UNIVERSITY OF SOUTHAMPTON

FACULTY OF ENVIRONMENTAL AND LIFE SCIENCES

School of Health Sciences

Volume 1 of 1

The lived experience of engaging with mindfulness in Dialectical Behaviour Therapy: An Interpretative Phenomenological Analysis of the experiences of adolescents and practitioners

by

Jennifer Ann Eeles

Thesis for the degree of Doctor of Philosophy

June 2019

UNIVERSITY OF SOUTHAMPTON

ABSTRACT

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Background: Dialectical Behaviour Therapy has been developed to treat what has been termed multi-problem adolescents (Miller et al., 2006) and as such is being used within Child and Adolescent Mental Health Services in the UK. Mindfulness is an element of Dialectical Behaviour Therapy which, although studied widely as part of other interventions, has not been fully examined in relation to its use with adolescents in Dialectical Behaviour Therapy. The aim of this thesis was to demonstrate historical development of mindfulness as a clinical treatment; the body of research in relation mindfulness in Dialectical Behaviour Therapy and to understand how adolescents and practitioners experience mindfulness in Dialectical Behaviour Therapy as taught in clinical practice. .

Methods: This Interpretative Phenomenological Analysis study recruited 16 participants from differing service user and provider perspectives from four NHS service. Single face to face interviews we carried out with resulting transcripts undergoing thematic analysis.

Findings: Eight superordinate themes were generated underlying two higher order concepts: a struggle with uncertainty and challenge and developing internal awareness with caution.

Conclusions: The study offers insight into the experience of mindfulness in Dialectical Behaviour Therapy from the perspective of adolescents and practitioners. The implications of this study have been considered in terms of clinical practice, future research and policy development. Recommendations have been made about orienting Dialectical Behaviour Therapy teaching towards self-compassion, trauma sensitive and interpersonal mindfulness

and to considering the specific needs of adolescents in Dialectical Behaviour Therapy to enable this group to access mindfulness.

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DECLARATION OF AUTHORSHIP

I, Jennifer Ann Eeles declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

The lived experience of engaging with mindfulness in DBT: An interpretative phenomenological analysis of adolescent and practitioners experiences

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission:

Signed: .....

Date: .....

Acknowledgements

Firstly I would like to thank the sixteen participants who agreed to be interviewed for my research. Their time and openness allowed for the development of a richer understanding of this topic.

Secondly, I would like to thank my supervisors. Due to staff changes at the university during my candidature I have been privileged to have had the direction of five supervisors in all: Dr Joanne Brown, Dr Dianne Carpenter, Dr Julie Wintrup, Dr Tracy Long-Sutehall and Dr Dawn-Marie Walker. Their knowledge, insight and support have been invaluable in completing the thesis.

Finally, I would like to thank my partner Matt; the rest of my family and all my friends who have encouraged me throughout this period of study. Their patience and support has been exceptional.

Abbreviations used in the Thesis

CAMHS – Child and Adolescent Mental Health Services

DBT – Dialectical Behaviour Therapy

DBT – PE –Dialectical Behaviour Therapy with Prolonged Exposure

MBCT –Mindfulness Based Cognitive Therapy

MBSR – Mindfulness Based Stress Reduction

MBI – Mindfulness Based Intervention

NICE – National Institute for Health and Care Excellence

PrP – Practitioner Participant

RO-DBT– Radically Open Dialectical Behaviour Therapy

SUP – Service User Participant

Chapter 1: **Introduction**

1.1 **The background to the research**

This thesis presents the findings from a study exploring the lived experience of adolescents who have undertaken mindfulness training as part of Dialectical Behaviour Therapy (DBT) and practitioners who provide DBT skills training.

The use of mindfulness meditation as a treatment for mental health problems has been of interest to clinicians and researchers since it was brought to the fore by Kabat-Zinn (1990) in his work on Mindfulness Based Stress Reduction (MBSR) . Mindfulness has been incorporated into different therapeutic approaches to develop therapies that focus on a person's relationship to their thoughts rather than the content of their thoughts (Hayes and Greco, 2008). Mindfulness Based Cognitive Therapy (MBCT) has been recognised as an effective intervention for prevention of relapse of depression in adults (Nice Clinical Guideline 90, 2009b) and is being applied to individuals with other mental health disorders such as OCD and PTSD (Sguazzin et al., 2017; Muller-Engelmann et al., 2018). Other Mindfulness Based Interventions (MBIs) have been developed and employed aimed at improving wellbeing in many different groups including physical health, education and the work place (All Party Parliamentary Committee, 2015).

Dialectical Behaviour Therapy (DBT) is a therapy that incorporates mindfulness, developed specifically to treat Borderline Personality Disorder (BPD) as defined by DSM IV (American Psychiatric Association, 2013) (Appendix A). The equivalent diagnostic category in ICD-10 Classification of Mental and Behavioural Disorders (WHO, 2010) is Emotionally Unstable Personality Disorder. DBT is an evidenced based treatment that has been identified for use by NHS services in the National Institute for Health and Care Excellence (NICE) guidelines for the treatment of BPD when reduction of self-harm is a priority (NICE Clinical Guideline 78, 2009a). DBT has been adapted for adolescent populations(DBT-A) (Miller et. al., 2007) and is offered by Child and Adolescent Mental Health Services (CAMHS) in the UK as demonstrated by the British Isles DBT training benchmarking website (British Isles DBT Training, 2019). The specific adaptations made in DBT-A include: a shorter treatment length (12-16 weeks), simplifying language and reducing the number of skills taught, including family members in skills training. Whilst the adolescent form of DBT has been subject to research studies (Miller et, al., 2000; Lenz, et al., 2016; Tebbett-Mock et al., 2019), the evidence base for the use with adolescents is less extensive than for the adult population for which it was originally developed.

Freeman et al. (2016) reviewed six studies that had used DBT-A with outpatients and concluded that although the studies showed results in favour of using DBT-A with outpatients, there were many differences in the delivery of DBT-A in the studies in terms of length and intensity of the programmes along with difficulties in ensuring therapist adherence to DBT.

1.1.1 Mindfulness as used in DBT

Linehan (1993a) proposed a DBT programme offering four modes of treatment. Three of the modes that are used directly with service users (group skills training, individual therapy and telephone coaching) are outlined in Table 1. Some DBT providers have adapted DBT by offering group skills training only, condensing skills training modules or omitting the telephone coaching mode of treatment alongside varying the intensity and duration of the programme (Dimeff and Koerner, 2007). This has implications for understanding the elements of DBT that are required for good clinical outcomes and for stating the effectiveness of a modified programme (Dimeff and Koerner, 2007).

Table 1 Overview of three modes of treatment in DBT adapted from Linehan, (1993a) Cognitive Behavioural Treatment of Borderline Personality Disorder

Mode of Treatment	Treatment Content
Individual therapy	Targeting a hierarchy of service user behaviours: • Life threatening behaviours i.e. self –harm and violence • Behaviours that interfere with receiving therapy • Behaviours that impact on quality of life i.e. drug use, offending behaviour, disordered eating This mode is conducted by a therapist with one service user.
Group skills training	Teaching skills to people in a didactic format

Mode of Treatment	Treatment Content
	• Interpersonal effectiveness • Distress tolerance • Emotional regulation • Mindfulness This mode conducted by two to three therapists and a group of service users.
Telephone coaching	Service users are encouraged to call the therapist/DBT team when they are struggling to manage a situation and are at risk of reverting to unhelpful coping behaviours. They will be coached to use skills over the phone.

The group skills training element of DBT offers a lesson type structure for enhancing the group members' skills in dealing with emotions, relationships and impulsive behaviours. Mindfulness is taught as a set of seven skills in the group skills training as follows:

- **Wise mind** – developing a balance between emotional and reasonable ways of approaching situations.
- **Observe** - enhancing observation in situations and decreasing assumptions based on previous experience.
- **Describe** – enhancing ability to describe exactly what is happening without using language that includes judgements or assumptions.
- **Participate** – this encourages people to enter into a situation fully without distraction.
- **Non-judgemental stance** – noticing when values and pre-conceptions are being applied to a situation.
- **Practising effectiveness** – behaving in a consciously effective way rather than following automatic responses.

- **One Mindfully** – doing just one thing at any one point in time without attending to the past or the future.

Mindfulness is practised in each session, taking the form of short (2 -3 minute) exercises. For example, services users may be asked to mindfully taste a raisin while being fully aware of their senses during the exercise; to notice any thoughts that arise that do not relate to tasting the raisin and to bring their focus back to tasting the raisin should they notice any other thoughts. Other examples of mindfulness exercise include: observing sounds, playing a simple game, colouring, blowing bubbles and being aware of the sensation of breathing. All of these exercises have the aim of increasing and focusing awareness on just one object or experience.

Elements of mindfulness are present within all DBT skills modules. For example in the emotional regulation module service users are taught the skill – 'Letting Go' which encourages service users to allow emotions to come and go without becoming stuck to them or pushing them away. Examples of mindfulness as taught within other DBT modules are outlined in Table 2.

Although mindfulness is an integral part of undertaking DBT there is less emphasis on learning mindfulness as a sitting practice compared to other mindfulness based interventions. Typically, MBSR and MBCT encourage daily practice of sitting with focus on the breath, awareness of bodily sensations (body scan) or mindfulness of movement for 20 minutes and more; whereas DBT uses short mindfulness exercises to highlight how an individual can observe, describe and participate in his/her experience whilst being focused, non-judgemental and doing what works. The mindfulness practices in DBT are deliberately short and less breath focused because of the level of emotional dysregulation that may be triggered by long inward focused meditation in those that have emotional avoidance as their main coping strategy (Woodberry et. al., 2008).

Table 2 The teaching of Mindfulness in DBT by module adapted from Linehan (1993b) Skills Training Manual for Treating Borderline Personality Disorder.

Module	**Mindfulness teaching within the module**
Emotional Regulation	• Being mindful of positive experiences • Being unmindful of negative experiences • Allowing emotions to come and go as a wave
Interpersonal Effectiveness	• Improving interactions with others through observing the situation, describing factually what happened and participating effectively in the interaction.
Distress Tolerance	• Breathing awareness • Mindfulness during everyday activities • Radical Acceptance – this encourages people to identify those things that cannot be changed in a situation and move towards accepting things as they are so they can move on

There are some similarities between mindfulness based approaches with regard to the principles of mindfulness that are taught, i.e. being able to just notice the experience or being non-judgemental of the experience, but the way in which group members are guided to access these principles is substantially different (long sitting practice vs mindfulness activities).

Wagner et al. (2006) described how the mindfulness module was developed to meet the needs of adolescents (DBT-A). The mindfulness skills of non-judgemental presence, practising effectiveness and one mindfully are relabelled as don't judge; do what works and stay focused but the principles being taught remain the same. The focus on short and activity based

(sensory and movement) are employed frequently with the aim of tackling potential barriers to engaging with mindfulness of impatience, impulsivity and self-consciousness. Because modifications have been made to DBT to make it accessible to adolescents (Wagner et al. 2006), adolescents have only around 16 weeks rather than a year, to learn and practise the mindfulness skills and this may impact what can be learnt. The addition of parents/carers to the DBT-A programme adds another variable for consideration in terms of the effectiveness of the intervention

1.2 **Adolescence and mindfulness**

The present study focussed on the experience of adolescents aged between 14 and 21 which covers the period from middle to late adolescence (Smetana, 2013). Adolescence is a time of rapid, complex and interrelated changes. An individual develops physically, cognitively, behaviourally, emotionally and socially to complete transition from childhood to adulthood (Wright and Ketcher, 2013). As such, there are changes in an adolescent's sense of self, motivation and evaluation of their worlds (Siegel, 2014).

It is of note that typical adolescent development includes the development of some abilities which are necessary for being mindful. Growth in the capacity for insight, increased emotional stability and examination of inner experiences are all outcomes of adolescent maturation American Academy of Child and Adolescent Psychiatry (2015) which mirror the effects of developing mindfulness - insight, non-reactivity, reflection (Siegel, 2007). There may therefore be developmental barriers to the development of mindfulness experienced in early to middle adolescence that become less significant as an individual matures. The typical adolescent development of meta-cognition (Siegel, 2007) and theory of mind (Hughes et. al, 2015) indicate that the development of mindfulness and the maturation of the adolescent brain may have a reciprocal relationship with deficits in one area leading to deficits in another and vice versa.

The developmental milestones in middle to late adolescence that may be important to consider with regard to the development of mindfulness are outlined in Table 3

Table 3 Typical adolescent development taken from the American Academy of Child and Adolescent Psychiatry (2015)

	Behavioural	Emotional	Cognitive
Middle Adolescence ~14-18 years of age	Tendency to distance selves from parents - drive for independence Driven to make friends Rule/limit testing Experimentation with adult behaviours i.e. alcohol	Moodiness Increased self involvement - changing between high expectations and poor self concept	Growth in capacity for abstract thought Greater capacity for setting goals Interest in moral reasoning Thinking about the meaning of life
Late adolescence ~19-23 years of age	Ability to delay gratification Increased independence and self reliance	Increased emotional stability Firmer sense of identity	Ability to think ideas through Examination of inner experiences Capacity to use insight Interest in moral reasoning

The changes that occur in adolescents can be experienced as opportunities or threats to the individual (Siegel, 2014). For instance, increased flexibility in thinking can lead to creativity but

also to impulsivity or rule breaking (Siegel, 2014). The threats and opportunities of adolescence have been recognised by mindfulness researchers who have wondered if mindfulness may help to increase the opportunities and decrease the threats that arise in adolescence such as increasing mood stability and decreasing impulsivity (Roeser and Pinela, 2014). Roeser and Pinela (2014) proposed that adolescents would benefit from mindfulness through enhancing self-regulation, enhancing somatic and relational awareness, promoting compassionate evaluations of self and others, promoting empathy and social perspective taking and promoting pro-social motivation and behaviour. However, an evidence base for the helpfulness of these particular areas of mindfulness training has not been fully developed (Roeser and Pinela, 2014). Despite limitations to the evidence for the use of mindfulness based interventions in adolescence and the possibility that mindfulness may be incompatible with some stages of adolescent development, mindfulness is being used within mental health, and educational settings in an effort to improve adolescent wellbeing (Burke, 2010).

1.3 **Rationale of the study**

The interest for conducting this study was based upon my experience as a mental health nurse working within child and adolescent services (CAMHS) and delivering DBT as a treatment to adolescents. I completed my mental health nurse training in 2001 and began work on an inpatient CAMHS unit in 2002, moving to community based practice in 2006. I have been delivering DBT skills training, individual therapy and telephone coaching since completing DBT intensive training in 2004.

Whilst engaged in the delivery of DBT I observed that adolescents often appeared unreceptive to the mindfulness element of the therapy. I therefore wondered if it was the way in which mindfulness was taught that led to the apparent non-receptiveness, although I found that some adolescents seemed to talk about engaging with mindfulness more than others.

My concern was that l understood very little about what it was like for adolescents being taught mindfulness in DBT. I was concerned that I was offering mindfulness in DBT to help adolescents with their mental health difficulties without understanding if they experienced the mindfulness that was being taught as helpful or accessible to them. I therefore saw the research as a matter of clinical integrity, to understand what it was like when an adolescent was offered mindfulness as a way out of their problems.

I also noted that practitioners had a variety of ideas and practices related to mindfulness in DBT. Whilst practitioners that I worked with followed the skills training manual content there

was a difference in approach with regard to what this content meant and how it could be applied to the lives of adolescents undertaking DBT.

Since I observed DBT as applied to adolescents becoming more widely used as a treatment in the UK there seemed to be a need to better understand the therapy and its' features. In particular, the mindfulness element of DBT proved to be little understood in the research and not considered in relation to the adolescent experience of mindfulness, highlighting the need to explore this element of DBT further. Furthermore, the research into Mindfulness Based Interventions (MBIs) for mental health disorders was mostly focused on interventions that were based on longer mindfulness practices rather than the skills based teaching used in DBT. These differences made it difficult to compare findings between mindfulness taught in DBT and the research with regard to other studies.

The aim of the study presented in this thesis was to answer the research question: *What is the lived experience of adolescent service users and DBT practitioners engaging with mindfulness in DBT?*

More specifically I aimed to answer the following questions:

- What does the experience of adolescents undertaking DBT tell us about how adolescents utilise mindfulness?
- What does the experience of practitioners teaching DBT tell us about how practitioners approach the teaching of mindfulness?
- What does the experience of adolescents and practitioners tell us about the place of mindfulness in DBT?

The findings from this study are intended to develop the understanding of what it is like to be taught mindfulness in DBT and the experience of using the skills that are learned. It is anticipated that by developing an understanding of the lived experience of mindfulness in DBT that there will be implications for the clinical practice of DBT and also wider implication for teaching mindfulness as a clinical intervention for adolescents. Since research into mindfulness in DBT and in particular the experiences of adolescents of mindfulness in DBT has been scant it is anticipated that this study will highlight areas that require further exploration and clarification through future research.

1.4 **Thesis structure**

The document is divided into seven further chapters.

Chapter two presents the development of mindfulness as a clinical intervention. Debates that have emerged in the literature about the proliferation of mindfulness as an intervention both non-clinically and clinically, about the difference between state and trait mindfulness and about the way in which mindfulness can be defined and measured are discussed. Finally an exploration is made of the features pertaining to practitioners and mindfulness based interventions.

Chapter three outlines the current state of the empirical research into mindfulness as a clinical intervention and situates the study within existing literature. This scoping review is focused on understanding the available research with regard to mindfulness in DBT; mindfulness as it pertains to BPD; mindfulness based interventions for adolescents and qualitative research of mindfulness based interventions for mental health disorders.

Chapter four presents Interpretative Phenomenological Analysis (IPA) as a research methodology and as such explores the theoretical underpinnings; phenomenology, hermeneutics and idiography. The application of IPA as a research method is outlined and critiqued.

Chapter five outlines the research procedure that was followed in the study including the process of gaining ethical approval for the study, the process of recruitment and consent procedures.

Chapter six demonstrates the process of analysis that was conducted to generate the findings of the study. This chapter outlines the detailed analysis of one service user participant transcript, the development of themes across the service user participant data set and the development of themes across the practitioner participant data set.

Chapter seven presents and discusses the findings of the study. Two higher order concepts - *A struggle with uncertainty and challenge* and *Developing internal awareness with caution* are demonstrated through the presentation and discussion of superordinate and subordinate themes.

Chapter eight concludes the thesis by presenting implications of the study alongside limitations and reflections on the research process.

Appendices, references and glossary of terms are provided to support the reading of the thesis.

As there are two groups of participants they are referred to as service user participants and practitioner participants. The term 'service user participant' (SUP) has been used to indicate a research participant who was engaged in mindfulness in DBT because they are receiving treatment for a mental health problem. The term 'practitioner participant'(PrP) has been used to indicate a research participant who was a mental health professional who is delivering mindfulness in DBT within a clinical setting. The term participant is used when the same process was applied to both groups.

Chapter 2: **Background and development of mindfulness as a clinical intervention**

Mindfulness has been developed as a secular form of Buddhist meditation and is being used as a way of cultivating wellbeing in western societies (Monteiro et al. 2015). Mindfulness meditation involves an individual bringing their attention to a point of focus (breathing, sounds) and redirecting their attention back to this point of focus should they begin to pay attention to something else (sensations, thoughts, other sounds) (Rosenburg, 1998).

Mindfulness is a complex phenomenon to define. Mindfulness has been defined by the Oxford Dictionaries as:

1. The quality or state of being conscious or aware of something.
2. A mental state achieved by focusing one's awareness on the present moment, while calmly acknowledging and accepting one's feelings, thoughts and bodily sensations, used as a therapeutic technique.

In this definition mindfulness is given four characteristics: focus; awareness of the present moment; calm acknowledging and acceptance of thoughts, feelings and bodily sensations. As illustrated above, mindfulness can be considered to be a state or trait (quality). The complexity of the definition of mindfulness has led research into mindfulness to be complex and wide ranging. Researchers have begun to explore but not fully answer questions such as: Is what we call mindfulness one homogeneous skill/experience/way of being? How does mindfulness work? The discourse around mindfulness as both a clinical and non-clinical phenomenon has been shaped in particular by emphasis on the difference between state and trait mindfulness; the measurement of mindfulness; the mechanisms of change present in mindfulness and the heterogeneity of mindfulness as a concept across interventions.

Dimidjan and Linehan (2003) called for a consensus on the core components of mindfulness and the testing of these in a reliable and valid way so that the benefits of mindfulness as a treatment could be better understood. In the years since this discourse was started there has been an explosion of research into mindfulness as a clinical tool, mindfulness as an intervention for promoting wellbeing in everyday life and mindfulness as a spiritual exercise.

2.1 The social, political and ethical context of mindfulness

Since emerging as an intervention used in medical settings in the 1980's Mindfulness Based Interventions in health care settings have become of interest across a whole range of physical and mental health problems. In 1990 Jon Kabat- Zinn outlined the Mindfulness Based Stress Reduction (MBSR) programme that he had developed to reduce stress and chronic pain (Kabat-Zinn, 1990). The development of mindfulness as an intervention has since been applied to a range of health needs including cancer care (Ledesma and Hiroaki, 2009) depression (Piet and Hougaard, 2011) and chronic illness (Bohlmeijer, et al. 2010). The application of mindfulness has developed beyond health care in an effort to improve wellbeing in the work place, in schools and in the criminal justice system. In 2015 an All Party Parliamentary Committee paper – Mindful Nation UK was published, outlining mindfulness as a way of developing the 'mental capital' of the nation due to the evidence that mindfulness increases resilience in the face of stress and improves flexible learning skills. This evidence was collated from a panel of expert witnesses who were delivering and researching mindfulness in health, mental health, the workplace, education, the criminal justice system and gangs. The paper concludes that mindfulness is an innovation that can increase productivity and increase creativity thereby being of value to improve the UK economy. Purser and Roy (2013) raised grave concerns about the use of mindfulness as a tool for boosting the economy. They identified that the taking up of mindfulness in the corporate arena placed the responsibility of stress reduction on the individual, removing the responsibility of companies to consider the causes of the stress. They suggested that the way in which mindfulness was being adopted so widely and indiscriminately as a quick fix would lead to eventual disillusionment with regard to mindfulness. The proliferation of mindfulness in schools has also been raised as a concern due to the focus on this as particularly important for wellbeing above other forms of cultivating wellbeing (Patterson, 2015). Patterson's fear seems to be that mindfulness is being adopted as a cure all and in doing so becomes a fashion which is most useful for making money for those invested in it. Kabat-Zinn (2015), who many recognise as the founder of mindfulness based intervention, tried to redress the commercialism of mindfulness, reiterating that mindfulness is not a quick-fix and that the indiscriminate use of mindfulness to improve wellbeing would be ineffective. Schmidt (2016) discussed the growing critique of the indiscriminate proliferation and concluded that it is important not to overstate the effectiveness of mindfulness. Schmidt (2016) stated that using mindfulness to reduce stress can serve to support the continuation of unhealthy conditions that people are subject to in the work place and within their lives in general; stating that by placing the responsibility of wellbeing on the individual being mindful

systemic changes that would improve health would not occur. Therefore the political appetite for the widespread use of mindfulness as a way of addressing issues in health, education, criminal justice and the workplace may therefore need to be tempered in terms of the expectations of what mindfulness alone can achieve. Consideration needs to be given to the reason people are being encouraged to be mindful – to make them feel better, to improve their work, to get them back to work, to develop a better society. The parliamentary paper - Mindful Nation UK (2015) promoted widespread funding for MBIs and for the development of MBIs with a more preventative focus. Some attention was paid to potential pitfalls of the widespread proliferation of mindfulness. These pitfalls were outlined as: the dilution of the MBIs which could reduce the effectiveness of the interventions; poor practice in those that are not adequately trained or convinced by mindfulness as an intervention and the unknown effectiveness of those MBIs that have not had adequate research (only MBCT and MBSR were identified as having been adequately studied to establish effectiveness).

There is some debate with regard to whether it is important for mindfulness based interventions to follow the Buddhist meditation philosophy from which it stems. Monteiro et al. (2015) suggested coherence with traditional mediation would involve including the concepts of 1) right mindedness 2) insight into the root of suffering and 3) the ethics of wholesome living in mindfulness based interventions. However, Monteiro et al. (2015) highlight that introducing these important elements of the Buddhist tradition into clinical practice could be problematic due to the religious value system that is promoted. Schmidt (2016) argued that the promotion of living an ethical life through MBIs was not problematic as the MBI did not prescribe what the person should be doing, only how they could get there. However, MBIs were developed using terms that suggest an ethical dimension to the use of mindfulness such as non-judgemental, kindness and wisdom (Kabat-Zinn, 1990).

Stanley (2013) proposed that MBIs are a secularised form of meditation as they do not encourage the participant to adopt a more ethical way of living to relieve suffering, but that engagement with mindfulness changes thoughts and therefore the brain, subsequently bringing symptomatic relief. Secularising meditation into mindfulness may make it more palatable to those providing and entering into MBIs. However, McDonagh (2014) deplored the separation of mindfulness from faith as she believed that this made mindfulness too individualistic and focused on individual reduction of suffering rather than wider societal suffering. She also warned that non-judgemental consideration of actions without the ethical element of Buddhist meditation could lead to acceptance of doing things that are morally wrong and complacency about changing things that are harmful. It is likely that contemporary

mindfulness in the form of MBIs will continue to develop along secular lines. Over time further research and clinical insights will be able to delineate whether the move away from the ethical Buddhist roots of traditional meditation is problematic, or whether the evolution of contemporary mindfulness into a distinct model for developing wellbeing is valid in its own right.

2.2 Mindfulness as a state and trait

It is important to understand the difference between an individual who is in a state of mindfulness and an individual who has a trait of mindfulness. This is because the relative effects of these are somewhat different. A state of mindfulness is a transient state which can be occurring or not occurring in any one moment. It occurs when a person has the intention of 'doing' a mindfulness practice and intends to evoke certain dimensions of mindfulness i.e. focused attention, non-reactivity. A trait of mindfulness is related to the way in which an individual approaches their life in a way which could be considered mindful – with focused attention and non-reactivity. It is also important to understand if the aim of the MBI is to increase the incidence of being in a state of mindfulness or to develop a trait of mindfulness in an individual. It may be that any particular MBI aims to do both of these things.

Some researchers have been interested in trait mindfulness and whether those with greater dispositional mindfulness have a greater number of positive outcomes. Thompson and Waltz (2010) suggested that dispositional mindfulness was predictive of the level of avoidance symptoms in PTSD (greater mindfulness = less avoidance). Lundh et al. (2007) identified that adolescents in Sweden who self-harmed had significantly lower scores on the Mindful Attention Awareness Scale (MAAS) than those that did not. Marks et al. (2010) were interested in whether the level of mindfulness or rumination exhibited by an adolescent would affect the levels of depressive symptoms, anxiety and stress experienced associated with 'life's hassles'. They concluded that higher levels of dispositional mindfulness helped young people to deal with life's 'hassles' and may therefore reduce the levels of psychopathology in adolescent populations. Kok et al. (2011) explored self-harming behaviour in adolescents in relation to how often the adolescents acted mindfully. Kok et al., (2011) found that those that sometimes acted mindfully had fewer episodes of self-harm and fewer injuries per episode. However, those that sometimes acted mindfully engaged in self-harm that was more damaging; did not attend to their wounds and experienced more shame and regret than those who often act mindfully. Therefore there is evidence that those who possess mindfulness as a

trait experience indicators of increased wellbeing. This does not necessarily mean that trait mindfulness causes increased wellbeing. It is unclear whether the route to increased trait mindfulness is the practice of state mindfulness. It would be useful to establish further whether a) everyday trait mindfulness can be increased by mindfulness practice and b) whether the teaching of mindfulness in MBIs increases either state mindfulness or trait mindfulness or both.

The understanding of the balance between state/trait mindfulness and overall wellbeing may begin to uncover the mechanisms of change in MBIs. This can further the understanding of the essential elements of MBIs overall.

2.3 Measurement of mindfulness

Due to the heterogeneity of the use of the term mindfulness, some researchers have attempted to distil the term mindfulness into constituent parts which can be measured by self-report. In doing this they have endeavoured to identify people as more or less mindful either in terms of state or trait mindfulness. Measurement of mindfulness is an attempt to objectify and detail the necessary and sufficient characteristics that need to be present for a phenomenon to be called mindful. These characteristics have been identified as behaviours, thoughts, attitudes and beliefs which are grouped in different combinations and to different extents in each mindfulness measurement scale. Such scales make it easier to make valid and reliable claims about the effects of the levels of mindfulness as defined by each scale. However, the use of different scales in different research makes it difficult to compare studies as different scales measure mindfulness in a different way. For example, some measures have a focus on state mindfulness and others on trait mindfulness.

The Toronto Mindfulness Scale (TMS) is a self-report measure that was developed to measure state mindfulness as experienced during mindfulness meditation (Lau et. al., 2006). It was developed by a team of experts who constructed an operational definition of mindfulness through a set of features of the state of mindfulness. Baer et al. (2006) sought to evaluate and bring together a number of mindfulness questionnaires in an effort to develop a measure of mindfulness encompassing the features of other measures. Baer et al. (2006) identified the common facets that had been used to define mindfulness across the questionnaires and developed the Five Facet Mindfulness Questionnaire (FFMQ) which measures dispositional (trait) mindfulness. Baer et al. (2006) hoped that the FFMQ would assist in the identification of the relationship of the components of dispositional mindfulness to other areas of study such as

dissociation or psychiatric symptoms. The development of these questionnaires can be considered to be a process of classification. The authors of the questionnaires have tried to delineate the core of what it is to be mindful. To identify the nature of mindfulness as a set of conditions that are met or not met in any one instant. Although these conditions describe behaviours, e.g. "When I take a bath or shower I stay alert to the sensation of water on my body" (FFMQ, (Baer et al., 2006)), these behaviours do not describe what improvements mindfulness makes to the person's life, e.g. 'therefore I know to turn the temperature down when it gets too hot'. Respondents are asked to rate the frequency with which they engage in certain acts/attitudes such as whether they '*put beliefs, opinions and expectations in to words*' or '*pay attention to how my emotions affect my thoughts or behaviour*'. However, there is no sense in whether doing these things is experienced as desirable or not by the individual (Five Facet Mindfulness Questionnaire - (Baer et al., 2006)). Li et al. (2014) sought to move away from the presence of a mindfulness state or trait and capture the way in which MBIs impact on how people deal with every day issues. They described this as a process measure, the Applied Mindfulness Process Scale (AMPS), which they hoped would complement the state and trait approach to measurement. This scale begins to look at the possible benefits of mindfulness to the individual. However, the desirability of each of the dimension still remains implicit.

An overview of the measures that have been developed to measure mindfulness is outlined in Appendix B. This table is based on the work of Bergomi et al. (2013) who explored the available measures in the light of: the coverage of the questionnaires; the relationships between questionnaires and the validity of self-report in the measurement of mindfulness.

The measurement of mindfulness through self-report has become wide ranging and yet there are concerns about measuring mindfulness in this way. Firstly, Bergomi et al. (2013) noted that many of the items on the scales were ambiguous and therefore may be interpreted differently by different respondents. Furthermore, the use of mindful language is likely to be developed and recognised more by those with experience of mindfulness than those who are naive to the concepts. Bias based in the completion of the Freiburg Mindfulness Inventory(FMI) was identified as being introduced through learning statements about mindfulness during a mindfulness retreat (Buchheld et al., 2001). Other factors that would not necessarily indicate an increase in mindfulness, but may change the outcome of self-report measurement are that participation in a mindfulness course increases the awareness of the mindful response to a question and increases the intent of the participant to be mindful (Grossman , 2011)

Secondly, there is some debate as to whether the domains highlighted in the questions can only be present during mindfulness. Goldberg et al. (2016) discovered that mindfulness as outlined by the FFMQ increased during an explicitly non-mindfulness based intervention. Therefore, the dimensions measured as being necessary for a phenomenon to be called mindful may not be unique to mindfulness intervention. Goldberg et al. (2016) suggested that cognitive or behavioural states that are not necessarily developed through mindfulness may lead to positive results on measures of mindfulness.

Thirdly, there is an issue with regard to the different conceptualisations of mindfulness. Grossman (2011) noted that it was possible for an individual to score high for mindfulness on one scale and score low on a different measure. Furthermore, it is possible to have high scores in one dimension of a measure and low in a different dimension within that measure suggesting that one dimension of mindfulness can be learnt without an effect on another dimension – making them exclusive concepts. It may therefore be that an overall high score of mindfulness does not reflect the presence of each dimension of mindfulness as outlined by the measure (Grossman, 2011). The necessary and sufficient conditions for a phenomenon to be considered mindful are therefore still not understood and demonstrated by the measures. Some measures appear to measure some dimensions as state mindfulness and other as trait mindfulness (Medvedev et al., 2017). Understanding which of these is being measured is important to understand the effectiveness of interventions over time – since a state of mindfulness is transient whereas a trait is applicable to everyday life.

Finally, the scientific deconstruction of mindfulness has been highlighted as insufficient to understand mindfulness as a whole, understanding the dimensions of mindfulness does not adequately encompass the experience of doing mindfulness (Noguchi, 2017). Furthermore, despite the careful creation of these scales researchers have already begun to find it necessary to deconstruct the scales into subscales in order to identify the specific levels of more narrowly defined concepts such as self-compassion or acceptance (Schroevers and Brandsma, 2010; Thompson and Waltz, 2010). This is leading researchers to consider that different elements of mindfulness may be more effective in treating different disorders or traits and as such those specific elements may need to be emphasised or employed as a treatment in their own right. However, it could be questioned whether deconstructing mindfulness to this extent is consistent with mindfulness overall. The specific element of mindfulness found to be significant in the change process may only be present if cultivated within the wider concept of mindfulness. For example, engaging in non-judgemental presence may not have the same effect without engagement with other facets of mindfulness. The difficulties in the objective

measurement of mindfulness have led for calls for a qualitative or phenomenological approach to the study of mindfulness as this may be more effective in capturing the features of mindfulness (Grossman, 2011; Noguchi, 2017)

2.4 Mechanisms of change in mindfulness

As MBIs have become more extensively studied and been shown to be effective in treating certain conditions, it has become desirable to understand more about the mechanisms of change that are at work. Research has produced an extensive catalogue of possible mechanisms of change in MBIs. The edited book by Baer (2010) explored a variety of mechanisms for change in MBIs, highlighting the potential for the diverse impact of these interventions on different individuals. The possible mechanisms of change explored in each chapter were, psychological flexibility, emotional regulation, self-compassion, spiritual engagement and working memory. Some authors have looked to distil the variety of mechanisms of change into more general theories of change in mindfulness. Shapiro et al. (2006) proposed that the process of intentionally attending with openness and being non-judgemental led to a process of re-perceiving. Lindsay and Creswell (2017) proposed a theory to explain mindfulness effects on cognition, affect, stress and health outcomes. They believed that Monitor and Acceptance Theory, whereby the effects of mindfulness are explained by attention monitoring, improving cognitive functions and acceptance, thereby reducing affect reactivity. They proposed that attention monitoring and acceptance are features of all MBIs and therefore this theory offers a way to assess a broad range of outcomes – thus transcending the type of MBI and the type of disorder which is being targeted.

The various proposed mechanisms of change are summarised in Table 4. In this table they are grouped into common themes to summarise the commonalities and variance across theories.

Sh(Shonin and Van Gordon, 2016)(Shonin and Van Gordon, 2016)(Shonin and Van Gordon, 2016)(Shonin and Van Gordon, 2016)(Shonin and Van Gordon, 2016)(Shonin and Van Gordon, 2016)(Shonin and Van Gordon, 2016)(Shonin and Van Gordon, 2016)(Shonin and Van Gordon, 2016)(Shonin and Van Gordon, 2016)(Shonin and Van Gordon, 2016)(Shonin and Van Gordon, 2016)(Shonin and Van Gordon, 2016)(Shonin and Van Gordon, 2016)(Shonin and Van Gordon, 2016)(Shonin and Van Gordon, 2016)(Shonin and Van Gordon, 2016)(Shonin and Van Gordon, 2016)(Shonin and Van Gordon, 2016)onin and van Gordon (2016) summarised the literature on mechanisms of change with regard to mindfulness and mental health as follows: structural brain changes, reduced autonomic arousal, perceptual shifts, increase in spirituality, greater situational awareness, values classification, increase in

self-awareness, addiction substitution, urge surfing and letting go. They noted that the mechanism of change is likely to be different depending on the approach; the clinical symptoms being targeted; the personal history of the service user and the approach of the practitioner (Shonin and van Gordon, 2016). Therefore an individualistic approach to understanding how change occurs in mindfulness may be more appropriate than developing an all-encompassing theory of how mindfulness works, as there seem to be numerous variables that could lead to measurable changes in mindfulness.

Table 4 Overview of mechanisms of change identified in the research

Mechanism	**Defined by**	**Present in**
Physical	Structural brain changes Reduced autonomic arousal	Shonin and van Gordon (2016)
Cognitive	Psychological flexibility Working memory Perceptual shifts Greater situational awareness Decentring Cognitive flexibility and exposure Reduced rumination Attention monitoring	Baer (2010) Shonin and van Gordon (2016) Shapiro et al. (2006) Lebois et al. (2015) Ciesla (2012) Lindsay and Cresswell (2017)
Emotional	Emotional regulation Self-compassion Urge surfing Letting go Emotional flexibility and exposure Regulating reactivity to	Baer (2010) Shonin and van Gordon (2016) Shapiro et al. (2006) Lindsay and Cresswell (2017)

Mechanism	Defined by	Present in
	emotional experience	
Spiritual	Spiritual engagement Increase in spirituality	Baer (2010) Shonin and van Gordon (2016)
Self	Values classification Increase in self-awareness Self-regulation	Shonin and van Gordon (2016) Shapiro et al. (2006)
Other	Addiction substitution Behavioural flexibility and exposure Decoupling internal experience from behaviour	Shonin and van Gordon (2016) Shapiro et al. (2006) Levin et al. (2015)

The variety of possible mechanisms are abundant and therefore pinning down a theory which encapsulates the mechanisms of change in mindfulness overall is somewhat daunting. Eisenlohr-Moul et al. (2015) outlined three possible ways of investigating mechanisms of change in MBIs: outcomes studies that measure potential mediators of change at different time points; cross-sectional studies of the relationships between variables i.e. that if one variable is present another will not be; laboratory experiments that induce mindfulness and measures the effects on specific variables.

The exploration of measurement of mindfulness, the difference between state and trait mindfulness and the mechanisms of change in mindfulness are all important in the conceptualisation of mindfulness as a whole. The way in which these concepts are used in any one study will determine what is studied and how. The researchers of any particular study will have a hypothesis based on the way they have conceptualised the problem in the first place. This will determine their choice of measurement, the process they are looking to observe and the outcomes they expect. It is unsurprising therefore that it is difficult to draw together coherently the variety of research that is available with regard to mindfulness.

2.5 **Mindfulness in DBT**

Wolbert (2019) described how DBTwas developed afterMarsha Linehan recognised that clients presenting with suicidal and self-harming behaviour, often did not benefit from a CBT intervention. Marsha Linehan theorised that the change element of CBT needed to be balanced with being able to accept reality as it is (Wolbert, 2019). She therefore introduced aspects of Zen Buddhism into the therapy by adding a mindfulness module to the teaching of skills.

The DBT skills manual for adolescents outlines the reasons for teaching mindfulness in DBT as follows (Rathus and Miller, 2015):

- Giving greater choice and control over behaviour
- Reducing suffering - increasing pleasure
- Helping to make important decisions
- Focusing attention to make you more effective and productive
- Increase compassion for yourself and others
- Lessen pain, tension and stress

These reasons to engage with mindfulness are very similar to those used in other MBIs. However, there are important differences in the emphasis on behavioural change, awareness and insight in the explanations as to why mindfulness is included in each MBI. Segal et.al (2013) described the benefits of engaging with Mindfulness Based Cognitive Therapy through the feedback of participants including: Becoming aware of the workings of my mind; recognising patterns; taking a kinder, more gentle attitude towards myself; knowing how to focus on the here and now. Although both approaches adopt mindfulness as a way of improving mental health the emphasis as to the intended benefits are somewhat different.

In the examination of research pertaining to MBIs only a few of the studies were found to have included mindfulness in DBT. Many of the systematic reviews/meta-analyses of mindfulness interventions deliberately excluded mindfulness as taught in DBT (Chiesa and Serretti, 2010; Hofmann et. al., 2010; Mars and Abbey, 2010). The exclusion of DBT from such meta-analyses

seemed to be due to the way in which the mindfulness in DBT is taught as part of a wider treatment programme rather than as the main treatment, meaning that it was more difficult to account for the effect of mindfulness alone.

Chiesa and Malinowski (2011) explored how the philosophical context of mindfulness is different between different MBIs. They highlighted that DBT focuses on walking a middle path between acceptance and change and that it does this by teaching principles of mindfulness as opposed to engaging in sitting meditation. Chisea and Malinowski (2011) stated that the two more widely recognised MBIs (MBCT and MBSR) have a greater emphasis on insight into symptoms through directed mindful meditation. Bass et al. (2014) compared DBT with other mindfulness based interventions – Acceptance and Commitment Therapy (ACT) and Mode Deactivation Therapy (MDT). They highlighted the differences in approach to mindfulness in these therapies in terms of techniques that are used to impart mindfulness and the aims of using mindfulness in the therapy. The main differences in the techniques were the emphasis on brief vs. lengthy mindfulness exercises and the relative priority given to self-regulation (MDT), acceptance (DBT) and diffusion of thoughts (ACT). Jennings and Apsche (2014) explored how DBT and MDT modified the underlying aim of teaching mindfulness and therefore the way in which mindfulness was taught in these therapies based on the needs of the group that was being targeted. They suggested that the central aim of mindfulness in DBT was changed to meet the needs of women with Borderline Personality Disorder (BPD) who were being targeted by DBT. They identified these needs as being extreme emotional reactivity; sensitivity to perceived rejection and inability to self soothe. Therefore the mindfulness elements of DBT were focused specifically on reducing emotional reactivity; being non-judgemental about experience and radical acceptance of the present as it is. This would suggest that other elements of mindfulness are given less focus in DBT than in other MBIs. Although all MBIs can be thought of as mindful in some way it seems that mindfulness is used differently in different MBIs to support the philosophical underpinnings and goals of the particular MBI. The different MBIs can be thought of as distinct; therefore it is important to bear in mind the distinct nature of these approaches when comparing them in terms of efficacy and mechanisms of change. Chiesa and Malinowski (2011) questioned an approach to research which treated all of these MBIs as equivalent in the philosophical background, aims and practices. They suggested that further research was necessary to understand the differences in clinical outcomes and underlying psychological mechanisms between MBIs.

Mindfulness in DBT is particular in the following areas: the teaching of the principles of mindfulness specific skills and the use of short mindfulness exercises as opposed to lengthy

practices which illustrate the different mindfulness skills. A skills based approach to the development of mindfulness is thought helpful to identifying particular deficits in mindfulness and to identify the outcome of becoming proficient at particular mindfulness skills – thus making the skill easier to reinforce (Wagner et al. 2006). This may have an impact on the conceptualisation of the aims and mechanisms of change pertaining to mindfulness in DBT.

2.5.1 The teaching of mindfulness in DBT

The overarching reason to develop mindfulness in DBT is to develop a state of 'Wise Mind' which encourages service users to develop actions that are not purely emotion-dependent or dependent on rationalisation (Stanton and Dunkley, 2019). This focus on the development of wisdom is particular to mindfulness in DBT as an intervention and relates closely to foundations in Zen principles (Wolbert, 2019).

Central to the teaching of mindfulness in DBT is the idea of mindfulness being an eyes open, participatory practice that is practiced by living each moment mindfully rather than engaging in longer mindfulness meditations. In this way service users are encouraged to step back from their interpretations of a situation and to see reality for what it is (Stanton and Dunkley, 2019).

The DBT adolescent skills manual directs the practitioner to offer two sessions that cover the content of the mindfulness module at the start of every other module giving eight sessions of mindfulness over the course of the treatment. There are eight handouts that are used to outline the basis of the teaching as summarised in Table 5

Table 5 Overview of teaching materials used in DBT-A with regards to mindfulness

Handout	Summary of Contents	Summary of rationale from Skills manual
Taking hold of your mind	Taking control of your mind rather than letting your mind be in control of you. Full awareness (Opened Mind) Attentional Control (Focused mind	Many people feel controlled by their minds, experiencing intrusive thoughts that cause distress. Mindfulness can help develop an awareness of everyday experiences that can leave us feeling more in control of our minds
Mindfulness: Why bother?	Reasons for practicing mindfulness.	Mindfulness helps us to take hold of our mind to: Give greater choice and control over behaviour; Reduce suffering - increasing pleasure; Help to make important decisions; Focus attention to make you more effective and productive; Increase compassion for yourself and others; Lessen pain, tension and stress
Three States of Mind	Emotional mind	Identifying the difference between what we think to be

Handout	Summary of Contents	Summary of rationale from Skills manual
	Reasonable Mind Wise mind	true (reasonable mind), feel to be true (emotional mind) and what you know to be true (wise mind) through using you intuition.
Observing yourself in each state of mind	Practice sheet recording what service users notice about the three states of mind over the course of a week.	Encouraging home practice and increasing willingness to practice.
What Skills	Observe Describe Participate	Observing to slow down our conclusions about the world and to reduce the word filled interpretations that we make Describing to put precise words to the experience using statements such as I notice that…….. and I feel……. Participate to increase experiencing without self-consciousness.
How Skills	Don’t Judge	Don't judge to reduce evaluations of experience and

Handout	Summary of Contents	Summary of rationale from Skills manual
	One mindfully Do what Works	observe how judgements change our thinking One Mindfully to slow down and reduce overload from multitasking Do what works - to cut the cord between feeling and doing. Reduce the impact of emotions on controlling behaviour.
Mindfulness cheat sheet	Three steps to practicing mindfulness: 1.chose something to focus on 2. Bring you attention to the object of focus 3. When your attention wanders notice it has happened and bring your attention back to the object. Don't judge yourself for your attention wandering.	Giving an overview of what a mindfulness exercise includes. By this point in the module they will have experienced several mindfulness exercises.
Practice exercise: Mindfulness what and how	Practicing each skill during the week. Described how you	Encouraging home practice and increasing willingness to

Handout	Summary of Contents	Summary of rationale from Skills manual
skills	used the skill. Describe how the skill affected your thoughts and feelings. Notice your ability to use wise mind, notice the present and focus your attention.	practice.

Each skill is illustrated by a mindfulness exercise for example the skill of Observe may be illustrated by 2 minutes of focussing on the sensation of the feet on the floor. Practitioners will introduce the exercise which will mostly be completed in silence although some exercises are guided i.e. tasting a raisin, body scan. The components to introducing the exercise are as follows: Simple, clearly defined focus of attention; noting that the mind will wander and that returning the mind to the focus of attention is the act of mindfulness (Dunkley and Stanton (2014).

Once the mindfulness module is complete each session thereafter is started with a mindfulness exercise. Practitioners are also encouraged to rehearse, correct and model mindfulness within individual sessions to support the development of mindfulness (Stanton and Dunkley, 2014). During individual sessions practitioners have the opportunity to attend to any barriers to developing mindfulness, that are experienced by individual service users.

As a comparison to the teaching of mindfulness as an intervention, a typical MBCT course would be 8 weeks of teaching focussed on mindfulness as follows:

Session 1 Awareness and automatic pilot

Session 2 Living in our heads

Session 3 Gathering the scattered mind

Session 4 Recognizing aversion

Session 5 Allowing/letting be

Session 6 Thoughts are not facts

Session 7 “How can I best take care of myself?”

Session 8 Maintaining and extending new learning

(Health education England, 2017)

Whilst there are similarities between the elements of what is taught in both programmes the rhetoric with regards to mindfulness is different. The DBT mindfulness teaching uses ideas of control, focus and states of mind whereas the MBCT session titles use terms such as allowing, gathering and letting be. This may reflect the difference in rhetoric between mindfulness as skills based competency and mindfulness as an investigation into the nature of the mind.

Shapiro et. al (2006) theorised that the changes associated with practising mindfulness were based on intention, attention and attitude rather than the type of mindfulness practice that was undertaken. The intention shifted from self-regulation to self- liberation as individuals engaged in mindfulness more fully. Therefore the type of practice that individuals engage in may shift over time as self-regulation lends itself more to a behavioural control focus and self-liberation more to an insight focus. The intention and attitude of the practitioner will guide participants as to the intention and attitude of the MBI and will therefore direct what participants learn from the practice.

We can assume that the experience of engaging with mindfulness is somewhat different depending on which MBI an individual experiences. Despite having broadly the same reasons to include mindfulness in therapy the emphasis on mindfulness as a skill, way of being, a trait to be developed, a practice to be established will all affect the emphasis the individual will place on different facets.

2.5.2 Mindfulness as it relates to BPD

Since DBT was developed specifically to treat the symptoms of BPD, the literature relating to mindfulness and BPD may help to understand the specific focus of mindfulness in DBT and some of the mechanisms of change that may be at play. Wagner et al. (2006) theorised that mindfulness was particularly important to adolescents exhibiting BPD features because practising mindfulness would encourage awareness, acceptance and non-judging which would

in turn reduce emotional dysregulation and improve validation between family members. This approach suggests that mindfulness is used in DBT to specifically target the symptoms of BPD.

Mindfulness has been considered in studies with regard to BPD diagnosis, in particular whether there is any connection to the level of dispositional mindfulness in those with BPD symptoms. Wupperman et.al. (2008) provided evidence that mindfulness as a trait correlated negatively with features of BPD in adults. However, this was not based upon a clinical sample nor did it establish that improved mindfulness through mindfulness interventions would decrease BPD symptoms. Other studies have linked BPD symptoms to characteristics that would seem at odds with being mindful, characteristics such as thought suppression (Sauer and Baer, 2009), impulsivity and emotional dysregulation (Chapman et. al., 2008). Overall in the study of mindfulness and BPD there is a sense that mindfulness and symptoms of BPD cannot co-exist. Wupperman et al. (2013) were concerned with whether deficits in mindfulness underlie the presence of self-injury and harmful dysregulated behaviour in BPD. They found a significant relationship between higher levels of mindfulness and reduced report of self –injury. However, they were unable to establish that this was a causal relationship. Fossati et al. (2011) demonstrated a link between lower levels of mindfulness as measured by the MAAS to BPD symptoms and insecure attachment. They suggested that the results indicated that mindfulness may be an essential component to effective treatment of BPD. Those with BPD were shown to struggle more with mindfulness tasks demonstrating less focus and difficulty with refocusing (Scheibner et al., 2016). It may be therefore that some characteristics necessary to access mindfulness are lacking in those with BPD.

Robbins (2002) explored the use of mindfulness in DBT and suggested that it may be useful to those with BPD symptoms because it reduces levels of rumination, increases the capacity to enjoy small pleasures, enhances awareness of impulses and the ability to stay grounded in the presence of emotional distress. Lynch et al. (2006) hypothesised that mindfulness was useful in reducing the problematic behaviours associated with BPD because of its role in providing a context for exposure to and extinction of previously problematic emotional responses; improving emotional regulation by changing automatic responses to emotions; changing the person's relationship to their thoughts as just thoughts rather than truths and increasing the individual's ability to turn their attention to where they choose.

Some specific mindfulness processes have been outlined as having specific impact in BPD, in particular the relationship between mindfulness and rumination has been of interest. Sauer and Baer (2012) suggested using mindful self-observation as opposed to rumination had the

effect of reducing angry emotions. Selby (2016) found that there was a distinct relationship between the effect of rumination on decreasing mindfulness and the effect of decreased mindfulness on increasing BPD symptoms. In addition to the relationship between rumination and mindfulness studies have highlighted connections between attachment disturbances (Fossati, 2011); and non-judgement (Peters et al., 2013). There is therefore a small but growing evidence base that mindfulness could help to relieve the symptoms of BPD. This begs the question as to whether mindfulness can be cultivated in those with BPD in order to reduce symptoms. Soler, et al. (2016) examined the role of brief mindfulness training on impulsivity related variables through self-report. Those involved in the mindfulness training showed ability to delay gratification and changes in time perception. However, trait impulsivity and response inhibition remained unchanged, suggesting that the benefits of the mindfulness training were temporary and situation specific.

The types of indicators explored in studies of mindfulness and BPD are wide ranging and may have some limitations as many of the findings were based on BPD symptoms in healthy populations rather than those diagnosed with BPD. There is a big difference in understanding how a person's level of mindfulness relates to symptoms of BPD and whether a mindfulness intervention has an effect on the level of mindfulness experienced or the presenting symptoms. Furthermore, if a deficit in mindfulness relates directly to certain BPD symptoms it is unclear if this deficit is rectified in the long term by a mindfulness intervention. Since DBT was developed to specifically target the symptoms of BPD the research as it pertains to the efficacy of the mindfulness element of DBT may help to establish whether mindfulness intervention can improve outcomes for this population.

2.6 **Practitioners and mindfulness**

Some researchers have been interested in understanding practitioner related factors in the delivery of MBIs. The studies have explored levels of mindfulness present by self-report in practitioners and compare them to outcomes in therapy; the experience of practitioners delivering MBIs and the relationship between self-report levels of mindfulness and practitioner wellbeing.

Most of the studies identified were concerned with how practitioner mindfulness, the level of mindfulness experienced by practitioners as measured by self-report scales, effects the way therapy is conducted or the outcomes of the therapy (Millon and Halewood, 2015; Razzaque et al., 2015; Keane, 2014 ; Fatter and Hayes, 2013; Aggs and Bambling, 2010; McCollum and

Gehart, 2010; Grepmair et al., 2007a, 2007b, 2008; Stanley et al., 2006). These studies indicated that there was a positive relationship between levels of mindfulness as measured for the practitioner and outcomes for the service user. There is evidence from these papers that therapists who use mindfulness or are more mindful will regard the service user more positively and see better outcomes in their delivery of MBIs. These findings indicate that whilst the research question for this study is not concerned with the level of mindfulness displayed by the practitioner it will be important to be aware of the practitioner's own relationship to mindfulness. Crane et. al. (2012) conceptualised competence in teaching mindfulness as having both teaching and relational skills and that these skills need to be grounded within the teacher's personal experience and embodiment of mindfulness. This has become central to the training offered for MBCT practitioners.

Other practitioner related studies focused on the effect of mindfulness on practitioner wellbeing (Di Benedetto and Swaddling, 2014; Dorian and Killebrew, 2014; Hopkins and Proeve, 2013). Again although this is not the focus of this study it may have some bearing on the experience of practitioners delivering mindfulness as an intervention, since if a practitioner has experienced mindfulness as beneficial to their own wellbeing they will connect to the concept and teach it in a way that is different to a practitioner who has not had this experience.

One paper set a precedent for understanding mindfulness drawing on both therapist and client experiences. Horst et al. (2013) explored the experiences of therapists with regard to the use of mindfulness in their relationship counselling sessions. This was presented alongside the experiences of their adult clients. The questions used in the Horst (2013) study were evaluative e.g. "what in your opinion contributed to the success (or failure) of mindfulness in the sessions?" and produced a set of themes. The findings of the study were that the use of mindfulness in the therapy session was useful as it helped with transitions in the therapy; facilitated conversation and helped with specific problems. The use of mindfulness was also reported to slow the pace of the sessions. The findings also drew upon the therapist and client experience to give recommendation for the use of mindfulness in therapeutic sessions: shared experience; flexibility; prefacing/processing; development of trust. It will be interesting to see whether the approach taken by Horst (2013) in evaluating from both practitioner and client perspective resonates with the experience of practitioners delivering mindfulness in DBT.

There is scant research into practitioner experience of mindfulness as used within an intervention. However, practitioner factors were highlighted as important when researching MBIs due to practitioner influence on how MBIs are delivered. Considering MBIs from a practitioner perspective may therefore help to identify factors that support or hinder the delivery of and the experience of MBIs.

2.6.1 Training in mindfulness for DBT practitioners

Practitioners are trained in DBT over a six month period commencing with a five day training week that covers all four modes of treatment: skills training, individual therapy, telephone coaching and consultation to the therapist. The teams of practitioners are trained at the same time, although there is opportunity to access the training individually so long as an individual is affiliated to an established DBT team. The five-day intensive training is followed by a six month implementation period where teams complete a series of homework assignments to apply what has been learnt at the initial training. At the end of the six months teams return to present the work they have completed and have further training to attend to the problems that teams have encountered and questions they need answered. The process of DBT training is illustrated in Figure 1

The homework includes two tasks related to mindfulness out of an overall 17 homework tasks that relate to other elements of the DBT programme. These tasks are:

- to lead the consultation team in a mindfulness exercise on which team members will give feedback.
- to develop a plan for gaining experience in mindfulness, present this to the team and discuss contingencies

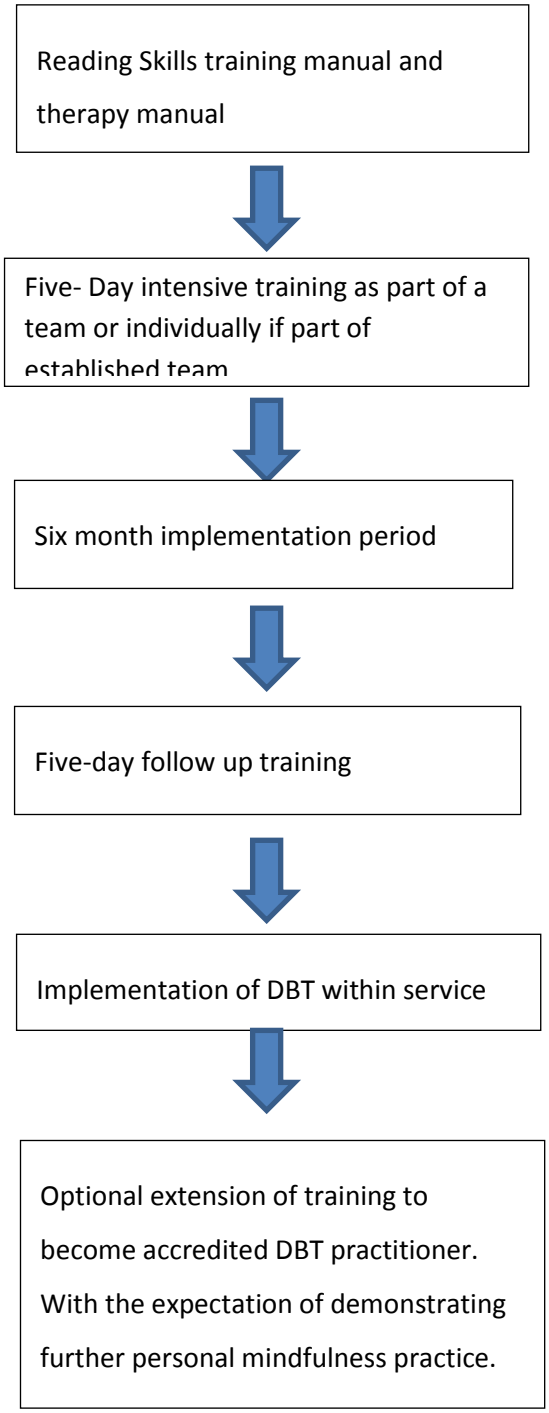
(Behavioural Tech, 2017)

The balance of homework tasks between mindfulness focussed and none mindfulness focussed indicates the way in which mindfulness is one element of DBT and not the central focus of the training.

Once the training has been completed teams are able to practice DBT within their clinical settings. In order to extend training to be accredited, practitioners have to demonstrate the development of their practice though further training, supervision and hours of implementing the therapy. As part of the accreditation process practitioners need to demonstrate that they

have engaged with a regular mindfulness course/practice. However, accreditation is optional and has been attained by relatively few practitioners across the UK (Society for DBT, 2019).

Figure 1 Outline of training for DBT practitioners



Because DBT is a therapy that is not focussed solely on the use of mindfulness, this may not have been the draw for many practitioners to DBT. The approach to the training in DBT

means that it is likely that practitioners have a range of experience of and connection to mindfulness. As such it is difficult to be certain how able and adherent practitioners are in teaching mindfulness to service users.

Other MBI's have a somewhat different training pathway. For example, the Health Education England (2017) suggest a training programme towards offering MBCT which consists of 4 units delivered by a recognised training centre that assesses the level of competency. The training units are as follows:

Unit 1: Theory underpinning MBCT (including cognitive science formulation), research, evidence base and ethical framework

Unit 2: The MBCT curriculum

Unit 3: Assessment and outcome monitoring in MBCT

Unit 4: Supervised MBCT practice.

(Health education England, 2017)

As mindfulness is central to MBCT much more time is given to mindfulness across the course of this training than would be given to mindfulness training in DBT and one would imagine that therefore practitioners have a deeper understanding of mindfulness as an intervention.

The UK Network for Mindfulness-Based Teachers (2015) has developed good practice guidelines for mindfulness-based course to include: 'Familiarity through personal participation with the mindfulness-based course curriculum that they will be learning to teach, with particular in-depth personal experience of all the core meditation practices of this mindfulness-based programme' and 'Commitment to a personal mindfulness practice through: daily formal and informal practice and participation in annual residential teacher-led mindfulness meditation retreats.' UK Network of Mindfulness Teacher Training Organisations (2015)

As such these good practice guidelines suggest a role for practitioner experience of mindfulness as important to their teaching of mindfulness. The teaching of mindfulness based interventions has developed over time to include a measure of competence in the teaching of mindfulness (The Mindfulness-Based Interventions: Teaching Assessment Criteria (MBI:TAC)) (Crane et. al., 2013). Integral to the assessment of competence in teaching mindfulness is the coverage of ideas; pacing and organising of teaching; relational skills; embodiment of

mindfulness; guiding mindfulness practices; conveying themes through interactive inquiry and didactic teaching (Crane et. al, 2011).

Although research that links the adherence to the core teaching assessment criteria for MBI's is new and inconclusive as yet, it is hypothesised that those who have sufficient competence to adhere to these criteria are likely to provide interventions that have better outcomes. This is especially so since learning mindfulness is experiential and therefore hugely affected by the teachers approach, competence and personal attunement to mindfulness (Crane et.al., 2012).

Although mindfulness is an important element of DBT there are many other elements that practitioners need to learn to become competent in the therapy. As such there is less emphasis on mindfulness in DBT training than there is in the training to teach other MBIs. It is not clear what the effect and difference is on the outcomes and experience of teaching in these different approaches based on adherence to the model. However, DBT appears to be an intervention of which mindfulness is a part as opposed to be entirely mindfulness based. Therefore the emphasis on specific competence with regards to mindfulness is less than for other MBIs.

2.6.2 Summary of background

The use of mindfulness as an intervention is complex and contentious. Consensus is yet to be reached about the measurement of mindfulness and the mechanisms of change in those engaging with mindfulness. That withstanding deficits of mindfulness have been shown to be present in those presenting with BPD and mindfulness is being used in DBT to help service users with BPD type presentations. Mindfulness in DBT teaches core mindfulness skills through short activities that illustrate particular elements of mindfulness, rather than longer mindfulness practices as in other mindfulness based approaches. The proliferation of mindfulness as a treatment in mental health services has been wide ranging, leading to research pertaining to the effectiveness and experience of MBIs which will be explored in the next chapter.

Chapter 3: **Literature Review**

This chapter presents the existing empirical research with regard to mindfulness within DBT and mindfulness as used with adolescents. The qualitative study of MBIs is examined to set the scene within which the findings of the current study can be placed.

3.1 **The current state of mindfulness research**

Mindfulness based interventions have been subject to widespread research. Mindful Nation UK (All Party Parliamentary Committee, 2015) reported that 500 research papers a year were being published. However, despite the plethora of research papers there continues to be calls for more high calibre research into mindfulness as there needs to be a wider understanding of exactly what mindfulness can and cannot do across conditions (Kabat-Zinn, 2015).

Research into MBIs is complicated by the presence of other elements of the interventions that are not specifically mindfulness. In Mindfulness Based Cognitive Therapy (MBCT) there is a component of Cognitive Behavioural Therapy (CBT) through thought monitoring whereas in Dialectical Behaviour Therapy (DBT) there is a process of skills training and behavioural analysis. Teasing out the place of mindfulness in the effectiveness of these interventions is therefore complex. Some researchers have tried to do this through measuring the change in levels of mindfulness (Ritschel et al., 2012) as a result of the intervention. Some approaches have also focused on exploring only the mindfulness element of the approach. i.e. teaching DBT –M (a mindfulness only module) (Soler et al., 2012).

Meta-analyses of mindfulness research have been conducted to try to synthesise the findings of research across quantitative research studies (Khoury et al. 2013; Strauss et al., 2014). Khoury et al. (2013) conducted an effect size analysis of 209 studies that offered findings on the pre-post effects or controlled effects of mindfulness based interventions. These studies considered both psychological disorders and physical conditions. Khoury et al.'s (2013) meta-analysis concluded that there was evidence that mindfulness based therapy was effective in treating psychological disorder in particular depression and anxiety. In a smaller scale meta-analysis of twelve randomised control trials of mindfulness based interventions for adults, evidence was found for benefits of mindfulness on symptoms of depression but not on acute symptoms of anxiety (Strauss et al., 2014). Therefore, consideration of research findings as a whole has suggested that MBIs have positive effects on some psychological symptoms.

Research into MBIs is very varied, with regard to the target population, particulars of the intervention, and the effects that are measured. This makes it difficult to bring firm conclusions about the effectiveness of the different MBIs . An overview of Cochrane reviews conducted with regard to MBIs concluded that high quality research trials were needed to establish firm evidence with regard to the effectiveness of these interventions (Rodriguez et al., 2016). Rodriguez et al.'s (2016) overview reiterates concerns that the interest and growth in mindfulness based interventions is developing ahead of the research base (All Party Parliamentary Committee, 2015).

Additional concerns have been raised with regard to the quality of the research and it's reporting. In particular Coronado -Montoya et al. (2016) found that statistical analysis of the results of 124 studies suggested a positive reporting/publication bias in mindfulness research. That is only studies that showed an MBI to be effective were reported in the literature. Coronado -Montoya et al. (2016) also commented that positive results in research studies do not necessarily infer that there would be positive results in clinical practice. They were particularly concerned by the number of studies that put a spin on negative results through caveats thus distorting the overall understanding of the interventions. Nam and Toneatto (2016) raised a concern with regard to the loss of data from research due to participant drop out and the possible effect of positive reporting based on those that had found the intervention helpful enough to complete it. They suggested that researchers did not go far enough to find out the experience of those who did not continue with the treatment programmes. The loss of data from those who do not complete the intervention due to finding it unhelpful, aversive or unacceptable could have significant bearing on the overall understanding of the effectiveness of MBIs.

It is important that a clear direction is set by the research community around mindfulness. This may require separating out distinct interventions rather than considering MBIs as a whole and also to focus on the effect of MBIs as applied to different disorders. As such the defining characteristics of each MBI need to be clearly understood and the application of them needs to stay close to the defined model. Building on the existing research in a meaningful way rather than a scatter gun approach to applying mindfulness would help to clarify the implications of existing studies on the future of MBIs. Researchers need to welcome criticism of the work and be open to reporting negative and equivocal outcomes. If a clear direction is not maintained the research into this area risks making the understanding of MBIs more opaque and less relevant to clinical practice.

3.2 Scoping review of empirical research

The scoping review had three aims:

1. To examine existing qualitative research findings pertaining to mindfulness.
2. To examine the research base for mindfulness as used within DBT
3. To examine the research as it pertains to the delivery of MBIs to adolescents.

The strategy for identifying empirical research relating to these aims is summarised in the PRISMA diagrams based on Moher et. al. (2009) in Figures 2-4

Figure 2 PRISMA diagram for search: Mindfulness (in Subject Term) limited by the term: Qualitative Research, clinical case study, meta-analysis and journal article

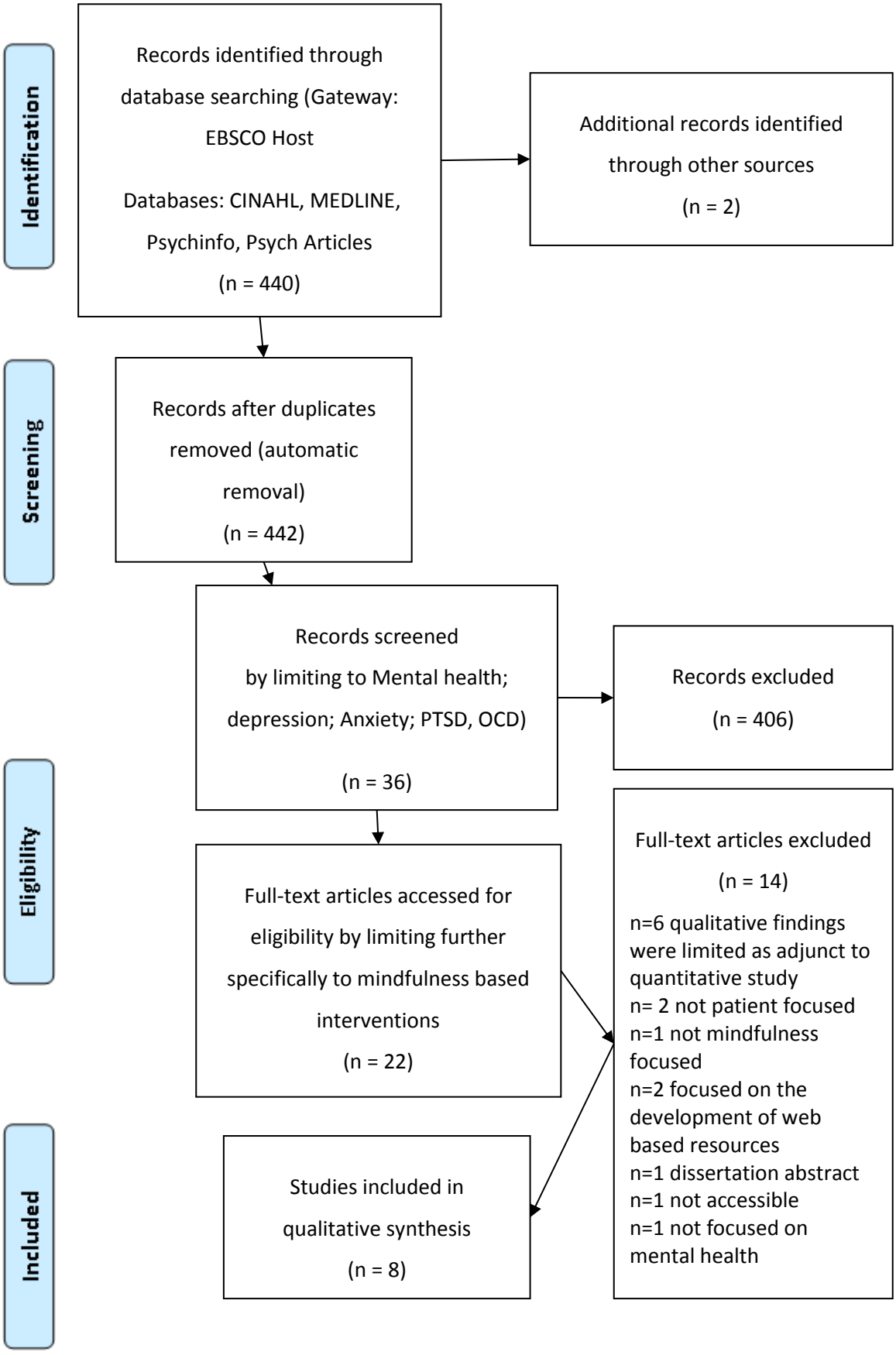


Figure 3PRISMA diagram for search: Mindfulness (in title)and (DBT or Dialectical Behaviour Therapy or Dialectical Behavioural Therapy) (in title)

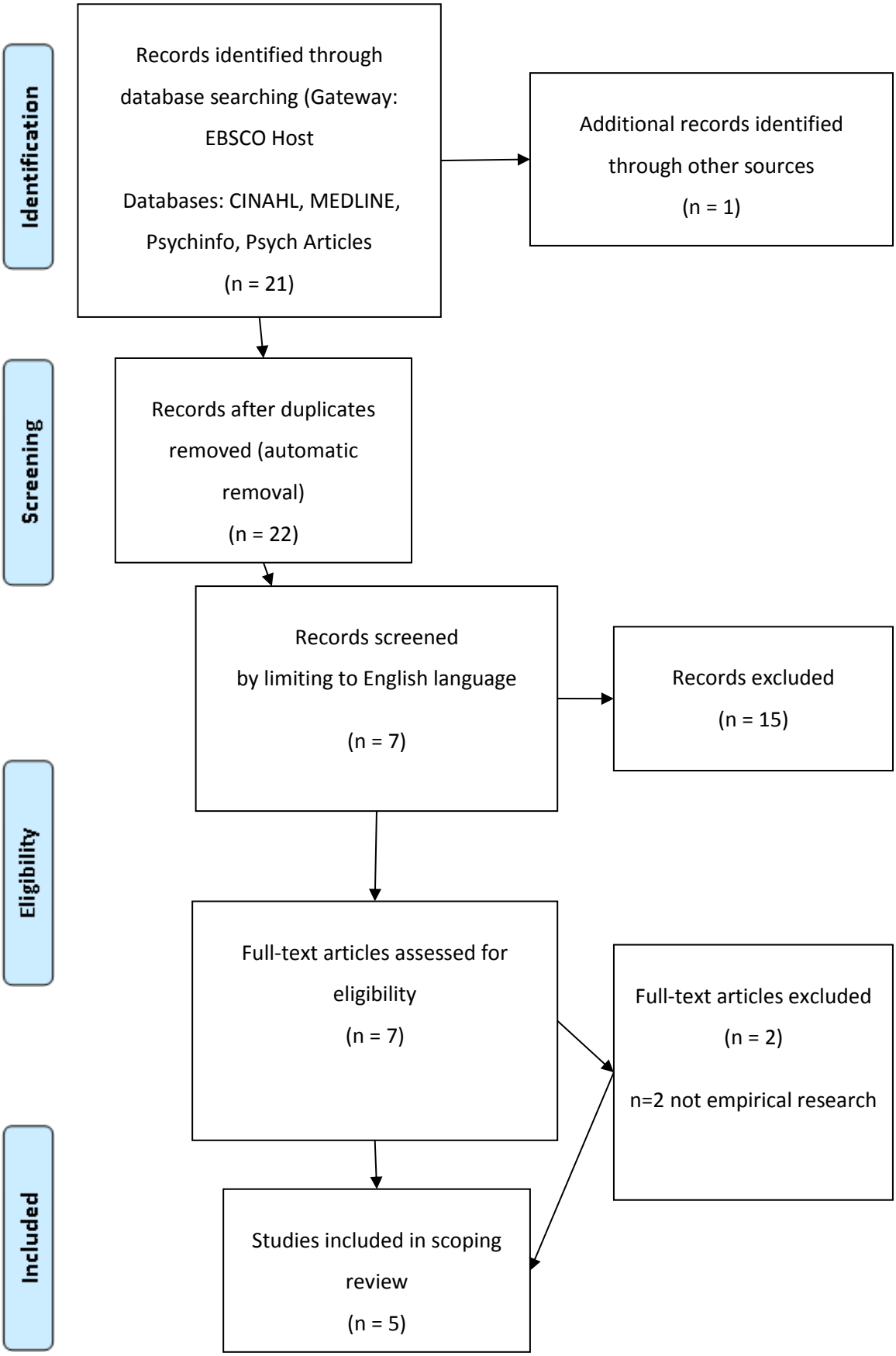
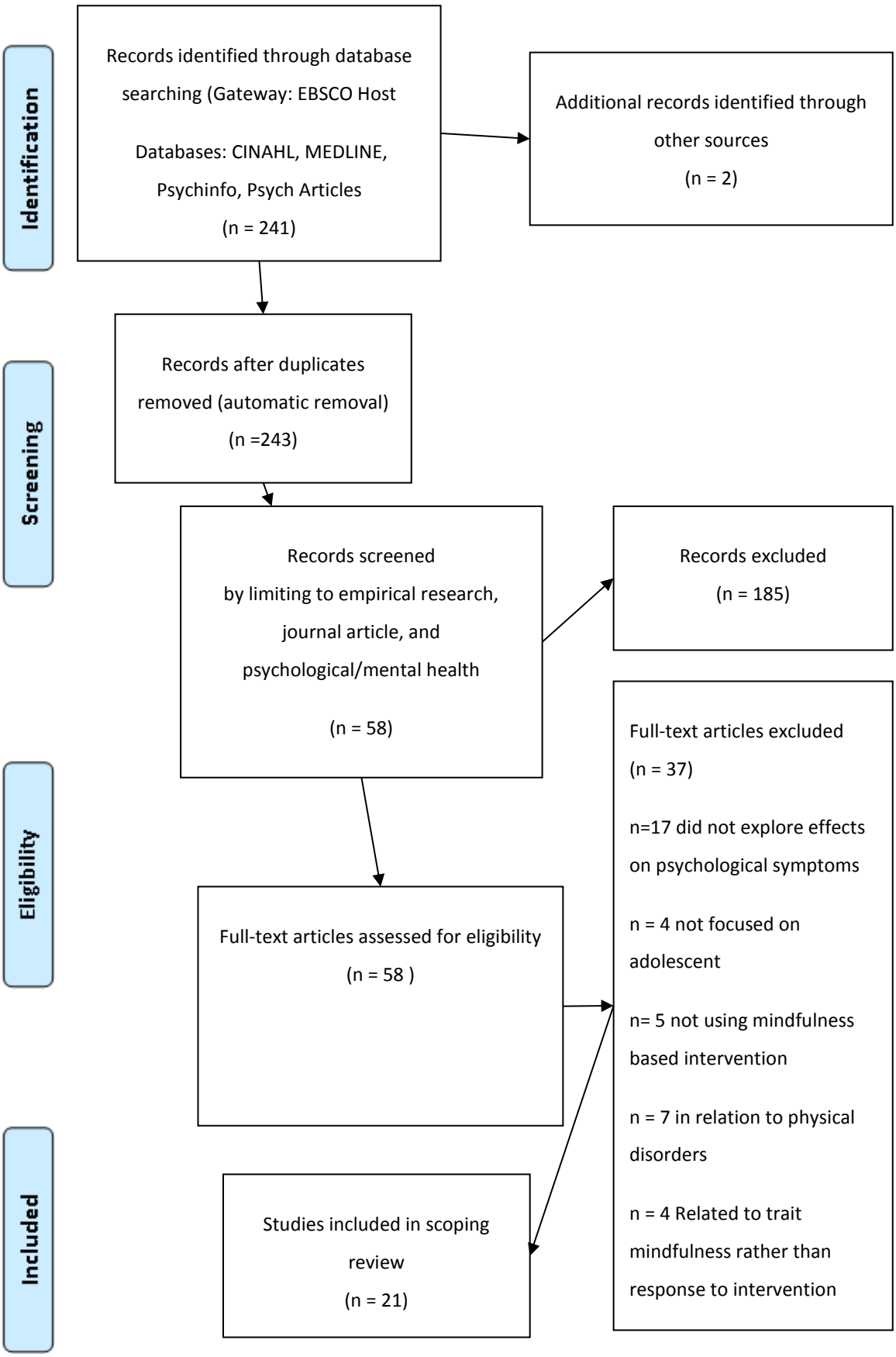


Figure 4 PRISMA diagram for search: Mindfulness (in title)and (Adolesce*)



3.3 Qualitative studies of MBIs relating to adults with mental health difficulties

Qualitative research into MBI's has focused on the experience of mindfulness for individuals who have engaged in an MBI. Qualitative studies of mindfulness have focused on MBCT, MBSR and non-manualised mindfulness based treatments and the experience of these regarding both physical and mental health. These studies mainly analysed interview data to develop themes relating to the characteristics of the experience of MBIs, although some used diary entries and artwork as data (Morone et al., 2008; Dellbridge and Lubbe, 2009). The studies differ in the philosophical and methodological underpinnings but all presented their results as a collection of themes. The studies used these themes to produce new theories, consolidate existing theories or justify the use of the approach and further research.

The growing number of qualitative research studies have made it possible for meta-syntheses to be conducted and therefore commonalities between the experience of mindfulness across approaches and targeted disorders have begun to emerge (Malpass et.al; 2012; Wyatt et al., 2014). Malpass et al. (2012) conducted a meta-ethnography of 14 papers relating to patient experience of MBCT and MBSR (regardless of clinical presentation) between 2001 and 2010. Wyatt et al. (2014) carried out a meta-synthesis of 15 papers relating to mindfulness based intervention for mental health disorders between 2008 and 2011. There was an overlap of 7 papers that were used in both analyses.

Malpass et al. (2012) organised themes chronologically into a model which illustrated the journey through mindfulness whereas Wyatt et al. (2014) placed themes in relation to each other but not chronologically to illustrate a cyclical process of the experience of mindfulness in MBIs. Both papers presented very complex interwoven themes.

The model proposed by Malpass et al. (2012) identified 3 phases to the experience of MBCT/MBSR. These are perceived safe uncertainty; safe uncertainty and grounded flexibility; which they suggest moved the participants from maladaptive coping mechanisms to a new experience of self and illness. Malpass et al. (2012) concluded that across the studies there was evidence of people developing the skills that mindfulness based interventions are designed to deliver. They also compared their model to some of the theories about mechanisms of change. In particular they use their model to reinforce ideas that mindfulness desensitises participants to negative emotions; develops balance in thoughts, emotions and attention and relieves distress through meta-cognitive awareness.

Wyatt et al.(2014) discussed their findings in relation to how mindfulness could be facilitated in order to make it most accessible and effective. They identified the following as important: mindfulness should be learnt in a group; that care should be taken to clarify the aims and ethos of MBI to manage the expectations of participants; that participants should be aware of the potential of distress during mindfulness practice. They also believed that the descriptions of the experiences were consistent with some of the mechanisms of change that have been proposed with regard to mindfulness. These were attention regulation, body awareness, emotional regulation and change in perspective on self (Holzel et al., 2011). Wyatt et al. (2014) compared their findings to wider therapeutic approaches noting that increased agency which is identified in other approaches as useful in the process of change seemed to be present in MBIs

Since the publication of Wyatt et al. (2014) further qualitative studies of mindfulness have been published. These additional papers have been considered for this literature review in order to compare findings between the meta-syntheses and subsequent papers.

3.3.1 Quality assessment of qualitative papers

The Critical Appraisal Skill Programme (CASP, 2018) tool for qualitative research was used as a framework for considering the quality of the research papers. However, it was difficult to compare papers because some papers seemed to have limited descriptions of method, results and discussion. The approach taken by Wyatt et al. (2014) was followed in this review. Wyatt et al. (2014) did not exclude studies due to apparent methodological limitations because they believed that the edited nature of published studies meant that some studies were unable to fully disseminate the process and outcomes of the study. Whilst weaknesses were highlighted these have not been used as a reason to exclude the study. The examination of the weaknesses helps to put the overall strength of the studies into context. The relative strengths and weaknesses of the papers alongside the research aims and methods are outlined in Table 6.

Table 6 Summary of qualitative studies of MBIs for mental health 2011-2017 with quality summary

Author	**Type of mindfulness intervention**	**Sample**	**Research aim**	**Data collection/analysis**	**Relative strengths or weaknesses**
Langdon et al. 2011	MBCT	Physical issues, depression and anxiety Aged 31-76 10 Female 3 Male	What assists/hinders people to continue to use mindfulness after MBCT	Semi-structured interview Grounded Theory	Longer write up allowed for greater transparency of the research design, in particular a detailed description of the researcher's experience of mindfulness and research philosophy. It was also offered a detailed comparison to other theories.
Ashcroft et al. 2012	Non standardised group mindfulness	Early Intervention in Psychosis (EIP) Mean age 25.56 2 Female 7 Male	Explore participant's experience of mindfulness offered within an EIP service	Semi-structured interviews Grounded Theory	This was the shortest of the papers. The paper described strength as validity through the analyst having no prior experience of mindfulness but weakness in the group facilitator also conducting the interviews which may have influenced responses. Ensured more validity through respondent validation by 2 participants. Presented some possible mechanisms of change but stopped short of a theory. The research compared findings with other qualitative literature but did not propose implication of the findings.

Hertenstein et al. 2012	MBCT	OCD Mean Age 41.8 years 3 Female 9 Male	Exploration of the subjective changes of experience and behaviour; helpful and problematic aspects of MBCT; suggestions of adaptations for OCD	Semi-structured interviews Inductive data driven thematic analysis	This paper offers a very clear description of the development of the interview schedule and of the analysis undertaken. It has clear reasoning behind the design of the study. The results are somewhat limited with only 2 out of 5 themes being discussed in detail.
Lilja et al. 2015	MBCT	Depression Aged 30 -68 17 female 2 Male	After 12 months participation in MBCT classes, how do patients describe their treatment	Semi-structured interviews Inductive thematic analysis	This paper presented a high level of transparency and in depth reporting of the themes. Long passages of verbatim were used to illustrate themes so keeping the reader close to the data. The discussion is detailed and relates to other research. The discussion acknowledges that the CBT element of the intervention that may impact on results.
Murphy and Lahtinen 2015	MBCT	Depression Aged 41 – 60 5 female 1 Male	Focusing on how MBCT practices worked for participants by looking at how the practices changed their relationship to their thoughts	Semi-structured interviews Interpretative Phenomenological Analysis	Due to the IPA method the paper presents a lot of verbatim data. The authors discuss limitations with regard to what this type of data can say due to the influence of the CBT element of MBCT, the participant's predisposition for engaging in mindfulness and the data being experiential not theory generating. The gives an account of reflexivity.

Smith et.al 2015	MBCT (with patient and their partners)	Depression Age not provided 7 Female 5 Male	Developing a theory of engaging in MBCT as a partnership	Semi-structured interviews Grounded Theory	The research was clearly described at all stages including data analysis. Quality assurance was discussed and outlined including triangulation, reflective diary and facilitator validation. A theory was posed that was discussed in the light of other theories.
Sguazzin et al. 2017	MBCT	OCD Mean Age 44.04 12 female 16 Male	Exploration of participant's perceptions of the benefits and acceptability of the MBCT intervention (completed as part of a wait list control trial)	Semi-structured interviews Thematic Analysis	This paper has the biggest sample and the research was conducted as part of a wider quantitative study. As such more emphasis is put on how frequently certain themes occur rather than the description of the themes. The paper is very transparent with regard to the interview schedule and coding which focuses more on the evaluation of the treatments than the experience/process of the treatment.

3.3.2 Summary of qualitative findings

The findings of the qualitative studies published after 2011 were reviewed and compared with the findings of the meta-syntheses of Malpass et al. (2012) and Wyatt et al. (2014). As such a summary of the findings of qualitative research into MBIs is presented below.

The qualitative research papers presented themes that were associated with participants having prior expectations of mindfulness (Malpass et al., 2012; Wyatt et, al., 2014). These prior ideas and experiences had an impact on participants and meant that participants had to resolve these in order to continue their journey with mindfulness (Malpass, et al., 2012).

Malpass et. al.(2012) and Wyatt et. al. (2014) generated themes (*Shift in relationship to self: emergence of observing self* and *Relationship with self and others*) that suggest the experience of mindfulness is one where there is a fundamental change to the way in which participants approach their lives. This can be linked to the findings of other studies to specific changes in thinking emotions and experience.

The meta-syntheses of Malpass et al.(2012) and Wyatt et al. (2014) presented themes in relation to changing perspectives on, or relationship to, thoughts and emotions (*Transforming the perceptual situation* and *relating differently to thoughts and feelings*). Findings of the subsequent qualitative papers were in keeping with these themes with the effect of mindfulness on thinking summarised as: Changing relationship to thoughts (Murphy and Lahtinen, 2015); decentring from thoughts (Lilja, et al., 2015); and refocusing on thoughts (Hertenstein et al., 2012). Changes in thinking processes were related to being able to cope better and experience a greater sense of wellbeing. The overall sense being that thinking styles contribute to the development of mental health difficulties and that by changing thinking through mindfulness practice there was an alleviation of symptoms. This focus on thoughts may be due to the seven out of the 8 papers being focused on MBCT which teaches an element of CBT with a focus on ideas around the effect of unhelpful cognitions on emotions and actions. Findings relating to effect on emotions were not as common as those with regard to thinking. There were a number of studies that highlighted mindfulness as resulting in relaxation or calm in distressing situations (Hertenstein et al., 2012; Langdon et al., 2011; Lilja et al., 2015; Murphy and Lahtinen, 2015; Sguazzin et al., 2017). Pausing before thinking , feeling or doing seemed to be an important finding in the change of approach participants experienced when they were engaged with an MBI (Ashcroft et al., 2012; Hertenstein et al., 2012; Lilja et al., 2015; Murphy and Lahtinen, 2015; Sguazzin et al., 2017).

Malpass et.al. (2012), Lilja et al. (2015) and Sguazzin et al. (2017) highlighted mindfulness as changing the experience of symptoms and illness as a whole. Changing the experience of symptoms also related to the general ability to cope with stress and an overall sense of wellbeing (Ashcroft et al., 2012; Hertenstein et al., 2012; Langdon et al., 2011; Lilja et al., 2015; Murphy and Lahtinen, 2015; Sguazzin et al., 2017; Smith et al., 2015) and a better sense of wellbeing (Ashcroft et al., 2012; Hertenstein et al., 2012; Langdon et al., 2011; Lilja et al., 2015; Murphy and Lahtinen, 2015; Sguazzin et al., 2017; Smith et al., 2015). Findings overall did not relate to the reduction of specific symptoms relating to the mental health problem with themes suggesting that mindfulness allows a person to make the best of their lives and have a sense of wellbeing despite ongoing mental health problems.

Specific dimensions of mindfulness that were of importance to participants were reported in study findings. These included acceptance (Murphy and Lahtinen, 2015; Sguazzin et al., 2017) and awareness (Lilja, et al., 2015) . Acceptance and awareness were also presented as themes by Wyatt et al. (2014) and awareness was also identified in the theme *Exposure and Inquiry* developed by Malpass et al. (2012). Murphy and Lahtinen (2015) described awareness as fundamental to the other changes that occur in terms of relationship to thoughts and emotions.

The findings of the recent qualitative studies and of Wyatt et al. (2014) demonstrate that mindfulness is a challenging form of intervention. Participants experienced mindfulness as requiring effort and dedication. Almost of all of the papers noted the participants talking of it being difficult to practice for a variety of reasons such as mindfulness being weird (Ashcroft et al., 2012) and specific conflicts between symptoms and mindfulness (Hertenstein et al., 2012). Langdon et al. (2011) described participants as slipping out of the cycle of mindfulness due to reduced practice. There was a sense that mindfulness was hard to come to in the first place due to mindfulness feeling weird (Ashcroft e. al., 2012) and that some people they may find the practice unpleasant (Hertenstein et al., 2012).

There were non-mindful elements of MBIs highlighted as being important in the findings of the studies. Malpass et al. (2012) generated themes of *Group process: normalised and motivated counter intuitive practices* and *Group process: reduced sense of stigma and isolation* and Wyatt et. al. (2014) generated the code *normalising and supportive process of the group.* Subsequent studies also highlighted group processes as important in helping people to feel de-stigmatised; understood by others and allowing for self-reflection (Ames et. al., 2014; Ashcroft et al., 2012; Hertenstein et al., 2012; Langdon et al., 2011; Sguazzin et al., 2017; Smith et al., 2015).

The findings of recent studies pointed to an importance of the use of mindfulness in everyday life and not simply as a practice within the MBI sessions This type of mindfulness did not necessarily mean daily practice but more an attitude of awareness (Murphy and Lahtinen,2015). It was establishing a cycle of everyday mindfulness that seemed to translate to improved wellbeing (Langdon et al., 2011; Lilja et al., 2015;).

Ashcroft et al., (2011) related mindfulness to the participants in their study to changing the way they related other people. This was also the case in Smith (2015) and Lilja et al. (2015), where the use of mindfulness in relationships reduced stress and conflict. Wyatt et al. (2014) also noted that mindfulness seemed to lead to a shift in relationship with others. These findings suggest that mindfulness can lead to interpersonal as well as intrapersonal changes.

The findings are fairly consistent across the qualitative research. There are two ways of conceptualising the high level of cohesion. Firstly, that the qualitative exploration of mindfulness as an intervention (in particular MBCT) is becoming saturated and therefore there is little more we can learn with regard to the reported experience of mindfulness. The other is that the way in which the experience is conceptualised by the participant and the researcher is highly shaped by the language of mindfulness. There seems to be a paucity of the reporting of negative experience. The lack of negative reports may reflect methodological issues: the time at which the qualitative data was collected (close to the end of an intervention); the way in which participants were selected (the ones who finished the treatment or self-selected), the way in the interview was conducted (by people involved in the intervention); the focus of the questions asked (which may have provoked more positive responses) and the way in which it was analysed (by people invested in mindfulness).

3.4 **Mindfulness in DBT**

The mindfulness element of DBT had been subject to research in order to understand the effect of this element of DBT. The studies identified by the systematic search considered the effect of mindfulness as taught in DBT on a variety of outcomes. Table 7 summarises the five studies that were identified in the systematic search.

Table 7 Summary of quantitative studies relating to the use of mindfulness in DBT

Author	**Sample**	**Design**	**Findings**	**Limitations**
O'Toole et.al 2012	165 women with BPD diagnosis	Correlation survey Five Facet Mindfulness Questionnaire; Multi-dimensional Scale of Perceived Social Support; survey of physical and emotional wellbeing (MOS-36)	Higher levels of mindfulness correlated with greater emotional well-being.	Possible self- selection bias. Homogeneity of sample in terms of race.
Perroud et.al 2012	52 outpatients meeting criteria for BPD diagnosis	One year follow up study Kentucky Mindfulness Scale; Beck Depression Inventory; Beck Hopelessness Scale	Accepting without judgement increased over course of 11 month DBT programme. Observe, describe and acting with awareness did not change significantly	Self-report of mindfulness No control group The increase of Accepting without Judgement may be caused by or the cause of the changes in BPD symptoms.
Soler et.al 2012	19 General Psychiatric management (GPM), 40 DBT-M plus GPM	Non-randomized control trial CPT-II (attention test) Hamiltion Depression Rating Scale Brief Psychiatric Rating Scale Profile of mood states Five facet Mindfulness Questionnaire Experiences Questionnaire	General improvement of measures for attention and impulsivity Correlation of longer formal practice on reduced depressive and confusion symptoms.	Those assigned to GPM may be less motivated to complete as not in active treatment.

Feliu-Soler et.al. 2014	17 General Psychiatric management (GPM), 18 DBT-M plus GPM	Non- randomized control trial of DBT- M (mindfulness only DBT in group format) Hamilton Depression Rating Scale; Brief Psychiatric Rating Scale; Experiences Questionnaire; Self-Assessment Manikin questionnaire; Salivary cortisol	Self-report and physical observation did not detect any difference between groups with regard to emotional regulation. Increased levels of mindfulness practice correlated with a greater sense of calm and sense of control. Increased levels of mindfulness practice	The procedure may not have elicited sufficiently intense emotion Small sample size. Presence of pharmacological treatment. Groups not completely comparable
Elices et al. 2016	32 to mindfulness module 32 to interpersonal effectiveness module	Single centre randomized trial Psychiatric diagnostic screening questionnaire; Borderline symptoms list; Five Facet Mindfulness Questionnaire; Experience Questionnaire	The mindfulness module had more effect on reducing BPD severity than the interpersonal effectiveness module. Decentring may account for change in BPD symptoms. Non-judgement and describing improved after mindfulness training.	High number of drop outs – more drop outs from mindfulness group. No treatment adherence measure. Patient preference.

These were: whether participant's ability to engage in mindful skills of observe, describe, act with awareness and accept without judgement increased over the course of treatment (Perroud et al., 2012); whether DBT-M (which focused solely on the mindfulness element of DBT) modified attention in those with a BPD diagnosis (Soler et al., 2012); the effects of levels of mindfulness on levels of emotional wellbeing, health care usage and prescription medication (O'Toole et al., 2012), whether treatment using DBT-M as compared to general psychiatric management had an effect on emotional reactivity (Feliu-Soler et al., 2014) and the effects of mindfulness training as compared to interpersonal effectiveness training on BPD symptoms (Elices et al., 2016). As such these studies give a variety of information with regard to mindfulness in DBT.

In the studies pertaining to mindfulness in DBT some clinical symptoms were reported to improve over the course of treatment. These included BPD symptoms overall (Elices et al., 2016) and also specific symptoms including: impulsivity (Soler et.al., 2012) reduction in confusion and depressive symptoms; and change in reactivity to inner experiences (Soler et.al.,2012) and emotional reactivity (Feliu-Soler et al., 2014). O'Toole et al. (2012) found that higher levels of mindfulness were associated with greater emotional wellbeing and fewer health care appointments. In Soler, et al. (2012) improvement in symptoms was dependent on amount of practice undertaken. Furthermore, other factors such as group influence and involvement in active therapy were only controlled for in Elices et al. (2016). Therefore it would overstate the outcomes of the studies to say that there is a causal link between teaching mindfulness in DBT and symptom reduction. There does however, seem to be some correlation between the intervention, increased mindfulness and improved clinical symptoms.

Mindfulness as taught in DBT was shown to have some effect on increasing mindfulness skills. Perroud et.al (2012) found that the only significant increase in elements of mindfulness was in the use of accepting without judgement, although it is unclear whether this was as a result of increased mindfulness or reduced BPD symptoms. It seems somewhat surprising that levels of observe, describe and acting with awareness were not detected after exposure to the DBT programme for 11 months, especially as these are explicitly taught in the mindfulness module of DBT. Soler et al. (2012) found that those undertaking DBT-M had some improvement in attention and an increased ability to decentre was observed by (Elices et al., 2016). Therefore there seems to be some evidence that engagement in mindfulness as taught in DBT does increase the presence of some elements of mindfulness, although not all that would be

expected. When looked at alongside symptom reduction these improvements in mindfulness could begin to point to mechanisms of change within mindfulness as taught in DBT.

This small number of papers focused on the effects of mindfulness in DBT raises some interesting questions about the role of mindfulness in DBT. Firstly, the results are not overwhelmingly affirmative of the effectiveness of mindfulness as part of DBT. Perroud et al. (2012) showed that some of the intended benefits of the mindfulness intervention were not experienced by the participants in their study and Elices et al. (2016) noted a high number of dropouts from the DBT mindfulness training intervention. They suggested that this could be due to the implicit nature of efficacy in mindfulness. It would be interesting to know if this is always the case or whether it was something about how these particular DBT programmes were taught.

Being taught mindfulness alone (without accounting for the amount of practice) did not show effects on emotional reactivity as expected in the Feliu-Soler et al. (2014) paper. Therefore improvement may be better accounted for due to level of motivation in the therapy. O'Toole et al. (2012) were unable to establish whether the teaching of mindfulness and DBT made a difference to the levels of mindfulness reported or whether these were existing trait levels of mindfulness. This is important to consider since it may be that those with higher trait mindfulness would be able to access therapy more readily making the intervention more effective for them.

There was little exploration of other factors at play during the interventions. Although two of the papers noted correlations between amount of mindfulness practiced and improvements of symptoms this could not be established as causal. Factors such as the effect of being in a group, the effect of being in active treatment, adherence to treatment by the facilitator and the absence of other elements of DBT that may have an effect on the acquisition of mindfulness skills (individual sessions, telephone coaching) were not given adequate consideration and discussion. It is undoubtedly difficult to research mindfulness as a distinct element of DBT due to the number of confounding factors at play during the intervention. Understanding the contribution of mindfulness to the overall outcomes in DBT would enable DBT practitioners to understand the mechanisms of change that are at play and tailor their therapeutic actions accordingly. It is possible that DBT could increase its effectiveness overall by a more honed approach based around the relative effectiveness of the constituent parts. However, it is important to bear in mind that mindfulness in DBT is a constituent of the whole

and that researching it as a separate part may be somewhat misleading about how it adds to the efficacy of DBT overall.

3.5 MBIs delivered to adolescents

There is yet to be a study published with regard to adolescents receiving mindfulness in DBT. However, two dissertations were accessed by using an internet search engine with the terms adolescent mindfulness DBT. These small-scale dissertations considered the use of mindfulness in DBT-A with adolescents and pre-adolescents (Talley, 2012; Maleva, 2017). The findings of Talley (2012) pertained to a comparison of DBT-A, DBT-A without the mindfulness module and a mindfulness only intervention for adolescents in a residential treatment facility. The findings suggested that although mindfulness increased for those in DBT-A (and more so in mindfulness only intervention) that mindfulness was not key to the effectiveness of DBT as reduction in symptoms was greater and longer lasting in the DBT-A group compared to the mindfulness only group (Talley, 2012). However, Talley's study was very small (30 adolescents in total) and so the power of the statistical analysis was limited. Malvera (2017) studied the application of the DBT mindfulness module followed by the emotional regulation module to a group of five 9-11 year olds. The findings indicated that mindfulness, as measured by the childhood mindfulness measure (CAMM), increased during both modules but not for all participants, suggesting extraneous factors as to why mindfulness was not developed universally (Malvera, 2017). These studies generate further questions about mindfulness and adolescents in DBT – what place does mindfulness have in the effectiveness of DBT for adolescents and what extraneous factors meant that mindfulness did not increase universally for pre-adolescents.

Because there are similarities between mindfulness taught in DBT and other mindfulness based programmes it is worthwhile exploring what has been written about adolescents using mindfulness outside of DBT and as such the systematic scoping review was applied to adolescents and mindfulness based interventions and psychological variables.

Mindfulness with adolescents has been studied in a variety of ways, focusing on mindfulness as both a trait and a treatment for a range of mental and physical health problems. Black et al. (2009) noted that Mindfulness Meditation was being taught more and more within schools and clinics but with scant amounts of research to demonstrate the efficacy of these interventions. They systematically reviewed the literature available at that time to reveal that 16 quantitative studies had been conducted with those less than 18 years old for a variety of

meditative approaches, measuring a variety of outcomes. None of these studies included mindfulness in DBT. It was highlighted that there were some problems with the studies in terms of lack of comparison groups for studies of psychological/behavioural outcomes and also incomplete data reporting. Nevertheless, the authors concluded that there was evidence for the efficacy of sitting meditation as an intervention for physiological, psychological and behaviour problems among adolescents (Black et. al., 2009). However, it was acknowledged that 16 heterogeneous small scale studies did little to provide a solid evidence base for use of sitting meditation as a treatment for under 18's for specific disorders.

Burke (2010) reviewed papers that focused solely on mindfulness approaches being used for psychological difficulties and wellbeing. She excluded DBT from this review. In general Burke (2010) found that the studies were useful in that they established the feasibility, safety and initial evidence for effectiveness but did not do so in a rigorous enough way to make substantial claims. She commented on the heterogeneous nature of the interventions and populations.

The published research in relation to mindfulness used with adolescents has been sustained over almost 10 years and the variety of research that has been conducted shows that researchers, clinicians and school professionals are all proposing mindfulness as a way of improving a variety of outcomes for children and adolescents.

A full summary of the studies that met the aim of the search to identify the outcomes that have been established for adolescents receiving mindfulness based interventions for psychological and behavioural problems is in Appendix C. 16 of the papers offered quantitative findings in relation to mindfulness, adolescents and psychological domains and five papers offered qualitative findings. Only six out of the 22 papers focused on clinical populations with the remainder focused on clinical indicators in non-clinical populations. It is not possible to infer that improvements in psychological wellbeing in a sample of school children would relate directly to improvements in the mental health of people with a mental health diagnoses, therefore the evidence for the use in clinical populations is weak, relating to only six quantitative studies of a diverse nature.

The key findings of quantitative papers are outlined in Table 8 with six studies pertaining to clinical populations in italics.

Table 8 Overview of quantitative findings in relation to adolescents and mindfulness and psychological domains

Author	**Sample**	**Findings**
Singh et al. 2007	Aged 13 and 14 Non-clinical sample recruited from one school 2 males 1 female	Adolescents were able to learn mindfulness and use it in situations that would have previously led to aggression. The behaviour of the three participants improved over the course of the intervention.
Bogels et al. 2008	Age 11-17 (mean 14.4) Clinical Sample Referred to community mental health centre Maastricht 8 male 6 Female Parental involvement varied between none, one and both parents present.	*Waitlist showed no improvement during wait period* *Intervention group improved significantly with regard to:* *Personal goals, attention, awareness, impulsivity, being attuned, social problems and happiness.* *Children's internalising and externalising behaviours were reduced.* *Improvements were maintained at 8-week follow-up* *Drop-out rate was high and completers showed most improvement*
Grosswald et.al 2008	Age 11-14 Clinical sample Attending specialist language-based learning difficulties school 9 male 1 girl 6 with co-morbidities Differences in medication being used with each child	*Mindfulness technique improved level of stress, anxiety and ADHD symptoms between pre-test and post-test on 6/7 subscales as rated by students but only 1/7 subscales as rated by teachers . Both rated significant positive impact on overall problems at p≤ 0.5* *Improvement on 7/11 subscales of executive functioning as rated by teachers. Improvements in expressive attention performance.* *(Tower of London and Connor's CPT excluded from analysis)*
Biegel et.al 2009	Age 14-18 Clinical sample recruited through health provider	*Significant improvement in MBSR group in state-trait anxiety, perceived stress, self-esteem and 4/6 indicators of psychopathology compared to TAU group. Greater decrease in diagnosis and GAF scores in*

Author	Sample	Findings
	15 male 35 female MBSR and treatment as usual (TAU) 12 male and 40 female TAU only	*MBSR group* *More practice= greater amount of change.*
Semple et al. 2010	Age 9-13 Non-clinical sample Recruited from remedial reading programme 10 male 15 female Control matched for age and gender	MBCT-C effective in reducing attention problems which was maintained at follow-up. MBCT-C may help children with elevated anxiety and behaviour problems
Tharaldsen 2012	Age 9-11 Non-clinical sample Recruited from Baltimore elementary schools 38 male 59 female	No increase in the use of coping skills in intervention group from quantitative data Deterioration in quality of life satisfaction in intervention group No improvement in psychological symptoms in intervention group No enhancement of mindful coping strategies Qualitative report of using mindful awareness and coping skills
Kuyken et al. 2013	Age 12-16 Non clinical Sample Recruited from 12 secondary schools in UK 156 female 366 male (N=522)	High acceptability Fewer depressive symptoms post mindfulness intervention and at follow up (3 month) compared to controls Lower stress and greater wellbeing at follow up associated with degree of practice.
Jennings and Jennings 2013	Age 17-18 Non clinical sample Recruited from American High School 5 males 3 females (N=8)	Short term effect of reducing anxiety (low power due to sample size) Feasibility of a shortened mindfulness programme
Metz et al.	Mean age 16.5	Small significant effect on reduction in emotional regulation difficulty, psychosomatic complaints, self-

Author	Sample	Findings
2013	Non clinical sample Recruited from two high schools in the US 73 males 171 females (N=244)	report stress levels in mindfulness group No effect on impulse control of mindfulness group significant increase of self-regulation efficacy in mindfulness group
Ames et al. 2014	*Age 12-18* *Clinical Sample* *Recruited from CAMHS* *7 Females*	*MBCT is feasible for this population* *Reduction of depressive symptoms, worry and rumination (limited power due to very small sample)* *Increase in perceived quality of life*
Raes et al. 2014	Age 14-17 Non clinical sample Recruited from Dutch High School 240 females 128 males (N=368)	Significant reduction in depressive symptoms in mindfulness group after 6 month follow up Mindfulness programmes can be successfully integrated into education
Sibinga et al. 2014	Age 13-21 Recruited from a primary care clinic in USA 28 females 7 males (N=35)	No significant effects in self-report measures Interview data reported effects of increased calm, conflict avoidance, self-awareness and self-regulation.
Tan and Martin 2015	*Age 13-18* *Clinical sample* *Recruited from community mental health teams* *63 females 28 males (N=91)*	*Increase in mindfulness pre-post –follow up (3 months)* *Improvement in mental health, self-esteem, psychological flexibility in mindfulness group which were maintained/improved at follow up* *No significant effect for resiliency*
Atkinson and Wade 2015	Age 14-18 Non clinical sample Female Sample size: 347	The expertise of the facilitator had an effect on the efficacy of the intervention with a smaller benefit with less experienced facilitation. There seemed to be a delayed effect of mindfulness intervention in reducing eating disorder risk factors.

Author	**Sample**	**Findings**
De Bruin et al. 2015	*Aged 11-23* *Clinical sample* *17 males 6 females (N=23) plus parents*	*Increase in reported quality of life and decrease in rumination* *No change to worry, ASD core symptoms or mindful awareness* *Parents reported no change in core ASD symptoms in child but some improvement in social aspects* *Parents reported differences in parenting style as a result of the training*
Johnson et.al 2016	Mean Age 13.6 Non clinical sample Recruited from high school in Australia Sample size unclear	High acceptability No improvement in any of the outcome variables post – follow up (3 month) Higher self-rated anxiety post mindfulness intervention

Some studies showed limited or no effect of mindfulness intervention on certain domains. Johnson et al. (2016) found that there was no improvement in any of the outcome variables at 3 month follow-up and that there was higher self-rated anxiety post mindfulness intervention. Similarly, De Bruin (2015) found no change to worry, autistic spectrum disorder core symptoms or mindful awareness as a result of mindfulness intervention. Other studies found that expected changes to resiliency (Tan and Martin, 2015), impulse control (Metz et.al , 2013)and a whole variety of self-reported psychological measures (Sibinga et al.,2014) were not evident after the MBI. Tharaldsen (2012) found that there was no detectable increase in the use of mindful coping skills in intervention group or reduction of psychological symptoms from quantitative data and that there was reported deterioration in quality of life satisfaction in the intervention group. These findings suggest that the effectiveness of mindfulness as an intervention for adolescents is not universal and may be specific to only a small number of domains or target populations.

Some of the studies that showed positive effects had limited power (Jennings and Jennings (2013); Metz, et al. (2013); Ames et al. (2014); Sibinga et al. (2014)). Many of the programmes studied were taken from recognised mindfulness based interventions but were modified by the researchers. As such the content of the mindfulness course was not clear for all of the studies making it difficult to make direct comparisons and to identify important features of mindfulness teaching. The programme may also be variable with regard to the quality of teaching. Some described ways in which fidelity to the programme was maintained (Singh et al. (2007); Jennings and Jennings (2013)). Only three studies measured the amount participants' practised mindfulness in their own time all of which suggested that the amount of mindfulness practiced outside of the teaching programme was influential on the results (Beigel et al. (2009); Kuyken (2013); Johnson et al. (2016). It is unclear from the other studies whether there was an expectation for practice between sessions. This is an important distinction since learning mindfulness and practicing mindfulness may have different effects. Many of the studies did not take follow up measurements to establish whether any efficacy was maintained post intervention. This is of interest in terms of lasting effects but also whether there are changes in the person's trait mindfulness as a result of the intervention or whether the changes relate solely to continued practice of state mindfulness.

The particulars of why some programmes showed effectiveness and others did not could only be established through comparison of the very diverse programmes. Since the domains that were studied were so varied, for example, behaviour or symptoms of ASD, making direct

comparisons with regard to the overall effectiveness of mindfulness for adolescents is not possible. Furthermore, replication of studies for specific groups is also not present within the research with regard to mindfulness and adolescents meaning that the effectiveness of specific interventions for specific populations is also far from established. It is also not possible to identify necessary features of MBIs that make a mindfulness intervention successful because of the diverse nature of the samples and research design. Each study tested a certain domain; however, the untested domains may have been key to the success or otherwise of the intervention over all.

There were several methodological constraints as to the evidence that make conclusions difficult to make: Some of the studies reported high drop-out (Bogels et al., 2008; Semple.et al., 2010; Sibinga et al., 2014; Johnson et al., 2016). This may indicate that mindfulness based approaches are not acceptable to young people or that particular groups of young people are less likely to engage in a mindfulness based intervention. This loss of data has implication for what can be surmised from the data. Some of the studies of clinical populations had very small sample sizes (Bogels et al., 2008; Grosswald et.al, 2008; Ames et al., 2014). Smaller samples have an impact on what general conclusions can be made from the outcomes of the study. This is especially so when statistical analyses are being applied. Many of the studies had a reliance on questionnaire based self-report (Tharaldsen, 2012; Kuyken et al., 2013; Jennings and Jennings, 2013; Metz, et al., 2013; Tan and Martin, 2015; Atkinson and Wade, 2015; Johnson et al., 2016). Whilst the studies used questionnaires which are recognised as being valid and reliable, the use of self-report measures can be problematic. Firstly not all of the measures used had been validated for those under 18. Secondly, the chosen measure may not be sensitive to any change that occurred. The mindfulness interventions were offered as part of a group in all but one of the studies and therefore the effect of group intervention needs to be considered (Dellbridge and Lubbe, 2009). Apart from Sibinga et al. (2014) who used a group programme control, the RCT studies used treatment as usual groups and wait list groups for the controls. Programme adherence by the facilitator/other facilitator will also have been an important factor in the efficacy of the intervention (Singh et al., 2007; Dellbridge and Lubbe, 2009; Tan and Martin, 2015; Raes et al., 2014; Jennings and Jennings 2013).

The efficacy of mindfulness for adolescents in clinical populations is evident in the studies but the consistency of this efficacy is inconclusive. Harnett and Dawe (2012) presented an overview of mindfulness based interventions being used with children and adolescents which led them to propose that the continued proliferation of interventions without an understanding of the mechanisms by which change occurs in these interventions was

unhelpful. In this way they questioned the notion of applying mindfulness approaches that have been shown to work in one population to another without a broader understanding of why the changes occur. They identified that there may be other factors that account for change in children and adolescents, in particular parental influence, and as such they suggested a model in which mindfulness approaches are used within programmes that help address family functioning. Rawlett and Scrandis (2016) reviewed the studies which pertained to 'at-risk' adolescents and concluded that there was evidence for the efficacy of mindfulness in improving health outcomes for adolescents and that there was evidence emerging for the application of mindfulness to improve academic performance which needed to be studied further. The broad application of mindfulness interventions seems somewhat contrary to the evidence base as a whole and risks use by unqualified facilitators with poor adherence to programmes that have been identified as effective. Furthermore, the variety of programmes offered makes it difficult to ascertain which elements of the programmes are essential to successful outcomes making the proliferation of these programmes or the establishment of new programmes uncertain. Perry-Parish et al. (2016) commented that in order for MBIs to take a role in clinical treatment that it needs to show the same legitimacy as other treatments and be delivered with fidelity to the tested interventions. They were particularly concerned by the transfer of tested interventions from research based programmes to the day to day offer of these interventions into mental health treatment settings. However, they continued to be positive about the possible application of mindfulness-based interventions and called for the mechanisms of change based on MBIs to be understood through further research.

There have been six qualitative studies into adolescent experience of mindfulness as it relates to psychological domains. They vary greatly in their scope and purpose, being summarised in Table 9

Table 9 Overview of qualitative findings in relation to adolescents and mindfulness and psychological difficulties

Author/ Year	**Type of mindfulness intervention**	**Sample**	**Research aim**	**Data collection/analysis**	**Findings**
Dellbridge and Lubbe 2009	Undefined individual mindfulness instruction	Setting not stated 1 female 17 yrs old	Understanding adolescent subjecting experience of mindfulness	Interview Diary entries Typology	Two concepts of: Being task oriented Personal growth and development
Kerrigan et al. 2011	MBSR	Urban youth 2 males 8 females African-American 13-19 years old	Explore context perceptions and experiences of MBSR	Interview Content analysis	Four themes relating to: Process of awareness opening up to new psychological possibilities Greater acceptance of thoughts and feelings Reduction of stress and hostility Feeling more relaxed
Monshat et al. 2012	6 week non-manualised mindfulness training programme	Non-clinical youth 11 participants (8 completers) 16-24 years old	To understand experiences of young people with regard to mindfulness practices	Semi structured focus group and Individual Interviews Grounded Theory	Phases of mindfulness: Distress and reactivity Gaining stability Insight and application

Author/ Year	Type of mindfulness intervention	Sample	Research aim	Data collection/analysis	Findings
Himelstein et al. 2012	10 week Non-manualised mindfulness course	Incarcerated adolescents 23 males 14-18yrs old	To understand the experience and feasibility of a mindfulness based intervention for incarcerated youth	Semi-structured interviews Thematic analysis	Four themes relating to: Increase in subjective wellbeing Increase in self-regulation Increase in awareness Accepting attitude towards treatment intervention
Tharaldsen 2012	Conscious coping mindfulness course	High school students 3 females 4 males 16-27 years old	Evaluate the conscious coping programme	Semi-structured interviews Content analysis	Four themes relating to: Increased awareness Constructive self-distraction Preventing negative emotions Constructive self-assertion
Ames et al. 2014	MBCT	Clinical sample -depression 11 Participants Aged 12-18 10 female 1 Male	To evaluate the feasibility and acceptability of the measures and intervention	Semi-structured interviews Interpretative Phenomenological Analysis	Five themes relating to: Increased awareness Relating differently to thoughts and feelings Using mindfulness when distressed Working it out together Formal meditation vs simple sensory exercises

In closely considering the experience of one 17 year old female Dellbridge and Lubbe (2009) were able to offer the most experiential account of mindfulness of all the qualitative papers. Their findings were that the experience of mindfulness in this instance was that of being 'task-orientated' in being focused on mainly external stimuli. They interpreted the experience as one of 'personal development and growth' noting how the participant struggled through self-criticism to develop awareness that connected the participant to what the researchers called 'heart qualities' of mindfulness such as self-compassion, non-judgement and acceptance. The findings from Kerrigan et al. (2011) explored the way in which urban youth experienced a MBSR programme. The findings explored the descriptions of the experience of mindfulness, that of being able to accept thoughts and feelings that had previously been problematic, a process that the researchers interpreted as 'shifting perspectives on self and life'. It was highlighted that at times mindfulness was used specifically to reduce distress in the moment (Ames et al.;2014). Ames et al. (2014) noted that the adolescents in their study had doubts that mindfulness would work when they were distressed (Ames, et al., 2014)

Ultimately mindfulness left the participants in Kerrigan et al.'s (2011) study feeling relaxed and less prone to stress and hostility. Himelstein et al. (2012) generated themes of 'increase in self-awareness' and 'increased self-regulation experienced' by a group of incarcerated young people. These themes echo the findings of Kerrigan et al. (2011) with regard to a shift in perspective and 'increases in subjective wellbeing' associated with feeling less stressed. Ames et al. (2014), whose paper was brief in its descriptions, did not have explicit findings relating to coping with symptoms/increased wellbeing, however, they alluded to them as follows; "Two reported stepping back from strong emotions and consequently enjoying life more." (pp.75). Monshat et al.'s (2013) findings are consistent with the findings of the other qualitative studies. However, they extended their findings by developing a theory with regard to mindfulness is developed over time in young people. They conceptualised the

experience of the participants in their study as one of moving from a state of 'distress and reactivity' where participants would overreact to emotional stimuli to a state of 'Insight and application' where participants would feel confident in dealing calmly with the situations in their lives. Tharaldsen (2012) used a mixed methods approach to explore the effectiveness and experience of a programme developed to increase coping in high school students. Tharaldsen's (2012) perception of participants' experiences of mindfulness was that they often engaged with 'constructive self-distraction' which was helpful for the management of short term difficulties but maladaptive when it increased avoidance of emotion. He also suggested that the experience of participants demonstrated that the increase of focus on troublesome emotions was counterproductive, leading to a lesser sense of wellbeing.

The findings of the qualitative studies point to changes in the way adolescents approach their day to day lives when they engage with mindfulness. These changes were with regard to changes in how they experienced their emotions and changes in the way they behaved. Changes in self-concept or shifts in dispositional mindfulness were indicated at times but not fully explicated by the findings of the studies.

Overall the research suggests that the enthusiasm with which the use of MBIs with adolescents is being proliferated may be over stating the effectiveness of such approaches to improve wellbeing in this group. It is not clear whether there are specific features of adolescents as a group which may inhibit the effectives of mindfulness and whether specific modifications to MBIs may increase the effectiveness for adolescents.

3.6 **Conclusion to literature review**

The literature review has demonstrated that there is evidence to suggest that increased levels of mindfulness are beneficial and that teaching mindfulness increases levels of mindfulness which then improves clinical symptoms. So overall the research indicates that using mindfulness interventions for clinical populations is legitimate.

Research has begun to offer an understanding of mechanisms of change due to MBIs, however, the diversity of this research makes it difficult to draw conclusions about what is happening when mindfulness is offered as an intervention. The findings of research as it pertains to MBIs with clinical populations of adolescents is scant and complicated because at times the interventions used were not established MBIs.

Although mindfulness has become accepted as an intervention for certain mental health problems, research has not established mindfulness as an effective element of DBT. Furthermore, because DBT is being used for the adolescent population as well as adults there may be specific issues with regard to the experience of the mindfulness that is used in DBT for this age group which are different to the experience of mindfulness overall. The literature review therefore demonstrates the need for further research into mindfulness as it is used in DBT.

Although mindfulness in DBT has been considered by a small number of quantitative studies it has not been considered from an experiential perspective through qualitative research. The qualitative examination of mindfulness in general has been well developed and this gives an opportunity to compare mindfulness as used in DBT from a qualitative research perspective. The findings of qualitative research studies will be important for the exploration and interpretation of the findings from the current study.

Chapter 4: **Methodology**

This chapter presents Interpretative Phenomenological Analysis (IPA) as the methodology chosen to help answer the research question – What is the experience of service users and practitioners of Mindfulness as taught in DBT? Phenomenology, hermeneutics and idiography are explored as the theoretical underpinnings of IPA and the application of these theories to research is considered.

The second half of the chapter examines the practical application of IPA as a research design including sampling, analysis and the use of interviews as a data collection technique.

4.1 Qualitative methods and the selection of IPA

The aim of the study was to understand mindfulness in DBT from the point of view of the adolescent service user and practitioner – their personal experience. The inquiry I was making was naturalistic as I wished to engage with participants to develop an understanding of the experience of mindfulness in DBT as taught in actual clinical practice rather than in experimental conditions (Armstrong, 2010). I wanted the service user participant and practitioner participant experience to be at the centre of the new knowledge generated by the study as it was clear from the review of the literature that this experience had not been understood or considered in the development of mindfulness within DBT. A method that would elicit personal perspectives of the experience and utilise my clinical experience to co-construct an understanding of mindfulness in DBT was required. Therefore a qualitative approach was selected.

Qualitative methods that provide insight into service user and practitioner experience are part of the evidence base for clinical practice as they provide real-world findings (Davies and Gray, 2016). Ethnography and grounded theory were considered as alternative approaches to answering the research question. Ethnography would have provided observations of how mindfulness in DBT was used in practice and the responses of service users within sessions; this did not meet the aim of understanding the personal experience of participants (Saldana, 2011). Grounded Theory research would have produced an explanation about the processes or mechanisms of mindfulness in DBT (Creswell, 2007). Although this approach was of interest

given that research had been undertaken about mechanisms of change in mindfulness I believed using a grounded theory approach would move the research away from the core aim of understanding what it was like to experience mindfulness in DBT.

4.2 Interpretative Phenomenological Analysis (IPA)

Interpretative Phenomenological Analysis (IPA) is a methodology used to research the experience of individuals or groups of individuals concerning a certain phenomenon. IPA was of interest as a research methodology because of its application in a range of health and psychology fields and in particular, to the experience of mindfulness in other therapeutic interventions (Ames et al., 2014; Murphy and Lahtinen, 2015). IPA focuses on the lived experience of a certain phenomenon through the meaning that individuals ascribe to their experience (Smith et al., 2009). In the handbook developed for IPA research Smith et al. (2009) suggested that IPA researchers are interested in lived experience as follows:

'IPA researchers are especially interested in what happens when the everyday flow of lived experience takes on a particular significance for people. This usually occurs when something important has happened in our lives.' (pp1)

Smith et al. (2009) identified that the intention of researchers using IPA as a methodology is to understand the way in which people experience the world. Therefore, IPA researchers make interpretations of the meaning that individuals talk about in relation to the phenomenon. The research question guiding this thesis was concerned with the lived experience of service users and practitioner pertaining to mindfulness as part of DBT therefore the aims of IPA were consistent with the aims of this research project.

4.2.1 Theoretical underpinnings of IPA

The three theories that underpin IPA are: phenomenology, hermeneutics and idiography (Smith et al., 2009). These theories have been developed over a number of years and have been discussed and extrapolated by a number of different authors. Therefore the sources used to understand these theories are often secondary sources that commentate on the original philosophical texts. In particular the work of Harre (2000), Fay (2003) and Zimmermann (2015) have been used to understand the development of phenomenology and

hermeneutics over time in relation to the work of Husserl, Heidegger, Gadamer and Schleiermacher.

Phenomenology was developed with the notion that human knowledge can be advanced through personal, subjective experience (Harre, 2000). This principle is used in IPA as personal, subjective experiences collected through interview or other means are the data which are analysed to extend knowledge of a phenomenon. Harre (2000) noted that Husserlian phenomenology was based on the notion that, by examining a phenomenon with full consciousness and carefully reducing the influence of previous knowledge, a phenomenon can be perceived in its purest form.

The philosophy of phenomenology has given rise to research methodologies by which researchers intend to understand a phenomenon as described by its essential characteristics (van Manen , 1990). The emphasis of such research methodologies being the experience of a phenomenon rather than the measurement of a phenomenon.

Health care phenomenological research differs in its emphasis on the use of descriptive, interpretative and critical phenomenology (Lopez and Willis, 2004). Descriptive phenomenology presents a phenomenon described by its essential parts, whereas interpretative phenomenology presents an understanding of a phenomenon through the meaning ascribed to the experience (Tuohy et al. 2013). Thus taking a descriptive or interpretative phenomenological approach to understanding a phenomenon affects the type of findings that are possible from the research (Braun and Clarke, 2006).

Due to the focus on individuals' experiences, a phenomenological approach is of value for research into mental illness and psychological states (Stubblefield and Murray , 2002) and to understanding patients and professionals in health care research (Thomas and Polio, 2002). Both descriptive and interpretative phenomenological research has been used to understand individual's responses to physical health conditions (Lopez and Willis, 2004) and the practice of health care professionals (Miles et.et al. 2015). Phenomenology lends itself well to answering research questions about the experience of being human because the phenomenological approach is focused on what it is like to experience a phenomenon, the researcher being concerned with human lived experience (Van Manen, 1990). The term 'lived experience' is used widely in phenomenological research and is used to describe the intention to focus on a

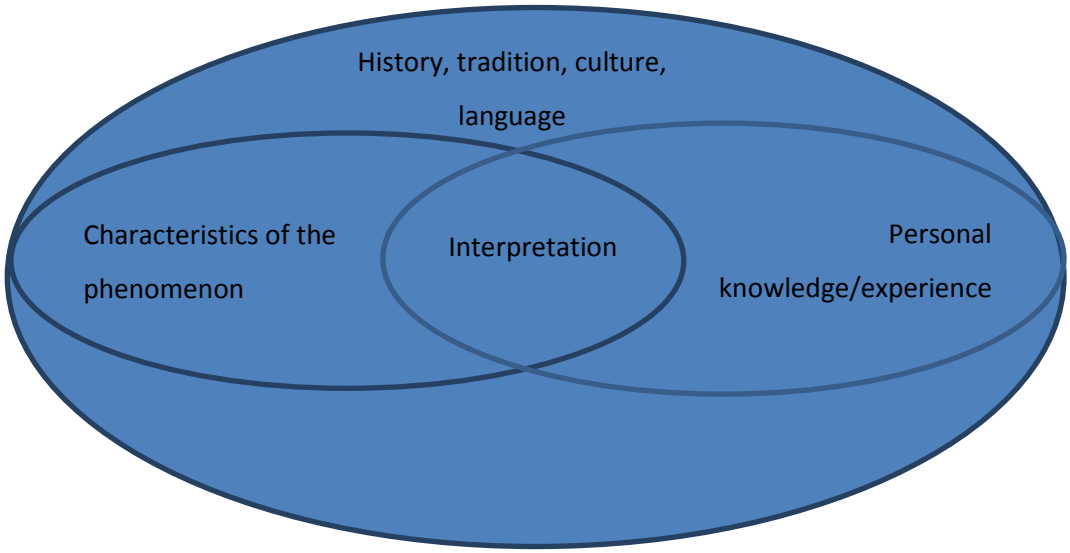
phenomenon as it lived – what is it like to be a teacher?, rather than the perception of the phenomenon – what is teaching? (Van Manen, 1990; Miles et al. 2015). The understanding of a phenomenon as it is lived can be conceptualised as peeling away layers to expose the significant elements of the experience (Miles et al. 2015). Phenomenological researchers interrogate interviews, diary extracts, artworks and the like to develop a better understanding of a subject – the lived experience of a particular situation (Churchill, 2018).

The second theoretical foundation of IPA is that of hermeneutics which means the process of interpretation. Before the notion of hermeneutics was developed, phenomenology was based on the idea that people could transcend their previous experiences and knowledge and experience a phenomenon in its purest form – through direct experience (Zimmermann, 2015). Hermeneutics departed from transcendental phenomenology with the notion that experience is interpretative in nature because it is perceived by an embodied individual (Fay , 2003). Hermeneutic philosophers countered the idea of pure experience because they believed that the idea that people could transcend their previous experiences was false. Believing instead that all phenomenon must be experienced through the filter of the perceivers context (Zimmermann, 2015).

Fay (2003) suggested that, because human understanding of the world develops within the social and linguistic context of the individual, the idea that it is possible to have pure experience unaffected by external influence is problematic. Fay (2003) noted that Heidegger considered that all phenomena are perceived by a 'Being' within the world and not simply within a consciousness that transcends context. The existence of an individual's consciousness is dependent on the influence of the language, tradition and culture in which it develops. Therefore, when a phenomenon is subject to a thought or word, the perception of the experience changes in relation to the previous experience and knowledge of the perceiver (Zimmermann, 2015). Once the perceiver begins to consider the experience, to describe or consider- 'what is this?' they no longer merely perceive the appearance of the phenomenon but interpret the experience. Thus, phenomena are necessarily perceived within context and through previous knowledge and experience.

Hermeneutic philosophers therefore developed the concept that interpretation is knowledge as perceived by an individual with particular prior experience when they consider the way in which the phenomenon relates to the context. The process is illustrated in Figure 5

Figure 5 Hermeneutics as the interpretation of a phenomenon by an individual within context

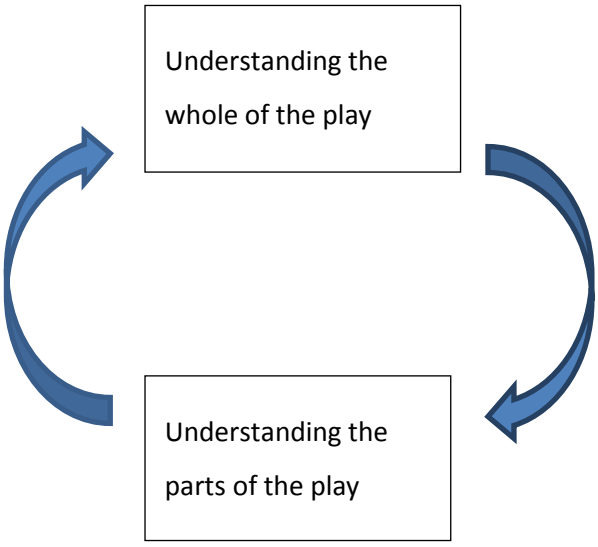


A criticism of interpretation is that it is subjective or relativistic and therefore meaningless in the development of true knowledge (Zimmermann, 2015). When knowledge is relativistic it is thought to be so bound in context that it can only be applied to very specific conditions. Zimmermann (2015) used the work of Gadamer to counter the claim that interpretative phenomenology was relativistic by defining the process as a synthesis of different perspectives within the historical, traditional, cultural and linguistic context. The knowledge gained through interpretation becomes relativistic if the interpreter fails to synthesise context, personal knowledge and relational knowledge. Larkin et al. (2006) proposed that in IPA the engagement with prior knowledge, the resonance with or challenge to this knowledge protects IPA findings from subjective relativism.

The process of interpretative synthesis requires the perceiver to move between specific parts of a phenomenon in relation to the whole. As the understanding of the whole changes, the understanding of the parts of the phenomenon changes. Zimmermann(2015) considered the work of Schleiermacher to outline the development of human understanding through the

process of a hermeneutic cycle. Zimmermann (2015) demonstrated the hermeneutic cycle by using the analogy of a well-known play. Before seeing the play the individual had an understanding of the whole – I'm going to see a play about X. However, when watching the play the idea of what the play means changes based on the lines delivered by the actors. The sense of the whole changes by attending to the parts. When watching the play again the meaning of the lines given by the actors is changed by the prior knowledge and experiencing of the play. In this way understanding is developed as illustrated in Figure 6.

Figure 6 Circular relationship between the understanding of the whole and understanding of the parts of a play



Hermeneutics in research

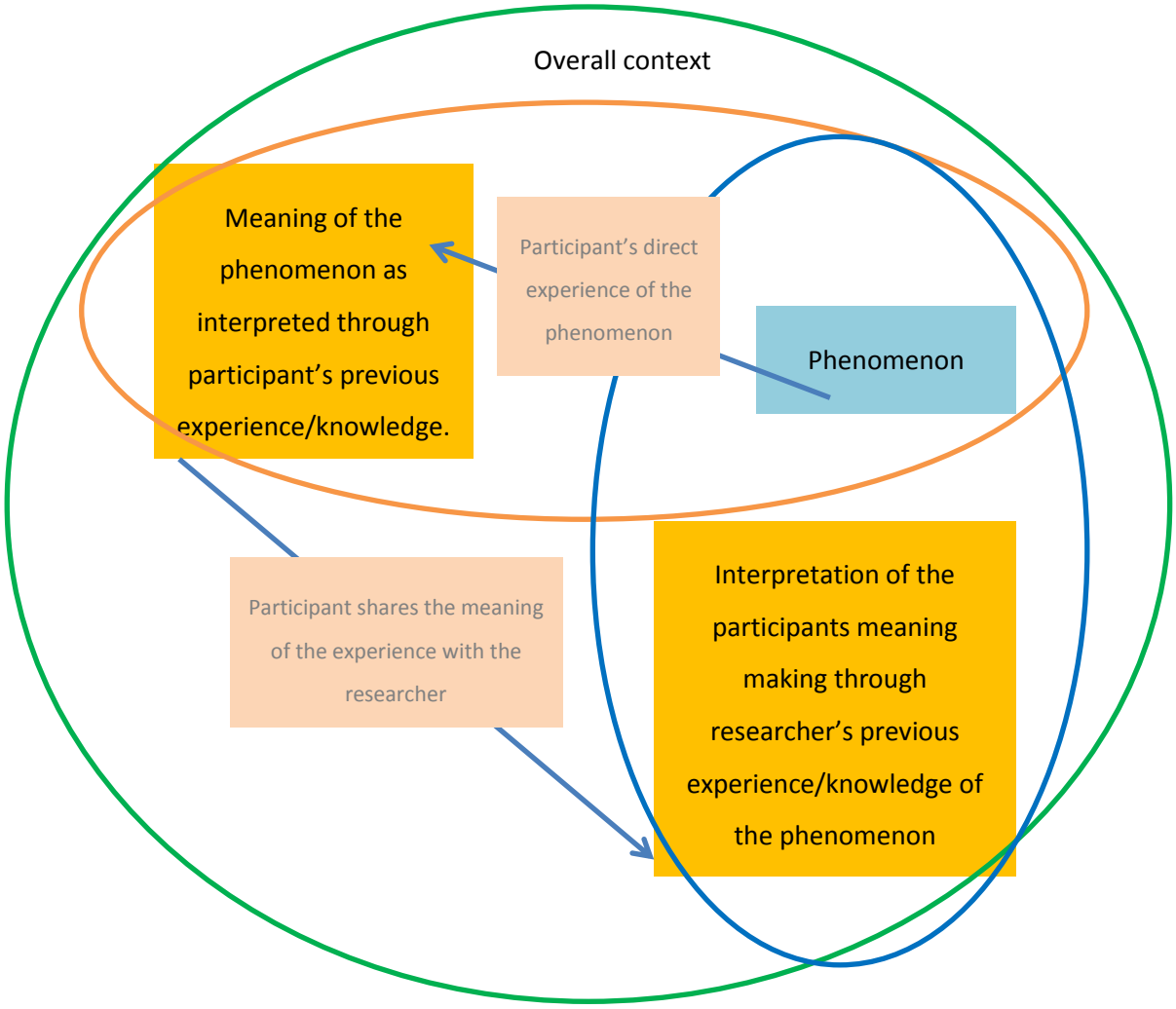
The use of hermeneutics in research has given rise to interpretative phenomenological methods (Greatrex-White, 2008). The findings in interpretative phenomenological research are based upon the meaning of the participant's experience rather than the features of the experience (Churchill, 2018). The researcher makes interpretations of the meaning that participants ascribe to their experience and in doing so develops an understanding of the phenomenon in question (Schwandt, 2007). The researcher acknowledges the impact of their previous knowledge and experience to the context of the phenomenon but transcends prior understanding to become critical in their interpretations of the data (Greatrex-White , 2008).

The researcher acknowledges that they choose one interpretation of what is said by the participant above another and in doing so recognise the interpretation to be co-constructed within the research.

IPA researchers implement the hermeneutic cycle when the researcher moves between focusing on the words of the participant; to focusing on the meaning of these words in context and back to the words of the participant (Smith, 2007). The findings of the research are constructed but are not subjective as the findings relate directly to the participant's experience of the phenomenon in question (Larkin et al. 2006).

The aim of employing hermeneutics is for the researcher to understand the phenomenon in context, through the meanings ascribed by the participant to the experience of the phenomenon (Smith et al., 2009). Because the researcher is making meaning with regard to the experience of someone else a double hermeneutic is created as demonstrated in Figure7. The orange oval shows the participant's connection to the phenomenon through their previous knowledge and experience. The blue oval shows the researcher's connection to the phenomenon through previous knowledge and experience. The Yellow squares show the two interpretative processes occurring within the double hermeneutic. The green circle shows the overall context within which the interpretative processes take place.

Figure 7 Illustration of the way in which a double hermeneutic is created within IPA research



An understanding of the phenomenon is constructed between the researcher and participant at interview and by the researcher during analysis. The researcher develops an interpretation of the experience in the discussion of the findings and in relation to the extant literature. Once presented as research findings the reader interprets the findings adding another layer of interpretation to the understanding of the phenomenon (Smith, 2009).

4.2.2 Bracketing in phenomenology, acknowledging fore-structures in IPA.

Previous knowledge and experience of a phenomenon make it difficult to perceive the essence of a phenomenon because the researcher may draw quick conclusions based on presuppositions and assumptions rather than the information that is accessible through the research (Van Manen, 1990). When using descriptive phenomenology as the basis for research the researcher tries to remove the filter of their previous knowledge and experiences, this process is bracketing. By bracketing the researcher tries to get as fresh a perspective on the phenomenon as possible, as if they had never come across the phenomenon before (Creswell, 2007). The researcher makes explicit their previous knowledge and experience of the phenomenon, and attempts to remove this from the process of analysis to be able to see the phenomenon for what it is without the influence of assumptions and prior beliefs (Stubblefield and Murray, 2002).

Hermeneutic or interpretative phenomenologist's take a different approach whereby the researcher acknowledge the influence of prior experience and knowledge on the process of analysis rather than attempting to remove these (Le Vasseur, 2003). Previous experience and knowledge is called the researchers forestructures in IPA (Smith et al. 2009). Because previous knowledge and experience is so integral to the process of perception, an individual may not be aware of their prior beliefs and knowledge (Smith, 2007). Le Vasseur (2003) offered the idea of curiosity as a way of reducing the impact of previous knowledge and experience as a barrier to acquiring a new understanding about an experience, believing that the intention to see the phenomenon without presuppositions through curiosity balanced the notions of coming fresh to an experience and being aware of prior conceptions. Researchers may also deal with the issue of prior knowledge and experience by using reflexivity, by which the researcher promotes awareness of the influences on their decisions and interpretations through reflexive

discussion and writing (Clancy , 2013). Smith et.al (2009) noted that a researcher's fore-structures change through the course of the research thus requiring ongoing reflexivity throughout the data collection, analysis and discussion of findings. By remaining reflexive throughout the research I was able to note the way in which participant accounts resonated or challenged my previous experiences and assumptions. I kept reflexive notes and was able to speak reflexively with my supervisors, who at times noted alternative interpretations to the ones that I was making.

4.2.3 Idiography

The interview data collected in IPA are the thoughts shared by the participant with regard to the phenomenon at a specific moment in time and is as such idiographic in nature (Smith, 2007). Idiographic research is based on the notion that knowledge can be gained from exploration of single, particular cases (McLeod, 2007). In contrast to a nomothetic approach, where the aim is to establish laws that have a general application, an idiographic approach uses the particulars of a case to understand something about the phenomenon as a whole (Saldana, 2011). The findings of idiographic research may be described as insights (Smith, 2009); understandings (Creswell, 2007); or examinations (Saldana, 2011). An idiographic approach has been used to research phenomenon that are personal, private or particular to a context and as such do not lend themselves easily to the application of general laws (McLeod, 2007). By exploring a particular instance of the phenomenon the researcher has opportunity to consider previously held generalisations formed from previous experience, knowledge, assumptions and beliefs. Smith (2004) promoted the use of even single cases so that the detail of an individual's experience could show the essence of the phenomenon that could be recognised in wider shared experience. In approaching a specific instance of a phenomenon Smith (2004) demonstrated an idea that the uniqueness of an experience can illuminate or resonate with what is important more widely.

IPA focuses the researcher on particular situations to understand the phenomenon in question because of a belief that the experience of a few individuals can shed light on the universal experience(Smith et al., 2009). The use of individual stories encourages reflection upon and prompts changes to the prior understanding of a phenomenon (Latif et al., 2004). As such, idiography offers the 'parts' which can change the understanding of the whole within the

hermeneutic cycle. Some researchers have chosen an idiographic approach to the study of mindfulness believing that by focusing closely on one or a small number of cases allowed for a more in-depth description and a more in-depth understanding of the experience (Stelter, 2009; Dellbridge and Lubbe, 2009).

4.3 IPA as a research approach

IPA was developed as a method for researchers in health psychology. Examples of phenomenon appropriate to research using IPA given by Smith et al. (2009) included sexuality, psychosis, motherhood and haemodialysis. More recently IPA has been used widely in clinical psychology; nursing and allied health. IPA research is concerned with the experience of a phenomenon and the interpretation of this phenomenon in order to understand the experience as it is lived by the individual. It is has been used to research such things as service user experiences of staff in mental health services (Bacha et al., 2019) and the experience of feeling fat in anorexia nervosa (Major, et al., 2019).

The theoretical underpinnings of IPA situate the researcher within a particular paradigm concerning the nature of reality (ontology); how knowledge is generated (epistemology); the role of values (axiology) and the process of research (methodology) (Creswell, 2007). The way in which IPA engages with phenomenology tells us that we can develop our understanding of the specific phenomenon, as it is and not as we assume it to be. The way in which IPA engages with hermeneutics tells us that we can develop our understanding of the phenomenon through the interpretations made about the meaning of the phenomenon. The way in which idiography is conceptualised in IPA is that by focusing on a particular instance we can understand something about the phenomenon as a whole.

4.3.1 Summary of theoretical underpinnings of IPA

I approached the research with a particular ontological and epistemological stance and I believed that the IPA approach was in keeping with this approach to the research. With regard to ontology, assumptions relating to the nature of reality, I took a relativist perspective that the world is understood through our experience of it and that reality is idiosyncratic, being

built upon the foundations of historical, cultural and traditional meaning making. The relativist perspective being demonstrated in IPA through descriptions of the context of the participants, the context of the interviews and the context of the researcher.

With regard to epistemology, the way in which knowledge is generated, I took a constructivist perspective that knowledge is constructed by people through their perception of the world. The constructivist perspective is demonstrated in IPA in the interview and analysis where the participant and the researcher are instrumental in co-constructing an understanding of the experience.

By choosing IPA as the research method the research was designed and implemented using the guidance developed by Smith et al. (2009).

4.4 Research design and methods

The research was developed as a single phased qualitative exploration of the lived experience of adolescent service user participants and practitioners of the mindfulness element of DBT. Semi-structured interviews were conducted and the interview transcripts analysed using the methods described by Smith et al. (2009). Additional guidance on conducting qualitative research and thematic analysis was sought from Saldana (2011) and Braun and Clarke (2006). As such the findings are presented as higher order concepts illustrated by superordinate and subordinate themes that were developed across service user and practitioner data sets.

4.4.1 Research context

As a clinician I work within Child and Adolescent Mental Health Services (CAMHS). Within CAMHS DBT is offered to adolescents separately and differently to adults and therefore the experience of mindfulness in DBT for adolescents was of particular interest. My clinical practice was a driver in deciding to focus on the experiences of adolescents to be participants in the research project because there seemed to be difficulties experienced by adolescents with regard to engaging with mindfulness – poor focus in group mindfulness activities; reporting that they did not use mindfulness day to day and reports of disliking mindfulness.

The usefulness of presenting findings from an adolescent standpoint was discussed by Christensen and Prout (2002) because the adolescent perspective is different to adults. The

literature review demonstrated that the adolescent experience of mindfulness had been studied separately to adults because of differences in developmental stage and cognitive development. I wondered if mindfulness in DBT was experienced in a particular way by young people and that understanding the experience from their point of view may change my understanding of mindfulness in DBT as a whole.

4.4.2 Sampling

The aim of this research was to understand the experience of a very particular group of people. A sample of adolescents with experience of learning mindfulness in DBT and accessing CAMHS services within two and a half hours from where the researcher lived was recruited. The sample was limited purposively by selecting sites that offered DBT treatments to adolescents; by convenience since recruiting sites were selected to allow for the research to be undertaken in a cost effective and efficient way and by self-selection as participants made a choice to participate in the study if it interested them to do so. The purposive seeking of people with the experience under investigation is essential in IPA to ensure that the participants have enough experience of the phenomenon on which to speak (Smith, 2009). As such inclusion and exclusion criteria were used to identify individual who could provide interviews about the experience of mindfulness in DBT (Creswell, 2007). Although the findings generated from a convenience sample are somewhat limited in terms of being able to generalise to a wider population (Etikan et. al. 2015), Smith et. al. (2009) were clear that theoretical transferability was central to the IPA process rather than the presentation of empirically generalisable findings. Self-selection was also necessary so that the participants were recruited within the ethical framework that was approved. Self- selection undoubtedly has an effect on the data that is gathered as participants will have chosen to participate often because they feel they have something in particular to say about the phenomenon. Despite all of the limitations that were necessary to recruit participants the sample remained acceptable to the methodology.

Bearing in mind the idiographic stance in IPA sample sizes are based on ensuring that the complexities of each individual's experience can be articulated whilst ensuring that the breadth of experience is explored, the total number of participants was kept small. In view of this the intended sample was 10-12 service user participants aged 14-18 years. The

recruitment of practitioners was sought to add another perspective to understanding the experience of mindfulness in DBT. In this way the parts (individual experiences of mindfulness in DBT) that added to the whole (overall understanding of mindfulness in DBT) were more varied, adding greater complexity to the findings. When the recruitment of practitioner participants was added to the study the intention was to recruit up to eight practitioners and eight adolescents, although only 7 service users were recruited.

4.4.3 Data collection methods

IPA researchers use a variety of data collection methods: interviews, participant diaries, social media posts and focus groups (Saldana, 2011). In this study semi-structured interviews were chosen as the data collection method. Semi-structured interviews facilitate the eliciting of in-depth account that are the cornerstone of gaining the lived experience if they are structured in such as way at to prompt and probe. As Smith et al. (2009) comments :

"Unless one has engaged deeply with the participant and their concerns, unless one has listened attentively and probed in order to learn more about their life world, then the data will be too thin for analysis" (pp58).

Engagement in thinking and talking about a phenomenon can be facilitated by the use of stimulus material such as vignettes or video clips. This approach has been shown be useful when asking young people to describe their experiences (Punch, 2002). Therefore, a stimulus video was used in service user interviews to encourage the service user participants to think directly about the experience of the mindfulness element of DBT. The video was developed to represent an explanation of a mindfulness exercise in a DBT group. The development of the video is outlined in Appendix E.

A semi-structured interview schedule was developed with the aim of getting a balance between directing the participant, supporting the interviewer to keep on topic and following the thoughts that were expressed during the interview. The semi-structured interview schedule included different questioning styles as outlined by Rapley (2004) and Walker (2011) and demonstrated in Figure8.

Figure 8 Development of interview schedule: reasoning behind the questions

Questions	**Prompts**	Reasoning behind the use of the question
How long have you been doing DBT?		This is a closed context question to help the researcher understand the amount of exposure the person has had to mindfulness.
What sort of things are you working on/learning?		This is a question to get participant thinking about DBT. It may also help the researcher to understand more about the way in which the participant in engaged with DBT – group only, completed etc
How is it going for you?		This is a context question to find out in general the participants' relationship to the treatment. It may need some clarification if the question comes across as too general. Clarification such as 'what do you think of it so far?' or 'are you finding it helpful so far?'
I'm going to be asking you some questions about the mindfulness bit of the DBT programme. I thought we could do an activity to help you start to think about mindfulness. Here is a video clip of someone introducing a mindfulness exercise.		The use of a video clip is to place the participants' mind back into the experience of mindfulness.
Tell me about one of the times that you did some mindfulness in your group.	Prompts: What did you do?	Linking the participant into reconnecting to a specific practical experience of mindfulness so that they can speak about this rather than the theory they have adopted with regard to mindfulness.

	What do you remember about how you felt about doing the mindfulness exercise? What do you remember about what you thought about it	
Tell me about the first time that someone spoke to you about mindfulness in DBT.	Prompts: Had you heard about it before? Tell me what you remember about how you felt about it. What did you think about it at that time?	This question is interested in what mindfulness is like to begin with. The participants first impression and how might that effect their ongoing relationship to mindfulness.
(If programme offered individual therapy) **Has there ever been a time that you talked about mindfulness in individual therapy?**	Prompts: What did you talk about? What did you think about it?	These questions will only be appropriate if the participant has access to these modes of treatment. These question are interested in the role of the different modes of treatment in the participant's experience of mindfulness.
(If programme offered telephone skills coaching) **Has there ever been a time that someone suggested using mindfulness in skills coaching?**	Prompt: Can you remember what was happening for you when they suggested it?	These questions will only be appropriate if the participant has access to these modes of treatment. These question are interested in the role of the different modes of treatment in the participant's experience of mindfulness.

Can you think of any times when you think you were mindful when you weren't at the DBT group?	Prompt: What was happening that made you think about using it ? How did you know you were being mindful? What did you do? What happened?	The other questions have asked the participant about mindfulness within therapeutic sessions. This question is interested in whether they have any experience of using mindfulness in their day to day living.
	All through – prompt using the word they use i.e. can you tell me what about it made you think that's rubbish?	Listening carefully to follow leads that the participant gives to the things that are important to them. The questions are meant to support the imparting of experience and are not to be used as direct comparisons between participants. Therefore there is no compulsion to use all questions with all participants. The level of structuring will depend on how easily each individual can access and recount their thoughts about the experience.

Smith (2007) argued that adolescents need a greater level of structuring to allow them to access their thoughts about an experience meaning that interviewers should use more directive questions and more prompts to get rich interview data. Therefore, many prompts were added to the interview schedule and further prompts used within interviews to assist the participants in extending their thinking about their experiences. The schedule was used as a guide not a checklist and as such ethical approval was given for an interview guide with the understanding that additional prompts would be added as necessary. Because I was able to demonstrate extensive experience with working with adolescents with regard to sensitive issues the flexibility in the schedule was deemed appropriate.

Three Child and Adolescent Mental Health Service (CAMHS) professionals were requested to review the interview schedule for service users to check for clarity and appropriateness for the age group. These reviewers commented on the need to have the additional prompts that were outlined in figure 8 and also the use of the introduction of 'think of a time when….' to help participants situate their response in actual experiences. The schedule was not piloted as this would have necessitated access to service users before ethics approval had been granted.

4.4.4 Interviewing style

Due to the flexibility in the interview schedule I gave careful consideration to the way in which I approached the interviews. I considered how leading or presumptuous questions have an impact on what the participant will and won't share about their experience (Smith, 2007). Asking value laden questions such as 'How did you deal with the difficulties posed by your partner's disability?' suggest the assumption that the participant experienced the partner's disability as difficult. However, it may be useful to follow a value laden statement to find out more about it e.g. 'you said that you found it difficult, can you tell me about that?'. Following rather than leading the participant through the interview helps to reduce the impact of the interviewers' views on the topic, (Rapley, 2004). Usual conversational patterns are full of verbal and non-verbal signals that convey empathy; link mutual experiences and direct the conversation to the things that we are interested in (Rapley, 2004). I was careful that efforts to encourage and engage in conversation may indicate approval of certain topics. To guard

against large amounts of influence, during the interviews I listened carefully to follow leads that the participant gave about the things that were important to them about mindfulness or things that they said that I wanted to clarify. I made notes about the interview and any reflections I had on things such as the rapport, power balance and flow of the interview. I was involved in on the spot reflexivity about the potential effect of my questions and I tried to maintain a neutral response to what was said in an effort not to influence participants.

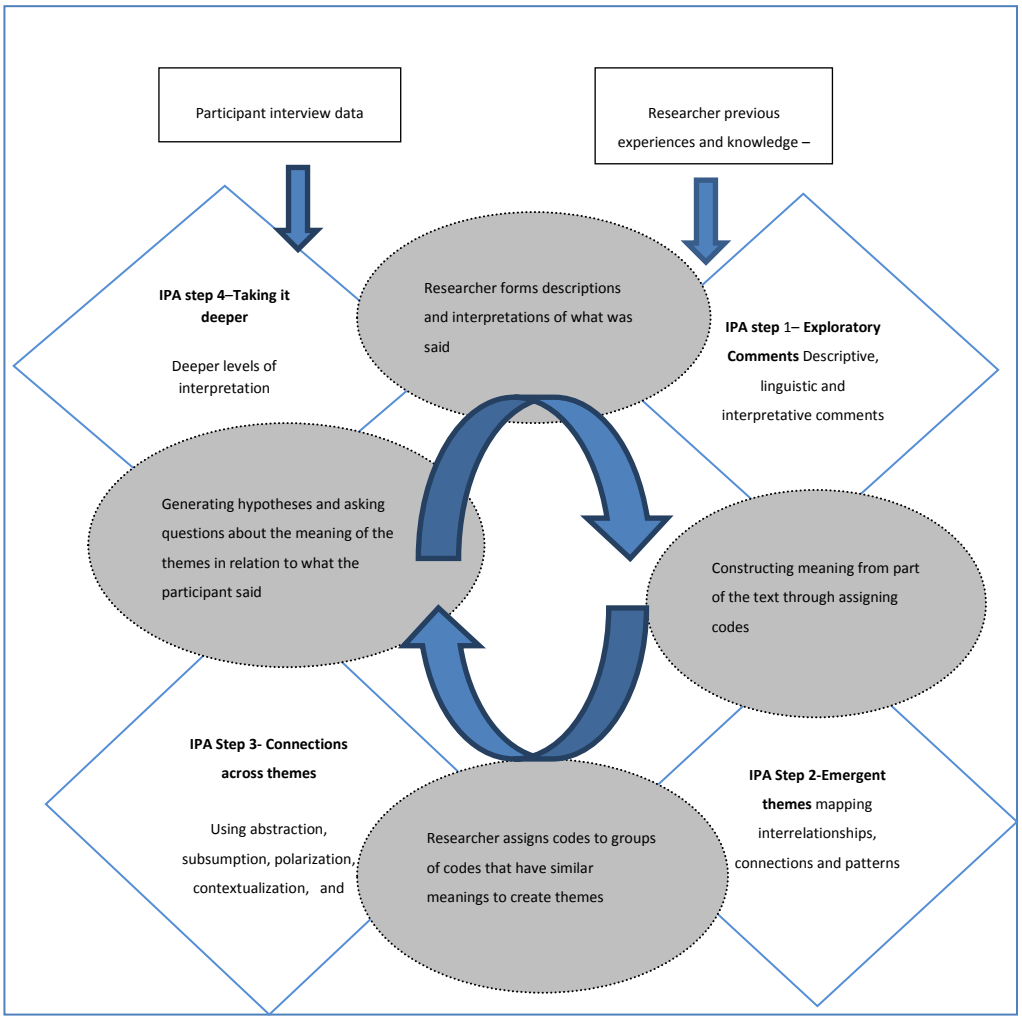
4.4.5 Data analysis in IPA

The aim of analysis is to use the experiences reported by individuals to form an understanding of the phenomenon as a whole. This is achieved by generating superordinate themes (the part) and ultimately higher order concepts (the whole as interpreted by the researcher) that characterise the phenomenon under exploration (Braun and Clarke, 2006). IPA requires an abstract level of analysis to demonstrate that the data has been interpreted and not simply described (Larkin et al., 2006). By interpreting the data the analysis produces a narrative about the meaning of what was said by the participants rather than simply describing statements that were similar between participants (Braun and Clarke, 2006). It is evidenced in some IPA research articles how some researchers remain at a descriptive level in their analysis becoming focused on describing an overview of what was said rather than providing a meaningful representation of underlying concepts or ideas (Smith, 2011). Interpretation of the interview data was made using a number of techniques including: choosing metaphor to describe events (Shinbourne and Smith, 2010); using excerpts of transcript to exemplify the meaning of a theme rather than listing text to illustrate a theme (Smith , 2011); using analytical statements rather than single word categories for theme names (Braun and Clarke, 2006).

Smith et.al (2009) summarised the process of analysis in IPA as the researcher reflecting on the responses they have when they engage closely with the account of the phenomenon as given by the participant. In this way the analysis demonstrates what the researcher has learnt about the phenomenon using the description from the participants as evidence for the conclusions that are drawn (Smith et al., 2009). In view of these recommendations the analysis in this thesis followed the specific analytic steps outlined by Smith et al. (2009) supported by the detailed process of thematic analysis outlined by Braun and Clarke (2006) (Figure 9). The cycle

shows how the research is grounded upon interview data and influenced by the researcher's forestructures at each stage of the analysis.

Figure 9 Illustration of the analytic process in IPA (Smith et al., 2009) alongside the thematic analysis cycle described by Braun and Clarke (2006)



Legend: thematic analysis cycle (oval), the steps described in IPA analysis (diamond), information input into the cycle (rectangle)

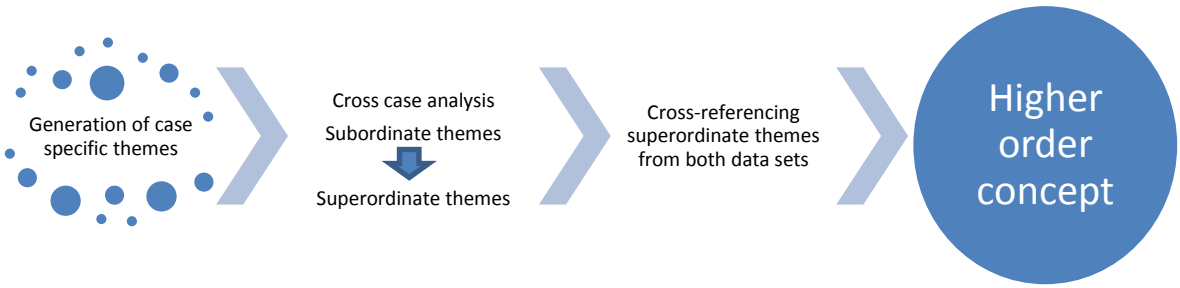
The aim of conducting analysis in IPA is to summarise the interpretations that were made of the interview data in a way that characterises participants' experience of the phenomenon (Smith, 2011). In this way IPA is inductive as it generates meaning from participant accounts

and also deductive as its findings are guided by the aim of answering the research question. The process of analysis builds themes at different levels of abstraction: participant specific themes; subordinate and superordinate themes generated across cases and higher order concepts generated from cross case analysis. The research question guides the analysis towards the production of higher order concepts.

4.4.6 The analytic process

The process of analysis followed the analytic stages suggested by Smith et al, (2009) as follows: generation of case specific themes (analysing each interview transcript); cross case analysis of themes (subordinate and superordinate themes generated from service user data set and practitioner data set separately); cross referencing superordinate themes from both data sets as illustrated in Figure 10.

Figure 10 Stages of analysis leading to the generation of a higher order concept



The analysis began with transcription of the recorded interviews. The resulting transcripts were read for general content with the generation of exploratory comments which began the interpretation of the data. The exploratory comments were notes on the preliminary ideas about the transcripts formed the basis of subsequent analysis and coding (Saldana, 2011; Braun and Clarke, 2006).

Although used widely in qualitative research the words 'coding' and 'codes' are not used by Smith et al.(2009). Smith et al. (2009) used the term *developing emergent themes* to describe

how they summarised sections of the account before *searching for connections across emergent themes*. Smith et al. (2009) described an *emergent theme* in the following excerpt:

'Themes are usually expressed as phrases which speak to the psychological essence of the piece and contain enough particularity to be grounded and enough abstraction to be conceptual.' (pp95).

Therefore, Smith et al.'s. (2009) description of an emergent theme as using both the data and the interpretations of the researcher to identify ideas that are similar and dissimilar could be said to be synonymous with coding. The terms emergent and searching imply that themes are present within the account ready to be discovered. These terms do not highlight that the researcher has in fact constructed the themes from their interpretation of what was said by the participant in the interview (Braun and Clarke, 2006). Therefore the terms code and coding have been adopted in this thesis to demonstrate the constructivist nature of the analysis.

In the analysis codes were used to summarise the data as units of meaning ascribed by the researcher to sections of the transcript as described by Braun and Clarke (2006). As such codes linked sections of the transcript that had similar meanings, and began to generate a narrative about the experience of the phenomenon (Saldana, 2011). Saldana (2011) suggested the use of code types (process codes, in vivo codes and versus codes) whereas Braun et al. (2014) suggest an evolving process of coding focused on how the data relates to the research question not guided by a code book. As such the approach to coding can be inductive whereby codes are drawn from the data or deductive whereby sections of the data are coded with reference to pre-defined codes. The approach in the current research was mainly inductive although as the analysis progressed codes were applied deductively based on the coding of previous transcripts.

4.4.7 Theme generation

Themes were generated by summarising codes (emergent themes) with similar meanings thereby creating connections between parts of the interview transcript (Smith et al., 2009).

The generation of themes involved identifying interactions and relationships between codes (Saldana, 2011) and was carried out by physically moving codes in relation to each other

creating maps of meaning (Miles and Huber man, 1994). Codes were connected in a way that constructed meaning from the data. These connections were made in a way that was coherent across the data in order to develop a strong narrative and to represent the data fully (Braun and Clarke, 2006). Mind maps, supervision and memos were used to ensure coherence of the themes were consistent with analytic claims. The intention of the careful implementation of all of these techniques was to generate interpretations of sufficient depth to make sense of the data (Saldana, 2011).

In applying different processes to the construction of themes the themes became more or less descriptive, inductive and deductive thereby offering different interpretation of the same data (Braun et al., 2014). The thematic analysis in the current study went through a number of iterations over the course of the research as themes were constructed from the codes that had been applied to the data (induction) and hypotheses were applied to the data (deduction). The processes described by Smith et al., (2009) of abstraction and subsumption (the use of one code to subsume others that are very similar) led in the main to descriptive themes which assisted in making sense of the data whilst polarization, contextualisation and function required a greater level of interpretation and therefore assisted in meaning making.

After themes were generated for each interview transcript themes were generated across cases. The generation of superordinate themes gave an understanding of the data overall, allowing the researcher to develop the findings of the research (Saldana, 2011). It was essential that the themes generated by the analysis offered and interpretation rather than description of the data to offer a greater level of abstraction and relation to theory as described by Braun et al. (2014).

Saldana (2011) suggested the use of reflexive writing to articulate the interpretations that are made in the analytic process. The term memo has been coined to describe the process of writing the thoughts of the researcher during data collection and analysis and may take a number of forms (Birks et al. 2008). In writing memos I wrote comments that related to the data (as in the exploratory comments); related the data to existing theories; developed hypotheses about the data; captured and critically analysed my thoughts and summarised discussions with supervisors about the analytical process thus keeping track of the way in which the data was analysed as outlined by Birks et al. (2008). There are no specific guidelines about the process of writing memos in IPA but Smith et al. (2009) noted that it is essential that

the comments are collated in such a way that the researcher can track back their train of thought so that their interpretations can be related back to the account.

4.4.8 Presenting findings

Clear presentation of findings provides the reader with the revelations from the research (Saldana, 2011). Findings in IPA analysis are presented alongside the extant literature in a way that confirms the current understanding of the phenomenon; problematises the current understanding of the phenomenon or extends the current understanding of the phenomenon (Smith 2009). Description allows the audience to see what was seen during the process, analysis allows for the audience to know how the researcher came to know what they know and interpretation allows the audience to understand what the researcher has understood by the findings (Saldana, 2011). Although the purpose of IPA research is to provide interpretation, descriptive and analytic writing is necessary to provide the scaffolding on which to place the interpretation. Numeration is a contested way of generating themes as the frequency of the theme does not necessarily represent the significance of the theme in data (Maxwell, 2010). Smith (2011) noted that providing an overview of the prevalence of a superordinate theme can allow the reader to understand the 'density of the evidence' for each theme. In the current study although themes were checked back to the interview transcripts to consider representativeness, themes were not counted across cases. However, efforts were made to represent each participant in the presentation of findings.

4.4.9 Quality in IPA research

The advance of qualitative inquiry has required the development evaluation criteria that reflect methods and intended outcomes of the inquiry (Lincoln and Guba, 1986). The position of the researcher as immersed in rather than removed from data collection and data analysis has shifted the focus of evaluation away from ensuring that results are correct to ensuring that how the research is conducted is trustworthy (Miles and Huberman, 1997). Terms used in quantitative research such as internal validity, reliability and objectivity have been replaced by terms that reflect the qualitative research paradigm - credibility; dependability and confirmability (Shenton, 2004). The use of evaluation criteria is a measure of overall

trustworthiness and authenticity of the research (Lincoln and Guba, 1986). Using specific research methods such as peer scrutiny (Shenton, 2004); member checking (Wagstaff and Williams, 2014) and searching for the negative case (Schwandt, 2007) have all been suggested as ways of attaining such trustworthiness and authenticity.

Smith et.al (2009) suggested the work of Yardley as helpful to assess the quality of IPA work. Yardley's work suggested four principles to make this assessment: Sensitivity to Context; Commitment and Rigour; Transparency and Coherence and Impact and Importance. Yardley (2000) proposed that these characteristics provide a framework for assessing the quality of diverse methods across qualitative approaches (Table 10). Yardley's principles were considered during the development of this PhD research including planning the method, undertaking interviews and analysis and producing findings.

Table 10 Yardley's quality principles as demonstrated within this PhD research

Quality principle	**How this is demonstrated in this PhD research**
Sensitivity to Context	Use of salient up to date literature to provide the context of the research. Description of the context of the research services and participants.
Commitment and Rigour	University of Southampton; NHS ethics committee and local Research and development office approval. Online General Data Protection Regulation training. In depth analysis of the data. Use of data extracts to demonstrate findings.
Transparency and Coherence	Description of negative cases. Demonstration of reflexivity throughout the research project. Through description of the analysis.
Impact and Importance	Discussion of the findings with clear implications for practice, research and wider social impact. Situating findings within the current research context.

4.4.10 Critique of IPA

Although IPA is used widely in health and psychology research the approach is not without its critics.

van Manen (2017) believed the P in IPA should refer to psychological and not phenomenological because of the interest paid to understanding individuals thoughts and feelings (cognitions) about their personal experience and not the essence of the experience itself. Smith et al. (2009) acknowledged the way in which IPA uses participant's cognitions in the process of analysis and noted how he believed IPA takes a phenomenological view of cognition. Smith et al. (2009) viewed cognition as a reflective activity, whereby participants generate the meaning of their experience which they believed makes cognition an integral part of the phenomenological process. However, van Manen (2017) stated that for him the focus on cognition in IPA takes the understanding of the phenomenon a step away from actually understanding what the experience of the phenomenon is like. As such, IPA is situated in a phenomenological framework in a very particular sense. It does not provide a description of the essential features of the phenomenon; it is focused on the experience of a particular phenomenon through researcher interpretations of the cognitions of the participant. Through clearly demonstrating the interpretative process the double hermeneutic applied to IPA should be evident allowing the reader to assess how far the interpretations have departed from focusing on the phenomenon in question. The presentation of data extracts provides an auditable connection between the phenomenon and the findings.

Chamberlain (2011) believed that there was ambiguity in the practical application of IPA as a research method as a phenomenological, interpretative and analytic endeavour in terms of the depth and precision of the approach. That the descriptions of the IPA method did not lead to the depth and precision of analysis required to lead to move beyond the identification of themes to a meaningful insight into the phenomenon (Chamberlain, 2011). Smith (2011) agreed that the depth and precision of the approach was liable to slippage and noted the variation in quality in IPA research papers. Poor quality thematic research paraphrases and describes what was said by participants without making any sense of the meaning of what was said (Braun and Clarke, 2006). In IPA there is a commitment to understanding the meaning of

the phenomenon as experience by the participant so that findings offer a narrative of meaning about the experience and not a list of unconnected themes (Smith, 2018).

The critiques highlight the limitations of IPA to generate certain types of knowledge. The type of knowledge that is enhanced in IPA is one of interpreted meaning of a particular instance of a phenomenon as experienced by a particular group of people. Therefore the presentation of the findings should offer the meanings of the phenomenon in this context. The findings are required to have sufficient depth of interpretation to offer a meaningful addition to the knowledge base. Consideration should be given to whether the meaning of the findings can be related to social or political influences to allow for critique of the context of the research.

Although IPA has some limitations it has been demonstrated as a methodology that is consistent with the aims of the study and my ontological and epistemological approach to the research. As such this study was implemented using the methods outlined by Smith et al. (2009) and following a rigorous research procedure.

Chapter 5: **Research Procedure**

Chapter five outlines the detailed research procedure undertaken to answer the research question. The approach taken to recruitment, consent and data management is summarised.

5.1 **Peer review and NHS Ethics Committee approval**

The study required access to NHS service users and as such the research protocol was subject to peer review at the University of Southampton (UoS) in November 2011 and ethical review by the Hampshire B NHS Ethics Committee in April 2013 (Research ethics committee reference 13/SC/0081 see appendix F). Approval was also sought and granted from the research and development departments the relevant NHS trusts; three in all as two of the services were within the same trust.

The local research ethics committee requested three amendments to the original protocol (REC ref 13/SC/0081):

1. To seek consent from parents/carers/guardians of participants aged 14-16 years old and assent from parents/carers/guardians of participants aged 17-18 years old. This was thought necessary by the committee to protect the researcher as well as the participants.

2. To use a research reply form given to the young person to return to the researcher rather than returned via the gatekeeper. This was to ensure that the young people would not be coerced into joining the study

3. For participants to be given the option of being sent feedback on the research at the point at which a report becomes available.

All of these changes were made to the protocol before seeking agreement to recruit from various research sites.

In April 2015 approval for a substantial amendment to the protocol (REC ref 13/SC/0081) was sought from the Hampshire B ethics committee with regards to two issues:

1. There had been a failure in recruitment to the study. On consultation with gatekeepers the need for parental consent for those under 16 and assent for those 17-18 was identified as a significant barrier to recruitment. Gatekeepers believed that parental/carer/guardian consent was unnecessary because there were minimal risks to patients taking part in the study. A request was made for the ethics committee to reconsider the need for this consent/assent.

2. Due to the difficulties with recruitment a request was also made for the inclusion of participants over 18. Both of the amendments were given favourable opinion.

In January 2016 approval for a further substantial amendment to the protocol was sought from to Hampshire B ethics committee to interview practitioners with regards to the use of mindfulness in DBT in order to give dual perspective to the study. This amendment was given favourable opinion.

5.2 **Recruitment of service user participants**

A pragmatic approach was taken to the identification of the services that would be used to recruit participants to the study. Participants aged 14-18 year olds were recruited from Child and Adolescent Mental Health Teams that were offering DBT within a travel time of 2.5hours from the researcher's home address. These teams were contacted by letter to ask if they would be willing to recruit participants (see Appendix G). Of the eight services contacted four services agreed to recruit participants. A summary of the services that agreed to take part is provided in Table 11. The elements available on each programme varied and none of the CAMHS services offered DBT-A as per manual.

Table 11 Summary of NHS services from which participants were recruited

Service Identifier	**Age range of service users being offered DBT programme**	**Details of DBT programme offered**
A	14-18 yrs	Group Individual work Phone Coaching Parent/carer group
B	14-18 yrs	Group Individual work
C	14-18 yrs	Group only DBT Parent workshops
D	18-65 yrs	Group only DBT or Group alongside individual work Phone coaching

5.2.1 Inclusion and exclusion criteria

The inclusion criteria were chosen to target participants with an experience of mindfulness in DBT rather than the presence of a specific diagnosis or behaviour.

To be included in the study service user participants were required to have had had recent (within a year) experience of mindfulness in DBT to facilitate recall of the intervention. Service users had to be currently open to the service to allow for gatekeeper follow-up. Those with a short experience (one module) of mindfulness in DBT were also eligible to participate in order to include individuals who had dropped out of treatment or were just starting, in addition to those who had a longer experience of mindfulness in DBT. The exclusion criteria were

developed to protect the participants and the researcher. The inclusion and exclusion criteria are summarised in Table 12.

Table 12 Inclusion and Exclusion Criteria for selection of service user participants

Inclusion	**Exclusion**
1. Service user has completed at least one module of DBT skills training which has included mindfulness within the last year 2. Service user is still open to the service	1. Service user is currently suffering from mental distress or illness that would make it unsafe for them to take part. This could be that due to the nature of their distress/illness: • they would not be able to provide informed consent to take part • they would be unable to take part in an interview of 60 minutes in length • they would be unduly distressed by the content of the questions • they would pose a risk to the researcher in a one to one interview 2. Service user does not have a level of conversational English that would permit them to participate on an interview conducted in English

5.2.2 Use of a gatekeeper

Gatekeepers from each service were identified to assist in identifying potential participants. The Gatekeeper was someone who had knowledge of the service user and who ensured safeguarding and risk issues were considered prior to participation. The specific tasks given to the gate keeper were to:

1. Provide suitable young people with the participant information sheet (appendix H). They only offered this to those who fulfilled the inclusion criteria. An information video was also made available (http://youtu.be/9UayLdZcsxo) to enhance accessibility of the information.

2. Sign the research reply form to declare that the respondent was fit to take part in the study.

3. Act as a contact for the researcher to feed back any safeguarding issues or distress that the young person wished to be followed up.

No case information about the service user was shared with the researcher as this was deemed superfluous to the aims of the study and may have introduced bias during the interview and subsequent analysis.

5.2.3 Recruitment of practitioner participants

The gatekeeper for each service made the participant information sheet (appendix I) available to colleagues who were DBT practitioners. The practitioners did not necessarily have direct contact with the service users that were recruited. Although some of the practitioners were aware of the service users participating in the study they were not asked to comment on the experience of those specific service users. Practitioners were self-selecting and had a choice on whether to participate in the study. Therefore no specific exclusion criteria were thought necessary. The inclusion criteria (Table 13) were developed to recruit practitioners with experience of teaching mindfulness in DBT. The criteria of currently teaching mindfulness or to have done so in the last year were included to facilitate recall of the intervention.

Table 13 Inclusion and exclusion criteria for selection of practitioner participants

Inclusion	**Exclusion**
Practitioners currently teaching mindfulness in DBT Practitioners who have worked mindfulness in DBT within the last year	None identified

The recruitment process culminated in seven service users and eight practitioners being recruited to the study. Table 14summarises the participants recruited from each service.

Table 14 Number of participants recruited from different research services

Service identifier	**Numbers of service users recruited**	**Numbers of practitioners recruited**
A	2	1
B	1	3
C	3	2
D	1	2

5.3 **Consent**

The initial research ethics approval for the study required the research to gain parental consent for service users 14-16 yrs and parental assent for service user participants aged 16-17 yrs to take part in the study. On consultation with gatekeepers the need for parental consent and assent was identified as a significant barrier to recruitment. An amendment was requested and granted to seek consent form the young people only.

The researcher contacted service user participants using the contact method that they had indicated on the research reply form (Appendix J). A suitable time was arranged to interview the participants in a private room on staffed NHS premises.

Consent forms were developed from the University of Southampton research consent template (Appendix K)

Before the interview the researcher checked that the participant had read and understood the information sheet. The consent form was explained and each participant was given the opportunity to clarify any points. Participants were informed as part of the consent process that if risk or distress were evident in the interview that the researcher would contact the gatekeeper to follow up. They were also informed that they could withdraw at any time from the research. The consent form was completed before the interview commenced and was retained with the participant reply forms. After the interview the research reply form and consent form were archived in locked filing cabinets with a participant number attached (the participant number was the date of the interview).

Service user participants were informed at the start of the interview that should they share risk information or become distressed during the interview that the gatekeeper would be informed in order to provide follow up to the participant. No risk or distress was highlighted by service user participants during the interviews and no request for follow up made. None of the participants withdrew from the research.

5.4 Data management

5.4.1 Audio recording of interviews

Each participant interview was audio recorded on a digital dictaphone. Participant's consent was gained at the start of the interview for the recording and use of verbatim extracts in the presentation of analysis and findings of the study. The recording of each interview was labelled with the participant number and stored on a password protected USB stick and the original recordings deleted from the dictaphone.

5.4.2 Interview transcription

The audio recordings of the interviews were transcribed by a University of Southampton validated professional transcriber. Any reference to people or places was anonymised in the transcript. Each transcription was checked by reading through the transcription whilst listening to the recording to ensure the accuracy of the transcription. A small number of words that could not be deciphered by either the transcriber or researcher were indicated in the transcript as - time*. The transcriber was asked to include sounds such as sighs and giggles indicated in brackets and pauses indicated by a dotted line, these pauses were not timed. The transcripts were typed into Word documents which included the participant speech indicated REC and the interviewer speech indicated INT. The identifier for the transcripts was the date of the interview. This identifier was later changed to a pseudonym to allow for ease of referencing. Transcripts were stored on password protected USB sticks and shared by the transcriber via secure e-mail.

The transcripts were formatted into a table with a column for transcribed speech alongside a column that numbered the sections of speech to allow for referencing later in the analysis. The table had one column for annotations with regard to exploratory comments and another column for codes that were assigned to summarise sections of the transcript. The format that was used during the analysis is illustrated below in Table 15.

Table 15 Example format used to annotate transcript during analysis with columns for exploratory comments and codes

Line number	Code	Original transcript	Exploratory comments
To allow for referencing	A short statement summarising the meaning given to a section of the transcript	The interview typed out word for word along with pauses and sounds.	Comments made with reference to descriptive, linguistic and conceptual interpretations of the transcript.
154.	Negative first impression Need openness to start	REC… and like don't judge your judgements as one of the therapists would say. And um, yeah, I, was well, this is a load bull crap. And then one, like, even my parents thought that. My Mum was a bit more lenient to the fact of, and she's actually very good at it now. She uses a lot of the terminology just in day-to-day conversations, just because, 'cos um, there's an adult's skills group as well, for the parents and carers.	This is bull crap Even parents thought it was bull crap Needing to be lenient to take on mindfulness *give it a chance*

Chapter 6: **Analysis**

The analysis chapter provides a summary of the steps that were taken to analyse the interview transcripts. Before the process of analysis is described the preparation that I completed to identify forestructures is outlined, followed by the preparation of transcripts and the demographics of participants. Each step that was taken during analysis is described using examples of how the analysis was performed. Explanations of the reasons for each step are discussed alongside reflections on the analytic process. At the end of the chapter two higher order concepts that were generated from the superordinate themes across service user participant and practitioner participant data are presented.

6.1 **Preparation for analysis**

6.1.1 Identification of forestructures

It is good practice for IPA researchers to develop an understanding of the forestructures that they have with regard to the research area (Clancy, 2013). By preparing a personal account of my own experience and knowledge of DBT, mindfulness and mental health, I intended to increase my awareness of the forestructures that I brought to the research study. IPA does not insist that the researchers leave previous experience and knowledge to one side in an attempt to become completely neutral. Rather they act as forestructures creating a dialogue in the analysis between researcher and data. By becoming more aware of my context I became vigilant about the impact of forestructures on the topics I pursued within interviews and the interpretations that I found interesting as suggested by Clancy (2013). IPA researchers have learned that the process of IPA often highlights previously unknown forestructures and therefore reflections on researcher influence are necessary throughout and not just at the start of the research (Smith et al. 2009).

I am a mental health nurse working with young people, practising DBT, including teaching mindfulness. Clinically I believe that mindfulness can be of help to service users. My own experience of mindfulness is one that is broadly positive; it has been helpful to me at times. Whilst I am not dedicated to mindfulness practice, I believe that mindfulness is useful to me and could be useful to other people and therefore see it as a useful part of the DBT programme. Because of my DBT training I have been engaged in reading about DBT (Swales

and Heard, 2009; Miller et al., 2007) and I have also read beyond DBT texts to learn about mindfulness as a way of cultivating wellbeing (Titmuss, 1998; Katagiri, 1998). A list of texts that have been influential in my understanding of mindfulness are outlined in the bibliography.

I was aware during the interviews that I felt particularly drawn or resistant to certain comments. I thought that some of the practices that were being described, for example watching YouTube, were not mindful but distraction. I noticed that I thought that practitioner participants had many experiences that were similar to my own, for example finding young people disinterested in mindfulness.

Through making memos I related the interpretations that I made back to what was said by participants and noted how the interpretations were connected to my knowledge and experience. I was alert to any tendency to pick out advantages over the disadvantages of mindfulness; to assume that service users were disinterested in mindfulness; to look for ways in which mindfulness was confused with distraction. However, I also tried not to discount topics that resonated with my previous experience and knowledge. It is through the process of working with the data and the forestructures brought by the researcher that IPA researchers make sense of what is said in a dynamic way. The understanding of the phenomenon is developed through interpretation, generating deeper levels of meaning with regard to the phenomenon (Smith, 2007).

6.1.2 Overview of the service user participant data set

There were two data sets generated by the interviews – a service user participant data set and a practitioner participant data set. These two data sets were analysed separately at first and then were cross referenced to generate higher order concepts that demonstrate the findings as a whole.

In this chapter the analytic process of the data from one interview is described, followed by the process that was used to generate subordinate themes and superordinate themes across each data set. Seven service user participants were interviewed with interviews lasting between 31.49 and 52.06 minutes. The age, research site, type of DBT programme that participants had experienced and the length of interview are outlined in Table 16

Table 16 Service user participant demographics

Pseudonym (gender)	**Age**	**Type of DBT programme**	**Interview length (mins.secs)**
Vicky (female)	17	Group Individual work Phone Coaching	31.49
Sam (female)	17	Group Individual work Phone Coaching	39.13
Philippa (female)	16	Group Individual work Phone Coaching	52.06
Kirsty (female)	18	Group Individual work	34.40
Tara (female)	18	Group only	33.39
Rachel (female)	17	Group only	38.05
Louise (female)	22	Group Individual work	34.55

The analysis outlined in this chapter pertains to the interview with Louise. Louise's interview transcript was chosen to demonstrate the analysis as it was the first to be analysed and therefore demonstrates the coding from initial stages, through to cross case analysis of service user participants and on to the cross referencing of service user participant and practitioner participant data sets.

Field notes were used to record the setting of the interview; comments about participant engagement and reflections on initial impressions of the interview (Phillippi and Lauderdale,

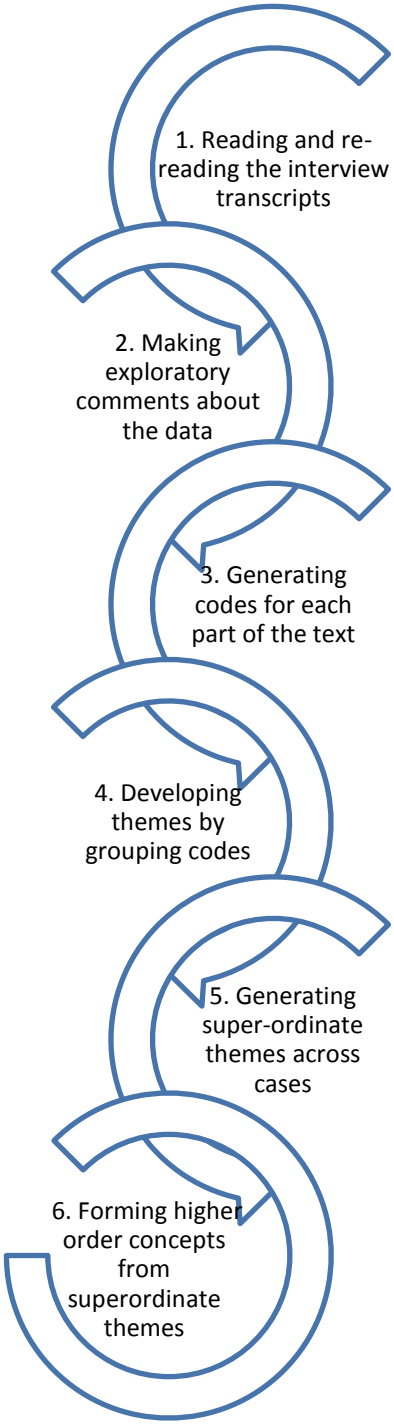
2017). In IPA field notes form part of the data that is available to contextualise the interview and develop analysis (Smith et al., 2009). Observations such as the way in which participants interacted during the interview were made in field notes at the end the interviews and used later during analysis to contextualise participant responses. For example, Philippa was noted to be enthusiastic in her responses and able to speak unprompted for extended periods of time whereas Sam was tentative in her responses and awkward during the interview. The notes that I made were brief, relating to the clinical setting and the interaction I had with the participant. Clinical notes were not reviewed as this was superfluous to the aim of the research question and therefore there was no ethical reason for accessing confidential medical information. Furthermore, reading clinical notes before interviewing service user participants would have changed the context of the interview by introducing additional forestructures with regard to my attitudes towards the participant.

Data extracts in the current study are identified for service user participants by the reference SUP Pseudonym Line number, for example SUP Louise 57 and for practitioner participants by the reference PrP Pseudonym Line number.

6.2 **Process of analysis**

The specific process of analysis that was followed within this study is outlined in Figure 11. This figure illustrates the practical steps that were taken to complete the analytic cycle for both service user participants and practitioner participants. Although presented as a stepped approach I moved back and forth between data, coding and constructions of themes many times in the research process. The first five analytic steps are outlined in this chapter with reference to one service user participant– Louise. Step six – generating superordinate themes across cases – is outlined in detail across the service user participant data and summarised for the practitioner participant data set. Step seven –formation of higher order concepts from superordinate themes is outlined at the end of the chapter in readiness for the presentation and discussion of findings.

Figure 11 Outline of the steps taken to analyse the data in this study



6.3 Analysis of interview data - generating case specific themes

6.3.1 Step one: Listening to the interview, reading and re-reading the interview transcripts

The key aim of listening to the interview, reading and re-reading transcripts is to familiarise the researcher with the interview content. The intention is to get to know the interview as a whole and the way in which narratives bind different sections together (Braun and Clarke, 2006). By developing an in-depth knowledge of the transcripts I was able to add depth and breadth to the analysis thereby demonstrating commitment within the research as recommended by (Yardley, 2000).

During the initial reading and re-reading I highlighted sections of the transcripts that I found interesting and made notes at the end of the transcript of the thoughts and initial questions that Smith et al. (2009) referred to as the 'noise' produced by the initial reading of the transcript. After the initial reading of the transcripts I moved on to making exploratory comments specific to sections of the transcript.

6.3.2 Step two: Making exploratory comments about each section of the transcript

The key aim of making exploratory comments is to highlight sections of participant accounts that relate to answering the research question (Smith et al. 2009). Preliminary noting of ideas about sections of the transcript formed the basis of subsequent coding (Saldana, 2011; Braun and Clarke, 2006). I made comments in relation to the query 'What are they saying about their experience?' In this way I connected the thoughts, emotions, actions and reflections that participants talked about to the way in which they had experienced mindfulness. Three types of comment used during this step of analysis (Smith et al., 2009):

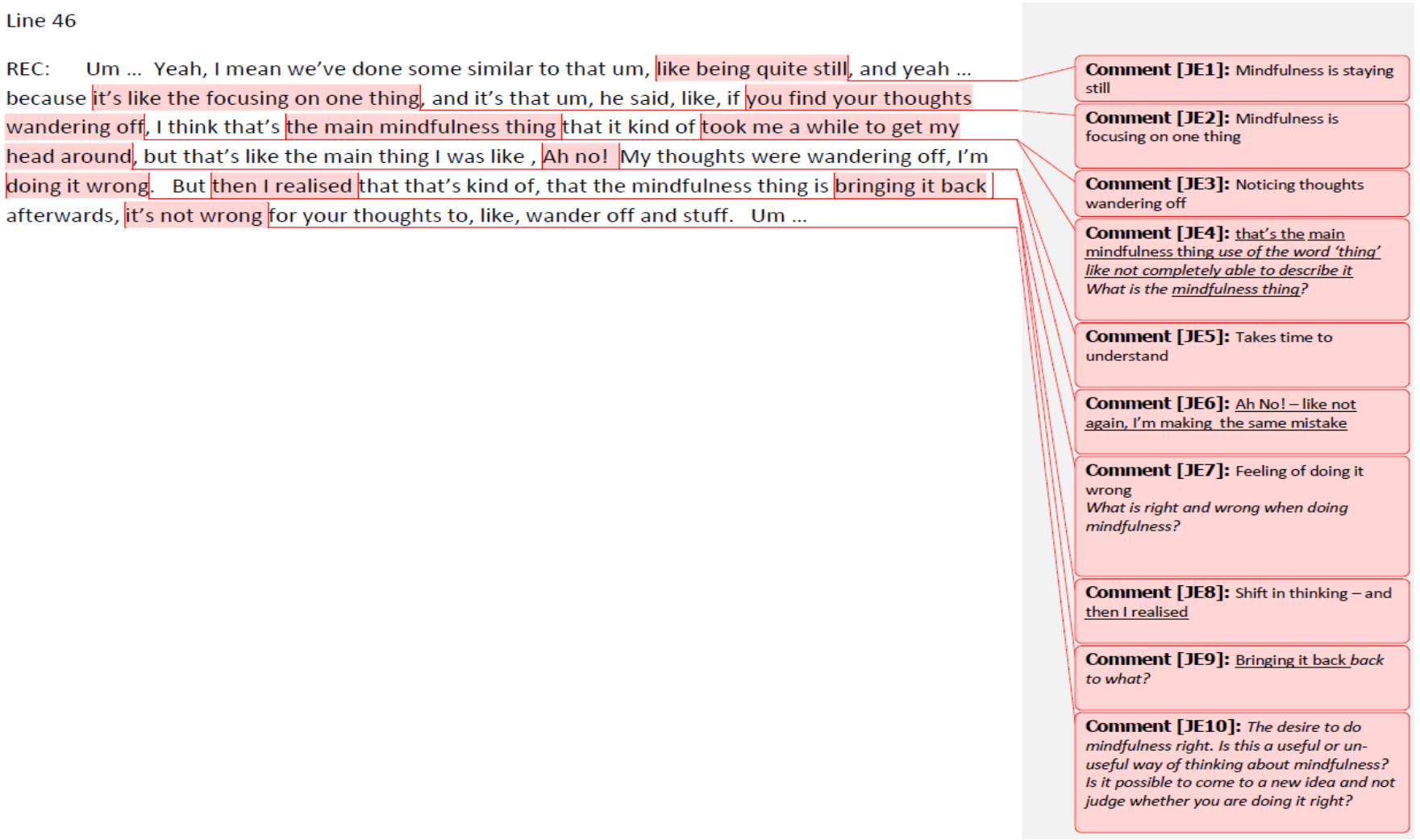
- **Descriptive comments.** What was described by participants? Achieved by summarising what the participants said. Comments are made without interpretation.
- **Linguistic comments.** The language used. This includes comments on the way in which a person spoke and emotional language that was used. Things such as fluency, tone, repetition, pauses, laughter, all aid the researcher to understand what was meant in the

account. Metaphors are also useful to construct meanings within what was said, particularly exemplified by figures of speech.

- **Interpretative comments and Questions** that the researcher has about the participant account. This was where I began to record my own suppositions and hypotheses.

Figure 12 provides an illustration of the way in which exploratory comments were made with reference to a section of the transcript. Different text formats were used to differentiate between the types of comment: descriptive comments written in normal font; <u>linguistic comments underlined</u> and *interpretative comments or questions in italics.*

Figure 12 Example of how exploratory comments were related to the transcript



The different comment types were useful in considering the transcript from different viewpoints. What follows is an example of the thought process related to the exploratory comments that I connected to extracts of the transcripts.

In making descriptive comments in line 46 (Figure 12) I drew on the information given about the direct experience of mindfulness. The extract from the transcript: 'like being quite still, and yeah … because it's like the focusing on one thing' (SUP Louise 46) was commented on because Louise had begun to describe how she experienced mindfulness. The exploratory comments from Line 46 JE1, mindfulness is staying still; Line 46 JE2, mindfulness is focusing on one thing; made direct reference to the words Louise used that seemed to say something about how she experienced mindfulness. Louise did not speak about other elements of mindfulness at this time, for example she does not speak of mindfulness being about awareness. Louise described difficulties in doing mindfulness and noted that she thought she was doing mindfulness wrong, giving an overall impression from the extract, 'My thoughts were wandering off, I'm doing it wrong. But then I realised that that's kind of, that the mindfulness thing is bringing it back afterwards, it's not wrong for your thoughts to, like, wander off and stuff.' (SUP Louise 46), that she did not find mindfulness easy. Again the exploratory comments highlight the importance of this description to understanding the experience of mindfulness for Louise - Line 46 JE3, noticing thoughts wandering off; Line 46 JE7, Feeling of doing it wrong . I noted that Louise learned new things about mindfulness over time as described in the transcript: 'it kind of took me a while to get my head around' (SUP Louise 46) and highlighted in the exploratory comment: Line 46 JE5, Takes time to understand; Line 46 JE8, Shift in thinking.

Linguistic comments with regard to line 46 (Figure 12) were made with consideration to the use of language that added to the understanding of Louise's experience as a whole. The use of the term 'mindfulness thing' (SUP Louise 46), and the pauses and giggles gave a feeling of uncertainty about mindfulness. I commented on the use of the term 'thing' as follows - Exploratory comment: Line 46 JE4, that's the main mindfulness thing *use of the word 'thing' like not completely able to describe it; What is the mindfulness thing?*. The level of giggling and apologising later in the interview suggested embarrassment at recounting experiences. The exclamation of 'Ah No!' (SUP Louise 46) within the account was in keeping with the idea of not

getting it right over and over leading to a greater level of exasperation - Exploratory comments: Line 46 JE6, Ah No! – like not again, I'm making the same mistake . That Louise stated she was doing it wrong seemed tempered somewhat by the experience that mindfulness itself was at fault as it was *stupid* and confusing: 'At first I was like, this is so stupid [giggles]. Like, it seems like one of those weird meditation things, and … yeah' (SUP Louise 50)

Lastly, *interpretations and questions* referred to the thoughts that I had that built upon the content of the transcript. I wondered whether taking up a new skill led to the experience of feeling incompetent as identified in the transcript: 'Ah no! My thoughts were wandering off, I'm doing it wrong' (SUP Louise 46)*;* Exploratory comment: Line 46 JE10, *The desire to do mindfulness right. Is this a useful or un-useful way of thinking about mindfulness? Is it possible to come to a new idea and not judge whether you are doing it right?)*

6.3.3 Step three: Generating codes for each part of the text

During this analytical step I assigned codes to sections of the transcript, drawing on the data extract, exploratory comments, field notes and initial noting to ascribe meaning to data. The field notes Figure 13 and initial noting Figure 14 were memos about the ideas I had about the context of the interview and reflections on my influence on the interview and analysis.

The field notes made in relation to the interview highlighted that I perceived Louise to be anxious and uncertain about mindfulness. I noted that my prior knowledge with regard to mindfulness and clinical work influenced the way in which I conducted the interview, reducing my curiosity about what was said. The post interview reflections led me to be more aware in the coding process that although some Louise's experiences were contrary to my understandings of mindfulness that I must ensure these were included in the coding.

Figure 13 Field notes made post interview

Field note – post interview 21/08/2015

Female 22years old

Met on NHS premises that were previously unknown to service user participant

I found it hard to move to a deeper level. I noted how hard it was not to conduct the interview as a clinical assessment as I would in clinical practice.

She was keen to get it right. Lots of apologies and checking if she was the right sort of person for the research. Seemed embarrassed – poor eye contact.

I had too much prior influence. Thoughts like I know where this is going stopped my curiosity. Things that she said I had heard before during clinical practice and this prevented me from looking for more. I had thoughts that she was not talking about the 'right' things.

The notes that I made after reading and re-reading the transcript from Louise's interview highlighted resonance and challenge to my preconceptions about mindfulness (Figure 14). I noted my interpretation that Louise's experience of mindfulness seemed to be that of ambivalence and that she spoke a lot about her body, not wanting to focus on her body. I wondered if she was really connected to mindfulness.

Figure 14 Notes made after first reading of the transcripts

Reflections/initial notes:

In writing the person seemed older than early 20's

Seemed to have a lot of ambivalence towards Mindfulness

Lots of what she can and can't do – is this due to a belief that she is not one of the mindful elite who have something she does not have?

Issues around the body – uncomfortable with being present in the body but seemed to be connected to her own specific issues about her body

Seems to use mindfulness as a distraction or a set of exercises does not feature as a way of being

Language of mindfulness/DBT using the language but seems mystified as to what mindfulness is doing for her. Is there a real cognitive connection? Has she internalised the language or is she mimicking the language. Are there any points where she is making her own connections or using her own language?

Experience remains unfathomable, unable to deconstruct the experience

Use of mindfulness superficially to focus the mind to deal with a problem not connected to it 'spiritually'

Only described use in superficial problems. Didn't describe a crisis situation. Is it not useful then or doesn't come to mind? I didn't push for more difficulties – sense of don't go near that

Can mindfulness be a threat to the self, body – opening up places that we don't want to go

Is she using it as it is taught in DBT to allow her to make wise decisions and not necessarily to process pain and trauma – aim of stabilising and therefore not using vipasana (insight) techniques

I considered the meaning that I ascribed to each section of the transcript and ascribed codes alongside sections of the transcript to represent my interpretations. Figure 15 shows the codes that were generated for Line 46 of the transcript. Excerpts from the transcript and exploratory comments are coloured in the same colour as the code that was assigned to summarise the meaning of the excerpt and comment. For example: a link between the transcript 'took me a while to get my head around' and the exploratory comments Takes time to understand and *Shift in thinking – and then I realised* was used to generate the code Taking time to understand mindfulness. The links are demonstrated by the use of the same colour (grey).

Figure 15 Example of coding alongside an extract from the transcript and exploratory comment

Extract from Transcript

Um … Yeah, I mean we've done some similar to that um, like being quite still, and yeah … because it's like the focusing on one thing, and it's that um, he said, like, if you find your thoughts wandering off, I think that's the main mindfulness thing that it kind of took me a while to get my head around, but that's like the main thing I was like , Ah no! My thoughts were wandering off, I'm doing it wrong. But then I realised that that's kind of, that the mindfulness thing is bringing it back afterwards, it's not wrong for your thoughts to, like, wander off and stuff. Um …SUP Louise 46

Codes assigned to extract

Focus on one thing **Bringing thinking back from wandering**

Uncertainty about doing it right **Taking time to understand mindfulness**

Using mindfulness language vs connection to mindfulness

Exploratory comments pertaining to extract

Staying still Focusing on one thing

Noticing thoughts wandering off – that's the main mindfulness thing *use of the word thing like not completely able to describe it*

Takes time to understand *Shift in thinking – and then I realised*

Feeling of doing it wrong *What is right and wrong when doing mindfulness?*

Ah No! – like not again, I'm making the same mistake

What is the mindfulness thing? Bringing it back

The desire to do mindfulness right. Is this a useful or non-useful way of thinking about mindfulness? Is it possible to come to a new idea and not judge whether you are doing it right?

How much is what she saying about using the language of mindfulness or a connection to the experience of mindfulness?

In the section of the transcript illustrated in Figure 15 I noted that Louise spoke about doing it wrong and also realising that it was not wrong for her thoughts to wander. She had a desire to get it right which I highlighted in exploratory comments, *'Ah No!' – like not again, I'm making the same mistake*, but was uncertain about what doing it right was. Uncertainty seemed characteristic of how she spoke –'kind of', 'stuff', 'thing' – all seeming to show uncertainty rather than a clear understanding. Therefore I applied the code – uncertainty of doing it right.

In Figure 16 it is possible to identify the presence of different code types as outlined by Saldana (2011). Although these code types were not used to guide the analysis, the retrospective identification of a range of code types indicates that there was breadth in interpretation of the data. The code I'm lacking vs mindfulness is lacking is a versus code that represents the tension within Louise's account about whether mindfulness is difficult because of personal deficits or because mindfulness is lacking in being the solution to her problems. The code "Why does it work?" is an In vivo code that uses Louise's words to illustrate the meaning of that section of the transcript. The code "Why does it work" was generated in relation to transcript excerpts mindfulness still really confuses me, why does it work? and this is so stupid and the exploratory comments Continue to feel confused, Asking lots of questions - Why does mindfulness work? and *Very difficult for her to explain mindfulness – lots of uncertain pauses*.

Figure 16 Example two of coding alongside an extract from the transcript and exploratory comments

Extract from Transcript

'Yeah, yeah. I think it took a while … I mean I've only really … I still, mindfulness still really confuses me because it, its like why … its like why does it work? and its … At first I was like, this is so stupid [giggles]. Like, it seems like one of those weird meditation things, and … yeah.' SUP Louise 50

Codes assigned to extract

Taking time to understand mindfulness **I'm lacking vs mindfulness is lacking**

"Why does it work?" **Mindfulness is weird**

Exploratory comments pertaining to extract

Taking time

Continue to feel confused

Asking lots of questions - Why does mindfulness work?

At first stupid – *still feel embarrassed by mindfulness? giggles?*

Weird – because it's like meditation

Very difficult for her to explain mindfulness – lots of uncertain pauses.

Is it mindfulness or is it personal deficits that are leading to the problems?

27 codes were generated as a result of coding the transcript from Louise's interview. These codes were used in the next step – generating themes. A master table of themes developed across the analysis of service user and practitioner participant data is outlined in Appendix L.

6.3.4 Step four: Developing case specific themes by grouping codes

The generation of themes for each case was the next step towards an understanding of the phenomenon of mindfulness in DBT. Themes for the case were generated by grouping codes that had been assigned to sections of the transcript. Each code was printed onto a separate label so that the codes could be moved and placed into groups on a table top. Code labels were retained for future reference and groupings recorded in word documents. Smith et al. (2009) described six different processes in the generation of themes in IPA as described in Table 17:

Table 17 Processes used in IPA for the generation of themes as outlined by Smith et al. (2009)

Abstraction	Putting codes with similar meanings close to each other and creating a new name for the grouping.
Subsumption	Using one of the codes to become the name for a group of codes with a similar meaning.
Polarization	Identifying codes with opposite meanings which may be used to organise further interpretations.
Numeration	The frequency with which a theme is reported.
Contextualization	Placing themes in an order that represents the context within the account, for example themes about beginnings.
Functional	Identifying themes that have a level of meaning beyond what is said for example themes that represent the participant's uncertainty.

These processes were used to group codes into themes specific to the data from Louise's interview. Four abstraction groupings were generated by identifying codes with similar meaning as outline in Table 18.

Table 18 Themes generated through abstraction grouping of codes

Themes generated in relation to the data from Louise	**Codes grouped by abstraction**
Then and Now	DBT takes time for change Taking time to understand mindfulness Timing of being introduced to mindfulness Mindfulness developing over time Things get easier through practice over time
New perspective	Dealing with difficult input from the outside Clearing up thoughts Giving space to breathe Awareness of feelings Ordering (processing) thoughts Dealing with being over whelmed Way in to managing difficult situations Dealing with the situation differently after a period of mindfulness
Blocks to mindfulness	Difficult to do Become frustrated If not focusing on an activity Situation can become too difficult for mindfulness to work Certain exercises difficult due to personal preference/characteristics Some exercises don't seem useful Some types of exercise are more or less accessible
Impact of teacher	Explanation needs to be down to earth Discussing the exercise helps it make sense
Key elements of mindfulness	Relaxation Focus on one thing Focused on a mindfulness exercise Bring your mind back when it wanders Focus on activity to self soothe

The theme **Then and Now** collated codes that pertained to the idea that things had changed over time for Louise and that Louise saw the learning of mindfulness as a process. **New perspective** was used as a way of summarising the codes that explained the way in which mindfulness led to changes in how Louise approached her thoughts, feelings and decisions. **Blocks to mindfulness** highlighted that there were several codes about finding mindfulness difficult to do. There were codes that pertained to the way in which mindfulness was presented in DBT that were collated into the theme **Impact of the teacher.** The theme **Key elements of mindfulness** drew together codes that illustrated the ways in which Louise engaged with mindfulness e.g. through focusing.

The themes generated through abstraction were mainly descriptive and needed to be developed further to provide a meaningful level of interpretation in the analysis. These case specific themes became the basis for further interpretation when analysed across cases during which a greater level of interpretation was necessary, especially when there were different experiences within a theme. For example mindfulness over time was experienced differently by different participants and participants identified different elements of mindfulness as important to their experience.

The codes 'calming' and 'slowing' were evident throughout the interview transcript and exemplified the notion that mindfulness was used extensively to calm Louise. Therefore these terms were subsumed and the code **Calming** was adopted as a theme as in Table 19.

Table 19 Theme generated through subsumption grouping of codes in relation to data from Louise

Theme generated in relation to the data from Louise	**Code grouped by subsumption**
Calming	Slowing thoughts down

Contextualisation, whereby codes that highlight the background or setting of the experience are grouped, was used to generate three themes. The theme **initial view of mindfulness** was generated from codes that highlighted the context of Louise's view of mindfulness at the outset (Table 20). This was followed by the theme **approaching mindfulness** that pertained to codes about how Louise approached mindfulness as a result of her experiences. A theme of

use of mindfulness language was generated which related to the context of Louise acquiring language to explain mindfulness. These contextualised themes were important in providing a basis for the interpretation of the experience overall. These themes led to interpretations of the experience being that of initial scepticism and wariness in the approach to mindfulness

Table 20 Themes generated through contextualisation grouping of codes

Themes generated in relation to the data from Louise	Codes grouped by contextualisation
Initial View of mindfulness	Initial negative thoughts about mindfulness First experience was scary Initial negative effect Initial scepticism
Approaching mindfulness	Doing mindfulness because someone tells you to Taking a leap of faith Suspending disbelief and jumping in Doing it because others are Being in it together
Use of mindfulness language	Use of mindfulness language

Functional groupings of codes that represent the meaning that participants assigned to the experience are outlined in Table 21. The theme **Strangeness** exemplified codes that characterised the experience of mindfulness as strange or weird as this experience was common in Louise's account. The theme **Uncertainty** was also generated to represent Louise questioning the purpose and efficacy of mindfulness alongside codes that represented questions about whether she was doing it right. The theme **Just sitting there** highlighted the interpretation that Louise found that she did not connect to some of the mindfulness exercises and **The Body** drew together the codes that indicated a particular aversion to mindfulness exercises that focused on the body.

Table 21 Themes generated through functional grouping of codes

Themes generated in relation to the data from Louise	**Codes grouped by function**
Strangeness	Hippy Strangeness Embarrassing Silly exercise "One of those weird meditation things" Mindfulness is weird
Uncertainty	"Why does it work?" Confusion What is the exercise about? Am I doing it right? What are the effects? Should I work on the ones I don't like? Should I do more or less of the things I dislike? It is confusing Has it got a place in my life? Why do we do it? What's the point of mindfulness? Can't measure it
Just sitting there	Connected or unconnected to mindfulness? Just sitting there
The body	Insight into emotions through physical awareness Understanding the emotions through body awareness Struggling with mindfulness of the body Focus on the body is uncomfortable/ makes things worse Focusing on the body is difficult Difficult to be mindful of the body

I became aware later in the analysis that some of the names that I had ascribed to the themes were not particularly helpful as they were too brief to ascribe nuanced meaning. For example the theme 'The Body' referred to the interpretation that Louise was averse to becoming aware of the body but this was not apparent in the initial theme name. Further analysis was possible

because the codes were available alongside the theme names and the data extracts and therefore could be developed further through consideration of the place of the coding and data extracts within the wider transcript.

Thirteen themes were generated from the analysis of Louise's interview transcript as illustrated in Table 22.

Table 22 Themes generated from analysis of interview data – Louise.

Case specific themes generated from the analysis of the transcript from	
Then and Now	Approaching mindfulness
New perspective	Use of mindfulness language
Blocks to mindfulness	Strangeness
Impact of teacher	Uncertainty
Key elements of mindfulness	Just sitting there
Calming	The body
Initial View of mindfulness	

By considering the themes that had been generated, a summary of Louise's experience was developed. This summary highlights the way in which I synthesised the data extracts (*grey italics*) with the interpretations I had made of Louise's account. An overview of the interpretations made in memos during the analysis of Louise's interview transcript is outlined below.

Louise had an uncertain relationship with mindfulness. Her motivation to engage with mindfulness were mainly external – other people telling me to, the group is doing it so I should join in.

'Yeah, 'cos … yeah, you're like, well they've told me to do this thing so I'm gonna do it 'cos they know what they're talking about I guess [giggles], um, but it still seems a bit, like … yeah.' SUP Louise Theme: Uncertainty

From the outset Louise found the idea of mindfulness scary, pointless and weird. Louise did not have any conviction that mindfulness would be useful to her and therefore just jumped in hoping it would be of use to her. However, she struggled to get away from the idea that mindfulness was simply weird or silly and she seemed embarrassed by the practices that were suggested to her.

'But it was a, like a plant pot, and I just didn't get it. I just didn't get it. I was like what? What is the point? Why am I looking at the plant pot [giggles] kind of thing, kind of thing? Yeah.' SUP Louise 72 Theme: Strangeness

Louise's uncertainty about mindfulness remained over time although she had a sense that her relationship to mindfulness got clearer and easier since she first began and also that it may continue to develop. She believed there were some parts of mindfulness that she might have got good at or have started to do right. However, overall she struggled with the idea of mindfulness and whether she was getting it right and will be able to get it right in the future.

'I don't know, like everybody kind of, kind of seemed to just be doing it, and so I kind of just jumped in and [giggles], um, yeah, did it with everyone else, and it still seemed a bit weird for a while, but then I kind of got it a little bit more, and I think I can do it a bit more in my own way.' SUP *Louise 80* Theme: Then and Now

Louise repeats throughout the interview some key elements of mindfulness as she experienced it. Focusing on just one thing; bringing her mind back when it wanders; and seeking relaxation/self-soothing. However, she is not sure completely what the effects of this should be.

'I don't know. I guess, I, I would say, like; it's just doing one thing and focusing on one thing, being in the moment. Um, and the main thing is that you kind of notice when your thoughts wander from that one thing, and then bring it back. So, um … I don't know whether I'd be able to explain why you would do that [giggles], like … or what it really helps with, still, I don't think.' Line 290 Theme: Key elements of mindfulness

Louise's relationship to mindfulness was based around carrying out mindfulness exercises. She found that by doing a mindfulness activity that she can order her thoughts better and slow

down racing thoughts. There was a sense that the mindfulness activity was a way of getting her mind into a place where she could then begin to deal with the difficult situation differently.

Um … That I could kind of, like, the slowing of my thoughts down so that I can, so that I'm not just getting overwhelmed by, like, just stuff in my head and like input and stuff; 170 Themes: New perspective and Calming/Slowing

She had a sense that mindfulness could also help her to understand her feelings better through awareness of her body/ sensations. However, she had an uneasy relationship with the idea of paying attention to her body as she believed this is particularly difficult for her and found she became more distressed before when paying attention to her body.

'Um … I think at first it was kind of a negative kind of, emotional effect, because, … I don't know. Like, I was suddenly being more aware of what I was feeling, and kind of, yeah, my body and stuff, and it was kind of like this is scary, [giggles]. Um … But I'm not sure, like now, whether it kind of has an emotional effect on me, but I'm not really sure.' 230 Theme: Body

Louise was unsure whether she should persevere with activities that she finds difficult or whether she should focus on the on the activities that are easy and she enjoys. There are some particular things that make it harder for her to do the mindfulness exercises – high emotion, when they are not activity based, when she becomes frustrated, personal preferences and abilities. She is unsure whether she can and should work at getting better at doing the things she struggles with.

'like people in the past have said to me that I'm not very connected to, like, what my body is doing, and when I'm asked to focus on, like, my, the sensation to my body, I find it really hard, and I think she's trying to help, like mindfulness with that, because obviously that links into other things, like if I'm able to tell what my body is kind of doing I might be able to kind of tell what emotion I'm having, and things like that. So I think that's why she was trying to help with, like, that bit. Kind of.' SUP Louise Themes: Approaching mindfulness and Blocks to Mindfulness

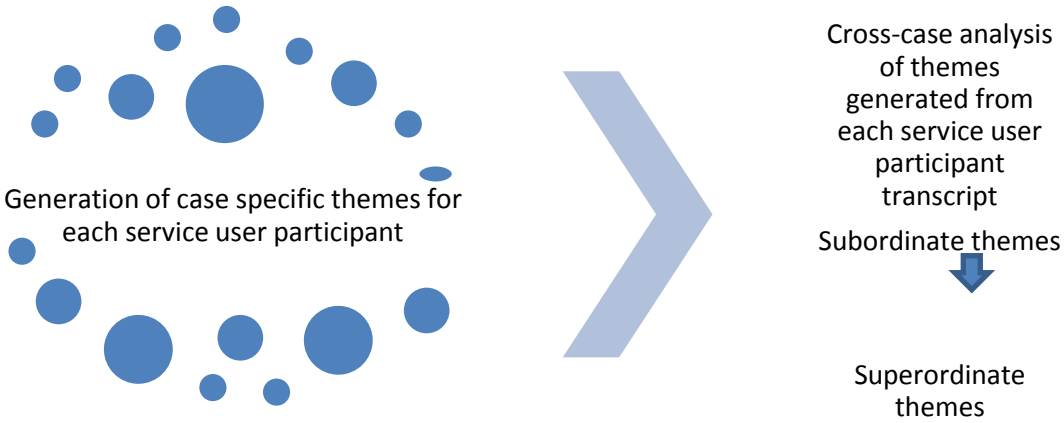
There are times when Louise seems very disconnected to mindfulness describing herself as just sitting there. She is not connected enough to the idea/experience of mindfulness to see it as something she would continue once she finishes DBT. She wonders whether her connection to

mindfulness might develop more over time and repeats throughout the interview that mindfulness requires time and practice to understand and fully experience. There is a sense that she is hoping/waiting for a mystery about this weird thing called mindfulness to be uncovered. She states that the approach of the person explaining mindfulness can have an impact and that it needs to be down to earth, with discussion of the point of silly exercises discussed.

6.3.5 Step five : Cross-case analysis - generating superordinate themes across the service user participant data set

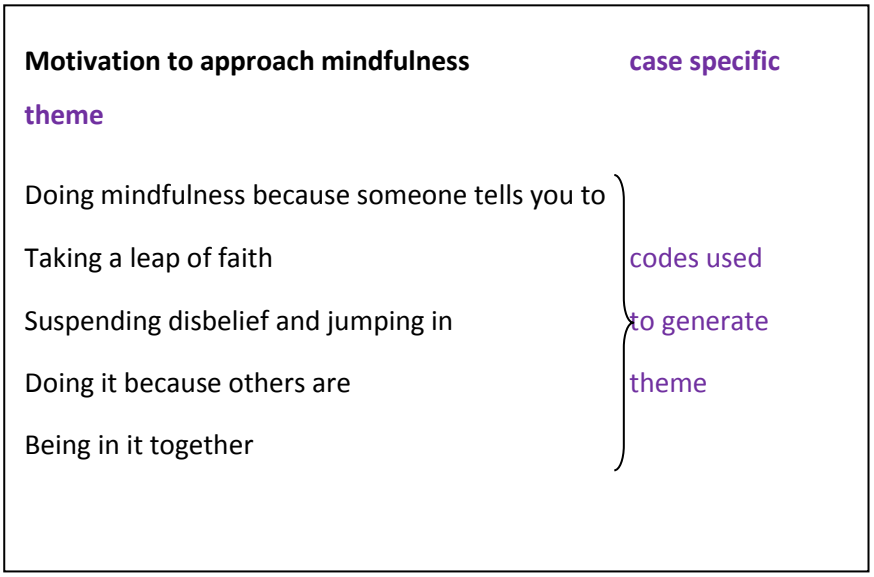
The purpose of cross-case analysis is to identify similarities and differences across service user participant cases. Smith et.al (2009) described the process as themes acting as magnets to each other as the researcher considers the meanings that have been constructed across the data set. The case specific themes that were generated from each of the service user participant interviews were considered alongside each other and I grouped case specific themes to generate subordinate themes across all of the service user participant cases. Subordinate themes were grouped further to generate superordinate themes across cases. This process is illustrated in Figure 17.

Figure 17 Illustration of the move from single case analysis to cross case analysis



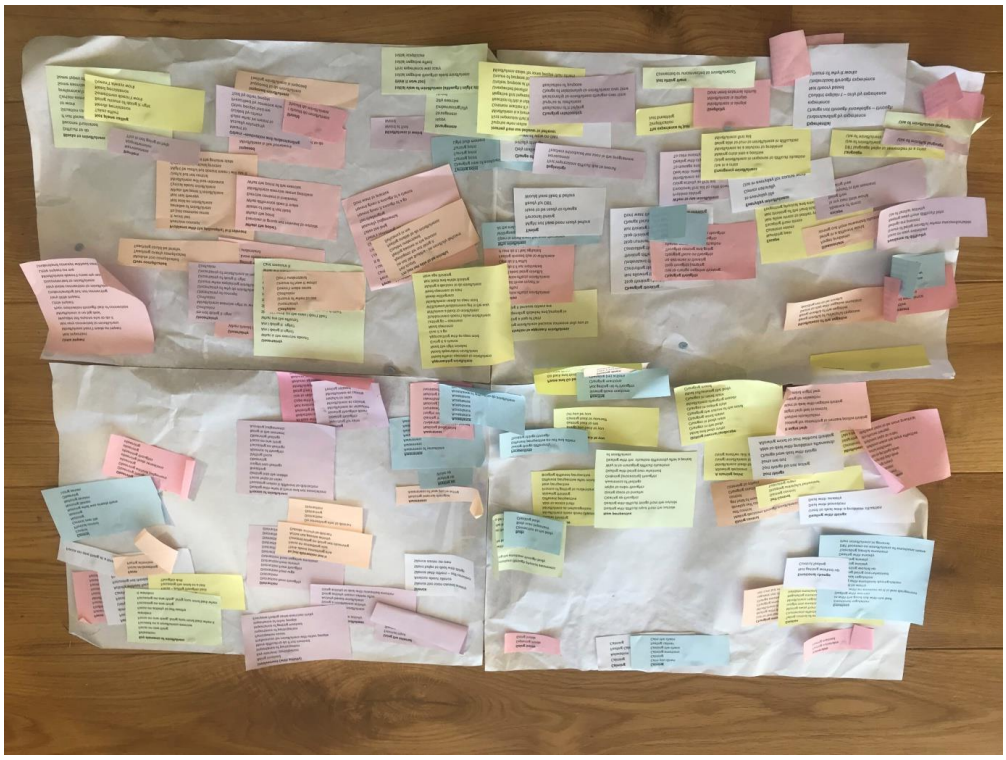
Themes specific to each service user participant were printed onto pieces of paper with the codes relating to the case specific themes printed underneath as illustrated in Figure 18

Figure 18 Example of theme - Motivation to approach mindfulness as defined by codes



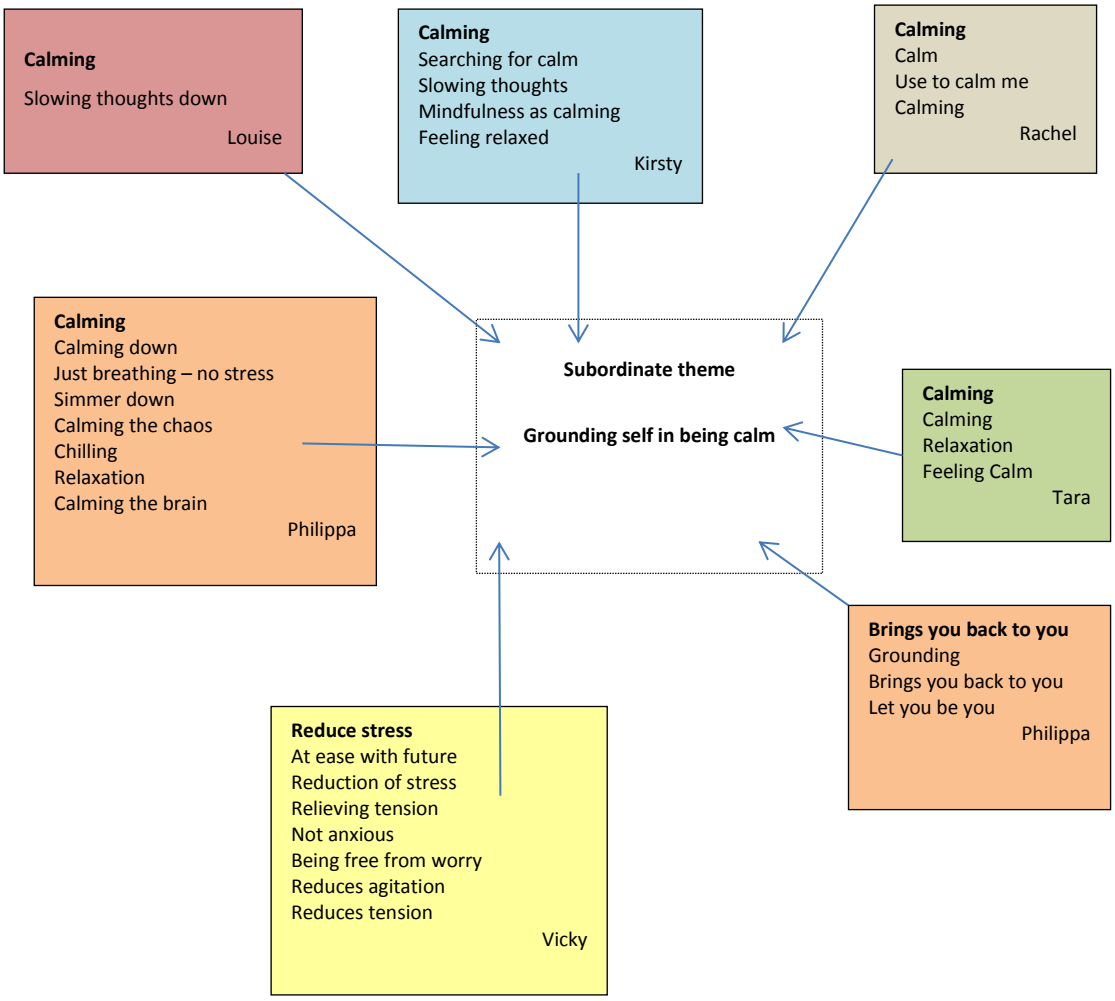
Each service user participant was allocated a colour to make case from which the themes originated distinguishable from one another. The printed codes were placed in relation to each other, generating groupings of similarity and difference across the cases as pictured in Figure 19.

Figure 19 Case specific themes printed and arranged into groupings



As I placed the printed codes in different areas of a large sheet of paper I considered the interactions, interplay and interrelationships between the case specific themes (Saldana, 2011). The groupings were developed and named, becoming the subordinate themes for the cross case analysis. The grouping that led to the theme grounding self in being calm is illustrated in Figure 20.

Figure 20 Grouping of service user specific themes to generate subordinate theme across cases



A process of moving through iterations of groupings and naming and renaming superordinate themes is outlined by Braun and Clarke (2006). Once service user specific themes had been grouped to form subordinate themes, these subordinate themes were grouped to develop superordinate themes. Subordinate themes were moved at times between groups to sit more securely within a different superordinate theme and new names were assigned at times to characterise the superordinate theme more clearly. Several iterations of the process were necessary and therefore superordinate themes were developed and renamed throughout the course of the analysis. In order to complete the hermeneutic turn within the cross-case analysis the interview transcripts were re-read. The re-reading allowed for the analysis to come back full circle considering whether participants' experiences had been represented adequately in the superordinate themes. This highlighted negative cases where particular

accounts were at odds with the superordinate theme that was generated. For example, Sam noted that engaging with mindfulness did not lead to feeling calm but heightened her sense of agitation. The interpretations that arose during the post analysis reading were included in memos about each superordinate theme.

Memos were written to develop ideas about the superordinate themes that had been generated. Memos were made during the reading of transcripts; during the generation of themes; during supervision sessions, and during the collation of findings. Many of the memos took the form of mind maps and diagrams that highlighted connections as they were being constructed. The memo in Figure 21 was written as a reminder of ideas that developed during the consideration of the subordinate themes pertaining to the superordinate theme - **A tension between being aware of painful thoughts or emotions or zoning out.** Memos were important in the development of the superordinate themes into a narrative about the experience of mindfulness as a whole.

Figure 21 Memo on the superordinate theme – A tension between being aware of painful thoughts or emotions or zoning out

- Mindfulness was difficult for some service user participants because it put them in the position of experiencing themselves or their emotions in a way that was uncomfortable.
- The experience of an increase in negative emotions or aversion to certain exercises was palpable in some of the service user participant accounts.
- There was a feeling of discomfort or exposure when doing mindfulness exercises.
- Discomfort signals that it is wise to stop? Some participants not engaging in some mindfulness exercises which encourage an internal focus
- Engagement in mindfulness is mostly described as activity based – colouring, blowing bubbles, watching YouTube or films. Preference for activity based mindfulness takes the participants attention outside of their minds and bodies.
- Self-awareness either avoided or not developed. Some service user participants were more at ease with internal focus and developed more awareness as a result.
- Avoidance of the internal focus could be seen as an avoidance of the self and the reality of what is in the moment.
- Tension between experiencing and non-experiencing had an impact on the type of exercises participants engaged with.

Four superordinate themes were generated from the cross case analysis as defined by sixteen subordinate themes.

The superordinate theme **Being Uncertain how mindfulness will help** (Table 23) highlighted that service user participants' experienced uncertainty about mindfulness. The level of uncertainty was different for different service user participants and changed in different ways over time. For example, Sam remained unconvinced that mindfulness could be helpful to her whereas Philippa had been initially sceptical but stated that mindfulness had been helpful to

her recovery. Philippa had suspended her doubts to be able to try mindfulness. Therefore, this superordinate theme represented a variety of participant experience.

Table 23 Superordinate theme - Being uncertain of how mindfulness will help - as defined by subordinate themes

Superordinate Themes	Subordinate Themes
Being uncertain of how mindfulness will help	▪ Not seeking mindfulness but being told to engage with mindfulness ▪ Experiencing mindfulness as weird ▪ Suspending doubts ▪ Not everyone is ready for mindfulness

The challenge of mindfulness (Table 24) was developed as a superordinate theme from subordinate themes that showed service user participants struggle to engage with mindfulness regardless of their level of conviction that mindfulness would be useful to them. However, some service user participants believed the challenge was based on their own ability. Again there was a variety of experience within the theme – Vicky believed that mindfulness was quite a natural state of being, whereas Rachel believed that people needed certain characteristics to be able to make use of mindfulness.

Table 24 Superordinate theme - The challenge of mindfulness - as defined by subordinate themes

Superordinate Themes	Subordinate Themes
The challenge of mindfulness	▪ Not always having the desire to be mindful ▪ Doubting personal ability to be mindful ▪ Mindfulness as contrary to everyday living ▪ Finding that mindfulness takes persistence

The superordinate theme **Should mindfulness be used to be aware of painful thoughts or emotions or to zone out?** (Table 25) was generated to demonstrate that service user participants had different purposes for engaging with mindfulness. Some used mindfulness to be more aware of their painful thoughts and emotions whereas others used mindfulness to

zone out. Increasing awareness and zoning out were ways of engaging with mindfulness that were opposed to each other.

Table 25 Superordinate theme - Should mindfulness be used to be aware of painful thoughts or emotions or to zone out? - as defined by subordinate themes

Superordinate Themes	**Subordinate Themes**
Should mindfulness be used to be aware of painful thoughts or emotions or to zone out?	▪ Internal focus intensifies difficult thoughts and emotions ▪ Focused on external focus. ▪ The experience of 'zoning out' from the painful thoughts or emotions ▪ The experience of becoming more aware of a painful thought or feeling

The superordinate theme **experiencing a new perspective** (Table 26) drew upon subordinate themes that related to mindfulness as changing the way service user participants conducted their lives. In the main this was to deal with thoughts and feeling in difficult situations. The superordinate theme experiencing a new perspective did not represent such a variety of experiences across service user participants. The experiences represented were more cohesive although some service user participants did have particular elements of mindfulness that they did or did not engage with. For example Kirsty was keen to engage with the 'participate' mindfulness exercises whereas Philippa liked to be guided by an audio recording. These preferences were idiosyncrasies separate from the core experiences of calming and pausing.

Table 26 Superordinate theme - Experiencing a new perspective- as defined by subordinate themes

Superordinate Themes	**Subordinate Themes**
Experiencing a new perspective	▪ The hope that mindfulness will change thoughts and emotions in difficult situations ▪ Pausing rather than reacting ▪ Grounding self in being calm ▪ Making different choices

The subordinate themes were checked back against the service user participant specific themes to keep the superordinate themes coherent with the service user participant accounts. Table 27shows how ten of the themes specific to the analysis of Louise's interview were subsumed into the superordinate themes generated across cases. The themes **impact of teacher** and **use of mindfulness language** that were generated from the analysis of Louise's interview were not represented it the superordinate themes generated in the in the cross-case analysis. The themes were discarded but remained important for the contextualisation of the accounts.

Table 27 Superordinate themes and Subordinate themes alongside themes generated in the analysis of Louise's transcript

Superordinate Themes	**Subordinate Themes**	**Themes generated in analysis of Louise's trancript**
Being uncertain of how mindfulness will help	▪ Not seeking mindfulness but being told to engage with mindfulness ▪ Experiencing mindfulness as weird ▪ Suspending doubts ▪ Not everyone is ready for mindfulness	▪ Uncertainty ▪ Approach to mindfulness ▪ Strangeness ▪ Then and Now ▪ Initial view of mindfulness
The challenge of mindfulness	▪ Not always having the desire to be mindful ▪ Doubting personal ability to be mindful ▪ Mindfulness as contrary to everyday living ▪ Finding that mindfulness takes persistence	▪ Blocks to Mindfulness
Should mindfulness be used to be aware of painful thoughts or emotions or to zone out?	▪ Internal focus intensifies difficult thoughts and emotions ▪ Focused on external focus. ▪ The experience of 'zoning out' from the painful thoughts or emotions ▪ The experience of becoming more aware of a painful thought or feeling	▪ The body ▪ Just sitting there
Experiencing a new perspective	▪ The hope that mindfulness will change thoughts and emotions in difficult situations ▪ Pausing rather than reacting ▪ Grounding self in being calm ▪ Making different choices	▪ New perspective ▪ Key elements of mindfulness ▪ Calming/Slowing

Tables of data extracts that exemplified subordinate themes were collated to ensure that I was able to make clear connections between my interpretations and participant accounts. Line numbers were kept alongside data extracts for reference back to the whole transcript to enable referencing of previous and subsequent lines that provided the context for the extract. The following extracts from the transcript of Louise's interview were collated for the superordinate theme – **Being uncertain how mindfulness will help**

'Yeah. I, I think it was during my DBT assessment kind of thing, and yeah, the person assessing me she was like, we're going to do a mindfulness thing, and it was about, like, imagining your thoughts floating on a leaf, like away, or something, and I was just sitting there like this, the stupidest thing I've ever done, like [giggles]. Like what is the point of this? And I couldn't do it at all, because I couldn't imagine it, I just … I was just like this is stupid.' SUP Louise 54 **Not seeking mindfulness being told to engage with mindfulness**

'Um … No. I mean … I'm not sure. I think, although I've been there six months I'm still one of the kind of, like, newer, members of the group, so when I got there … I don't know, like everybody kind of, kind of seemed to just be doing it, and so I kind of just jumped in and [giggles], um, yeah, did it with everyone else, and it still seemed a bit weird for a while, but then I kind of got it a little bit more, and I think I can do it a bit more in my own way.' SUP Louise 80 **Suspending doubts; Experiencing mindfulness as weird**

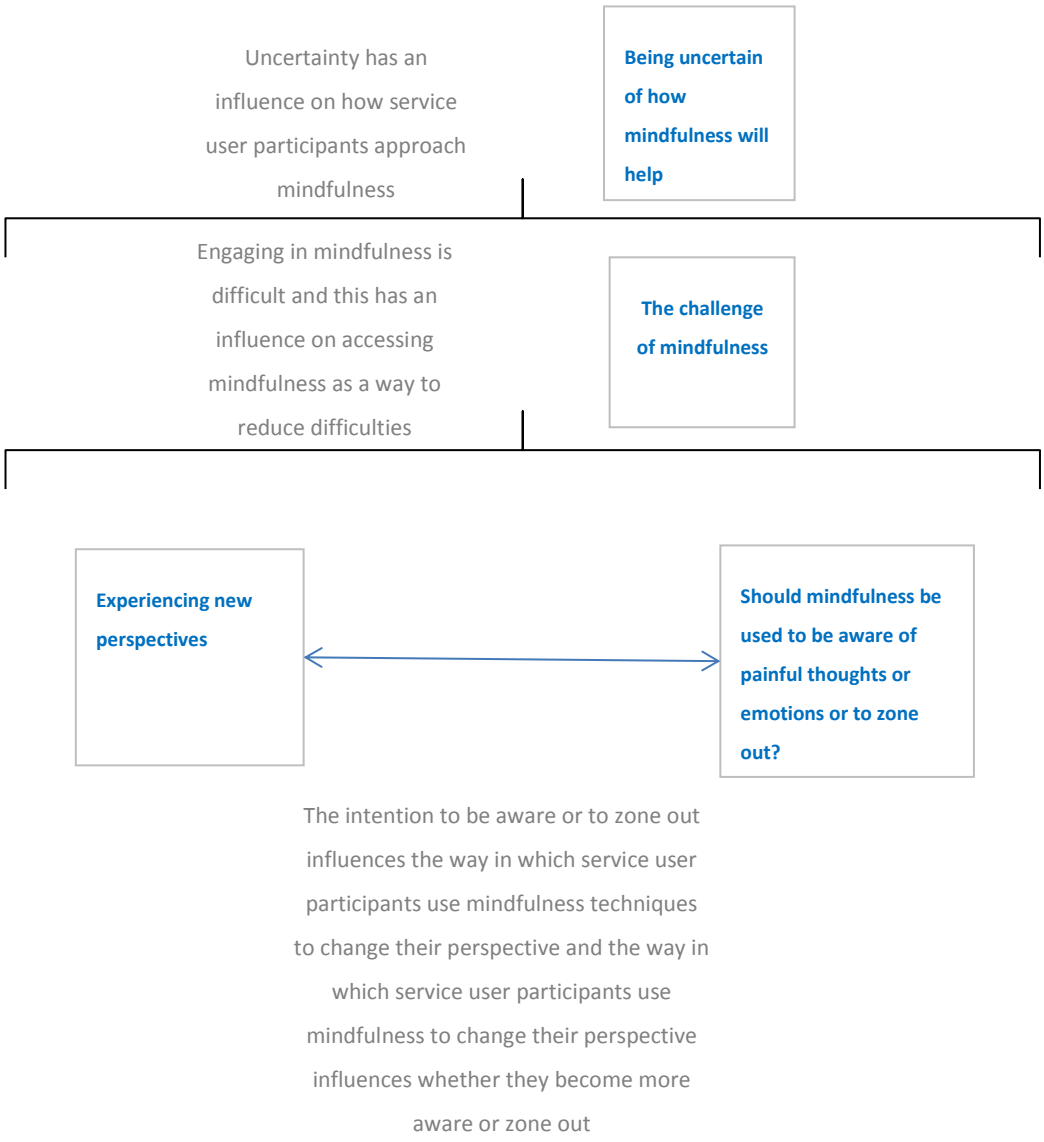
'Yeah, 'cos … yeah, you're like, well they've told me to do this thing so I'm gonna do it 'cos they know what they're talking about I guess [giggles], um, but it still seems a bit, like … yeah.' SUP Louise 140 **Not seeking mindfulness being told to engage with mindfulness**

Mind maps were used to consider the way in which superordinate themes related to each other as illustrated in Figure 22. These were useful in the development of the narrative with regard to mindfulness in DBT as they developed ideas about the relationships between superordinate themes.

This mind map demonstrates the thoughts I had about the way in which the superordinate theme ***Being uncertain of how mindfulness will help*** seemed to influence the way in which

service user participants approached mindfulness – with reservation and at times resistance. ***The challenge of mindfulness*** had an impact on the ability of service user participants to access mindfulness because there were factors that service user participants stated made mindfulness difficult to engage with and service user participants wondered if mindfulness is more difficult for some people than others. There seemed to be a reciprocal relationship between ***Should mindfulness be used to be aware of painful thoughts or emotions or to zone out?*** and ***Experiencing a new perspective*** as the intention to be aware or to zone out influenced the way in which service user participants used mindfulness to change their perspective and the way in which service user participants approached a change of perspective influenced whether they increased awareness or zoned out form their experiences.

Figure 22 Mind map of connections between service user participant superordinate themes



The outcome of the analysis of service user participant as a list of superordinate themes as defined by subordinate themes is outlined in Table 28.

Table 28 Final list of Service User Superordinate and Subordinate themes

Superordinate Themes	Subordinate Themes
Being uncertain of how mindfulness will help	▪ Not seeking mindfulness but being told to engage with mindfulness ▪ Experiencing mindfulness as weird ▪ Suspending doubts ▪ Not everyone is ready for mindfulness
The challenge of mindfulness	▪ Not always having the desire to be mindful ▪ Doubting personal ability to be mindful ▪ Mindfulness as contrary to everyday living ▪ Finding that mindfulness takes persistence
A tension between being aware of painful thoughts or emotions or zoning out	▪ Internal focus intensifies difficult thoughts and emotions ▪ Focused on external focus. ▪ The experience of 'zoning out' from the painful thoughts or emotions ▪ The experience of becoming more aware of a painful thought or feeling
Experiencing a new perspective	▪ The hope that mindfulness will change thoughts and emotions in difficult situations ▪ Pausing rather than reacting ▪ Grounding self in being calm ▪ Making different choices

6.4 Analysis of practitioner participant data

The practitioner participant analysis was undertaken in the same way as the service user participant analysis. The practitioner participant analysis was carried out separately so that

the service user participant and practitioner participant perspectives could be explored in their own right and the findings compared.

There seemed to be a high level of resonance between service user participant and practitioner participant experiences. The similarity between transcripts may be due in part to the way in which the interview schedules were mirrored, therefore bringing forth similar topics of conversation. However, the ideas I had in relation to the experience of mindfulness in DBT had changed during the analysis or service user participant transcripts. Therefore, the interpretations I made in relation to practitioner participant transcripts were based on different forestructures. Furthermore, I was aware that my personal experience as a DBT therapist would influence my interpretations.

Practitioner participant specific coding and theme development were completed using the same steps as the service user participant specific coding and theme development. The analysis of practitioner participant data is summarised here from step five – cross-case analysis.

6.4.1 Overview of practitioner participants

Eight practitioner participants participated in the study (Table 29). Some of these practitioner participants were involved in group only DBT or were trained in skills group leadership only.

Table 29 Practitioner participant demographics

Pseudonym	**Service**	**Type of DBT offered**	**Interview length (mins.secs)**
Sarah	A	Group Group for parents Individual Phone coaching	38.35
Michelle	B	Group Individual work	37.47
Phoebe	B	Group Individual work	23.51
Grace	B	Group Individual work	31.32
Elaine	C	Group only	39.52
Helen	C	Group only	31.43
Julie	D	Group Individual work Phone coaching	59.18
Mark	D	Group Individual work Phone coaching	31.43

6.4.2 Step Five: Cross-case analysis - generating superordinate themes across the practitioner participant data set

Four superordinate themes, as defined by ten subordinate themes, were generated across the practitioner participant data set.

The superordinate theme **Practitioner participants are unsure of mindfulness in DBT** outlined the way in which practitioner participants experienced the teaching of mindfulness (Table 30). This related to their level of comfort or discomfort and also the way in which they perceived service user participant reactions to mindfulness. The uncertainty held by practitioner participants varied with some believing mindfulness was essential to success in DBT (Julie, Mark) whereas others were less sure (Phoebe). There was a diverse range from confidence to awkwardness in the experience of teaching of mindfulness in DBT.

Table 30 Superordinate theme practitioner participants are unsure of mindfulness in DBT as defined by the subordinate themes

Superordinate Themes	Subordinate themes
Practitioner participants are unsure of mindfulness in DBT	▪ Different levels of comfort about own experience of mindfulness ▪ Doubting that it is realistic for service user participants to be mindful Confidence vs awkwardness ▪ Being unsure of the importance of mindfulness

The superordinate theme **striving to make mindfulness easier** brought together subordinate themes that pertained to the efforts made by practitioner participants to make mindfulness more accessible and acceptable to service user participants as outlined in Table 31.

Table 31 Superordinate theme striving to make mindfulness easier as defined by the subordinate themes

Superordinate Themes	Subordinate themes
Striving to make mindfulness easier	▪ Trying to apply it to everyday experiences ▪ Validating service user participant doubts ▪ Awareness of self –consciousness

Fear of exposing service user participants to thoughts and feelings denotes the subordinate themes indicating a sense of uneasiness about the effects of mindfulness on service user participants versus the desire to help service user participants to experience their thoughts and emotions more fully. The intention of practitioner participants to expose service user participants to painful thoughts and feelings varied. The confidence and experience of practitioner participants may have influenced the comfort about mindfulness exposing service user participants to difficult thoughts and emotions. This Superordinate theme is outlined in Table 32.

Table 32 Superordinate theme fear of exposing service users to painful thoughts and emotions as defined by the subordinate themes

Superordinate Themes	Subordinate themes
Fear of exposing service user participants to painful thoughts and emotions	▪ Wary because exposure to painful feelings can cause problems ▪ Avoidance of mindfulness exercises that might cause painful thoughts and feelings ▪ Encouraging service user participants to increase awareness despite the risks of experiencing painful thoughts and feelings. ▪ Introducing mindfulness gently

Finally the superordinate theme **Hoping changes in relationship with thoughts and emotions will change behaviour** (Table 33) represents the way in which practitioner participant's hoped for service user participants to gain an new perspective on thoughts and emotions which in

turn would change service user participant behaviour. This was not defined by subordinate themes as these were subsumed into this superordinate theme.

Table 33 Superordinate theme hoping changes in relationship with thoughts and emotions will change behaviour as defined by the subordinate themes

Superordinate Themes	**Subordinate themes**
Hoping changes in relationship with thoughts and emotions will change behaviour	Subordinate themes subsumed

Memo writing continued throughout the analysis of practitioner participant accounts and across practitioner participant accounts (Figure 23). The following memo pertains to the cross case analysis that generated the theme fear of exposing service user participants to thoughts and feelings. The ideas in the memo were discussed in supervision to develop the superordinate theme.

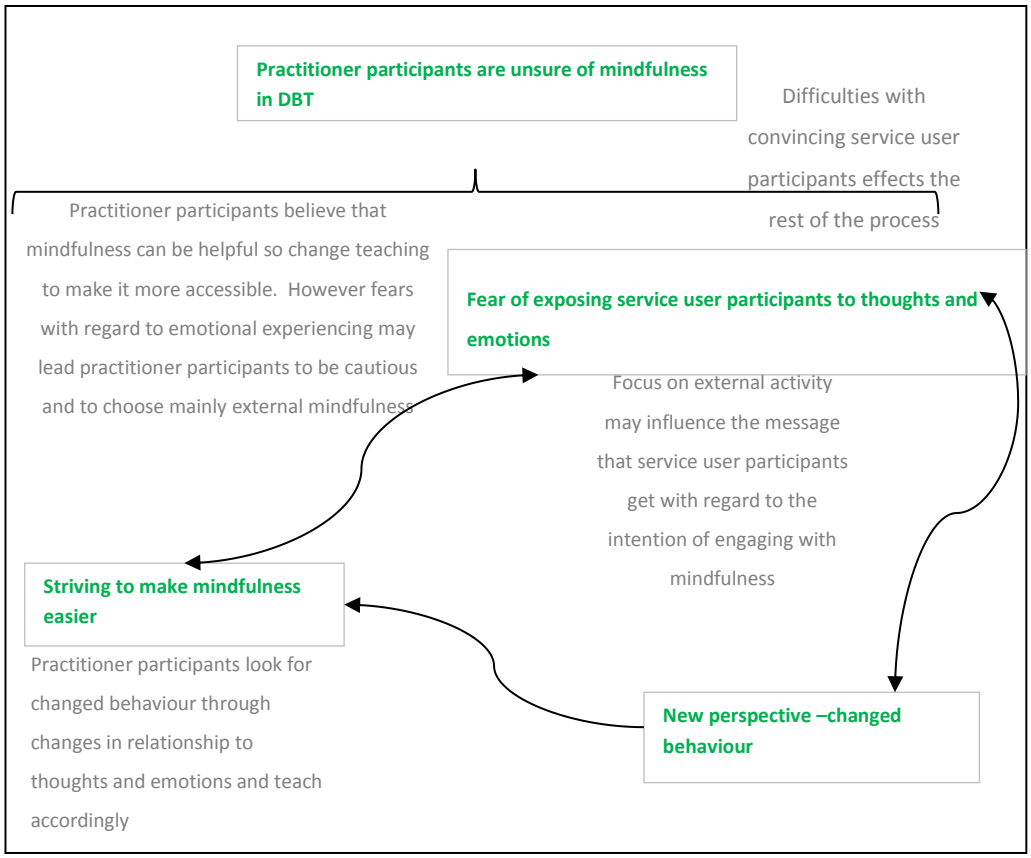
Figure 23 Memo on the practitioner participant superordinate theme – fear of exposing service user participants to thought and feelings

- Types of people being offered DBT often avoidant of thoughts, feelings, memories and bodily sensations. Practitioner participants noted this to be due to service user participants having lived in environments of trauma, abuse and invalidation.
- Present culture endorsed limited exposure to feelings, highlighting the numerous distractions available to people day to day.
- Emotional experiencing as outside of people's awareness and understanding regardless of their experience of trauma or abuse.
- Practitioner participants fear of moving from a state of blocking experiences to that of being aware and connected.
- Practitioner participants experience service user participants as emotionally dysregulated, making it even more difficult to access mindfulness.
- Practitioner participants identified significant fear of service user participants being connected to their emotions, memories and emptiness.
- Practising mindfulness has the potential for highlighting and linking people into emotional pain that they had previously distracted from or blocked out.
- Ability to tolerate feelings important to changing reactions to emotional pain.
- Practitioner participants anxious about the potential harm experienced through practising mindfulness
- Types of mindfulness exercises that were introduced to the group focused upon activity based mindfulness exercises rather than quiet introspective exercises.

Mind maps were developed to explore the relationships between practitioner participant superordinate themes. One such mind map is shown below in Figure 24. ***Practitioner participants are unsure of mindfulness in DBT*** is an umbrella theme as it influenced the approach taken to teaching mindfulness overall. The difficulties that practitioner participants noted when teaching mindfulness led to ***striving to make mindfulness easier***. However, by striving to make mindfulness easier practitioner participants at times refrained from challenging the ***fear of exposing service user participants to thought***

and emotions by softening the message of mindfulness and avoiding more challenging mindfulness activities. Practitioner participant's observed that behavioural change occurred through changes in the way service user participants experienced thoughts and feelings - ***new perspective- changed behaviour***, which was influenced by how practitioner participants approached mindfulness activities given the fear of exposing service user participants to thoughts and emotions.

Figure 24 Mind map of connections between practitioner participant superordinate themes



6.5 Higher order concepts

Two higher order concepts were developed by analysing service user participant superordinate themes alongside practitioner participant superordinate themes. The superordinate themes were grouped into shared meanings through mind maps and interpretative memos. The way in which each higher order concept relates to service user participant and practitioner participant superordinate and subordinate themes is demonstrated in Table 34

Table 34 Higher order concepts as they relate to service user participant and practitioner participant superordinate and subordinate themes

Higher Order Concept	Service user participant Superordinate Themes	Service user participant Subordinate themes	Practitioner participant Superordinate Themes	Practitioner participant Subordinate themes
A struggle with uncertainty and challenge	Being uncertain of how mindfulness will help	Not seeking mindfulness but being told to engage with mindfulness Experiencing mindfulness as weird Suspending doubts Not everyone is ready for mindfulness	Practitioner participants are unsure of mindfulness in DBT	Doubting that it is realistic for service user participants to be mindful Being unsure of the importance of mindfulness
	The challenge of mindfulness	Not always having the desire to be mindful Doubting personal ability to be mindful Mindfulness as contrary to everyday living Finding that mindfulness takes persistence	Striving to reduce uncertainty	Trying to apply it to everyday experiences Validating service user participant doubts Awareness of self -consciousness

Higher Order Concept	Service user participant Superordinate Themes	Service user participant Subordinate themes	Practitioner participant Superordinate Themes	Practitioner participant Subordinate themes
Developing internal awareness with caution	**A dilemma between being aware of painful thoughts and emotions or zoning out**	The hope that mindfulness will change thoughts and feelings in difficult situations Mindful focus intensifies difficult thoughts and feelings The experience of 'zoning out' from the painful thoughts or emotions The experience of 'just sitting' with a painful thought or feeling	Fear of exposing service user participants to thoughts and feelings	Wary because exposure to painful feelings can cause problems Avoidance of mindfulness exercises that might cause painful thoughts and feelings Encouraging service user participants to be mindful despite the risks of experiencing painful thoughts and feelings. Introducing mindfulness gently
	Experiencing a new perspective	Pausing rather than reacting Grounding self in being calm Focused on focusing Making different choices	Hoping changes in relationship with thoughts and emotions will change behaviour	

6.6 **Summary of the analysis**

Careful and systematic coding and thematic analysis of each interview transcript followed by cross case analyses has generated five superordinate themes pertaining to service user participant experience and four pertaining to practitioner participant experience. The analysis of the service user participant and participant interviews has generated two higher order concepts that will be explored in the findings chapter.

Chapter 7: **Introduction to Findings**

7.1 **Introduction to findings chapters**

The findings chapters explain each of the higher order concepts that were generated with reference to the superordinate themes from both data sets. The aim of the research was to generate an understanding of the lived experience of engaging in mindfulness in DBT with a particular focus on the adolescent experience. As such the higher order concepts provide a synthesis of the superordinate themes that were generated pertaining to the lived experience of mindfulness in DBT. Findings that highlight particulars of the adolescent experience of mindfulness are also discussed.

Analysis of the data led to two higher order concepts which are discussed in this chapter. The higher order concept ***A struggle with uncertainty and challenge*** illustrates the way in which both service user participants and practitioner participants experienced uncertainty about the value of and need for mindfulness in DBT; doubts as to there being a universal ability to be mindful and an ongoing struggle to engage with DBT. The higher order concept ***Developing internal awareness with caution*** illustrates that service user participants and practitioner participants were cautious about using mindfulness in DBT to increase exposure to potentially distressing thoughts and emotions. Service user participants approached mindfulness primarily through focused attention on external stimuli to develop a change in their relationship to thoughts and emotions which led to behavioural change. Discussion in relation to existing research and commentary that add an understanding to the findings is offered throughout the presentation of findings and also in summary of both higher order concepts.

As was demonstrated in the literature review the term mindfulness is not a homogeneous concept. The concept includes actions and characteristics that are considered to be mindful. The term mindfulness was used by both service users and practitioners with a wide range of meaning. The term was used for describing activities such as doing a mindfulness exercise; practicing mindful meditation; approaching a situation using the skills of observing, describing or participating, or to describe the concept being mindful through being non-judgemental; being effective or using wise mind. The term 'engaging in mindfulness' is used in the findings chapter to describe the broad range of meaning of the term mindfulness that was employed by participants.

7.1.1 Biographies of research participants

Short descriptions of the participants are offered to situate the findings of the research in the context of those who participated. The nature of personal experience is grounded in context with each individual's context leading to a different experience of the same phenomenon. Therefore the context of each participant is important in understanding what they have said.

Service user participants experienced mindfulness in different contexts. They also had somewhat different experiences of mental health treatments. For some DBT was their first treatment and for others they had experienced previous treatments for a variety of mental health problems. Limited detail is given to previous treatments as these were not explored at interview and clinical notes were not referenced with regard to previous treatment.

Vicky, a 17-year-old female engaged in a 16 week DBT programme offering group and individual sessions. She was 15 weeks into a 16 week programme. She had also received treatment for an eating disorder. She was studying A levels in a sixth form.

Philippa, a 16-year-old female who had completed a 16 week DBT programme offering group and individual sessions. She had completed the programme within the three months prior to the interview. She was attending a vocational course at college.

Tara, an 18-year-old female who had completed a 16 week CAMHS DBT programme offering group only DBT. She spoke of experiencing other therapeutic interventions before being offered DBT. She was studying A levels at college. Tara had completed the programme in the two weeks prior to the interview.

Kirsty, an 18-year-old female who had completed in a 16 week CAMHS DBT programme offering group and individual sessions. She had completed the programme in the month prior to the interview. She was studying A' levels at college.

Rachel, a 17-year-old female who had completed a 16 week DBT programme offering group only DBT. She was studying A' levels at college. Rachel had completed the programme in the two weeks prior to the interview.

Sam, a 17-year-old female engaged in a 16 week DBT programme offering group and individual sessions. She was 13 weeks into the 16 week programme . She was studying A levels at college.

Louise, a 22-year-old female was six months into a 12 months programme with an adult mental health service DBT programme offering group and individual sessions. She was attending university. By some definitions Louise was considered to be an adolescent/young person although she was being treated in adult services (Sawyer, et al., 2018).

Practitioners taught mindfulness within different contexts and within different programmes. Practitioners had a variety of personal experience of mindfulness. Practitioners were also from different professional backgrounds.

Elaine, was a social worker. She was a group only DBT practitioner working with young people 14-18yrs old. Elaine's experience of mindfulness practice was through being a DBT practitioner. She noted that it took her 2 years to begin to understand mindfulness and only used it as it pertains to teaching in the group.

Grace, was a systemic psychotherapist. She was a group and individual DBT practitioner working with adults and young people. Grace had a small amount of personal experience of mindfulness. She explained how surprised she was that people are willing to give it a go and that they seem to want to do it.

Helen, was an occupational therapist. She was a group only DBT practitioner working with young people 14-18yrs old. Helen had a very small amount of experience of mindfulness associated with yoga practice. However, her understanding of the concepts of mindfulness came from teaching in DBT.

Julie, was a clinical psychologist. She was a group and individual DBT practitioner working with adults. Julie reported 25 years of personal experience of mindfulness and a lot of experience using mindfulness within therapy - including DBT and Acceptance and Commitment Therapy (ACT). Julie referred throughout her account to her personal and work related experience of mindfulness as being really important in the delivery of mindfulness in DBT.

Mark, was a clinical psychologist. He was a group and individual DBT practitioner working with adults. Mark's experience of mindfulness practice was through being a DBT practitioner. He noted that mindfulness was something that he now valued in his own life. Of note, Mark is the only male participant in the study.

Phoebe, was a nurse. She was a group and individual DBT practitioner working with young people 14-18 yrs old. Phoebe's experience of mindfulness practice was through being a DBT

practitioner. Phoebe spoke about herself as someone for whom mindfulness is difficult as she is easily distracted. Phoebe noted reluctance in herself to engage in mindfulness activities which encourage an internal focus.

Sarah, was a nurse. She was a group and individual DBT practitioner working with young people 14 – 18 years old and their parents. Although Sarah's initial contact with mindfulness was through being a DBT practitioner she had been attending a mindfulness course for her personal development. She spoke in the interview about the difference between the practice of mindfulness in DBT and her experience on the mindfulness course.

Michelle, was a nurse. She was a group and individual DBT practitioner working with young people 14 - 18 years old. Michelle's experience of mindfulness practice was through being a DBT practitioner. Although Michelle did not regularly practise mindfulness she did use examples in her account of when she had personally engaged with mindfulness.

The service user participant and practitioner participant groups were not homogenous in many ways: service users experienced mindfulness in DBT within different services, offering different DBT programmes delivered by different practitioners. The most that could be said about the homogeneity of the participants is that they had an experience of mindfulness in a programme that followed the principles of DBT to some extent. It is this homogeneity that has allowed for synthesis across cases.

The findings synthesise the experience of service user participants and practitioner participants and as such summarise the shared experience of participants in relation to the experience of mindfulness. Whilst each of the higher order concepts resonates across cases, the idiographic nature of the research highlights differences between experiences of each participant in relation to the concepts. For example, whilst Vicky experienced certainty with regard to the efficacy of mindfulness, Rachel and particularly Sam remained unconvinced of the place of mindfulness in their treatment. Similarly practitioners had a range of experience from utterly convinced (Julie) to entirely unsure (Pheobe). Therefore differences were evident with regard to some concepts: mindfulness is natural or unnatural; mindfulness is important or unimportant to DBT outcomes; service users enter into awareness or distract; with some participants presenting as negative cases to experiences that were consistent across other cases. For example Vicky presents as a negative case to the experience that mindfulness was strange and unnatural. Although negative cases offer some variance within the synthesis of findings and although thoughts about the reasons for the variance can be explored, causal and

deterministic connections cannot be made from analysis of the interview data. Many of the concepts that were generated presented as spectrums of experience with some participants being more or less certain, struggling more or less with mindfulness relative to each other indicating a complex set of factors that led to each participants' personal experience.

7.1.2 Format of findings

The higher order concepts (HOC) presented in this chapter represent a synthesis of the superordinate themes from both data sets. Each HOC is discussed with reference to both service user participant and practitioner participant superordinate themes that were used to generate the concept. A blue colour is used to indicate ***superordinate*** themes and ***subordinate*** themes that were generated from the service user data set. A green colour is used to indicate ***superordinate*** themes and ***subordinate*** themes that were generated from the practitioner data set. ***Higher order concepts*** are indicated by black bold font. Data extracts are used to illustrate the analytic interpretations that led to the development of each higher order concept. Data extracts from service user participant transcripts are indicated by indented italicised quotes and referenced with - **SUP** (to indicate service user) **Pseudonym Line number** for example SUP Louise 57 (time since starting/completing DBT programme). Practitioner participant data extracts are referenced with **PrP** (to indicate practitioner) **Pseudonym Line number**.

Chapter 8: Higher order concept - A struggle with uncertainty and challenge

The concept, **A struggle with *uncertainty and challenge*** was developed from the superordinate themes ***Being uncertain of how mindfulness will help; The challenge of mindfulness; Practitioners are uncertain of mindfulness in DBT*** and ***Striving to reduce uncertainty.***

The superordinate theme ***Being uncertain of how mindfulness will help*** is used to sum up the way in which service user participants responded to the experience of mindfulness. Service user participants had similar experiences that led to the generation of subordinate themes ***not seeking mindfulness but being told to engage with mindfulness*** and ***experiencing mindfulness as weird*****.** However, some service user participants became more convinced than others over time about the usefulness and need for mindfulness in helping them with their problems. The differences in the experience of uncertainty appeared to be connected to the predisposition of the service user for being open to trying something new and unconventional that they did not completely understand illustrated in the subordinate theme - ***suspending doubts***. There were also particular circumstances in the service user participant's lives that they associated with being ready or not to engage with mindfulness- ***Not everyone is ready for mindfulness***.

The superordinate theme ***Practitioners are uncertain of mindfulness in DBT*** was generated to illustrate the practitioner participant experience of uncertainty with regard to the necessity and usefulness of mindfulness in DBT. Practitioner participants had reservations that mindfulness was accessible to service user which generated the subordinate themes - ***Being unsure of the importance of mindfulness*** and ***Doubting that it is realistic for service users to be mindful***.

The superordinate theme ***The challenge of mindfulness*** was generated with reference to the subordinate themes ***Not always having the desire to be mindful, doubting personal ability to be mindful, mindfulness as contrary to everyday living*** and ***finding that mindfulness takes persistence***. The experience of challenge was universal but also idiosyncratic as each service

user struggled with their own particular difficulties arising from their particular set of circumstances.

Finally the superordinate theme ***Striving to reduce uncertainty and challenge*** was generated from the subordinate themes ***trying to apply it to everyday experiences, validating service user doubts*** and ***awareness of self–consciousness*** and illustrates that despite their best efforts practitioners doubts could be obstructive to teaching mindfulness with clarity and accuracy.

An overview of the Higher order concept as defined by the superordinate and subordinate themes and the codes used in the theme generation is provided in Table 35. This table illustrates the way in which the narrative across the whole data set was developed from coding parts of individual transcripts.

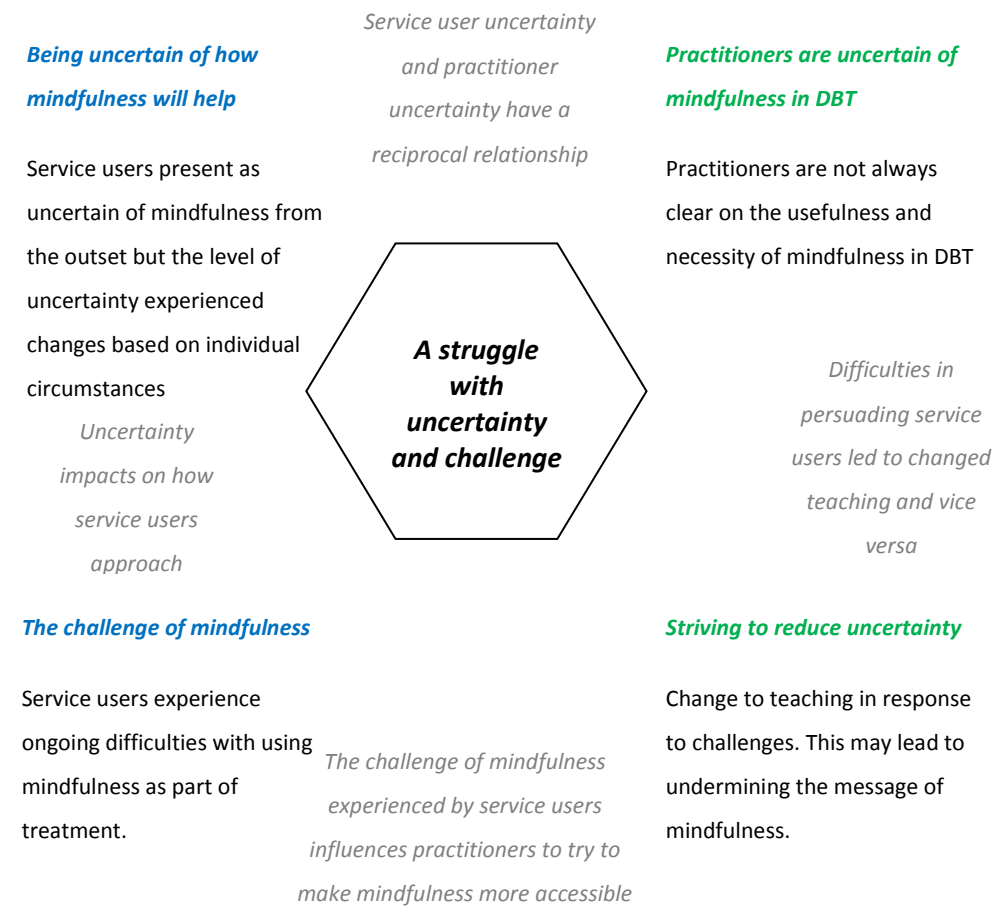
Table 35 Overview of themes and codes pertaining to higher order concept A struggle with uncertainty and challenge

Higher order concept	**A struggle with uncertainty and challenge**							
Service User Superordinate Themes	**Being uncertain of how mindfulness will help**				**The challenge of mindfulness**			
Service User Subordinate Themes	**Not seeking mindfulness but being told to engage with mindfulness**	**Experiencing mindfulness as weird**	**Suspending doubts**	**Not everyone is ready for mindfulness**	**Not always having the desire to be mindful**	**Doubting personal ability to be mindful**	**Mindfulness as contrary to everyday living**	**Finding that mindfulness takes persistence**
Codes	1. Beginnings 2. Uncertainty 3. Motivation 4. Imposed mindfulness 5. What's the point?	1. Mindfulness is weird 2. Strangeness	1. Then and Now 2. Journey from non-believer to believer 3. Approaching mindfulness 4. Experiential 5. Change of	1. Not plane sailing 2. Turning point 3. Waking Up 4. Little impact	1. Initial view of mindfulness 2. Is it relevant? 3. Wilful about being mindful	1. Barriers 2. Blocks to mindfulness 3. Confusion 4. I'm just not able to be mindful 5. Personal inability	1. In the now	1. Changing relationship 2. Practice 3. Need repetition

			opinion	5. Timing		6. Natural mindfulness		
Practitioner Superordinate Themes	**Practitioner participants are unsure of mindfulness in DBT**				**Striving to reduce uncertainty**			
Practitioner Subordinate Themes	**Doubting that it is realistic for service user participants to be mindful**	**Being unsure of the importance of mindfulness**			**Trying to apply it to everyday experiences**	**Validating service user participant doubts**	**Awareness of self - consciousness**	
Codes	1. Emotional dysregulation 2. Mindfulness is abstract 3. Difficulties for young people 4. Specific difficulties	1. Difficult to make it relevant 2. Important to other skills 3. Problems with mindfulness causing drop out 4. Practitioners find it difficult			1. Using it in the real world 2. Importance of generalising 3. People don't tend to generalise outside of group	1. Block of being told to do it 2. Find it invalidating at first 3. Acknowledging its weird 4. It ok to have doubts 5. Undermining the message	1. Fear of looking silly 2. Self-consciousness 3. Difficulties in group	

The interpretation of the way in which the experiences demonstrated by the superordinate themes interacted within ***a struggle with uncertainty and challenge*** is illustrated in Figure 25. The uncertainty faced by service users and practitioners were interdependent. Practitioner participants struggled to teach service users who were struggling with mindfulness when they shared service user doubts. Service users became somewhat unconvinced by uncertain explanations of the usefulness of mindfulness. The experience of uncertainty - ***Being uncertain of how mindfulness will help*** made it difficult to persist with difficulties of engaging with mindfulness – ***The challenge of mindfulness***. The superordinate theme - ***The challenge of mindfulness*** was developed from the service user participant data to demonstrate service user participants experienced difficulty in engaging with mindfulness in DBT. Practitioner participants were aware of the difficulties that service users faced in engaging in mindfulness in DBT and therefore began to modify the way in which they approached mindfulness teaching as illustrated by the superordinate theme - ***Striving to reduce uncertainty***. The experience of service users as uncertain and struggling and practitioner participants' personal doubts about mindfulness in DBT influenced whether practitioners were convinced of the usefulness of mindfulness in DBT - ***Practitioners are uncertain of mindfulness in DBT***. Practitioner participants strived to make mindfulness easier for service users - ***Striving to reduce uncertainty***, but at times diluted the teaching of mindfulness which may have made convincing service users to engage with mindfulness more difficult.

Figure 25 Higher order concept *A struggle with uncertainty and challenge* illustrated through the relationships between superordinate themes



8.1.1 Synthesis of subordinate themes pertaining to the higher order concept – A struggle with uncertainty and challenge

8.1.1.1 Superordinate themes Being uncertain how mindfulness will help and Practitioners are uncertain of mindfulness in DBT

The starting point for all service users was that they engaged with mindfulness because it was part of the DBT programme – ***Not seeking mindfulness but being told to engage with mindfulness***. The experience of being directed towards mindfulness led to uncertainty because the first experiences of mindfulness did not fit with the service user's expectations of what

would be helpful. The instruction service user participants were given with regard to mindfulness did not connect with service user participants ideas about what would help them with their problems; highlighted in the recurrent refrain - what's the point? As a result service user participants experienced doubts and became sceptical of mindfulness. Service user participants deferred to the expertise of professionals without any personal conviction that mindfulness would be helpful.

> *'yeah, you're like, well they've told me to do this thing so I'm gonna do it 'cos they know what they're talking about I guess [giggles], um, but it still seems a bit, like … yeah.'* SUP Louise 140 (six months into a twelve month programme)

Louise was uncertain that professionals really knew what they are doing when they offer mindfulness as a treatment, qualifying her trust in professionals with '*I guess'* and indicating continued uncertainty with an uncommitted ending to her thoughts *'it still seems a bit like….yeah'.* Service users experienced initial uncertainty about the place of mindfulness in their treatment and entering into mindfulness on the say so of others did not provide an adequate rationale to service users as to the reason to engage with mindfulness. Similarly practitioner participants exhibited uncertainty about mindfulness (***Being unsure of the importance of mindfulness***) and the ability for service users to use mindfulness (***Doubting that it is realistic for service user participants to be mindful***). Rachel used her experiences at school to try to make sense of her experience of mindfulness. Despite being told that mindfulness was useful it was experienced as disconnected to the goal of an improved life.

> *'Well, OK, OK. Um, … I, I went to a Catholic school, so I have a lot of experience with, like, ski-, like, kind of like, stupid, like, marking schemes, and like just unnecessary things that they bring, for example into an exam, or into like your everyday teaching and stuff, like … I can't remember what it was called but it was basically this thing they had to mark us on, and there was stuff in it like spelling and all that which is normal, but just so unnecessary, like, you don't need to make a scheme round it, just, it's common sense to mark on that kind of thing. And I just, just … I don't know, I guess I was just like* (mindfulness)*, just sounds like another unnecessary thing that they're bringing into the world that's going to get forgotten soon.'* SUP Rachel 119-121 (completed 16 week programme two weeks prior)

Rachel drew similarities between the frustration experienced at school when faced with apparently meaningless schemes and her experience of mindfulness in treatment. Service user participants were sceptical that mindfulness is necessary or meaningful to recovery. Sam's

experience of mindfulness led to a complete disconnection in her mind between mindfulness and getting help for her problems. She failed to see how anyone could be interested in or care about mindfulness.

> *'So, like, if I was explaining it to a friend, like, I'd just kind of, like, say, Yes it's an exercise. This is Mindfulness, and I'd just would, like, they'd probably, like, lost interest after, like, a minute; they'd be, like, OK, I don't really care.' SUP* Sam 334 (13 weeks into a 16 week programme)

Some service users spoke about it being the right time for them to accept mindfulness as part of the solution to their problems- ***Not everyone is ready for mindfulness*****.** The timing being right was connected to the experience of other therapies failing to make a difference and being unable/ unwilling to tolerate their problems any further.

> *'I'd been in counselling for a lot of years, and kind of the talking therapy wasn't working for me, and coming into this group and kind of being given the chance to help myself, I think I was ready to do that* (help myself)*, and I was ready to go on from that and kind of improve my life myself, rather than getting talking therapy help and all the other stuff.'* SUP Tara 186 (completed 16 week programme two weeks prior)

Tara noted that a greater level of self- efficacy in dealing with her problems had been influential in improving her life and may have made her more inclined to engage with mindfulness. Other service users noted that perhaps the timing of being taught mindfulness was not right for them and wondered if mindfulness was something they would come back to later. Being ready for mindfulness (perhaps cognitively or emotionally) or being mature enough for mindfulness were ideas shared by both practitioner and service user participants. For example, Rachel struggled with her level of scepticism and wanted to see mindfulness make a difference in her life but the timing was not right for her. In fact she could not see mindfulness being relevant until she was old – in sixty years' time she would be seventy-seven suggesting that she thought that she was currently too young to make use of mindfulness.

> '*hopefully, hopefully, so I can actually manage my illness. Um, but it* (mindfulness) *will become, like, a core thing. I don't know. Conscious decision of, right lets test out those* (mindfulness) *techniques that those people taught me sixty years ago [laughs]. Um … [long pause]. Yeah. I probably will remember, like, some stuff* (mindfulness).' SUP Rachel 281 (completed 16 week programme two weeks prior)

Overall there was not a clear reason for time being right to be taught mindfulness. Service user participants made suggestions about needing to be at the right developmental stage, for example being young being a barrier to mindfulness. There was also suggestion that specific circumstances may provide a turning point in having a greater desire for change and therefore openness to trying anything, including mindfulness. However, the reason that some service users took to mindfulness when others did not remained unclear.

Practitioner participants also had ideas about what made circumstances right for engaging in mindfulness. When talking about service users who found it difficult to engage with mindfulness practitioners spoke about service users not being ready(Mark), not being mature enough (Helen, Michelle) or being too traumatised to access mindfulness (Julie, Grace). Practitioners doubted that service users could fully engage with mindfulness due to developmental, circumstantial or personality factors. ***Doubting that it is realistic for service users to be mindful***

Barriers to engaging with mindfulness were identified in the observations of practitioner participants often in response to the interview question: Think of a time that particularly stands out when you have been doing mindfulness with an individual or in a group when you believed they were not really getting mindfulness? Practitioner participants described a sense of individual barriers to mindfulness and this seemed to undermine practitioner participants' confidence that mindfulness would be accessible and helpful to service users. However, practitioners continued to teach mindfulness, because they seemed to believe it could be useful if barriers were surmounted or simply because it was part of the DBT programme. Phoebe noted that service users being asked to approach mindfulness in the context of DBT were likely to be emotionally dysregulated, making it even more difficult for them to access mindfulness.

> *'And I also think that what we're asking, when we're asking people to be mindful it's really difficult for them to be mindful, 'cos I find it difficult, and I'm not emotionally dysregulated. So I imagine if I'm asking a young person to try and be mindful when they're dis-regulated it must be really difficult for them. So I think that's probably what gets in the way of it.'* PrP Phoebe 11

Phoebe noted how she finds mindfulness difficult for herself and therefore hypothesises that a service user who is emotionally dysregulated would find mindfulness more difficult. Elsewhere Phoebe notes a personal difficulty with sitting in silence. Practitioners who experienced

personal barriers to mindfulness found it particularly challenging to teach mindfulness to service users.

The ability to be mindful as a result of being taught mindfulness was not thought to be universal, with practitioner participants talking about some service users being more able to engage with mindfulness than others.

> *'so the people that I've had the better experience with I think tend to the ones where I'm pushing a bit on an open door anyway. You know, it kind of works with them that kind of idea. Um, whereas the ones that are more, um - er, what's the word? – um, you know, the ones that are a bit more impulsive for example, find that sort of more difficult.'* PrP Michelle 11

The idea of pushing on an open door also suggests that practitioners were coming across some service users who presented with trait mindfulness, those who had developed characteristics of mindfulness in their approach to everyday experiences. Service users had also identified that innate abilities also had an impact on how easily people could use mindfulness (Rachel – 'unless you're like Buddha'). However, more often practitioners identified a range of internal and external factors (high level of self-criticism; experience of trauma; difficulties with concentration; chaotic living environment; neurodevelopment difference; age; previous negative experience of mindfulness) that they considered impeded the way in which service users were able to use mindfulness. Sarah shared her thoughts that gender had an influence on engagement with mindfulness:

> *'I think men … when you're talking to them about it, so I've got one a Polish father who I think, if we're talking about emotions, is a, he's a … look it clearly makes him feel very uncomfortable. Um … and I think there's something about that introspection that we in this culture are probably more used to doing than in other culture. And then plus gender – I think men are less likely to share.'* SUP Sarah 15

Helen wondered if those more prone to hyperactivity would struggle more with accessing mindfulness.

> *'and ones* (service users) *that have been quite restless, and like a bit kind of hyper and fidgety, they seem to struggle with doing it for very long. Um, whether it might be sitting still, or … yeah, like refraining from um, impulses. Yeah.'* SUP Helen 54

Being a young person was also highlighted as a potential barrier to being ready for mindfulness.

> *'I am interested in how, um, [sighs], how it's received by adolescents as opposed to adults, and whether some of the expectations of Mindfulness at adolescence, you know, if we're following the, the sort of, you know, the programme, is, you know, I do sort of wonder how realistic it is for, for some adolescents to take that on, and whether they feel like quite sort of mature concepts, um …'* SUP Michelle 207

The idea, borne out in Michelle's experience, that adolescence is developmentally at odds with the teaching of mindfulness was shared by other practitioners (Helen, Phoebe, Elaine). Practitioner and service user experience suggests that trait mindfulness is developmental in nature and not innate, with the ability to be mindful being associated with cognitive maturity i.e. metacognition or with the development of emotional regulation both of which are developing throughout adolescence (Schneider, 2008; Ahmed et al. 2015).

Each practitioner spoke about an individual difference at some point in their accounts that they cited as reason for the particular individual finding mindfulness difficult. Overall there was a feeling that mindfulness was more accessible to some people due to their particular set of experiences and disposition. The subordinate theme ***Doubting that it is realistic for service users to be mindful*** is particularly diverse in identifying individual differences that may prevent engagement with mindfulness, illustrating the complexities of teaching mindfulness to a group of people that have such a spread of experiences and pre-dispositions.

Practitioner participants understood and often shared service users' uncertainty about mindfulness. They did not see service users as wilfully avoiding engaging with mindfulness. Many practitioners shared the experience of struggling to develop mindfulness and identified that the group of service users they were teaching had additional difficulties that made engaging mindfulness very difficult.

8.1.1.2 Superordinate themes The challenge of mindfulness and Striving to reduce uncertainty

Service user participants questioned whether everyone had the ability to be mindful - ***Doubting personal ability to be mindful***. Engaging in mindfulness was averse because service users found themselves unable to partake comfortably in the exercises. Not being logical enough, calm enough, focused enough, clever enough were all reasons given for the inability

to engage in mindfulness. Sam's experience was of an inability to engage with Wise Mind – one of the mindfulness skills taught in DBT.

> *'I just … I just stay in emotional mind. I don't … I, like, I can, I don't … wise mind just doesn't exist within me, like, I just, I can't do it. Yeah. I don't know. I'm not … yeah, I don't know, I, I'm not a very logical person anyway, so no. I don't know. Oh well.'* SUP Sam 248 (13 weeks into a 16 week programme)

The notion that mindfulness is more natural to some people than others resonates with the idea of trait mindfulness. If there is a spectrum of being more or less mindful there is a suggestion that there is a spectrum of ability to be more or less mindful. Some service user participants experienced mindfulness as being beyond their capability. Louise experienced that her struggle to use visualisation became a barrier to engaging in some of the mindfulness exercises. She wondered if this could improve or if she should focus on other types of mindfulness exercise.

> *'I can't visualise things very well. But I'm like … its, it's a bit hard to work out whether, so should I try and improve on that, or does it not matter, and I should just go with the stuff that works, or seems to be, like, going OK, and that I like.'* PT Louise 258 (six months into a twelve month programme)

Service users were unsure whether to practice more in an effort to overcome the difficulties with mindfulness or whether to stick with the things that came more naturally. Aversive experiences of mindfulness seemed to re-enforce service user participants idea that they were deficient in some way, which rendered them incapable of learning mindfulness. The feeling of not being able may not be based on actual ability. Service users use of words such as 'should' and terms such as 'not (imaginative, calm, logical) enough' indicated an idea of being deficient. This was interpreted as some service user participants (Louise, Sam, Rachel) believing they were simply not good enough to do mindfulness. Such a response could undermine attempts to engage with mindfulness.

Service user participants were baffled by mindfulness, especially the connection of the mindfulness exercises used in the group and the helpfulness in everyday life. Service user participants were confused about why they were being asked to do mindfulness exercises - the exercises had no meaning for them. Philippa was unable to see the point in the first mindfulness exercise that she encountered; in fact the experience just caused her to laugh.

> *'so I'm just like looking around the room at different things. And I was just sitting there, I was just like, why? What, What's the point in this? We're just sitting here doing nothing, listening to some recording that just makes me laugh a little bit.' SUP* Philippa 166 (completed 16 week programme 3 months prior)

The idea of just sitting there was used a way of describing the experience of mindfulness by a number of participants (Louise, Philippa, Kirsty) in a way that suggested their experience of mindfulness was somewhat underwhelming, perhaps falling short of expectations of what a therapeutic intervention should be. Philippa's experience of laughing along with giggling and bemused embarrassment about the mindfulness exercises was common across the service user participant accounts. In fact encountering mindfulness as part of a treatment for a mental health problem proved to be a strange experience for the service users - ***Experiencing mindfulness as weird***. Being unsure of the purpose of mindfulness and engaging in mindfulness exercises that seemed to lack purpose such as staring at a coin led to a sense of mindfulness being silly or weird. The words weird, strange, silly, odd were all used to describe the unfamiliarity and awkwardness of the mindfulness exercises.

> *'I was just thinking, this is, like, really weird, like, why are we doing this? Like, I don't think this is going to help me in any way. But, like, that, that's what I kind of thought in the first kind of session.'* SUP Kirsty 106 (completed 16 week programme in the month prior)

Louise referred to mindfulness throughout her account as 'new age' and 'hippy' which suggested to me that she believed mindfulness lacked scientific substance as the term new age is related to mystical and not scientific practices. Service users desired to understand why mindfulness should produce any change at all from silly, meaningless exercises. They were unable to make links between activities such as staring at a coin or focusing on the sounds in the room with tangible changes to their lives. They were left feeling confused and self – conscious.

> *'I w-, I was like, What is this? But everyone else was kind of doing it, so you just do it as well. It makes you feel, like, silly in a way. Um ..... You're just sitting down, like, looking at a coin, or like, really, really focusing on eating a piece of orange, so it does seem a little bit silly, like, explaining it to somebody would seem really silly.' SUP* Louise 336-340 (six months into a twelve month programme)

Practitioners experienced that the group situation made people self-conscious and less able to settle into mindfulness- ***Awareness of self –consciousness***

> *'I think when they're in the group practising it they're often not practising it because they're very distracted by kind of other people that in the room with them, and they seem to feel quite silly; I think they feel quite silly sometimes, and it feels really unnatural. Um … and so they tend to get quite giggly, um, and not necessarily er, able to, to practise it very well in the session.'* PrP Helen 4

Practitioners observed feelings of silliness about mindfulness which led to being giggly. This self-consciousness may be related to the way in which mindfulness is not socially congruent. Most people rarely experience doing things with others, being silent and staying still. Therefore the experience of mindfulness in DBT becomes awkward and embarrassing. These feelings were also experienced by practitioners perhaps making them uncomfortable with what they were teaching.

Practitioner participants spoke about mindfulness in DBT in a way that suggested variance in individual certainty about the need and usefulness of teaching mindfulness. Julie expressed concerns about the message that inexperienced practitioners would give service users about how mindfulness could help.

> *'the biggest risk in, you know, when staff don't practise mindfulness much themselves, or aren't very experienced at using mindfulness clinically, is that you use it like a prescription, and then you are unintentionally, or unwittingly, giving the wrong message to the client. You're giving the client the message that if you do this you will feel better, and you should never, ever give them that message. That is not the purpose of mindfulness. If you feel better it's a bonus, it's not the primary intention. And you only really understand that if you practise a lot of mindfulness yourself.'* PrP Julie 203

Julie has strong ideas that it is not the intention that engaging with mindfulness will bring immediate relief from distress and that to teach this notion would be misleading. However, because service user participants were looking for relief from distress they found it difficult to understand the point of mindfulness (***Being uncertain of how mindfulness will help***). The

intention of using mindfulness as treatment was at odds between practitioners and service user participants.

The notion that the wrong message could be given with regard to mindfulness was shared by Mark. Mark noted that being professionally and personally inexperienced with mindfulness made it hard to explain to service users how mindfulness as part of the DBT programme may be useful to them.

> *'I think you need to go and explain it all* (mindfulness) *[sighs] properly in terms of … yeah, more of why it's helpful and what it is and what it isn't for, um … it's quite a difficult sell, to sell to people, this idea you're sitting with difficult stuff sometimes. Um … The thing that I think is the main thing, um, when people are new to it* (mindfulness) *and teaching it in a group, they'll often read from the script, yeah, um, which is not necessarily a problem, but I think it … [sighs] … can become a bit um, limited, you know, a bit stunted trying to do the same things, and I think clients know if you're reading from a script*' PrP Mark 105

Mark seemed to suggest that the concept of mindfulness may seem somewhat inauthentic to service users if the person explaining the concept is relatively inexperienced and knowledgeable of mindfulness themselves. Doubts about usefulness of mindfulness and whether mindfulness could be taught effectively as part of treatment seemed to lead practitioners to become awkward about teaching mindfulness.

> '*I think it's a really useful thing to do, and the idea that we can teach it as a skill really appeals to me, to say to someone that could develop a skill of being mindful, I really like that idea. But I don't know how much of it is a skill and how teachable it is. That's my experience. It's a really hard thing to teach, and maybe it's more of an emotion or a, a way of being that is hard to put those kind of clear, rational this is how you do it.'* PrP Elaine 140

The idea that mindfulness as unteachable, that it cannot be distilled into a skills based programme was a challenge for practitioner participants tasked with imparting mindfulness to service users in need of support. The idea that there is something unteachable about mindfulness was resonated in Tara's account of understanding mindfulness through doing it rather than being taught it. Tara persisted with mindfulness because it proved useful to her in dealing with their problems.

> *''cos she was, like, but why? Why, why do you do this? And I said because it helps, I don't know. I, I don't really … 'cos I'm, I know what it is but I just can't describe it to someone; and I know why I do it but I can't … it's difficult to kind of tell people. Like, when they told us I didn't really understand, but through doing it I started to understand it from my point of view. And I think that's the only way anyone's ever going to understand it.'* SUP Tara 162(completed 16 week programme two weeks prior)

Practitioners experienced service users as often sceptical about mindfulness, finding mindfulness silly or irrelevant to their situation. As many of the practitioners had experienced their own doubts or difficulties with mindfulness they were able to genuinely validate the doubts of the service users - ***Validating service user doubts***. Mark spoke about sharing his personal experience of mindfulness as strange in order to let service users know that this was a normal experience of mindfulness.

> *'really just, you know, normalise these kind of, um … yeah, yeah, thoughts people have about it being strange, because it is a strange thing; it's very different to what you usually do, that's why it's good, but it, it is, it is … a bit whacky. [laughs]. It really is.'* PrP Mark 141

Practitioners were able to identify with the experience of the strangeness of mindfulness because they had this experience also. By speaking from their own experience practitioners were able to encourage service users to stick at mindfulness with the knowledge that over time it begins to make more sense.

> '*I guess saying to people this won't, this will take a long time, this is not something that session one, two, three you'll just get, and it will make sense, it is going to seem strange and it will seem strange for ages. And the idea that practising though, making time to do it, sort of forcing yourself to do it is a useful thing to do.' PrP Elaine 190*

Elaine's experience of mindfulness taking time to develop and therefore feeling strange for a long time resonates with service user participant experiences of strangeness leading to doubts about usefulness and the need for persistence being a barrier to engagement. Practitioner participants whose experience of mindfulness was somewhat averse, found encouraging service users to engage with mindfulness difficult. Too much focus on validating mindfulness as difficult may have had the effect of giving the message that mindfulness is in fact too difficult.

Keeping eyes open; refraining from spending too much time on mindfulness exercises or making the participation in a mindfulness exercise optional all indicated that practitioners had doubts about whether mindfulness was the right approach to be taking. Grace noted the caveats she used when introducing mindfulness exercises to service users.

> *'people have been very, you know, they've really not wanted to close their eyes. So we make it very clear that, that people don't have to do that, and, you know, we make it very clear they don't have to do any, you know, they can par-, just participate as much as they can .....and you know, where … we always say to people, If you need to leave the room that's absolutely fine, but if you could just try and do it as quietly as you can, and try and bring yourself back in again.'* PrP Grace 109-111

Trying to make the experience of mindfulness as comfortable as possible for service users may inadvertently reinforce the notion that mindfulness is scary and that service users may not be able to cope with the thoughts or feelings that arise. There may therefore be a balance to be struck between highlighting that mindfulness is often experienced as weird or uncomfortable and reassuring service users that whilst difficult mindfulness has been experienced as helpful by many people.

At times it seemed that service user participants chose to suspend their uncertainty and enter into the experience alongside fellow group members - ***suspending doubts.*** I interpreted the notion that 'everyone was doing it so I did it too' and 'it was just what we did in group' as service user participants suspending doubts on the basis of social conformity. I also conceptualised that being generally open to new things, as indicated by openness in other areas of experience enabled some service user participants to suspend their doubts.

Service user participant Vicky presented as a negative case to the experience of uncertainty from the outset. Vicky wondered whether people may be using aspects of mindfulness without realising it. This seemed to make the idea of mindfulness simpler and not as confusing to Vicky and she continued to speak of mindfulness as mainly straight forward throughout her.

> '*Um … I think how it was quite a simple thing, and that maybe some sort of observing we might do sort of naturally without realising it, how maybe some of us do it without realising it quite a lot.'* SUP *Vicky 68* (15 weeks into a 16 week programme)

Identifying Vicky as a negative case suggested that rather than mindfulness necessarily causing uncertainty that the experience of uncertainty was influenced in some way by service user participants' particular circumstances. It may be that Vicky had fewer of the personal

characteristics that were identified as barriers to mindfulness and more of the characteristics that led to suspending doubts. It may be that Vicky possessed trait mindfulness before encountering mindfulness as an intervention and therefore she was more able to make use of the mindfulness that was taught.

The ability of the practitioner to deliver the concepts of mindfulness was seen as closely connected to how receptive the service users were – 'an open doorway'. The combination of a belief that service users may not be receptive coupled with practitioner difficulties in understanding and experiencing mindfulness for themselves led to a variation of certainty as to the place of mindfulness as part of DBT treatment.

Practitioner participants spoke of mindfulness being a very difficult concept and this was another reason to be uncertain of the usefulness of mindfulness in DBT. Practitioner participants observed that it was not easily apparent to people what they were being asked to do and why. The concept of mindfulness was described to be abstract and very different to the usual language of everyday life leaving service users 'bamboozled' (Sarah) by mindfulness.

> *'I think that young people will always struggle to get it (mindfulness) at the beginning. But I'm not sure particularly there's anything that we do that could change that, because I think that the concept of it (mindfulness) is really difficult. So I think they will always struggle with that.'* PrP Pheobe 148

Pheobe noted the challenge of understanding mindfulness for herself and young people, a barrier that she thought would be present regardless of practitioner approach. Practitioners spoke about having difficulty understanding and explaining mindfulness because they saw it as a complex concept. It was hard for practitioners to find the words to describe the benefits that service users could get from mindfulness, especially because some were unsure of the benefits themselves**.** Helen was wary that service user may have preconceived ideas about mindfulness and therefore tried to convey the concepts of mindfulness through situations that may be familiar to the service users. Perhaps highlighting, as Vicky did, that mindfulness may be more of a natural occurrence that it first seems.

> *'sometimes I've tended not to, … maybe with certain people not to kind of start off by saying "mindfulness" 'cos it seems like they, whatever they associate that with sometimes they can kind of dismiss it. Um … I've tried to kind of relate to practical things, I'll be quite practical with it, 'cos it's quite abstract I guess; I think that's because some people struggle with that.' PrP* Helen 86

Making mindfulness practical in an effort to make it more tangible led practitioners towards activity based mindfulness. This approach proved to have pros and cons in terms of what service users gleaned with regards the purpose of mindfulness: to distract externally or become aware internally (***Should mindfulness be used to be aware of painful thoughts or emotions or to zone out?***).

Practitioner participants use of the words persuade, compel, sell was interpreted as mindfulness being a concept that is not readily accepted in therapy. Michelle seemed to desire to be more convincing in her teaching of mindfulness and wondered if being an expert with regard to mindfulness would increase her confidence. However, she seemed to have been unable to maintain the understanding that she had of mindfulness when she was at the training being compelled by the experts.

> *'you know, like any behaviour becomes self-perpetuating, I doubt that I'm going to do it* (teach mindfulness) *very convincingly and therefore I, you know, I'm sure it's a classic thing – if you're more confident you know when you go on the DBT training and you have these experts and they're an amazing team, well just like that [laughs]. Um, and a lot of what, you know, I think a lot of the good DBT training is actually they are very confident, um, and that's very compelling.'* PrP Michelle 9

Some of the difficulty in persuading service users to engage with mindfulness seemed to be connected with practitioner participants doubts that mindfulness was a useful and necessary part of DBT - ***Being unsure of the importance of mindfulness***. At first mindfulness felt abnormal and uncomfortable for many practitioner participants, as it had for service user participants. Elaine noted that she persisted with mindfulness because it was part of the DBT programme that she was teaching.

> *'But because I've had to … because I've run the group and had to kind of show this is how you do it, by doing it I've got more comfortable doing it, and now I feel like it's a more normal thing to do.'* PrP Elaine 186

Practitioners did not necessarily value the experience of mindfulness themselves. Mindfulness seemed to be taught at times because that was what was expected not because it was meaningful to the practitioner. Mark noted the way in which this connected to the experience of service users.

> *'sometimes in the DBT consult I think it kind of can be seen as sometimes a bit, sort of, just like tokenist, like … Ooh, just do the mindfulness, sort of, let's get on with it.*

> *Um … which may well be exactly how our clients are doing it. It's tokenistic and weird little ritual we have at the start of your session.' PrP* Mark 173

The practitioner participants indicated that mindfulness was important for the development of other skills. However, different practitioners had different experience of the necessity of mindfulness to gain benefit from DBT. Mark saw mindfulness as essential to DBT and had observed service users who encountered problems with mindfulness to disengage from DBT therapy.

> *'Mindfulness is an integral part of DBT and er, it's er… it's not … you can't compromise on it really; you can't negotiate um, if, you know, it is as simple as this, even if you don't want to do Mindfulness you're out of DBT because it's such an important part; it flows to everything in DBT you do you know; all the different modules, it's a part of it because it affects, you know, it's part of distress tolerance it's part of emotional regulation; it's important in its own right.'* PrP Mark 39

Mark and all of the other practitioners spoke about mindfulness as helpful in developing the other skills in DBT. However there was a level of divergence in practitioner participants' views on the centrality of mindfulness in DBT. Elaine noted it was other skills that the young people that she taught were drawn to.

> *'I don't get many young people saying this week I was really mindful, or I used mindfulness. I don't often hear that. Um … so that's when I think even though we're making them do it it's not a natural one they're drawn towards.'* PrP Elaine 206

Elaine's observation that mindfulness is not a natural skill fits with the experience of most of the service users with the exception of Vicky. This extends the question about whether mindfulness is accessible to everyone. There is a dilemma about the access to DBT with or without engagement in mindfulness. Whether mindfulness is core to the benefits of DBT or whether the other skills taught in DBT are adequate to help the service user is not established in the research and practitioners struggled to know whether it was worthwhile to continue with DBT without service user engagement in mindfulness.

All service users spoke about mindfulness being difficult in some way. Service users spoke about believing that they *should* be doing mindfulness; *should* try harder and described how exercises were *supposed* to be done. At times there was a lack of desire to engage with mindfulness due to a strong emotion, feeling physically unwell or tired. However, at times

service user participants simply did not want to engage in mindfulness - ***Not always having the desire to engage with mindfulness***.

> *''cos I wouldn't really be that motivated to do it* (mindfulness)*, so it's, like, … it would feel like … it's kind of like when you've got, like, homework or something and you're just like I really can't be bothered to do it. Like I feel like I'd be like that, and I'd be like, Well seeing as I don't have to do it, I might just not do it.'* SUP Sam 472 (13 weeks into a 16 week programme)

The idea of mindfulness as mandatory homework was not appealing and had the effect of reducing motivation to engage with mindfulness. Philippa related to mindfulness as doing it because I have to do it and that this stemmed from being in a *'wilful mood'.*

> *'There, there has been, yes, when I've been in er, what they would call "Wilful moods" where I'm just stubborn and not wanting to do part, and doing it* (mindfulness)*because I have to do it, not because I feel it will help. And that's kind of, the kicker with Mindfulness – if you don't want to do it it's not going to work.' SUP Philippa 132* (completed 16 week programme three months prior)

The term wilful was used by Philippa and Vicky to describe times when they did not choose to use mindfulness despite believing this would have led to a better outcome. Other service users Sam and Rachel described choosing not to be mindful at times that they thought it would be useful because they didn't want to.

Vicky spoke about a dilemma of whether to be mindful when she didn't want to be. This process caused some stress for her as on the whole she believed that mindfulness was a good thing. For Vicky the idea of overcoming wilfulness has a feel of overcoming a weakness of some sort. That if only she was better, more willing, she could experience the benefit of mindfulness.

> *'Um, I think sometimes if I, I don't particularly want to do it* (mindfulness)*, you know, it's quite hard to overcome, you know. Um, I think there are Mindful, Mindfulness activities that you can do to overcome wilfulness, but if you don't want to do one in the first place it doesn't really help to then be stressed into doing one to overcome the wilfulness, you know.'* SUP Vicky 299 (15 weeks into a 16 week programme)

Wilfulness or lacking the desire to be mindful is likely to be a much more complex phenomenon than just not being bothered or being stubborn. Service users indicated that

engaging with mindfulness was not always advantageous. Exposure to negative thoughts during mindfulness and the desire to be reactive to emotions made service users less likely to engage with mindfulness.

Rachel questioned whether she should be mindful against her will. She suspected that there was something important to her about going with her emotion rather than holding it back through mindfulness. She saw mindfulness as emotional control and therefore had a dilemma about whether to experience her emotion fully or to suppress it.

> 'Er, first probably 'cos I didn't know that, but sometimes you're just so angry, or upset, and like there's a little voice in your head that's saying, Well maybe you should try and be mindful, and then you're like, Nah! Nah. Not right now.....Like, you know the same situation is like you kind of enjoy being angry, like, [shouting] like I'm letting out so much steam right now, this is amazing. You also can end up like hands on the ceiling, so don't like, you know, … in the moment you're like this is wonderful, I haven't, I haven't shouted at anyone in ages. Um, and I guess I don't use it then. Or, when I'm feeling like really sad. You know, sometimes sadness is, like, really addictive, and you just kind of … you're sucked into a black hole, and actually it's like, Just leave me here, I want to stay here in my dark pit of sadness.' SUP Rachel 237 - 241 (completed 16 week programme two weeks prior)

The interpretation of Rachel's account was that she was not willing to let mindfulness interfere with her lively yet tricky emotional life. She had the desire for emotional reactivity rather than a measured calm response to her emotional state and she did not see mindfulness as compatible with experiencing her emotions fully.

Service user participants varied somewhat in the way they experienced mindfulness as feeling natural or unnatural in their everyday lives but all found some aspects of mindfulness as contrary to how they lived their lives, ***Mindfulness as contrary to everyday living***. As illustrated earlier Vicky was a negative case in terms of experiencing mindfulness as completely natural, although she did talk about some difficulties with participating in mindfulness activities and using progressive relaxation.

The DBT mindfulness skill of 'non-judgemental' was particularly troublesome to service users. Not judging themselves or others did not come naturally to service users and was an area of discomfort. The accounts highlighted that service users were unsure if they had the capacity for being non-judgemental; whether being non-judgemental was possible and whether it was

desirable. Service users struggled to explain the concept of non-judgemental. Service users seemed doubtful that being non-judgemental was a realistic skill to develop. Kirsty noted that being non-judgemental was contrary to the social norms that she was familiar with.

> *'we were meant to, like, not judge when we're judging other people, like not judging ourselves when we're judging other people. And, like, that's actually really hard, because like, obviously, like, everyone judges everyone else, like that's just, like, a normal society.'* SUP Kirsty 432 (completed 16 week programme in the month prior)

The process of noting wandering thoughts and refocusing on a particular stimulus presented Rachel with a paradox about the way in which the mind works – she could not understand how she was to notice that her mind had wandered because the fact that her mind had wandered meant she was unaware that she was no longer focused.

> *'Unless … unless … unless a thought brings you back into the moment, there's no way of forcefully bringing yourself back if you're not thinking about it. Like, 'cos you know you can only focus on one thing … like, you can't control something that you don't know it's happening – I do-, it's like giving me, like, a mental breakdown; I can't think about it, great. Do you know what I mean, really? I don't know.'* SUP Rachel 63 (completed 16 week programme two weeks prior)

Rachel later went on to state the 'unless you're Buddha' that mindfulness would be contrary to the natural way of being. Suggesting to me that for Rachel mindfulness was not a natural state of being. Service user participants were unsure whether they could change the natural, unmindful, state of their lives.

Practitioner participants sought to make mindfulness more tangible to service users by ***trying to apply it to everyday experiences***. Practitioners stated over and over that unless mindfulness made it out of the group situation and into the lives of their service users that it would have little impact.

> *'Well we're trying … the way we teach it in DBT, the DBT that we do, we say there's two parts , we say there's the meditation practice and there's the mind-, trying to be more mindful in your every-day life. And I supose that's, in a way, more what we're focusing on. So we're trying to focus, that it gradually, it will open back into their everyday life, and they'll be much more mindful of how they are thinking;'* PrP Grace 121

Grace saw everyday mindfulness as awareness of feelings. She talked about this as a gradual extrapolation from the activities that are done in the group to everyday life. However, it is not clear in her description how this transfer from group to everyday life will happen. Practitioners seemed keen to demystify mindfulness as a state that can only be reached through meditation and connect people to the state of mindfulness that can be experienced through being immersed in an activity. This type of everyday mindfulness focused less on awareness of particular emotional states or thoughts and was more intuitive in nature. Practitioners looked for moments of spontaneous mindfulness to illustrate mindfulness in everyday life.

> *'So, when I've related it so, talked about, like, just being in the moment and being with the flow, and when you are doing an activity that you're just really in the zone and you're not thinking about this or that, um, and ask them to think of a time when they were experiencing that. Um, they seem to have responded quite well to that and kind of got that and said Oh, well, you know, there was a time when I was um, climbing, or I don't know, doing something like that, when they're just kind of really in the moment and they could … that … people seem to respond quite well to that because they can relate to actual experiences they've had where they are quite in the moment, without … and then kind of linking that to mindfulness'* PrP Helen 86

Illustrating concepts of mindfulness through mindfulness exercises was noted by practitioners to be misconstrued by service users, observing that service users used the exercises at home rather than applying the concepts to everyday activities.

> ''Cos I think that's what people get caught up in; I think they get caught up in having to do a mindful act-, mindfulness activity rather than being mindful in general. And the young people that I've found it really works with have started building it into their everyday lives, and when they're using the other skills they'll be, Oh I'm doing that mindfully, and then they'll suddenly get it, and they'll, and it will suddenly work.' PrP Phoebe 15

Phoebe noted that mindfulness was helpful to the young people using mindfulness in everyday life; perhaps cultivating trait rather that state mindfulness.

A few participants noted that mindfulness was present in their lives at times other than situations where they were particularly struggling with unwanted experiences. They spoke of being mindful about everyday occurrences.

> *'when I'm doing coursework I guess I'm mindful, because I'm completely focused on the coursework. Stuff like that. I've never really thought of it before, but yeah, I guess that you are, like, I cook a lot for myself now 'cos I'm 18, so yeah I guess you are mind-, well I am mindful a lot, but like in situation rather than just taking a step back from things. I don't know, I've never thought of it like that.'* SUP Tara 174 (completed 16 week programme two weeks prior)

Tara becomes aware that she does some activities mindfully in her life without intending to. It is not connected to an intentional step back to gain a new perspective on a situation. Mindfulness of everyday life was secondary to dealing with stress and was not as conscious to service users.

> 'sometimes it's like on holiday I was kind of snorkelling and stuff, and like just watching the fish, and I was suddenly like, I'm probably being mindful right now, 'cos I'm doing one thing, like, in the moment using beginners mind, kind of thing, so I'm probably doing mindfulness right now [giggles] without kind of realising it.' SUP Louise 210 (six months into a twelve month programme)

The subordinate theme ***developing mindfulness takes persistence*** was widely acknowledged by service user participants. Repetition, frequency and effort were all suggested by participants as necessary to become accomplished in mindfulness. By sticking at it, giving it go service users had some experience that re-enforced further engagement with mindfulness. Philippa gave mindfulness a go and had experiences that made her think mindfulness maybe helpful to her.

> *'like OK, let's stop being bitchy about it, and lets just sit down, give it* (mindfulness) *a go and see what happens. And the first time I did it and I did it, and yeah, it worked a bit, and I just felt a bit more calm. I was like, Ooh! OK, this could be going somewhere. And so I tried a little bit more to be more enthusiastic about it, and it really helped.' SUP* Philippa 453 (completed 16 week programme three months prior)

Service users experienced that mindfulness can't be rushed, by approaching mindfulness with haste the experience would not be adequate enough to encourage further practise. Service users noted that mindfulness requires a patient approach so as to not become frustrated with the process.

The recognition that mindfulness takes time and practice was difficult. Engaging with mindfulness repeatedly over time seemed to be difficult for some of the service users and the

experience that mindfulness did not offer a quick solution to their problems made engaging in mindfulness aversive. Sam noted that her personality was one which liked to master things quickly. This seems to stop her before she has started to encounter mindfulness.

> ''*Cos I know pe-, like I know what some of them have said, like, oh, that you have to, like, practise it a lot. But I'm, like, the worst person at practising things, like. I just want to … when they say practise I just want to be good at it now, like, I hate, I hate having to, like, persevere or whatever; I just wanna know how to do it now. So probably, like, I dunno. Maybe they're quite patient people. I'm just, like, guessing really, I don't know.'* SUP Sam 394 (13 weeks into a 16 week programme)

8.1.2 Discussion of the higher order concept - A struggle with uncertainty and challenge

The experience of the participants in this study was that mindfulness as taught in DBT is experienced as challenging to both service user and practitioner participants. The combination of initial confusion and doubt followed by ongoing obstacles to engaging in mindfulness led to the experience of uncertainty about whether mindfulness had any value to service user participants as a way of overcoming their problems and an ongoing struggle to engage with mindfulness. Service user participants experienced that mindfulness required persistence and was not a quick solution to their problems. At times this led to low motivation to pursue mindfulness although many did continue to persist. Service user participants found it difficult to associate the practice of mindfulness with a reduction in their suffering. Whereas the idea of 'just sitting with it' was a relief for some, for others the concept of sitting there doing nothing did not live up to their expectations of what would help them out of their suffering. Service user participants were invalidated by the notion that mindfulness would be effective in relieving them of their high levels of distress. Therefore on the whole service user participants approached mindfulness with scepticism and low expectation which when coupled with the challenges of mindfulness led to a desire not to engage. For many of the service user participants there was recognition of a desire to do a better job of being mindful. However, those who were able to move past their initial scepticism continued to find times when they did not want to be mindful about a situation.

8.1.2.1 Mindfulness as a challenging process across approaches

The experience of mindfulness as a challenge is consistent across a number of therapeutic approaches for a variety of service user groups (Wyatt et al., 2014). Qualitative studies of mindfulness based interventions have generated themes that relate to the experience of

mindfulness as challenging. In their review of 15 qualitative studies Wyatt et al. (2014) generated a theme of struggles. The theme 'struggles' was characterized by practical difficulties; difficulties with the core concepts of mindfulness; low motivation and aversive emotional effects. These findings are reflected in the higher order concept ***struggle with uncertainty and challenge*** that was generated as a higher order concept from the interpretation of service user participants experience as being unsure of the usefulness and necessity of mindfulness and experiencing difficulties in engaging with mindfulness in their search for a solution to their problems.

In their meta-ethnography across qualitative studies of MBSR and MBCT, Malpass et al. (2012) developed a theory about phases in the process of engaging with mindfulness. The second phase was that of safe uncertainty. During this phase the experience of service user participants was conceptualised as an attempt to understand how mindfulness could be of help to them and difficulties in changing established patterns of behaviour. The service user participants in the current study were similarly looking for answers as to how the experience of mindfulness would benefit them. They entered a dilemma wherein they had to suspend their doubts in order to experience mindfulness in a way that was helpful to them. Service user participants spoke about accepting the advice of others to try mindfulness and giving it a go as a way of dealing with their uncertainty. However, the descriptions of the dilemma and subsequent challenge in engaging with mindfulness did not give the impression of the uncertainty being safe. Rather the uncertainty and challenge led to despondency, self-criticism and shame for some of the participants.

8.1.2.2 Feelings of resistance and personal propensity to use mindfulness

Service user participants identified times when they chose not to engage in mindfulness. The service user participants experience that they did not always have the desire to engage with mindfulness brought to mind the notion of resistance. Resistance is a lack of change in psychotherapeutic work when the process of therapy is experienced as negative (Ucar , 2017). The phenomenon of resistance as experienced in therapy develops from a complex combination of thoughts, feelings, habits and relationship factors that are present during therapy (Arkowitz, 2002). That individuals find it difficult to make changes in therapy is familiar to therapists (Engle and Arkowitz, 2008). Furthermore, Sommers-Flanagan et al. (2011) suggested that resistance for adolescents may indicate an adaptive behaviour by preserving adolescent autonomy and identity, suggesting the adolescents in the current study will have

found it challenging to engage in therapeutic change. If reluctance to change and resistance to therapeutic intervention are common in therapy the experience of not having the desire to be mindful may not be related to mindfulness per se but the complexity of change within psychotherapeutic settings in general and a feature of the adolescent mind set and cognitive development.

Specific characteristics of children who were less receptive to mindfulness practice such as, negative feelings toward themselves or others and low self-esteem, have been identified suggesting that some children are more prone to accepting mindfulness as a treatment (Keller, 2017). The findings of this study indicated that service user participants felt bad about themselves when they did not 'get it' or did not chose to use mindfulness – indicated by embarrassment, apologies and a repetitive feel that they should be better at engaging with mindfulness. Therefore despite being taught as a set of skills of which one is having non-judgemental approach to experience, service user participants judged themselves negatively as a result of experiencing uncertainty and challenge.

If being willing to do mindfulness is thought to be key to success with mindfulness, then consideration may not be given to the notion that service users are perhaps not equal in their ability to engage with mindfulness. Some service user participants experienced that no matter how much they tried they could not develop mindfulness as a way of dealing with their problems. Service user participants conceptualised this as personal deficits such as lack of imagination, lack of patience or simply not being the right sort of person (not Buddha). Practitioner participants noted that there were characteristics of service users that made engaging in mindfulness particularly difficult. Studies on dispositional mindfulness and brain regions show that individuals have differences in their natural ability to be mindful influenced by characteristics such as low trait attention; judgemental thinking nurtured throughout childhood and a variety of other abilities that are necessary to be mindful (Kong et al., 2015). The research into mindfulness and clinical presentations suggests that mental health problems have a role in disrupting the ability to be mindful. Other non-mental health variables, such as positive self-esteem, have also been connected with receptivity to engaging with mindfulness (Keller et al., 2017). Hertenstien et al. (2012) found that mindfulness was more difficult for those with OCD because the OCD symptoms conflicted with engaging in mindfulness. Wupperman et al. (2008) explored BPD in relation to mindfulness. Their findings suggested that those with BPD symptoms had very low levels of awareness of their own experiences. They conceptualised this as a deficit in these dimensions of mindfulness. Siegel (2007) identified strong genetic and developmental components that determined the ability to

develop capacities for self-regulation and reflection – which he named a 'mindful brain'. Siegel also identified that individual difference in terms of childhood experiences also played a clear role in developing the neural pathways that are needed for mindfulness. This way of conceptualising the development the capacity for mindfulness resonates with the bio-social theory in DBT – that there are those with a predisposition to dysregulated emotions who find themselves in invalidating situations which leads to the development of BPD symptoms. Wagner et al. (2006) believed that adolescents had capacity to understand and apply mindfulness because they were developing abstract and critical thinking. However, the adolescents being targeted in DBT also have symptoms of BPD which suggests that the ability to be mindful may have been disrupted through invalidating environments. Practitioner participants experience of adolescents was that they did not like mindfulness and had limited capacity to develop and generalise mindfulness skills which suggests that the specific challenges for these adolescents needs further consideration.

Some of the service users were able to access mindfulness despite finding the process challenging. What cannot be established from the data is what made these service users more prone to engage with mindfulness. Whether service users with the least psychopathology engaged most fully with mindfulness cannot be established. Some suggested high trait mindfulness (unless you're Buddha) and an openness to being mindful were necessary to be able to engage with mindfulness. There was a strong sense that service users developed an understanding of mindfulness through the experience of doing mindfulness. Siegel (2007) suggested that individuals have capacity to cultivate mindfulness despite low levels of inherent mindfulness in the context of psychotherapeutic relationships. In group only DBT it may be difficult to develop a psychotherapeutic relationship which may be necessary to overcome specific developmental deficits in mindfulness (attachments difficulties, trauma). Julie spoke of using mindfulness in individual session in a carefully titrated way to help service users overcome their difficulties with mindfulness. Being attentive to the particular doubts, blocks and deficits experienced by an individual may be somewhat difficult in group only DBT. Therefore practitioners took a tentative approach to introducing and titrating of mindfulness in the group setting.

8.1.2.3 Practitioner's effect on the teaching of mindfulness

The group experience of mindfulness has been identified as central to the process of change in MBIs (Cormack et al., 2018). Practitioner participants in the current study spoke about using group member's experiences to encourage the generalisation of mindfulness. Whereas in

other studies group members were seen as giving support during times of uncertainty (Moss et al. 2008) this was not the case in the current study in which both service users and practitioners described that practising mindfulness as a group increased self-consciousness. Although self-consciousness and feelings of inadequacy became blocks to remaining open. Those that were more connected to the feeling that mindfulness was embarrassing or that they were inadequate were the service users that also found giving mindfulness a go quite difficult. The notion of openness suggests vulnerability to being uncertain and flexibility to experiencing something new.

Most practitioners admitted to having limits to their own understanding of and connection to mindfulness. Some spoke candidly that they were not completely clear about the process of mindfulness and struggled to translate the concepts into tangible benefits for the service users. Practitioners shared the experience of uncertainty with service users and therefore tried to validate service user experience of struggling with mindfulness. Service users were unclear about how mindfulness offered a solution to their problems and as such showed considerable ambivalence, which practitioners found difficult to disrupt. By validating the service user's experience of self-consciousness and inadequacy practitioners may have addressed some of the shame service users felt with regard to not being right for mindfulness (Brown, 2006). There may be additional ways of addressing the uncertainty of service users with regard to mindfulness. Practitioners were keen to give confident, knowledgeable explanations of mindfulness and also noted that they had a role in modelling mindfulness to service users. The combination of knowledge and experience was thought to lead to the right messages with regard to mindfulness being imparted to service users.

Practitioners noted similar struggles to service users with engaging in mindfulness and this had an impact on their confidence, at times doubting that mindfulness could be taught in a useful way. That practitioner experience of mindfulness is contributory to their ability and to their confidence in teaching mindfulness is not surprising. Clinical psychology trainees found that personal experience of mindfulness meant that they were better able to use mindfulness as a way of helping their clients (Hemanth, 2015) and the need for a personal mindfulness practice is recommended for the effective teaching of mindfulness (Shonin and van Gordon, 2015). By exemplifying mindfulness whilst teaching in groups, through showing in vitro mindfulness practice like observing, describing and being non-judgemental practitioners model mindfulness to service users (Cormack et al., 2018). Practitioner's personal practice leading to service users having an improved understanding of mindfulness concepts (Hemanth, 2015). Therapists 'being with' rather than 'doing to' the client was experienced when therapist engaged in

mindfulness in therapy (Cigolla, 2011). Since practitioner participants experience many of the same doubts and struggles as service users in their attempts to engage with mindfulness the approach of 'doing' rather than 'being with' may have come across more in the mindfulness teaching.

Shonin and van Gordon (2015) noted, as participants did, that not everybody is ready to try mindfulness and recommended that practitioners do not insist that service users should engage with mindfulness. Practitioner participants were split with regard to whether mindfulness was a necessary part of DBT and should be mandatory for service users in DBT treatment. Views ranged from mindfulness being essential in DBT to mindfulness being a useful but not an essential part of DBT. The wish to be compelling or convincing was frustrated by personal doubts and the experience of service users as resistant.

Therefore, it is unclear whether practitioners should try to convince service users to engage with mindfulness or be flexible with the notion that all service users should do mindfulness. Mindfulness is clearly outlined as important in the original and subsequent literature pertaining to skills training in DBT and therefore practitioners may not wish to drop this element of DBT from their teaching (Linehan, 1993a) However, teaching mindfulness while having doubts about mindfulness would require practitioners to hold a level of dissonance, where on one hand teaching mindfulness is outlined as part of the DBT programme and on the other practitioners at times doubt the use of and teachable nature of mindfulness as a treatment. Practitioner doubts led to low confidence and changes in the teaching of mindfulness and at times to questioning the value of mindfulness as part of the DBT programme.

The higher order concept – ***a struggle with uncertainty and challenge*** poses a number of dilemmas for practitioners and service users embarking on DBT. Knowing whether difficulties with mindfulness are due to mindfulness being a skill that takes time to master; motivational problems or an inability to be mindful may not be immediately apparent. The approach taken to supporting the service user with each of these difficulties is somewhat different. Its seems that validation is useful in approaching the difficulties experienced by service users but too much validation can undermine service user confidence and subsequently their motivation to engage with mindfulness. Low motivation requires a clear connection between mindfulness exercises and desired outcomes of mindfulness in order for service users to suspend doubts and give it a go. Approaching inability requires an individualised relationship based approach that can identify and ameliorate specific issues.

Chapter 9: Higher order concept – Developing internal awareness with caution

Developing internal awareness with caution demonstrates that service user and practitioner participants experienced high levels of wariness about using mindfulness to connect service users to thoughts, emotions and bodily sensations. This concept was developed from the superordinate themes of ***A dilemma between being aware of painful thoughts and emotions or zoning out; Fear of exposing service users to thoughts and emotions***; ***Shifting perspective in difficult situations*** and ***Hoping changes in relationship with thoughts and emotions will change behaviour***.

Hoping changes in relationship with thoughts and emotions will change behaviour draws together the way in which practitioners observed change in service users. Practitioners referred to the development of different facets of mindfulness such as focus and awareness with the development of these being useful for understanding thoughts and emotions. The changes that practitioners observed were summed up as a shift in perspective. Practitioners stated that increased awareness was central to the effectiveness of mindfulness as it allowed for a different relationship with thoughts and feelings. However, due to the challenges of mindfulness a change in perspective was not consistently observed in service user participants. Therefore the experience was described as a hope rather than a tangible change in many instances. The superordinate theme ***Shifting perspective in difficult situations*** was generated from grouping themes that pertained to experiences that led to an end point of seeing things or relating to and conducting life in a different way- *pausing rather than reacting, grounding self in being calm, focused on focusing, making different choices*. There was a sense of movement from one position which was harmful to another more helpful position.

Practitioner participants talked about mindfulness as being specifically challenging for service users from an emotional perspective - ***Fear of exposing service users to thoughts and emotions.*** Practitioner participants' experience of being wary because exposure to painful feelings can cause problems led to some practitioner participants experiencing avoidance of mindfulness exercises that might cause painful thoughts and feelings. However, practitioner participants were hopeful that service user participants would develop an experience of emotional tolerance and ability to be non-reactive to behavioural urges leading to the generation of the subordinate theme encouraging service user participants to be mindful

despite the risks of experiencing painful thoughts and feelings. Due to practitioners' sensitivity to service users' experiences this meant that they titrated the expectation of emotional experiencing leading to the subordinate themes Introducing mindfulness gently.

Service user participants presented as somewhat cautious about increasing their emotional experiencing, using distraction instead. The superordinate theme ***A dilemma between being aware of painful thoughts and emotions or zoning*** was generated from a large number of subordinate themes that highlighted the dilemmas in using mindfulness to become more aware of thoughts and emotions. *The hope that mindfulness will change thoughts and feelings in difficult situations* *was contrary to the experience of* *Mindful focus intensifies difficult thoughts and feelings* *and* *The experience of 'zoning out' from the painful thoughts or emotions was contrary to* *The experience of 'just sitting' with a painful thought or feeling.*

An overview of the Higher order concept as defined by the superordinate and subordinate themes and the codes used in the theme generation is provided in Table 36

Table 36 Overview of themes and codes pertaining to Approaching internal awareness with caution

Higher order concept	**Developing internal awareness with caution**							
Service User Superordinate Themes	**A dilemma between being aware of painful thoughts and emotions or zoning out**				**Experiencing a new perspective**			
Service User Subordinate Themes	**Internal focus intensifies difficult thoughts and emotions**	**Focused on external focus.**	**The experience of 'zoning out' from the painful thoughts or emotions**	**The experience of becoming more aware of a painful thought or feeling**	**The hope that mindfulness will change thoughts and emotions in difficult situations**	**Pausing rather than reacting**	**Grounding self in being calm**	**Making different choices**
Codes	1. Mindfulness makes strong emotions difficult to manage 2. Anxious about silence	1. Using the external 2. Activity based mindfulness 3. The body 4. Focus	1. Avoidance of difficulty 2. Distraction 3. Disassociate	1. Just sitting there 2. Awareness 3. Acceptance 4. Being with the unpleasant	1. Escape 2. Shifting internal landscape 3. Moving away from negative emotion 4. Reducing being overwhelmed	1. Process of mindfulness 2. Pause and Go back 3. Brings you back to you 4. Changing thinking 5. Stepping back	1. Calming 2. Slowing 3. Reduce stress	1. New perspective 2. When to use mindfulness 3. Mindfulness in action 4. Self -control 5. Mindfulness leads to decision making 6. Changing reactions 7. Sort things 8. Practical mindfulness
Practitioner	**Fear of exposing service user participants to thoughts and feelings**				**Hoping changes in relationship with thoughts and emotions will change**			

Superordinate Themes					behaviour			
Practitioner Subordinate Themes	Wary because exposure to painful feelings can cause problems	Avoidance of mindfulness exercises that might cause painful thoughts and feelings			Encouraging service user participants to be mindful despite the risks of experiencing painful thoughts and feelings.	Introducing mindfulness gently	Hoping changes in relationship with thoughts and emotions will change behaviour	
Codes	1. Leads to distress 2. Dissociation 3. Encountering difficult thoughts 4. Trauma	1. Activity based mindfulness 2. Giving people a choice 3. Avoid internal awareness 4. Do difficult exercises 1:1			1. Mindfulness inseparable from DBT 2. Believing it will help	1. Short exercises 2. Offering compassion 3. Doing internal awareness later in programme	1. Acceptance 2. Awareness 3. Wise decisions 4. Sit with emotion 5. Reduced harmful behaviour	

Figure 26 shows the interpretation of the way in which the superordinate themes relate to the higher order concept - ***developing internal awareness with caution***. Practitioner participants shared experiences of caution with regard to increased awareness of emotions. Practitioner participants hoped service users would develop a different relationship to thoughts and emotions and thereby change their behaviour. This was evident in the experience of service user participants. However, practitioner participants' desire that service user participants would increase emotional experiencing through mindfulness was not evident in the experience of service user participants.

Figure 26 Higher order concept *Developing internal awareness with caution* illustrated through the relationships between superordinate themes

9.1.1 Synthesis of subordinate themes pertaining to the higher order concept – Developing internal awareness with caution

9.1.1.1 Superordinate themes A dilemma between being aware of painful thoughts and emotions or zoning out and Fear of exposing service user participants to thoughts and feelings

Throughout the service user participant accounts mindfulness was used as a kind of emotional first aid to deal with peaks in negative emotion and distressing thoughts, thereby helping service user participants to function again- ***The hope that mindfulness will change thoughts and emotions in difficult situations***. Service user participants engaged in mindfulness in response to unwanted thoughts and emotions. Service user participants spoke of using mindfulness in drastic situations when they were experiencing the most severe emotions and thoughts;

> '*I personally use it* (mindfulness) *as a way to, like, calm myself down in, like, drastic situations. And yeah, it was a bit difficult it in those, but it did help a lot.'* SUP Philippa 76 (completed 16 week programme three months prior)

Engaging in mindfulness in distressing situations was described as preventative of self-harm, arguing and being violent. Service user participants engaged in mindfulness as a tool to avoid harmful behaviours associated with distress;

> *'Like, basically, um, there was one time when I was, like, in the session and – this going to sound really bad – but I had a huge urge to self-harm.....we used, like, mindfulness…'* SUP Kirsty 342 (completed 16 week programme in the month prior)

The DBT approach of skills-based mindfulness lends itself to mindfulness being used in discrete moments of distress to deal with unwanted feelings and urges. There is a sense of participants wanting to change their state of mind and urges very quickly. This was valuable to many of the participants - to have a way of calming themselves and taking a step back from their situation, which led to change in their behavioural response. Rachel changed her response to feeling angry by taking a breather:

> *'I argue a lot with my Mum. ..... I'm just like, no, I'm just gonna, I'm just gonna leave it, I'm just gonna take a breather, and, and do some colouring, and that. That's,*

> *it's basically arguments 'cos I'm not very good at arguments, that I use it* (mindfulness) *in.'* SUP Rachel 99 (completed 16 week programme two weeks prior)

Overall, there was little sense of mindfulness being useful to the participants outside of stressful, upsetting situations. Everyday mindfulness was noted to be a way of gaining perspective on life overall but in general was not present in accounts as a way of reducing propensity to emotional dysregulation.

Service users were cautious about connecting to emotions rather than using mindfulness to focus away from painful emotions and urges. The teaching of mindfulness in DBT has a practical focus, applying mindfulness to life situations. The application of mindfulness as a behavioural skill was apparent in service user participant accounts. Service users did not necessarily increase awareness of the situation, they engaged in a benign activity to reduce awareness of the situation.

Practitioner participants noted that changed relationship to emotions was instrumental in some changes that were observed in service users;

> *'his capacity to experience joy and, you know, have a life..... he was in his flat on his own, you know, 99% of the time, 'cos his level of shame was so horrendous, um, he couldn't face, you know, being around people; couldn't go in a supermarket for most of the, you know, seven, six out of seven days a week type of thing. He says things like: Oh I spoke, I went out, I did opposite to emotion action, you know, I was feeling whatever, and um, I, I just didn't want to go out so I went out and – and this is because he gets mindfulness.' PrP* Julie 245

Julie's observation was that this man made the change from being controlled by anxiety to making a choice to do the opposite of staying in the house because he understood mindfulness. He is described as acting opposite to how he feels, requiring awareness of his emotion and an intention to change. Elaine was hopeful that being able to tolerate emotions would change patterns of behaviours.

> *'That they can tolerate feelings instead of blocking them away, and so instead of thinking – or not thinking – instead of just doing and, you know going into old patterns of what's happened before, being able to form new patterns because they've been able to recognise that that's a path I normally go down when I don't choose that route.'* PrP Elaine 62

Practitioners described the process of change as 'taking a step back' (Grace); 'forming new patterns' through 'recognising' usual patterns (Elaine); 'balance' to 'control and influence what happens'(Sarah). Practitioners observed a change in the way in which service users approached distressing thoughts. Helen noted the change in thinking to be confined to when service users were in distressing situations.

> *'I think they get that it's a, it can be a time when they're preoccupied with all their different thoughts - they're kind of letting go of their thoughts - but I don't know that they see it as like a practice of letting go of their thoughts so that they can do that more in life in general. I think they think it may be a bit more of an immediate thing, like if I'm really stressed out, I'll do some mindful colouring and then I can let go of some of those thoughts, rather than like exercising that muscle of being able to do that in life in general, like as a skill. Yeah. They see it more as an immediate thing in some situations.'* PrP Helen 136

Helen observed service users distracting from their thoughts in order to feel less stressed. However, distraction did not give service users a different perspective on life day to day. Practitioners were hoping for something different in the change of thinking and approach to emotions, for service users to actively let go of thoughts and to tolerate their emotions in life in general.

Service users had a dilemma as to whether they should increase their awareness of painful thoughts or emotions or zone out from them. Service user accounts told stories of emotional pain, distressed thinking and harmful behaviour which they were trying to deal with through mindfulness. Engaging in mindfulness was difficult for service users because it put them in the position of experiencing themselves or their emotions in a way that was uncomfortable- ***Internal focus intensifies difficult thoughts and feelings***. Service users noticed that they experienced an increase of negative emotion when they engaged in mindfulness. Sam was uncomfortable about focusing on her feelings.

> *'Then I just feel uncomfortable, like, about your body, and then, like, when you feel like sensations, like, … and then you're, like, focusing on them, then they, like, they get, like even more like distracting, and then, so you just get to feel really uncomfortable. And I don't find it at all relaxing. I feel like it just makes you feel more, like, on edge, or however you're feeling.'* SUP Sam 210 (13 weeks into a 16 week programme)

Service users were often averse to focusing on their body and had therefore avoided using mindfulness exercises that were body related.

> *'Um … I think at first it was kind of a negative kind of, emotional effect, because, … I don't know. Like, I was suddenly being more aware of what I was feeling, and kind of, yeah, my body and stuff, and it was kind of like this is scary, [giggles].'* SUP Louise 230 (six months into a twelve month programme)

Louise experienced fear with regard to becoming aware of her emotions and body. This seemed to extend beyond the discomfort to become an aversion to engaging in mindfulness that placed awareness on her emotions and body.

Some service users decided not to engage in mindfulness exercises that encouraged an internal focus on their thoughts, bodies or sensations preferring mindfulness exercises that were activity based – colouring, blowing bubbles, watching Youtube or films. The preference for activity based mindfulness took the participants attention outside of their minds and bodies.

> 'I was really stressed out about having to pack and I was like, I'm going to forget something. And … or, you know, go wrong and everything, and I was like … 'cos I have like that kind of self- soothe/mindfulness kind of box thing, and I got the bubbles out and just um, yeah, kind of watched the bubbles kind of popping. Um … and, I don't know, after that I was like, OK I can just breathe, I can do this kind of thing.' SUP Louise 190 (six months into a twelve month programme)

Silent mindfulness exercises were experienced as a trigger for distress. Engaging in silent mindfulness gave mind space for difficult thoughts and emotions and was seen as something to be avoided.

> *'Like, for example, when I'm doing observe, is where we just have to, like, just, like, listen in to sounds and, like, stay silent. Like, that's the one I kind of avoided because whenever I do that it just triggers so many thoughts and, like, I just can't seem to, like, distract myself from all my thoughts when we have to stay silent.' SUP* Kirsty 378 (completed 16 week programme in the month prior)

Service users were cautious that they would become overwhelmed should they spend time being aware of difficult thoughts and feelings and experienced feeling exposed by mindfulness exercises that required an awareness of the self.

When service users noticed an exercise that they found averse they also wondered whether the exercise would be of benefit to them. There was a dilemma between whether the experience of discomfort signalled that it was prudent to stop or that a level of discomfort was necessary to experience the benefits of mindfulness. Kirsty described one mindfulness exercise in particular which left her feeling exposed and vulnerable. Despite the discomfort this caused she believed the process was helpful to her.

> *'I suppose straight afterwards* (the mindfulness exercise) *I didn't like it. Like I didn't like what I saw, you know, inside of me I suppose. But then I think it helped because it allowed me to, I suppose, expose, you know, myself to myself, um, and I was able to see, like, what was there.'* SUP Vicky 259 (15 weeks into a 16 week programme)

The dilemma between engaging in internally or in externally focused mindfulness was a tension between mindfulness as distraction and mindfulness as awareness of the experience. The avoidance of the internal focus could be seen as an avoidance of the self and the reality of what is in the moment. The caution experienced seemed to be based on the idea that experiencing thoughts and emotions fully would be damaging in some way through triggering damaging behaviour.

Practitioner participants noted that service users showed reluctance about being aware of their emotions, memories and feelings of emptiness. Practitioner participants stated that service users were likely to be emotionally dysregulated, making practitioner participants cautious as to whether service users could engage with emotional experiencing without high levels of distress.

Practitioner participants wondered if practising mindfulness had the potential for linking service users into emotional pain. Service user participants and practitioner participants seemed to assume that emotional experiencing would be harmful or at best unhelpful and this led to a pattern of being cautious- ***wary because exposure to painful feelings can cause problems,*** this was especially so for those service users who had experienced high levels of trauma or had experienced dissociation.

> *'So what you get with some service users, particularly with a trauma history is..... actually as they progress in DBT, as they practise more mindfully, they feel horrendous' PrP* Julie 101

> *'…because they're not blocking the chronic emptiness, or the trauma, you know, sequelae, the, the you know, memories, flashbacks, emotional states, um, and I think that's really, really hard, you know.' PrP* Julie105

The notion that mindfulness could put people into a position of emotional experiencing had the effect of making some practitioners cautious about encouraging awareness through mindfulness. The anxiety about the potential harm experienced through practising mindfulness had an effect on the types of mindfulness exercises that were introduced to the group- ***avoidance of mindfulness exercises that might increase awareness of painful thoughts and feelings.*** In particular practitioner participants favoured external mindfulness activities, mirroring the service user desire to distract from rather than to be more aware of thoughts and emotions.

Some of the practitioner participants didn't want to elicit unwanted emotions in the group session and therefore focused mainly upon activity-based mindfulness exercises rather than quiet introspective exercises. The practitioners had experienced aversive reactions to some of the activities that they had introduced which led them to be careful with the type of activities they initiated.

> *'But yeah, the body scan I would say is the one that there have been a few uncomfortable moments over the years when people have found it very difficult. And I suppose it's just stirring up … it's talking about parts of the body as you go up that are probably a bit uncomfortable for people, and sort of triggering um … So it's just being aware of that really.'* PrP Grace 111

The experience was one of doing more and more externally focused activities as these were preferred by the group members. However, practitioners were not completely comfortable with keeping an external focus, suspecting that this was part of continued avoidance of emotional experiencing.

> *'Er, I think it's harder to get them to sit through it. I think it's harder for them to tolerate, and so if you think behaviourally, actually you get reinforced with the active don't you? And you get an aversive when you get them* (service users) *to stop and tune in.'* PrP Sarah 67

It is possible that the reinforcement of active exercises begins to strengthen the idea for service users that mindfulness is about distraction from difficulties. In sticking with externally focused exercises the message that mindfulness is about being aware of and open to

difficulties is diminished because distraction from emotion and awareness of emotion are opposite activities. However, if awareness of an emotion causes high levels of distress it is possible that distraction is of benefit. There was therefore a dilemma as to whether to take the lead from service users and stick with what they experience as comfortable or to encourage discomfort due to believing that increased awareness would lead to a better outcome.

Avoidance of silent introspective mindfulness was linked to such activities being so unlike everyday life. Practitioners noted that people in general do not take time to pause and reflect. Living with constant distraction leading to a fear of developing awareness of thoughts or emotions. Emotional avoidance being culturally sanctioned by the way in which people live their lives.

> *'Um … maybe, maybe 'cos they have got so much going on in their head it's kind of a bit scary to stop all that distraction, and actually kind of … kind of sit with what is going on in their head, or their emotions. I think that, maybe that feels quite kind of scary for them, or a bit overwhelming, if they're used to kind of, kind of like distracting themselves and getting on with this other stuff that's going on.'* PrP Helen 98

Practitioners experienced service users as finding it easier to engage with activities that took the focus away from introspection. They were compassionate towards the fears of service users. Practitioners understood the apprehension that service users had with regard to emotional experiencing and had experienced the difficulties that greater awareness could bring.

> *'I wonder if sometimes, I wonder if sometimes we're not ready for how difficult it is to look inside. Um, … And so when you've been practising for a while you forget how hard it is.'* PrP Sarah 135

9.1.1.2 Superordinate themes Experiencing a new perspective and Hoping changes in relationship with thoughts and emotions will change behaviour

The outcome of practising mindfulness that seemed the most universal for service user participants was that of being calm and composed- ***grounding self in being calm***. Although the word calm was predominantly used by participants the terms relaxation, reducing stress and being still were all terms that pointed to the experience of calm when engaging in mindfulness. Many of the participants described living in stressful and emotionally chaotic

worlds from which they were seeking refuge. Mindfulness offered the opportunity to be calm within their tumultuous lives.

> *'tsk, this is going to sound really cringe, but I guess to be like more at peace as opposed to like angry and sad and fiery. ' SUP* Rachel 317 (completed 16 week programme two weeks prior)

Service users found that mindfulness calmed the effects of their emotions. Calming the anxiety of coursework (Tara, Vicky), calming anger in an argument (Rachel, Philippa) all had the function of enabling service users to engage once more in their lives.

> *'I just felt calmer; like I usually do it when … I sort of, I've downloaded coursework and stuff, and I'd just be sitting there and I'd be like really bored and kind of like anxious about it, doing the work; and then I'll colour for a bit and I just feel a little calmer, and a lot like I can get back to work now, it kind of refreshes me.'* SUP Tara 60 (completed 16 week programme two weeks prior)

Service users noticed that mindfulness calmed very strong emotions. Being calm left service users in control of intense emotions and led to a change in behaviour. Mindfulness calmed service users both physically as well as psychologically. Philippa experienced dysregulation as her brain shaking and experienced this phenomenon being directly affected by mindfulness.

> *' I think of it like when you're in crisis your brain is shaking; - well this is just a personal thing – like your brain is shaking, your thoughts are everywhere, you don't know what to do. Mindfulness lets your brain calm down, think about the one thing that you're doing, 'cos it takes your mind off of it, and like gets you away from the emotion for a minute and just lets you, just be calm.'* SUP Philippa 355 (completed 16 week programme three months prior)

Service users noticed that the experience of being calm was the first step to changing their relationship to their thoughts and emotions. Philippa described this as 'it brings you back to you'. The idea of bringing you back to you evokes an image of mindfulness helping service users return to something authentic about themselves that they had lost. The idea of being genuine and true to oneself is pertinent, outlining that the participants felt dragged off course by their painful emotional worlds and destructive thinking patterns and that by being calm they were about to reconnect to what was important to them.

> *'It calms you, and like it brings you back to yourself, instead of thinking about everything else going on, like daily stresses and whatnot. It just brings you back to you, and just … your mind, and just letting everything calm down for a moment before whizzing back up into real life again.' SUP* Philippa 142 (completed 16 week programme three months prior)

Service user participants used mindfulness to distract from unwanted emotions or sensations. They entered a world protected from thinking about their problems or experiencing their distress - ***the experience of 'zoning out' from the painful thoughts or emotions***. There were many references to distraction from thoughts and experiences. Participants gave descriptions of being zoned out (Rachel) and of mindfulness cancelling everything out (Philippa). Mindfulness acted like a cushion between the person and the reality in which they were living giving some temporary space from their hectic, chaotic worlds. Kirsty's use of mindfulness was clearly about not thinking and not experiencing whatever was causing distress.

> '*It kind of, like, when I cancel everything out it feels like that, I'm in my own little world, and, like, I'm in, like, my own little world where I can just like relax, and, like, I'm just free really.'* SUP Kirsty 194 (completed 16 week programme in the month prior)

The experience of freedom from the experience of the world suggests that the thoughts, emotions and experience of the real world leave Kirsty feeling trapped. Service users valued the opportunity of focusing solely on one activity to forget their problems, becoming very disconnected from what was happening in the real world, being cut off from the senses and cancelling out thinking. However, there was a distinction between ordinary zoning out and mindfully zoning out. When engaged in mindfulness Tara took a step back from rather than becoming completely disconnected to her thoughts.

> *'I think when you just randomly zone out, you're, you're kind of, you're still thinking about the problems in your life, um, and stuff like that; whereas if you mindfully zone out you're kind of, you're, kind of thinking about nothing, so you're taking a step back from your life, and I think that's why it helped me so much, 'cos I don't have to think about me 24/7; I can think about nothing, and it works like that.'* SUP Tara 218 (completed 16 week programme two weeks prior)

Stepping back from the intensity of the situation prevented ruminative introspection, although it is not clear whether Tara intends to take a step back from ruminating or a step away from being self–aware.

Activity-based mindfulness seemed to be blurred with the DBT teaching around distraction and it may be that mindful distraction is useful in order to prevent rumination. Distraction is based on the idea that when a person is overwhelmed by an emotion the best they might be able to do in that situation is to distract themselves until the intensity of the emotion has passed. By distracting the hope is that the person won't intensify the emotion through ruminating.

The experience of cancelling out, blocking out and distracting are at odds with the mindfulness discourse with regard to acceptance (Kabat-Zinn, 1990). There is a sense that by using mindfulness in these unwanted situations that the mindfulness acts as a kind of first aid or anaesthetic to the unwelcome emotion. The service user participants focused on something they chose to put in the moment and not the distressing content of the moment.

Focus was central to the difference between doing an activity mindfully rather than just doing it ordinarily – being completely absorbed in an activity to the exclusion of anything else- ***Focused on external focus***.

> *'I would say that to be mindful you have to think about one … you have to focus on one thing; um, completely clear your mind; forget about your life at that ti-, at that time, um, just, just don't think really. Or if you're doing it, if you're doing a certain activity, so if you're colouring completely focus on the colouring and don't let any other thoughts come into your head.'* SUP Tara 190 (completed 16 week programme two weeks prior)

The process of focusing was about clearing the mind, not thinking, not letting thoughts into service users' head. The process of focusing reduced distress by keeping attention on something innocuous. As such the focusing on a task prevented a cycle of rumination by decreasing rather than increasing awareness. Similarly, Kirsty entered the process of focusing as a way of not thinking about distressing thoughts.

> *'I was just like concentrating on the music really, like, I didn't really have any thoughts 'cos like, I was just, like, mainly concentrating on the music, like, just focusing on, like, the sounds really.'* SUP Kirsty 138 (completed 16 week programme in the month prior)

For Kirsty the absence of awareness of her current emotional state was being mindful – being completely absorbed in an activity to the exclusion of anything else. Thoughts were no longer at the centre of her mind as she focused on the music. The way in which focus is picked up on so frequently by the participants suggests that focusing in this way is different to their usual

way of being. Difficulties with choosing where to put one's attention could be the cause of difficulties with intrusive thoughts/memories and rumination. Therefore, by developing the ability to choose where to put their focus some participants demonstrated that they could reduce the effects of rumination. Philippa described this as follows:

> *'once you just focused and you just don't really think anything and feel anything, you just are solely focused on what, on um, sometimes a recording, sometimes the colouring, or just whatever – you're just completely focused, and you … it just like … it doesn't … it kind of leaves your body heavy, like, you know after you've laid down for a while and you're completely relaxed'* SUP Philippa 329 (completed 16 week programme three months prior)

Whilst being completely focused and relaxed Philippa does not engage with awareness of her situation. In fact, the efficacy of the focus for Philippa is that she doesn't think or feel anything. The idea that it is the bringing back of the mind to the task which is the moment of mindfulness is a core concept within mindfulness teaching. The participants used focus without a strong connection to the concepts of observe, describe and participate as a way of controlling what they were thinking. The process was more about preventing thinking than understanding and being involved with their own thoughts. The participants were seeking a sense of control over what they thought through focus rather than any insight into their thinking. They avoided internal awareness which they feared would lead to ruminative thoughts rather than an ability to 'sit with' the experience.

Practitioner participants were hopeful that mindfulness would help to change patterns of behaviour by changing the relationship to thinking and emotions that were unhelpful to service users. This was referred to as tolerance (Elaine), insight (Sarah) and awareness (Helen). Forming new patterns required engaging in life based on a different relationship to everyday experiences. Forming new patterns required a belief that the old patterns were unhelpful and a desire to change behaviour as a result.

Some changes in perspective were seen as interpersonal. Mindfulness notions of awareness, acceptance and being non-judgemental led to changes in the service users' approach to other people. Practitioners hoped that through changing perspectives on relationships, service users would have a greater ability to influence their life outcomes.

> *'balance, essentially is what I'm hoping. So that they will get the ability to check in on themselves and to work out what's theirs and what's their child's, or the other person.*

> *So, I'm hoping that they get that kind of insight into regulation so that they get more opportunity to control and influence what happens' PrP* Sarah 49

Changing perspective on emotional experiencing was considered to be pivotal to the success of DBT. By having a different relationships to emotions, practitioners hoped that service users could identify the way in which emotions affect them and respond in a way that was not determined by that emotion. This was not necessarily through emotional experiencing – at times it was choosing not to entertain a particular emotion.

> *'mindfulness I think also gives them – and I'm kind of laying what it gives me – is that ability to say "yes" or "no" to certain worries. Um, when is a good time to worry about an argument or a conflict with a colleague, or a house friend, you know. And to be able to choose, actually no, I'm not doing that now.'* PrP Sarah 55

Practitioners hoped that being in the moment, not worrying about the future, would reduce emotional distress. Practitioners referred to changing the way in which the service user related to emotions rather than changing emotional states e.g. from sad to happy. Practitioners related mindfulness closely to tolerating emotions which does not necessarily imply experiencing the emotion. Distracting from an emotional state until it passes could be seen as tolerating.

> '*I think journey with anxiety, you know, if they can, if they can get to the bit of being in the moment and not actually, you know, predicting that, you know, catastrophic things can happen, or even if they know that they might not do very well at the exam, you know, not feeling overwhelmed with anxiety about it, and being able to pull that, pull that back.'* PrP Michelle 29

It is not clear how much a change in perspective on emotions comes from engaging with mindfulness rather than other elements of DBT, such as teaching emotional regulation. The development of emotional understanding was connected to being able to label the emotions, interpreting internal sensations accurately.

> *'So yes, and it, you know, it's a huge relief for a lot of people that once they can label that emotion, well that's half the battle, 'cos they then know that there are certain skills they, they can use, for instance to manage their anxiety once they're able to manage their anger, or um, … So yes, and that, that's, that's a massive part of it – we spend quite a bit of time on that.'* PrP Grace 77

For Grace, changing service users' relationship with emotions appeared to be two-fold – increasing knowledge of emotions through education and increasing awareness of emotions through mindfulness leading to increased understanding of emotion overall.

Practitioner participants spoke of mindfulness as an exercise in exposure, the idea of sitting with difficulties rather than responding. Practitioner participants spoke of using mindfulness for the secondary effects of trauma on emotion and thinking rather than direct exposure to the traumatic event. Only one of the practitioners (Julie) talked of engaging with recollections of trauma in sessions through mindfulness.

Julie had a lot of experience working with people with trauma but rather than finding that this contra-indicated the use of mindfulness, Julie continued to use mindfulness with these people as she believed this would help them to manage their trauma in the long run. Titration of exposure to mindfulness based on knowledge of the service user was important but was only possible during individual work.

> *'So it's like monitoring this, her capacity to tolerate exposure to the loss, and gently helping coach her to do that using mindfulness. But also gauging how much to do that .....So you get to know, not just if they're doing … not just if they're being mindful, er, but also the level at which you can place your expectation of how much mindfulness they can tolerate.'* PrP Julie 43

Some service user participants described using mindfulness to deal with unwanted experiences by becoming more aware of rather than zoning out from the experience. Service users made references to ordering thoughts, slowing down, taking a step back and grounding.

The use of a mindful focus led to a point of stillness in contrast to the usual racing thoughts experienced by service users - ***pausing rather than reacting***. Service users' minds were often overwhelmed by thoughts and they wanted to be able to clear up the mess in their minds - by slowing things down rather than solving the situation in itself. Service users had the experience of mindfulness activity being a way of getting their mind into a place where thoughts were manageable. Louise noted that her mind was overwhelmed by lots of thoughts and she desired to clear up the mess in her mind.

> *'I find sometimes I just get overwhelmed with the amount of stuff that I feel like I've got to do, and I feel like I've got a whole long list, and if I just go, like do the washing-up mindfully, then after that um, I could kind of process things a bit more clearly, and not just, be like my thoughts just running around ..... Like, I think it just slows it down*

a bit, 'cos, not just like a million worries on top of each other , like just going too fast, like, they kind of overlap and I can't process any of them. So it just, like, slows it down a bit so that they're still there but I can think about them, like, kind of one by one, rather than a big mess.' SUP Louise 104 (six months into a twelve month programme)

Service users seemed to value the order that mindfulness promoted in their minds. Mindfulness helped service users to process the situation- by slowing things down- rather than solving the situation in itself. Service users valued the calm and relaxation in the midst of the unwanted experience of thoughts whizzing (Philippa) round their heads. Mindfulness was experienced as pressing the pause button (Philippa) 'taking a step back' (Tara) and 'taking a breather' (Rachel). Mindfulness slowed things down and allowed service users to think things through and de-escalate from intense emotions. Mindfulness provided an escape from the stresses of everyday life and emotional pain.

'because life is, as I've said many a time, life is hectic and sometimes we can't get away from it, like we can use it with um,.....just sitting there and just blocking everything else a bit, and just focusing on one thing; just … it's, it's wonderful really; just knowing that you … it's not exactly an escape, it's more just a … a pau-, it's a pause button on life for a bit.' SUP Philippa 383 (completed 16 week programme three months prior)

That Philippa spoke about mindfulness as '*not exactly an escape'* suggested to me that at some level Philippa related to mindfulness as exactly that – an escape from her life. However, she also seemed to acknowledge that it was not the purpose of mindfulness to escape but to pause and relate to life differently.

Vicky used awareness to control her fear of the dentist. Although wary of becoming aware and noting an increased sense of vulnerability, the use of mindfulness allowed her to open up quite literally to her fears.

'I was observing, like, the different um, sensations in my mouth as he used, like, the different sort of tools. .....It felt quite weird to start with, you know. It made me feel a bit more vulnerable. But I don't know, it felt a bit more like, but now I know what's going on, you know. It made me feel more aware and more in control.' SUP Vicky 196 (15 weeks into a 16 week programme)

The use of awareness to deal with emotions was a difficult process for service users. Those that used awareness approached mindfulness as a project in understanding what they were

thinking and feeling. The use of awareness connected service users to thoughts and feelings rather than disconnection and pushing away from thinking.

The sense from the participants who spoke about this theme is that the reason to use mindfulness is to be more connected to the way in which they function through awareness of thinking, sensations or emotions. Service users described using mindfulness to have a better understanding of how they related to thoughts.

> *'Well I start off with, like, breathing to, like help me get into it and focused; and then I observe the thoughts that are there, and then I start to show myself that these are thoughts, and they're not facts.'* SUP Vicky 160 (15 weeks into a 16 week programme)

Dealing with unwanted thoughts and feelings by increasing awareness, by just sitting there, was experienced as aversive to some service users. Sitting with discomfort was very difficult and service users were cautious about doing mindfulness when it caused discomfort.

> 'we did, like, er, one, an exercise in group where we actually like, have to, like, sit with the discomfort of, like, I don't know, just feeling like little things in our body that feel, like, uncomfortable and resist the urge to like do anything about them. And I found that really hard. I was like … So yeah, it's kind of uncomfortable in that way, sometimes.' SUP Louise242 (six months into a twelve month programme)

Whilst some service users warned against continual pushing away, as would teaching in DBT, other participants found relief from rumination by blocking things out. In DBT the teaching refers to observe, describe and participate rather than block out, zone out and avoid. That Vicky was a negative cases in her willingness and ability to use mindfulness to be more aware of their painful thoughts and emotions, suggests that there are extraneous factors that affect the ability to increase awareness. It is not possible from the service user accounts to interpret why some of them chose to use mindfulness to distract and block out and others to experience thoughts and feelings more fully. Participant accounts do not suggest that avoidance of awareness was due to the levels of distress experienced. Some service users seemed to come to the conclusion that pushing away distressing experiences had been counterproductive for them and so tried something different.

The ability to tolerate feelings for practitioners was seen as pivotal to changing reactions to emotional pain- ***encouraging service users to increase awareness despite the risks of experiencing painful thoughts and feelings.***

Practitioner participants saw mindfulness as challenging for service users from an emotional perspective. They noted that practising mindfulness had the potential for highlighting emotional pain. This was especially so for those people who had experienced high levels of trauma or had experienced dissociation.

Practitioners noted that most service users seemed to experience emotional experiencing as harmful or at best unhelpful and this had led to a pattern of avoidance.

> *'common logic dictates that if you do that* (sit with an emotion)*, especially if, I think people in, with EUPD, if you let yourself feel, you're gonna be overwhelmed and you're gonna be a complete mess, crying on the floor. Um, but actually what – I remember doing it once in the group … you know, most of the people in the group kind of found actually, it was anxiety mostly, and when they actually sat with it, it went up, but then it came down. So actually fully opening up to it, counter-intuitively, made the feeling reduce. Which is a, a massive thing if you think that these people had spent years, or decades doing just self-destructive ways to get rid of those reactions, and running from the emotions, you know. So you've run from a monster for years and then you find you turn around and realise it's actually ……., it's not a monster at all.'* PrP Mark 61

Mark stated that service user participants had a fear of feeling overwhelmed by the monster of emotions but that in his experience fully opening up demystified emotional experiencing and led to being less distressed. The way in which this was related closely to EUPD (or BPD) suggests that this process is especially so in EUPD.

Practitioners were keen to approach the use of mindfulness in a way that helped service users to learn how to be more aware of thoughts and feelings whilst not overwhelming them with distressing thoughts and emotions - ***Introducing mindfulness gently***. Practitioners noted that the first experiences of mindfulness needed to be accessible and helpful to those who had been living with difficulties for a long time. Practitioners spoke of introducing silent introspective exercises later in the therapy programme when service users may be more prepared for managing the emotions or memories that might arise

> *'So we normally start off with the basics. So because we're seeing people with sort of long-term difficulties, um, if we started off people trying to be mindful of their sort of thoughts and feeling they [laughs]. Probably run out of the door and not come back again to be quite honest.'* PrP Grace 37

Practitioner participants were cautious with the rate at which they introduced awareness of thoughts and emotions and took into account the individual service user's ability to tolerate mindfulness. Screening and preparation was thought necessary to ensure that there would be no harmful side effects of the therapy.

> *'if we thought that there was something about Mindfulness or, you know, in terms of sort of trauma or dis-associational anxiety, then obviously, you know, that's one of the reasons why we do, um, obviously do pre-treatment. So if, you know, if we, if we felt that that was something that was, that it was going to be contra-indicated, or indeed the other person was saying that they felt it was, then obviously we wouldn't, you know, we wouldn't proceed'* PrP Michelle 113

Incidents of distress connected with becoming mindful were noted in practitioner and service user accounts. Practitioners had experienced times when service users had dropped out or made complaints specifically because mindfulness had been distressing for them.

> 'it was someone who made a formal complaint 'cos they just felt like um, … tsk, in a way it was, um … it did, it picked up a lot of unpleasant stuff; he didn't know what he was getting himself into in terms of what would show up' PrP Mark 39

The service user in this example had not felt prepared for how mindfulness could affect him. Practitioner participants wondered if mindfulness needed to be paid more attention during pre-treatment in order to prepare service users for what lay ahead and for some a service user not being able to engage with mindfulness meant that they could not continue with DBT.

Practitioner participants were hopeful that behavioural change would happen as a result of service users taking a different approach to thinking about the problems that they encountered. However, behavioural change was based directly in mindfulness; not as a result in changes to emotion or thinking. Practitioner participants spoke about mindfulness as being able to notice and tolerate behavioural urges. This had a direct effect on changing behaviour without necessarily changing perspective on the thought or emotion that led to the urge. The process of mindfulness as the ability to 'sit with' whatever urges came up was practiced directly within the group.

> *'I think a really key one which I ought … which has, again, had that big impact on groups and individuals is relating it to what we call urge surfing: so similar to the emotion but you know, this idea that urges to drink, urges to self-harm, urges to spend or gamble, they just go up and up and up and up until you have to give in, and that's*

the only way to kill the urge. Um, and you know I can't think about that, I can't think about self-harm, I can't think about spending or I'll go out and do it. But again, rather than people mentally, you know, trying to block it up – which doesn't work – if they're able to just notice the urge and mindfully, you know, describe it, where is that feeling, you know, an urge, an urge to self-harm, where is the feeling in your body? OK, it's in your stomach. How's your heart? You know, your heart's racing a bit, OK, you know, what's going through your mind, and open up to it, um, you do get a bit of a burst where the urge goes up, but then you can actually sit with it' PrP Mark 63

Service users may have previously held the belief that emotions were a signal to act. However, practitioner participants hoped service users would develop a new perspective that urges could pass without action.

'So for self-harm when they … if they notice that their urges are really strong, by observing and describing and noticing that it, it ta-, it enables them to take a step back and think, Actually, is this the most effective thing to do?' PrP Grace 49

Practitioner participants saw the process as service users taking a step back and considering the outcomes of an action and deciding to tolerate the urge to act until the urge dissipated.

The effect of pausing and calming allowed a new perspective on the appropriate response to the difficult situation. As such the impact of the mindfulness practice allows for a change in behaviour- ***Making different choices***. The change in behaviour was referred to as being in control, making wise mind choices and being more organised. Tara noted that mindfulness enabled her to consider the appropriate action to take in her situation.

'I will just sit there and completely focus on that. ....and I then kind of come out of it and that's the point where I was like, very … what can I do now um, to sort out my life.' SUP Tara Line 128 (completed 16 week programme two weeks prior)

Service users focused, paused, slowed down their thoughts so that they were no longer paralysed by the overwhelming experience of too many thoughts or too much to do. Once focused away from the problem for a while service users were able to organise their thinking and make decisions about what to do.

'…..and then focusing on what, that one thing, and just doing that one thing, and bringing thought back to that one thing, kind of, … Then after I've done that for a little while I can kind of focus on one thing at once, rather than everything……instead

> of thinking, Oh my God, I have, like, a million things to do, I was, could think, OK, well I'll just, I'll do this first, and then that, and then it'll be fine.' SUP Louise 190 -203 (six months into a twelve month programme)

Despite her reservations with regard to mindfulness, Sam was able to imagine that mindfulness could leave her feeling more in control of her life due to being focused more on the present than the future. By focusing away from the big picture to the moment or day in hand service users found that they felt more in control.

> *'probably like, you'd feel, like, in control maybe; like, if you were, like, … 'cos you knew what was going on and, like, there was just about, like, that moment, like, in that day, or whatever; probably feel a bit more like in control than if you've got, like, your whole future to, like, worry about.'* SUP Sam 310 (13 weeks into a 16 week programme)

Service users described mindfulness as a practical tool to get things done. Referring to behaviours as effective suggested that using mindfulness made service users feel more successful in reaching their goals. This feeling of effectiveness was related to the use of wise mind as a way of conceptualising decision making. Vicky spoke about how her decision making was changed by mindfulness.

> *'I think maybe it would sit more in one of the extremes, which would maybe have one extreme benefit, but it may also have one extreme disadvantage; whereas if it's in wise mind then I'm able to balance out both to make sure that I get the best possible decision.'* SUP Vicky 487 (15 weeks into a 16 week programme)

9.1.2 Discussion of the higher order concept - Developing internal awareness with caution.

9.1.2.1 Developing a different perspective

The subordinate themes *pausing without reacting* and *grounding self in being calm* were used to describe the experience of service user participants in relating differently to their thoughts and emotions. This was a process that was developed through either mindfully distracting from or becoming increasingly aware of thoughts and emotions. These experiences are consistent with other studies where changes to thoughts, feelings and behaviour were noted

as part of the findings. Himelstein et al. (2012) developed themes with regard to adolescents experiencing increased emotional, behavioural and cognitive regulation; a finding that linked a change in perspective with a change in behaviour. Findings from other studies also suggested the experience of relating to thoughts or emotions differently with a subsequent change in behaviour: relating differently to thoughts and feelings and a sense of control and choice (Wyatt et al., 2014); clarity of mind and conscious control (Monshat et al., 2012) and experiencing the neutral mind (Murphy and Lahtinen, 2015). It may be, therefore that the experience of behaving differently as a result of a change in perspective is common across MBIs.

The change of perspective on thoughts and emotions seemed to be in part due to non-reactivity to inner experience as identified in in the superordinate theme ***pausing without reacting*****.** Service users described how if they could disrupt thoughts that led to unwanted behaviour - through pausing rather than reacting – they could make different choices. This experience is similar to the description of non-reactivity to inner experiences as outlined in the Five Facet Mindfulness Scale (I perceive my feelings and emotions without having to react to them; When I have distressing thoughts or images, I "step back" and am aware of the thought or image without getting taken over by it) (Baer, 2006). Such non-reactivity was highlighted in a study of service users with OCD receiving MBCT when they became less focused on obsessions (Sguazzin et al. 2017). Levin et al. (2015) explored the notion that mindfulness supports non-reactivity through a process of decoupling internal states from negative thinking or harmful behaviours. When engaged in decoupling the individual changes the behavioural outcome of the experience, rather than changing the experience itself. The experience of doing or thinking about something else led service user participants to not react to urges which seems to demonstrate a process of decoupling their thoughts from their actions. Feldman et al. (2010) found that decoupling behaviour from negative thinking was associated with decentring from thoughts by being less focused on the thought. Therefore engaging in a process that moves attention away from negative thinking and urges is likely to reduce the frequency of harmful behaviours. Distraction may have the effect of de-centring from thoughts, without the need to engage with mindfulness.

9.1.2.2 Decentring from thoughts and feelings

Service user participants reported a sense of calm associated with being decentred from a negative emotional state. Wagener et al. (2006) theorised and observed that adolescents benefitted from detached observation of emotional states – of developing the notion of having

an emotional state rather than being an emotional state. However, service user participants noted that mindfulness was less effective whilst they were in negative emotional states, echoing a finding that some young people did not use mindfulness in distressing situations because they doubted it would 'work' (Ames et al., 2014). These findings suggest that the ability to decouple from thoughts and emotion may be impeded by the strength of emotion that accompanied the thought. Whilst service user participants sought a feeling of calm when they engaged with mindfulness or relaxation, practitioner participants noted that engaging with mindfulness would not necessarily leave service users feeling this way. Practitioner participants were more inclined to hope that service users would tolerate and be aware of their emotions. This difference in conceptualising the intended outcomes of mindfulness may have added to the confusion about the point of mindfulness and the feeling from service user participants that they weren't doing it 'right'.

Tolerance and non-reactivity during a heightened emotional state was interpreted as being related to non-attachment to emotions. Non-attachment is central to Buddhist teaching and has been connected to improvements in wellbeing from the practice of mindfulness (Weiss et al., 2014). In meditative terms the practice of focused attention (samatha) is considered to be a different discipline to a meditative practice that promotes insight into the self (vipassana) (Rosenberg, 1998). Both practices are regarded as useful to the meditator and often the practice of focused attention is taught in order to allow the meditator to progress to insight meditation. Vicky referred to engaging at times with insight into her thoughts and feelings but more frequently offered the idea that mindfulness helped her to learn to sit with her emotions. Such sitting with emotions relies on accepting the emotion without judging the experience as right or wrong.

9.1.2.3 Acceptance of emotional states

Perroud et al. (2010) found that the mindful skill of accepting without judgement was enhanced in DBT and was effective in decreasing BPD symptoms whereas other taught skills (observe, describe, acting with awareness) were not enhanced during DBT. It would therefore seem that acceptance and being non-judgemental of experience are important to those people who experience emotional regulation difficulties as present in BPD. Hayes et al. (1996) believed the acceptance of emotional states to be preferable to the blocking of emotional states because they believed blocking increased psychological distress. Furthermore, Ciesla et al. (2012) found that promoting increased awareness was ineffective in improving mood in

adolescents, whereas the processes of non-judgement and acceptance of a stressful experience proved more effective, suggesting that both non-judgement and acceptance are important to improved outcomes. Neither non-judgement nor acceptance engages the individual in changing their emotional state or external experience. Non-judgement and acceptance change the individual's response to the emotion by changing their relationship to their emotional state from critical to accepting. Therefore, changing the context in which the emotion occurs to a mindful context of acceptance and non-judgement changes the outcome of the thought or experience. This way of managing distress echoes that of the participants whose experience was to 'sit with it'. They allowed the thought or experience to be and did not try to change it but approached the experience from a mindful position –using acceptance and non-judgement of the experience.

Service user participants' experience spoke about being non-judgemental as a difficult skill to master. Finding it hard to be non-judgemental when engaged in practices that increase awareness of emotions may be problematic, which may account for the increase in emotional distress when service users engaged in mindfulness. If service users are to become more aware of a negative emotion but engage with judgement of the emotion or themselves for experiencing that emotion then more distress will ensue. The calming effect of mindfulness in the service users' experience seems to be connected with decentring or detaching from emotions rather than increasing emotional experiencing which would cause distress.

Within other research mindfulness was found to increase emotional awareness and experiential acceptance leading to greater wellbeing in adolescents (Ciarrochi, 2011). Service user participants in the current study did not regularly speak of acceptance; those that did were those that spoke of being able to 'sit with' (or tolerate) their emotions. What is not clear is whether acceptance was necessary to tolerate emotions or whether acceptance relates more to entering into increased emotional experiencing. The distinction is that tolerance requires non-reactivity to emotion only whereas emotional experiencing requires the individual to allow themselves to feel emotions without distancing alongside non-reactivity. The urge surfing that was described by practitioner participants was associated with being aware of emotional states and accepting the presence of emotions to avoid reacting to the associated behavioural urge, seeming to relate to emotional tolerance rather than increased emotional experiencing.

The focus on change of behaviour as a result of engaging with mindfulness was clear for both practitioner and service user participants. Practitioner participants noted that changing service

users' responses to their emotional states was a clear aim for mindfulness in DBT. Service user participants achieved non-reactivity to inner experience through pausing and calming in relation to their thoughts and feelings. This non-reactivity could be seen as the basis for the concept of wise mind that service user participants referred to as a way of making different choices. Wise mind is a process of balanced decision making that is not wholly based on either logic or emotional states and relates closely to the concept of intuition (Linehan, 1993a). Such intuitive balanced decision making (wise mind) became important to secure positive outcomes for service user participants through the changed relationship to thoughts and emotion.

9.1.2.4 A variety of aims for engaging with mindfulness

Service user participants' and practitioners participants' reason to engage with mindfulness was to change behaviour, not necessarily to gain insight. This may have reinforced further the tendency to use mindfulness to deal with difficult situations rather than to use in everyday life to change their relationship to everyday thinking and feelings. Tolerating emotion was adequate for behavioural change and for inducing the feeling of calm. DBT is targeted at reducing life-threatening behaviours, followed by reducing therapy-interfering behaviours and quality-of-life-interfering behaviours. To reduce these behaviours a change in the relationship between thoughts/emotions and behaviours may be helpful. However, deep emotional experiencing or self-realisation do not appear necessary for inducing this change in behaviour. Practitioner participants shared some hopes that service users would be more insightful and experience their emotions more fully but it may be that this is beyond the remit of using mindfulness within DBT.

Previous qualitative studies have proposed models of phases or stages in the development of mindfulness. Malpass et al. (2012) proposed a staged model which noted that a transformation of perception was followed by a change in the relationship to the self, from a maladaptive state of limited insight to one which observed and developed insight into internal experiences. The service user participants in the current study experienced a shift in perception with regard to their thoughts and emotions but did not speak of a change in relationship with themselves. It may be that the specific difficulties that they had with acceptance and being non-judgemental of their experiences meant that they stopped short of a changing their perspectives of themselves as individuals. This may have been exacerbated by developmental stage as mid to late adolescence is a time of great change with regards to the development of identity (Siegel, 2015). A contributory factor to changed perspective on self

that was noted in the Malpass et al. (2012) study but absent in the current study was that of kindness. Kindness and self-compassion leading to a change in relationship to the self. Perhaps therefore DBT needs to expand the teaching of mindfulness to include kindness and self-compassion alongside non-judgement and acceptance so that service users can develop a more compassionate perspective on themselves as individuals.

Monshat et al. (2012) proposed a phased model where participants moved from distress and reactivity to a greater sense of stability and finally gained insight and behaved in a different way. This is very much in keeping with the findings of the current study and ideas such as pausing, calming and dealing with strong emotions resonate between the findings of both studies. However, it is not clear in the current study that service users necessarily go through all the phases in order to experience benefit. In the current study service user participants favoured different ways of approaching mindfulness – mindfulness met their needs in different ways either through decentring from negative thinking or tolerating emotions. Less frequently non-judgemental acceptance of emotion (emotional experiencing) was stated as helpful to changing their experiences. Pepping et al. (2016) found that individuals engage with mindfulness for different reasons and the goals that individuals have develop from practical reasons (feeling better) to existential reasons (understanding themselves) as they progress in their experience of mindfulness. This finding and the experience of the service user participants in the study suggests that emotional experiencing and changing perspective on the self may be advanced outcomes in mindfulness, requiring a greater degree of proficiency. It therefore seems important that the goals of using mindfulness in DBT are clear to both service users and practitioners as the goals of decentring; non-reactivity and emotional experiencing require subtle differences in the approach to mindfulness. Furthermore, these goals need to be considered in relation to the length of treatment if some outcomes of mindfulness are considered to be advanced skills that require engagement with mindfulness over time. The goals also need to be considered with regard to developmental stage as younger adolescents in particular may not have developed adequate abstract thinking or existential reasoning abilities (Hacker, 1994).

9.1.2.5 Emotional experiencing vs decentring from emotions

Practitioners and service users were cautious about the outcome of becoming more aware of emotions so they made changes to how they approached mindfulness. Service user participants spoke about limiting the amount of internal focus that they used in mindfulness due to their fear that they would become overwhelmed by their emotions. There was a

tendency to stick with externally focused exercises that distracted service user participants from their thoughts and feelings. Practitioner participants spoke about taking things very gently or avoiding certain mindfulness exercises that they had experienced service users finding aversive due to the increase in internal awareness. For some service users, engaging in mindfulness gave relief from unwanted experiences by providing distraction – a blocking out of thoughts or feelings, whilst others used mindfulness as a platform to endure the experience whilst being aware of the distress. The experience of heightened distress as a result of exposure to difficult thoughts and feelings has been identified in other studies as a barrier to engaging with mindfulness which would suggest that service users may avoid mindfulness practices that made them feel worse (Finucane and Mercer, 2006; Banerjee et al., 2017). Service user participants spoke about an aversion to using mindfulness to experience their body, mind or emotions. Service user participants tended not to increase awareness of unwanted thoughts and emotions. Service users chose a different benign activity to focus on which reduced feelings of distress. Avoiding an internal focus was an avoidance of experiencing unpleasant internal states.

During the analyses I was aware of my preconception that the use of distraction is not particularly mindful as by distracting an individual is not in the present moment, they have created a moment to be present in. Although participants used the some skills of mindfulness during distraction, they were intentionally focused on just one thing, they had awareness of an activity of their choosing rather than their emotional state. Engaging with mindfulness through distraction had the desired outcome of reducing distress and preventing harm.

Service user participants described changing the way they approached their thoughts – pausing, stepping back and not reacting. The relationship to the function of thoughts as triggers for action was changed. Murphy and Lahtinen (2015) found that adults with depression were identified as relating in a more neutral way to thoughts, becoming less reactive; supporting the idea that mindfulness encourages a different relationship with thoughts. Similarly, mindfulness has been noted to have the effect of helping individuals to stop ruminating and to consider their thoughts as separate from themselves (Stelter, 2009).

The link between rumination and distress may be connected to the way in which service users chose to engage with mindfulness. Rumination has been identified as having a key role in producing negative emotional states and harmful behaviours in response to stressful life events and increased rumination has been demonstrated with increased BPD symptoms (Ciesla et al. 2012; Selby et al., 2016). For the service user participants, mindful distraction

blocked the processes of rumination and emotional experiencing. Lebois et al. (2015) found that engaging in mindful attention shifted the individual's focus and engaged the individual in the effort of attention, thereby disrupting rumination. The process of mindful distraction would seem to be consistent with this way of reducing rumination – the participants shifted their focus away from the distressing thought and they put effort into paying attention to the new stimuli.

Service user participants and practitioner participants indicated that distracting from thoughts may be problematic if done repeatedly over time. Tharaldsen et.al (2011) found that distraction increased the psychological distress of high-school students, a phenomenon that they attributed to the use of distraction over a long time as a way of dealing with ongoing problems. Tharalsden et al. (2011) therefore made a distinction between distraction (not thinking about thoughts) in the short term – which could be adaptive, and long-term – which appeared to be related to increased distress. Researchers have connected long-term distraction from thoughts to thought suppression or experiential avoidance. Sauer and Baer (2009) established that thought suppression – the intentional pushing away of unpleasant thoughts - had a big effect on the development of BPD symptoms. This suggests that distraction from thoughts was therefore maladaptive rather than adaptive. Pushing away of thoughts and emotions was experienced as problematic by some of the participants in the study. As the current study was not longitudinal in nature it is not possible to know whether in the long term the distraction employed by many of the service user participants continued to be beneficial. Nevertheless, the usefulness of distraction for service users in the cessation of ruminative thoughts was evident. The service user accounts suggest that distraction is adaptive through disrupting rumination whereas the literature suggests that long term suppression of thoughts and feelings is in fact maladaptive. It may be that both are true as indicated by the experience of the service user participants in the study.

The fact that mindful distraction was more common in this study indicates a preference for mindfulness that did not increase awareness of thoughts and emotional experiencing. Service user participants and practitioner participants experienced a fear that emotional experiencing through mindfulness would be harmful. Sauer and Baer (2009) found that fear of emotion led to increased thought suppression. Painful emotions were avoided by not engaging in distressing thoughts. Similarly, service user participants and practitioner participants noted the experience of distress when focused on internal states and subsequent avoidance of introspection to avoid heightened emotional states. Hayes et al. (1996) proposed that this type of experiential avoidance (which includes suppression of thoughts, emotions, sensory

experiences and memories) was a contributing factor to many types of psychopathology, not just BPD. However, service user participants had a dilemma about whether to avoid emotional pain if at all possible or to experience the emotional pain, which seemed counter-intuitive. After all, service user participants sought relief from emotional pain.

Whilst ruminating, thoughts become problems to be solved – if only I could change that experience by thinking about it over and over. Sitting with the thought or feeling through acceptance and non-judgement does not engage the individual actively in their thoughts to change them. They do not have to solve the problem – they just have to let it be. They do not see the thought as right or wrong only that the thought is present. Therefore the individual tackles rumination not by blocking rumination through distraction but by engaging in a process that is opposite to rumination. The participants in the study who chose to sit with experiences described the benefits as freedom from distress and a reduction in their experience of emotional pain. They were no longer fighting rumination head on but were taking the power out of rumination by allowing their thoughts to be, even traumatic thoughts that had once caused high levels of distress, thereby experiencing relief from the associated distress. For a few of the service user participants there was evidence in their accounts that they found it very hard to employ acceptance or non-judgement when faced with distress and therefore slipped quickly into rumination. Service users pursued distraction over acceptance and awareness intentionally in order to protect themselves from the risk of distress associated with their internal states.

Despite being counterintuitive there is reason to believe emotional experiencing would reduce rather than increase distress and mental health difficulties (Krause et al., 2003; Sauer and Baer, 2009; Thompson and Waltz, 2010). However, avoidance of emotional vulnerability is not particular to those with mental health difficulties and has been identified as widespread (Brown, 2006). Practitioner participants experienced service users as incredibly vulnerable and too fragile for the task of emotional exposure. Practitioners noted that the service users accessing DBT in their services were often avoidant of thoughts, feelings, memories and bodily sensations. Most of the practitioners noted this to be due to service users having lived in environments of trauma, abuse or invalidation. The notion that emotional avoidance and thought suppression are associated to symptoms of BPD and other psychopathology is borne out through research (Sauer and Baer, 2009; Im and Follette, 2016). However, practitioners also identified the way in which the present culture endorsed limited exposure to feelings, highlighting the numerous distractions available to people day to day. This suggested that

practitioners had a belief that being open to emotional awareness was outside of everyday culture regardless of the experience of trauma or abuse.

Practitioners spoke about service users having a fear of moving from a state of blocking experiences to that of being aware and connected. Practitioners feared what would be uncovered, the level of distress that may be let loose and their own capacity to deal with this, especially in a group setting. There was a dilemma for practitioners with regard to how much they encouraged mindfulness as a way of exposing service users to painful emotions, memories and thoughts. On one hand there was a belief that avoidance of these things was central to some of the problems that were being experienced by service users. Practitioners referred to the difficulty in engaging in mindfulness for their service users as associated with the experience of trauma. Some practitioners referred to specific trauma and others the experience of traumatic developmental environments. Developmental trauma is the repeated experience of chronic and prolonged traumatic events in early life or the absence of the nurture and care required for development (van der Kolk, 2006). The idea of developmental trauma has links to the notion of invalidating environments which are suggested as instrumental in the development of emotional dysregulation and BPD (Grove and Crowell, 2018). There are also many parallels between developmental trauma and attachment patterns that were identified as disruptive to the development of a 'mindful brain' (Siegel, 2007)

It is not possible to tell which of the participants in the current study had been subject to trauma or had developed symptoms of PTSD. However, research suggests that around 53.1% of those with BPD have co-morbid PTSD (Scheiderer et al., 2015). Furthermore, Treleaven (2018) explored how the impact of non-PTSD trauma reaction is likely to affect a much wider range of people. Therefore, it seems reasonable that the practitioners were cautious that service users would be subject to the effects of trauma. Trauma, whether specific or developmental has a number of effects on individuals. Individuals who have become 'traumatised' find it harder to modulate physical and emotional responses to reminders of trauma (van der Kolk, 2006). Practitioners believed that trauma would affect service users' ability to engage with mindfulness, the fear being that mindfulness would leave service users more vulnerable to memories and re-experiencing trauma and subsequent dysregulation. Williams and Swales (2004) noted that the experience of some service users with trauma histories engaging in mindfulness made them more vulnerable to emotional dysregulation and subsequent suicidal urges. That many of those in DBT had been using coping strategies precisely to avoid exposure to post trauma experiences was noted by Linehan (1993a) when she developed DBT. These difficulties were the basis for mindfulness in DBT being focused on

skills for living rather than prolonged meditations. However these adjustments may not have been sufficient for those with specific trauma histories to engage with mindfulness.

The treatments available for PTSD are varied, with the central tenet of many being a level of exposure to the thoughts, feelings or memories associated with the traumatic event(s). Fiorillo and Fruzzetti (2015) highlighted the way in which the mindfulness as practiced in DBT could be helpful to those who had experienced trauma. They saw each of the mindfulness skills as having something specific to offer those affected by trauma. By observing they noted that service users took a step back from their experiences rather than being embroiled in them, in describing that they would begin to understand that their experiences did not need to dictate behaviour and that by practising 'participate' the service user would begin to step out of habitually defined behaviours. They went on to propose that those affected by trauma would benefit from considering their experiences non-judgementally and one-mindfully to prevent the experiences affecting their whole self- image. Fiorillo and Fruzzetti (2015) focus mainly on the exposure to the feeling associated with thoughts and memories of trauma and blocking any maladaptive responses such as shame. Their case example is based on an individual therapy session rather than a group context. The parallels they draw between the desired outcomes of mindfulness and the usefulness in treating trauma seem credible and are similar to the ideas that were proposed by some of the practitioners. However, this approach to introducing mindfulness to people who may have experienced trauma was uncomfortable and worrisome to some of the practitioners, leading to a preference for externally focused exercises. Practitioners used measured exposure to mindfulness in a way that gradually exposed people to their thoughts and feelings. This was somewhat more difficult in a group setting meaning that practitioners erred on the side of caution, sticking with mainly outwardly focused mindfulness exercises. Furthermore, factors such as the relatively short duration of many of the DBT interventions offered, the adolescent developmental stage of the service users and the aims of therapy to change behaviour would also impede the delivery of mindfulness in DBT as a way of treating trauma.

The additional needs of those with PTSD symptoms have been identified as benefitting from exposure work alongside DBT (Harned et al., 2004). In this augmentation of DBT the protocol for treating trauma, Prolonged Exposure (PE) is offered alongside DBT, with standard DBT offering a period of stabilisation before the introduction of PE protocol. Previously the approach to DBT was that the treatment of trauma should occur after standard DBT was completed. However, the research showed that taking the combined approach was preferable to 76% of those offered DBT-PE. The researchers hypothesised that this was due to the

combined approach relating more closely to the experience of the service users. Such an approach suggests that standard DBT does not treat trauma fully as a stand-alone treatment. If mindfulness in DBT is making service users vulnerable to re-experiencing trauma or the emotional effects related to this trauma it would make sense that both service users and practitioners are reticent about engaging in mindfulness without the addition of interventions to address the trauma-related difficulties.

Whilst mindfulness –oriented interventions for trauma have become of interest to practitioners involved in many types of mindfulness interventions, some practitioners are, in the way that the practitioner participants are in the study, recommending caution in the use of mindfulness for those with trauma histories. Treleaven (2018) described the need for trauma-sensitive mindfulness practice and for specific trauma-focused work to be done with service users rather than seeing mindfulness in itself as a treatment for trauma. Briere (2015) also suggested that mindfulness offered in isolation had limitations in the usefulness to those having experienced trauma. Both Treleaven (2018) and Briere (2015) offered specific guidance as to how mindfulness could be modified to support recovery from trauma. Treleavan (2018) described these as five principles of trauma-sensitive mindfulness practice: staying in the window of tolerance; shifting attention; keeping the body in mind; using relationships and understanding context.

Whether to promote emotional awareness through mindfulness seemed to cause the greatest amount of apprehension for the practitioners. There were a number of dilemmas facing the practitioners when it came to dealing with unwanted emotions: Should they stay focused on external activities which appear less challenging or develop the ability of service users to participate in internally focused exercises? Should they avoid potential distress or encourage service users to learn to 'sit with it'? There seems to be a difference between the benefits and risks of external focus and internal focus. External focus allows for a reduction in rumination but may increase emotional blocking; internal awareness allows for emotional experiencing but may lead to increased distress.

Practitioner participants had a notion that they were not equipped to support those who have experienced trauma to access mindfulness. This is borne out in the literature surrounding mindfulness and trauma. Only a few of the service users were able to use mindfulness in the way described by Fiorillo and Fruzzetti (2015) to enable exposure to and subsequent relief from experiences associated with trauma. These service users required guidance in 1:1 sessions or additional guidance from mindfulness practitioners in addition to the DBT group.

Practitioner participants became avoidant of using mindfulness as a tool for introspection and self-awareness. For the majority of practitioners in the study, fear and lack of knowledge with regard to the effects of mindfulness on those with a history of trauma limited the use of mindfulness. Therefore practitioners using mindfulness in DBT may need extra training and insight into the advantages and limitations of using mindfulness with those experiencing trauma. Julie who was the most bold in using mindfulness as a way of exposing to fear of emotional experiencing spoke mostly about doing this individually with service users and that she used this individual time to tune into that person to be very precise about the rate at which she encouraged the exposure to painful experiences. Many of the practitioners in the study only had the opportunity to engage with service users in a group context where they knew less about the individuals and had to be attentive to each person's needs. They would therefore not have had the opportunity to work closely with individuals to support them to become more open to emotional experiencing.

Chapter 10: **Discussion of Findings**

10.1 **Overall synthesis of findings**

There were two higher order concepts that outlined the experience of service users and practitioners in this study. Both concepts presented as complex and highlighted dilemmas for the use of mindfulness in DBT.

A struggle with uncertainty and challenge relates to how mindfulness was experienced as difficult to engage with as a practice and as a treatment. As a result, attempting to engage with mindfulness had the potential to induce feelings of uncertainty, confusion and inadequacy. At times this inadequacy was experienced as self-consciousness and embarrassment. In the case of service user participants difficulties in engaging with mindfulness also led to a sense of shame.

Alongside the notion that an individual may have particular difficulties with accessing mindfulness was the notion that mindfulness in and of itself is difficult to access. Practitioner participants were aware of and tried to resolve difficulties in engaging with mindfulness. Their confidence to do this related to their personal beliefs and experiences of mindfulness. Practitioner participants and service users were left with a dilemma as to how much to push ahead despite difficulties in engaging with mindfulness.

Developing internal awareness with caution highlights the uncertainty about whether the outcome of mindfulness is to avoid, tolerate or experience painful thoughts, emotions and bodily sensations. Fears as to the outcome of using mindfulness to become fully aware of internal states led to caution demonstrated through the focus on external, activity based mindfulness. The focus on behavioural change did not seem to necessitate the development of internal awareness and therefore positive change was experienced despite the favouring of distraction above awareness. Changes in relationships to thoughts and emotions were evident and this change produced a sense of calm and considered decision making in challenging situations. It is not clear however if the approach that favoured distraction led to relief of distress over time. The experience of those who developed the ability to tolerate rather than distract seemed more lasting although this cannot be established because participants were interviewed only once.

10.1.1 Building an individual experience of mindfulness

The idiographic nature of this study has highlighted how service user participants build an individual and complex experience of mindfulness. Although the service users' experiences resonate with each other the individual experience was influenced by the service user participants unique set of circumstances in terms of uncertainty, challenge and how they used mindfulness to deal with difficult thoughts and emotions.

Wagner et al. (2006) described the approach to mindfulness in DBT-A as centred on re-focusing attention on a task when the adolescent experiences their mind wandering. This is in keeping with the descriptions of service user participants and the apparent mechanisms of change at play – decentring and decoupling. However, Wagner et al. (2006) also indicated that the aim of mindfulness in DBT for adolescents was to increase awareness, non-judgement and acceptance, skills that were not described by most of the adolescent service user participants. In fact Wagner et al. (2006) made special mention of desensitisation to negative emotional states through mindfully observing emotions as a wave, this desensitisation was not reflected the mindful distraction employed by many of the adolescent service user participants. Although the theory of the benefits of using mindfulness with adolescents in DBT is in keeping with the extant literature it is not fully demonstrated in the experience of the participants in this study. More needs to be understood about whether the disconnect between theory and practice is due to flaws in the theory of what is possible for adolescents with BPD symptoms or flaws in the delivery of DBT-A e.g. through limited understanding of practitioners or modifications to programmes (no access to phone coaching, no parent/carer present).

The findings demonstrate the way in which individual practitioner participant's experiences and attitudes were instrumental in the way in which they approached teaching mindfulness in DBT including their confidence, the value they place on mindfulness in DBT and the caution with which they approach developing internal awareness.

Mindfulness was rarely reinforced by everyday life. In fact participants noted that being non-judgemental was not reinforced by day to day life whereas being distracted from thoughts and emotions was reinforced daily. Practitioner participants recognised the need to make mindfulness easier – to make the connections between mindfulness and everyday life and to make mindfulness relevant to the issues that their service users were facing. Overcoming uncertainty with regard to mindfulness was related to ensuring that clear links were made between mechanisms of change (emotional non-reactivity, non-judgement, acceptance) and desired outcome (changed behaviour) and to ensuring that specific barriers were identified for

individual service users who struggled to make use of mindfulness. Practitioner participants noted the need for pre-treatment and an individualised approach to ensure that service users could make use of mindfulness. Whilst the exclusion of those who cannot make use of mindfulness would be difficult it is also problematic to offer a treatment that is not suited to a particular individual; more work needs to be done to be able to highlight those that can make use of mindfulness.

10.1.2 Consistency and difference with other findings

The two higher order concepts have a high level of consistency with other studies. The outcomes of mindfulness identified by participants in this study resonate with those identified in previous qualitative studies. That mindfulness has an effect on thoughts and feelings, 'transforming the perceptual situation' (Malpass et al. 2012) and 'relating differently to thoughts and feelings' (Wyatt et al., 2014) were parallel to the findings of the current study. As were the themes of pausing (Ashcroft et al., 2011; Hertenstein et al., 2012; Lilja et al., 2015; Murphy and Lahtinen, 2015; Sguazzin et al., 2017) and reducing distress (Ames et al., 2014).

The usefulness of the group setting (Malpass et al., 2012; Wyatt et al. , 2014), awareness (Malpass et al. 2012; Wyatt et al., 2014) was not identified in the current study. In fact disadvantages were identified with regard to the group programme such as self-consciousness and distractions from other group members which may have been exacerbated by the fact that most of the groups were being delivered to adolescents.

10.1.3 Mindfulness in not experienced as completely benign

That mindfulness can have undesired outcomes has been identified in previous studies although these ideas have not been extended to indicate that mindfulness should be contra-indicated for certain individuals (Hertenstein et al., 2012). Practitioners in the current study questioned if mindfulness was indicated for everyone and whether it could be contra-indicated at times. Service users were unsure as to whether they should persist with mindfulness if it contributed to discomfort and distress. Practitioner participants also differed in the belief that distress indicated a reason to stop or to carry on. Consideration of whether individuals experience harmful effects of mindfulness has been recommended and caution advised for those who experience adverse effects whilst engaging with mindfulness (Treleaven, 2018). The experiences of service user and practitioner participants in this thesis suggests that rather

than being applied indiscriminately that an individualised approach to mindfulness should be taken, targeting the specific areas upon which the service user needs to focus.

Service user participants had the most adverse experiences when they attempted awareness of internal states and as a result often chose an external focus for mindfulness. When reading the accounts I noticed a difficulty for myself as researcher and clinician between the usefulness of mindfulness as experienced by the service user participants and my desire that they use mindfulness in a more profound way to experience their emotion as more fully, with more insight into their own emotional states. Ultimately, changing the relationship they had to themselves as individuals. A similar belief is held within psychology and psychotherapeutic approaches. For example a website reviewing psychotherapy services stated the author's belief as follows:

'Once the painful memories are out in the open, they begin to lose their power. You feel less burdened by them as your therapist will help you carry their weight. Verbalizing the emotions and sensations you feel as you remember helps your brain to better process the information, helping you to feel differently or change your perspective.' (Khaefi, 2011 https://www.goodtherapy.org/blog/talk-painful-feelings-therapy/)

This quotation suggests that experiencing emotional pain is necessary for recovery from psychological difficulties. However, the notion that emotional experiencing is necessary for improved outcomes may in fact be a false assumption. Emotional suppression has been shown to be adaptive in nature and cognitive reappraisal shown to have negative effects in certain situations –when a situation is inside of someone's control (Dunn et al., 2009; Brockman et al. 2016). Therefore my assumption and the assumption of other therapists that pain in therapy is a signal to continue to push and avoid emotional experiencing may not be desirable or indeed necessary for positive outcomes. Furthermore, placing individuals' experiences at the centre of therapy may lead to an assumption that all distress is intrapersonal and not associated with social causes (Masson, 1993). There may therefore be limits to the usefulness of increased self-awareness and a mentally healthy life may not be contingent on increased experiencing of thoughts and emotions. Conversely, symptoms of BPD have been associated directly with emotional avoidance and thought suppression (Sauer and Baer, 2009). This association may indicate that increasing awareness of thoughts and emotions and greater emotional experiencing is necessary to reduce symptoms of BPD but perhaps socio-political factors that contribute to the development of BPD need to be explored so that the emphasis is not wholly on intrapersonal change. Mindfulness that is socially and interpersonally focused

may be helpful in this respect. That interpersonal mindfulness improves the quality of relationships has been established (Pratscher et al., 2017) and improved quality in relationships is one of the goals of DBT skills training (interpersonal effectiveness). Wagner et al. (2006) highlighted the usefulness of developing mindful communication within session that included parents/carers and adolescents, theorising that this redressed some of the invalidating experiences that maintain BPD symptoms in adolescents. Doing more to link mindfulness with interpersonal effectiveness may maximise the preference for externally focused mindfulness exercises and balance the emphasis of intrapersonal change with that of interpersonal change.

The two higher order concepts convey a mix of fear and hopefulness about mindfulness in DBT. Although decentring from thoughts and tolerating emotion led to desired behaviour change, service users and practitioners avoided engaging in mindfulness to experience emotions more fully. Emotional inhibition and shame seemed to perpetuate a fear of engaging more fully in mindfulness. Service users and practitioners experienced a dilemma between whether engaging in mindfulness was fundamentally difficult or whether the individual trying to engage with mindfulness was restricted with regard to ability to be mindful. When mindfulness was assumed to be at fault there was a sense that the wrong approach had been offered and when the individual was assumed to be incapable, a level of embarrassment, self-consciousness and shame was experienced as a result. Shame and self- invalidation of emotions increase negative emotional states (Brown, 2006; Krause et al. 2003). Therefore it may not be mindfulness in itself that leads to adverse experiences but a self-concept that has the propensity for shame and self-invalidation. Both of these have been identified as being particularly connected to those with BPD symptomatology (Linehan, 1993a; Rizvi and Linehan 2005). Therefore those who deliver treatments that use mindfulness need to be conscious of the likelihood that shame and invalidation will make it difficult for an individual to use mindfulness effectively. This is especially so in DBT as it targets those with BPD who are especially vulnerable to the experience of shame.

10.1.4 Non-judgement as a particular deficit - self compassion as the antidote

In DBT the concept of non-judgement is taught as a way of being more able to consider situations without classifying them as good or bad (Linehan, 1993a). Therefore, increased non-judgement, which was highlighted as particularly difficult for service user participants in the study, may reduce the impact of shame and self-invalidation experienced in mindfulness. The idea of non-judgement relates closely to self-compassion. Whilst mindfulness teaches non-

judgemental awareness of the present moment, self-compassion teaches a non-judgemental perception of the individual having the experience (Neff and Davidson, 2016). As such self-compassion allows individuals to connect to their own suffering without judgement of themselves as individuals. Neff and Davidson (2016) highlighted that self-compassion required a mindful approach to prevent over identification with, or rumination about, thoughts and emotions.

Bluth and Blanton (2014) theorised that self-compassion worked alongside mindfulness in promoting well-being in an adolescent sample and developed a model of a reciprocal association between mindfulness and self-compassion. Service user participants in the current study often appeared more connected to shame with regard to their engagement in mindfulness rather than noting times of self-compassion. This did not seem mirrored or re-enforced by practitioner participants who spoke more frequently about acceptance and were compassionate towards service users struggle with mindfulness and emotion. Both adults and adolescents experiences greater wellbeing when they are able to be self-compassionate (Neff and McGehee, 2009). However, adolescent's cognitive development and family factors affect their ability to be self-compassionate (Neff and McGehee, 2009) which may have been the case for the adolescents in the current study.

MBCT has been shown to have the effect of reducing internal shame and increasing self-compassion suggesting that self-compassion has a role in improved outcomes (Proeve et al., 2018). By increasing self-compassion those receiving MBCT were better able to accept negative emotions and have less of a tendency to emotionally avoid (Bakker et al., 2018). Furthermore, in Turkish adolescents self-compassion was found to mediate between mindfulness and resilience suggesting that self- compassion is necessary to benefit from mindfulness (Sunbul and Guneri, 2019). Self-compassion extends the concept of non-judgement through the notion that the experience of negative affect does not reflect negatively on the individual and therefore mindfulness exercises that increase self-compassion may need to be adopted in DBT to help service users with feelings of shame and invalidation that are activated when they engage with mindfulness. Since self- compassion has been identified as a moderator between emotional regulation and BPD symptoms – those with higher levels of BPD symptoms having lower levels of self-compassion and emotional regulation (Loess, 2015) there seem to be ample grounds for increasing the focus on self-compassion focused mindfulness in DBT.

Chapter 11: **Conclusion, Implications and Reflections**

11.1 **Key findings from this study**

This research study aimed to understand the lived experience of mindfulness in DBT from the perspective of adolescent service users and DBT practitioners. The findings of the study highlight a number of interpretations made about the experience of mindfulness in DBT that have implications for clinical practice, research and social policy.

The aim of the study presented in this thesis was to answer the research question: *What is the lived experience of adolescent service users and DBT practitioners engaging with mindfulness in DBT?*

More specifically I aimed to answer the following questions:

- What does the experience of adolescents undertaking DBT tell us about how adolescents utilise mindfulness?
- What does the experience of practitioners teaching DBT tell us about how practitioners approach the teaching of mindfulness?
- What does the experience of adolescents and practitioners tell us about the place of mindfulness in DBT?

11.1.1 How adolescent participants utilised mindfulness

The experience of service user participants and practitioner participants was that of engaging in mindfulness was a way of decentring from thoughts (Lebois et al., 2015) and being non-reactive to emotion (Levin et al. 2015). These facets of mindfulness can be seen in the teaching of mindfulness in DBT. The skill of 'one minded' encourages focus on one thing which may help to decentre from thoughts; the skill of 'non-judgement' relates to non- attachment to emotions by reducing thoughts that may increase an emotional reaction to a situation and 'practising effectiveness' relates to non-reactivity through changing the decision making process. However, it was processes that were implicit in the teaching of mindfulness – pausing and calming that were most commonly stated as useful by service user participants. Moreover, service user participants experienced pausing and calming primarily through focused attention on an external stimulus rather than on their thoughts and emotions. This was interpreted in the current study as mindful distraction rather than present moment

awareness. Mindful distraction is encouraged through the activity based mindfulness exercises practised in the skills training group. The focus of reducing distress at a particular moment of time engaged service user participants in mindfulness in a particular sort of way that lends itself to symptoms reduction but not necessarily to long term change in their distress overall. A small number of service user participants spoke of increasing their awareness of emotions in order to reduce distress in everyday life, changing how they responded to emotions and thoughts. For others, continued emotional avoidance was encouraged by a focus on external focused distraction. The experience of participants suggested that continued mindful distraction would not result in sustainable change, highlighting that using mindfulness as a behavioural strategy may not result in overall reduction in distress or symptoms.

There were clear reasons within service user and practitioner accounts as to why there were fewer service user participants that engaged in emotional awareness. Fear of being overwhelmed by emotion, becoming dysregulated and experiencing symptoms related to unprocessed trauma led to avoidance of internal focused mindfulness. Since behavioural change was possible without increased emotional awareness, encouraging emotional awareness was unnecessary to the DBT process and was therefore avoided by most practitioners. That mindfulness can be averse to those who have experienced trauma has been noted in clinical practice (Treleaven, 2019) and therefore practitioners face dilemmas between using mindfulness behaviourally to reduce immediate distress or existentially to increase self-awareness and emotional experiencing.

11.1.2 The place of mindfulness in DBT

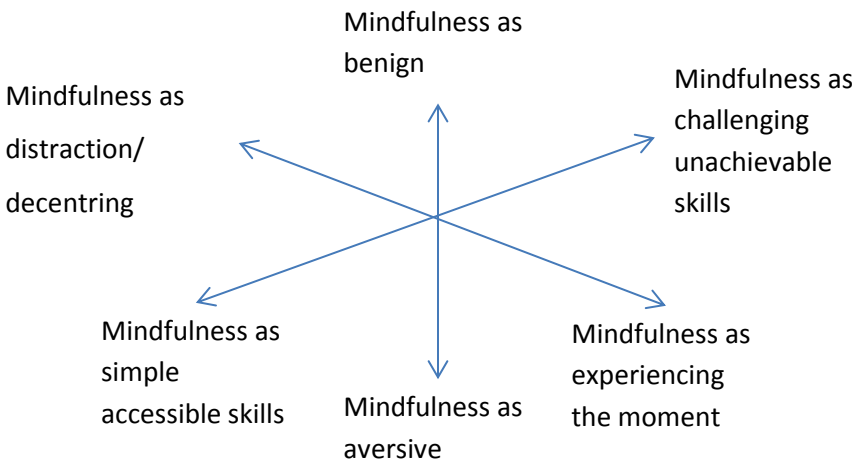
The aims of DBT encourage a specific way of engaging with mindfulness and success in DBT may not necessitate engagement with mindfulness. The aims of DBT are to reduce certain behaviours; behaviours that are physically damaging, interfere with therapy and reduce the quality of life for service users (Linehan, 1993). This behavioural focus was present within the accounts of service user participants and practitioner participants and therefore mindfulness was employed ultimately to change behaviours through disrupting the belief that thoughts or emotions are a signal for behaviour. Engagement with mindfulness helped to meet the behavioural aims of DBT through decoupling and decentring from thoughts and emotions. Some practitioners thought behavioural change was possible in DBT without engagement with mindfulness whilst others thought it central to the ability to use other skills. It is unclear from the service user and practitioner accounts whether mindfulness is in fact a necessary

component to change in DBT and more research would be necessary to establish the importance of mindfulness in DBT

11.1.3 Findings as dialectical dilemmas for service users and practitioners

The higher-order concepts that were generated highlight a number of dilemmas that service user and practitioner participants navigated in order to find a route into mindfulness: Whether actual or perceived inability to be mindful can be surmounted; whether mindfulness was a helpful part of the treatment and whether the goal of mindfulness in treatment is symptom reduction or improved self-awareness. Some of these dilemmas relate to wider beliefs about the role of mental health services; the constituents of a mentally healthy life and the necessary characteristics of an effective psychotherapeutic treatment. As such these dilemmas can be thought of as the dialectics of mindfulness practice in DBT. The dialectics that seem most pertinent to the findings of the research are outlined in Figure 27.

Figure 27 Dialectics of Mindfulness in DBT



The struggle and uncertainty that were experienced by service user and practitioner participants brings in to question the way in which mindfulness is used within DBT. There were indications that mindfulness cannot be accessed equally by service users and that mindfulness presents a specific challenge to adolescents. Practitioner participants experienced uncertainty also and therefore struggled to ease the uncertainty about mindfulness for service users. However, because mindfulness is only a part of DBT the barriers experienced while

trying to engage with mindfulness were not given adequate time and attention in therapy – leaving service users feeling inadequate. Hall (2013) noticed that practitioners often felt discouraged in the use of mindfulness in the group due to service user's finding it difficult or irrelevant, leading practitioners to devalue mindfulness as part of the DBT treatment. However, in order to reduce the impact of uncertainty and struggle, DBT practitioners would need to be more extensively trained in mindfulness, spend more time on mindfulness teaching and be more convinced of the necessity of mindfulness.

11.2 Clinical implications

The findings of this study encourage DBT practitioners to take a fresh look at the way in which mindfulness is used and taught in DBT. These can be divided into recommendations for the mindfulness curriculum in DBT; the training and personal practice of DBT practitioners and the approach taken in day to day clinical practice.

11.2.1 The DBT mindfulness curriculum

Making the intended outcomes and the proposed mechanisms of change clear to service users is vital in helping service users engage with mindfulness. There are a variety of outcomes to engaging with mindfulness from the perspective of DBT; decentring from thoughts, non-attachment to emotion and emotional non-reactivity. That these particular facets of mindfulness seem to relate closely to the behaviourally defined targets of DBT may mean that insight or emotional experiencing is beyond the remit of DBT treatment. This may be especially pertinent in the context of the use of DBT in NHS services where the type of treatments offered is related closely to the improvement of specific outcomes. It is therefore important to be clear with service users about the intended goal of mindfulness as a skill.

DBT practitioner participants were certainly sensitive to the notion that for those who have experienced trauma mindfulness could be aversive. They also employed short practices to minimise distress and gave choice to people about how they engaged with mindfulness. However, there was uncertainty about whether mindfulness would be unsafe for those with a trauma history. The addition of self-compassion, vulnerability and trauma sensitive mindfulness practice may be important to the development of mindfulness within DBT. DBT practitioners could become versed in trauma-sensitive mindfulness practices to increase their confidence in approaching mindfulness with service users who are potentially traumatised.

Treleaven (2019) noted five principles to guide practitioners and service users to use mindfulness despite the influences of trauma. These principles are:

- to stay in the window of tolerance - teaching service users to be aware of their level of arousal and to adjust mindfulness practices accordingly
- to shift attention to support stability - teaching service users to use anchors of focus should they notice that they are entering fear or freeze
- to be aware of the possibility of dissociation - being cautious of body scan and smells, encouraging eyes open practice, encouraging movement practice
- to practice in relationship - for service users to have opportunity to explore their experience of mindfulness and for practitioners to understand individual's particular experiences of mindfulness.
- to understand the social context - for practitioners to be sensitive to the influences of social marginalisation and oppression associated with race, gender and the like.

Likewise the addition of compassion focused practices focused on reducing self-criticism and increasing curiosity, responsibility and peace with the self. Compassion focussed practices may extend the usefulness of mindfulness, through self-kindness, identification with common human difficulties and being able to step back from common challenges of life (Bluth and Blanton, 2014).

There is precedent for the development of DBT to target different service user groups with particular symptom profiles. Mindfulness principles have been extended with more focus on non-reactivity to emotions in DBT- PE (Harned et al., 2012) and to develop self-inquiry into mind states in Radically Open-DBT RO-DBT (Lynch, 2018). Modifications may be made to mindfulness teaching to make it more accessible to those with certain characteristics. The current research has highlighted the addition of self-compassion and trauma sensitive practice as particularly useful in reducing the experience of mindfulness as aversive. However, consideration may need to be given to excluding those for whom mindfulness is contra-indicated. Without adaptations to mindfulness in DBT to deal with characteristics that may make mindfulness particularly challenging the teaching of mindfulness may become counterproductive for some service users.

Modifications such as the addition of teaching on self-compassion, an individualised assessment of aptitude for mindfulness and targeting of specific barriers to mindfulness within a psychotherapeutic relationship may all be helpful in making the mindfulness element of DBT more meaningful to service users. Such modifications may however require DBT to become mindfulness focused rather than teaching mindfulness as a skill alongside other skills for the service user's emotional toolbox. This would require mindfulness to have more focus within the training of practitioners.

Specific thought and modification needs to be given to the use of mindfulness with adolescents. Considering how the adolescent developmental stage may affect their ability to engage in mindfulness. Although thought has been given to making the mindfulness exercises more engaging for an adolescent audience (Miller et. al., 2007) specific teaching on adolescent development as it relates to mindfulness also seems indicated from the study.

Some of the struggles with mindfulness within DBT may be well illustrated within the teaching by the dialectics identified in Figure 27. Service users and practitioners will be familiar with the notion of finding a middle path in order to navigate such contradictions in their experience. Therefore, discussions highlighting these common dialectics will help service users to understand the struggles and challenges that they face.

11.2.2 Practitioner training and personal practice

Practitioners should consider their personal influence in the teaching of mindfulness. Practitioners need to be aware that the way they teach mindfulness will be influenced by their own experience and knowledge. By teaching mindfulness skills from a script, practitioners will attempt to impart the concepts of mindfulness but are less likely to be able to inspire service users to connect to mindfulness and to be able to manage the specific barriers experienced by individual service users (Crane et. al. 2012). Therefore it is likely that those practitioners with an understanding of mindfulness beyond the teaching programme will be more effective in supporting service users to engage with mindfulness.

In the development of mindfulness teacher competencies Crane and Kuyken (2019) identified the importance of knowledge and teaching skill alongside embodiment of mindfulness within the teacher. This would suggest that in order to improve service user understanding and experience of mindfulness practitioners need to be given more knowledge about mindfulness and also to develop a personal practice of mindfulness.

There have been additional texts written specifically to extend the understanding of mindfulness practice within DBT for practitioners (Dunkley and Stanton, 2014; Hall, 2013) and service users (Dunkely and Stanton, 2017; Koons, 2016). It would therefore seem helpful for these texts to be included in the DBT home work for the intensive training. In addition an understanding of the research into mindfulness - the mechanisms of change, the multi-faceted nature of mindfulness outcomes and wider understanding of the characteristics of mindfulness practice that contribute to its effectiveness would extend practitioner's competence in dealing with individual differences. Evidence of mindfulness practice and reflection on this practice

would also be helpful in addition to the presentation of a plan to develop practitioner personal mindfulness.

11.2.3 Clinical practice

There were factors experienced in an effort to engage with mindfulness that seemed insurmountable for some service users. These factors seemed connected to extant characteristics that made mindfulness inaccessible – developmental stage of the adolescent, cognitive abilities such as imagination, previous experiences such as trauma. Without attending to these specific characteristics it seems that service users and adolescents in particular may continue to struggle to engage with mindfulness in a meaningful way. The development of the ability to be mindful and the accessibility of mindfulness seem to be rather reciprocal in nature and therefore practitioners need to be able to adapt mindfulness as the need arises rather than following a set programme of mindfulness skills. Flexibility in teaching to respond to specific barriers to mindfulness would require practitioners to have a clear and substantial understanding of mindfulness.

The use of mindfulness in DBT needs to be accompanied with supporting individuals to overcome specific barriers to mindfulness. This requires knowledge of the facets of mindfulness and the potential barriers to engaging with mindfulness such as hyperactivity, previous trauma and having a life full of distractions. Service users would benefit from practitioners being alert to particular adverse responses to engaging in mindfulness. The experience of shame with regard to not being good enough to use mindfulness effectively and the experience of fear with regard to being exposed to distressing emotions require a balance between validation and encouragement to increase openness and the courage to give mindfulness a go.

Taking an individualised approach to mindfulness teaching may be necessary for those who find they are unable to access mindfulness through the skills training group. The introduction of emotionally challenging , introspective mindfulness exercises is likely to be better supported within individual therapeutic interactions than within a group due to self-consciousness and caution from both service users and practitioners. However, the teaching of mindfulness in a group should not be abandoned as interpersonal mindfulness and group based mindfulness have been shown to be helpful (Cormack et al., 2018). The aversion and self-consciousness experienced by practitioner and adolescent service user participants with regard to group based mindfulness is contrary to the findings of other studies and therefore a balance needs to

be struck between validating the self-consciousness and encouraging connection within the group with regard to mindfulness practice. Furthermore those practitioner participants involved in teaching adults noted that sharing mindfulness in the group seemed to lead to better generalisation of mindfulness to everyday life.

Emotional experiencing should be approached with care and with the consent of the service user. Service users need to be fully informed of the effects and potential benefits of emotional experiencing. The potential benefits of emotional experiencing identified by service user participants included overall reduction in emotional reactivity. However, potential adverse experiences identified included increased distress, being overwhelmed by sensory experience or emotional insights during the mindfulness practice, triggering of painful memories.

11.3 **Implications for future research**

Further research is needed to understand the dilemmas service user and practitioner participants faced in their experience of mindfulness.

It is clear that the term mindfulness is rather too broad to understand the way in which individuals apply particular facets of mindfulness. Moreover, it continues to be unclear whether mindfulness as a trait can be developed through mindfulness based interventions and whether engagement with mindfulness sustains changes in clinical symptoms. More research is needed with regard to the relative potency of different facets of mindfulness, with a clearer understanding of which difficulties benefit from which facet of mindfulness.

The uncertainty experienced by both service users and practitioners could be reduced by a greater knowledge of the outcomes that are expected through the use of mindfulness in DBT treatment. Preliminary research suggests that accepting without judgement is more evident in individuals as a result of engaging with mindfulness in DBT (Perroud et al. 2012). However, this was not clearly the case in the experience of the service user participants in the current study. An increased ability to de-centre was noted when focusing on DBT-M (more emphasis on mindfulness) and there may be some usefulness in this in reducing BPD symptoms. Similarly to the experience of service user participants in the current study behavioural change via reduced impulsivity (Soler et al., 2012) and emotional reactivity (Feliu-Soler et al., 2014) has already been identified as outcomes of mindfulness in DBT. More clarity about expected outcomes and how these relate to mechanisms of change may help to reduce the uncertainty of how mindfulness relates to symptoms/difficulties. For example, increasing knowledge in DBT

practitioners that decentring reduces the impact of rumination and therefore the individual is more able to be non-reactive to the associated emotion.

The experiences of service user and practitioner participants raised a question about whether emotional awareness is the same as emotional experiencing. Further research to establish the exact nature of awareness would be helpful in order to understand if emotional experiencing rather than emotional tolerance or non- reactivity is necessary in the effectiveness of DBT. The experience of service users and practitioners in the study and the discourse with regard to trauma sensitive mindfulness highlights the need to establish the relative usefulness and risk of entering emotional experiencing. Although emotional experiencing is thought to reduce the effects of emotional inhibition there are potential adverse reactions to emotional experiencing that need to be understood more fully.

11.4 **Policy implications**

The findings of this study highlight some implications for the use of mindfulness more widely.

Mindfulness is being ever more widely promoted in a variety of settings (All Party Parliamentary committee, 2015). This comes with an assumption that choice is the only factor that will make mindfulness practice useful to an individual. Difficulties engaging with mindfulness that were clear within this and other studies are important to consider in the wide variety of forums within which mindfulness is being promoted. The political will that mindfulness be proliferated widely in health services, prisons and education may need to be tempered in the light of possible increase in distress for those with certain circumstance and the range of abilities that there may be for engaging with mindfulness. The use of mindfulness in education, the criminal justice system and in occupational health may become an issue with refusal to take part in mindfulness practices seen as being non-compliant to curriculums, rehabilitation or performance management.

Care may need to be taken with regard to the proliferation of mindfulness to adolescents without considering specific barriers to mindfulness that may be present to developmental stage and cognitive development.

The use of skilled mindfulness teachers during the development of mindfulness programmes seems to be important to ensure programmes are developed and delivered with confidence and validity. The experience of practitioners in the current study suggests that following a

programme without prior personal experience of engaging with mindfulness may lead to practitioners becoming stuck at the same blocks and uncertainties as those they are teaching.

Clear goals for mindfulness based programmes need to be considered to ensure that the different facets of mindfulness are targeted at those goals.

11.5 Methodological considerations and limitations of the study

This section outlines the limits to the study design and findings. These limits indicate how the findings can be applied within the wider discourse about mindfulness as a treatment. The study findings need to be considered within the specific context of the participants. All but one of the participants was female therefore the findings show the experience of mindfulness for primarily adolescent females within DBT within NHS services in England.

The balance of safeguarding and practicalities had a substantial impact on recruitment of participants leading to limitations on the findings. The intention was for service users to be self-selecting, in order to prevent coercion into the study. In reality the use of the gatekeeper to safeguard participants meant that gatekeepers had a role in selection. Therefore gatekeepers may have chosen those service users that were more positive about mindfulness. That service users continued to be open to services, for safeguarding reasons, meant that those that dropped out were not given the opportunity to participate. Practitioners were self-selecting and as such were people who believed they had something to say about mindfulness.

The use of multiple sites was necessary for the recruitment of enough participants. The DBT programmes at the sites were not subject to control in this study and therefore there was heterogeneity in the type of programme that service users were exposed to and that practitioners taught. Although all of the services provided what they called DBT there were substantial difference in the participant's involvement in group, individual work, phone coaching and DBT consult. As mindfulness may be a feature of any part of the DBT programme the 'mindfulness' that each participant was referring to was different. Although the intention was that participants would be referring to the same phenomenon in reality the actual phenomenon that they experienced was different. These contextual differences are likely to be as influential on the experience of the phenomenon as intrapersonal differences. However, since the intention was to undertake a naturalistic study on real world clinical practice it was helpful to gather experiences from a range of DBT services. Although the use of different sites has advantages in giving a breadth of experience, what is not possible in IPA is to identify exactly the way in which the different features of the phenomenon relate to the different

features of the experience. Therefore it remains unclear the specific impact that practitioner experience and knowledge; length of DBT programme or delivery of a group only programme have on the experience of mindfulness in DBT.

The initial intention of the study was to understand the experience of adolescents being taught mindfulness in DBT. Due to recruitment concerns the targeted sample was widened to include adults. Despite this, seven out of the eight participants were between the ages of sixteen and twenty- two. Although adolescence has been defined as occurring between 10–19 years of age (WHO), a definition of youth as between 10–24 years of age has been identified as more useful for the development of services (Sawyer, et al., 2018). Therefore only Maria could be said to be an outlier in terms of age or developmental stage at 50 years of age. Causal connections cannot be drawn between age and the particulars of what was said by Maria. However, there were some characteristics of what Maria said that may have occurred due to the context of age and it is of note that Maria presented as the most connected to and convinced by mindfulness. Developmental stage was thought to be influential to the development of mindfulness by practitioner participants with some practitioners citing immaturity as a barrier to engaging with mindfulness. More research would need to be done to establish whether age has a significant impact on the ability to engage with mindfulness.

Practitioner participants were represented by more practitioners working with young people than those working with adults. Six out of eight practitioners worked with young people. The development of DBT with and adolescent focus suggests that the needs of adolescents are somewhat different to those of adults and therefore a different approach is required. The two practitioners involved with teaching adults were the strongest advocates for increased emotional experiencing and had the highest expectations for how mindfulness could be helpful to service users. The context of working with adults may stimulate practitioners to treat service users as less self-conscious and as having greater self-efficacy. Furthermore resistance to change due to external influence has been identified as possibly greater in adolescence (Sommers-Flannagan, 2011)

The research was conducted at a moment in time without follow up interviews with the participants. Longitudinal studies allow researchers to understand the ways in which experiences change in relation to changing contexts and whether the experience of participants remains stable over time (Holland et al., 2006). The findings of this study do not give a sense of whether participants developed or discarded mindfulness practices. Although participants seemed at different point on a journey with mindfulness the absence of follow up

data means that the nature of this journey cannot be defined. Despite there being notions that mindfulness develops over time, through decentring, tolerance and eventually to experiencing, the findings of the study cannot establish whether this is the case. These apparent stages may be progressive or related solely to the particular characteristics of the service user.

Participants used large amounts of mindful language in their accounts – language that is used in the teaching or mindfulness but that might not be used in the same way in everyday speech. Observe, describe, in the moment, just sitting with it, non-judgmental and wise mind were used in particular ways and not always with a clear understanding of the definition of these terms. Being able to judge whether an individual has had an experience of these phenomena rather than retelling what they have learned is very difficult. This has been identified as a problem with the use of self-report measures with participants being more likely to identify a feature of mindfulness when they have learnt the language associated with that feature (Buchheld et al., 2011). There were times when I felt that the description being given did not fit with the definition of a particular feature of mindfulness as I understood it.

IPA is idiographic and as such the findings of the study are particular to the participants who participated in the study. However, the comparison of the findings of this study with research into mindfulness based interventions has shown that many of the findings are consistent with existing theories and interpretations.

11.6 **Reflections on my role as a researcher**

I entered into this research because of my own experience of mindfulness as DBT practitioner and as meditator. I had many prior influences on my thinking with regard to DBT: offering training on implementing DBT; supervising DBT; developing DBT programmes. I had developed my knowledge and experience of mindfulness through books, groups and two Buddhist style retreats.

Some service user and practitioner participants were aware that I am a DBT practitioner. It is likely that this information had influence on the interviews as I would not have been considered a neutral researcher. Participants who were aware of me as a DBT practitioner may have made assumptions that influenced the way in which they spoke about their experiences. I was aware that participants often used shortcuts to talk about concepts of mindfulness and could not be sure if this was because they assumed that I knew what they were talking about. This may have restricted the depth of their descriptions. There may have

also been assumptions about me having or looking for positive accounts of mindfulness practice.

Remaining reflexive throughout the research was somewhat difficult. After each stage of analysis I was able to speak reflexively with my supervisors and they were able to speak about their ideas. The reflexivity took the form of speaking about my work and the way in which I noted connections with what the participants were saying and my own experiences. This was especially so because of the amount of resonance that was present within the experiences. I noted my own intention for patients to enter into emotional experiencing and the challenge to my thinking as I realised this may not be necessary to the benefit from learning mindfulness and may in fact be counterproductive. I noted the challenges to my position as therapist that emotional experiencing may not be desired by patients and that it may be beyond my remit as an NHS employee when symptom reduction is all that is measured. I noted my judgement that practical mindfulness that focused on behaviour change was second rate in my view to existential mindfulness. I noticed my connection to some of what the patients said feeling empathy for those who could not connect to mindfulness.

I have undoubtedly had my view of mindfulness in DBT changed. I noticed a change in my practice when teaching mindfulness as I continued with the research. The idea of changing relationships to thoughts, feelings and urges has become much more central to my mindfulness teaching. The idea that mindfulness is not benign has also become more central to the way in which I approach mindfulness with people, previously I thought that people were over anxious in their approach to mindfulness and that by courageously facing emotions no harm could be done.

Engaging with participants' descriptions of their experiences and co-constructing and understanding of mindfulness in DBT has been challenging and rewarding. Developing my skill as a researcher, applying to process of IPA has similarly presented me with challenges and rewards.

11.7 **Concluding remarks**

Despite the dilemmas and challenges of engaging with mindfulness in DBT the experiences of service user and practitioner participants indicated that the continued use of mindfulness in DBT seemed reasonable. However, the experiences indicated the need to improve the teaching of mindfulness and the development of mindfulness in DBT– compassion, trauma sensitive approaches and interpersonal mindfulness. The DBT practitioner community have

the opportunity to consider the dilemmas evoked in the use of mindfulness to treat this service user group. Dilemmas such as: mindfulness as too difficult for anyone vs accessible to everyone; mindfulness in DBT should be focused on behavioural change vs existential change; mindfulness exercises should have an internal focus vs external focus. Since synthesis of dilemmas is central to the practice of DBT, the DBT community is well placed to undertake this challenge.

Appendices

Appendix A Diagnostic criteria for Borderline Personality Disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. **Note:** Do not include suicidal or self-mutilating behaviour covered in Criterion 5.

2. A pattern of unstable and intense interpersonal relationship characterized by alternating between extremes of idealization and devaluation.

3. Identity disturbance: markedly and persistently unstable self-image or sense of self

4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). **Note:** Do not include suicidal or self-mutilating behaviour covered in Criterion 5.

5. Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour

6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).

7. Chronic feelings of emptiness

8. Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights).

9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

Appendix B Overview of scales developed to measure state and trait mindfulness

Scale	Date	Dimensions	Use	Limitations
Freiburg Mindfulness Inventory	2001	Presence and Acceptance	Experienced meditators	Found to be misinterpreted by those without meditation experience
Mindful Attention Awareness Scale	2003	Attention	Any population	Measures based around negative response which may exclude some elements of mindfulness; doesn't differentiate between Attention and Awareness
Toronto Mindfulness Scale	2006	State dimensions of Decentring and Curiosity	Any population – mindful state not trait	The dimension of curiosity may only pertain to specific conceptualisations of mindfulness
Cognitive and Affective Mindfulness Scale - revised	2007	Willingness and capacity for:	Clinical studies	

		Attention Present focus Awareness Acceptance/Non-judgement Thoughts and feelings Particularly useful in assessing psychological distress		
Philadelphia Mindfulness Scale	2008	Awareness and Acceptance	Any population – short scale	Narrow conceptualisation of dimensions and acceptance dimension seems to capture experiential avoidance
Southampton Mindfulness Questionnaire	2008	How mindfully one relates to distressing thoughts and images as described by: Decentred Awareness vs. Being lost in	Clinical studies of mental health	Too specific for general use and those less prone to distressing thoughts and images may find it difficult to relate the dimensions to

		reacting to cognitions Allowing attention to stay in contact with difficult cognitions vs. Experiential avoidance Acceptance of difficult thoughts and feelings vs being judgemental Letting go and being non-reactive to cognitions vs. Rumination or worry		their experiences
Kentucky Inventory of Mindfulness Scale	2004	Mindfulness as described by DBT including: Observing Describing Acting with awareness Accepting without judgement	Any population but especially relevant to DBT participants	Focuses on the ability to verbally describe an experience which may be extraneous to the concept of mindfulness

Five Facet Mindfulness Questionnaire	2006	Non react: Non-reactive to inner experience Observe: Observing/noticing/attending to sensations/perceptions/thoughts/feelings Actaware: Acting with awareness/automatic pilot/concentration/nondistraction Describe: Describing/labelling with words Non judge: Non judging of experience	Any population	Questions may be misinterpreted by those without meditation experience Some aspects of mindfulness are absent
Applied Mindfulness Process Scale	2016	Application of mindfulness as described by:	Those practicing mindfulness especially	The scale may not have captured all of the processes used by people

		Decentring Positive emotion regulation Negative emotion regulation	those participating in MBIs	being mindful Is yet untested for external validity
End State Mindfulness Questionnaire	2017	The tendency to : See things moment by moment without judgement	Any population – trait mindfulness	

Appendix C Inclusion and exclusion criteria for selection of research papers pertaining to adolescents and mindfulness based intervention

	Criteria	Rationale
Inclusion	Empirical study (i.e. not theoretical paper, general case discussion or clinical experience) Exploring effects on psychological symptoms Using a mindfulness based intervention/treatment	The literature review seeks to understand the research that has been conducted into mindfulness interventions which focus on the emotional/mental wellbeing of adolescents Mindfulness is being used in a variety of ways but the focus here is on psychological symptoms The intervention needs to be predominantly mindfulness so that the effects of mindfulness in particular can be explored.
Exclusion	Non-English language papers Psychological measures in relation to	The researcher does not have another language nor the means to get papers translated Primary physical disorder

	physical disorders Studies relating to trait mindfulness rather than response to intervention	with co-morbid psychological symptoms. The interest here is the effect of teaching mindfulness to people as an intervention not how a person's responses are effected by how mindful they are.

Appendix D Summary of research articles pertaining to mindfulness based interventions for adolescents targeting psychological and behavioural problems

Those studies which have a *clinical sample are indicated in italics (N =6)* those studies which have a **qualitative element are indicated in bold (N =8).** One study had both clinical sample and a qualitative element.

Author	Year	Design	Sample	Measures	Claims	Limitations
Singh et al.	2007	Small scale comparison to baseline study of the effect of a 'mindfulness on the soles of feet' exercise on aggressive behaviour 12 session non-group intervention over 4 weeks then once a month top up.	13 and 14 Non-clinical sample recruited from one school 2 males 1female (N=3)	Baseline incidents of target behaviours for each child. These were: bullying, fire setting, aggression, cruelty to animals and non-compliance	Adolescents were able to learn mindfulness and use it in situations that would have previously led to aggression. The behaviour of the three participants improved over the course of the intervention.	No comparison group Very small sample size No control for affect of threatened expulsion Treatment fidelity on self-report
Bogels et al.	*2008*	*Wait-list non-randomised and pre-test post-test*	*Age 11-17 (mean 14.4)*	*Report by Children and Parents*	*Waitlist showed no improvement during wait period*	*Small sample size* *Multiple comparisons were*

Author	Year	Design	Sample	Measures	Claims	Limitations
		comparison of child and parent mindfulness training on attention, impulsivity and externalising symptoms in children with symptoms of ADHD, ODD/CD and ASD. 8 session group intervention over 8 weeks.	*Clinical Sample* *Referred to community mental health centre Maastricht* *8 male 6 Female* *(N=14)* *Parental involvement varied between none, one and both parents present.*	*Personal goals* *Child behaviour checklist* *Youth self-report* *Children's social behaviour questionnaire* *Self-control rating scale* *Subjective happiness Scale* *D2 test of attention* *Pediatric quality of life inventory* *Mindful attention*	*Intervention group improved significantly on:* *Personal goals, attention, awareness, impulsivity, being attuned, social problems and happiness.* *Children's internalising and externalising behaviours were reduced.* *Improvements were maintained at 8-week follow-up* *Drop-out rate was high and completers showed most improvement*	*made* *Other treatments occurring during wait time and follow-up* *Unclear whether the child or parent training was more potent* *Disparate group of diagnoses no comparison of relative effects for different groups*

Author	Year	Design	Sample	Measures	Claims	Limitations
				awareness scale		
Grosswald et.al	*2008*	*Single cohort pre-test post-test of children with ADHD with language-based learning disabilities. Using transcendental meditation (TM) to reduce stress and anxiety as a way of reducing impact of ADHD and improving executive functioning. Twice daily meditation for 3 months.*	*Age 11-14* *Clinical sample* *Attending specialist language-based learning difficulties school* *9 male 1 female* *(N=10)* *6 with co-morbidities*	*Report by Children and Teachers* *Achenbach child behaviour checklist* *Achenbach youth self-report* *Revised child manifest anxiety scale* *Behavioural rating inventory of executive function* *From performance testing* *Cognitive assessment*	*TM technique improved level of stress, anxiety and ADHD symptoms between pre-test and post-test on 6/7 subscales as rated by students but only 1/7 as rated by teachers. Both rated significant impact on overall problems at p≤ 0.5* *Improvement on 7/11 subscales of executive functioning as rated by teachers. Improvements in expressive attention performance.* *(Tower of London and Connor's CPT excluded from analysis)*	*Small sample size* *Mainly male sample* *No control group* *No comparison for medication differences* *No follow up tests administered*

Author	Year	Design	Sample	Measures	Claims	Limitations
			Differences in medication being used with each child	*system expressive attention* *Delis-kaplan executive function system verbal fluency* *Tower of London* *Connor's CPT II*		
Biegel et.al	*2009*	*RCT(intervention vs. treatment as usual) of impact of mindfulness based stress reduction (MBSR) on adolescents with different diagnoses in outpatients;*	*Age 14-18 Clinical sample recruited through health provider*	*From clinician report* *DSM diagnosis* *Global Assessment of*	*Significant improvement in MBSR group in state-trait anxiety, perceived stress, self-esteem and 4/6 indicators of psychopathology compared to TAU group. Greater decrease in*	*16 receiving MBSR failed to complete, disparate group in terms of disorders but mainly mood/anxiety* *Level of reliability of*

Author	Year	Design	Sample	Measures	Claims	Limitations
		depression, anxiety, sleep and self esteem. Also on diagnostic outcomes and global function. 8 session group intervention over 8 weeks.	*15 male 35 female (in intent to treat treatment group) (N=50)*	*functioning* *From baseline measures* *No. of psychotherapy visits; hospitalisations; type of medications and dose;* *From self-report scale* *Perceived stress scale;* *Hopkins symptom checklist (six of 9 subscales)* *Rosenberg self-esteem scale;* *MBSR practice diary*	*diagnosis and GAF scores in MBSR group* *More practice= greater amount of change.*	*diagnosis via DSM not measured; assessed change through number of diagnoses not severity of condition; MSBR group may have had more face to face treatment over time frame; Bias on self-report.*

Author	Year	Design	Sample	Measures	Claims	Limitations
Dellbridge and Lubbe	**2009**	**A single case study of the a mindfulness programme taught 1:1 with a**	**Aged 17** **Female**	**Unstructured interview** **Field notes** **Research Journal** **Artwork**	**A list of themes were identified from the analysis of the data.** **The specifics of these themes will be discussed further later as bias in the analysis in this study may be biased by themes in this paper**	**The first author was a participant in the programme and the research and therefore observer based bias may have been introduced** **The author used some of their own ideas about mindfulness in the research interviews** **Participant trying to please/give the right answers in the interviews**
Semple et al.	2010	Wait-list RCT of impact of Mindfulness based cognitive therapy for children (MBCT-C)	Age 9-13 Non-clinical	Report by children and parents	MBCT-C effective in reducing attention problems which was maintained at follow-up.	No measure of effect of being in a group

Author	Year	Design	Sample	Measures	Claims	Limitations
		on attention, anxiety and behavioural problems. 3 month follow up for half the sample. 12- session intervention over 12 weeks.	sample Recruited from remedial reading programme 10 male 15 female (N=25) Control matched for age and gender	Child behaviour checklist Multi-dimensional anxiety scale for children State-trait anxiety scale for children	MBCT-C may help children with elevated anxiety and behaviour problems	No corrections for multiple analyses Mainly non-clinical presentations limited the possible improvement that could be detected Drop-out rate 5/25 (attending fewer than 8/12 sessions)
Kerrigan et al.	**2011**	**Qualitative study or a MBSR course**	**Age 13-21** **Non- clinical sample**	**Semi-structured interview**	**A list of themes were identified from the analysis of the data.** **The specifics of these themes will be discussed further later**	**Convenience sample used** **Interview at one point in time post intervention**

Author	Year	Design	Sample	Measures	Claims	Limitations
			Sample size 10		**as bias in the analysis in this study may be biased by themes in this paper**	
Tharaldsen	**2012**	**Comparison study between 14 weeks Conscious Coping which includes high level of mindfulness and non intervention group**	**Age 16-27** **Mean age 17.4** **Non clinical sample** **Recruited from high school in Norway** **Sample size 82** **Approx 57 female 25 male** **(N=82)**	**Mindful Coping Scale** **Symptom Checklist 90 Revised** **Satisfaction with Life Scale** **Qualitative Interview data focused on reflections on expectations; potential useful coping skills; skills participants found lees/more useful; whether they**	**No increase in the use of coping skills in intervention group from quantitative data** **Deterioration in quality of life satisfaction in intervention group** **No improvement in psychological symptoms in intervention group** **No enhancement of mindful coping strategies** **Qualitative report of using**	**Disproportionate no of females** **Possible pleasing the interviewer effect in qualitative data** **Poor support from teachers for the programme** **Reliance on self-report measures**

Author	Year	Design	Sample	Measures	Claims	Limitations
				experienced changes in coping .	**mindful awareness and coping skills**	
Monshat et al.	**2012**	**Qualitative study of a six week Mindfulness Training programme**	**Age 16-24** **Non clinical sample** **Recruited from self-selected young people in response to posters in Australia** **Focus group N=7** **Interveiws N=5**	**Focus group** **One to one open ended interviews**	**Authors constructed an explanatory model of young people's experience with mindfulness** **The specifics of the model will be discussed further later as bias in the analysis in this study may be biased by themes in this paper.**	**Research team bias due to previous engagement with mindfulness** **Small sample**

Author	Year	Design	Sample	Measures	Claims	Limitations
Himelstein et al.	**2012**	**Qualitative study of 10 week mindfulness- based intervention for incarcerated males**	**Age 14-18** **Recruited from young offenders institution in US** **Sample size 23**	**Semi structured interviews after the final class**	**Acceptable intervention** **Improved subjective well being** **Increase in self-regulation**	**Same person facilitated the intervention, interviews and analysis** **Effect of facilitator rapport on the intervention** **Participants not involved in the project planning** **No negative feedback indicates bias in responses** **Interviews performed directly after intervention therefore no follow up effect.**

Author	Year	Design	Sample	Measures	Claims	Limitations
Kuyken	2013	Non- randomised controlled parallel group study comparing the Mindfulness in Schools Programme to non-intervention group	Age 12-16 Non clinical Sample Recruited from 12 secondary schools in UK 156 female 366 male (N=522)	Warwick-Edinburgh Mental wellbeing Scale Perceived Stress Scale Centre for Epidemiologic Studies Depression Scale Amount of mindfulness practice Evaluation form	High acceptability Fewer depressive symptoms post mindfulness intervention and at follow up (3 month) compared to controls Lower stress and greater wellbeing at follow up associated with degree of practice.	Disproportionate no males No randomisation Reliance on self-report measures Little diversity of schools
Jennings and Jennings	2013	Pilot Study Four 50 minute sessions delivered by peer facilitator	Age 17-18 Non clinical sample Recruited from	Becks Anxiety Inventory Interaction Anxiousness Scale	Short term effect of reducing anxiety Effectiveness of a shortened mindfulness programme	Very small scale study Results for reduced anxiety in non-clinical population Facilitator known to the

Author	Year	Design	Sample	Measures	Claims	Limitations
			American High School 5 males 3 Females (N=8)			group Level of competence on peer facilitator No long term follow up
Metz et al.	2013	Quasi experimental pre-test/post-test study of school based 6 session Learning to BREATHE programme	Mean age 16.5 Non clinical sample Recruited from two high schools in the US	Difficulties in Emotional Regulation Scale Psychosomatic complaints scale Affective Self-Regulatory Efficacy Scale	Small effect on reduction in emotional regulation difficulty, psychosomatic complaints, self-report stress levels in mindfulness group No effect on impulse control of mindfulness group	Disproportionate number of females Lack of power for statistical analyses Reliance on self-report

Author	Year	Design	Sample	Measures	Claims	Limitations
			73 males 171 females (N=244)	Acceptability and social validity survey	Moderate increase of self-regulation efficacy in mindfulness group	
Ames et al.	***2014***	***Evaluative study of an 8 week MBCT programme for adolescents with residual symptoms after treatment for depression across 2 Child and Adolescent CAMHS services using both qualitative and quantitative measures***	***Age 12-18*** ***Clinical Sample*** ***Recruited from CAMHS*** ***7 Females***	***Mood and Feeling Questionnaire*** ***Child Response Style Questionnaire*** ***Penn State Worry Questionnaire*** ***Child Acceptance and Mindfulness Measure (CAMM)*** ***Paediatric Quality of Life Enjoyment and Satisfaction***	***MBCT is feasible for this population*** ***Reduction of depressive symptoms, worry and rumination.*** ***Increase in quality of life and mindfulness*** ***Qualitative outcomes with regard to acceptability, process and use of mindfulness***	***Very small sample for quantitative results*** ***Qualitative results reported in brief*** ***Only 1 month follow up*** ***No control group - Possible effect of natural recovery***

Author	Year	Design	Sample	Measures	Claims	Limitations
				Questionnaire ***Strengths and Difficulties Questionnaire*** ***Qualitative Semi Structure interview***		
Raes et al.	2014	RCT study of a school based programme designed for adolescents based on MBCT and MBSR	Age 14-17 Non clinical sample Recruited from Dutch High School 240 females 128 males	Depression Anxiety Stress Scales	Lower level of depressive symptoms in mindfulness group after 6 month follow up Mindfulness programmes can be successfully integrated into education	Unknown fidelity to the intervention Disproportion of females Self report questionnaire only No treatment control to assess non specific aspects of mindfulness

Author	Year	Design	Sample	Measures	Claims	Limitations
			(N=368)			
Sibinga et al.	**2014**	**Pilot RCT of MBSR compared to Healthy Topics programme**	**Age 13-21** **Recruited from a primary care clinic in USA** **28 females 7 males (N=35)**	**Symptom Checklist 90 Revised** **State-Trait Anxiety Inventory** **Positive and Negative Affect Schedule** **Qualitative interview addressing daily stressors, coping mechanisms, motivation for participation, changes in thinking, experience**	**No significant effects in self report measures** **Interview data reported effects of increased calm, conflict avoidance, self awareness and self regulation.**	**High dropout rate** **Disproportionate number of females** **Small sample size for quantitative data** **Participant mindfulness not measured**
Tan and	*2015*	*RCT comparing a mindfulness*	*Age 13-18*	*Depression Anxiety Stress*	*Increase in mindfulness pre-post*	*Disproportion of females*

Author	Year	Design	Sample	Measures	Claims	Limitations
Martin		*intervention (Taming the Adolescent Mind) with treatment as usual*	*Clinical sample* *Recruited from community mental health teams* *63 females 28 males (N=91)*	*Scale* *Rosenberg Self-esteem Scale* *Resiliency Scales for Children and Adolescents* *Avoidance and Fusion Questionnaire for Youth* *Child Acceptance and Mindfulness Measure (CAMM)* *The Child Behaviour Checklist*	*–follow up (3 months)* *Improvement in mental health, self-esteem, psychological flexibility in mindfulness group which were maintained/improved at follow up* *No significant effect for resiliency*	*Reliance on self report measures* *Possible facilitator effect*
Atkinson and Wade	2015	School based RCT comparing 3 session mindfulness –based intervention 3 session	Age 14-18 Non clinical	Weight and shape concern	The expertise of the facilitator had an effect on the efficacy of the intervention with a smaller	Randomisation across classes meant that there may be change factors

Author	Year	Design	Sample	Measures	Claims	Limitations
		dissonance based intervention or classes as usual and the impact on eating disordered symptoms	sample Female Sample size: 347	Thin-Ideal and social cultural pressures EDE-Q (eating disorder symptoms) Child and Adolescent Mindfulness Measure (CAMM) Programme acceptability	benefit with less experienced facilitation. There seemed to be a delayed effect of mindfulness intervention in reducing eating disorder risk factors.	accounted for by being in a certain class. The introduction of a guest speaker into one class Self-report only Short follow up window of 6 months

Author	Year	Design	Sample	Measures	Claims	Limitations
De Bruin et al.	*2015*	*Evaluative study of MYmind – 9 week programme for Autistic Spectrum Disorder (ASD) with parallel parent mindfulness instruction*	*Aged 11-23* *Clinical sample* *17 males 6 females (N=23)*	*Autism Questionnaire – short version* *Mindful Attention Awareness Scale* *Penn State Worry Questionnaire* *Ruminative Response Scale* *Parent report :* *Social Responsiveness Scale* *Five Facet Mindfulness Questionnaire* *Parenting Scale*	*Increase in reported quality of life and decrease in rumination* *No change to worry, ASD core symptoms or mindful awareness* *Parents reported no change in core ASD symptoms in child but some improvement in social aspects* *Parents reported differences in parenting style*	*Small sample size* *No control group*

Author	Year	Design	Sample	Measures	Claims	Limitations
				Parenting Stress Index-Competence Scale		
Dariotis et al.	**2016**	**Qualitative evaluation of a 16 week school-based mindfulness and yoga programme**	**Age 10 -13** **Sample size: 22**	**Focus group discussion focusing on what students had learned and whether they use the skills outside of the programme. Also teacher focus groups focusing on expectations and behavioural change**		
Johnson et.al	2016	RCT study of 8 week school-based mindfulness programme compared to lessons as normal.	Mean Age 13.6 Non clinical sample	Depression Anxiety Stress Scale Eating Disorder	High acceptability No improvement in any of the outcome variables post – follow	High dropout rate Possible poor programme adherence

Author	Year	Design	Sample	Measures	Claims	Limitations
		Measuring the effectiveness of the programme in reducing risk of anxiety, depression and eating disorders.	Recruited from high school in Australia Intervention N=132 Control N= 176	Examination-Questionnaire Warwick-Edinburgh Mental wellbeing Scale Child and Adolescent Mindfulness Measure (CAMM) Difficulties in Emotional Regulation Scale Self-Compassion Scale Amount of Home practice Qualitative interview addressing drop out/ acceptability	up (3 month) Higher self-rated anxiety post mindfulness intervention	Reliance on self-report

Author	Year	Design	Sample	Measures	Claims	Limitations
				Acceptability ratings		

Appendix E Development of stimulus video

The stimulus video was recorded on a laptop and used during the interviews to stimulate service user participants to think about the mindfulness element of DBT. The video was not used with practitioner participants.

The video featured a DBT practitioner who had been asked to explain a mindfulness exercise in a way that he would do in a typical DBT skills group session.

The interview was typically introduced as follows:

So we're going to be focusing on mindfulness, um, and that bit of the DBT programme, and the way we're going to start this is just to have a look at someone, introducing a mindfulness exercise.

The following is the transcript of this video:

OK, so what's relevant is another Mindfulness exercise, um, and that's why I've got these gongs here. What I'm going to do is I'm going to bang each of the gongs, um, during a two minute time period, and all I want you to do is I want you to notice the sound of the gong, the sound it makes. Now it's going to fade out; I want you to notice as it fades, and what I want you to do is if you find your thoughts drifting onto something else, I want you to just gently bring those thoughts back to the sound that the gong is making.

So I kind of want you to empty your thoughts of almost everything other than the sound of the gong. OK? So in two minutes starting now, lets see how you're doing. [sound of gong]. Long silence.

The video was typically followed as follows:

So we're not actually going to do the mindfulness. So how does that compare to the sorts of mindfulness exercises you have done?

The video was developed to introduce the topic gently and to establish if service user participants experiences of mindfulness exercises in the skills training group were very different to what I believed they would have been taught. All service user participants identified that the exercise was similar to their experience.

Appendix F Ethics committee approval

NHS
Health Research Authority
NRES Committee South Central - Hampshire B
Level 3 Block B
Whitefriars
Lewins Mead
Bristol
BS1 2NT
Tel: 0117 342 1384

10 April 2015

Miss Jennifer Eeles
Highly Specialist Community Nurse Therapist
Solent Healthcare - Portsmouth Child and Adolescent Mental Health Service
Falcon House
St James Hospital
Locksway Rd, Portsmouth
PO4 8LD

Dear Miss Eeles

Study title:	**A qualitative study of the lived experience of young people learning mindfulness in DBT using Interpretative Phenomenological Analysis**
REC reference:	**13/SC/0081**
Protocol number:	**Submission Number 3414**
Amendment number:	**1**
Amendment date:	**28 January 2014**
IRAS project ID:	**82554**

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

The Committee approved the change of inclusion criteria to include adults, young people providing their own consent and associated documents.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Covering letter on headed paper [Protocol Amendment 2]		
Covering letter on headed paper [Response to Committee's queries]		08 April 2015
Notice of Substantial Amendment (non-CTIMP)	1	28 January 2014
Other [Research Reply Form]	3	26 January 2015
Participant consent form [Adult]	5	08 April 2015
Participant consent form [Young Person 14 - 18]	4	08 April 2015
Participant information sheet (PIS) [Adult]	2	08 April 2015
Participant information sheet (PIS) [Young Person 14 - 18]	5	08 April 2015
Research protocol or project proposal	5	16 March 2015

NHS
Health Research Authority

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

13/SC/0081:	Please quote this number on all correspondence

Yours sincerely

pp

Dr Andrew Scott
Alternate Vice-Chair

E-mail: nrescommittee.southcentral-hampshireb@nhs.net

Enclosures: *List of names and professions of members who took part in the review*

Copy to: *Ms Alison Cooper, HIOW CLRN Shared RM&G Service*
Diana Galpin

NRES Committee South Central - Hampshire B

Attendance at Sub-Committee of the REC meeting by correspondence

Committee Members:

Name	*Profession*	*Present*
Mrs Angela Iveson	Acute Oncology Clinical Nurse Specialist	Yes
Dr Andrew Scott – Chair	Course Leader, M.Sc. Clinical Exercise Science	Yes

Also in attendance:

Name	*Position (or reason for attending)*
Miss Libby Watson	REC Manager

Appendix G Letter to services requesting involvement in recruitment to the study

What is it like for young people learning mindfulness in DBT?

An opportunity to help with a research project

Why answer this question?

- The usefulness of mindfulness has been established for other therapies (mindfulness based cognitive therapy, mindfulness based stress reduction) but it has yet to be studied fully as part of DBT.
- The usefulness of mindfulness for adolescents has been researched on a very limited basis so we do not know what learning and using mindfulness is like for adolescents
- We could learn a lot about teaching mindfulness in DBT to adolescents by finding out about their experiences of mindfulness

What I need from you

- I am looking for DBT programmes delivering mindfulness teaching to adolescents within the age range of 14-18 years.
- I need a nominated contact from your programme team to act as a gatekeeper. The gatekeeper will sign the research reply form to confirm the young person is able to participate in the study and will act as a contact with regard to any safeguarding concerns.

What I will do?

- **I have NHS ethics approval for this study.** If you are in a position to help with recruitment I will contact your local Research and Development Office to get approval for recruiting participants in your area

Once we have the go ahead:

- I will supply you with information sheets for you to give to the young people and a vidcast of me explaining the study which you can use with young people. I will also be happy to liaise with the nominated gatekeeper to discuss their role.
- I will ask you to return to me any completed 'research reply' forms.
- I will then arrange to meet the young people directly with them after sending information and gaining consent from their parents/carers. I will meet them on staffed premises.
- I will feed back the analysis of their interview and the wider report findings to the young people. I will not be able to feedback the outcomes of the interviews directly to your programme since this would breach the confidentiality agreement with the participant. However, you will be able to access the report summary and any publications from the research.
- I will use the outcomes of the interview to inform the DBT community about the use of mindfulness (through publication and conferences) and feed this into work on what is important about how we teach mindfulness

Appendix H Participant Information Sheet – Service User

Version 5 08/04/2015

Mindfulness

My name is Jennie Eeles. I am studying at University of Southampton for a PhD.
That means I am doing some research on something that has not been explored in this way before.
I am asking if you if you would consider participating in the research project so that we can answer the question:

What is mindfulness like for young people in DBT?

Before you decide if you want to take part you need to understand what the research is about and why I am doing it. It is important that you read this sheet or go through it with me or someone in your care team. I will answer any questions you may have before you decide whether to take part. You can also take a look at a video of me explaining the research on the website www.youthmindfulness.blogspot.com

.

Why is the research being done?

DBT is being used to help young people with lots of different problems and in DBT young people learn mindfulness. No-one has looked into what young people think about the mindfulness they learn in DBT.

It is important to understand young people's experiences so we can find out what works best for them.

Why have I been asked to join?

You have been asked to join because you have been taught some mindfulness as part of DBT. I am interested in talking to young people aged 14-18 who have completed at least one skills training module that included some mindfulness.

Do I have to take part?

No. It is up to you. If you decide you want to take part I will ask you to sign a form to say you are happy to be interviewed and for me to use the interview in the research. It is fine if you decide to stop at any time during the interview without giving a reason. If you decide not to take part this will not affect the care you receive.

What will I be asked to do?

I would like to meet you to ask you some questions about your experience of mindfulness. I would arrange to meet you at the clinic or ward that you are receiving treatment from but no-one from your care team will be part of the interview.

Still interested……? Read the next page……

Version 5. 08/04/2015

Who will know what they have said?

I will be recording what we talk about on a dictaphone because I would like to use some of the things you say in the research report. I will change your name and not give details about who you are so people won't know they took part. I will only use the recording for this study. The recording will be kept safe so that only I can use it.

Is everything they say confidential?

If you tell me something that makes me think you or someone else is at risk I will have to tell your key care worker.

Are there any downsides to taking part?

I will meet you for around 1-1.5hours. You can choose what to talk about but there is a chance they might talk about something that you find upsetting. If you feel too upset they can stop at any time and ask me to tell my contact with your team that you have been upset.

Are there any good things about taking part?

I cannot promise that the research will help you but the information we get from the research may improve what we know about using mindfulness in DBT. This might help us to make it more useful or easier to understand for young people.

Still interested……? Read the next page……

Version 5 08/04/2015

What will happen afterwards?

I will write a research report that will be examined by the University. We will contact you when we are ready to publish the results of the study, to see if you wish to receive the feedback. I will try to share the research with lots of different people who work with young people in DBT.

Who has reviewed the Research?

All research on NHS patients is reviewed by a group of people called a Research Ethics Committee. They try to make sure the research is safe and fair.
The South Central Southampton B Research Ethics Committee have looked at this research and think it is ok to ask young people to take part.

I'm interested. What do I do now?

You need to let the person who gave you this information sheet know that you want to rake part. They will sign a form that you can send back to me so that I can contact you to arrange a time to meet you.

If you have a concern about this study you should contact Diana Galpin, Head of the Governance Office at The research Governance Office (Address: University of Southampton, Building 37, Highfield, Southampton SO17 1BJ; Tel 02380595058; email rgoinfo@soton.ac.uk) If you remain unhappy and wish to complain formally, Diana can provide you with the University of Southampton Complaints Procedure.

Thank you for reading this info sheet.
There is a vidcast and more information available at
www.youthmindfulness.blogspot.com

Appendix I Participant Information Sheet - Practitioner

Participant Information Sheet

A qualitative study of the lived experience of people learning and teaching mindfulness in DBT using Interpretative Phenomenological Analysis

Researcher: Jennie Eeles

NHS Ethics No. 13/SC/0081

This study aims to understand the experience of learning about mindfulness in DBT and also about the experience of teaching mindfulness in DBT. Participants have already been interviewed to explore their experience of learning mindfulness as part of their DBT. This part of the study is focused on the experience of practitioners who teach mindfulness as part of DBT.

By exploring and understanding the experience of teaching mindfulness I hope to offer some insights into the key features of the experience

What is the research about?

I am a PhD student and this study is being carried out as a PhD in Health Sciences at the University of Southampton. When the PhD is completed findings of the study will be prepared for publication. The research is being carried out because the experience of learning and teaching mindfulness in DBT has not been fully explored in current research literature.

Why am I being invited to join?

You are being invited to join the study because you are a practitioner who has taught mindfulness in DBT within the last year.

What would taking part involve?

I would like to find out about your experience of teaching mindfulness in DBT (or skills group only). To do this I would like to invite you to an interview in which we would have a

conversation based around some questions that would like to explore, but the interview will be mainly focused on the things that are important to you. This face to face interview will take around an hour. With your permission I will record this conversation on a *dictaphone* and have the interview transcribed so that I can explore what is said and use it alongside the experiences described by other people

Consent

Before we start recording the interview I will ask you to fill out a consent form to ensure that you have understood what is being asked of you and what I will be doing with the recording of the interview and the transcript. You will have the chance to ask any questions before you sign this form. You can change your mind about taking part in the study and stop the recording at any point without giving a reason.

Confidentiality

I will be using some of the things that you say in the write up of the study, but with names changed and no identifiable data i.e. where you work. Any things that you say in the interview that may identify where you work will not be used in the research report.

Data Protection

The audio files and transcripts are identified by participant number and not your name/place of work. The audio file and transcript will be kept on a password protected computer for the duration of the study and then stored in accordance to the University of Southampton protocol for 10 years (in case of quality assurance/risk inquiries). The data will then be destroyed as per University protocol.

What are the possible benefits of taking part?

There are unlikely to be any direct benefits to you from taking part although talking about mindfulness in DBT will give you time to reflect on your experiences. It is hoped that the research will contribute to the understanding of mindfulness on DBT.

What are the possible disadvantages and risks of taking part?

You can choose what you talk about and can stop the conversation at any time. There is a very small chance that you may find some of the things you talk about emotionally distressing. If

this were the case you would be able to use your supervisory/wellbeing structures in your organisation for support and I can signpost you to relevant services.

I'm interested. What do I do now?

If you would like to take part please contact me to let me know that you are interested. You can do this by e-mail jennifereeles@nhs.net or phone/text 07811824776. I can meet you at a time and place that is convenient for you.

If you have a concern about this study you should contact Isla-Kate Morris, Research Integrity and Governance Manager, , at The research Governance Office (Address: University of Southampton, Building 37, Highfield, Southampton SO17 1BJ; Tel 02380595058; email rgoinfo@soton.ac.uk)

Appendix J Research Reply form

What is the experience of people learning mindfulness in DBT?

Researcher: Jennie Eeles

If you are interested in taking part in the research please fill in this form and get the person who gave you the information sheet to sign it before sending it to me in the stamped addressed envelope

Name:

Address:

E-mail:

Telephone:

Preferred contact method for arranging interview?

For the CAMHS worker

The above young person is interested in taking part in the study **What is it like for young people learning mindfulness in DBT?**

They have been given an information sheet and have capacity to consent to taking part. There are no concerns that this young person would be unable to take part due to current mental illness or distress.

They are happy for you to contact them using the details above to arrange to meet them.

Signed

Gatekeeper..... Name(print).....

Position.....Date.....

I am happy for you to contact me to arrange an interview

Signed..... Name (print).....

Date.....

Please return to: Jennie Eeles, Falcon House, St James Hospital, Locksway Rd, Portsmouth PO4 8LD

Appendix K Consent forms

Consent Form for Service Users

Project: What is the experience of people learning mindfulness in DBT?

Researcher: Jennie Eeles , Research Student

University of Southampton

Please initial each box:

1. I have had the research explained to me and was given a copy of the research information (information sheet Version 5 dated- 8th April 2015 to read before today.

2. I have had the chance to ask questions about the research

3. I understand that the interview will be electronically recorded and then written out so it can be read

4. I understand that I can stop the interview at any time without giving a reason or chose not to answer any question

5. I understand that .....(member of care team) is a contact for any information that may need to be shared or if I need any support after the interview

6. I understand that the recording and written copy of what I say will be stored at the University of Southampton for 10 years

7. I understand that information collected about me during my participation in this study will be stored in a locked facility at the university or on a password protected computer and that this information will only be used for the purpose of this study. All files containing any personal data will be made anonymous

8. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from The University of Southampton; from regulatory authorities or from the

   NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records

9. I am happy for this interview to be used as part of the research project and for some things I say to be put into the report (with my name changed and with no details about where I am from)

10.I understand that my participation in this research is voluntary and I can withdraw my consent at any time without giving a reason, without my medical care or legal rights being affected.

11. I agree to take part in this research

Participant
Signed..... Name(print).....
Date.....Time.....

Researcher
Signed..... Name(print).....
Date.....Time.....

Consent Form for Practitioners

Project: What is the experience of young people learning mindfulness in DBT?

Researcher: Jennie Eeles , Research Student

University of Southampton

Please initial each box:

1. I have had the research explained to me and was given a copy of the research information (information sheet version 1 dated- 25th April 2016) to read before today.

2. I have had the chance to ask questions about the research

3. I understand that the interview will be electronically recorded and then written out so it can be read

4. I understand that I can stop the interview at any time without giving a reason or chose not to answer any question

5. I understand that the recording and written copy of what I say will be stored at the University of Southampton for 10 years

6. I understand that information collected about me during my participation in this study will be stored in a locked facility at the university or on a password protected computer and that this information will only be used for the purpose of this study. All files containing any personal data will be made anonymous

7. I am happy for this interview to be used as part of the research project and for some things I say to be put into the report (with my name changed and with no details about where I am from)

8. I understand that my participation in this research is voluntary and I can withdraw my consent at any time without giving a reason legal rights being affected.

9. I agree to take part in this research

Participant
Signed..... Name(print).....
Date.....Time.....

Researcher
Signed..... Name(print).....
Date.....Time.....

Appendix L Example of interview transcript with comments and coding - Philippa

Interview - 150821.001

Transcriber : Barbara Hellyer.

1.	**Code**	**Transcript**	**Exploratory Comments**
2.		**INT: How long have you been doing DBT for?**	
3.		REC: About six months. I think I'm halfway through.	
4.			
5.		**INT: OK. So it's a year programme?**	
6.			
7.		REC: Yeah, yeah.	
8.			

1.	**Code**	**Transcript**	**Exploratory Comments**
9.		**INT: And um, what sort of things have you been kind of learning and working on?**	
10.			
11.		REC: Um … I'm trying to think, 'cos it's been really wide. [giggles]] Sorry it might take me a minute …	
12.			
13.		**INT: OK.**	
14.			
15.		REC: … to get comfortable [giggles].	
16.			
17.		**INT: No, it's fine.**	
18.			
19.		REC: Um … I mean obviously like reducing	Not much info on what she has needed to work

1.	**Code**	**Transcript**	**Exploratory Comments**
		target behaviours and stuff, and …	on ?DBT rule?
20.			
21.		**INT: Yeah.**	
22.			
23.		REC: … and then using like the Mindfulness and emotional regulation stuff and distress tolerance. Um … yes.	
24.			
25.		**INT: Yeah. So is it going … does it … is it going all right for you? Is …**	
26.			
27.	DBT takes time for change	REC: Yeah. It kind of took a while for me to be like, its actually making a change, but by like, target behaviours have gone down a	Change taking time Change separate from her - target behaviours

1.	**Code**	**Transcript**	**Exploratory Comments**
		lot, um, and I've kind of been able to do some stuff like … that, was my r-, … well I thought I wasn't going to be able to continue with the DB team …	
28.			
29.		**INT: Oh OK.**	
30.			
31.		REC: … because various things, but I managed to get, like, a part-time job and um, a place to stay so I can now continue with it, but without the DBT I don't think I would have been able to do those things …	
32.			
33.		**INT: Oh, OK.**	
34.			

1.	**Code**	**Transcript**	**Exploratory Comments**
35.		REC: … to continue with the DBT, so … yeah, I think it has helped. A bit, yeah.	Tentative positive connection to DBT
36.			
37.		**INT: Cool. So we're going to be focusing on mindfulness, um, and that bit of the DBT programme, and the way we're going to start this is just to have a look at someone, um, in … introducing a um, mindfulness exercise. As well I've got to see whether the technology is my friend today.**	
38.		**INT: So we're not actually going to do the mindfulness [giggles]. So how does that compare to um, the sorts of things you have done, *[00.03.13] exercises?**	
39.			

1.	Code	Transcript	Exploratory Comments
40.	Taking time to understand mindfulness Uncertainty about doing it 'right' Key elements of mindfulness: focus on one thing; bringing thinking back from wandering	REC: Um … Yeah, I mean we've done some similar to that um, like being quite still, and yeah … because its like the focusing on one thing, and its that um, he said, like, if you find your thoughts wandering off, I think that's the main mindfulness thing that it kind of took me a while to get my head around, but that's like the main thing I was like , Ah no! My thoughts were wandering off, I'm doing it wrong. But then I realised that that's kind of, that the mindfulness thing is bringing it back afterwards, it's not wrong for your thoughts to, like, wander off and stuff. Um …	Staying still Focusing on one thing Noticing thoughts wandering off – that's the main mindfulness thing Takes time to understand Feeling of doing it wrong Shift in thinking – and then I realised What is right and wrong when doing mindfulness Ah No! – like not again, Im making the same mistake Bringing it back What is the mindfulness thing? *The desire to do mindfulness right. Is this a useful of unuseful way of thinking about mindfulness? Is it possible to come to a new*

1.	**Code**	**Transcript**	**Exploratory Comments**
			idea and not judge whether you are doing it right? *How much is what she saying about using the language of mindfulness or a connection to the experience of mindfulness*
41.			
42.		**INT: So that kind of clicked with you at some point?**	
43.			
44.	Mindfulness is weird Mindfulness is confusing Initial scepticism	REC: Yeah, yeah. I think it took a while … I mean I've only really … I still, mindfulness still really confuses me because it, its like why … its like why does it work, and its … At first I was like, this is so stupid [giggles]. Like, it seems like one of those weird meditation things, and … yeah.	Taking time Continue to feel confused Why does mindfulness work? At first stupid – *still feel embarrassed? By giggles?* Weird – because it's like meditation

1.	**Code**	**Transcript**	**Exploratory Comments**
45.			
46.		**INT: Can you remember when you were first told about it then?**	
47.			
48.	Just sitting there is non-connection to mindfulness Mindfulness as stupid	REC: Yeah. I, I think it was during my DBT assessment kind of thing, and yeah, the person assessing me she was like, we're going to do a mindfulness thing, and it was about, like, imagining your thoughts floating on a leaf, like away, or something, and I was just sitting there like this, the stupidest thing I've ever done, like [giggles]. Like what is the point of this? And I couldn't do it at all, because I couldn't imagine it, I just … I was just like this is stupid.	First impression – the stupidest thing I've ever done – more giggles – embarrassed? *Why would this make any difference to me?* Difficulty in the process – couldn't imagine. What made this hard? *are some people more predisposed to being able to do it than others? is it more important for those who find it easy or find it hard or doesn't it make a difference?* *While doing it thinking it stupid – did that make it harder?*
49.			

1.	**Code**	**Transcript**	**Exploratory Comments**
50.		**INT: So there was this kind of … was the stupidness, what was that about? Was it , I don't know …?**	
51.			
52.	Difficult to do Become frustrated Mindfulness is Hippy (new age)	REC: I was just … it just seemed like really hippy, and kind of … And then I think I was also a bit frustrated because I couldn't do it. Like, and I … I like to do things [giggles], in a kind of right, and I was quite frustrated 'cos …	Connected to be hippy, negative connection – *not real? Relevant? About me?* Frustration – I want to do it right. I couldn't do it. *What blocked the 'ability' to do it at the outset?*
53.			
54.		**INT: So there's this sense that it had to be right? I had to be …**	
55.			

1.	**Code**	**Transcript**	**Exploratory Comments**
56.	Mindfulness taking time Uncertainty about being right	REC: Yeah. Yeah. Which I've kind of gotten out of it; it's not about being right, but it took me a while to get there.	Tentatively found a change – I've Kinda gotten out of Realisation of not about being right – *is she telling this to herself because she heard it or because she believes it? Acquiring the language of mindfulness or making a cognitive shift?* Taking time
57.			
58.		**INT: So the first one you ever did was this leaf floating thing?**	
59.			
60.		REC: Yeah. Or, I think it might have been mentioned a couple of times over …	
61.			

1.	**Code**	**Transcript**	**Exploratory Comments**
62.		**INT: Yeah.**	
63.			
64.	Timing of being introduced to mindfulness matters	REC: … the years, like, yeah, before this I hadn't really, like, engaged or whatever, so yeah, I think that was the first time I was …	Being mentioned before – people had identified that mindfulness may help over the years but not engaged with it before – *why now? Timing of being introduced to mindfulness*
65.			
66.	Difficult to understand the point to mindfulness	Oh no! Actually that was the time [giggles]] before that as well. Um, at the university like counsellor, and she was kind of trying to explain it, about it, by saying like focusing on an object, and stuff like that. But it was a, like a plant pot, and I just didn't get it. I just didn't get it. I was like	Difficult to explain, people had tried in the past First explanation – focusing on something The first point in time –I didn't get it. *What's the shift between didn't get it and now i get it?* *Does the first thing focused on matter – a plant pot what's the point* *No connection to how focusing on an object*

1.	**Code**	**Transcript**	**Exploratory Comments**
		what? What is the point? Why am I looking at the plant pot [giggles] kind of thing, kind of thing? Yeah.	*might be useful at first.*
67.			
68.		**INT: So it didn't connect with you with anything else, it was kind of …?**	
69.			
70.		REC: No, I was just like, what? I don't, I don't get it, kind of, yeah.	What? Like you haven't heard it or not heard it correctly. You can't really be saying that.
71.			
72.		**INT: And does that seem to be the sense that, sort of, when you've been in a group and stuff, that other people are saying those sorts of things as well? Like, well,**	

1.	**Code**	**Transcript**	**Exploratory Comments**
		I'm not quite sure why this would be?	
73.			
74.	Suspending disbelief and jumping in	REC: Um … No. I mean … I'm not sure. I think, although I've been there six months I'm still one of the kind of, like, newer, members of the group, so when I got there … I don't know, like everybody kind of, kind of seemed to just be doing it, and so I kind of just jumped in and [giggles], um, yeah, did it with everyone else, and it still seemed a bit weird for a while, but then I kind of got it a little bit more, and I think I can do it a bit more in my own way.	Although I didn't get it everyone else seemed to be accepting it so I did it too. Just jumped in –to the unknown, didn't hold back due to others doing it already. Weird what does that mean to her? Unsettling, unusual, unnatural *Continues to be uncertain as to whether she has 'got it'. Maybe has made it her own but not what is right.*
75.			
76.	Focus on the body is difficult	Like I still … 'cos there are the, like, different exercises, and there are ones	Personal preference for activity. How does she connect to focusing on her

1.	**Code**	**Transcript**	**Exploratory Comments**
		which you kind of have to focus on your body, and things like that, and I find those ones really hard. But then, ones when I'm doing activities and focusing on doing the activities I find easier. And, yeah, my like individual therapist has said that we're going to focus a bit more on, like, the body ones, and stuff like that …	body? Why is her therapist suggesting she do this? Focusing outside of body is easier.
77.			
78.		**INT: Oh, OK.**	
79.			
80.		REC: … but, but yeah, I can … I'm pretty good at doing the activity, kind of doing something and, yeah. Mindful.	I'm good at this part – comfortable?
81.			
82.		**INT: What, what do you think it is about**	

1.	**Code**	**Transcript**	**Exploratory Comments**
		the activities that make that easier?	
83.			
84.	Focus on the body uncomfortable/ make things worse	REC: Um … I'm not really sure. [pause]. I don't know. I think maybe its just for different situations, 'cos there was a time where I was, like … where it was … I was first doing mindfulness and I'd only really learnt about, like, the bodily sensation and kind of focusing on outside stuff, and I tried to do it when I in quite a, like, heightened state, and that didn't really work, it … 'cos when I was focusing on my body it just made everything worse 'cos I was just like, Oh my God! My heart's going so fast, and it just freaked me out more, like, yeah … I don't know, the activities …	Mindfulness in a heightened state difficult Body focusing focused on the difficult sensation – 'made things worse' rather than better. Could mindfulness make things worse? Freaked out by the feelings in her body – when first doing mindfulness *Where is mindfulness' place in dealing with unwanted/uncomfortable feelings?*
85.			

1.	**Code**	**Transcript**	**Exploratory Comments**
86.		**INT: So that the timing of using it made you …?**	
87.			
88.	Preference for mindfulness as relaxation	REC: Yeah, yeah. 'Cos I think at that point I could have used, like, a kind of mindfulness kind of relaxation kind of thing; I like the one where you like blow bubbles and focus on just the bubbles and them popping, and stuff like that; I find that one, like, quite relaxing. But, yeah. I think the time of like …	Is mindfulness being used as relaxation/distraction Different points call for different mindfulness Bubbles – why are they important? Timing of what you do important in some way.
89.			
90.		Like, 'cos er, I don't know, I feel like there's all sorts of different mindfulness activities, yeah.	Difference within mindfulness
91.			

1.	**Code**	**Transcript**	**Exploratory Comments**
92.		**INT: Are there any others that stick in your mind? You're saying the bubble one, and …?**	
93.			
94.	Mindfulness as a way of ordering (processing) thoughts Slowing thoughts down	REC: The bubble one um … [giggles], more … its kind of, still got bubbles, but like mindful washing up kind of thing. I find sometimes I just get overwhelmed with the amount of stuff that I feel like I've got to do, and I feel like I've got a whole long list, and if I just go, like do the washing-up mindfully, then after that um, I could kind of process things a bit more clearly, and not just, be like my thoughts just running around [giggles].	Overwhelmed During mindfulness I process things Not just my thoughts 'running around' Before head full, thoughts running Afterwards thoughts processed – head clear *Pictures of the mind – analogies- running – how you understands the problem in your mind determines what you pick up from mindfulness?*
95.			

1.	**Code**	**Transcript**	**Exploratory Comments**
96.		**INT: So it makes a difference to those thoughts?**	
97.			
98.	Slowing thoughts down Clearing up thoughts	REC: Yeah. Like, I think it just slows it down a bit, 'cos, not just like a million worries on top of each other [giggles], like just going too fast, like, they kind of overlap and I can't process any of them. So it just, like, slows it down a bit so that they're still there but I can think about them, like, kind of one by one, rather than a big mess. Yeah.	After mindfulness the running slows Pre mindfulness Piles of worries, overlapping can't be processed Thoughts continue but can be processed and are tidier rather than one big mess
99.			
100.		**INT: So, you do the mindfulness as part of the group …**	
101.			

1.	**Code**	**Transcript**	**Exploratory Comments**
102.		REC: Yeah.	
103.			
104.		**INT: … yeah, but you also said something about um, talking about it in individual therapy as well.**	
105.			
106.	Struggling with mindfulness of the body	REC: Yeah. Um, I've kind of … like, it's mainly in the group that we do it, but I've … 'cos at the start I really didn't kind of get it, we did a couple of ones um, individually, like in individual therapy, um, like the body scan one, because that's something that I was really, like, struggling with when I tried to do that the first time, like, I just, I couldn't feel my body, I could feel my head but I couldn't feel, like, anything down, like,	Needed more guidance for body focus Focusing on the body was blocked –I can't do that

1.	**Code**	**Transcript**	**Exploratory Comments**
		yeah, being asked to focus on it, I was like, "I can't do that". And yeah, just *[00.10.50].	
107.			
108.		**INT: What do you think that was about?**	
109.			
110.	Should I do more or less of the things I dislike Insight in to emotions through physical awareness	REC: I don't know. Um … [pause]. I don't know, like, I kind of … like people in the past have said to me that I'm not very connected to, like, what my body is doing, and when I'm asked to focus on, like, my, the sensation to my body, I find it really hard, and I think she's trying to help, like mindfulness with that, because obviously that links into other things, like if I'm able to tell what my body is kind of doing I might be	Unsure of connecting up to the body – is there a good reason for this? Other people notice problems with connecting to the body Links from problems in the body to other things *Do i need to be mindful of my body to be mindful of my emotions?* *Mindfulness as connection physically and*

1.	**Code**	**Transcript**	**Exploratory Comments**
		able to kind of tell what emotion I'm having, and things like that. So I think that's why she was trying to help with, like, that bit. Kind of.	*emotionally* *Mindfulness as uncovering the unknown – if I can tell what my body is doing…*
111.			
112.		**INT: Connecting up somehow?**	
113.			
114.		REC: Yeah. Yeah.	
115.			
116.		**INT: And, and so, you know, when you've been doing stuff in individual therapy has it come up as kind of, like um, you know, maybe mindfulness is part of the solution in this, in this process?**	
117.			

1.	Code	Transcript	Exploratory Comments
118.	Mindfulness as a way in to managing difficult situations Situation can become too difficult for mindfulness to work Unable to measure the effects of mindfulness	REC: Um … I'm trying to think. [long pause]. I think sometimes, like, 'cos, you know, we like do the chain analysis, and things like that, and obviously it won't come up, like, later in the chain, but its like maybe if I'd done some kind of mindfulness right at the start, then things wouldn't, possibly, like, snowball. And its kind of come up like, like with that, but honestly its one of, like, … I feel like I'm quite confident with, like, the emotional regulation and distress tolerance, but the mindfulness I'm kind of not, and I don't know whether that's just because its less, like … you can't kind of quantify it, its this weird thing [giggles], that you, you can't really tell whether its, like, is it working or not because its not something that's, like, works. I don't know. It's just	Mindfulness preventing the 'snowball' Can be too late to use mindfulness – not later in the chain Low confidence with using mindfulness – it cant be measured, it is hard to tell if it makes a difference – is it working or not. Not something that <u>works</u> – (in the conventional sense of cause and effect?) Still weird Strange Mindfulness as mysterious

1.	**Code**	**Transcript**	**Exploratory Comments**
		weird. I find it really strange.	
119.			
120.		**INT: There was … it can't be measured in the same way that the others can?**	
121.			
122.	Uncertainty about whether it is working Uncertainty of doing it right Need to do mindfulness over a period of time to see effects	REC: Yeah. Yeah. 'Cos, I don't know … like, … yeah. I guess it's that same thing like you can't tell if you're doing it right, or whatever. And has it, like, worked or not. [giggles]. Um … because its supposed to be like this ongoing kind of thing. It's not like just something you do once and it fixes this thing; like it's supposed to be kind of, ongoing. It's kind of confusing. Yeah.	Can't tell if it's right Not instantly changing things – ongoing, no quick fix *How long does it take to fix things?* Why keep going with something that seems weird and immeasurable? What gives the push to keep trying it?
123.			

1.	**Code**	**Transcript**	**Exploratory Comments**
124.		**INT: So its … it doesn't feel like a skill in the same way as …?**	
125.			
126.		REC: Yeah. Like the others.	
127.			
128.		**INT: Mmmm.**	
129.			
130.		REC: Yeah. I find it kind of frustrating *[00.13.55].	Frustration of it being immeasurable
131.			
132.		**INT: It's hard to know if it's working>**	
133.			
134.	Doing mindfulness because someone	REC: Yeah, 'cos … yeah, you're like, well they've told me to do this thing so I'm	Having faith in the leaders – they know what they are talking about

1.	**Code**	**Transcript**	**Exploratory Comments**
	else tells you to Taking a leap of faith	gonna do it 'cos they know what they're talking about I guess [giggles], um, but it still seems a bit, like … yeah.	Suspending disbelief due to the relationship. *Do you have to do mindfulness on faith to begin with or can it be explained adequately in order to completely understand the reasons for doing it and the benefits?*
135.			
136.		**INT: So is it something that you ever talk to kind of other people about? Do you ever kind of mention mindfulness to other people, or …?**	
137.			
138.		REC: Um, I tried to explain it to one of my friends once …	
139.			

1.	**Code**	**Transcript**	**Exploratory Comments**
140.		**INT: Yeah.**	
141.			
142.		REC: … because I was gonna lead a, like, at the group …	
143.			
144.		**INT: Yeah, OK.**	
145.			
146.		REC: … um, and I was just doing a thing where you were focusing on an object, and it was a two pence piece; I was trying to explain to him what I was gonna do [giggles].	
147.			
148.		**INT: Yeah.**	

1.	**Code**	**Transcript**	**Exploratory Comments**
149.			
150.	Mindfulness as embarrassing/silly Using mindfulness language	REC: Um, and so I was explaining, like, you focus on this object, and um, what it looks like and feels like, and like, yeah, and everything like that, and every time your thought wanders off you bring it back to the coin, and he was like … he was just like, well my thought's wandered off while you were telling me that [laughs]. But yeah, he was just like that. That sounds really weird, which is what I thought when I first heard about it, probably with the plant pot, so yeah.	Feeling silly when explaining – because of experience of thinking it was weird like the plant pot experience Others feeling silly about it – making a joke *Explaining just like it would be taught in DBT – learnt the language*
151.			
152.		But I haven't really talked to anyone else about it, like … I guess people have heard of it because its getting kind of more	

1.	**Code**	**Transcript**	**Exploratory Comments**
		popular now, but … I don't know.	
153.			
154.		**INT: But hard to explain somehow?**	
155.			
156.		REC: Yeah. Yeah. I don't know. I think until you kind of do it, it doesn't make any sense, [giggles], you're just like, yeah [giggles].	Need to do it for it to make sense
157.			
158.		**INT: So, you said about kind of in the training *[00.15.52], sometimes you put um, you think maybe mindfulness might come at the early stages …**	
159.			
160.		REC: Yeah.	

1.	**Code**	**Transcript**	**Exploratory Comments**
161.			
162.		**INT: … um, what would be your hope of doing that? What …**	
163.			
164.	Slowing thoughts down Dealing with difficult input from the outside Understanding emotions through body awareness	REC: Um … That I could kind of, like, the slowing of my thoughts down so that I can, so that I'm not just getting overwhelmed by, like, just stuff in my head and like input and stuff; but then also I guess being like mindful of the body sensations and stuff so that I can figure out what I'm feeling and kind of do something [giggles] before it just gets to really, really high emotions, and, and I'm like, Oh! [giggles] OK. Like, that escalated.	Prevention of being overwhelmed by in head input and stuff By understanding what I feel I can do something to prevent escalation Prevention of high emotion *Mindfulness being used as an antidote to too much input into the mind/brain?*
165.			

1.	**Code**	**Transcript**	**Exploratory Comments**
166.		**INT: Mmmm.**	
167.			
168.		REC: Kind of, yeah.	
169.			
170.		**INT: And does it ever come … I don't know … do you have, like, skills coaching as well as part of the DBT programme that you're on, that you can 'phone in ?**	
171.			
172.		REC: Um, yeah. I haven't used it that much I have to say though [giggles]. But yeah.	
173.			
174.		**INT: I was just wondering whether it had ever been, kind of, mentioned during skills**	

1.	**Code**	**Transcript**	**Exploratory Comments**
		coaching, kind of using *[00.17.16]?	
175.			
176.		REC: No, I … I haven't really used it that much [giggles]. Um, working on it by telephones, I'm not … not, not …	
177.			
178.		**INT: OK.**	
179.			
180.		REC: … into, so yeah.	
181.			
182.		**INT: OK. So, can you, can you think of times when you have used mindfulness, when you haven't been in group, when you haven't been in individual therapy, it's just kind of like, yeah I think mindfulness is**	

1.	**Code**	**Transcript**	**Exploratory Comments**
		what I need to do right now – can you think of a time like that?	
183.			
184.	Focusing on an activity to self soothe Mindfulness giving space to breathe	REC: Um … I can think of a time, I'm just trying to think what was going on. [pause] Um … like it was before I went on holiday, so a couple of weeks ago, and I was really stressed out about having to pack and I was like, I'm going to forget something. And … or, you know, go wrong and everything, and I was like … 'cos I have like that kind of self- soothe/mindfulness kind of box thing, and I got the bubbles out and just um, yeah, kind of watched the bubbles kind of popping. Um … and, I don't know, after that I was like, OK I can just breathe, I can do this kind of thing. I don't … yeah.	Self soothe and mindfulness connected Prompted to use mindfulness due to stress, fear of forgetting, fear of things going wrong Watching bubbles popping – what is it about bubbles? After mindfulness I can just breathe Sense of can do afterwards Shifting of emotion and cognition

1.	**Code**	**Transcript**	**Exploratory Comments**
185.			
186.		**INT: What do you think happened in you that, I don't know, what … how would you describe what happened that got you to that point where you could breathe?**	
187.			
188.	Minfulness as focus on one thing Mindfulness dealing with difficult things from the outside Dealing with being overwhelmed	REC: [pause]. I don't know, just focusing on one thing, rather than, like, just everything [giggles], if that makes sense, 'cos I, like, I had a lot of, like, thoughts going around in my head and then, like, sensory [giggles] stuff from outside, like the noises outside, and it just all gets very [giggles] kind of loud, if that makes sense …	Process of focusing brought the thoughts into order, reduce impact of external stimulus Emotional element to having to think about everything rather than just one thing – not just cognitive Use when things are loud
189.			

1.	**Code**	**Transcript**	**Exploratory Comments**
190.		**INT: Yeah.**	
191.			
192.	Mindfulness as focusing on one thing Mindfulness helps to order thoughts	REC: … and then focusing on what, that one thing, and just doing that one thing, and bringing thought back to that one thing, kind of, … Then after I've done that for a little while I can kind of focus on one thing at once, rather than everything.	One thing Focus Allows for processing thoughts
193.			
194.		**INT: So it changed the situation afterwards, in what way?**	
195.			
196.	Dealing with the situation differently after a period of mindfulness	REC: Um … well in this particular instance instead of thinking, Oh my God, I have, like, a million things to do, I was, could think, OK, well I'll just, I'll do this first, and then	Allowing her to do one thing at once which made the task more manageable

1.	**Code**	**Transcript**	**Exploratory Comments**
		that, and then it'll be fine [giggles], kind of thing. But yeah, I don't know.	*Self talk in the situation rather than reaction to situation* Panic of a million things becomes a calm just one thing at a time
197.			
198.		**INT: You've said a few times um, about this kind of, it's weird what mindfulness is it, um, how do you measure it …**	
199.			
200.		REC: Yeah.	
201.			
202.		**INT: … how do you know when you're being mindful?**	
203.			

1.	**Code**	**Transcript**	**Exploratory Comments**
204.	Mindfulness focused on a mindfulness exercise Using mindfulness language	REC: Um … that's a hard one actually. I think I can tell when I'm being mindful when I've … yeah. I don't know. 'Cos I can tell sometimes, obviously, when I'm, when I've gone, I'm going to do a mindfulness exercise now, but um … sometimes it's like on holiday I was kind of snorkelling and stuff, and like just watching the fish, and I was suddenly like, I'm probably being mindful right now, 'cos I'm doing one thing, like, in the moment using beginners mind, kind of thing, so I'm probably doing mindfulness right now [giggles] without kind of realising it.	Difficult to explain the sense of being mindful Activity based mindfulness Did catch herself doing it – using beginners mind, one thing in the moment – *using the language of mindfulness when she's not sure how to explain the process from within.* Self-doubt about whether she is doing it right im probably being mindful right now
205.			
206.		**INT: So, so its something you notice even, at times even if you're not frightened of**	

1.	**Code**	**Transcript**	**Exploratory Comments**
		the mindfulness exercise?	
207.			
208.		REC: Yeah. Yeah, I was like well this probably counts [giggles], kind of, yeah.	
209.			
210.		**INT: Do you think there's been any other times that you've kind of caught yourself being mindful?**	
211.			
212.		REC: Mmmm … I don't know, that's a big one I can think of.	
213.			
214.		**INT: Mmmm.**	
215.			

1.	**Code**	**Transcript**	**Exploratory Comments**
216.		REC: [long pause]. I'm not really sure.	
217.			
218.		**INT: So most of the time it's about doing the exercises?**	
219.			
220.	Uncertainty about the effects of mindfulness Things getting easier through practice	REC: Yeah, yeah. For me at the moment, I'd say I need a bit more practise with it, but yeah. I don't know, I think some kind of, with reading I've become a bit more mindful because, yeah, I used to find it like really hard, and I'd just wander off and I'd be like I haven't read any of that page, I don't know what's going on. But I think I've … like, I can concentrate on it better and, I don't know whether that has anything to do with mindfulness, but … I	Improved concentration Activity based mindfulness Unsure if mindfulness is the cause of better concentration *Internal dialogue changed from Ive wandered off i don't know whats going on to Ive wandered off thats fine lets go back.*

1.	**Code**	**Transcript**	**Exploratory Comments**
		think it kind of does 'cos I just catch myself wandering off and I'm like, OK, that's fine, but lets go back. Kind of.	
221.			
222.		**INT: And … Are there any times, sort of, um, I don't know that … um, tsk, … mindfulness has had an effect emotionally on you? Say, how would you say it does, you know?**	
223.			
224.	Initial negative effect Difficult to mindful of the body	REC: Um … I think at first it was kind of a negative kind of, emotional effect, because, … I don't know. Like, I was suddenly being more aware of what I was feeling, and kind of, yeah, my body and stuff, and it was kind of like this is scary,	Initially negative to be aware of what she was feeling and her body – this was scary Unsure if there is a emotional effect now Sudden awareness *after avoidance of awareness or just natural autopilot*

1.	**Code**	**Transcript**	**Exploratory Comments**
		[giggles]. Um … But I'm not sure, like now, whether it kind of has an emotional effect on me, but I'm not really sure.	
225.			
226.		**INT: So there was a bit of fear about it to begin with?**	
227.			
228.	First experience was scary	REC: Yeah. To begin with, 'cos … yeah, I think I was kind of … It is this, like, new thing and I was kind of experiencing it, and I was like, This is different and kind of scary [giggles]. Yeah.	Different – not like anything before – so scary I was experiencing it (it?) Being different
229.			
230.		**INT: And it … there was something uncomfortable about , you know, just saying …**	

1.	**Code**	**Transcript**	**Exploratory Comments**
231.			
232.		REC: Yeah. Yeah. I don't know.	
233.			
234.		**INT: And do you find that now? That at times it's uncomfortable?**	
235.			
236.	Mindfulness where no distracting activity is difficult Focusing on the body is difficult	REC: Um … yeah, I don't know. Like, … I don't know. The only thing I can think of at the moment is that we did, like, er, one, an exercise in group where we actually like, have to, like, sit with the discomfort of, like, I don't know, just feeling like little things in our body that feel, like, uncomfortable and resist the urge to like do anything about them. And I found that really hard [giggles]. I was like … So yeah, it's kind of	Hard to sit with experience and not react Resist the urge to do anything about the uncomfortable feelings – *not looking to change the feeling looking to change the urge associated with the feeling*

1.	**Code**	**Transcript**	**Exploratory Comments**
		uncomfortable in that way, sometimes.	
237.			
238.		**INT: So that, that sounds like you've kind of, um, purposely becoming aware of discomfort?**	
239.			
240.		REC: Yeah, yeah. Like, yeah, on purpose, and then just being mindful of it, but not doing anything about it, which … yeah.	
241.			
242.		**INT: So how do these kind of um, exercises in-group then relate to dealing with your own stuff?**	
243.			
244.		REC: Um … I don't know sometimes	Mindfulness as activities to try which may of

1.	Code	Transcript	Exploratory Comments
	Different exercises more or less useful Discussing the exercise helps to understand – uncertainty about what the exercise is about	[giggles]. Um … I don't know, 'cos we do like a wide range of them, I think it gives you, like, ideas of what you can try by yourself, um, 'cos yeah, some of them I haven't found helpful and some of them I've kind of … like the bubble blowing one is one that I learnt in group and then I kind of, it was like yeah, that was really good, I'll do that at home, and stuff. But … And sometimes, like at the end of the mindfulness exercise, they do like a little [giggles], not speech but a little bit about, like, what that kind of relate to, um … which kind of makes it, kind of make more sense in a way, but …	may not be helpful Trying by yourself is different to doing it in the group – *try an activity, see if it works rather than a process of insight* – <u>try it</u> Experience of activities being really good – liking them – what is it about bubbles? More sense when joined up by leaders *Exercises as mindfulness in everyday life in itself or as an illustration of how you can come to your own experiences. Mindfulness as a tool/first aid or as a new way of coming to life i.e rather than doing a mindfulness exercise to deal with a problem situation coming to the problem situation mindfully observe etc the*

1.	**Code**	**Transcript**	**Exploratory Comments**
			situation rather than inserting a mindfulness exercise.
245.			
246.		**INT: And there's some that you haven't really liked?**	
247.			
248.		REC: Yeah. Yeah.	
249.			
250.		**INT: Have you kind of stayed away from completely?**	
251.			
252.	Some types of exercise more or less accessible	REC: Um … I still kind of don't do the kind of body sensation [giggles] ones, or like, well that first kind of floating, thoughts	Blocks to certain ways of being mindful – not imaginative enough, focusing on the body

1.	**Code**	**Transcript**	**Exploratory Comments**
	Should I work on the ones I don't like/find difficult?	floating away on a leaf thing, 'cos I can't visualise things very well. But I'm like … its, it's a bit hard to work out whether, so should I try and improve on that, or does it not matter, and I should just go with the stuff that works, or seems to be, like, going OK, and that I like.	Unsure whether to do more of the things that are difficult – does it matter if don't do some of the exercises? Is it ok to stay with the ones i like? *Are some mindfulness exercises more mindful than others? Is there a hierarchy away from distraction to embodiment?*
253.			
254.		**INT: What's your gut feeling about that? May be you should be working more at that, or leaving it, or …?**	
255.			
256.		REC: Well, I'm thinking kind of if its hard I should probably be trying to do it more [giggles], but …	

1.	**Code**	**Transcript**	**Exploratory Comments**
257.			
258.		**INT: I wonder what makes those harder than the other ones?**	
259.			
260.	Certain mindfulness exercises difficult due to personal characteristic	REC: Yeah. I don't know. Like, I know, like, the visualisation one is just 'cos I, I have real trouble visualising things in my head, um, and for me, personally, I don't know, I just find experiencing like body sensations really hard. So I think its just a personal kind of …	Personal reasons for not liking certain activities – or is it wider than that? Not wanting to experience body sensations
261.			
262.		**INT: 'Cos that … do you know of other people who would really like those ones?**	
263.			

1.	**Code**	**Transcript**	**Exploratory Comments**
264.	Just sitting there = no connection to mindfulness	REC: Yeah. Yeah. Like, 'cos obviously we do like the feedback after, afterwards, and they're like, yeah I really liked that one. And I was just sitting there like, why did you like that [giggles]. Um, so I guess it's different for different people.	Other people's feedback suggests that there might be a personal element to which ones are liked. I was just sitting there *use of just sitting to indicate no connection to the exercise*
265.			
266.		**INT: And where do you think it will go from here with mindfulness?**	
267.			
268.		REC: I don't really know. [long pause] I guess me, I'm just going to continue doing it, um …	
269.			
270.		**INT: Do you see it as something kind of that you will continue doing, or just be**	

1.	**Code**	**Transcript**	**Exploratory Comments**
		kind of around while you're in DBT? What is it …?	
271.			
272.	Mindfulness developing over time Uncertainty as to place in her life	REC: I think I'll probably continue doing it, but, because I'm only kind of half-way through it'll probably develop and, like, my feeling might change about it, and … I, I don't really know [giggles] I, like, after DBT. I'll probably keep some of the stuff around, but I'm not sure yet.	Not embedded as part of life, unsure if would go back after treatment My feeling might change about it – *change from the current uncertainty to something more positive?* Feeling that there is more to learn – that mindfulness is something that develops.
273.			
274.		**INT: And you said you'd tried to talk to your friend a bit about it …**	
275.			

1.	**Code**	**Transcript**	**Exploratory Comments**
276.		REC: Yeah.	
277.			
278.		**INT: … how, how would you describe it to someone? You know, in terms of what it does …**	
279.			
280.		REC: Yeah.	
281.			
282.		**INT: … whether it, you know, …?**	
283.			
284.	Key elements to mindfulness: focus on one things, bring mind back when it wanders	REC: I don't know. I guess, I, I would say, like, its just doing one thing and focusing on one thing, being in the moment. Um, and the main thing is that you kind of notice when your thoughts wander from that one	Can use the language and explanation of the practical process

1.	**Code**	**Transcript**	**Exploratory Comments**
		thing, and then bring it back. So, um …	
285.			
286.	Uncertainty as to effect of mindfulness – why do we do it?	I don't know whether I'd be able to explain why you would do that [giggles], like … or what it really helps with, still, I don't think.	Harder to explain the process and reasoning behind mindfulness What does it help with? *Leap of faith to use mindfulness- it is not clear how it helps – I do it because I am told it will help*
287.			
288.		**INT: That's still a mystery to you?**	
289.			
290.		REC: A little bit, yeah [giggles]. Yeah.	
291.			
292.		**INT: Have you got any kind of inklings of what, you know, what its done for you, not**	

1.	**Code**	**Transcript**	**Exploratory Comments**
		what kind of it's supposed to do, but … ?	
293.			
294.	Effect of mindfulness – awareness of feelings, slowing thoughts down Uncertain as to effects of mindfulness	REC: Yeah, um … [pause]. Yeah, for me I guess I have become more aware of what I'm feeling, like, and … I don't know, like … obviously the times where I can like slow down my thoughts. I don't [giggles] … I'm still, I'm still a bit in the dark [giggles]. Yeah.	Still in the dark about why she is being taught mindfulness to help her Awareness of feelings *Starts to wonder if it is being more aware of what she is feeling or being able to slow down her thoughts – doubting self*
295.			
296.		**INT: But possibly something about being aware of feelings …**	
297.			
298.		REC: Yeah.	
299.			

1.	**Code**	**Transcript**	**Exploratory Comments**
300.		**INT: … and being able to slow them down?**	
301.			
302.		REC: Yeah. But I don't know [giggles].	
303.			
304.		**INT: Just check that there's nothing else on my little ….**	
305.			
306.		REC: OK [giggles].	
307.			
308.		**INT: … schedule that I haven't asked you about. Oh yes! There is.**	
309.			
310.		REC: [giggles].	

1.	**Code**	**Transcript**	**Exploratory Comments**
311.			
312.		**INT: Um, tsk, so all the way through kind of, um, being told about mindfulness, all of that, what, what have you made of the people that are telling you about it? What have you made about they've gone about it, and …?**	
313.			
314.	Explanation needs to be down to earth Initial negative thoughts about mindfulness	REC: Um … Well I have to say, like, the first person, like the person that's asked me, was like a psychiatrist, and it, kind of, felt like, yeah this is just some rubbish you're telling me, like. I don't know, like, I don't know; when I, when I've … 'cos my individual therapist is a nurse and just, for me, kind of personally, like, the situation she, she is like more down-to-earth and so	Experience of an explanation being airy fairy but needing it to be down to earth Connecting the profession with the ability to explain Experience of it being like rubbish (*nonsense, bad advice, stupid idea?)*

1.	**Code**	**Transcript**	**Exploratory Comments**
		her telling me about it, like, made it seem less like, airy fairy; this psychiatrist just said do this thing, in a way. I don't know. Like, its not just something a doctor has been, like, yeah this works, kind of. I don't know. Does that make any sense[giggles].	Not enough for someone to prescribe it – like a doctor saying this will work.
315.			
316.		**INT: What, what do you think she said or did that made it seem less airy-fairy?**	
317.			
318.		REC: Um … I'm trying to remember back now [giggles]. [pause]. I can't remember.	
319.			
320.		**INT: That's OK.**	
321.			

1.	**Code**	**Transcript**	**Exploratory Comments**
322.	Needing to have time to understand	REC: I really can't. Oh no! I think she might have just taken a bit more time to kind of explain it, maybe, rather than just kind of throwing me in, like, yeah, we're going to do this mindful exercise now [giggles]. But I'm not sure really, 'cos it was a while ago, I can't really …	Taking time to explain helps rather than being thrown in *like into deep water. Sense of loss of control. Will I be able to swim? What will the temperature be like?*
323.			
324.		**INT: And how about in the group when its sort of introduced to the group?**	
325.			
326.	Strangeness of mindfulness	REC: Um … I thought it was a bit weird at first; it was like the gong thing [giggles]. Um … But now I think its quite good with that, just the beginning and end, like very obvious. Um … I'm not sure.	*Gong not used in every day life (hippy connections)?* Mindfulness practice having a beginning and end. *Exercise vs lifestyle*

1.	**Code**	**Transcript**	**Exploratory Comments**
327.			
328.		**INT: Do you think they could have done anything differently in how they kind of … ?**	
329.			
330.	Being in it together Doing it because others are	REC: Um … Not really, no. I th-, I do actually, I quite like how it was done in the group, that everyone does it at the same time, regardless of how long they've been there, and stuff. Because, obviously, me coming in as a newbie, I w-, I was like, What is this? But everyone else was kind of doing it, so you just do it as well [giggles], . It makes you feel, like, silly in a way. Um …	Mindfulness not belonging to those with the longest experience Encouraged by the group doing it Conforming to what is expected despite it feeling silly *The sense of people doing it together no matter how experienced – does this help with the 'silly' factor?*
331.			

1.	**Code**	**Transcript**	**Exploratory Comments**
332.		**INT: There's a silly factor to it?**	
333.			
334.	Mindfulness as silly Uncertainty of how a silly exercise can help	REC: Yeah. Well there is. You're just sitting down, like, looking at a coin, or like, really, really focusing on eating a piece of orange, so it does seem a little bit silly, like, explaining it to somebody would seem really silly [giggles]. But yeah.	The activity itself seems silly. How can just sitting be important?
335.			
336.		**INT: Yeah. Cool. Thank you.**	
337.			
338.			
339.			
340.			

1.	Code	Transcript	Exploratory Comments
341.			

Reflections/initial analysis

- In writing the person seemed older than early 20's
- Seemed to be a lot of ambivalence towards Mindfulness
- Lots of what she can and can't do – is this due to a belief that she is not one of the mindful elite who have something she does not have?

-issues around the body – un comfortable with being present in the body but seemed to be connected to her own specific issues about her body

- seems to use mindfulness as a distraction or a set of exercises does not feature as a way of being

- language of mindfulness/DBT using the language but seems mystified as to what mindfulness is doing for her. Is there a real cognitive connection? Has she internalised the language or is she mimicking the language. Are there any points where she is making her own connections or using her own language?

- experience remains unfathomable, unable to deconstruct the experience

- use of mindfulness superficially to focus the mind to deal with a problem not connected to it 'spiritually'

-only described use in superficial problems. Didn't describe a crisis situation. Is it not useful then or doesn't come to mind? I didn't push for more difficulties – sense of don't go near that

-can mindfulness be a threat to the self, body – opening up places that we don't want to go

- is she using it as it is taught in DBT to allow her to make wise decisions and not necessarily to process pain and trauma – aim of stabilising and therefore not using vipasana (insight) techniques

Appendix M Tables of subordinate themes across cases defined by case specific themes.

Table 37 Subordinate themes across service user participants as defined by service user themes

Subordinate Themes Across Service User Cases	**Service user themes**	**Subordinate Themes Across Service User Cases**	**Service user themes**	**Subordinate Themes Across Service User Cases**	**Service user themes**
Not seeking mindfulness but being told to engage with mindfulness	6. Beginnings 7. Uncertainty 8. Motivation 9. Imposed mindfulness 10. What's the point?	**Mindfulness as contrary to everyday living**	1. In the now 2. Modern day distraction	**The hope that mindfulness will change thoughts and emotions in difficult situations**	1. Escape 2. Shifting internal landscape 3. Moving away from negative emotion 4. Reducing being overwhelmed
Experiencing mindfulness as weird	3. Mindfulness is weird 4. Strangeness	**Finding that mindfulness takes persistence**	4. Changing relationship 5. Practice 6. Need repetition	**Pausing rather than reacting**	1. Process of mindfulness 2. Pause and Go back 3. Brings you back to you 4. Changing thinking 5. Stepping back
Suspending doubts	6. Then and Now 7. Journey from non-believer to believer	**Internal focus intensifies difficult thoughts and emotions**	3. Mindfulness makes strong emotions difficult to manage	**Grounding self in being calm**	1. Calming 2. Slowing 3. Reduce stress

Subordinate Themes Across Service User Cases	Service user themes	Subordinate Themes Across Service User Cases	Service user themes	Subordinate Themes Across Service User Cases	Service user themes
	8. Approaching mindfulness 9. Experiential 10. Change of opinion		4. Anxious about silence		
Not everyone is ready for mindfulness	6. Not plane sailing 7. Turning point 8. Waking Up 9. Little impact 10. Timing	**Focused on external focus.**	1. Using the external 2. Activity based mindfulness 3. The body 4. Focus	**Making different choices**	1. New perspective 2. When to use mindfulness 3. Mindfulness in action 4. Self -control 5. Mindfulness leads to decision making 6. Changing reactions 7. Sort things 8. Practical mindfulness
Not always having the desire to be mindful	4. Initial view of mindfulness 5. Is it relevant? 6. Wilful about being mindful	**The experience of 'zoning out' from the painful thoughts or emotions**	1. Avoidance of difficulty 2. Distraction 3. Disassociate		
Doubting personal ability to be mindful	7. Barriers 8. Blocks to mindfulness 9. Confusion	**The experience of becoming more aware of a painful thought or**	1. Just sitting there 2. Awareness 3. Acceptance 4. Being with the		

Subordinate Themes Across Service User Cases	**Service user themes**	**Subordinate Themes Across Service User Cases**	**Service user themes**	**Subordinate Themes Across Service User Cases**	**Service user themes**
	10. I'm just not able to be mindful 11. Personal inability 12. Natural mindfulness	**feeling**	unpleasant		

Table 38 Subordinate themes across practitioner participants as defined by participant themes

Subordinate theme	Practitioner themes	Subordinate theme	Practitioner themes	Subordinate theme	Practitioner themes
Doubting that it is realistic for service user participants to be mindful	1. Emotional dysregulation 2. Mindfulness is abstract 3. Difficulties for young people 4. Specific difficulties	**Validating service user participant doubts**	1. Block of being told to do it 2. Find it invalidating at first 3. Acknowledging its weird 4. It ok to have doubts 5. Undermining the message	**Encouraging service user participants to be mindful despite the risks of experiencing painful thoughts and feelings.**	1. Mindfulness inseparable from DBT 2. Believing it will help
Being unsure of the importance of mindfulness	1. Difficult to make it relevant 2. Important to other skills 3. Problems with mindfulness causing drop out 4. Practitioners find it difficult	**Wary because exposure to painful feelings can cause problems**	1. Leads to distress 2. Dissociation 3. Encountering difficult thoughts 4. Trauma	**Introducing mindfulness gently**	1. Short exercises 2. Offering compassion 3. Doing internal awareness later in programme
Trying to apply mindfulness to everyday experiences	1. Using it in the real world 2. Importance of generalising 3. People don't tend to	**Avoidance of mindfulness exercises that might cause painful thoughts and**	1. Activity based mindfulness 2. Giving people a choice 3. Avoid internal	**Hoping changes in relationship with thoughts and emotions will change behaviour**	1. Acceptance 2. Awareness 3. Wise decisions 4. Sit with emotion 5. Reduced harmful

Subordinate theme	Practitioner themes	Subordinate theme	Practitioner themes	Subordinate theme	Practitioner themes
	generalise outside of group	**feelings**	awareness 4. Do difficult exercises 1:1		behaviour
Awareness of self - consciousness	1. Fear of looking silly 2. Self- consciousness 3. Difficulties in group				

Glossary of Terms

Borderline Personality Disorder	A diagnosis described in the diagnostic statistical manual characterised by emotional and relationship instability
Decentring	A process whereby an individual does not focus on their thoughts
Decoupling	A process whereby an individual separates thoughts and emotions from behavioural urges
Emotional experiencing	A process whereby an individual does not block emotions and chooses to be aware of the experience of an emotion
Emotional tolerance	A process whereby an individual does not try to change and does not react to their emotions
Mechanism of change	Features of a phenomenon that are proposed as essential to subsequent outcomes
Mindfulness	A trait or state of being when an individual has present moment awareness
Mindfulness Based Cognitive Therapy	A therapeutic manualised approach that combines CBT and mindfulness
Mindfulness Based Intervention	A therapeutic approach that has mindfulness as a core element
Mindfulness Based Stress Reduction	A manualised approach that uses mindfulness to treat chronic pain and stress
Practitioner	A mental health professional

Self-compassion	A process by which an individual approaches personal difficulties with compassion
Self-report measure	A measure which determines the amount to which a feature or phenomenon is present through an individual reporting their personal experience.
Service user	An individual who has made use of mental health services

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