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Qualitative Paper

An ongoing process of reconnection: A qualitative exploration of mindfulness-based cognitive therapy for adults in remission from depression

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Objectives. Mindfulness-based cognitive therapy (MBCT) is an 8-week relapse-prevention intervention designed for people who have experienced multiple episodes of depression and remain vulnerable to relapse. Previous qualitative explorations of the effects of MBCT for people in remission from depression have suggested a number of themes regarding changes arising from participating in MBCT ranging from awareness, agency, perspective, group processes, self-related change, and new ways of understanding depression. We aimed to qualitatively explore how participants in remission from depression experienced MBCT both post-MBCT and during a follow-up period.

Methods. In a preference-choice trial design, 35 participants took part in qualitative interviews and assessments post-MBCT and at three time points during a 12-month follow-up. Data were analysed using reflexive thematic analysis.

Results. Two overarching themes were developed as follows: (1) 'reconnection with experience, self, and others' and (2) 'acknowledging an ongoing process of change'. In theme one, sub-themes captured participants' experiences of increasing levels of awareness of their experience (e.g., thoughts, emotions, sensations, and present moment) from which they described changes in their relationship with experience describing increases in control, choice, acceptance, and calm. Participants described shifts towards reconnection with aspects of the self and relationships with others. In theme

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two, sub-themes reflected participants' conflict between avoidance and engagement in mindfulness practices, and the recognition of the gradual change following MBCT and long-term investment needed in mindfulness practices.

Conclusions. Our findings have clinical implications in terms of facilitating MBCT and point to important themes around recognizing the ongoing process of reconnection with experiences, self, and others.

Practitioner points

- Participants with histories of depression may have experienced disconnection and isolation from internal experiences (e.g., thoughts and emotions), self, and others; MBCT encourages a deliberate shift towards reconnection with these experiences.
- Practitioners could encourage more psychoeducation and discussions around depression during MBCT to encourage reflections on the process of reconnection.
- Practitioners should maintain an awareness of the ongoing, gradual processes of change and potential for conflict experienced during MBCT
- Practitioners could provide a stronger emphasis on building awareness of body sensations during MBCT, with suggestions provided in the discussion section.

Mindfulness-based cognitive therapy (MBCT) was designed for people who have experienced multiple episodes of depression and remain vulnerable to relapse (Kuyken et al., 2016; Segal, Williams, & Teasdale, 2013). Two meta-analyses have shown that MBCT can prevent relapse up to 60 weeks post-MBCT compared with treatment as usual (TAU) and those on maintenance antidepressant treatment (Kuyken et al., 2016), and that MBCT was more effective than TAU in preventing relapse, although the latter study included samples with remitted, current, and bipolar depression (McCartney et al., 2021). MBCT is an 8-week intervention, typically delivered in groups, with an all-day practice session around week six and regular reunion sessions post-MBCT. MBCT encourages an experiential participation in mindfulness practices to enable individuals to increase their awareness of depression-related triggers or warning signs for depression, complemented by psychoeducation and thought challenging exercises from cognitive therapy (Segal et al., 2013).

A number of studies have employed qualitative approaches to explore participants' experiences of MBCT. Cairns and Murray (2015) conducted a meta-synthesis of seven studies reporting five themes including a sense of increased control, the impact of the group setting (e.g., support and decreased isolation), changes in feelings towards the self, the importance of taking skills into daily life, and expectations around MBCT, although this meta-synthesis included participants with cardiac conditions or Parkinson's disease thus was not specific to participants with depression. More recent studies specific to participants with recurrent depression have highlighted additional themes including increased self-acceptance, awareness and control of depression-related thoughts and emotions, reduced rumination, improved relationships and communication with others, and increased self-care (Bihari & Mullan, 2014; Lilja, Broberg, Norlander, & Broberg, 2015; Tickell, Ball, et al., 2020; Tickell, Byng, et al., 2020; Williams, Meeten, & Whiting, 2018). In a systematic review and meta-synthesis of 19 qualitative studies exploring the experiences of participants with recurrent depression taking part in MBCT, we identified three overarching themes around 'taking action', 'acceptance', and 'ambivalence and variability' (Williams et al., in preparation).

Across the qualitative studies to date, some only interviewed participants during a follow-up phase (typically between 12 and 36 months since MBCT) thus potentially missing early changes attributable to MBCT, or interviewed participants when the link between their current situation and awareness of the impact of MBCT may have faded. Others interviewed participants at pre- and post-MBCT with no follow-up, potentially missing the long-term impact of MBCT. Two studies conducted interviews both post-MBCT and during follow-up, although these were specific to older adult populations with some subsequent adaptations to content and style (Smith, Graham, & Senthinathan, 2007; Williams et al., 2018). Tickell, Ball, et al. (2020) and Tickell, Byng, et al. (2020) conducted interviews both post-MBCT and at follow-up although the sample was purposively sampled and restricted only to participants using antidepressants. Therefore, a comprehensive exploration of qualitative experiences both immediately post-MBCT and during a follow-up period in adults with recurrent depression is warranted; we aimed to address this in this study. Our primary research question focused on: 'How did participants with depression experience taking part in MBCT?', with a focus on the potential benefits and challenges of MBCT.

Method

Study context

This study formed part of a larger preference-choice mechanistic trial (Williams et al., 2018; Williams, Elliott, Barnhofer, Zahn, & Anderson, 2020); only the qualitative data were analysed and reported in this study. Ethical approval was granted by the NHS (NHS North West Preston Research Ethics Committee). We followed the Consolidated Criteria for Reporting Qualitative research (COREQ; Tong, Sainsbury, & Craig, 2007) guidelines when drafting this manuscript (Supplementary Material S1).

Design

Participants were recruited from the north-west of England either from an existing departmental database of previous study participants who provided consent for contact in the future studies or had responded to adverts which were placed in health centres, University campus and online announcements, social media, and community websites (e.g., Gumtree). Participants contacted the lead researcher and were sent study information. Participants chose to either take part in MBCT + TAU or a TAU group; the latter did not undertake MBCT. All qualitative interviews were carried out by the lead researcher. Interviews were carried out at baseline (N = 53), post-MBCT (N = 35), with open-ended questionnaires obtained during the 12-month follow-up period (three [N = 29], six [N = 35], and twelve [N = 35] months). Attrition between baseline and post-MBCT was due to participants deciding not to continue with MBCT; the main study recruitment flow chart details the specific reasons (Williams et al., 2020). All baseline and post-MBCT interviews were audio recorded in a face-to-face setting in the research department; two participants preferred to write their responses. All follow-up data were captured on a written questionnaire document completed online.

Participants

Participants were aged 18 years or over and had all experienced at least two self-reported previous episodes of major depression, defined using the DSM-IV criteria and assessed

using the Mini International Neuropsychiatric Interview (M.I.N.I.; Sheehan et al., 1998). Participants were defined as currently meeting criteria for either full or partial remission and were, therefore, either free from or experiencing mild symptoms of, depression (defined by scoring below a cut-off score of 12 on the Montgomery Åsberg Depression Rating Scale; MADRS; Montgomery & Åsberg, 1979). There were no exclusions regarding antidepressant medication, but if participants were currently taking antidepressants, there should not have been any recent (in the last 3 months) or upcoming medication changes during the study timeframe. Participants were excluded if they met criteria for additional DSM-IV diagnoses other than major depression or comorbid anxiety, if they had previously engaged in a similar mindfulness-based intervention (MBI), had a current meditation practice, or had completed psychotherapy in the last 12 months.

Intervention

MBCT was delivered across five groups with approximately ten participants in each group between 2015 and 2017; MBCT groups were co-facilitated by two of the authors (KW; KB), both who had completed relevant training in facilitating MBCT. MBCT groups were delivered in accordance with the manual (Segal et al., 2013) and the good practice guidelines (BAMBA, 2011) and included 2-hr weekly sessions across 8 weeks, with an all-day session around week six. Participants were also offered four optional reunion sessions during the follow-up period.

Data collection

The semi-structured interviews were conducted by the lead researcher. Interview schedules were used to guide the interview content post-MBCT and were used as specific questions at follow-up. The semi-structured interviews included prompts for participants to consider the potential benefits, challenges, barriers, facilitators, and intentions to continue practice. Full interview schedules are in Supplementary Material S2.

Analysis

Reflexive thematic analysis (TA) was conducted in line with the six-step guidelines from Braun and Clarke (2006, 2013, 2020; Supplementary Material S3). Reflexive TA allows for identification of key themes in keeping with a 'critical realist' framework acknowledging the space for an 'ultimate reality' whilst accounting for the potential impact of the researcher's assumptions and the individual social and cultural contexts of participants (Braun & Clarke, 2006, 2013). As the active and subjective nature of the role of the researcher is fully embraced and is an integral part of the analysis process and final themes generated, coding reliability methods were deemed unnecessary (Braun & Clarke, 2020). Further, to mitigate the potential impact of the researcher's experience with and knowledge of MBCT, the lead researcher maintained a reflective log and discussed the themes with the wider team (Braun & Clarke, 2013; Supplementary Materials S1 and S4). All interviews were listened to multiple times and transcribed verbatim. A proportion of the interviews (N = 28; 14%) was transcribed by a research assistant (MD) and cross-checked for accuracy by the lead researcher, who subsequently transcribed and checked all remaining interviews (N = 175; 86%).

Transcripts were entered into NVivo 12 (QSR International, 1999) and in line with a critical realist framework, were coded at a data-derived, semantic level (remaining close to

the actual content and mirroring participants' language and concepts; Braun & Clarke, 2013) to limit the impact of researcher assumptions and expectations (Braun & Clarke, 2006). Transcripts were coded by the lead researcher in five time point-specific batches (baseline, post-MBCT, three, six, and 12 months). However, due to similarities across codes, all follow-up data were combined and analysed in one batch. Supplementary Material S5 includes an example of the coding tree. Codes were developed into themes, which were mapped out visually and refined by ongoing checking against the entire dataset (transcripts and codes) and through discussions with the research team. Due to similarities in themes across time points, the post-MBCT and follow-up themes were combined. To ensure fidelity with the analytic process, Braun and Clarke's 15-point checklist for TA was completed (Braun and Clarke, 2006; Supplementary Material S6). Additionally, two researchers, one with and one without MBCT experience, offered reflections and thoughts on the themes; both researchers stated that the themes fit with either their understanding of or expectations of MBCT. Finally, as our research question focused on the experiences of taking part in MBCT, rather than pre-existing beliefs and expectations, baseline data were not analysed.

Results

Table 1 details the demographics at baseline and post-MBCT. As described, there was some attrition between baseline and post-MBCT. By the 12-month follow-up, 28.6% ($N = 10$) of the sample had experienced at least one relapse into depression (i.e., meeting criteria for a DSM-IV diagnosis of depression). Further details regarding demographics and attrition are in the main trial publications (Williams et al., 2018, 2020).

As seen in Figure 1, taking part in MBCT and across a 12-month follow-up, participants reported changes across two overarching themes. The first overarching theme, 'reconnection with experience, self, and others', comprised three sub-themes including participants' connection with, or (in the light of previous depression experiences) reconnection with, increasing awareness of and changing relationships with experience, and enhanced connection with self and others. The second overarching theme, 'acknowledging an ongoing process of change', includes two sub-themes comprising the recognition of processes of avoidance versus engagement with experience and the long-term investment in an ongoing process of change. Participants' gender (all defined as either F/M) and age are given in parentheses following substantial quotes. Table 2 includes brief descriptions of the overarching themes.

Overarching theme one: Reconnection with experience, self, and others

This theme reflected how participants have gained something which they perceived themselves as having previously lost or become disconnected from during their

Table 1. Demographics

	Baseline $N = 53$	Post-MBCT $N = 35$
Age	$M = 37.04$ ($SD = 10.56$)	$M = 37.60$ ($SD = 10.99$)
Gender (% female)	75%	74%
N previous episodes	6.50 ($SD = 4.22$)	6.79 ($SD = 4.83$)
MADRS	$M = 4.89$ ($SD = 4.74$)*	$M = 4.53$ ($SD = 6.71$)*

Note. MADRS = Montgomery Åsberg Depression Rating Scale (1979); *$p = .57$.

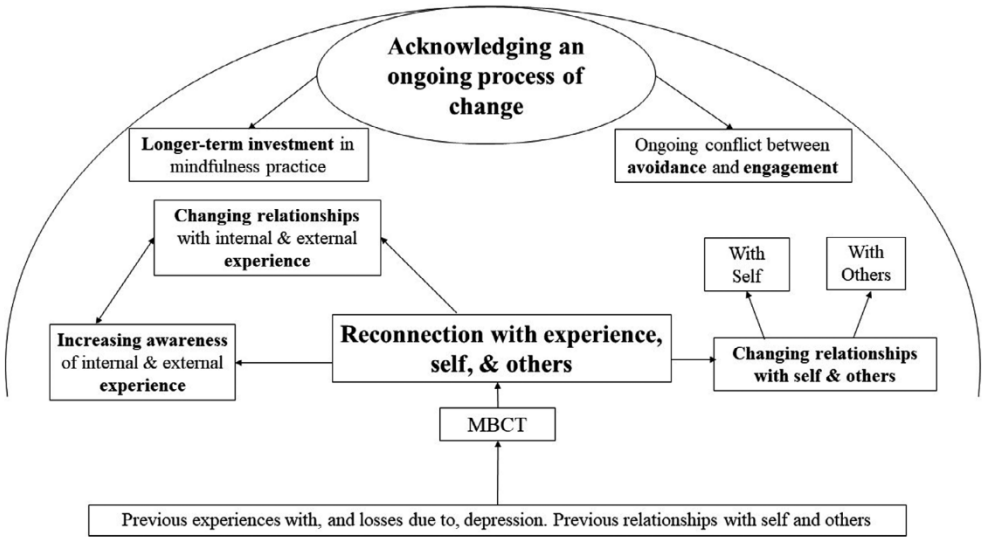

Figure 1. Participants' experiences of MBCT.

experiences of depression. Specifically, participants described how prior to MBCT they felt 'overwhelmed' by or easily caught up in thoughts ('overthinking' and 'catastrophizing'), emotions ('caught in a cycle of worry' (F, 31)), and described less conscious, automatic, 'reactive' relationships to their thoughts or emotions ('a small intrusive thought that just ends up spiralling into something completely ridiculous' [F, 31]). Participants described feeling 'dislocated' or 'isolated' from themselves and in their relationships with others. Following MBCT, participants described shifts towards a reconnection with their experiences, developing increased awareness of and different ways of relating to their experience, self, and others. Although this overarching theme contains distinct themes, there are interrelationships to an extent under the umbrella of reconnection.

Increasing awareness of internal and external experience

Participants described becoming more aware of the present moment, recognizing tendencies to 'go into autopilot' (F, 23), and feeling more present with their thoughts and emotions. One participant reflected that practising mindfulness and staying 'present' helped them to feel like they now lived 'in the present instead of worrying about the future and getting upset about the past' (F, 48). Some reported regret of time spent ruminating or worrying when 'living in the past or the future' (F, 23). Further, through connecting with the present moment, participants recognized the urges to engage in 'doing' mode versus 'being' able to allow experience to be there and to 'appreciate the present moment' (F, 33). This was not always easy, as one participant described how they 'found it very difficult. . .being in the moment, rather than. . .fixing something' (F, 53).

Participants reflected on how mindfulness practice allowed for an increased awareness of thoughts ('becoming more aware of some of my thought patterns' [M, 45]) and emotions ('I am more aware of my feelings. . .when I'm getting anxious, stressed, emotional' [F, 39]). Participants noticed the, at times, hidden automaticity of thoughts and emotions ('I can make myself quite. . .anxious and. . .upset without even realising' [F, 55]).

Table 2. Overarching themes and descriptions

Themes	Core ideas
Overarching theme 1: Reconnection with experience, self, and others	
Increasing awareness of internal and external experience	Increased awareness through connecting with the present moment, noticing more thoughts, emotions, and body sensations
	Automaticity of thoughts and emotions.
Changing relationships with internal and external experience	Less reactivity
	Distance between reacting and responding to thoughts and emotions through control and choice, acceptance, and calm
	Control over depression
	Acceptance of emotions and depression
	Effortless calm, resistance to calm
Changing relationships with self and others	Reconnecting with the self, worthy of self-care
	Confident and empowered
	Shifts from self-criticism to self-compassion
	MBCT group experienced as a safe, normalizing, shared place, helping to foster healthier, joyful, more communicative, and appreciative relationships
Overarching theme 2: Acknowledging an ongoing process of change	
Ongoing conflict between avoidance and engagement	Practical, logistical, and psychological impacts on avoidance and engagement in mindfulness practices
	Benefits and conflicts around the 'sitting with difficulty' practice
	Avoidance of difficulty practice and a lack of group support during the follow-up
A longer-term investment in mindfulness practice	Gradual change
	Recognizing the commitment and space needed to facilitate ongoing practice
	Reflections on intentions/choices to continue practice

Although described less often and in less depth than for either thoughts or emotions, some participants reported increased noticing of and ability to pay attention to their body. Specifically, participants reflected that they became 'more aware of sensory sensations' (F, 33), 'more aware of *(my)* breathing' (F, 48), and how '*(I)* can pay attention to what *(I)* am doing or how *(my)* body is feeling' (M, 24). One participant wondered 'is that (*pain*) there all the time?. . .it makes me think my body's really tense even when I feel relaxed' (F, 31).

Changing relationships with internal and external experience

Participants described how through increased awareness, they noticed changes in their relationships with experience. Specifically, participants noted shifts in reactivity whereby they now felt able to 'step back' and allow 'space' and a more responsive, as opposed to

reactive, interaction with thoughts and emotions ('I don't react as quickly any more which gives me more time to think through a more appropriate response' [F, 39]). Participants described gaining control over their thoughts and tendencies to catastrophize and ruminate ('there's definitely a tendency to make up stories and imagine the worst, which I feel like I'm getting control of now' [M, 55]). For participants who have experienced multiple episodes of depression and potentially engaged in ruminative strategies over many years, gaining control and choice over thought processes felt 'life-changing' and, for some, they no longer felt they were a passive recipient or 'hostage' but instead felt more active control over negative thoughts. Specifically, one participant realized that they could now choose not to engage in a familiar, ruminative thought cycle:

> there's probably been about three situations where I thought I can actually choose not to go down this horrible ruminating self-torture response to this thought and I've never thought that I could actually do that (F, 31).

This shift from reactivity to feeling in control also applied to emotions with participants describing previous hypervigilance or rumination over the meaning of or the urge to 'fix' emotions, yet reflecting that they now had space to 'step back' and observe emotions. However, this was not easy and for some, engaging in mindfulness practice felt intense and contributed to feelings of uncontrollability and distress around thoughts and emotions; one participant explains how:

> difficult thoughts and emotions simply took over. . .I found it incredibly difficult to settle myself so that I felt anything other than a deep distress (F, 52).

Many participants reflected on an increased sense of control over their understanding of and vulnerability to depression. Some described feeling equipped and 'empowered' with knowledge and 'tools' for recognizing and attending to negative depression-related thoughts and emotions 'before they become a real problem' (F, 37). Some described how prior to MBCT the 'lows would have been worse' (M, 37) or 'longer'. Following MBCT, many commented on how they hoped that their experience of depression might be different in the future, 'at the start I was resigned to the fact that I would probably have depression again. . .whereas now I'm hopeful that I might not' (F, 31).

Participants developed a 'greater acceptance and tolerance' (F, 35) towards their experience, through accepting the presence of emotions ('it's possible for me to feel something and for that to just be' [F, 30]) and what can or cannot be changed ('it's ok to feel when you are feeling down' [F, 35]). Participants described resilience alongside acceptance ('suffering is temporary and I can cope with it' [F, 31]). Participants reported feeling able to 'let go' of their desire to 'fix' depression and accept that MBCT would not provide a 'miracle cure'. One participant reflected:

> When I originally signed up I thought. . .I'll find a way to fix depression, or. . .fix me. . . I think I held onto that illusion for longer than maybe I should have (F, 26).

Participants reflected on feeling 'calmer' and having developed feelings of gratitude, both around their experience of MBCT and the facilitators. Some expressed gratitude and protectiveness over their experience of MBCT, describing it as 'a special thing' and 'just for me'. It was particularly noticeable how many participants described an 'effortless calm', taking a 'more measured' approach for 'things that would have rattled me before'

(F, 48). However, this sense of calm was not relevant to all participants as some described resistance to it; one participant reflected that 'I'm not sure I want to be that calm all the time' (F, 38) but spoke instead of redirecting their attention and making a choice about what they needed at that specific moment ('spending a bit more time with myself but not necessarily doing a practice' [F, 38]). Overall, new ways of relating to experiences encompassed interconnections between awareness, control, choice, acceptance, and calm. Indeed, one participant described these interconnections between reactivity, rumination, awareness, and acceptance:

> If you've had several periods of depression, you start looking for stuff and you worry desperately all the time. . .is this a sign? You try and think of ways that you will be able to hold it off. *(Now)* I don't have to do that. . .I can just be aware that it's happening, that it might be the start of a pattern, or it might not (F, 30).

Changing relationships with self and others

Firstly, some participants reported feeling lost or 'disconnected' with their sense of self when depressed. MBCT had provided space and an ability to reconnect with their 'old self', with many participants commenting on how their 'energy levels are better' (F, 22), they felt a sense of relief ('a bit of weight off of my shoulders' [M, 55]), 'happier', and 'less despondent'; some had reconnected with a loss of libido (the body scan 'has helped me to regain some of the drive' [F, 56]). Many participants described feeling more 'empowered', 'more assertive', and confident around making decisions.

Participants described their familiar, well-established thoughts and emotions related to self-criticism, 'blame', 'self-disgust', 'shame', and 'guilt' and the difficulties in feeling self-compassionate prior to MBCT. Following MBCT, participants reported how whilst self-critical thoughts were still present, the intensity and power of such thoughts and emotions were lessening and, similar to rumination, participants could 'step back' and allow 'distance' from such thoughts and emotions. Participants commented on how they felt less 'judgemental' and 'critical', and 'haven't beaten *(myself)* up' (M, 40). One participant described how they 'feel a tiny bit freer from the self-disgust and shame' (F, 37) and another reflected how whilst they cannot 'immediately go down the positive path. . . *(I)* can stop being so critical of myself' (F, 37). Participants reflected on a different way of relating to themselves through becoming more 'compassionate', 'patient', 'kinder', 'forgiving', and taking a 'softer approach to thoughts' (F, 23) alongside a realization that they are worthy of 'taking the time to feel good' (F, 35) and prioritizing self-care as they recognized their 'value'. Some described how they could extend self-compassion to difficult memories ('I suddenly felt so sorry for myself. . .from that moment. . .I've. . .learnt to be kind to myself' [F, 48]). As is a common experience for people who have experienced depression, self-compassion can feel like unfamiliar territory, as one participant describes how they now:

> feel a lot more compassionate *(to myself)* which I've never felt. . .never, ever, ever felt that ever. . .not for one minute have I ever felt like I want to be kind to myself. . .and I do now (F, 48).

Participants described their sense of improved relationships with others both in the MBCT group and wider context (with family, friends, and colleagues). This was strongly represented across both time points, suggesting that relationships with others were an

important aspect of participants' experience of MBCT. Whilst some participants felt reticent about taking part in a group ('something I wasn't looking forward to' (F, 42); '*(I'm)* not particularly good with groups' [F, 55]), participants described it as a 'pleasant', 'friendly', enjoyable, 'supportive and convivial' experience, with a sense of 'peer support'. Participants described how listening to others' experiences with depression helped to create a 'safe', 'shared' experience ('we're in it together' [F, 23]), where participants felt understood, less isolated, and 'less stigmatized' ('other people are also having the same feelings' [F, 42]); 'it's not just me it's happening to' [F, 48]). Once MBCT had finished, some expressed feelings of loss through 'missing the weekly meetings' (M, 55), having valued 'the practice atmosphere. . .and practicing with others' (F, 33).

Particularly during the follow-up, participants described feeling better able to relate to others in a 'healthier' way, expressing 'joy' in spending time with family and friends. Some reflected on how they were able to distance themselves from others' reactions ('can't control others' reactions' [F, 37]) recognizing that there may be different explanations, breaking down a sense of 'me versus them' ('it doesn't feel like (*I'm*) being permanently singled out and bombarded with things going wrong' [F, 48]). Some described feeling content and relieved that they felt 'much more communicative' (F, 37) with others and that others now related differently to them ('everyone seems to smile at me now. . .I think it's because I'm smiling!' [F, 42]), fostering a greater appreciation of relationships with others. One participant commented on how they now felt able to 'seek help from other people quicker' (F, 37) as the stigma and sense of isolation from others had lessened. Finally, many described the joy in noticing changes in other participants and expressed hope that others might benefit similarly from MBCT ('it was good to see other people benefitting' [F, 42]).

Overarching theme two: Acknowledging an ongoing process of change

This overarching theme captured participants' conflict around avoidance versus engagement patterns, as well as their recognition of the immediacy of change and their investment in mindfulness practices. As depicted in Figure 1, this theme also encompassed many of the changes in the overarching 'reconnection' theme whereby participants were on different trajectories of change, acknowledging that MBCT allowed for a gradual change to what are often lifelong patterns of relating to experience, self, and others ('it feels like it's just the beginning' [F, 31]).

Ongoing conflict between avoidance and engagement

Prior to MBCT, participants described tendencies to avoid difficult thoughts or emotions ('easier to. . .push them down and not actually deal with them' [F, 46]). Following MBCT, there remained a consistent conflict between the desire and inclination to avoid versus engage, particularly in mindfulness practices and MBCT itself. Specifically, many reported obstacles around time (e.g., 'physical time constraints', 'struggle to form new habits' [M, 48]), logistics (e.g., other commitments, 'lack of suitable space to practice' [F, 26]), and psychological barriers ('if I was having a stressful day, I'd avoid it' [F, 55]), impacts of guilt, low mood, or anxiety). Participants described difficulties being with others in the group ('general awkwardness'), but a large proportion of the conflict appeared in reflections around the sitting with difficulty practice. For some, this practice enabled a safe space to explore difficult emotions which they may otherwise have ignored or attempted to suppress ('I feel a lot more comfortable facing and thinking about my more uncomfortable

feelings' [F, 28]). Some reflected on how sitting with their difficulty meant that they felt lighter around feelings of 'guilt and self-blame' and their impact (felt 'able to release them' [F, 31]) and noted a less painful connection with their experience: 'in the moment I burst into tears because it was an extremely painful memory. But by the end of it (*practice*), it felt more distant and it didn't feel like it had such a hold on me' (F, 48). However, for some, self-worth was an inhibiting factor contributing to the avoidance ('I practise less than I hoped. . .because I purposely do little self-care. . .linked to my negative self-worth' [M, 40]). Others commented on how they 'would like to do sitting with difficulty more often' (M, 48) but at the same time felt worried or fearful of what might arise ('worried to confront feelings of inadequacy' [M, 24]).

Whilst reflections around the conflict between avoidance and engagement continued during the follow-up, fewer of the reflections focused on the 'sitting with difficulty' practice specifically and centred more around the impacts of time, other commitments, motivation, or lack of habit. Some participants commented on the lack of group support and how engaging in practices which were more likely to elicit difficult thoughts and feelings felt much harder without the group support. Despite the difficulties expressed, some participants acknowledged the value of these practices:

> if you're feeling anxious or miserable. . .it (*sitting with difficulty*) can intensify those feelings so. . .I didn't want to engage in them like the body scan. Although, I realise that I see it as a way of building tolerance to that feeling (F, 31).

A longer-term investment in mindfulness practice

Some participants described MBCT as 'life-changing' and the beginning of a 'long-term investment' in mindfulness practice and principles, acknowledging the need for ongoing commitment to practice, and the 'space' and 'discipline' needed to facilitate this. Some participants acknowledged that change was not immediate, but gradual and required trust in the process. One participant described the changes as 'I feel happy that I'm a work in progress and not perfect' (F, 39), recognizing that 'the journey is still ongoing, but it has started' (F, 48). Participants acknowledged that these changes were not easy ('still feels like I'm learning it' [F, 39]) and continued to feel unfamiliar at times, particularly considering the long histories participants had with depression ('not spending my life beating myself up is a very new way of living' [F, 48]). Participants reflected on the non-linear trajectory whereby if the habit of mindfulness practice is disrupted, 'it's something you can just step back into' (F, 31).

During follow-up, participants expressed their intentions to continue practising mindfulness although some decided to continue more with informal practices ('I try to incorporate very informal mindfulness practices when I can' [F, 52]) or to use mindfulness practices reactively when feeling low or stressed (if 'something was bothering me I feel like that might help me to regain a bit of calm' [M, 51]). However, for a few, taking part helped them to make informed decisions that mindfulness practice was not for them: 'I made a conscious decision that any kind of formal practice wasn't for me' (F, 28).

Discussion

Using reflexive TA, we aimed to explore the experiences of participants with recurrent depression post-MBCT and during a 12-month follow-up period. Across time points, we

described two overarching themes comprising a number of interconnected themes. Our findings suggest that MBCT enables an ongoing process for reconnection with experience, through increased awareness of experience (e.g., present moment, thoughts, emotions, sensations, and depression) and a changing relationship with experience (e.g., reduced reactivity, shifts from passive to active relationships around control, choice, and acceptance). Participants described a process of reconnection with aspects of their sense of self and others which were previously lost through depression. Reconnection with experience was part of a gradual and long-term ongoing process of change incorporating an understanding of the investment needed for mindfulness practice and tendencies to be in conflict around avoiding or engaging with experience, particularly with the ability to stay with the difficult aspects of experiences.

Overall, our findings fit with other qualitative investigations of MBCT (Cairns & Murray, 2015; Chesin et al., 2018; Lilja et al., 2015; Malpass et al., 2012; Murphy & Lahtinen, 2015; Tickell, Ball, et al., 2020; Tickell, Byng, et al., 2020; Williams et al., 2018; Wyatt, Harper, & Weatherhead, 2014). Our findings fit most similarly with the 'relating mindfully' model proposed by Bihari and Mullan (2014). In their model, the authors described similar changes but with a stronger emphasis on the impact of intrapersonal change on interpersonal change. However, our study adds to and expands on previous research by directly positioning our findings in terms of the reconnection with experience, as well as relationships with the self and others, alongside the recognition of an ongoing, long-term process of change. Further, in contrast to previous studies, our findings were taken from both the immediate post-MBCT stage and during a 12-month follow-up allowing for a more comprehensive exploration of changes. However, our findings suggest that the core themes were similar across time points. For some specific experiences, the intensities sometimes varied as, for example there were fewer comments around the 'sitting with difficulty' practice during follow-up, which may suggest that participants practised this less or felt less connected with it once they were no longer in the MBCT group environment. Finally, this research was conducted in a research centre with no links to any major MBCT research or teacher training centre.

In our first overarching theme, participants described becoming more aware, shifting away from a passive, reactive, disconnected, and isolated relationship with experience, self, and others. Becoming more aware of experience may have allowed for disengaging or decentring from difficult or ruminative thoughts, emotions, and sensations (Farb et al., 2018; Siegel, 2009; van der Velden et al., 2015), in line with the aims of MBCT (Barnhofer & Crane, 2009; Crane, 2009; Segal et al., 2013). Further, changes towards a less reactive, more accepting relationship with experience and an understanding of 'suffering' may have enabled participants to decentre from a self-critical, isolated standpoint with a realization that 'suffering' is a fundamental part of being human (Teasdale and Chaskalson, 2011). Our findings suggested shifts towards a more self-compassionate attitude as well as discovering more joyful, communicative, open, and less stigmatized relationships with others. These changes fit with the aims of MBCT (Kuyken et al., 2010; Segal et al., 2013) as well as psychotherapy more broadly in terms of groups fostering change in interpersonal relationships (Yalom, 1995). Finally, our findings are particularly important to individuals with long histories of depression whereby links between thoughts, emotions, and body sensations may have become strengthened through each episode of depression, with the subsequent re-experiencing of these more easily triggering depression (Barnhofer & Crane, 2009; Teasdale, 1999). Given that depression often encompasses lifelong accounts of loss, disconnection, and isolation from experience, sense of self, and others (Morgan, 2005; Renner et al., 2012; Saris, Aghajani, van der Werff, van der Wee, & Penninx, 2017),

our findings suggest that a key therapeutic process of MBCT may be through encouraging a shift towards reconnection with experience in a realistic way through recognizing the ongoing process.

It is not unusual to experience some difficulty or uncertainty in mindfulness practice (Moss, Waugh, & Barnes, 2008), especially as it embraces learning to face all experiences (positive, negative, or neutral). Indeed, Kabat-Zinn (1990) emphasized the importance of exposure to all emotions in order to achieve the benefits of mindfulness. Our theme of avoidance versus engagement may tie in with ongoing experiential avoidance linked with depression (Tull, Gratz, Salters, & Roemer, 2004), whereby difficult thoughts, emotions, and body sensations may be too difficult to be in touch with and are, therefore, avoided (Aldao, Nolen-Hoeksema, & Schweizer, 2010; Barnhofer, Brennan, Crane, Duggan, & Williams, 2014; Crane, 2009; Hayes, 2004). One of the core foundations of MBCT involves the acknowledgement of experiential avoidance and the development of skills to turn towards experience (Crane, 2009; Segal et al., 2013).

Although participants were able to turn towards experience, our findings highlighted an ongoing conflict between avoidance and engagement, as engagement in mindfulness practice was not easy with participants acknowledging the ongoing, long-term process. This is especially important in the light of the relapsing nature of recurrent depression and, indeed, the fact that nearly 30% of our sample experienced at least one relapse during the follow-up. Participants described the realization that some lifelong patterns (e.g., rumination and self-criticism) were not resolved or 'fixed' but with new ways of relating to these, participants spoke to allowing for trust in an ongoing process (Harris, 2014). Other qualitative explorations of MBCT for participants with depression have reported that change varied between participants and was not a case of simply more or less change, but was focused on individual trajectories of change (Allen, Bromley, Kuyken, & Sonnenberg, 2009; Bihari & Mullan, 2014; Ma, 2002). Finally, for some participants in our study, engaging in mindfulness practices felt too intense. Whilst there is an emerging evidence-base regarding the potential for adverse effects of mindfulness (Baer et al., 2020; Farias & Wikholm, 2016; van Gordon, Shonin, & Garcia-Campayo, 2017), much still remains unknown, and it is worth acknowledging that not all difficulties arising from a mindfulness practice can or should be tolerated.

Limitations

Participants took part in a non-randomized preference-choice trial; therefore, participants were interested in and chose to take part in MBCT and so the sample may be distinct in some ways if compared with those who chose not to take part in MBCT. This may have impacted participants' responses as they may have felt more hopeful for positive experiences from MBCT. Further, the different data collection methods may have impacted on what participants felt able to comment on (either in a face-to-face interview or a written document), particularly given that the lead researcher also co-led the MBCT groups. As the lead researcher took the lead in coding, generating, and refining themes, interpretations were inevitably drawn in line with the researcher's expectations, knowledge of, and interest in MBCT, and potentially influenced by the key research themes of self-compassion and rumination in the main trial (Williams, 2018). Regular discussions and reflections with the research team helped to mitigate this, particularly as the two supervisors of this analysis were not involved in the original trial nor trained in MBCT.

Further, it should be noted that the research team and the majority of participants were white, and predominantly, middle-class thus limiting the transferability of the experiences of our sample. Other studies have reported similar sample demographics (Chin, Anyanso, & Greeson, 2019; Tickell, Ball, et al., 2020; Tickell, Byng, et al., 2020; Waldron, Hong, Moskowitz, & Burnett-Zeigler, 2018) suggesting that our skewed demographics may represent a larger issue with recruitment to MBIs. Specifically, it remains difficult to know whether people of other ethnicities and demographics would feel safe enough to participate in MBCT or whether they would feel heard in terms of their individual and collective experiences, particularly with regards to racial trauma and inequality (Ahsan, 2020). Future studies would benefit from directly exploring a more diverse range of views around access to, interest in, and feelings of safety around participating in MBCT. Additionally, future studies might benefit from longer follow-ups to explore whether themes continue beyond 12 months. In the light of our findings around avoidance and engagement, it would be beneficial to understand the reasons for attrition for which there may be a number of reasons including the lack of ongoing group support, not wanting to let others down, finding the group aspect more supportive than mindfulness, or dropping out when it felt 'easier' to do so.

Clinical implications

Our findings have direct clinical implications in terms of encouraging MBCT facilitators to recognize themes of reconnection in the light of experiences of depression, possibly through increased emphasis on psychoeducation and reflection around depression experiences during MBCT. Further, our findings highlight the importance of acknowledging a steady, long-term process of change and the conflict participants might experience whilst engaging in mindfulness-based practices. Despite the focus in MBCT on developing awareness of body sensations (Segal et al., 2013), this was not as prevalent as other themes in our data (e.g., thought awareness). This may reflect how prevalent experiential avoidance of difficult emotions and sensations is in depression (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996), even during remission (Barnhofer et al., 2014). Our limited findings regarding body awareness suggest that there may be a need for more emphasis on developing body awareness in MBCT for depression, especially given that experiential avoidance and cognitive processes are key factors in the risk of relapse (Spinhoven, Drost, de Rooij, van Hemert, & Penninx, 2016). Practitioners could encourage more explicit exploration of body sensations during mindfulness practices, inquiry processes, and didactic elements, with future research evaluating these body-focused adaptations to better understand the role of MBCT in the link between body awareness and depression. Overall, our findings suggest that MBCT allows for an ongoing process of moving towards deliberate reconnection with experience through increased awareness, a changing relationship with experience, self, and others, alongside an understanding of the ongoing process of change. Our finding that participants were at different trajectories in their mindfulness learning may suggest that MBCT facilitators could offer additional opportunities for engagement in MBCT through practice days, reunions, or follow-up mindfulness-based groups (e.g., mindfulness-based compassionate living; Bartels-Velthuis et al., 2016).

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Conflicts of interest

The authors have no conflicts of interest to declare.

Author contribution

Merryn Dowson (Investigation; Project administration; Writing – review & editing) Rebecca Elliott (Conceptualization; Project administration; Supervision; Writing – review & editing) Peter Taylor (Conceptualization; Formal analysis; Project administration; Supervision; Validation; Writing – review & editing) Kelly Birtwell (Investigation; Supervision; Writing – review & editing) Kate Williams (Conceptualization; Data curation; Formal analysis; Investigation; Project administration; Visualization; Writing – original draft; Writing – review & editing) Samantha Hartley (Conceptualization; Formal analysis; Project administration; Supervision; Validation; Writing – review & editing) Ian M Anderson (Conceptualization; Project administration; Supervision; Writing – review & editing).

Data availability statement

The qualitative interview data are not being made publicly available out of respect for the privacy and confidentiality of all participants.

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