed to evaluate the impact of the training with regards to work related stress. They provided a 'learning pack' comprising of six sections; each of which had a corresponding group workshop facilitated by mental health trainers. Group workshops had a minimum of 4 weeks between them and lasted approximately 2.5 hours. The OSI (Occupational Stress Indicator) and an adapted version of the NSI (Nurse Stress Index) were completed by the 27 participants within 8 weeks before and after the intervention. There was a general decrease in many components of the "Sources of stress" subscale within the OSI and a significant decrease in 'factors intrinsic to job' and 'managerial role'. There was a significant decrease in the following items of the NSI – fluctuations in workload, dealing with relatives, involvement with life and death situations, difficult patients and difficulty dealing with aggressive people. Overall, this training does seem to have led to a decrease in work related stress, particularity in terms of aspects of work that relate to risk which is an encouraging finding given that factors that relate to risk are often considered a source of stress in staff working in mental health settings (Moore and Cooper, 1996). Unfortunately, the MBI was not used to measure any changes in burnout and so this limits the studies comparability to others. Furthermore, the lack of a comparable control group also limits the strength of the findings.

### *Training in potentiality*

Chen, et al. (2010) provided a 'potentiality education programme' to a group of psychiatric nurses (n=26) sampled from three psychiatric hospitals in China. Potentiality is defined as a human being's "inherent capacity for growth or development" (Chen, et al., 2010, p.85). The potentiality education programme in this study consisted of helping participants to understand potentiality and cultivate organisational and coping abilities. The programme was delivered over 2 months (four 3.5 hour sessions in total). The Chinese version of the IWS (Index of Work Satisfaction) was used to assess the difference between the control and experimental groups after the potentiality education programme had been delivered. Compared to the control group (n=33), participants in the experimental group were shown to have significantly higher 'Job Satisfaction', 'Task Requirements' and 'Organisational Policy' subscale scores after the intervention. This study indicates that this type of intervention could have some benefit in terms of reducing burnout levels. However, as only a proxy measure of burnout was used it is difficult to compare these results to others in terms of the ability of the intervention to reduce burnout per se.

### **Psychological Interventions**

Psychological interventions in the context of this systematic review, (as defined by Cahill, et al., 2004) constitute any intervention that involves a psychotherapeutic component. Four studies included in this review met these inclusion criteria for a psychological intervention. None of these studies included a control group.

#### *Assertiveness training with elements of CBT*

Scarnera, et al. (2009) provided assertiveness training with elements of cognitive behavioural therapy to mental health professionals in a psychiatric

inpatient unit in Italy. They split participants into two groups based on whether their job role involved direct care of patients, (group 1, n=14) or was a managerial role (group 2, n=11). Each group received 6 workshops (monthly) of 3-5 hours with the aim of helping the participants to develop techniques to manage interpersonal relationships. The first session differed for each group. Group 1 was given a workshop intended to achieve cognitive restructuring of their attitudes towards severe mental illness with the aim of re-defining dissonant emotions. Group 2's first workshop focussed on task planning, leadership style and supporting staff. The remaining 5 workshops were carried out with both groups together and covered a range of topics such as: 'handling different levels of interpersonal relationships, communicating apprehensions, avoiding anger and fostering positive professional relationships'. The MBI was administered before the intervention (baseline), directly after it and 18 months after baseline. The DP subscale of the MBI was significantly lower at the end of the intervention and at 18 month follow up. PA was significantly lower after the intervention although, this had returned to baseline levels at the 18 month follow up. The intervention had no effect on the EE subscale at post intervention or follow up. A strength of this study is its follow up length which allowed for the sustained effect of the DP subscale to be demonstrated, this suggests that participants experienced a sustained increase in their ability to relate to patients and colleagues. In addition it demonstrates that the participants' levels of PA did not show sustained improvement. Unfortunately, the absence of a control group means the generalisability of this study is limited as these changes may have taken place due to external factors unrelated to the intervention.

#### *One-day workshop on burnout prevention principles*

Salyers, et al. (2011) conducted a one day workshop (6 hours in length) for 74 mental health professionals in a community mental health team setting designed to improve awareness of burnout prevention principles. This included cognitive behavioural coping skills, mindfulness, meditation, the

identification of personal meaning, and the development of practices of gratitude. Participants completed the MBI at baseline and 6 weeks after the intervention. Results showed a significant decrease in EE and DP and a non-significant change in PA. In terms of effect sizes, the intervention resulted in a medium effect size in the EE subscale (0.65) and small effect size in the DP subscale (0.43). Again, the lack of a control group makes these results difficult to generalise and the lack of a longer follow up period also reduces the generalisability of these results. However, the relatively large sample size does suggest that the positive effects on EE and DP may be replicable in a similar setting.

### *Mindfulness Based Interventions*

Two studies that examined mindfulness-based interventions met the inclusion criteria for the current review. Mindfulness has been defined as the sustained intention to focus attention on the reality of the present moment, accept it without judgement and in turn, minimise the natural process of allowing one thought to follow on to the next (Segal, et al., 2002). It is taught through meditation exercises and the core skills are observing, describing and acting with awareness (Baer, et al., 2004).

Brady, et al. (2012) conducted a Mindfulness Based Stress Reduction (MBSR) group lasting 1 hour per session over 4 weeks with 16 mental health professionals. In terms of measures of burnout and stress they used the Mental Health Professionals Stress Scale (MHPSS) and the MBI. The overall stress score of the participants' as measured by the MHPSS was reported to significantly decrease after the MBSR group. The EE, DP and PA subscales of the MBI were not significantly different at the end of the MBSR group, although there was a trend towards significance in the EE subscale and a medium effect size – suggesting that mindfulness did have an effect on feelings of emotional exhaustion but that the sample size may have been too small to detect this difference. One of the reported findings of mindfulness-



based interventions is a reduction in 'striving' (Segal, et al., 2002), that is, a reduction in the constant pursuit of goals and recent research has demonstrated that the effects of mindfulness may be mediated by an increase in self-compassion (Kuyken, et al., 2010). It could be hypothesised that the decrease in the EE subscale (although non-significant) found in Brady, et al.'s (2012) study is as a result of an increase in compassion towards the self (i.e. participants are putting themselves under less pressure) as this subscale measures one's feelings of being overextended by the emotional demands of one's work. Further research is needed to more fully demonstrate this link.

DeZoysa, et al. (2012) investigated if the benefits of an 8-week Mindfulness Based Cognitive Therapy (MBCT) programme "modified for healthy individuals" completed by 10 participants 18 months previously was sustained. A proxy measure of burnout was used (the General Health Questionnaire – 12 (GHQ-12). Three months after the intervention the GHQ-12 scores were significantly improved compared to baseline measures, however 18 months after the intervention ended there was found to be no significant difference in terms of GHQ-12 score between the 10 participants' baseline scores and scores at 18 month follow up.

## DISCUSSION

### *Main findings*

This systematic review aimed to identify, synthesise and discuss key findings from studies published since 2000 that examined educational and psychological stress management interventions to reduce levels of burnout for staff working in mental health settings. Seven studies were identified that examined the ability of educational interventions to reduce levels of burnout and four studies were identified that examined the ability of psychological interventions to reduce levels of burnout. The results of this systematic review are consistent with Edwards and Burnard's (2003) systematic review of stress intervention strategies which noted variations in methodological rigour limited the generalisability of the interventions they identified. In the thirteen years since their review was completed it appears that the deficits in methodological rigour they identified are still highly prevalent. Cahill, et al.'s (2004) systematic review of strategies designed to improve morale in inpatient services identified that educational interventions may be beneficial although noted that most evidence for this came from specialist settings (e.g. forensic inpatient units). The majority of studies identified in the current review have also been carried out with staff who work in specialist inpatient settings (n=6, table 3) or inpatient and community settings (n=2, table 3). A potential reason for the over representation of staff from these settings is due to the practical reason that staff who work in inpatient settings are in the same location for the entirety of their shift, compared to staff who work in the community who are more likely not to be based in one place throughout the day. This may make it more challenging for community staff to set aside protected time to engage in an intervention to reduce burnout.

In terms of educational interventions, Ewers, et al. (2002), Doyle, et al. (2007) and Redhead, et al. (2011) all demonstrated that the symptoms of burnout as measured by the MBI reduced after PSI training in qualified and unqualified

staff working in mental health settings. However, significant reductions were only found in all three subscales of the MBI in the Ewers, et al. (2002) study. All three studies have similarities in terms of sample size, the settings in which they were carried out (forensic settings) and the fact they all used a control group. However, a potentially important difference between the Ewers, et al. (2002) study and the other two is that their intervention was carried out over a period of 6 months and provided a total of 20 days of training, whereas Doyle, et al. (2007) and Redhead, et al. (2011) provided less than half this amount of training. It may be that there is an optimum number of sessions that this type of intervention is required to offer in order to impact on the level of burnout in staff working in mental health settings.

Berry, et al. (2012) found that providing registered mental health nurses and support workers with a 3-hour workshop aimed at promoting increased awareness of factors that maintain challenging behaviour had no significant effect on the DP or PA subscales of the MBI but that there was a significant increase in EE after the workshop. The increase in EE may indicate that an intervention as short as this one (3 hours), which lacks any follow up session may serve to make staff more aware of their lack of training in an aspect of their work and therefore increase feelings of being overextended and exhausted by the emotional demands of one's work. Furthermore, the significant increase in EE may be partly explained by the probable differences in level of experience between the nurses and the support workers. Tatten and Tarrier (2000) note that staff with less training in working with challenging behaviour tend to respond in instinctual but potentially detrimental ways when faced with challenging behaviour. They note that when staff become more aware of their reactions through learning about the functions of challenging behaviours this may cause an increase in feelings of guilt regarding their previous reactions to it, this may explain the increase in EE in Berry, et al.'s (2012) study. Given that the sample contained mental health nurses and support workers it may have been useful to analyse the baseline and post-intervention scores of these 2 groups separately to examine if there was any

overall difference in their EE subscale scores, although this was likely not carried out due to the small sample size.

Sharkey and Sharples, (2003) provided a range of mental health staff with training on risk management, which led to a decrease in work related stress relating to risk. The small sample size and uncontrolled nature of this study makes the ability to draw conclusions from it limited. Given that this intervention related to increasing the risk management skills of staff it is understandable that the authors may have felt it unethical to provide training in this for one group of staff and not another. Finally, Chen, et al. (2010) found that job satisfaction, task requirements and organisational policy all increased as measured by the IWS when staff undertook a potentiality education programme. This may suggest that this type of programme has the effect of increasing the capacity of the participants' to cope with stress although little information is provided on what constitutes a potentiality programme and so generalisability is limited.

Four studies met the inclusion criteria as psychological interventions. Scarnera, et al. (2009) demonstrated that assertiveness training with elements of cognitive behavioural therapy was able to significantly reduce the DP subscale of the MBI at the end of the intervention and at 18 month follow up. This represents a sustained reduction and is one of the few studies to include this length of follow up period. Salyers, et al. (2011) demonstrated significant reductions in the EE (medium effect size) and DP (small effect size) subscales of the MBI after a one-day workshop introducing staff to various ways of coping with stress. However, the lack of control group and relatively short period of time before the post-intervention measure was taken (6 weeks) makes generalisability of the results difficult. Finally, two studies (Brady, et al., 2012; DeZoysa, et al. 2012) attempted to use mindfulness-based interventions to reduce burnout amongst mental health staff. The amount of time required to complete Brady, et al.'s (2012) intervention was 4 hours, whereas the MBCT course delivered in DeZoysa, et al.'s (2012) study lasted a

total of 16 hours and caused a significant change in GHQ-12 score after 3 months but this was not sustained after 18 months. Despite the difference in length of intervention, Brady, et al.'s (2012) study was still able to cause a significant reduction in the 'overall stress score' of the MHPSS. The lack of follow up information in Brady, et al.'s (2012) study limits how much confidence can be had in how sustainable the effects from this short mindfulness-based intervention are. However, it is promising that there does appear to be some change from a relatively short mindfulness-based intervention as the time commitment to longer interventions may dissuade staff from attending stress reduction interventions.

Overall, the quality of the studies investigating educational interventions was higher (1 high, 2 moderate, 2 low and 2 poor) than of studies investigating psychological interventions (2 low and 2 poor). From this systematic review there appears to be more good quality evidence from educational interventions than psychological interventions, especially from the 3 studies that evaluated the effects of PSI on staff burnout levels of which one was of 'high' quality and two were of 'moderate' quality. This is consistent with the recommendations for working with patients with psychosis in the UK where PSI is recommended by NICE (2009). Less well researched methods to reduce staff stress such as attempting to reduce staff stress indirectly by teaching staff to use DBT (Perseus, et al. 2007) require further research to determine if they would be effective in reducing staff stress in the longer term. Short educational interventions regarding challenging behaviour may serve to increase levels of stress in staff as demonstrated by Berry, et al. (2012). Sharkey and Sharples, (2003) demonstrated that education regarding risk management could serve to reduce stress and finally a more innovative method attempting to increase potentiality from Chen, et al. (2010) demonstrated some potential to be used as a stress reduction method.

Despite the quality of studies that used educational interventions being higher there does appear to be a developing evidence base around psychological

interventions for stress reduction in mental health staff. Scarnera, et al. (2009) demonstrated the sustained decrease in the DP subscale of the MBI with an intervention focussing on assertiveness training with elements of CBT and Salyers, et al. (2011) demonstrated a lowering of a number of MBI subscales after a day long workshop to improve awareness of burnout prevention principles, although there was no follow up period. Mindfulness-based interventions were carried out by Brady, et al. (2012) and DeZoysa, et al. (2012) and appear to have some promise in terms of reducing stress via interventions that require a relatively short time commitment.

### *Methodological limitations of the reviewed studies*

A number of methodological problems were identified in the 11 included studies. The majority of studies (n=10) recruited participants via convenience sampling meaning the sample may not have been representative of the population to which the results may be generalised. The majority of studies (n=8) assigned participants to the control or experimental group based on the participants' interest in the intervention. This means that most samples were self-selecting and that those participants may have been more enthusiastic towards learning new information and possibly more amenable to change, in terms of their beliefs and attitudes, than those who did not volunteer. In addition to this, self selected samples in this population may represent those who have the time to spare to be involved in an intervention related to reducing burnout whereas the individuals who are over-worked would perhaps find it more difficult to set aside time to attend an intervention to reduce or protect against burnout. Furthermore, most of the interventions were delivered by and subsequently reported on by practitioners who worked in the settings where they were carrying out the intervention meaning the potential for bias was high. Only four out of the 11 studies included a control group, uncontrolled studies leave open the possibility that findings may have been due to other latent variables. Sample sizes were generally small resulting in underpowered studies and furthermore no studies reported a power

calculation. The majority of the included studies used the MBI to measure burnout, however three studies used proxy measures of burnout meaning the ability to compare between studies was limited. Greater consistency in the measures used would facilitate easier comparisons between studies in the future.

A particular methodological problem was related to the heterogeneity of the samples. The majority of the studies included in this review attempted to assess the impact of an intervention designed to reduce burnout by using staff employed in a range of job roles within the mental health profession as participants. This is likely to be due to the pragmatic nature of these studies, however, this heterogeneity in terms of sample characteristics presents problems in terms of generalisability. Ewers, et al. (2002) and Chen, et al. (2010) used participants in specific job roles; 'forensic mental health nurses' and 'psychiatric nurses' respectively. Redhead, et al. (2011) included two categories of mental health professional job roles (unqualified and qualified nursing staff) in their study, however they broke down the results of their study in terms of the distinct job roles they included. The remaining eight studies used participants who were employed in a range of job roles and failed to stratify their results in terms of specific job roles. One study in this review, Scarnera, et al. (2009) did attempt to deliver a more individualised session at the beginning of their intervention by splitting up "direct care staff" and "managers" and providing them with job role specific information on stress reduction but then failed to analyse the pre and post measures of these groups separately. Grouping the participants of each study by their individual job roles and then analysing them separately (as opposed to as one group) would highlight whether those participants in particular job roles responded differently to each intervention and could potentially suggest what areas it would be beneficial to focus on for specific groups. However, it is understandable why the authors of the majority of studies in this review chose not to stratify their results by job roles in this way due to the small sample

sizes. Overall, these methodological restrictions limit the generalisability of the findings reported in this systematic review.

### *Limitations of this review*

Accessing unpublished material was impractical and therefore only studies from peer-reviewed journals were included in this systematic review, this introduces the potential of publication bias, however this also meant that the reviewed studies were of higher quality than would have otherwise been the case if literature from non peer-reviewed sources had been used. This review only considered English language publications with quantitative outcomes which may have led the exclusion of potentially relevant studies. A further limitation of this review is that it did not cover environmental/structural interventions or interventions delivered at an organisational level. Finally, the majority of the included studies were underpowered and lacked a control group meaning the ability to draw firm conclusions from the results is limited.

### *Implications for clinical practice*

The findings from this systematic review offer several recommendations regarding clinical practice. From the studies included in this review it appears that the ability to effect a significant change in burnout level may not be dependant on the time invested in the intervention. Comparing studies that required a relatively large investment of time from participants (Ewers, et al., 2002; Doyle, et al., 2007; Redhead, et al., 2011; Persieus, et al., 2007) to those which required considerably less (DeZoysa, et al., 2012; Brady, et al., 2012) is not entirely possible due to the differences in measures used. However, broadly, those interventions that lasted longer did not seem to have significantly greater or longer-term effects than those interventions that lasted a shorter length of time. This may mean that shorter interventions, which are more amenable to busy staff and the practicalities of a busy working environment, are a viable option in terms of reducing burnout. However, as



found by Berry, et al. (2012) providing less experienced staff with information regarding challenging behaviour could lead to an increase in EE. This highlights an important consideration for short term educational interventions in relation to considering the amount of experience staff have before providing them with a brief introduction to a topic area.

Further research is needed to ascertain the time commitment required to reduce levels of burnout and how long these reduced levels are sustained. It is also notable that no study in this review attempted to make stress reduction sessions a regular, integrated part of the working lives of the participants in terms of providing regular follow up groups after the initial intervention had finished. Regular groups may provide a sense of consistency and respite in the busy working life of a mental health professional, however this does present challenges in terms of resources.

In this review, studies which implemented interventions which ran for a relatively long length of time tended to suffer from a lack of a control group, potentially due to ethical reasons of not wishing to deny a potentially stress relieving intervention to a group of stressed people. The possibility of being randomly assigned to a control group may have dissuaded potential participants from entering the study. Carson, et al. (1999) note that for staff to be willing to attend stress reduction groups they are required to be supported at a managerial level and this is more likely to happen if a case can be made for the benefits of stress reduction interventions. However, to demonstrate the efficacy of these interventions requires well constructed research that not only assesses the amount of change in terms of levels of burnout amongst staff but also examines the cost-effectiveness of the interventions from an economic viewpoint. No study in this systematic review included economic data as part of their outcome measures. When both these aspects of outcomes are considered and presented this may contribute to providing the rationale for the implementation of stress reduction interventions with managerial support.

Related to the above point, studies that have invested longer amounts of staff time in stress reduction interventions have tended to have an element of proposed direct patient benefit associated with them (e.g. PSI training, DBT training) and been educational in nature. These methods look to reduce burnout indirectly, by increasing the skill sets of staff in terms of their ability to treat patients. It may be that interventions that can be evidenced to promote recovery in patients, the by-product of which is lowered staff stress levels, are more likely to receive investment from health services.

Finally, there may be practical reasons why most investigations into effective stress management interventions have been carried out in specialist settings (e.g. inpatient settings) such as the physical location of staff in inpatient units being more consistent than staff based in the community. However, it has been found that staff who work in community mental health teams experience more exhaustion (as measured by the MBI, EE subscale) than their inpatient counterparts (Hill, et al., 2006). A potential reason for this is that staff who work in community settings tend to work in a more isolated role throughout the day, receive less support from their colleagues and less opportunity for role confirmation through contact with others employed in the same role. Role clarity has been a factor that has been associated with high levels of burnout (Edwards and Burnard, et al., 2003; Maslach, et al., 2001) and given the differences in the role of the community mental health worker versus that of the inpatient mental health worker this may mean that community mental health workers are more susceptible to burnout. Therefore, future research should focus more on evaluating the effectiveness of stress reduction interventions in this population.

## **CONCLUSION**

The studies reviewed above provide some evidence that certain educational interventions, particularly PSI, can reduce the symptoms of burnout in certain populations of staff working within a mental health setting. Psychological

interventions utilising such techniques as mindfulness may also be effective in reducing burnout in staff working in a mental health setting, although the quality of the intervention studies is poorer than those that assess educational interventions. The problem of burnout in staff who work in mental health settings is an established finding. However, well-designed trials, which contain control groups and are of sufficient size to detect effects are lacking. Further poor quality, small-scale intervention studies are unlikely to influence policymaking and practice. Future research should therefore look to examine both the economic impact of stress reduction interventions as well as the impact on staff stress levels. When both these aspects of outcomes are evaluated this is likely to improve the probability of stress reduction interventions becoming an integral part of the lives of staff who work in mental health settings.

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## CHAPTER TWO: MAJOR RESEARCH PROJECT

**A qualitative study examining the experiences of healthcare staff 12 months after their completion of an 8-week Mindfulness Based Stress Reduction course**

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*Submitted in partial fulfilment of the requirements for the degree of  
Doctorate in Clinical Psychology (DClinPsy)*

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## PLAIN ENGLISH SUMMARY

Mindfulness is a word that means to 'pay attention on purpose'. More specifically it means to focus our attention on the reality of the present moment, accept it without judgment and in turn, minimise the natural process of allowing one thought to follow on to the next. Many mental health problems such as anxiety and depression are maintained because people have a natural tendency to attempt to make predictions about what might happen in the future, allowing their mind to wander through many (usually negative) possible outcomes to a given situation. Mindfulness Based Stress Reduction (MBSR) groups train people how to be more mindful by teaching 'formal' mindfulness practices such as meditation and 'informal' mindfulness practices such as being more aware of one's thoughts and physical feelings when carrying out relatively everyday activities such as brushing one's teeth.

Previous research has shown that healthcare staff without diagnosed mental health problems were less stressed after attending MBSR groups. The current study aimed to build on this research by interviewing eight healthcare staff twelve months after they had completed an MBSR group to aid in the understanding of how people experience mindfulness. It was possible to group what the participants said into three main themes that related to their experience of the group.

**Theme 1:** Participants reported attending the group because they wanted to reduce stress in their lives and because they thought that being more mindful would be a way to do this.

**Theme 2:** The participants felt the course was special because it was about their thoughts and feelings and not just about teaching them a new way to help patients. They also said that the other members of the group and the facilitators made them feel safe and comfortable to try out new ways of reacting to thoughts and feelings.

**Theme 3:** Finally, the participants said that some parts of the course had been challenging and that it had made them more aware of the fact they were sometimes quite critical of themselves and others. They said the course had helped them to be less like this and discussed a number of ways they had fitted mindfulness into their lives since the group had ended.

This research demonstrates that the healthcare staff that attended the MBSR group valued it and shows that after 12 months these participants were still using mindfulness to good effect. It highlights the importance of the group facilitators being experienced and trusted mindfulness practitioners, as without this the group members may not have felt comfortable enough to experiment with being more mindful. It also shows us that perhaps follow up groups should be more routinely held after the main groups have ended. The government has recently published guidelines stating that the NHS workforce should show increased compassion towards patients. This study and others have shown that the benefits of mindfulness that people experience might be related to people being more compassionate to themselves and others after taking a mindfulness course. Therefore MBSR groups may offer a way of increasing compassion in line with these government guidelines.

## ABSTRACT

**Background:** Several quantitative studies have demonstrated that Mindfulness Based Stress Reduction (MBSR) may be able to reduce levels of stress in staff who work in a healthcare setting by increasing wellbeing and enhancing the ability to cope with stress. There is a dearth of qualitative research regarding the experiences of healthcare staff that undertake MBSR courses.

**Method:** Eight participants were recruited and interviewed from a group of twenty healthcare staff who had completed an 8-week MBSR course. Interpretative Phenomenological Analysis was used to explore the participants' experiences of the MBSR course.

**Results:** Three superordinate themes emerged from the data. Quotations from the participants were used to label each theme. Superordinate theme 1 - *"I would love to be like that"*, relates to the participants' aspiration to attain the qualities they observed in 'mindful people' and their hope that mindfulness could assist them to feel less stressed in their personal and work life. Superordinate theme 2 - *"It was about going along...for me. And that was something I hadn't experienced before"* captured the surprise that the participants felt regarding the fact that the course was focussed on their self-care as opposed to the care of patients and the safeness and security they experienced whilst in the group. Finally, superordinate theme 3 - *"Whereas before I would probably just let it take over and consume me"*, related to the participants' experiences of adopting a less passive and self-critical response to stressful thoughts after they had completed the mindfulness course.

**Discussion:** The MBSR course led to changes in most of the participants' ways of being. Participants described mindfulness as an appealing personality characteristic to have and that the groups were a novel experience because of the focus on their own self-care as opposed to patient care. The facilitators

and group members contributed to the group as being described as experienced like a 'sanctuary'. The changes that came about as a result of increased mindfulness were particularly described as relating to an increase in awareness of low self-compassion and then a drive to increase compassion towards the self and others. This fits with recent research regarding how mindfulness achieves its treatment effects. These findings offer insight into potential areas for further exploration in future research such as the importance of the group effect, quantitatively examining the interpersonal and intrapersonal changes that mindfulness can lead to in terms of increased compassion as well as evaluating the importance of formal and informal practices of mindfulness.

## INTRODUCTION

Mindfulness has been defined as the sustained intention to focus attention on the reality of the present moment, accept it without judgement and in turn, minimise the natural process of allowing one thought to follow on to the next (Segal, et al., 2002). This mental state is said to maximise the possibility of perceiving thoughts and feelings as transient and subjective (Kabat-Zinn, 1990). The values and approaches of mindfulness have been distilled into two predominant mindfulness-based programmes: Mindfulness Based Stress Reduction (MBSR) and Mindfulness Based Cognitive Therapy (MBCT). Mindfulness is also a key element of several 'third wave' cognitive behavioural therapies such as Dialectical Behaviour Therapy (DBT) and Acceptance and Commitment Therapy (ACT) (Hayes, 2004).

MBSR is a clinical programme which was originally developed to facilitate adaptation to physical illness (Kabat-Zinn, 1982). It is a structured 8-week, group programme with groups usually numbering 10 to 40 participants (Segal, et al., 2002). Each session covers particular exercises and topics that are examined within a mindfulness context including meditation practice, mindful awareness during yoga positions and enhancing mindfulness during stressful situations. Regular and repeated practice is a central tenet of MBSR and each participant is expected to set aside 45 minutes each day during the course to engage in various 'formal' mindful exercises such as meditation (Kabat-Zinn, 1990). 'Informal' practices are also encouraged, for example focussing on the moment-to-moment experience of carrying out daily tasks such as brushing one's teeth or cooking a meal. Carmody and Baer (2008) and Finucane and Mercer (2006) highlight the importance of continued practice of mindfulness techniques after the completion of a mindfulness programme in order to maintain any effects.

A number of Randomised Controlled Trials (RCTs) of MBSR have been conducted using clinical and nonclinical (i.e. individuals without a clinical

diagnosis) populations, mostly utilising a waiting list control design. MBSR has been found to reduce self reported levels of anxiety and worry (Vøllestad, et al., 2011; Anderson, et al., 2007; Shapiro, et al., 1998), depression (Grossman, et al., 2010; Sephton, et al., 2007; Specia, et al., 2000), rumination (Anderson, et al., 2007) and general psychological distress, including perceived stress (Bränström, et al., 2010; Shapiro, et al., 2005) as well as increasing well-being (Brown and Ryan, 2003; Epstein, 1999). Two reviews have also demonstrated the ability of mindfulness approaches to enhance psychological well-being, mental health and physical health in addition to reducing psychological distress in clinical populations as well as nonclinical populations under stress (Baer, 2003; Grossman, et al., 2004). A number of researchers have also demonstrated that gains made from the participation of clinical participants in MBSR groups (such as: increased quality of life scores, decreased stress scores, decreased cortisol levels and lower blood pressure) appear to be maintained for up to 3 years in comparison to control groups (Grossman, et al., 2007; Bränström, et al., 2011; Miller, et al., 1995; Carlson, et al., 2007).

Qualitative research into the experience of undertaking a mindfulness course has mostly utilised adult populations with clinical diagnoses such as depression, various anxiety disorders and physical health problems such as Parkinson's disease (Allen, et al., 2009; Mason and Hargreaves, 2001; Finucane and Mercer, 2006; Stelter, 2009; Griffiths, et al., 2009; Proulx, 2008; Fitzpatrick, Simpson & Smith 2010). Common themes that have emerged from these qualitative studies include:

- The process of learning to become more mindful requiring patience, persistence, openness and discipline.
- Group support in the context of loss and a society that stigmatises difference.

- The amount of benefit that the individual gains from mindfulness appears to be moderated by a sense of mastery and increased awareness.
- Benefits to the individual include: a greater feeling of self-acceptance, a shift from negative to more positive thinking.
- Common behavioural changes included: symptom reduction, improvement in coping skills, applying mindfulness in everyday tasks and improved sleep.
- Common difficulties regarding implementing mindfulness were: confusion regarding the concept of thoughts as transient, a focus on the present moment and sometimes frustration and disengagement regarding not being mindful in the “right” way.

#### *Mindfulness and Nonclinical Populations.*

In addition to the ability of mindfulness to reduce symptoms of psychological distress and increase wellbeing in clinical populations there is a growing research base relating to the ability of mindfulness approaches to increase the wellbeing of nonclinical populations (i.e. individuals without a clinical diagnosis). Several quantitative studies using medical students, premedical students and stressed community volunteers have demonstrated the effectiveness of MBSR on self-report measures of anxiety and depression, as well as increased ratings of empathy and spirituality (Shapiro, et al., 1998; Rosenzweig, et al., 2003; Astin, et al., 1997; Williams, et al., 2001). One study employing qualitative methods found that counselling students improved in domains such as interpersonal functioning and coping with stress after completing a mindfulness course (Christopher, et al., 2006).

A nonclinical population that has been the subject of a large amount of research into the effects of mindfulness practice is staff who work in healthcare settings. Healthcare staff are a population particularly vulnerable to the effects of high levels of stress which can lead to depression, emotional



exhaustion, anxiety, psychosocial isolation, decreased job satisfaction, reduced self esteem, disrupted personal relationships and loneliness which can then impact on their practice (Shapiro, et al., 2007; Marine, et al., 2006; van Wyk, et al., 2010). May and O'Donovan (2007) found that higher levels of mindfulness were associated with increased work satisfaction and decreased burnout among mental health professionals (burnout is a specific work-related mental health impairment consisting of emotional exhaustion, a detached and cynical approach to patient care and reduced feelings of personal accomplishment, Maslach et al., 1996). Shapiro et al. (2005) demonstrated that measures of self-compassion and perceived stress were improved after a modified MBSR programme was undertaken by health professionals compared to a waiting list control group. However, changes in psychological distress, stress and life satisfaction did not reach statistical significance. Mackenzie et al. (2006) found that a briefer, 4 week, version of the 8 week MBSR programme completed by nurses and nurse aides was sufficient to significantly improve life satisfaction and burnout symptoms when compared to waiting list controls. In terms of improving work performance Grepmaier et al. (2007) carried out an RCT that found trainee psychotherapists who had undergone mindfulness training received higher client evaluations on measures of the therapeutic relationship. In addition, MBSR has been found to reduce measures of burnout in nursing students whilst improving their subjective physical and mental health, empathy, and wellbeing (Beddoe, et al., 2004; Young, et al., 2001). Two studies have examined the longevity of MBSR's effects on health professionals, finding that reductions in measures of distress, rumination, negative affect and increases in measures of wellbeing and mindfulness were maintained at 3 month follow up (Martin-Asuero and Garcia-Banda, 2010; Schenström, et al., 2006).

Compared to the number of qualitative research studies examining the experiences of clinical groups who have undertaken a mindfulness course there have been comparatively less examining the experiences of nonclinical groups, such as healthcare staff, who have undertaken a mindfulness group.

A mixed-methods study by Cohen-Katz et al., (2005) evaluated the experiences of nurses who had undertaken the 8-week MBSR course. They found that reasons for participating in the course included learning to better cope with family and work stress. Nurses reported increased work performance, improvements in public speaking and driving skills and an ability to let go of perfectionist thinking. The authors also note that the benefits of mindfulness are not easily captured by traditional psychological self-report inventories and the qualitative component of their study allowed for the emergence of new data.

### *Aims of the current study*

The above literature illustrates that there is an increasing body of research that demonstrates the effectiveness of mindfulness approaches to decrease stress and improve wellbeing in a wide range of clinical and nonclinical populations. Within the nonclinical population of healthcare staff in particular, there have been several quantitative studies that have demonstrated the ability of mindfulness to decrease levels of burnout or work based stress and increase levels of wellbeing. However, there is a dearth of research using qualitative methods to examine how individual healthcare staff experience the process of beginning and attending an MBSR group and how they conceptualise their experiences after the group has ended. Given that investigations into the phenomenon of mindfulness are still in their relative infancy, especially in this population, it is important to use a wide range of methods in order to demonstrate not only that quantitative changes are possible but also to attempt to describe how these changes come about in this particular nonclinical group. Given this gap in the literature, the present study will explore the individual experiences of a group of healthcare staff who undertook an 8-week MBSR course. Research related to mindfulness is particularly suited to a qualitative approach as mindfulness is a highly subjective and experiential phenomenon and the ability to practice mindfulness depends on intrinsic motivation factors unique to each person

(Segal, et al., 2002). Interpretative Phenomenological Analysis (IPA) is a method of qualitative analysing and exploring the complex nature of everyday lived experience (Smith, et al., 2009) and is therefore well suited to the aims of this study, described below.

### *Primary Research Question and Objectives.*

Smith, et al. (2009) emphasise the need for an open primary research question when using IPA. However, they also highlight the necessity of knowing when you have answered the research question and so suggest identifying objectives to assist with this.

### *Primary Research Question*

How do healthcare staff who have undertaken an 8-week Mindfulness Based Stress Reduction course understand and describe their experiences of mindfulness before, during and after the course?

### *Objectives*

- Describe the key features that make up an individuals desire to begin the mindfulness course and what maintains their involvement in it.
- Describe the key features of mindfulness that contribute to an increased sense of wellbeing in the participants.
- Describe the key features that facilitate and inhibit continued formal and informal practice of mindfulness after the course's completion.
- Describe the key features that participants perceive as differences in their clinical practice following the mindfulness course.

## METHOD

### *Recruitment*

Prior to commencing recruitment, ethical approval was gained from Glasgow University Ethics Board (Appendix 2.1). Research and Development approval was obtained from NHS Greater Glasgow & Clyde (Appendix 2.2).

Recruitment took place between January 2013 and February 2013. Participants were recruited from a pool of twenty who completed an 8-week MBSR course in March 2012. Participant information packs were provided to this group (Appendix 2.3) which contained information about the study and an 'opt-in' form. The chief investigator (RT) also attended the penultimate session of the MBSR group in order to inform the group members of the current study. Members of the group who expressed an interest in becoming involved in the study were invited to contact the chief investigator by completing and returning the 'opt-in' form. Those who 'opted-in' were contacted by the chief investigator and interviews were arranged. It was stipulated that a participant would only be eligible for inclusion into the study if they had attended at least 6 out of the 8 MBSR sessions and were English speaking. All participants satisfied these inclusion criteria.

Participants were selected via purposeful homogeneous sampling, meaning that the sample is selected because they have certain features which make them a mostly homogenous group as per the requirements of IPA (Smith, et al., 2009). Smith, et al., (2009) note that this homogeneity is crucial to IPA given that picking a sample that have various features in common based on theoretical factors relevant to the research question allows the researcher to: "examine in detail psychological variability within the group, by analysing the pattern of convergence and divergence which arises" (Smith, et al., 2009, p.50). Despite the fact that the participants differ in some aspects in terms of their profession within the healthcare service they are homogenous in other

important ways, namely, they had all experienced the MBSR group prior to the interview.

### *Participants*

Eight participants were recruited. This is within the recommended sample size for Doctorate level research studies employing IPA (Smith, et al., 2009). Participant information is shown in Table 1 and gender appropriate pseudonyms were used to maintain anonymity.

**Table 1:** *Participant characteristics*

<b>Participant Pseudonym</b>	<b>Age</b>	<b>Profession</b>
<b>Kate</b>	50	Clinical Dietician/Team Lead
<b>Luna</b>	29	Counselling/Research Psychologist
<b>Nicola</b>	46	Physiotherapist
<b>Faye</b>	47	Physiotherapist
<b>Melanie</b>	50	Reader in applied health research and a nurse
<b>Janet</b>	54	Information scientist
<b>Bryan</b>	41	Forensic Psychologist
<b>Skye</b>	49	Charge nurse in a physical rehabilitation ward

### *Procedure*

Interviews were carried out at the participant's place of work, which was an NHS site within the Greater Glasgow & Clyde health board. Each interview was digitally recorded and transcribed verbatim. Written consent (see Appendix 2.4) was obtained prior to commencing the interviews which included consent to record the interview and publication of anonymised quotations.

### *The programme*

The 8-week programme is based on the protocol of MBSR as detailed in Kabat-Zinn (1990). Two experienced mindfulness practitioners delivered the programme.

### *Data collection*

Data was collected through non-directive semi-structured interviews which were carried out by the chief investigator (RT) on a one-to-one basis. In line with Smith, et al., (2009) the questions that made up the semi structured interview were designed to be open and expansive, beginning with one that allowed the participant to recount a fairly descriptive episode or experience so as to facilitate a comfortable interaction between interviewer and participant. Topics for the interview were generated by drawing on the experience of researchers within the field and drawing on the limited amount of qualitative research in this topic area. The resulting semi structured interview schedule (Appendix 2.5) naturally took on a chronological format – exploring the participant's journey from beginning the group, their experiences during the group and after it, attempting to illicit any perceived changes in themselves and the impact of these. Interviews were conducted in a flexible manner, using open-ended questions with further probes and specific questions as required, to encourage participants to elaborate on important topics. The researcher also remained alert to different topics raised by the participants themselves during the interviews and encouraged participants to elaborate on these. An emphasis was placed on establishing rapport throughout each interview and attempting to understand the participant's perspective and 'lived experience'. Empathetic communications skills were utilised to facilitate this process. The interviews lasted between 36 and 59 minutes (mean: 45 minutes).

### *Data analysis*

This study employed an interpretative phenomenological analysis (IPA) approach to analysing the transcripts. Careful consideration was taken over which qualitative methodology to utilise when analysing the resulting data from the interviews. IPA was selected as it aims to gain a detailed understanding of the 'lived experience' of individuals who share a particular experience, how each person makes sense of their experience and the meanings they attach to it (Smith, et al., 2009). This methodology is not intended to test pre-determined hypotheses or generalise across large groups but rather to explore, flexibly and in detail, an area of concern and is best at highlighting individual's stories or accounts (Smith, et al., 2009). Other methodologies such as thematic analysis (Braun and Clarke, 2006) and grounded theory (Charmaz, 2006) were considered. However, given that this study was exploratory in nature, concerned with how individuals within a particular group (healthcare staff that have completed an MBSR course) make sense of mindfulness rather than orientated towards hypothesis generation or comparing across groups, IPA was felt the most appropriate choice given its focus on personal meaning and sense-making in a particular context.

Transcripts were analysed using IPA as described by Smith, et al., (2009). This involved repeated and careful reading of the transcripts whilst listening to the original recording. Significant and interesting responses were noted in the right hand margin, these related to any striking features of the data in terms of content or use of language, e.g. metaphor. The researcher then re-read the transcripts noting emergent themes in the left hand column (see Appendix 2.6 for samples of coded interview transcripts). These emergent themes were then listed together and the researcher attempted to make connections between the emerging themes and 'cluster' them together. These themes were then arranged into 'superordinate' and 'sub' themes, which appeared to most accurately represent the participant's narrative. This process was repeated for each transcript. Similarities and differences between transcripts

were only considered after themes emerged from each individual transcript, this allowed the researcher to maintain the unique aspects of each individuals experiences and maintained IPA's idiographic commitment (Smith, et al., 2009). Overarching superordinate themes were then identified and discussed in research meetings with the chief investigator's research supervisors. Two transcripts were analysed independently by a research supervisor to further verify the reliability of the analyses as recommended by Elliot, et al. (1999)

### *Researcher reflexivity*

The role of the researcher as dynamically interpreting the data is central to IPA. It is explicitly recognised that the researcher's own beliefs and assumptions will influence how they interpret and make meaning from the participant's account. This creates a dynamic two-stage interpretive element to the process. The IPA researcher is encouraged to reflect on and 'bracket off' their own conceptions during the data gathering and analysis stages of IPA so that they do not overtly influence the process (Smith, et al., 2009). The researcher (RT) undertook their own 8-week MBSR course, completed between September and November 2012. This allowed the researcher to experience the phenomenon of mindfulness from a personal perspective, thus allowing them to get as close to the participants experiences as possible as recommended by Toma et al., (2003) as a way of enhancing the breadth and depth of a qualitative study. Completing this course served to enrich the researcher's understanding of the phenomenon of mindfulness. During the course the researcher kept a detailed reflective diary of their experience which was subsequently referred to in the analysis stage in order to assist the researcher in acknowledging thier assumptions when selecting significant themes.



## RESULTS

Three superordinate themes concerning the participants' experiences of the group emerged from the interviews. Quotations from the participants have been used to label each theme as this was felt to best represent the true meaning behind each theme and kept the themes grounded within the participants' experiences. These themes were labelled: *"I would love to be like that"*, *"It was about going along...for me. And that was something that I hadn't experienced before."* and *"Whereas before I would probably just let it take over and consume me"*. See Appendix 2.7 for a full table of superordinate themes and associated subthemes.

Extracts from individual participants have been selected to illustrate the evidence behind each theme, whilst also discussing the theme at a group level, in keeping with the hermeneutic cycle in IPA. Participant quotations are presented in italics with pauses in speech indicated by a series of three dots (...) and where extracts have been condensed the missing text is illustrated by a series of three dots encapsulated by square brackets [...]. Non-verbal behaviour is also presented in square brackets, e.g. [laughter]. Participants' often referred to the facilitators of the group by name and so to preserve confidentiality these names have been transformed to 'FACILITATOR 1' or 'FACILITATOR 2'.

There was generally a high degree of concordance between the accounts of the individual participants. One participant, Janet, deviated from other group members in terms of the fact she had not explicitly integrated mindfulness or used it after the group and extracts from her account are often used to represent important, divergent perspectives.

Within the results and the discussion section of the current study the word 'being' is often used in the context of, for example, 'a new way of being'. The word 'being' in this context relates to the broad concept that encompasses a

person's objective and subjective experiences of reality. For example, 'a new way of being' describes that a person has perhaps changed in their overall demeanor or approach to life as a whole.

### **Superordinate theme 1**

*"I would love to be like that."*

*(Nicola, lines 85 - 89).*

The first theme captures the aspects of the course that initially sparked the participants' interest in attending it. This moves from more explicit reasons such as the applicability of mindfulness in both personal and work life to a more interpretative subtheme concerning the participants' desire to acquire the qualities of people they perceived as embodying the characteristics of mindfulness.

#### *Subtheme 1: The course as potentially applicable to work and personal life*

The majority of participants noted that the potential of the mindfulness course to help them to cope with stress at a personal as well as professional level was appealing. Here, Nicola, a relatively senior physiotherapist with responsibility for managing others conveys a sense of optimism and hope when discussing her initial motivations:

*"I thought this is something that is ticking several boxes, I'm going to personally benefit out of it but I think it could be very relevant to work in terms of my role in helping staff to feel motivated, to be resilient and cope with the stresses of the job." (Nicola, line 22).*

Here, Nicola first says that she hoped to personally benefit from attending the course but this is not elaborated on and she continues to say exactly how she thought the course would benefit her in work terms in more detail in her role as a senior clinician. This suggests that the course's ability to enhance her work life was potentially, initially, of more importance to her than any effect it may have on her personal life. Below, Kate describes the sometimes stressful elements of the life of a busy healthcare professional:

*Kate: "I love my job."*

*Interviewer: "Sure."*

*Kate: "But I think it's very full on, very stressful and very often I find that um, it's continually chasing myself [...] and there's very little time, and this is no reflection on anyone I think it's just sort of NHS in general, that reflective time to maybe stop and think.[...]so maybe that was why I was open to it." (Kate, lines 15-19).*

Kate's use of metaphor here ("*chasing myself*") conveys the idea that she was not living in the present moment at this point in her life, a central feature that mindfulness practice aims to promote. Kate then goes on to discuss the idea that within a fast-paced work environment time for reflection is limited. She is also quick not to blame anyone in particular for this, deferring to the 'culture' of the NHS as one in which there is a general sense that people are always busy and there is little time for self reflection. Kate is at a similar level of seniority to Nicola, in that they both have responsibility for other clinicians, these positions necessitate that they be proficient in a number of areas beyond direct patient care, for example in managing other staff. Below, Faye reflects on the "stage in life" that participants in the course were at and how mindfulness fitted well with this stage:

*“I do think a lot of it to do with where you are in life, I think there’s an age-related thing too in terms of career development and do you know when you get to a certain age looking for broader things that help you deal with everyday stuff.” (Faye, line 6)*

Here Faye alludes to the stage in career development that she is at where there is a large level of knowledge and experience but that with this comes more responsibility and less ‘black and white rules’ with the potential for stress levels to increase, again echoing both Nicola’s and Kate’s sentiments above. There appears to be a general sense of searching for “*broader things*” from the participants, which may be related to the senior positions which many of them held.

Several participants also described that personal circumstances related to stress also influenced their decision to join the group:

*“It sounded that it would definitely help me manage things better in my personal life, which I think... I was reacting to a lot of situations, you know probably making the situations worse, just, em family issues, em and I was probably bringing about a lot more stress into my life than actually needed to be there.” (Skye, line 4).*

There is almost a sense of desperation in this extract from Skye. To say that something sounds like it would “*definitely*” help her to manage things better is a bold statement to make and suggests that, for her, the course was something she invested a lot of hope in.

A somewhat divergent perspective is found in Janet's description of her initial motivations for attending the course:

*Janet: "When we were actually doing the course, you know we thought it was interesting and whatever but we couldn't imagine incorporating it into our lives unless we felt a real need for it."*

*Interviewer: "Right, okay."*

*Janet: "which wasn't obviously the attitude that I'd gone into it with you know I just thought it might be something I'd learn to do and then do."  
(Janet, lines 89–91.)*

Janet's implicit description of the MBSR course here is that she believed that it was something that you 'complete', then you have 'learned it' and then you 'do it'. This appears to be at conflict with the ethos of mindfulness on a number of levels and perhaps indicates that Janet did not experience the gains that others did. The way she describes only incorporating mindfulness if she felt a "need" for it suggests that the idea of building mindfulness into her life was challenging for Janet and that she was perhaps searching for something more immediate that required less long term practice to reap any rewards such as lowered stress levels. Janet refers to "we" in the passage due to her attending the course with a colleague.

#### *Subtheme 2: The intrinsic appeal of mindfulness and 'the mindful person'*

A number of participants noted that they had had some experience of similar practices to mindfulness (e.g. yoga) before undertaking the group such as Luna, a researcher and counseling psychologist:

*" I started to notice the qualities of people that were teaching these types of things, the nature of how they were." (Luna, line 205).*

In describing people who engage in mindfulness practices we see that Luna notes there is something appealing about these people. The use of a mindful language here “*how they were*”, is significant because Luna here does not describe specific features of the personalities of the people she is alluding to but instead opts to use the more general descriptor of how they “*were*”. This indicates that there is something hard to articulate or intangible about the “mindful person”. This was a common finding amongst the participants:

*“I see behaviors modeled in the teachers [...] there is a sort of common tone and kind of vibe from them which I think is really attractive and I think I would love to be like that.” (Nicola, lines 85 - 89).*

Nicola describes people who practice mindfulness as having a “*common tone and kind of vibe*”, similar to Luna’s description, these are relatively general terms and hint at the fact that mindfulness, and the qualities that it embodies can often be hard to describe but this is not experienced in a negative way. Indeed, considering the use of the word “*attractive*” it is almost that there is perhaps an element of seductiveness regarding the qualities of a mindful person. A small number of participants moved beyond articulating the general features of mindfulness and why these were appealing and described how features of their personality also fitted with the ethos of mindfulness as seen below in the extract from Skye:

*“...within this department, em although things are happening in people’s lives that aren’t always going the way they plan and there’s lots of difficulties in all our lives,[...] recognising that what’s happening might not be good but things are impermanent” (Skye, line 6).*

Skye’s job as a charge nurse on a physical rehabilitation ward would likely have involved working with patients who may ruminate on past abilities or think far ahead into the future regarding their recovery. She notes that the idea

that things are “*impermanent*” is important to her. The idea of impermanence and not living life in the future is a central tenet of mindfulness and so here we see that Skye’s personal coping style (remembering that things are impermanent in a working environment where there is an increased potential for rumination on lost abilities) fits with the ethos of mindfulness and therefore mindfulness presents as intrinsically appealing to her.

## **Superordinate Theme 2**

*“it was about going along...for me. And that was something that I hadn’t experienced before.”*

*(Skye, lines 83-86)*

The second superordinate theme captures the recurring comments that a unique factor of the mindfulness group, when compared to other groups, training events or meetings that participants had attended, was the ethos that was promoted in the group. The ethos of the group was one where a mindful style of interaction with others was promoted by the facilitators initially and then embodied by the participants during the course. Over time, this atmosphere led to the majority of participants feeling safe and contained, which contributed to the novel experience of the group. How this unique ethos was experienced, why it was important and the components that potentially contributed to it are explored in the subthemes below.

### *Subtheme 1: The novelty of the experiential and personal focus*

A recurrent experience for the majority of participants was their surprise that the course had more of an experiential than academic focus:

*Bryan: “I thought if you’re being allowed to do something in your work time it would be more about, em, learning a set of skills...and I kept waiting for that to happen.” [laughter]*

*Interviewer: "OK OK."*

*Bryan: "...but it didn't which I was quite pleased about." (Bryan, lines 21-22).*

There is a sense that Bryan, a forensic psychologist, was almost "on edge" waiting for this academic part of the course to begin and that this would detract from the refreshing part of the course, which was the fact that there was no overly academic component:

*"I think it's an experiential process, I think when you...it works you have to understand the state you're trying to elicit and how that subjectively appears to you." (Bryan, line 12).*

Bryan illustrates why the experiential element of learning about mindfulness is crucial. He notes that there is a 'subjectivity' to mindfulness that can only be understood when the individual achieves a mindful state, i.e. one can read numerous definitions of what mindfulness is but actually experiencing it is something unique to the individual. This is an encouraging finding as Segal et al., (2002) emphasize that "experiential learning" in MBSR is crucial and that intellectual knowledge by itself is "wholly inadequate" (Segal, et al., 2002, p. 91). When asking participants to articulate the differences in the group in comparison to other training courses or groups participants often had difficulty with this. The extract below from Melanie, a reader in applied health research and a nurse exemplifies this difficulty:

*Interviewer: "What was different about that group and another group that you may go to or another meeting?"*

*Melanie: "Well I think probably, there isn't structure, well there is because obviously there's a purpose to each class [...] but it didn't..."*



*God that's hard, what is different? There's very little structure, there's an overall aim and there are certain activities that need to be achieved, well don't need to but the aim is to achieve them, [...] there is so much time to, for people to really look at those in depth and to appreciate and understand what they are about, so you don't usually get that."* (Melanie, lines 107-109).

Melanie weaves out of and back into a more goal orientated outlook several times in this passage, for example when she notes there is a purpose to each group session and then appears to question this (*"but it didn't"*) before attempting once again to try and place a Western, goal orientated framework on the group before again slipping out of this (*"well don't need to"*). She then ends by noting that there is something novel and unique about the group (*"you don't usually get that"*). Below, Skye notes her shock that the course was focussed personally on her, a potential factor that contributed to the uniqueness of the group:

*"...any previous training that I've been to, you know a lot of it is just, em, cerebral, [...]and it doesn't feel personal [...] but I think in the first instance it was about going along, em, ... for me. And that was something that I hadn't experienced before."* (Skye, lines 83 - 86).

Skye's pause here, at the end of the penultimate sentence, is significant. Upon reading the last line of this quote there is the sense that Skye is experiencing a sense of almost disbelief that the course was primarily focussed on her and attempting to benefit her in some way as opposed to a course that had a more concrete, external learning objective related to patient care for example:

*"...new ways of treating back pain or whatever that's great but it's not really benefiting me on a personal level."* (Nicola, line 96-98).

Here, Nicola provides further evidence of the novelty of the personal focus and the refreshing nature of the course as not just being about another way to treat patients and more focussed on her.

### *Subtheme 2: The group as a sanctuary*

The majority of participants reflected that attending the group provided opportunity for respite in an otherwise busy work and personal life.

*“Um, it felt, very caring [...] it comes back to what I wanted in the first place, that you could take some time out and to reflect... um , it was just a really nice little pocket, in my week.” (Kate, line 154).*

*“[Smiling], I just remember it being a really... the word that comes to mind when you say that is ‘Oasis’ ” (Nicola, line 24).*

*“you felt very held”. (Bryan, line 53).*

Kate’s use of the descriptor “*pocket*” conveys connotations of protectiveness, of a cocoon in which she felt safe and contained during the group. Nicola communicates a similar image with the use of the word “*oasis*”, which conveys a sense that she felt that the group was acting to rejuvenate her. If the image is taken further it also has connotations of the group being a sanctuary within a desert, the desert perhaps being the stress that the participants of the group are attempting to achieve some respite from. Finally, Bryan conveys a sense of relief when articulating his experience of attending the group and further indicates a sense that the group acted as somewhere he felt “*held*”, echoing Kate’s sentiment when she described the group as a “*pocket*”. Below, Kate describes that attending a new group would not be something that appealed to her:

*“I know they’re out there and maybe I’m a bit reluctant to go to another group, you know, different atmosphere, different dynamic, I don’t know, I think that group is quite special, I liked it so much so maybe that’s why I haven’t really pursued that.” (Kate, line 284).*

The use of the word “*special*” indicates the distinctive nature of the original group and the tone this was said with conveys a sense of warmth and familiarity, which again has parallels with the idea of the group being a sanctuary.

*Subtheme 3: The importance of the group atmosphere as created by the facilitators and the group members*

The atmosphere of the group was highlighted by all the participants as an important part of what contributed to the uniqueness of the group. There appeared to be two main components that contributed to this atmosphere – the stance of the facilitators and the relationships created between the group members. This atmosphere, as created by the facilitators and the group members, may be a potential reason why the group was experienced as novel (subtheme 1) and as a sanctuary (subtheme 2). Below, Bryan notes the novel way the facilitators facilitated the group:

*“I mean they didn’t, there was no challenging in, ... you know that way in an academic lecture someone might challenge you [...] and they did do that but it was very subtle [...] it was done in a way that still kept the atmosphere of being mindful.” (Bryan, line 53).*

Bryan notes that the facilitators modelled a mindful way of ‘being’ and that this was unique to the group and important to teach the participants the central features of mindfulness. He notes that there was a subtlety to the way that the facilitators did this suggesting they conveyed more than the teaching of skills and that they had a way of being that resonated with Bryan, this relates back

to subtheme 2 of theme 1 ('The intrinsic appeal of mindfulness and 'the mindful person'.'). Below, Melanie notes a similar experience with regards to the stance of the facilitators:

*"I think FACILITATOR 1 and FACILITATOR 2 were really really excellent so there was a loss of them you know that whole sort of, um, guidance from, but they weren't guiding I mean, it was a weird one, because they weren't teaching or guiding they just...but they were."* (Melanie, line 98).

Here Melanie describes the stance the facilitators took by noting an almost 'guided discovery' aspect to the process of facilitating the group as opposed to leading and directing the participants. She corrects herself during the extract, noting that they "weren't guiding" after saying they offered "guidance". This highlights again the difficulty the participants had in pinning down the features of what the facilitators actually did to create and foster the atmosphere in the group. It is possible that what they were doing was demonstrating how to embody the characteristics of mindfulness without explicitly saying this. The stance of the facilitators appeared to act as a precursor to the participants feeling able to explore new ways of being, several participants alluded to be given implicit "permission" to test out new ways of being:

*"I remember at the start FACILTATOR 1 said [...] there is kind of homework and you can do it if you want, you don't have to do it [...]and for me I'm a real organised, I do all the pre-reading, I like theoretical, I'm a theorist kind of thing, that's how I learn, and I like the pre-course reading, I always do it, I do my homework I'm very I'm a girly swot type person, and em, to actually be given permission...just don't do it I thought okay I'll actually not do it, [laughter], so that felt a really different experience."* (Nicola, line 32).

Here, Nicola notes that before the course her approach to learning any new

skill was very methodical, organised and goal driven. These descriptors are almost the antithesis of what mindfulness aims to promote. Considering that this way of being has been successful for Nicola for most of her life, relinquishing this striving could potentially be perceived as frightening and something to be wary of so a strong facilitator is needed to give her permission to do this. Along with the facilitators giving permission for the participants to experiment with new ways of being it emerged that an important part of the group members engaging with or ‘buying into’ mindfulness as a concept was the facilitators appearing credible:

*“...in order to believe in it you kind of need to believe in them.” (Faye, line 54).*

Faye notes that there is a level of faith required in the facilitators, particularly in the initial stages of the group. Mindfulness does not offer a tangible ‘end goal’ to aim for and in order to buy into this concept it appears necessary for Faye and other participants to invest a level of trust in the facilitators. The atmosphere of the group appeared to be contributed to not only by the stance of the facilitators but also by the sense of mindfulness embodied by the participants of the group themselves:

*“It was lovely, em, they were, it was really relaxed and a really lovely group of people, like it felt, kind of... I felt... I felt like it was a place where if I wanted to say something I was kind of free to say it so I didn’t feel intimidated or awkward or like I’d be judged.” (Luna, line 88).*

Here Luna describes the safeness and non-judgmental ethos that she experienced in the group. There is a clear sense of warmth in her description of the group members here, the extract evokes connotations of mindfulness itself – e.g the idea of non-judgementalness. Exploring why this sense of acceptance from group members was important in creating a place where the participant felt this sense of safeness, Skye noted:

*“I think probably because ... you’re revealing things about yourself”  
(Skye, line 69).*

Here Skye notes that due to the focus on the experiential nature of the group there was an opportunity to talk about “*yourself*”. This could potentially be seen as making Skye feel vulnerable and indeed there is a sense that she experienced this as initially intimidating but that this was diminished over time potentially due the non-judgemental attitude of the group. The majority of other participants also noted the unique nature of the group in terms of the stance of their fellow group members. Below, Kate chooses to highlight the uniqueness of the mindfulness group by contrasting it with experiences of other non-mindfulness groups:

*“...and you often don’t get that, you know at meetings [...], not that I’m saying people are judgmental but there’s a different kind of atmosphere and coming together as a group like that, it felt very safe, protected, um, inspiring, it was just a very nice balance I think, and I think when we’re always working as hard as we do, you often don’t get that kind of dynamic.” (Kate, line 178).*

Kate notes the idea of a group ‘*dynamic*’ and how a ‘*safe, protected*’ atmosphere is not usually experienced within her normal working life. Her tone here is wistful, as if she longs for this type of dynamic to be experienced in others aspects of her working life but acknowledges that this is challenging, in part because of the busy working lives that most people lead. This relates back to her earlier comment regarding the lack of “*reflective time to maybe stop and think*” (Kate, line 17). Importantly, not all participants experienced this group dynamic as illustrated by Janet below:

*“I think I was probably surprised, although I shouldn’t have been really, at the lack of group dynamic really, in that I mean essentially it’s an*

*individual practice [...] but normally I, I can be quite gobby at these things and I wasn't, and I don't really know why, maybe I just didn't think it was appropriate for some reason, I don't know." (Janet, lines 28 - 34).*

Janet notes that when attending groups her personality tends to be one of the stronger ones (*"I can be quite gobby"*) but that at the MBSR group she did not experience her usual urge to be *"gobby"*. She is unable to offer an explanation for this, only being able to say that she didn't think it was *"appropriate for some reason"*. This suggests that despite her noting that there was a lack of group dynamic there may have been an implied message from the group that strong personalities and *"gobbiness"* are not qualities that embody mindfulness and so would perhaps not be welcomed in the group. Furthermore, Janet noted that she felt fraudulent (*"so I maybe felt that I was working at kind of one removed from everybody else."* Janet, line 141) during the group, because she was not going to use the mindfulness skills in a clinical capacity with patients as her job only involved research so this may explain the lack of experienced group dynamic. Luna also noted a downside to the safe and freeing nature of the group:

*"I was aware that, em, everybody else seemed to be quite tired in the group as well, so on the one hand it was nice to come together with a group of people who were slowing down [...] but on the other hand [...] it kind of felt like an emotional dumping [...] you would be picking up on other people's stuff." (Luna, lines 78-80).*

Here Luna notes that although the group was experienced as positive for her on the whole she also experienced a degree of transference in terms of picking up on emotions from other people in the group. The phenomenon of transference is regularly experienced in therapeutic settings and it is likely that Luna was perhaps more sensitised to recognise these feelings given her job role as a practicing counseling psychologist.

### Superordinate theme 3

*“Whereas before I would probably just let it take over and consume me”*

*(Skye, line 92)*

The third theme captures the participants' experiences of integrating mindfulness into their lives. Participants noted that this integration did not happen easily, reporting a sense that the concept of mindfulness often jarred with their long held beliefs regarding the world and that the process of re-orientating themselves towards experiences was challenging, although ultimately rewarding. This re-orientation to thoughts and feelings often resulted in an increased awareness of their relationship with themselves, in particular participants became more aware of their low levels of self-compassion. The final elements of this superordinate theme relate to the benefits and challenges the participants experienced in terms of integrating mindfulness into their lives and how they planned to retain a mindful element in their lives.

#### *Subtheme 1: Recognition of the East/West clash*

The majority of participants reflected on the fact that mindfulness represented an ethos that was almost alien to them when they began the course. Below, Nicola reflects on the process of attempting to reconcile this clash:

*“I think it's really been a real journey to really try and get your head around a completely different way of thinking [...] I feel that, a year on, I'm still, you're so ingrained to behave in a Western, goal orientated way and I, I suppose I really buy into that having had quite an academic career, a problem solver [...] so to step out of that is quite an effort but it's really good to become aware, I think I've become much*



*much more aware of my thought process and what I'm doing.” (Nicola, line 38).*

Here Nicola notes a realisation that her mind is “*ingrained*” to think in a Western way and that she “*buy[s] into*” this way of thinking – essentially meaning that she has investment in this way of thinking, potentially because it has been successful for her at least in terms of career achievement. Her increased awareness of her thought patterns has not come easily to her, “*to step out of*” them is challenging and potentially frightening which again is potentially due to the rewards she has gained from striving and goal-orientated behaviour. However, despite these rewards there is a realisation that there are negatives to this type of behaviour (e.g. increased levels of stress, evidenced by her attending the course) and despite the fact that breaking from this “*ingrained*” path is challenging she has persevered with it and begun to reap some benefits (“*become much much more aware*”) suggesting that this has reinforced her use of mindfulness practices. At a group level, all the participants were well-established practitioners who, by the nature of their successful careers, have all been invested in a goal-orientated, Western way of thinking. Recognising that there is an alternative path but also recognising the difficulty of breaking from their established path was experienced as unnerving but liberating for most of the participants. Below, Bryan relates his personal experience of being driven to excel in his career to the idea that this has shaped his outlook and orientation towards life and contrasts this with the principles of mindfulness:

*“...you’re jumping through hundreds of hoops to get to a point where you’ve got qualified and then you’re continually looking for hoops to jump through,[...] and I don’t think that encourages a way about being centered and non-attaining you know not driving yourself to attain.” (Bryan, lines 100-101).*

Here, Bryan echoes the sentiment of Nicola and appears to be discussing the idea of social constructionism – the idea that, in a Western world, striving is considered normal because the majority of people are motivated to attain goals valued by society such as material objects. This is at odds with the Eastern traditions of mindfulness where non-striving is promoted. He discusses the idea of jumping through hoops in an almost passive way – that this striving is almost something that is inevitable given that he has been conditioned over many years to work and think in this way. He also notes that people actively search for more hoops to jump through – again this description is at the heart of striving in that striving necessitates prolonged thinking about the future and ways to ‘attain’ which has the effect of not being able to experience the present moment – which is at the heart of what mindfulness aims to promote. It appears that this realisation is experienced as quite unsettling for some participants and first requires an awareness of this difference and then an ideological shift to move towards reconciling this uncomfortable feeling.

*Subtheme 2: Increasing awareness of the relationship with the self and increasing self-compassion*

The majority of participants noted that as they began to practice mindfulness they became more aware of how they related to themselves. Below, Kate describes a moment of realisation, a moment where she identified with the metaphorical concept of the mind as being ‘stalked’ and therefore became more attuned to her emotional state:

*“...he said when your mind is always digressing and very busy like that, the mind feels as if it’s being stalked [...] and I thought, oh my gosh you know that’s really what happens to me all the time and I don’t realize it because of all this busyness [...] it’s being stalked so it’s just ferociously moving all the time and it’s chaotic and the mindfulness was*

*fantastic because all of a sudden I learned how to just come back into the breath and clear the mind” (Kate, lines 104-105).*

Kate’s use of the emotive word, “*ferociously*”, indicates that her previous thinking style had a predatory quality to it, which would eventually catch up with her and this would perhaps manifest in the form of stress. She notes not being aware of this process due to “*all this busyness*” and that when she employed mindfulness she not only became more aware of the process but also found that mindfulness provided a grounding effect for her as she describes she learned how to “*come back into the breath*”. This suggests that mindfulness gave her the opportunity to tame the ferociousness and “*chaotic*” nature of her thoughts. A number of participants spoke of the difference between how they related to thoughts before and after the course. Below, Skye notes that developing an increasing practice of mindfulness has heightened her awareness of unhelpful thoughts that contribute to rumination:

*“I recognise when I’m not doing it and I think that’s certainly developing an awareness of when my mind is becoming agitated [...] whereas before I would probably just let it take over and consume me, you know.” (Skye, line 92).*

Skye contrasts her reaction to her mind becoming “*agitated*” before and after attending the group in this extract. She adopts a passive tone when describing her reaction to an agitated mind before attending the group (“*probably just let it take over*”). This process of following thoughts wherever they lead in a passive fashion is akin to the beginning of rumination on thoughts (the process of compulsively focussing attention on thoughts in a circular fashion) and strikingly echoes Kate’s comments above, regarding being “*stalked*”. Below, Nicola describes a similar level of increased awareness as Skye and Kate:

*“I tend to have certain thought patterns that I go into, my little records that I play in my mind so again I’m just much more aware of that’s what I’m doing, that’s why I’m doing it, this is what I feel.” (Nicola, line 63).*

Nicola’s use of the word “records” suggests that “*thought patterns*” run on a loop and are familiar to her. There is a sense that Nicola’s increased level of awareness of her relationship to these thoughts allows her to recognise the beginnings of rumination. Nicola appears to have given these thoughts an almost trivial quality by referring to them as “*little*”, i.e. something that does not take over and consume her mind and something that she has control over (“*I play*”). This speaks to a central feature of mindfulness – that of accepting negative thoughts as part of life and not attempting to banish them.

Most participants described a specific form of increased awareness of their relationship with the self, that of an increased awareness of a low level of self-compassion. This is perhaps not a surprising finding given that mindfulness explicitly promotes an increased level of compassion towards the self and others:

*Melanie: “I would have shouted to myself [...] and just got very frustrated really, just ended up going home and shouted at my husband [laughter].”*

*Interviewer: “So when you say kind of shouting at yourself and that’s what you might have done in the past, that might suggest that you came to relate to yourself differently?”*

*Melanie: “Yeah, I think you probably develop awareness I suppose [...] I think we all have massive expectations of ourselves [...] and if things don’t always turn out as you want them to turn out that you have to, you have to just forgive yourself really so yeah I think I think that’s true*

*I wouldn't have done that before, that's definitely a result of mindfulness." (Melanie, lines 133 – 136).*

Here Melanie talks about herself in the past tense initially, noting that she “*would have shouted*” at herself when feeling frustrated. She notes that this emotion *would* have stayed with her, potentially in the form of ruminative thoughts until she found a way to displace it, in this case, by shouting at her husband. Further in the extract she notes a realisation that, in general, people tend to have expectations of themselves that are somewhat unrealistic and then goes on to describe that she learned the importance of showing compassion to the self and forgiveness of the self. This appears to be represent a shift in the way she relates to herself which she relates directly to mindfulness. Her tone is one of non- judgmentalness towards the self and acceptance of the situation as it is. It appears that this shift in mental state makes for a more peaceful sense of self and has the additional benefit of less displaced emotion towards others.

### *Subtheme 3: The benefits and challenges of integrating mindfulness into work and personal life*

When describing the integration of mindfulness into their lives, several participants noted that mindfulness provided them with a choice that was not present before the group in terms of recognising unpleasant emotion and taking a different approach to coping with it:

*“It's just a wee switch that goes on and makes you stop and slow down, recognise how you're feeling, recognise what's going on around you and em it doesn't have to be like that, that you have the ability to change it.” (Faye, line 85).*

Here Faye notes that mindfulness arises as a potential coping strategy for her in moments of stress. The way she describes this suggests that there is an

almost automatic or subconscious quality to the process of mindfulness arising in her mind as a potential way to cope with stress. Below, Melanie describes how the opportunity to be mindful arises in a range of situations throughout life, suggesting the generalisability of it:

*“Mindfulness is a funny thing really, [...] once you get it you can use it in situations that you wouldn’t necessarily have anticipated before.”  
(Melanie, line 29).*

Here Melanie notes that after an initial period of learning, perhaps using the more formalised practices such as ‘sitting meditation’, the ability to be mindful or find the opportunity to be mindful in a variety of situations becomes easier. At a group level this was a common theme, there was little discussion from the participants around using the formal practices of mindfulness (e.g. setting aside 30 minutes to engage in meditation practice) and more discussion of how they become more aware of carrying out everyday activities in a mindful way (e.g. being mindful whilst cooking a meal or brushing their teeth). The extract from Melanie below describes the stage after recognising that mindfulness may be a potential coping strategy for moments of stress and goes on to explain how being mindful was experienced by her personally. She compares the experience of mindfulness to the procedure of inducing an insulin coma in an injured sheep to promote recovery (or healing) from infection:

*“It’s that whole cycle of distress, pain, fear and what they do is they literally knock them out and then healing can start to take place [...] and I think in a way mindfulness is a bit like that, it’s that whole sort of stop everything, focus on, and almost taking you out of yourself. [...] yeh and I think that’s really quite important and that’s the skill that I never had before [...] - it’s like stop the world I want to get off, but just stop the world for 5 minutes.” (Melanie, lines 160 - 164).*

Melanie's use of this metaphor is a powerful way to describe mindfulness as akin to healing, an opportunity for respite in a "*cycle of distress, pain, [and] fear.*". What she describes is almost akin to 'grounding' herself, being present in the current moment and this being experienced as rejuvenating. This suggests mindfulness has provided her with an escape from the "*cycle*" she describes. At the end of the extract there is an element of the Western mind returning to her thought process as she notes "*but just stop the world for 5 minutes*", this implies that mindfulness has given her a tool to use in moments of stress that she did not have before the group. Below, Kate describes a change in her orientation to stressful situations:

*"I think how I approach stress is different, um, I think I stop and I breathe and um I'm less emotive, um, less quick to react [...] I'm just taking a bit more time and that's working better, um, than before where I was always just again that sort of stalking, chasing my tail, [...] and I think because of that I'm making better decisions."* (Kate, line 213).

Kate describes that her attitude to stressful situations has shifted, her tone in this extract is quite mindful, the use of the words "*approach*" and the phrase "*taking a bit more time*" suggest a more measured and contained response to a stressful situation than may have been the case before the MBSR group. This is further evidenced when she refers back to one of the first things she said in the interview regarding "*chasing myself*" (Kate, lines 15-19) – she notes that mindfulness has allowed her to gain clarity, to stop for a moment, reflect on a situation and in doing so, make better decisions. This extract describes Kate employing mindfulness techniques with the effect of helping her make better decisions which implies that mindfulness has had a positive effect on her ability to navigate the stresses of life and work. Participants noted specific benefits of mindfulness in both these areas. In particular, participants noted that mindfulness was helpful in their work with patients directly. All the participants, apart from Janet, worked directly with patients in a wide range of roles. Participants who worked clinically with patients reported

an increased sense of attunement with patients as exemplified in the extracts below from Luna:

*“Em, it probably has allowed me to be more ... present, when I’m in the therapy session.” (Luna, Line 222)*

*“When I first started if someone was upset I just immediately wanted to take their pain away [...] now I just sit with their distress, em, and just kind of look at how they can regulate that and be present with it.” (Luna, lines 224 - 228)*

These two extracts from Luna, a research psychologist who also works with patients in a clinical capacity as a counseling psychologist, describe the maturation of her as a therapist. She describes being more “*present*” in a therapy session suggesting that she would be more attuned to the patient’s needs. She goes on to note a shift in her stance towards unpleasant emotions. She is now more able to help the a patient sit with a level of distress and therefore is not acting to undermine the patients sense of self efficacy by ‘removing’ any distress that they experience or implying that negative emotion is to be avoided. Again, this sense of accepting negative emotion is a central component of mindfulness. Below she further describes becoming more comfortable with emotions in general:

*“...the practice of doing it means that learning how to sit with your own emotions and learning that they’re not as scary as you maybe initially thought they were means that there’s kind of a faith now and there’s a kind of , em,...experience that I’ve had that I can draw on.” (Luna, line 230).*

In describing what gave her the confidence to become more present with patients and a reduced feeling that she needed to “*take their pain away*” she notes that her own mindfulness practice had increased her “*faith*” in her ability



to sit with distressing emotions. This suggests that she perhaps presents in a more authentic way in therapy sessions. Luna's description of this more measured reaction to a patient's discomfort is mirrored in the extract below from Kate:

*"...with the people that I manage, I think are also feeling a bit more empowered to make their own decisions as well, as autonomous practitioners and that I've seen some good development." (Kate, line 215)*

Kate, a clinical team lead, implies that her previous reaction to a colleague asking for advice may have been to act as the 'rescuer' and offer solutions (in a similar way to Luna wishing to protect the patient from the consequences of negative thoughts by wishing to take their pain away), whereas she now reacts in such a way as to empower colleagues through increasing their autonomy. Essentially, Kate is relinquishing control here, not attempting to influence a situation and allowing the colleague to find their own solution in a similar way as Luna has developed her therapeutic style to give the patient a greater sense of autonomy. Skye, a charge nurse on a physical rehabilitation ward also noted that mindfulness is something that she attempts to integrate into her work with patients:

*"...when I'm talking to patients, in a one to one capacity I certainly bring mindfulness into the conversation but I might not use that term you know, but I might speak about just [...] how do you let go of thoughts that you would normally ruminate about and bringing some...calmness em to your, to your mind." (Skye, line 88).*

From this extract there is a parallel between how the facilitators within the group presented themselves during the group in that they embodied mindfulness (discussed in superordinate theme 2, subtheme 3 – 'The importance of the group atmosphere as created by the facilitators and the

group members’) and this was perceived as something desirable by the participants (discussed in superordinate theme 1, subtheme 2 – ‘The intrinsic appeal of mindfulness and ‘the mindful person’). Skye’s description of her way of bringing mindfulness into her workplace mirrors the approach taken by facilitators during the group – that is, embodying mindfulness as a way of setting an example of how to ‘be’. In addition to experiencing the benefits of mindfulness from a work perspective, the majority of participants also reflected on how mindfulness had been incorporated into their personal lives:

*“...it made me a better carer [...] it made me focus more, on the task of, you know feeding someone or the task of brushing someone’s hair, as opposed to, you know doing it as I’ve got to get this done so I can get onto something else [...] and I think sometimes you can build those practices into an everyday life really”. (Bryan, line 60).*

This extract from Bryan illustrates the fact that although the activities he describes are not ‘mindful exercises’ in the formal sense, nonetheless they were activities where having an awareness of what mindfulness was – appreciating the present moment and paying attention to it in a particular way – provided a framework for the task of caring for a disabled person. Here Bryan notes a greater awareness of the present moment and how this allows a greater level of attunement to the person he is caring for in his personal life in a similar way to the extracts from Luna and Kate above speak to the process of mindful awareness leading to greater attunement with patients and colleagues respectively. Here Bryan is recounting the same process – being present in the moment – but just in a different setting (at home with a disabled person), again this speaks to the broad-brush approach of mindfulness and it’s applicability in a range of situations. Nicola also noted this increased ability to use mindfulness in a personal setting:

*“...my daughters actually trying to tell me something [...] and I think I’m much more able to drop everything and be there totally 100% focussed*

*in that 5 minutes, [...] but to see the value and have the skills to be able to notice[...] rather than be distracted about the endless to-do list so that's a huge plus.” (Nicola, line 59).*

Nicola is a physiotherapist who also works from home in the evenings, suggesting that time spent with her children in the evening is sometimes limited. A significant component of this extract is Nicola's admission that she has “*the skills to be able to notice*”, this suggests that even when one is not practicing mindfulness in a formal or informal way there is almost an underlying heightened awareness of the importance of the present moment similar to the quote from Faye at the beginning of this subtheme. One participant, Janet, did not experience the benefits of integrating mindfulness into her home or personal life:

*“...what I was feeling was I don't think I can get anything more from doing the things I've learnt than I'm getting already from my yoga practice.” (Janet, line 92).*

Here, Janet, an information scientist who did not see patients clinically, notes that mindfulness did not offer her anything more than the physical practice of yoga. Janet's experience of the course may have been affected by the apparently small amount of investment she had in it from a personal perspective. She noted that she undertook the course because she was carrying out research into mindfulness and was advised to experience mindfulness first hand. This may indicate that reducing her personal stress level was less of a reason for undertaking the course than others in the group and therefore she may have been less inclined to undertake the formal practices and therefore be less able to integrate mindfulness into her life. In contrast all the other participants noted positive changes in their personal and work lives, which they attributed to increased levels of mindfulness.

#### *Subtheme 4: Beginning a journey.*

The majority of the participants noted that they had endeavored to retain a mindful element in their lives after the group had ended. Below, Nicola reflects on the non-striving nature of mindfulness and how despite this she still feels a benefit in continuing with the practice:

*“I think I just want to try and keep a regular practice and just see that as not trying to get somewhere,[...] it’s a funny thing it’s like not looking at it directly, you wouldn’t be doing it if you didn’t think something was changing about yourself. [...] but it’s quite subtle how it’s helping you.” (Nicola, line 77).*

Nicola notes “*it’s a funny thing*” suggesting that she still feels that there is something strange about there being no defined end point or overt ‘purpose’ in a Western sense to the practice of mindfulness. However, this is not experienced as a negative aspect of the practice. Nicola notes the idea that the way mindfulness works is “*quite subtle*” which echoes the idea that mindfulness and being mindful are difficult concepts to pin down and define. Kate also notes that mindfulness is something that has had a lasting impact on her:

*“I think this is something that’s not gonna go away.” (Kate, line 168)*

Kate’s tone here conveys one of companionship and stability – as if mindfulness has become part of her identity. This idea of mindfulness becoming part of some of the participants’ identities is further articulated in this extract from Melanie:

*“...this is a skill set and a way of I don’t know... a way of living I suppose that I well, well, yes that’ll be with me I would say pretty much most of my life, well all my life, from now I hope.” (Melanie, line 172).*

Here Melanie describes that the mindfulness course has instilled in her “*a way of living*” and hopes that it will be “*with*” her for the rest of her life. These are bold statements to make and indicate a profound change in Melanie’s experience of life. The use of language here illuminates a central feature that several participants experienced regarding the course - it is almost as if mindfulness has taken on a protective and comforting presence within their lives. Melanie use of the words “*with me*” suggests that, in a similar way to Kate above, mindfulness may have become part of her identity. This perhaps suggests a reason for the protectiveness that participants had over mindfulness which is further exemplified below in an extract from Skye:

*“It’s obviously stayed with me, you know because I’ve been on lots of training and you go and you’ll come back and you’ve got some thoughts on how to develop something and then you let it go and I’m not letting go of this, em, and I feel it’s become part of my life.” (Skye, lines 98 - 99).*

Skye echoes the sentiments from the extracts from Nicola, Kate and Melanie above. Similarly to Melanie she notes that mindful practice is something that has stayed “*with*” her, the use of this type of mindful language is distinct from perhaps other training courses where a skill is learned and then employed to help patients, for example, in a relatively concrete fashion (e.g. when a physiotherapist learns a new treatment for treating back pain). Skye and Nicola both noted that they are aware that mindfulness practice is not about goal attainment and that it is more akin to incorporating a “way of being” into daily life. Skye further emphasizes this by comparing the MBSR course to other training courses where after the training is completed, there is an initial enthusiasm which then dies down whereas this does not seem to be the case for the majority of the participants of this study.

A number of participants articulated a level of protectiveness over the concept of mindfulness, suggesting that it has brought something positive to their lives:

*“...with a lot of these therapies [...] they can just become victims of their own success really and I really hope that doesn’t happen to mindfulness,[...]I hope it doesn’t go down that route of you know the latest fad.” (Melanie, line 118).*

*“because it seems to be like it’s everywhere now, everyone’s speaking about it, and talking about it and it seems to be in the media now, and when things like that happen you start to wonder hmm is this going to be diluted.” (Kate, line 242).*

Here both Melanie and Kate consider the importance of preserving mindfulness as something pure. The use of the word “*diluted*” suggests that there is something potent about mindfulness and the overall tone of these two extracts suggests protectiveness over mindfulness. Their protectiveness suggests that they believe that mindfulness has provided them with something of value and is something worth preserving.

One participant talked of her frustration regarding the barriers to retaining a mindful aspect to her life:

*“...em so I think probably for me it was afterwards, ‘Oh where do we go now?’, You know and I felt that, that , was something that probably there was not really anywhere to go...I guess you know the support group was quite good for the few months that it lasted.” (Skye, line 39).*

Here, Skye notes that after the group ended she appreciated the support groups (a small number of participants continued to meet every few months to practice mindfulness together) however, there is a sense of frustration that there was no formalised way to further develop her practice and a sense that

she felt cast adrift at the end of the group. When the group ended the link to the sanctuary that participants had experienced was effectively severed, save for the support group that only met a small number of times. Skye was the only participant who explicitly said that she had hoped there would be a more formalised support structure after the course. However, majority of participants noted they had retained a mindful element to their lives due to their own interest and practice.

## DISCUSSION

The aim of this study was to examine how healthcare staff who had undertaken an 8-week MBSR course understood and described their experiences of mindfulness before, during and after the course. Three superordinate themes emerged from the interviews that captured the participants' experiences. *"I would love to be like that"* captures the initial appeal of mindfulness in terms of it being perceived as something that could benefit the participants in their work and home lives and the qualities of mindfulness being ones that they aspired to acquire. *"It was about going along...for me. And that was something that I hadn't experienced before."* relates to the novel experience of the group, the experience of it as a sanctuary and how these characteristics of the group were partly created and maintained by the facilitators and the group members embodying the characteristics of mindfulness. Finally, *"Whereas before I would probably just let it take over and consume me"* captured the changing relationship with the self that the participants' experienced, their less passive attitude to letting negative thoughts 'take over', their experience of the integration of mindfulness into their lives in both their work and home lives and how they have endeavored to retain a mindful element to their lives.

As noted in the introduction there is limited literature utilising qualitative approaches to examine the experiences of participants from clinical populations (e.g. participants with clinical diagnoses such as depression) who

have undertaken mindfulness-based interventions and even less examining the experiences of nonclinical populations. From the limited literature from qualitative studies examining clinical populations, common emergent themes regarding the experiences of mindfulness-based interventions have broadly noted: the process of becoming more mindful as challenging and requiring patience, persistence, openness and discipline; a greater feeling of self acceptance; a shift from negative to more positive thinking; group support as important and behavioral changes associated with mindfulness such as symptom reduction, applying mindfulness in everyday tasks and improved sleep (Allen, et al., 2009; Mason and Hargreaves, 2001; Finucane and Mercer, 2006; Stelter, 2009; Griffiths, et al., 2009; Proulx, 2008; Mackenzie, et al., 2006; Fitzpatrick et al., 2010). Although the current study used a nonclinical population, two of the three superordinate themes identified in the current study (*"It was about going along...for me. And that was something that I hadn't experienced before"* and *"Whereas before I would probably just let it take over and consume me"*) have some similarities to a number of the identified themes from the literature examining the experiences of clinical samples listed above. Both these themes capture the unique experience of a mindfulness group and the challenging but rewarding nature of integrating mindfulness into daily life. Therefore, broadly, these themes appear to be consistent across the available literature regarding clinical groups and the experiences of the participants in the nonclinical group in this study.

Superordinate theme 1 (*"I would love to be like that"*) appears to be less represented in the above qualitative studies of mindfulness in clinical populations and represents a relatively unique and important finding of this study. A possible reason for this theme not emerging from previous qualitative research using clinical populations is that the initial appeal of attending a mindfulness group in relation to a clinical diagnoses (e.g. depression) is likely to have been quite specific - e.g. to reduce the symptoms of a clinical diagnosis. In contrast, the initial appeal of mindfulness to the participants in the current study (i.e. a nonclinical group) appeared to be broader than this –



they described their expectations of reductions in stress in work or home life using broad and general terms as opposed to hoping for specific reductions in specific aspects of their mental health. One qualitative study that examined the experiences of a nonclinical group (nurses) who had undertaken an MBSR programme (Cohen-Katz, et al., 2005) provides support for this superordinate theme. Cohen-Katz et al. (2005) note that nurses commonly reported that being better able to cope with family and work stress was a significant factor in the initial appeal of attending their group. The study by Cohen-Katz, et al., (2005) also describes the benefits of the MBSR course with regards to improving interpersonal relationships. This relates to the superordinate theme *“Whereas before I would probably just let it take over and consume me”* identified in the current study. Overall, in addition to supporting key concepts from the clinical and limited nonclinical qualitative literature this study has identified further elements regarding the experiences of participants undertaking mindfulness-based interventions which offer insight into this emerging area of research. Below, the findings are linked to existing theoretical understandings of mindfulness and related psychological constructs.

Superordinate Theme 2 (*“It was about going along...for me. And that was something that I hadn’t experienced before.”*) relates to the novel experience of the group for the participants. Participants described the experience of attending the group using a range of descriptors that conveyed a sense of safeness and security which was interpreted as necessary in assisting the participants to explore new ways of being. This experience of the group as being like a sanctuary appeared to be created and fostered by the facilitators and subsequently the other group members who embodied the characteristics of mindfulness such as a non-judgmentalness and accepting attitudes. Allen, et al. (2009) examined the experiences of MBCT in a clinically depressed sample and noted that the inevitable social comparisons that occur in groups appeared to reduce self-devaluative thinking in their study. In effect, participants’ experiences were normalised by the group. A similar effect was

found in the current study, the group members contributed to an atmosphere of non-judgmentalness and acceptance. This was experienced as especially refreshing for participants with Kate noting: “*you often don’t get that*” (Kate, Line 178) in relation to the unique atmosphere that was created within the mindfulness group. This finding should be interpreted in the context of the sample. One important aspect that unites a clinical population is their clinical diagnosis (e.g. depression) and one aspect that united the participants in this study was their healthcare staff status. As articulated by a number of participants there is often a sense of competitiveness in this type of work environment that was not experienced as strongly in this group. One participant, Janet, did not experience this group atmosphere, noting that she felt mindfulness was more of an individual practice. Although this is a divergent opinion within this sample, the guidelines for delivering the 8-week MBSR programme (Kabat-Zinn, 1990) emphasise the experiential nature of mindfulness and the unique experience of this for the individual, there is little emphasis placed on group discussion in these guidelines. Therefore, the fact that the atmosphere of the group still emerges as a non-specific factor which appears to contribute to the sense of the group as a sanctuary and a safe place to experience new ways of being is important for considering how mindfulness achieves its effects in group settings.

The study by Allen, et al. (2009) described above highlights that the facilitators had invited the participants of their study to cultivate ‘kindly awareness’ and that this built self compassion which they hypothesise created the conditions for empathy, intimacy and effective communication. These findings echo the findings of the current study in terms of the facilitators acting to embody the qualities of mindfulness (e.g. non-judgementalness and acceptance). However, the current study has also highlighted that the facilitators alone did not act to maintain the mindful qualities of the group and that the group members also acted to co-create this atmosphere. Furthermore, the stance of the facilitators as credible, experienced and trusted appeared to act as a precursor to the participants feeling able to explore new

ways of reacting to situations that may have been perceived as frightening due to the fact that they were “so ingrained” (Nicola, line 38). Several participants alluded to being given implicit ‘permission’ to test out new ways of being. In order to try out these new ways of being it appears that it is important to trust the facilitators, the participants’ ‘old ways’ of being have been successful for them and so to relinquish elements of their personalities (such as the goal-driven and striving elements to their personalities) requires a facilitator that they experience as authentic and can trust. The relationship that the participants appeared to develop with the facilitators and with the other group members could be considered in terms of attachment theory. Attachment describes the emotional bond between an infant and a caregiver (Bowlby, 1982). The infant requires a “secure base” from which they can explore the world with the comfort that they can return to their caregiver for safety and guidance. This has parallels with the group as a “secure base” for the participants where they are encouraged to experiment with new ways of being and to recount these experiences to the group in a safe space. There is emerging evidence that facets of mindfulness are associated with attachment security. Mikulincer & Shaver (2007, p.180) note that: “*People who have experienced attentive, responsive and sensitive caregiving are likely to be more securely attached and more mindful.*”. Furthermore, Farber, et al. (1995) argue that therapists generally function as attachment figures for their clients, noting that they provide a secure base for exploration, are typically seen as wiser and stronger and that they are specifically sought out in times of need. The parallels in terms of how the facilitators were described by the participants in the current study are clear.

Superordinate theme 3 (“*Whereas before I would probably just let it take over and consume me*”) captured the changing relationship with the self that the participants’ experienced and their experience of the integration of mindfulness into their lives. A recent literature review of mindfulness approaches argues that mindfulness achieves its treatment effect by the “retraining of awareness and non-reactivity ... allowing the individual to more

consciously choose thoughts, emotions and sensations rather than habitually reacting to them.” (Chambers, et al., 2009, p. 569). This summary is consistent with the increased sense of self-awareness that the participants in the current study described experiencing. A more specific model of how mindfulness achieves its effects is presented by Shapiro, et al. (2006) who describe the central shift of focus that occurs during mindfulness training as ‘reperceiving’. They posit that reperceiving is a meta-mechanism consisting of three axioms – intention, attention and attitude. ‘Intention’ describes the individual’s reason for practicing mindfulness meditation and they note this may develop over time. In the current study there is a clear sense that the participants found a number of reasons to continue practicing mindfulness after the group ended and noted that they were able to apply mindfulness in a wider variety of situations than they had thought possible at the beginning of the course. This suggests that their experiences fitted with this aspect of the model due to their ‘intention’ developing over time. ‘Attention’ refers to observing one’s moment to moment internal and external experience, a central component of mindfulness, which was again experienced by all the participants except for Janet. Finally, ‘attitude’ refers to the qualities one brings to attention or *how* one attends to moment-to-moment experience – e.g. kindness to oneself, openness to experience and acceptance. Again, the experiences of the participants in this study map onto this axiom of reperceiving in terms of developing an increased awareness of how they related to themselves and others over the course of the group, especially in terms of their ability to allow the group to become a sanctuary and a safe place where they could experiment with different ways of being.

Of particular note in the current study is that the participants highlighted an increased awareness of the low level of compassion they showed themselves over the course of the group and beyond it. A recent study by Kuyken, et al. (2010) demonstrated that the effects of an MBCT course on participants with recurrent depression were mediated by increased levels of self-compassion suggesting that increased levels of self-compassion may be an important

element of how mindfulness achieves its effects. Support for this finding was found in the current study with the majority of participants noting that increased awareness of how they related to themselves as a result of mindfulness practices helped them to react in a kinder way towards themselves during times of stress. Increases in self-compassion are particularly relevant to the field of psychotherapy, as compassion for the self as well as for clients has been suggested as an essential part of conducting effective therapy (Gilbert, 2006). Henry, et al. (1990) found that therapists who lacked self-compassion and displayed critical and controlling features towards themselves tended to be more critical towards their patients and have poorer patient outcomes. Although only two of the participants (Luna and Bryan) were directly involved in conducting psychotherapy, the other participants (except for Janet) also worked directly with patients in a healthcare setting. Increased levels of compassionate care have been shown to help elicit better patient information which informs treatment plans and which in turn leads to better patient recovery and increased patient satisfaction (Matthews, et al., 1993; Halpern, 2011; Sanghavi, 2006). Therefore, this increase in self-compassion has the potential to have a positive indirect impact on patient experience via the healthcare professional being more compassionate towards themselves.

In terms of the integration of mindfulness-based practices in their lives, the broad range of disciplines represented within this study meant that this was accomplished in a number of ways. A central theme running through the integration of mindfulness within both work and personal life was that of the participants becoming increasingly attuned to their environment, that is, participants described being more able to recognise their own emotions and reactions to events and disconnect from these in order to re-orientate themselves to the present moment. A specific type of attunement, 'interpersonal attunement', is described by Siegel, et al. (2012) as focusing attention on the internal state of another individual. This type of attunement is especially important when working psychotherapeutically with patients. Cigolla

and Brown (2011) used IPA to explore the experiences of a group of psychotherapists who had practiced mindfulness for periods of time ranging from 4 to 20 years. The authors found that a superordinate theme: 'a way of being' was present across accounts which was made up of three subthemes: 'a way of being in personal life', 'a way of being in work life' and 'encouraging a way of being in others'. The subthemes from the current study within the superordinate theme: "*Whereas before I would probably just let it take over and consume me*" broadly map onto the superordinate theme of 'a way of being' from Cigolla and Brown's (2011) study. This suggests that despite the participants of the current study not practicing mindfulness for as long as the participants in Cigolla and Brown's (2011) study the changes that take place begin to happen relatively quickly (whether they are sustained or not is an issue to be further explored in future research). Especially striking are the similarities between the findings of Cigolla and Brown (2011) in terms of the increased level of awareness that therapists described in therapeutic sessions with clients which allowed them to be more aware of their own reactions during sessions with patients. Luna articulated a very similar increased awareness of her therapeutic style and her increased ability to tolerate feelings of distress and for this to empower the client. Cigolla and Brown's (2011) subtheme of 'encouraging a way of being in others' is also represented in this current study, Skye noted that although she did not explicitly teach mindfulness techniques, she attempted to embody the characteristics of mindfulness when interacting with patients and experienced this as improving her tolerance of the sometimes challenging nature of her work.

A further example of the potential benefit of increased interpersonal attunement in the current study was related to the changes that participants reported in terms of their interpersonal relationships with work colleagues and family members. For Kate this meant empowering colleagues to make more decisions for themselves which represented a relinquishing of control for her. Melanie described being more open to giving praise to colleagues. Nicola described being more able to notice when her daughter was: "*trying to tell*

*[her] something"* (Nicola, line 59). These changes in relationships may have come about from greater interpersonal attunement, in a similar way to the increased attunement to patients that Luna described in her psychotherapeutic work with clients.

### *Implications*

The majority of the participants did not report maintaining the formal practices of mindfulness (e.g. regularly setting aside time to complete a meditation exercise) but still reported that they used the informal practices and reported employing mindfulness when faced with a situation that caused them stress. This suggests that mindfulness was utilised more as a way to re-orientate oneself to a stressful situation or, as discussed above, develop the ability to 'reperceive' a situation (Shapiro, et al., 2006). Although Kabat-Zinn (1990) emphasises the importance of formal practices in mindfulness there is as yet no evidence to support the idea that formal practice is the main vehicle for change in mindfulness practices (Smith, 2004). Indeed, DeZoysa, et al. (2012) examined the effects of an MBSR programme on mental health professionals and found that there was no effect of weekly mindfulness practice in terms of levels of distress or wellbeing. However, when the practice data was split into formal practice and informal practice categories increased mindfulness was found to be related to duration of informal practice but not formal practice. A potential implication from this finding is that after an initial period of intense practice (the 8 week course) the formal practices are subsequently less necessary. Although there is a large amount of emphasis on maintaining the formal practices after the course has finished there should perhaps be more discussion in the group of the importance of informal practices.

The follow up groups that were run after the 8-week MBSR course were organised by the group participants themselves. Most of the participants in the study noted that they would have participated in a more formalised version of the follow up groups if they had been led by one of the original facilitators.

This may relate back to the facilitators being perceived as attachment figures and the opportunity to return back to these figures in the context of the sanctuary of the group is something that a number of participants noted they would have valued. If the group dynamics are considered in terms of attachment, as described above, then the ending of the group becomes of crucial importance in terms of making this a positive ending. The majority of the participants noted they were able to cope with this well by attending the follow up groups and widening their reading on the area of mindfulness. However, one participant, Skye, conveyed a sense of being 'cast adrift' at the end of the group, with little security in terms of being supported to continue her mindfulness practice. This aspect of the findings highlights the importance of positive endings of the group and the potential usefulness of follow up groups.

Furthermore, the novel aspects of the course in terms of its experiential and personal focus were experienced as especially refreshing for most of the participants. The fact that the course was able to transcend beyond work boundaries and be applicable to the participants' personal lives as well as their work lives may have contributed to the participants being motivated to retain a mindful element to their lives. It would perhaps be important to highlight this broad benefit of the group when promoting it to potential participants in this population.

Finally, recent guidelines from the Department of Health (2012) regarding 'Compassion in Practice' emphasise the importance of NHS staff fostering a culture of compassion towards patients to help improve the way patients perceive their care. These guidelines also highlight the importance of supporting the health and wellbeing of staff, noting that: "*The link between the values and behaviours that staff are shown by their employers, managers and peers and the way they in turn treat others, including their patients and users of the service, is very clear.*" (Department of Health, 2012, p. 10). However, this document does not specify how this is to be achieved. The ability of



mindfulness to lead to increased compassion for the self and others (Kuyken, et al., 2010; Chambers, et al 2009; Gilbert, 2006) and the findings of the current study in relation to the process by which this happens suggests that MBSR may fit well as a method for increasing compassion in healthcare staff in line with these guidelines.

### *Further research*

In terms of further research it will be of importance to quantitatively measure changes in the increased levels of self-compassion and compassion for others reported by participants of mindfulness-based interventions, as these are potential contributors to mediating the effects of mindfulness (Kuyken, et al., 2010). This will allow further exploration of the link between compassion and mindfulness and specifically, if increased compassion leads to improvements in patient care in healthcare staff populations. This would contribute to an economic argument for increased provision of MBSR groups within this population.

Further research could also examine the perspectives of those around the individuals who begin practicing mindfulness. This study and others (Cohen-Katz et al., 2005; Allen et al., 2009) have highlighted the role of mindfulness in improving a person's interpersonal relationships, however there has been no research examining how these relationships change and what changes others perceive in the person who practices mindfulness. This would give further insight into the ability of mindfulness to contribute to changes in interpersonal relationships as well as changes in the practitioner's intrapersonal relationship. Related to this, there is relatively little emphasis on considering the group dynamics of mindfulness groups in current research. The experiences captured within the superordinate theme "*It was about going along...for me. And that was something that I hadn't experienced before.*" emphasise the role of the group as a sanctuary and the atmosphere as one where the participants felt safe to explore new ways of being and the

facilitators and other group members as being important parts of this. Further exploration of what contributes to this experience and how to foster and maintain this atmosphere could potentially lead to improved outcomes from mindfulness groups and give further insight into how mindfulness achieves its effects in group settings.

One of the aims of the current study was to describe the key features that facilitate and inhibit continued formal and informal practice of mindfulness after the course's completion. Gathering this information during the interview was challenging as to ask for information as specific as this would have likely broken the flow of the interview, going against the ethos of IPA. However, this information is still important to support future group members to maintain their mindfulness practices during and after the group and could be gathered via a questionnaire in future research. Finally, in terms of maintaining practice it would be useful to examine how the use of any follow up groups contributed to consolidating participants learning as there has been little examination of this in the current literature.

### *Limitations and strengths*

A significant limitation of this study is that participants of the MBSR course who did not go on to use mindfulness after the course had finished are underrepresented. There was only one participant, Janet, who noted that they did not use mindfulness after the 8-week course. An additional limitation is that the participants were exclusively Caucasian and only one male was represented. Furthermore, the retrospective nature of the study means that the experiences recounted by participants may have been influenced by memory biases. It had been hoped that it would have been possible to carry out respondent validation to ensure the themes that emerged were true to the participants' experiences, however this was not possible due to time constraints. It is hoped that the robustness of the analytic process, the discussion of the emerging themes with the researcher's supervisors and the

researcher's focus on reflexivity throughout the process have led to the themes being grounded in the participants' accounts.

The time since the 8-week MBSR group was completed is both a strength and a limitation of the current study. It is a limitation in that a number of participants noted that they had taken up further mindfulness practices after the course and therefore the findings cannot be fully attributable to the discrete 8-week MBSR course completed 12 months before the interview. However, it is a strength given that there is little research regarding the longevity of mindfulness after the courses have finished. A further strength of the study is that the use of IPA has allowed for a detailed understanding of the participants' experiences of the MBSR group. This experience has not been captured by quantitative research and there appear to be differences in how clinical and nonclinical groups are experienced. Exploring topics as they were brought to the interview enabled participants to discuss their experiences without being restricted by the researcher's own agenda or beliefs. A transparent and rigorous process was also followed in terms of having two transcripts analysed by the researchers supervisor as a means of audit, the discussion of emerging themes in research meetings and through keeping a reflective diary throughout the process of the researchers own attendance at an MBSR group.

## **CONCLUSION**

This study represents the first to use IPA to explore the experiences of a group of healthcare staff who have undertaken an 8-week MBSR course. The resulting themes fit well with previous qualitative literature exploring the experiences of clinical and nonclinical participants who have completed mindfulness-based interventions. In addition, the current study offers new insights and identifies several implications for the implementation of future MBSR groups in this population along with areas for future study. Further research regarding how mindful practice is maintained is required in terms of the usefulness of formal practices versus informal practices. The findings of

this study related to increased self-compassion amongst the participants fit with recent research regarding how mindfulness achieves its treatment effects and further research should explore this link by considering changes in interpersonal relationships as well as intrapersonal relationships. Finally, the implications of this study with regards to the ability of mindfulness to increase compassion suggest that mindfulness-based interventions may be a potential vehicle through which to increase compassion in NHS staff and systems in line with current governmental objectives in addition to offering a pragmatic and useful way to reduce stress in staff who work in a healthcare setting.

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## **CHAPTER THREE: ADVANCED CLINICAL PRACTICE 1**

### **Reflective account**

#### **Saying: “I don’t know”. Becoming comfortable with and using uncertainty in clinical practice**

Ross Kennedy Turner

*Submitted in partial fulfilment of the requirements for the degree of  
Doctorate in Clinical Psychology (DClinPsy)*

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## **ABSTRACT**

This reflective account focuses on the thoughts and feelings I experienced when assessing a complex client over a number of sessions in a secondary care setting. I begin by describing the process of assessment – the initial formulation and treatment plan, how and why this changed, why this led to a feeling of uncertainty and finally how I used this to clinical effect with the patient. This reflective account is split into two parts. Part I focuses on my reflections regarding the case. This reflection draws on Boud, Keogh & Walker's (1985) framework for reflective practice to conceptualise the consecutive experiences. This model was chosen because it helps to capture the idea of returning to an experience after one has reflected on it at an emotional and cognitive level, taking new perspectives and finally taking action in terms of changing clinical practice based on the original experience. In part II, I discuss the development of myself as a clinician more generally with particular reference to my increasing tolerance of uncertainty. I use Stoltenberg's Integrated Developmental model (1998) and Kohlberg's Stages of Moral Development (1971) as frameworks around which to discuss this development. Finally, I reflect on the impact and implications of New Ways of Working for Applied Psychologists (2007) in terms of the increased necessity for clinical psychologists to work with complex cases, which often bring with them an increased feeling of uncertainty.

## **CHAPTER FOUR: ADVANCED CLINICAL PRACTICE 2**

### **Reflective account**

**An elephant in a darkened room: Reflecting on the power of generating a narrative around a person's experiences in terms of consultancy and qualitative research**

Ross Kennedy Turner

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Doctorate in Clinical Psychology (DClinPsy)*

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## **ABSTRACT**

This reflection relates to my experience of providing consultation to a multi-agency gathering of professionals regarding the generation of a formulation of a client in a child and adolescent mental health service. Using Boud et al's (1985) framework for reflective practice I reflect on how I coped with my feelings of apprehension before the meeting and the mix of emotions I felt whilst facilitating it. I then discuss how I had initially underestimated the value of the meetings for the people who attended it in terms of the fact the meeting was more than just a space to generate a shared formulation, it was also about normalizing the feelings of frustration and confusion that the attendees were experiencing via the creation of a shared narrative. I then reflect on the wider role that generating a narrative around a person's experiences has to play in terms of qualitative research within clinical psychology and how this can be used to offer unique insights into peoples' experiences as distinct from categorical approaches to mental health.

## APPENDICES

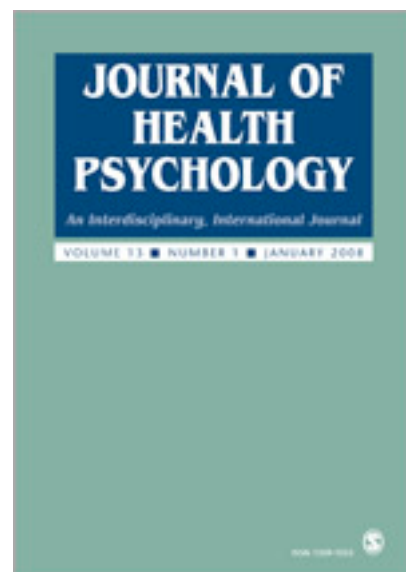
### Appendix 1.1 - Journal of Health Psychology Manuscript submission guidelines



#### Manuscript Submission Guidelines

##### *Journal of Health Psychology*

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**Journal of Health Psychology** is an international peer reviewed journal that aims to support and help shape research in health psychology from around the world. It provides a platform for traditional empirical analyses as well as more qualitative and/or critically oriented approaches. It also addresses the social contexts in which psychological and health processes are embedded.

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**Journal of Health Psychology** operates a strictly blinded peer review process in which the reviewer's name is withheld from the author and, the author's name from the reviewer. The reviewer may at their own discretion opt to reveal their name to the author in their review but our standard policy practice is for both identities to remain concealed.

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## 2. Article types

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- (c) Theoretical contributions and commentaries
- (d) Intervention studies
- (e) Brief reports
- (e) Signed editorials (about 1000 words) on significant issues.

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Please consult the Editorial concerning "Publication Guidelines for Intervention Studies in the Journal of Health Psychology" by David F. Marks J Health Psychol January 2010 vol. 15 no. 1 5-7: <http://hpg.sagepub.com/content/15/1/5.full.pdf+html> The criteria for publication include the application of the CONSORT, TREND and PRISMA statements.

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Authors must follow the Guidelines to Reduce Bias in Language of the Publication Manual of the American Psychological Association (6th ed). These guidelines relate to level of specificity, labels, participation, gender, sexual orientation, racial and ethnic identity, disabilities and age. Authors should also be sensitive to issues of social class, religion and culture.

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All contributors who do not meet the criteria for authorship should be listed in an 'Acknowledgements' section. Examples of those who might be acknowledged include a person who provided purely technical help, writing assistance, or a department chair who provided only general support. Authors should disclose whether they had any writing assistance and identify the entity that paid for this assistance.

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The text should be double-spaced throughout and with a minimum of 3cm for left and right hand margins and 5cm at head and foot. Text should be standard 10 or 12 point.

#### 9.4.1 Your Title, Keywords and Abstracts: Helping readers find your article online

The title, keywords and abstract are key to ensuring readers find your article online through online search engines such as Google. Please refer to the information and guidance on how best to title your article, write your abstract and select your keywords by visiting SAGE's Journal Author Gateway Guidelines on [How to Help Readers Find Your Article Online](#).

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Provide full contact details for the corresponding author including email, mailing address and telephone numbers. Academic affiliations are required for all co-authors. These details should be presented separately to the main text of the article to facilitate anonymous peer review.

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#### **9.4.5 English Language Editing services**

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### **11. Further information**

Any correspondence, queries or additional requests for information on the Manuscript Submission process should be sent to the Editorial Office as follows:

David Marks PhD: [jhpeditor@gmail.com](mailto:jhpeditor@gmail.com)

## Appendix 1.2 - Quality assessment and data extraction form

<b>Quality assessment form and data extraction form</b>	
<b>Quality assessment section</b>	
Study ID (Author, title, year of publication, journal title, page numbers.):	
Study Design:	
<b>Section 1: Methodology</b>	
1.1 The study addresses an appropriate and clearly focussed question or hypothesis.	Well covered – 2 Adequately addressed – 1 Poorly addressed – 0
1.2 The main objectives of the study are clearly stated.	Well covered – 2 Adequately addressed – 1 Poorly addressed – 0
1.3 The study details the procedures used/is replicable given the information stated.	Well covered – 2 Adequately addressed – 1 Poorly addressed – 0
<b>Total for section 1:   /6</b>	
<b>Section 2: Participants</b>	
2.1 Participants were recruited in a scientific manner and are representative of the defined population.	Well covered – 2 Adequately addressed – 1 Poorly addressed – 0
2.2 The study had a control group.	Yes – 1 No - 0
2.3. The study randomly assigned participants to treatment groups.	Yes – 1 No - 0
2.4 An adequate concealment method was used.	Well covered – 2 Adequately addressed – 1 Poorly addressed – 0
2.5 The treatment and control groups were comparable at the start of the trial.	Well covered – 2 Adequately addressed – 1 Poorly addressed – 0
2.6 The inclusion and exclusion criteria are explicitly stated.	Yes – 1 No - 0
2.7 The sample size is stated.	Yes – 1 No - 0
2.8 Intention to treat analyses are carried out.	Yes – 1 No - 0
<b>Total for Section 2: /11</b>	

<b>Section 3: Measures</b>	
3.1 A standardized measure of burnout (2 points) or a proxy measure of burnout such as a standardized measure of stress or psychological wellbeing has been used (1 point).	Well covered – 2 Adequately addressed – 1 Poorly addressed – 0
<b>Total for section 3: /2</b>	
<b>Section 4: Confounding factors</b>	
4.1 The main potential confounders are identified and taken into account in the design and analysis where appropriate	Well covered – 2 Adequately addressed – 1 Poorly addressed – 0
<b>Total for section 4: /2</b>	
<b>Section 5: Results/Statistical analysis</b>	
5.1 The analysis is appropriate to the design and type of outcome measure.	Well covered – 2 Adequately addressed – 1 Poorly addressed – 0
5.2 The results are clearly reported.	Well covered – 2 Adequately addressed – 1 Poorly addressed – 0
5.3 Effect sizes have been provided.	Yes – 1 No - 0
5.4 Confidence intervals have been provided.	Yes – 1 No - 0
5.5 Follow up data has been gathered and presented.	Well covered – 2 Adequately addressed – 1 Poorly addressed – 0
<b>Total for section 5: /8</b>	
<p>Overall Total: _____ out of 29</p> <p>Percentage:</p> <p>Classification: “High”           (≥75%)       [ ]</p> <p>                                  “Moderate”   (60-74%)   [ ]</p> <p>                                  “Low”           (50-59%)   [ ]</p> <p>                                  “Poor”           (≤49%)     [ ]</p>	

<b>Data Extraction Section</b>	
How many participants are included in the study?	
What are the main characteristics of the study population: What type of mental health professional are they? What setting do they work in?	
What are the main characteristics of the study: Is it an educational or psychological intervention? Is it delivered at an individual or a group level?	
Is a direct or indirect measure of burnout used?	
Are there comparisons being made in the study? i.e. between interventions or against a placebo/control group	
How long are participants followed up after the end of the study?	
<p>What size of effect is identified in the study?</p> <p>List all measures of effect in the units used in the study- e.g. absolute or relative risk. Include p-values and any confidence intervals that are provided.</p> <p>Note: include any adjustments made for confounding factors, differences in prevalence, etc.</p>	

### Appendix 1.3 - Matrix of quality rating scores

	Included studies																				
	Berry et al., (2012)		Brady et al., (2012)		Sharkey and Sharples, (2003)		Scarnera et al., (2009)		Perseius et al., (2007)		Chen et al., (2010)		DeZoyosa et al., (2012)		Salyers et al., (2011)		Doyle et al., (2007)		Ewers et al., (2002)		Redhead et al., (2011)
<u>Quality variable</u>																					
<b>Key:</b>  WC = Well covered = 2 AA = Adequately addressed = 1 PA = Poorly addressed = 0  Y = Yes = 1 N = No = 0																					
<b>Section 1: Methodology</b>																					
1.1 The study addresses an appropriate and clearly focussed question or	2		2		2		2		1		2		2		2		2		2		2



hypothesis. (WC, AA, PA)											
1.2 The main objectives of the study are clearly stated. (WC, AA, PA)	2	2	2	2	2	1	2	2	2	2	2
1.3 The study details the procedures used/is replicable given the information stated. (WC, AA, PA)	2	2	2	2	2	1	2	2	2	2	2
<b>Total: out of 6.</b>	<b>6</b>	<b>6</b>	<b>6</b>	<b>6</b>	<b>6</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>6</b>	<b>6</b>	<b>6</b>
<b>Section 2: Participants</b>											
2.1 Participants were recruited in a scientific manner and are representative of the defined population. (WC, AA, PA)	1	1	1	1	1	2	1	1	1	1	1
2.2 The study had a control group. (Y, N)	1	1	1	0	0	1	0	0	0	0	0
2.3. The study randomly assigned participants to treatment groups. (Y, N)	1	1	1	0	0	0	0	0	0	0	0
2.4 An adequate concealment method was used. (WC, AA, PA)	1	0	0	0	0	0	0	0	0	0	0
2.5 The treatment and control groups were comparable at the start of the trial. (WC, AA, PA)	2	2	2	0	0	2	0	0	0	0	0
2.6 The inclusion and exclusion criteria are explicitly stated. (Y, N)	1	1	0	0	1	0	0	0	0	0	0
2.7 The sample size is stated. (Y, N)	1	1	1	1	1	1	1	1	1	1	1
2.8 Intention to treat analyses are carried out. (All subject data randomly allocated to group is analysed) (Y, N)	0	0	0	1	0	0	0	0	0	0	0
<b>Total: out of 11</b>	<b>8</b>	<b>7</b>	<b>6</b>	<b>3</b>	<b>3</b>	<b>6</b>	<b>2</b>	<b>2</b>	<b>2</b>	<b>2</b>	<b>2</b>
<b>Section 3: Measures</b>											
3.1 A standardized measure of burnout (2 points) or a proxy measure of burnout such as a standardized measure of stress or psychological wellbeing has been used (1 point). (WC, AA, PA)	2	2	2	2	1	1	2	2	1	2	2
<b>Total: out of 2.</b>	<b>2</b>	<b>2</b>	<b>2</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>2</b>	<b>1</b>	<b>2</b>	<b>2</b>

<b>Section 4: Confounding factors</b>											
4.1 The main potential confounders are identified and taken into account in the design and analysis where appropriate (WC, AA, PA)	2	1	0	1	0	1	0	0	0	0	0
<b>Total: out of 2.</b>	<b>2</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Section 5: Results/Statistical analysis</b>											
5.1 The analysis is appropriate to the design and type of outcome measure. (WC, AA, PA)	2	2	2	2	1	1	2	1	2	2	2
5.2 The results are clearly reported. (WC, AA, PA)	2	2	2	2	2	2	2	1	2	2	2
5.3 Effect sizes have been provided. (Y, N)	1	0	0	1	0	0	0	0	0	0	0
5.4 Confidence intervals have been provided. (Y, N)	1	0	0	0	0	0	0	0	1	0	0
5.5 Follow up data has been gathered and presented. (WC, AA, PA)	0	0	0	0	2	0	2	2	0	0	0
<b>Total: out of 8.</b>	<b>6</b>	<b>4</b>	<b>4</b>	<b>5</b>	<b>5</b>	<b>3</b>	<b>6</b>	<b>4</b>	<b>5</b>	<b>4</b>	<b>4</b>
<b>Overall Total:</b>	<b><u>24</u></b>	<b><u>20</u></b>	<b><u>18</u></b>	<b><u>17</u></b>	<b><u>15</u></b>	<b><u>15</u></b>	<b><u>15</u></b>	<b><u>14</u></b>	<b><u>14</u></b>	<b><u>14</u></b>	<b><u>14</u></b>

## Appendix 2.1 - Glasgow University Ethics board approval



University of Glasgow | College of Medical,  
Veterinary & Life Sciences

Mr. Ross Turner  
Institute of Health and Wellbeing  
College of Medical, Veterinary and Life Sciences  
University of Glasgow  
1st Floor, Administration Building  
Gartnavel Royal Hospital  
1055 Great Western Road  
Glasgow G12 0XH

30 July 2013

Dear Mr. Turner

### MVLS College Ethics Committee

**Project Title: A qualitative study examining the effects of an 8-week Mindfulness Based Stress Reduction course on NHS staff post-completion.**

**Project No: 2012104**

The College Ethics Committee has reviewed your application and has agreed that there is no objection on ethical grounds to the proposed study. They are happy therefore to approve the project, subject to the following conditions:

- The research should be carried out only on the sites, and/or with the groups defined in the application.
- Any proposed changes in the protocol should be submitted for reassessment, except when it is necessary to change the protocol to eliminate hazard to the subjects or where the change involves only the administrative aspects of the project. The Ethics Committee should be informed of any such changes.
- If the study does not start within three years of the date of this letter, the project should be resubmitted.
- You should submit a short end of study report to the Ethics Committee within 3 months of completion.

Yours sincerely

Andrew C. Rankin  
Deputy Chair, College Ethics Committee

Andrew C. Rankin  
Professor of Medical Cardiology  
BHF Glasgow Cardiovascular Research Centre  
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## Appendix 2.2 – NHS Greater Glasgow & Clyde Research and Development approval



Coordinator/Administrator: Dr Michael Barber/Mrs Elaine O'Neill  
Telephone Number: 0141 211 6208  
E-Mail: michael.barber@ggc.scot.nhs.uk  
Website: www.nhsggc.org.uk/r&d

R&D Management Office  
Western Infirmary  
Tennent Institute  
1<sup>st</sup> Floor 38 Church Street  
Glasgow, G11 6NT,

20 December 2012

Mr Ross Turner  
Trainee Clinical Psychologist  
Institute of Health and Wellbeing  
Gartnavel Royal Hospital  
1<sup>st</sup> flr Admin Building  
1055 Great Western Road  
Glasgow G12 0XH

### NHS GG&C Board Approval

Dear Mr Turner,

<b>Study Title:</b>	A qualitative study examining the effects of an 8-week Mindfulness Based Stress Reduction course on NHS staff post-completion.
<b>Principal Investigator:</b>	Mr Ross Turner
<b>GG&amp;C HB site</b>	n/a
<b>Sponsor</b>	NHS Greater Glasgow and Clyde
<b>R&amp;D reference:</b>	GN12CP486
<b>REC reference:</b>	n/a
<b>Protocol no:</b>	V1; 08/11/12
<b>(including version and date)</b>	

I am pleased to confirm that Greater Glasgow & Clyde Health Board is now able to grant **Approval** for the above study.

#### Conditions of Approval

1. **For Clinical Trials** as defined by the Medicines for Human Use Clinical Trial Regulations, 2004
  - a. During the life span of the study GGHB requires the following information relating to this site
    - i. Notification of any potential serious breaches.
    - ii. Notification of any regulatory inspections.

It is your responsibility to ensure that all staff involved in the study at this site have the appropriate GCP training according to the GGHB GCP policy ([www.nhsggc.org.uk/content/default.asp?page=s1411](http://www.nhsggc.org.uk/content/default.asp?page=s1411)), evidence of such training to be filed in the site file.

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BoardApprovalLetter\_GN12CP486

2. **For all studies** the following information is required during their lifespan.
- a. Recruitment Numbers on a monthly basis
  - b. Any change of staff named on the original SSI form
  - c. Any amendments – Substantial or Non Substantial
  - d. Notification of Trial/study end including final recruitment figures
  - e. Final Report & Copies of Publications/Abstracts

**Please add this approval to your study file as this letter may be subject to audit and monitoring.**

Your personal information will be held on a secure national web-based NHS database.

I wish you every success with this research study

Yours sincerely,



Dr Michael Barber  
Research Co-ordinator

*Delivering better health*

[www.nhsggc.org.uk](http://www.nhsggc.org.uk)

Page 2 of 2

BoardApprovalLetter\_GN12CP486

Participant Information Sheet

**Study Title:** A qualitative study examining the effects of an 8-week Mindfulness Based Stress Reduction course on NHS staff post-completion.

**Introduction**

My name is Ross Turner and I am a Trainee Clinical Psychologist enrolled in the Doctorate of Clinical Psychology programme at Glasgow University. You are being invited to take part in a research study which aims to examine your experience of the 8 week Mindfulness Based Stress Reduction course you completed in March of 2012 with Dr Alistair Wilson.

You may remember that I came to the beginning of the penultimate session of the MBSR group in March and informed the group of this research study.

Before you decide if you would like to take part it is important that you understand why the research is being done and how you will be involved. Please take the time to read this information sheet and if you have any queries or would like more information please contact myself using the details at the end of this information sheet.

**What is the purpose of this study?**

Increased levels of mindfulness have been shown to increase feelings of wellbeing in clinical groups with mental and physical health problems, however there has been little research into the experiences of nonclinical groups such as health professionals. This study is designed to understand the experiences of health professionals who took part in the 8 week MBSR programme. We are interested in their journey from first considering attending the group, their experiences of the group itself and how or if attending the group has had any lasting impact on their lives.

**Why have I been chosen as a potential participant in the study?**

You are being asked to take part because you completed the 8 week MBSR course between February and March of 2012 with Dr Alistair Wilson. We are inviting everyone who completed this course to participate in this study.

**Do I have to take part?**

No.

Taking part is entirely voluntary. It is your choice whether or not you decide to take part. If you do decide to take part I will ask you to sign a consent form and give you a copy of this information sheet and the consent form to keep. If you decide to take part you are still free to withdraw at any time. If you decide not to take part you do not have to give a reason and your employer will not be informed.

**What will I be asked to do if I take part?**

If you decide to take part we will arrange a time that is suitable for us to meet for the one to one interview. The location of the interview can either be at your place of work, as long as a suitability quiet space can be arranged, or we can arrange for it to take place at the same location that the MBSR course you attended was run (Department of General Practice and Primary Care, 1 Horselethill Road, G12 0XH). This interview will only last as long as you feel comfortable with but no longer than an hour.

The interview will be recorded in order to make sure that I have an accurate record of what we talk about and from which I can analyse the responses. There will be no right or wrong answers, I am concerned about your personal experiences of the group not with testing your memory of the exercises in the group or if you still practice mindfulness.

**Will what I say be confidential?**

The tapes from the interview will be destroyed once they have been transcribed. The transcripts will be anonymised by removing any identifying information and replacing your name with a pseudonym. The transcripts will be stored on the hard drive of a password protected and encrypted computer at the University of Glasgow. Your contact details, pseudonym and transcript will always be stored separately from each other. I will only discuss your experiences anonymously (without identifying you) with my academic supervisor (Dr Kenneth Mullen) and field supervisor (Dr Alistair Wilson).

The only reason I would break this confidentiality agreement is if you tell me something that makes me concerned about your safety (e.g. risk from suicide) or the safety of others. In either of these cases I would inform you that I must break confidentiality and inform the relevant agencies.

**Will people know it's me in the written report?**

The transcripts from the interviews will be analysed by myself. I will then produce a report detailing the findings of the research and submit it to Glasgow University as part of my training. Direct quotes from you may be used in this report, however any information that could potentially identify you will be removed from the quote. The report may be submitted for publication in an academic journal and I may present the findings at conferences. You will not be personally identified at any point.

**What will happen to my information?**

Your contact details, pseudonym and transcripts will always be stored separately from each other. Contact details and pseudonyms will be destroyed one year after the completion of the study. The anonymised transcripts will be stored on a hard drive on a password protected computer for 5 years after the completion of the study before being destroyed.

**What are the benefits of taking part?**

We cannot say that the study will have any direct benefit to you but it may be helpful to discuss your experience of the course. Primarily, the information we get from the study is likely to be useful with regards to the future implementation of mindfulness based courses undergone by health professionals such as yourself and contribute to the growing evidence base behind mindfulness itself.

**Who has reviewed this study?**

The study has been reviewed and approved by the Institute of Health and Wellbeing, College of Medical, Veterinary and Life Sciences, University of Glasgow and the University of Glasgow Research Ethics Committee.

**What to do next.**

If you would like to take part in the study please send an e-mail to [r.turner.1@research.gla.ac.uk](mailto:r.turner.1@research.gla.ac.uk) indicating that you are interested in taking part in the study with your name and telephone number

OR

Telephone or text me on 07738225433

OR

complete the included "opt-in" sheet and return it in the freepost envelope included with this information sheet.

If you do not wish to take part in this study then you need take no further action.

Thank you for taking the time to read this information sheet,

**\*SIGNATURE\***

**Ross Turner (Principal Investigator).**

**Contact Details****Principal Investigator**

Ross Turner, Trainee Clinical Psychologist:  
Institute of Health and Wellbeing, College of Medical, Veterinary and Life Sciences, University of Glasgow, 1<sup>st</sup> Floor Administration Building, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH. **0141 211-0692 / 07XXXXXXXXXX**  
Email: [r.turner.1@research.gla.ac.uk](mailto:r.turner.1@research.gla.ac.uk)

**Academic Supervisor**

Dr Kenneth Mullen, Senior University Teacher:  
Institute of Health and Wellbeing, College of Medical, Veterinary and Life Sciences, University of Glasgow, 1<sup>st</sup> Floor Administration Building, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH. **0141 211-0692.**

**Field Supervisor**

Dr Alistair Wilson, Consultant Psychiatrist:  
Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH. **0141 211-3600.**

Consent form Version 2 (30/11/12)– post MBSR group study



Opt-in Sheet

A qualitative study examining the effects of an 8-week Mindfulness Based Stress Reduction course on NHS staff post-completion.

**Please initial the box.**

I am interested in becoming involved in this study and understand that returning this “opt-in” form does not mean I am consenting to being interviewed at this time.

☐

Name: \_\_\_\_\_

Please provide a telephone contact number or e-mail address in order for me to contact you to arrange a suitable date for your interview:

Telephone Number:

E-mail address:

Please return this “opt-in” form using the freepost envelope provided.

Thank you for your interest in taking part in this study, I will contact you soon.

**\*SIGNATURE\***

Ross Turner (Principal Investigator).

## Appendix 2.4 - Consent form



University  
of Glasgow

A qualitative study examining the effects of an 8-week Mindfulness Based Stress Reduction course on NHS staff post-completion.

### Consent form

#### **Please initial each box**

I confirm that I have read and understand the Patient Information Sheet (Version 2 – 30/11/12) for the above study and have had the opportunity to ask questions and had these questions answered satisfactorily.

I understand that my participation in this study is voluntary and that I am free to withdraw at any time, without giving a reason.

☐

I understand that my interview will be recorded and a transcript of this interview will be generated and stored securely.

I give my consent to anonymised quotations being used in the final research report and any journal articles or presentations that may result from the study.

I understand that if I disclose anything that causes concern for the researcher (in terms of your safety or the safety of others) during the course of the interview then there is a duty of care to report such a disclosure to the appropriate agencies.

I would like to receive notification via this e-mail address (E-mail address: \_\_\_\_\_) when the study is available online at <http://theses.gla.ac.uk/>

I agree to take part in the above study.

Name of participant:

Date:

Signature:

---

### **FOR RESEARCHER TO COMPLETE**

Name of person taking consent:

Date:

Signature:

Researcher name:

Date:

Signature:

**1 copy to participant, original to researcher.**

Consent form Version 2 (30/11/12)– post MBSR group study

## **Appendix 2.5 – Semi-structured interview schedule**

### **Preamble:**

“As you know from the information sheet, this study is designed to understand the experiences of staff members like yourself who have undergone the 8 week Mindfulness Based Stress Reduction (MBSR) course at Horselethill Road. We’re looking to understand your journey from first beginning the course, your experience of the course itself and after it, up until now.”

“As you will also know from the information sheet you are free to terminate the interview at any point or request a break and everything you say will be anonymised and kept confidential. However, if you were to disclose anything that I feel puts you or anyone else in danger I would have to act accordingly on this information as per my duty of care. The interview should last no longer than one hour.”

*Collect consent form from participant. Check it is signed and each part is filled in.*

“First I would like to ask you some background questions”

Respondent number: *[Filled in by researcher]*.

Gender:

Age:

Profession:

“I will now start the recorder.”

### **Topic guides (prompts indicated by bullets):**

#### *Before the group*

- 1.) Can you tell me about how you came to sign up for the group?
  - what was going on in your life?

- 2.) “What did you expect the group to be like?”

#### *The group itself*

- 3.) What do you remember about the group?
- 4.) What was your overall experience of the group?
  - What did you find more or less useful about it?
  - Did you find some parts of it more challenging than others?

### The present

- 5.) Do you feel that the group had any impact on you?
- Do you see yourself any differently now compared to when you began the course?
- 6.) Can you tell me about any impact you feel the course has had on your perception of your wellbeing?
- Do you feel there has been any change in your sense of contentedness?
- 7.) Can you tell me about any impact you feel the course has had on your perception of stress?
- 8.) Do you feel that your experience of the group has had an impact on your job?
- 9.) What's your explanation of any perceived changes?

### The future

- 10.) Do you plan to use mindfulness in the future?
- If so, how? If not, is there any reason why not?
- 11.) Before we finish do you have anything else you would like to share?

Thank the participant for their involvement and ask them if they would like to receive a notification when the final write up is available for viewing at <http://theses.gla.ac.uk>.

## **Appendix 2.6 -** Samples of coded interview transcripts

### **Appendix 2.6.1 -** Key to transcripts

**Bold** denotes interviewer speech.

Descriptive comments focus on describing the content of what the participant has said, the subject of the speech within the transcript (normal text).

Linguistic comments focus on exploring the specific use of language by the participant (*italic*).

Conceptual comments focus on engaging at a more interrogative and conceptual level (underlined).

## Samples of coded interview transcripts – Kate

Emergent Themes	Line number	Original Transcript	Exploratory Comments
Luxurious building – an oasis.  <i>Different from other courses.</i>	27	NAME, um, so I didn't really have any expectations , um when I arrived, yeh , I just remember going in the front door of that building and thinking this is so luxurious that I am getting two and half hours out of my daily job to come here and be with other people and just take some time out and learn about mindfulness,	"Front door of that building" – <i>so luxurious –the building itself, the physical space as something exotic and special as well as the symbolism of having time off from a stressful job as luxurious.</i>  "Just take some time out" – people don't usually describe training courses as "taking time out" so this clearly was not perceived as just a training course.
	28	Mhh hmm	
The physical space as luxurious and the course content as an escape ("taking time out").	29	I remember that instantly when I walked through the doors And I felt it was a real luxury to be able to do that	Again, saying the word "luxury" beside "walked through the doors" – connection between the physical space and the time "off" work.
	30	Mm hmm, and you spoke about how your job is usually quite stressful so I suppose that , kind of having that time to ,	
Stressful job vs. oasis of mindfulness group.  Disbelief that this was available on the NHS.	31	Yeh there was , yeh exactly, there was a nice contrast in just taking that time out, I couldn't believe I was getting paid to be able to do this	<i>Contrast – disbelief</i> – the idea that mindfulness is such a luxury that people are amazed they get time out to go.  Different to other training courses.
	32	Ok	
Opportunity – not a "course" but a chance to learn something new, fresh, exciting?  Emotive language.	33	So it was quite a , yeh, just a really really lovely opportunity	<i>"really really lovely" and "opportunity" – clear positive memories, double adverb</i>
	34	Ok and was that I suppose different to your usual kind of work day I suppose to	
Stressful job vs oasis of mindfulness group.	35	Definitely.	Strong tone here
	36	Having the time to reflect?	
Stressful job vs oasis of mindfulness group.  "Time out".	37	Having some time out and just think about things and live in the moment, you know be in the moment	Using mindfulness language – "live in the moment"

## Samples of coded interview transcripts – Luna

Emergent themes	Line Number	Original Transcript	Exploratory Comments
	90.	What do you think kind of cultivated that sense of non- judgmentalness , what, was there anything in the group or anything about the group do you think that...?	
Facilitators modeling mindfulness. Genuineness and validity.	91.	Probably em, a large proportion of it was the facilitators em FACILITATOR 1 and FACILITATOR 2 are just lovely, really relaxed, really straightforward em, em they presented it in a lovely way and they told lovely stories	Facilitators as a significant factor in believing in the effects of mindfulness. Deep knowledge of it enhanced by stories – real life experiences? Demonstrating it's applicability?  <i>“lovely, really relaxed, really straightforward” – emotive words accompanied by a warm tone of speech suggesting positive memories of the group.</i>
	92.	Yeh	
Facilitators “giving permission” to not complete tasks.  Re-orientating her relationship to striving. Becoming less critical of self.	93.	and also they told us like it was important that if we could to maintain ,em, a kind of daily practice but if we couldn't not to put stress on ourselves to try to em so it was this kind of balance of trying to do it but at the same time not getting into the kind of vicious cycle of the inner critic coming back and saying: “you must be doing this” because it was defeating the purpose	Accepting and non judgmental - again, modeling mindfulness  <u>Metaphor of a vicious cycle – negative thoughts feeding off each other.</u>  Inner critic, beginning to experience the benefits of mindfulness here?
	94.	yeh	
Mindfulness modeled by facilitators. Inspired by facilitators.  ‘The mindful person’ as appealing	95.	so I think there was this kind of genuine motivation that was cultivated because you could see from them about the benefits of doing it you know they were talking about what's present from doing it but also there was no force to do it which you were inspired to do it because you knew that it would be a good thing to do	<i>Genuine motivation – so beyond a surface level motivation? There was something intrinsically valuable in mindfulness?</i>  Could see from them. Validity – the effect of mindfulness was demonstrated in the facilitators.

## **Appendix 2.7 - Full table of superordinate themes and associated subthemes**

### **Superordinate Theme 1:** *“I would love to be like that.”*

Subtheme 1: The course as potentially applicable to work and personal life.

Subtheme 2: The intrinsic appeal of mindfulness and 'the mindful person'.

### **Superordinate Theme 2:** *“it was about going along...for me. And that was something that I hadn't experienced before.”*

Subtheme 1: The novelty of the experiential and personal focus.

Subtheme 2: The group as a sanctuary.

Subtheme 3: The importance of the group atmosphere as created by the facilitators and the group members.

### **Superordinate Theme 3:** “Whereas before I would probably just let it take over and consume me.”

Subtheme 1: Recognition of the East/West clash.

Subtheme 2: Increasing awareness of the relationship with the self and increasing self-compassion.

Subtheme 3: The benefits and challenges of integrating mindfulness into work and personal life.

Subtheme 4: Beginning a journey.



## **Appendix 2.8 - Major Research Project Proposal**

### **MRP Proposal**

A qualitative study examining the experiences of NHS staff 8 months after their completion of an 8-week Mindfulness Based Stress Reduction course.

<b>Name:</b>	Mr Ross Turner, Trainee Clinical Psychologist, 0401837t
<b>University Supervisor:</b>	Dr Kenneth Mullen
<b>Field Supervisor:</b>	Dr Alistair Wilson
<b>Date of Submission:</b>	20/7/12
<b>Version number:</b>	2
<b>Word Count:</b>	3094

## **Abstract**

### **Title**

A qualitative study examining the effects of an 8-week Mindfulness Based Stress Reduction course on NHS staff 8 months after its completion.

### **Background**

A number of studies have found interventions based on Mindfulness principles (e.g. Mindfulness Based Stress Reduction and Mindfulness Based Cognitive Therapy) are effective in reducing the symptoms of a range of mental health problems in clinical populations. Mindfulness practices have also been found to have prophylactic effects in relation to increasing well being, reducing distress, rumination and negative affect in health professionals and giving them the skills to better cope with work related stress. However, there is a limited amount of qualitative research in this area and little attention has as yet been devoted to considering the longevity of these positive results from mindfulness intervention in the health professionals (nonclinical) population or how these groups should be adapted to this population.

### **Aims**

To explore the experiences of health care professionals who have undertaken an eight-week MBSR course eight months after its completion.

### **Methods**

Participants selected via purposive sampling in order to capture a homogenous group. They will be interviewed using a semi structured interview format relating to their experiences of the mindfulness group. Interpretative Phenomenological Analysis will be used to analyse the resulting transcripts.

### **Applications**

Further understanding of the method by which mindfulness achieves its effects within the health professionals population and how this effect is maintained. Increased understanding of how mindfulness programmes should be best implemented in this population.

## **Introduction**

Mindfulness has been defined as the sustained intention to focus attention on the reality of the present moment, accept it without judgement and in turn, minimise the natural process of allowing one thought to follow on to the next. This mental state is said to maximise the possibility of perceiving thoughts and feelings as transient and subjective (Kabat-Zinn, 1996). The values and approaches of mindfulness have been distilled into two predominant mindfulness-based approaches – Mindfulness Based Stress Reduction (MBSR) and Mindfulness Based Cognitive Therapy (MBCT). Mindfulness is also a key element of several ‘third wave’ cognitive behavioural therapies such as Dialectical Behaviour Therapy (DBT) and Acceptance and Commitment Therapy (ACT) (Hayes, 2004). MBCT (Segal, Williams and

Teasdale, 2002) integrates cognitive therapy with mindfulness practices and has been found to be effective in alleviating psychological distress related to depression (Teasdale et al 2000, 2002) and reduce the likelihood of relapse (Ma & Teasdale 2004, Piet and Hougaard, 2011).

MBSR is a clinical programme originally developed to facilitate adaptation to physical illness (Kabat-Zinn, 1982). It is a structured 8 week, group programme with groups usually numbering 10 to 40 participants. Each session covers particular exercises and topics that are examined within a mindfulness context including meditation practice, mindful awareness during yoga positions and mindfulness during stressful situations. MBCT was derived from MBSR which has a more generic application that attempts to give users the tools to cope with a range of life stressors by employing mindfulness principles. Regular and repeated practice is a central tenet of MBSR and each participant is expected to spend 45 minutes each day during the course (and after it finishes) practicing various mindful exercises (Kabat-Zinn, 1996). Carmody and Baer (2008) and Finucane & Mercer (2006) highlight the importance of continued practice of mindfulness techniques after the completion of a mindfulness programme in order to maintain any gains made.

A number of Randomised Controlled Trials (RCTs) of MBSR have been conducted using clinical and nonclinical populations, mostly utilising a waiting list control design. MBSR has been found to reduce self reported levels of anxiety and worry (Vøllestad et al 2011, Anderson et al 2007, Shapiro et al 1998), depression (Grossman et al 2010, Sephton et al 2007, Specia et al 2000), rumination (Anderson et al 2007) and general psychological distress including perceived stress (Bränström et al 2010, Shapiro et al 2005) as well as increasing well-being (Brown & Ryan, 2003; Epstein, 1999). Two reviews have also demonstrated the ability of mindfulness approaches to enhance psychological well-being, mental health and physical health in addition to reducing psychological distress in clinical populations as well as stressed, nonclinical populations (Baer, 2003, Grossman et al 2004). A number of researchers have also demonstrated that gains made from the participation of clinical participants in MBSR groups (such as: increased quality of life scores, decreased stress scores, decreased cortisol levels and lower blood pressure) appear to be maintained for up to 3 years in comparison to control groups (Grossman et al 2007, Bränström et al 2011, Miller et al, 1995, Carlson et al, 2007).

Qualitative research into mindfulness has mostly utilised clinical adult populations to investigate the effects of applying mindfulness to a number of clinical diagnoses (Allen et al 2009, Mason and Hargreaves, 2001, Finucane & Mercer, 2006, Stelter, 2009, Griffiths et al 2009, Proulx 2008, Mackenzie et al 2006, Fitzpatrick, Simpson and Smith 2010). Common themes that have emerged from these qualitative studies include:

- The process of learning to become more mindful requiring patience, persistence, openness and discipline.
- The amount of benefit that the individual gains from mindfulness appears to be moderated by a sense of mastery and increased awareness.

- Benefits to the individual include: a greater feeling of self-acceptance, a shift from negative to more positive thinking.
- Common behavioural changes included: symptom reduction, improvement in coping skills, applying mindfulness in everyday tasks and improved sleep.
- Common difficulties regarding implementing mindfulness were: confusion regarding the concept of thoughts as transient, a focus on the present moment and sometimes frustration and disengagement regarding not being mindful in the “right” way.

These qualitative studies indicate that mindfulness can be experienced in similar ways by differing clinical populations and that an individual’s experience of mindfulness can partly depend on their intrinsic motivation to engage with it and remain engaged.

### **Mindfulness and Nonclinical Populations.**

In addition to the ability of mindfulness to reduce symptoms of psychological distress and increase wellbeing in clinical populations there is a growing research base relating to the ability of mindfulness approaches to increase the wellbeing of nonclinical populations. Several pre-post design quantitative research studies using medical students, premedical students and stressed community volunteers have demonstrated the effectiveness of MBSR on self-report measures of anxiety and depression, as well as increased ratings of empathy and spirituality (Shapiro et al 1998, Rosenzweig et al 2003, Astin et al 1997, Williams et al 2001). One study employing qualitative methods found that counseling students improved in domains such as interpersonal functioning and coping with stress after taking a mindfulness course (Christopher et al, 2006).

A nonclinical population that has been the subject of a large amount of research into the effects of mindfulness practices is health professionals. Health professionals are a population particularly vulnerable to the effects of high levels of stress which can lead to depression, emotional exhaustion and anxiety, psychosocial isolation, decreased job satisfaction, reduced self esteem, disrupted personal relationships and loneliness which can then impact on their practice (Shapiro, Brown and Biegel, 2007). May and O’Donovan (2007) found that higher levels of mindfulness were associated with increased work satisfaction and decreased burnout among mental health professionals. Shapiro et al (2005) demonstrated that measures of self-compassion and perceived stress were improved after a modified MBSR programme was undertaken by health professionals actively engaged in clinical practice compared to a waiting list control group, however changes in psychological distress, burnout, stress and life satisfaction did not reach statistical significance. Mackenzie et al (2006) found that a briefer, 4 week, version of the 8 week MBSR programme completed by nurses and nurse aides was sufficient to significantly improve life satisfaction and burnout symptoms. In terms of improving work performance Grepmaier et al (2007) carried out an RCT that found trainee psychotherapists who had undergone mindfulness training received higher client evaluations on measures of the therapeutic relationship. In addition, MBSR has been found to reduce occupational stress, or burnout, in nursing students whilst improving their subjective

physical and mental health, empathy, and well-being (Beddoe et al 2004, Young et al 2001). Two studies have examined the longevity of MBSR's effects on health professionals, finding that reductions in measures of distress, rumination, negative affect and increases in measures of wellbeing and mindfulness were maintained at 3 month follow up (Martin-Asuero & Garcia-Banda, 2010, Schenström et al, 2006).

There has been comparatively less studies employing a qualitative methodology to examine the experiences of health professionals undertaking an MBSR course. A mixed-methods study by Cohen-Katz et al (2005) found that a major reason for participating in the MBSR programme included learning to better cope with family, work and personal stress. Nurses reported increased work performance, improvements in public speaking and driving skills, and an ability to let go of perfectionist thinking. Cohen-Katz et al (2005) also note that the benefits of mindfulness are not easily captured by traditional psychological self-report inventories and their qualitative component allowed for the emergence of new data.

### **Aim of This Study**

The above literature illustrates that there is an increasing body of research that demonstrates the effectiveness of mindfulness approaches in a wide range of clinical and nonclinical populations. They indicate that MBSR in particular may have prophylactic effects by increasing wellbeing and enhancing features of coping with stress in everyday life and that this may have a positive effect on the practice of those within the health care population who have undergone an MBSR course. Within this population in particular there have been several quantitative studies examining the effects of attempting to increase levels of mindfulness and wellbeing in health professionals with positive results. However, there is a dearth of research using qualitative methods to examine how the individual health professional experiences the process of beginning and attending an MBSR group and how they conceptualize their experiences after the group has ended. Given that investigations into the phenomenon of mindfulness are still in their relative infancy, especially in this population, it is important to use a wide range of methods in order to demonstrate not only that quantitative changes are possible but also to attempt to describe how these changes come about in this particular nonclinical group.

Given this gap in the literature the present study will explore individual health professionals' experiences of an 8 week MBSR course in an effort to understand how mindfulness influences the lives of these individuals and thereby attempt to increase understanding of the mechanisms of mindfulness within this population. Research related to mindfulness is suited to a qualitative approach as mindfulness is a highly subjective and experiential phenomenon and the ability to practice mindfulness depends on intrinsic motivation factors unique to each person. Therefore a qualitative method that allows for the exploration of the complex nature of everyday lived experience is necessary. Interpretative Phenomenological Analysis (IPA) is a structured method of exploring an individual's phenomenological experience (Smith et al, 2009).

## **Primary Research Question and Objectives.**

Smith et al (2009) emphasise the need for an open primary research question when using IPA. However, they also highlight the necessity of knowing when you have answered the research question and so suggest identifying objectives to assist with this.

### **Primary Research Question**

How do health care professionals who have undertaken an 8 week Mindfulness Based Stress Reduction course understand and describe their experiences of mindfulness before, during and after the course?

### **Objectives**

- Describe the key features that make up an individuals desire to begin the mindfulness course and what maintains their involvement in it.
- Describe the key features of mindfulness that contribute to an increased sense of wellbeing in the health professionals' population.
- Describe the key features that facilitate and inhibit continued formal and informal practice of mindfulness after the course's completion.
- Describe the key features that participants perceive as differences in their practice following the mindfulness course.

## **Plan of investigation**

### **Participants**

Participants for this study will be recruited from an MBSR Group that was run from the 9<sup>th</sup> of February 2012 until the 29<sup>th</sup> of March 2012. The program is based on the curriculum of MBSR (Kabat-Zinn, 1996) The programme was delivered by Dr Alistair Wilson (Consultant Psychiatrist) who is an experienced mindfulness practitioner and teacher. Twenty people attended this group, all of whom were NHS staff from a range of disciplines, working in primary and secondary care services.

### **Inclusion and Exclusion Criteria**

#### ***Inclusion***

Participants must have attended at least 6 (out of a possible 8) sessions of the MBSR programme, be a current NHS employee and be English speaking.

#### ***Exclusion***

None.

## Recruitment Procedures

The researcher attended the beginning of the penultimate (7<sup>th</sup>) session of the MBSR group in order to make the group members aware of the current study. All group members were invited to ask questions.

Six months after the completion of the MBSR group (September 2012) all 20 members of the original group will be sent an information sheet which will detail the purpose of the study and ask them to return an opt-on form if they wish to take part in the study. If there is no response to this letter then there will be a follow up telephone call two weeks later to remind potential participants of the study.

## Design

In depth semi-structured interviews will be carried out on a one-to-one basis, audio-taped and transcribed verbatim. A preliminary interview schedule is located in Appendix I. In line with Smith et al (2009) the questions that make up the semi structured interview are designed to be open and expansive, beginning with one that allows the participant to recount a fairly descriptive episode or experience so as to facilitate a comfortable interaction between interviewer and participant. The interview questions are also subject to change as the interviews progress based on what topics are discussed in line with the ethos of IPA with regards to gaining a rich and detailed account from each participant.

Participants will be selected via purposeful homogeneous sampling, meaning that the sample is selected because they have certain features which make them a mostly homogenous group as per the requirements of IPA (Smith et al 2009). Smith et al (2009) note that this homogeneity is crucial to IPA given that picking a sample that have various features in common based on theoretical factors relevant to the research question allows the researcher to: “examine in detail psychological variability within the group, by analysing the pattern of convergence and divergence which arises (p.50)”. Despite the fact that the participants differ in some aspects in terms of their profession within the NHS they are homogenous in other important ways, namely, they will all have experienced the MBSR group prior to the interview and are all employees of the NHS. The fact they are different in ways such as their profession is a difference that may or may not have impacted how much the MBSR course has increased their well being or affected their practice and is therefore of interest in this study.

## Measures

No psychometric measures will be used given that this is a qualitative study.

## Data Analysis

Interpretive Phenomenological Analysis (Smith et al 2009) will be used to analyse the transcripts of the interviews. This methodology is not intended to test pre-

determined hypotheses or generalise across large groups but rather to explore, flexibly and in detail, an area of concern and is best at highlighting individual's stories or accounts (Smith et al 2009). Other methodologies such as thematic analysis (Braun and Clarke, 2006) and grounded theory (Charmaz, 2006) were considered. However, given that this study is exploratory in nature, concerned with how individuals within a particular group (health professionals that have completed the MBSR course) make sense of mindfulness and not orientated towards hypothesis generation or comparing across groups, IPA was felt the most appropriate choice given its focus on personal meaning and sense-making in a particular context.

Six stages of analysis will be carried out as recommended by Smith et al (2009) in order to construct a list of themes and categories from the transcript data. The analysis of the data will be iterative, meaning that the researcher will reflect upon the data and note emerging themes after each interview and consider if the interview questions may benefit from being altered. Coding will be checked by another researcher on a sample of the transcripts to ensure inter-rater reliability (Smith et al, 2009).

A reflective diary will be kept by the researcher in order to facilitate the development of the researcher's subjective views (Smith & Osborn, 2003). In relation to this the researcher has secured funding to attend a mindfulness group beginning in September 2012 order to enhance their own experiences of the philosophy underlying mindfulness.

### Justification of Sample Size

Smith et al (2009) recommends that the sample size for a Doctorate level study be around 8 participants as this should ensure enough information of sufficient quality is gathered. IPA has successfully been carried out with as few as 3 interviewees (Smith et al, 2009) given its purpose is not to gather a large enough sample as to be representative but rather to focus on a smaller number of people who have a common characteristic or experience, in this case being NHS employees and having completed an 8 week MBSR programme.

### Settings and Equipment

The interviews will take place at the same location as the MBSR group was run in a comfortable, quiet room in the Section of General Practice and Primary Care. A digital recorder will be used to record each interview.

A foot pedal will be required in order to assist in transcribing the interviews and qualitative computer software e.g. NVivo may be used to assist in analysing the data.

## **Health and Safety Issues**

### Participant Safety Issues



Staff may present as distressed during the interview due to the discussion of emotional or sensitive issues. If this were to happen the issue would be acknowledged by the researcher and discussed with the participant. Staff would be encouraged to seek support from their General Practitioner if this is felt necessary. If a staff member were to disclose something that amounted to a fitness to practice concern then the appropriate action would be taken by the researcher to inform this person's line manager. The consent form to take part in the research will stipulate that this will be the course of action should any staff member disclose fitness to practise issues.

The setting of the interviews is a safe venue that has a high number of staff within it.

### Researcher Safety Issues

The researcher may be exposed to emotional or sensitive information which they will discuss with the appropriate member of staff within the Doctorate in Clinical Psychology staff group at Glasgow University if necessary.

### Ethical Issues

Given that the potential participants of this study will be health professionals from a range of disciplines it may be useful to consider their profession as a possible mediating factor in how they employed mindfulness in the 8 months after the group ended. In order to do this each participants profession would have to be identified in the final write up making it more possible for them to be identified by themselves or by others. Participants will be asked to consent to this before the interviews take place.

A further possible ethical issue is that given that the potential participants of this study are all NHS staff and the study itself is being undertaken within the NHS it may be that the potential participants feel pressurised into participating in the study. In order to minimise the effects of potential participants feeling pressured to take part in the study they will only be contacted twice, via letter and then a follow up phone call if they do not respond to the letter (discussed above, in *Recruitment Procedures*).

NHS ethical approval is not required as the participants will be NHS employees however R & D review is needed from the NHS Research and Development Central Office.

Ethical clearance will need to be gained from the School of Medicine (Glasgow University).

## **Financial Issues**Equipment, stationary costs etc.

<b>Item(s)</b>	<b>Cost</b>
80 sheets of photocopied headed paper	£4.80 (0.08 per sheet)
20 A4 envelopes	51p
20 DL envelopes	20p
Freepost of 40 letters	£18 (45p per letter)
Recording device, NVivo 9 software and foot pedals for transcription	Supplied by department
Mindfulness Group	£190
<b>TOTAL:</b>	<b>£213.51</b>

## **Practical Applications**

Mindfulness therapies have been shown to have long lasting effects with regards to clinical populations. Research using nonclinical populations such as health professionals has shown mindfulness interventions can affect various quantitative markers of wellbeing and lower levels of perceived stress. However, little work has been done on understanding how these changes come about in the healthcare professional's population. It is important that if healthcare organisations such as the NHS are to further invest in mindfulness the processes by which it has its effects need to be explored.

## **Timetable**

<b>Date</b>	<b>Activity</b>
<b>February</b>	MBSR Group begins
<b>March 2012</b>	MBSR Group ends
<b>April 2012</b>	Submit Major Research Proposal
<b>August 2012</b>	Submit application to NHS R &D and submit ethics application to University Ethics Committee (School of Medicine).
<b>Mid September 2012</b>	Send information sheets and opt-in forms to MBSR group participants
<b>November – December 2012</b>	Begin data collection (interviews) and analysis
<b>January 2013 – March 2013</b>	Ongoing IPA.
<b>April 2013 – June 2013</b>	Write up
<b>July 2013</b>	Submit Major Research Project

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## **Appendix I**

### **Proposed Interview Schedule**

#### **Preamble:**

“As you know from the information sheet, this study is designed to understand the experiences of staff members like yourself who have undergone the 8 week Mindfulness Based Stress Reduction (MBSR) course, here, at Horselethill Road. We’re looking to understand your journey from first beginning the course, your experience of the course itself and after it, up until now.”

“As you will also know from the information sheet you are free to terminate the interview at any point or request a break and everything you say will be anonymised and kept confidential. However, if you were to disclose anything that I feel puts you or anyone else in danger I would have to act accordingly on this information as per my duty of care. The interview should last no longer than one hour.”

*Collect consent form from participant. Check it is signed and each part is filled in.*

“First I would like to ask you some back ground questions”

Respondent number: *[Filled in by researcher]*.

Gender:

Age/DOB:

Profession:

“I will now start the recorder.”

#### **Proposed interview questions:**

##### **Before the group**

1.) “Can you tell me about how you came to sign up for the group?”

Possible prompt: what was going on in your life?

2.) “What did you expect the group to be like?”

##### **The group itself**

3.) “What do you remember about the group?”

4.) “What was your overall experience of the group?”

Possible prompts: What did you find more or less useful about it?

Did you find some parts of it more challenging than others?

### The present

5.) “Do you feel that the group had any impact on you?”

Possible prompts: Do you see yourself any differently now compared to when you began the course?

6.) “Can you tell me about any impact you feel the course has had on your perception of your wellbeing?”

Possible prompt: Do you feel there has been any change in your sense of contentedness?

7.) “Can you tell me about any impact you feel the course has had on your perception of stress?”

8.) “Do you feel that your experience of the group has had an impact on your job?”

9.) “What’s your explanation of any perceived changes?”

### The future

10.) “Do you plan to use mindfulness in the future?”

Prompts: “if so, how? If not, is there any reason why not?”

11.) “Before we finish do you have anything else you would like to share?”

Thank the participant for their involvement and ask them if they would like to receive a notification when the final write up is available for viewing at <http://theses.gla.ac.uk>.

## **Appendix II**

### **Layman Summary**

**Title:** A qualitative study examining the effects of an 8-week Mindfulness Based Stress Reduction course on NHS staff 8 months after it’s completion.

Mindfulness is a word that means to “pay attention on purpose”. More specifically it means to sustain our intention to focus our attention on the reality of the present moment, accept it without judgement and in turn, minimise the natural process of allowing one thought to follow on to the next. Many mental health problems such as anxiety and depression are maintained because people have a natural tendency to attempt to predict what will happen in the future in that they will allow their mind to wander through many (usually negative) possible outcomes to a given situation. The principles of Mindfulness have been used in “talking therapies” with sufferers of the above problems and the mindfulness aspect has been found to be effective in minimising relapse and improving quality of life for these people.

Mindfulness has also been shown to have prophylactic properties in that people who have attended mindfulness classes tend to be able to cope with stress when they encounter it better than those who have not. Research has shown that health professionals without diagnosed mental health problems reported a reduction in stress after attending mindfulness classes.

My study aims to build on this research by interviewing a number of NHS staff six months after they have completed a mindfulness class. This will provide more information on how staff use mindfulness in their home and work life as well as helping to understanding if mindfulness classes have long lasting effects.