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# Mindfulness-based cognitive therapy for severe health anxiety (hypochondriasis): An interpretative phenomenological analysis of patients' experiences

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**Objective.** Severe health anxiety (hypochondriasis) is a common and disabling condition for which existing psychological treatments have limited effects (Thomson & Page, 2007). Hence, it is a priority to examine both the efficacy and acceptability of new psychological treatments for health anxiety. The aim of this study was to explore the experiences of participants with severe health anxiety who received Mindfulness-based Cognitive Therapy (MBCT) as part of a randomized controlled trial.

**Design.** Semi-structured interviews were carried out 3 months after participants completed MBCT in order to explore their experiences of the course and subsequent self-managed practice.

**Methods.** Interpretative Phenomenological Analysis (Smith, 1996) was used to analyze interview transcripts from nine participants who had received MBCT.

**Results.** Two main themes emerged from the analysis: (1) My awareness of barriers to experiencing change through MBCT, and (2) Cultivation of a new approach to health anxiety and my life in general.

**Conclusions.** The majority of participants considered MBCT to be an acceptable and beneficial treatment for health anxiety. Participants reported beneficial impacts of MBCT both on their health anxiety and on their broader functioning. Importantly, the focusing of attention upon bodily sensations required in MBCT practice did not exacerbate participants' health anxiety.

Severe health anxiety (HA), also described as 'hypochondriasis' (DSM-IV-TR: American Psychiatric Association, 2000), or 'hypochondriacal disorder' (ICD-10: World Health Organization, 1992), is characterized by the pre-occupation with the fear of having a serious disease, which persists in spite of appropriate medical reassurance. Up to 9% of patients in general medical practice clinics and up to 5% of the general population meet diagnostic criteria for HA (Asmundson, Taylor, Sevcur, & Cox, 2001; Creed & Barsky, 2004). HA not only causes great suffering for the patient and those around them but is also costly in terms of higher medical care utilization (Barsky, Ettner, Horsky, & Bates, 2001). Hence, it is a priority for the sake of both patients and healthcare service providers to develop effective treatments for HA.

To date, the effects of psychological treatments for HA have been limited, with a recent Cochrane review failing to find any superiority of cognitive-behavioural treatments (CBT) over non-specific therapies (Thomson & Page, 2007). The failure to demonstrate the superior efficacy of CBT for HA is in contrast to reports in many anxiety disorders (e.g., see McManus, Grey, & Shafran, 2008 for a review) and may be in part due to the inherent difficulty in disconfirming HA patients' feared predictions in comparison to other anxiety disorders. Because HA patients' fears tend to have a longer time course (e.g., developing cancer and dying in 5 years' time as compared to, for example, the patient with panic disorder who fears he will pass out in the next 10 minutes) they are more difficult to disconfirm via the use of standard CBT methods. If there is, as the literature suggests, an equivalence of effect amongst psychological treatments for HA then it remains a priority to investigate the efficacy and acceptability of novel treatment approaches. For these reasons, a randomized controlled trial of Mindfulness-based Cognitive Therapy (MBCT) for HA is being carried out (McManus, Williams, Surawy, & Muse, 2010). This article reports the results of a qualitative analysis of patients' experiences of receiving the MBCT treatment.

## Mindfulness-based Cognitive Therapy

MBCT was designed to target the cognitive processes that render depressed individuals vulnerable to repeated relapse and recurrence, such as rumination and high cognitive reactivity to mood shifts (Teasdale, Segal, & Williams, 1995). It incorporates mindfulness training (Kabat-Zinn, 1990) with components of CBT. Studies show that MBCT reverses processes hypothesized to underlie depressive psychopathology (e.g., Teasdale *et al.*, 2000) and is associated with positive changes in emotion-related brain activation (Barnhofer *et al.*, 2007). There is sufficient evidence for the efficacy of MBCT in preventing relapse in depression for it to be incorporated into the UK government's National Institute of Clinical Excellence guidelines for the treatment of recurrent depression (National Institute for Clinical Excellence, 2004). Additionally, initial studies have reported MBCT to benefit patients with chronic fatigue syndrome, psychosis, treatment resistant chronic depression, recurrent suicidal depression, bipolar disorder, and generalized anxiety disorder (see Didonna, 2009 for a review of recent studies). MBCT is a cost-effective 8-week class-based programme that teaches participants to observe their thoughts and feelings through the repeated practice of

intentionally returning attention to an object (e.g., the breath or body sensations) in the present moment. Participants are taught how to cultivate direct experiential awareness, together with an attitude of open-hearted, non-judgemental acceptance, towards whatever is present (including negative mood states that trigger anxiety and negative thinking). The cultivation of awareness during mindfulness practice enables participants to see more clearly when negative and ruminative responses are being triggered, and facilitates decentring from such patterns of thought, seeing them as mental events, rather than as valid reflections of reality. Unlike standard CBT, where the focus has traditionally been upon changing the content of thoughts, MBCT focuses on fostering meta-cognitive awareness and the modification of meta-cognitive processes that maintain unhelpful reactive or ruminative mind states.

There are several reasons to hypothesize that MBCT may have particular advantages and potential disadvantages for the treatment of HA. First, unlike standard CBT, MBCT does not aim to change the content of the patient's thoughts by disconfirming their feared predictions, but to reduce their impact by changing the individual's relationship to their thoughts. This may circumvent the difficulty of disconfirming HA patient's fears (which often relate to the distant future) through standard CBT methods, such as behavioural experiments. Second, rumination has been shown to be central to the maintenance of HA (Marcus, Hughes, & Arnau, 2008) and it is hypothesized that MBCT may enable patients to learn generic skills of attentional control that will enable them to break the pattern of excessive attending to somatic sensations leading to an escalation of anxiety via rumination on the potential negative meanings of sensations. Third, cognitive-behavioural conceptualizations of HA have emphasized the role of heightened bodily focused attention in the maintenance of the disorder (e.g., Warwick & Salkovskis, 1990). A central tenet of MBCT is the re-focusing of attention away from negative and ruminative responses that may break into the hypothesized maintenance cycles in HA and there is preliminary evidence that training in external attentional control strategies can be beneficial in HA (Papageorgiou & Wells, 1998). However, since some MBCT practices focus participants' attention internally (e.g., the body scan), it is possible that such practices may increase HA individuals' awareness of their bodily sensations that may lead to an exacerbation of anxiety. Finally, one previous study reported an exacerbation of HA patients' concerns in a group CBT treatment due to participants sharing their concerns with each other leading to an increased focus on illness concerns (Wattar *et al.*, 2005), so it may also be that the group setting has disadvantages in the treatment of HA.

## **Qualitative enquiry**

Alongside increasing recognition of the role of patients' views in research and service planning (Macran, Ross, Hardy, & Shapiro, 1999) is increasing recognition of the utility of qualitative methods for understanding the experiences of service-users, and for capitalizing upon their insights, within a systematic and epistemologically coherent framework (Hodgetts & Wright, 2007). Knowing that a treatment is efficacious in terms of reducing overall levels of psychological distress is a fundamental aspect of therapy outcome research. However, qualitative studies complement such outcome research in two ways. First, by providing rich descriptive detail that considers participants' motives, expectations, and concerns, along with salient contextual information that may have had an influence on treatment success. Second, qualitative studies examining patients' views on the acceptability and effectiveness of treatment can complement other established methodologies (e.g., mediation analyses and component evaluation trials) for identifying the more or less effective components, which may enable increases in the efficacy or cost-effectiveness of interventions by highlighting more or less effective procedures (e.g., McManus, Peerbhoy, Larkin, & Clark, 2010).

While data from quantitative studies have attested to the efficacy of MBCT for various disorders there have been few previous qualitative studies of MBCT, and these have focused on depression (e.g., Allen, Bromley, Kuyken, & Sonnenberg, 2009; Finucane & Mercer, 2006; Mason & Hargreaves, 2001; Smith, Graham, & Senthinathan, 2007). Qualitative approaches share a central concern with understanding the research participant's point of view. Interpretative Phenomenological Analysis (IPA – see Smith, Flowers, & Larkin, 2009) is one such experiential approach that has become well established in applied psychology (Brocki & Wearden, 2006; Reid, Flowers, & Larkin, 2005). It draws upon key concepts from phenomenology, hermeneutics, symbolic interactionism, and idiography, to focus upon the meanings that participants ascribe to events. IPA is particularly appropriate for the current study because both IPA and MBCT view participants as playing an active role in the construction and meaningfulness of experiences (Eatough & Smith, 2008; Segal, Williams, & Teasdale, 2002).

The current study uses qualitative methodology (IPA) to attempt to understand patients' experiences of MBCT for HA with the aim of understanding how different aspects of the treatment impact upon the patients in terms of perceived effectiveness and acceptability.

## **Method**

### **Ethical review**

Ethical approval for the study was attained through the local National Health Service (NHS) Research Ethics

Committee.

## Context and researchers

The research took place in the broader context of a randomized controlled trial of MBCT for HA, for which the second [FM] and fourth [JMGW] authors were the primary investigators. As one of the initial developers of MBCT, the fourth author [JMGW] provided supervision for the MBCT in this study, as well as checks for adherence and competence. Both the second [FM] and fourth authors [JMGW] had a background in the development and evaluation of CBT- and MBCT-based interventions for a variety of disorders, whereas the first [MJW] and third [KM] authors were relatively new to the field. While the research team shared a belief in the utility of psychological interventions to alleviate distress, there was no awareness of any pre-conceptions about the way in which the MBCT may benefit patients with HA. The research arose out of a shared desire to better understand the efficacy and acceptability of MBCT for treating HA so as to maximize the therapeutic impact of the treatment.

## Participants

All nine participants who had received MBCT as part of the same group in the randomized controlled trial were invited and agreed to participate in the study. All participants were of a Caucasian background and their ages ranged from 36 to 64 (mean age 49.2 years). The trial aimed to be ‘clinically representative’ and thus had few inclusion/exclusion criteria. Participants were included in the trial (and thus the current study) if they met DSM-IV-TR (American Psychiatric Association, 2000) criteria for the diagnosis of hypochondriasis, were aged 18–70, and were fluent in English. Participants were excluded if they were actively suicidal or met diagnostic criteria for a psychotic disorder, substance dependence, or bipolar disorder.

Table 1 shows participant characteristics. Names and identifying information have been altered to preserve anonymity.

To help situate the sample, scores on the Short Health Anxiety Inventory (Salkovskis, Rimes, Warwick, & Clark, 2002) were used to calculate whether clinically significant change to HA status was achieved (see Results).

**Table 1.** Participant Characteristics

Participant	Employment status	Years in full time education	Duration of current HA episode (years)	Comorbid diagnoses
Carol	Part time	16	20	Specific phobia
Tina	Sick leave	13	26	None
Penelope	Part time	13	18	None
Michael	Full time	20	29	Specific phobia
Andrea	Retired	11	6	GAD
Brian	Retired	20	15	Depression
Lisa	Full time	13	2	None
Chloe	Full time	11	14	Specific phobia
Lynette	Part time	16	9	Panic disorder

## Design

Qualitative data were generated from semi-structured interviews. Since it is widely believed that continued adherence to therapeutic exercises influences long-term efficacy, participants were interviewed about their experiences 3 months after completing the MBCT course.

## Measures

As part of their ongoing assessment in the randomized controlled trial, participants completed the Short Health Anxiety Inventory (SHAI; Salkovskis *et al.*, 2002) prior to receiving MBCT (pre-treatment), directly after receiving MBCT (post-treatment), and at 3 months follow-up. The SHAI consists of 18 items that assess HA independently of physical health status. Scores range from 0 to 54 with a score of 18 or above suggested as representing HA (Salkovskis *et al.*, 2002). The SHAI demonstrates good psychometric properties (Salkovskis *et al.*, 2002).

## Procedure

### MBCT treatment protocol

The MBCT course was delivered by an experienced MBCT therapist over eight, 2-hr weekly classes. Supervision was provided by JMGW. The program followed the protocol for MBCT for recurrent depression as outlined by Segal *et al.* (2002) but was modified for HA in that it was informed by Warwick and Salkovskis' (1990) cognitive model of HA. Handouts and practices focused on HA rather than depression, and psycho-education components (session four of the MBCT program) examined maintenance cycles in HA specifically (e.g., focus on bodily sensations, checking and reassurance seeking and HA thoughts).

### Semi-structured interview schedule and procedure

The schedule for the semi-structured interview was prepared in accordance with the recommendations of Smith (1995). Questions were open-ended, and designed to invite participants to narrate, and then reflect upon, their experiences of MBCT for HA. Questions were derived from an understanding of the demands involved in undertaking MBCT (e.g., Segal *et al.*, 2002), and a detailed literature search of studies exploring factors that influence treatment success, such as motivation, homework compliance, acceptance of the treatment rationale, and an external support network (e.g., Elliott & James, 1989; Helbig & Fehm, 2004; Schulte, 2008; Westra, Dozois, & Marcus, 2007). Table 2 shows the main topics covered in the interview schedule, with one example of the questions used to elicit responses to each of these topics.

**Table 2.** Summary of topics covered in the interview schedule and example questions used

Topic	Example question used
(1) Participants' overall experiences of the course	Can you tell me what you remember about your experiences of the MBCT course?
(2) The impact of practice during the course	Did attending the classes and practising the homework have any impact on you? If so, in what ways?
(3) Acceptability of specific aspects of the course	Could you describe your experiences of any specific aspects of the course that you feel resulted in these changes?
(4) Possible external influences on success	Can you describe whether anything else outside of your experiences in the classes either helped, or didn't help, with your success with MBCT?
(5) Continuation of MBCT practice post-course	Do you still practice the MBCT exercises that you learnt in the class? If so, please describe your experiences of it.
(6) Possible lasting impact of practice	Over the past three months, what changes, if any, have you seen in your life as a result of participating in MBCT classes?

All participants were interviewed by the first author [MJW], who was blind to participants' SHAI scores at the time. As recommended in IPA (Smith, 1995), participants were asked the planned questions of the interview schedule but the interviewer was flexible in allowing the follow-up of unexpected material, which emerged through participants' reflections. Interviews lasted between 28.39 and 74.41 min (mean = 52.91 min; standard deviation = 14.55), and were audio-recorded with participants' permission. Audio-recordings were subsequently transcribed verbatim, and anonymized at point of transcription.

### Clinically significant change procedure

Participants' scores on the SHAI were used to calculate whether clinically significant change (CSC) had been achieved in accordance with the Jacobson, Follette, and Revenstorf (1984) method, whereby CSC occurs if the individual moves to within two standard deviations of the normal population mean. Normative data were taken from Abramowitz, Deacon, and Valentiner (2007). Participants' scores were also analyzed to determine whether those who showed CSC did so reliably (Jacobson *et al.*, 1984).

### Data analysis

Standard analytic processes for IPA were followed (e.g., Smith *et al.*, 2009; Smith & Osborn, 2003). The first author [MJW] took the lead in developing a close, line-by-line analysis of the experiential claims, concerns, and understandings of each of the nine participants in turn, and in the subsequent identification of the emergent patterns within this experiential material across the data set. Once the initial overarching thematic structure had emerged, the nine transcripts were read again to ensure that the themes were appropriate to each case. Any amendment to the thematic structure resulted in returning to the data in this manner until the main researcher felt confident that the final themes accurately reflected participants' experiences. This was achieved through the rigorous collection of numerous example quotes from all participants that reflected the thematic structure. At each stage, the thematic structure was

discussed and developed through detailed collaboration with the second author [FM], who checked to ensure that the emergent themes accurately reflected the data and that the selected example quotes were relevant. The final thematic structure for these patterns was developed through discussion between MJW, FM, and KM.

## Validity

Guidelines for enhancing the validity of qualitative research were consulted during the planning of the study (e.g., Flick, 1998; Yardley, 2000), and were implemented if applicable (e.g., situating the sample, a ‘paper trail’ approach, and grounding in examples).

## Results

### Clinically significant change findings

Table 3 shows participants’ scores on the SHAI at pre- and post-treatment and 3-month follow-up, and also whether they show reliable and/or CSC. Five of the nine participants showed CSC immediately following treatment (Carol, Tina, Michael, Brian, and Chloe) and four showed CSC at 3-month follow-up (Carol, Tina, Penelope, and Michael). Three participants showed CSC at both post-treatment and follow-up (Carol, Tina, and Michael), whereas two participants showed CSC at post-treatment only, suggesting that for them the treatment had a temporary impact (Brian and Chloe). Penelope did not achieve CSC by post-treatment but had by follow-up, suggesting that the impact of the treatment accrued more slowly for her. Two participants did not achieve CSC at either time point (Andrea and Lynette), although neither became reliably worse. For Lynette, her scores improved reliably but not enough to be considered clinically significant.

**Table 3.** Scores on the SHAI at pre-treatment, post-treatment, and 3-month follow-up

	No of sessions attended	SHAI scores			CSC Post-treatment	CSC Follow-up
		Pre-treatment	Post-treatment	Follow-up		
Carol	8	23	19	13	Yes	Yes*
Tina	8	27	17	14	Yes*	Yes*
Penelope	8	33	27	22	No*	Yes*
Michael	3	30	22	22	Yes*	Yes*
Andrea	8	37	35	39	No	No
Brian	6	29	19	24	Yes*	No*
Lisa	6	12	15	14	NA <sup>a</sup>	NA <sup>a</sup>
Chloe	6	23	19	25	Yes	No
Lynette	8	35	26	27	No*	No*

*Note.* Yes = the occurrence of clinically significant change; \* = reliable change

<sup>a</sup> For Lisa, CSC could not be calculated as her initial score on the SHAI was below the cut-off for HA (i.e., eighteen or higher on the SHAI: Salkovskis *et al.*, 2002) so it was not possible for her to achieve CSC. This is because the SHAI measures health anxiety in the previous week, whereas inclusion in the RCT was on the basis of meeting diagnostic criteria for HA over the previous six months.

## Qualitative results

Two super-ordinate themes emerged: (1) My awareness of barriers to experiencing change through MBCT and (2) Cultivation of a new approach to HA and my life in general. Super-ordinate and sub-ordinate themes are outlined in Table 4, and are described, interpreted, and illustrated by transcript excerpts below.

### *Theme 1: My awareness of barriers to experiencing change through MBCT*

This theme emerged as a result of participants’ reflections on the aspects of the course, which they found challenging.

#### *My desire to experience change in the face of initial uncertainties.*

Most participants approached the MBCT course with an open-minded attitude and a desire to try anything that might help to ameliorate their HA symptoms. For example, Penelope was open to trying anything that may potentially help, since her anxiety was particularly severe prior to the course. Her ‘fairly open-minded’ attitude was mixed with some scepticism and uncertainty about mindfulness (‘you sort of go in thinking you are going to sit there and chant with

bells’). This scepticism was also shared by Carol and Lynette. Lynette was also keen to finally be getting help, since

**Table 4.** Summary of themes

Superordinate themes	Subordinate themes
(1) My awareness of barriers to experiencing change through MBCT	(1) My desire to experience change in the face of initial uncertainties (2) The struggle to find the time: Is practising MBCT regularly worthwhile to me? (3) My need for variety and flexibility
(2) Cultivation of a new approach to health anxiety and my life in general	(1) Validation and normalization of my experiences through MBCT (2) An awareness of my anxiety cycle enables me to break it (3) Acceptance of my experiences (4) A different outlook on my life in general (5) Change large enough for significant others to notice

she was ‘feeling pretty bad at the time’. However, Lynette approached the course with a less open-minded attitude and had significant reservations about the MBCT rationale:

Lynette: [MBCT seemed] a bit airy fairy and you know . . . not really *strong* enough, if you like . . . I suppose, you know, it seemed a bit unscientific . . . a bit kind of not quite sure it was gonna really work.

The scepticism that Lynette (and others) held at the start of the course changed when ‘something clicked’ and she started to notice that she was becoming less anxious in circumstances that would typically exacerbate her anxieties. Lynette also initially questioned whether MBCT was the right treatment for her since it conflicted with her natural desire to avoid her bodily symptoms and health anxious thoughts. Lynette was alone in fearing that MBCT may exacerbate her HA and her fears were not realized (she reported a positive impact from the course). Three participants (Penelope, Andrea, and Chloe) expressed an initial expectation that MBCT *must* provide a solution to their HA/physical symptoms. The expectations of Penelope and Chloe became more realistic throughout the course but Andrea’s high expectations remained, and she continued to struggle with them at the time of the interview, in the context of a strong desire to experience change (‘I was so determined that this was going to be very beneficial to me, and here I am, still as worried as I was before I came on the course’).

#### *The struggle to find the time: Is regular practice worthwhile to me?*

Seven participants explicitly noted the intensity of the course in terms of the time commitment requirement (Carol, Penelope, Michael, Andrea, Lisa, Chloe, and Lynette). Salient aspects of this theme were a need for a realistic approach to the amount of practice achievable, and the belief that the course required a shift in lifestyle to create the time for practices. These concerns were especially pronounced for participants in employment. Many resorted to practicing early in the morning or late at night, which proved challenging:

Carol: I found that if I did it when it was sort of late in the evening I would fall asleep (laughs), and I think doing it early in the morning I did just sort of feel, it was sort of a bit, trying to resist the urge to sort of want to race on faster than the CD was taking me.

Six participants spoke of the challenge of practicing late in the day and falling asleep, and most considered this problematic (Carol, Penelope, Michael, Lisa, Chloe, and Lynette).

Three participants (Carol, Andrea Brian, and Chloe) also expressed that, even if they had time, they struggled to prioritize MBCT practices (e.g., Chloe: ‘Although I’d like to help myself [by practicing], I find that as soon as I get home I’m on the computer again’). Both Brian and Chloe achieved CSC directly after the course, but not at follow-up, which may relate to their difficulty in continuing to practice.

There was a clear demarcation between participants who continued to practice regularly as a way of continuing to address their HA and be in the best possible place to react to future triggers (‘weaving the parachute’: Kabat-Zinn, 1990) and those who practised only in response to anxiety. Tina, Penelope, and Lynette practised regularly and there was a sense that MBCT practice was becoming a way of life for them. Motivations for regular practice included not going back to how they felt before, and a noticeable decrease in the negative impact of their anxiety upon their family (Penelope: ‘If *you* can’t get a handle on things . . . then the people you live with get dragged down with you’). Tina and Penelope both achieved CSC when assessed at the time of the interview.

In contrast, Carol, Brian, Lisa, and Chloe held the alternative view that MBCT practices were tools to be used when they became anxious in order to address negative affect, because they struggled to structure regular practices into their busy lives. However, they also noted the limitations of this strategy (Brian: ‘I can remember feeling that I must do it . . . But I felt too bad to do it at the time’). All participants who did not practise regularly acknowledged the missed

opportunities to reap potential benefits.

Five participants (Penelope, Andrea, Brian, Lisa, and Chloe) expressed a desire for ongoing support beyond the course, mainly as a result of their reported lack of discipline in continued practice and the fear that they may stop practising altogether:

Penelope: You haven't *got* to achieve something by a certain day, you haven't got any homework to do, I think the sort of human ways, you kind of slip a little bit with it.

There appeared to be an ongoing struggle within four of these five participants to take control by managing their own practice.

#### *My need for variety and flexibility.*

Overall, there seemed to be an appreciation for the variety of practices available so that participants were given choice over how to manage their care beyond the course (e.g., Carol: 'Some [practices] will suit some people more than others, but there was a variety and I thought that was helpful'). This was echoed by other participants (Tina, Penelope, Brian, Lisa, and Lynette).

The variety and flexibility of MBCT practices was considered important for three main reasons: the participants' age (Brian: 'I'm getting on a bit, and I'm not terribly supple, so the yoga side was a bit of a struggle to be honest. I mean, I didn't find that suited me particularly. It wasn't something I practiced afterwards'); health (Penelope: 'Although I've kept the other practices going, I haven't managed to keep [the 3-minute breathing space] up. Because I have limited amount of energy [due to suffering from ME] and there are certain things I want to get done, even a little break I sort of see as a slight intrusion and with the longer meditations, I suppose I can get into them more'); and Brian: 'Physically, it was just difficult to hold some of those positions. I mean, there were some I just couldn't do. I've had spinal surgery, for example. I've had surgery on my neck. There were various exercises that I just couldn't do. And I wouldn't do, because it gave me pain or discomfort'); and time available (Carol: 'Doing a 20 minute one in the evening was quite useful because it's usually quite easy to find 20 minutes whereas it's not easy to find perhaps 40–45 minutes, and it's never just the length of the tape. It's other things, and writing afterwards, so you're talking an hour with some of them. So yes, some shorter options and that sort of mix and match thing is quite useful'). These circumstances influenced which exercises were likely to be practiced more often and which were unlikely to be practiced at all after the course.

In contrast, Chloe highlighted that, for her, the variety of practices was not a positive aspect ('There seemed to be too much variety . . . doing lots of different things can kind of bog you down a bit') and cited this as a main reason for not continuing to practice after completing the course.

#### *Theme 2: Cultivation of a new approach to HA and my life in general*

This theme emerged as a result of participants' reflections on the impact that practising MBCT had upon them.

#### *Validation and normalization of my experiences through MBCT.*

Eight participants considered the group to be an extremely positive experience, from which they derived benefit. The central features, which were echoed across participants, were the importance of acknowledging similar concerns (especially homework difficulties) and an appreciation for the group setting whereby members could openly discuss difficulties. For many, (Tina, Penelope, Andrea, Chloe, and Lynette) the group was also a validating and normalizing experience regarding their HA (Lynette: 'A big thing is really just recognizing that this is something that lots of people have a problem with').

There was a sense that participants were then able to see their HA as something that was treatable, rather than as a personal failing.

However, Michael describes the group experience more negatively whereby he found himself feeling increasingly closed-off from the rest of the group due to perceived differences between himself and the others:

Michael: In nearly all of the sessions I was the only man there, and it often seemed like I was in a girls' club . . . And they were much more articulate about their problems . . . and I felt more and more kind of *fenced* in a bit . . . [MBCT] probably didn't work as well because of that.

In this sense, the appreciation for being with similar others, which typified participants' accounts can be contrasted with Michael's view of seeing himself surrounded by dissimilar others. Michael was also alone in expressing a preference for one-to-one therapy.

#### *Awareness of my anxiety cycle enables me to break it.*

Most participants (Carol, Tina, Penelope, Brian, Lisa, and Lynette) felt that they had gained an approach that was



helpful in dealing with stress and anxiety when it arose (Lisa: 'I became more aware of the tensions in my body and I began [practicing] to address that during the course of the day . . . I'm more aware of the things that are leading up to being stressed'). However, Tina, Penelope, and Lynette emphasized the benefit they received more explicitly in terms of understanding and breaking their HA cycles. For example:

Penelope: Before I did this, if I got back pain I'd be constantly thinking . . . "Is it worse if I move like this? If I move like that? What's making it bad?" You know, I'd just be moving, touching, my back all the time. And I think now, I am just sort of more accepting of it, and I think through meditating I recognise it's there, but I'm not – It's almost like I used to aggravate it.

Here, Penelope compares her reactions to bodily sensations before and after the course, and acknowledges the link between bodily sensations, thoughts, and the exacerbation of anxiety. The course helped her to feel she had a choice over how to respond to negative thoughts about aberrant bodily sensations.

Penelope: My mind isn't just me. It's got its own agenda, and it goes off down its own avenues. And I can choose whether I want to follow those avenues . . . I think I feel very aware of my thought patterns and how they function, and that there are ways not to react to my thoughts, to stop the anxiety.

Similarly, Lynette emphasized that practising MBCT provided her with space in which to rationalize aberrant bodily sensations:

Lynette: It's like not having an immediate panic about every slight thing that I feel . . . If I get a pain somewhere, or a sensation somewhere I'm still aware of it . . . I'm still conscious, but it's just much more "It's just a sensation. It's just a pain because your body's moving" . . . instead of my thoughts running away with me thinking "I've got something really serious here and no-one's taking me very seriously", I was aware that that was where my thoughts were going and that it would increase my anxiety.

Tina, Penelope, and Lynette were the participants who practised more regularly after the 8-week course, and were also the participants who most clearly acknowledged that it is the increased awareness of how their thoughts, bodily sensations, and emotions can affect one another, which helps them to keep their anxieties at a tolerable level.

#### *Acceptance of my experiences.*

Most participants explicitly expressed that they became more accepting of their experiences as a result of practising MBCT, whereby things that used to bother them no longer stayed with them for so long nor had such a negative impact (for example, Lisa and Chloe's greater tolerance of certain work colleagues, and Lynette's recognition that whereas she used to experience stress and irritation over minor things she is now more able to take a step back and reflect). Carol said that this increased acceptance was pervasive in most aspects of her life. However, others (Tina, Penelope, and Lynette) focussed on their greater acceptance in regards to their HA (e.g., Lynette: 'I was feeling ill . . . and I was focusing on my breathing . . . I think it just makes me more accepting of the situation'). This seemed to be because Carol's HA was at a lower level to start with, and so the impact that the course had on Tina, Penelope, and Lynette was perhaps more meaningful to them in terms of HA reduction. For Carol, this accepting attitude was an ongoing benefit despite not practising since the course.

Andrea expressed that engaging in MBCT increased her anxiety in certain respects, which she attributed to her inability to cultivate an accepting attitude towards her tinnitus:

Andrea: I did find that the actual meditation concentrates my mind too much on the tinnitus . . . the problem that I have, in myself particularly, is acceptance of the fact. And I think maybe I probably tried a bit too hard, thinking this has got to work for me, rather than I'll let it do hopefully what it should do and not worry about it too much. And in lots of respects it made me worse.

The impact she felt this had on her was an ongoing sense of disappointment, self-blame, and failure.

An interesting element that emerged for certain participants was a desire to change their experience to make it more conducive to having a 'successful' practice, rather than cultivating a 'grist to the mill' attitude (Segal *et al.*, 2002). For example, three participants (Michael, Andrea, and Brian) found the MBCT environment in which the classes were held a challenge for the practices. Andrea believed that there was a specific experience to be achieved, which was out of reach due to her being in the wrong environment ('It was a little bit . . . tight to experience I think what you should've experienced'). This was also reflected in their experiences of homework, in which potential distractions, such as the noise of family members were more likely to be seen as being detrimental to practices rather than as experiences to enhance practices (e.g., Brian). The participants who seemed to benefit the most from the course, however, did not express such desires to change their experience of practicing (e.g., Tina: 'I try to accept that [practicing] can be quite

hard rather than see it as not doing it properly or anything, but just that's my experience of it').

#### *A different outlook on my life in general.*

All participants except Michael, who only attended three sessions, expressed that practising MBCT resulted in a shift in how they perceived life. For some this involved an increased awareness and appreciation of the external environment (Carol: 'I sort of became extremely aware of the beauty of autumn leaves'). For others, it involved a more fundamental, positive change in how they view themselves (Penelope: 'Something with me is that I kind of *loathed* that side of me. It was just a troublesome side. But I think [the MBCT facilitator] taught me to sort of accept the whole of myself, basically'). Some participants also revealed how they are now more likely to try to take steps to be kinder to themselves when they notice that they are feeling negative or are experiencing difficulties (e.g., Carol, Tina, Penelope, and Lynette). For example, Carol said that she learnt 'a lot about being less tough on myself, and realized that a lot of other people experience similar things', suggesting that she was now more able to see general negative experiences as being common rather than specific to her. Similarly, Tina noticed that one of the most important things she's learning is 'not to judge yourself', and Lisa revealed that she is now more likely to take small breaks when she feels under pressure at work and to 'give myself nice things to do at the weekend and give myself rewards for things'.

#### *A change large enough for significant others to notice.*

Seven participants noted that the beneficial changes they experienced were commented upon by those close to them. For example, 'My mum said . . . that she thought I was doing a lot better and that I seemed a lot happier, and that she was really worried about me and she's not quite so worried now' (Penelope). Similarly, 'My partner's definitely noticed that I'm less anxious . . . just sort of a general difference I think' (Tina).

Contrary to the other participants' experiences, for Andrea, the people close to her noticed a negative impact, which was in accordance with her own view (Andrea: 'My husband said I'd lost my sparkle. Which I thought 'aw', you know'). Despite this, it seemed that for the majority of participants, success in dealing with HA is something to benefit not only oneself, but also close friends and family.

### **Comparison between qualitative and quantitative data**

There was an agreement between the qualitative findings and the CSC scores shown in Table 3. Andrea did not achieve CSC at either assessment time, in accordance with her experience that MBCT was not effective in reducing her HA. Brian and Chloe achieved CSC only immediately following the course, which is in accordance with their experience that benefits occurred as a result of practice, but that they struggled to maintain practice after the course. Carol, Tina, Penelope, and Michael achieved CSC when assessed at the time of the interview. Carol's HA was quite low prior to the course—despite not practising after the course, she found that MBCT gave ongoing benefit in terms of a more accepting attitude. Michael only attended three of the classes and generally felt that MBCT had little impact upon his HA. However, he believed that benefit occurred through the enhancement of his appreciation for the external environment. Tina, Penelope, and Lynette all felt that the course was life-changing in terms of helping them to reduce their HA, and all three continued to practice regularly. However, whereas Tina and Penelope achieved CSC at the time of the interview, Lynette did not achieve CSC either at this time or directly after the course. This could be because her initial score on the SHAI was very high. Despite not achieving CSC, Lynette changed reliably over the assessment times.

### **Discussion**

#### **Summary of findings**

Two overarching themes emerged from the IPA: *My awareness of barriers to experiencing change through MBCT*, and *Cultivation of a new approach to HA and my life in general*. These themes overlap with those identified by previous qualitative studies of MBCT for depression and are discussed in more detail below in the context of previous findings and conceptual understandings of MBCT and HA, with a focus upon participants' perceived effectiveness and acceptability of MBCT for HA.

#### **Was MBCT considered to be effective?**

The majority of participants in this study reported beneficial effects from MBCT and, as reported in other qualitative studies, these beneficial effects extended beyond the index disorder to a more widespread impact upon participants' lives (e.g., Allen *et al.*, 2009). More widespread benefits included an increased ability to relax, reduced anxiety in other situations (e.g., when driving), improved sleep or mood, increased self-acceptance and desire to nurture the self, a more accepting attitude to life in general, and increased ability to cope with everyday stressors. Several participants

noted how they were now kinder to themselves and less judgmental when they noticed that they were experiencing anxiety/difficult times, which accords with recent suggestions that the cultivation of self-compassion is a potential mechanism of change in mindfulness-based interventions (e.g., Kuyken *et al.*, 2010; Williams, Teasdale, Segal, & Kabat-Zinn, 2007). These general benefits were frequently cited as additional motivations for continuing to practice after completing the MBCT course. It is also noteworthy that several participants continued to experience benefits despite not practising formally after the course (e.g., having a different outlook on life and an increased appreciation for the external environment). It could therefore be that an acceptance of the underlying MBCT rationale, along with an intense period of practice, can alter participants' long-term outlook and perception of life, though it remains true that all mindfulness teachers urge participants to continue with some form of regular practice after the classes are over, using the analogy of keeping a skill 'alive'.

Warwick and Salkovskis' (1980) model of HA identifies three maintaining mechanisms: selective attention to bodily sensations and HA thoughts; misinterpretation of physiological arousal and bodily sensations; and safety-seeking behaviours. Participants' reports relate closely to the first two proposed mechanisms. First, although they reported an increased awareness of bodily sensations and thoughts, both in general and specific to their HA, this was accompanied by a decrease in automatically reacting to them. They reported a sense of 'the creation of space' to observe sensations and thoughts. Second, they reported an increased awareness of the relationship between, and impact of, bodily sensations, thoughts, and anxiety. Impact in terms of decreased safety-seeking behaviours was less explicit in participants' accounts. Thus, it appears that MBCT impacted primarily by targeting attention to bodily sensations and HA thoughts and misinterpretation of physiological arousal and bodily sensations. It is interesting to note that this increased attention to physiological sensations and HA thoughts, which may have been predicted to lead to an exacerbation of HA, did not have that effect for the majority of participants. This may be because MBCT encourages a focus on bodily sensations directly, as they are in themselves, without engaging cognitive or ruminative processes *about* those sensations. The exception was a participant who found that MBCT practice exacerbated her HA, which she attributed to her struggle to accept her tinnitus experiences during practice. However, it would be premature to suggest that tinnitus sufferers should not receive MBCT since there is evidence from both within this study (two other participants suffered from tinnitus) and from other studies (e.g., Sadlier, Stephens, & Kennedy, 2008) that MBCT may be effective in reducing the negative impact of tinnitus. Furthermore, despite the difficulties, this participant considered MBCT to be an acceptable treatment and intended to persevere with it.

In line with previous studies (Finucane & Mercer, 2006; Mason & Hargreaves, 2001) participants' expectations of therapy seemed to have a moderating role on outcome. For some, having high expectations at the start of therapy seemed to be related to negative experiences during the course and more limited treatment gains. Segal *et al.* (2002) suggested that extreme expectations can have a deleterious effect since a central feature of MBCT is the cultivation of an accepting attitude to whatever occurs in the present moment, rather than clinging to desired outcomes. Thus, it may be that MBCT has greater impact upon individuals who are more open to the development of an accepting attitude and who have more flexible expectations of treatment, and less impact for those who have more rigid expectations (e.g., that MBCT *must* work). Participants' responses also indicate that MBCT, like other approaches, is most effective for those who are highly motivated to engage in treatment—the participants who gained most from MBCT were those that were more explicit about the deleterious impact of their HA prior to treatment, and more accepting of the commitment that MBCT required and the need for continued practice.

Finally, in line with previous studies noting an impact of MBCT on relationships (e.g., Allen *et al.*, 2009), most participants in the current study expressed that close friends and family noticed beneficial changes in them as a result of MBCT. This is important, since HA has been found to not only impact negatively upon sufferers but also the people closest to them (e.g., Asmundson *et al.*, 2001).

### **Was MBCT considered an acceptable treatment?**

Most participants found MBCT to be acceptable, for example, as reflected in the sub-themes *Validation and normalization of my experiences through MBCT*, and *My need for variety and flexibility*. Although the course was also considered challenging, there seemed a general acknowledgement that change would not be easily accomplished. This is perhaps not surprising since participants' mean duration of HA, prior to engaging in MBCT, was over 15 years and most had had previous courses of treatment. This acknowledgement and acceptance of the challenges faced in the pursuit of change is consistent with the *Struggle* theme in Allen *et al.*'s (2009) analysis of participants' experiences of MBCT for depression. One of the main challenges for participants in the current study was the struggle to find the time for MBCT practices. This has not been prominent in previous studies of experiences of receiving MBCT (for depression) but the struggle to find the time and to prioritize one's own needs is mentioned as part of the *Struggle* theme in Allen *et al.* (2009). It may be that this difference is due to differences in the nature of the participants' disorders. MBCT practices may be more easily embraced by sufferers of depression who have low levels of activity and are searching for a means of coping without resorting to medication in order to gain a sense of mastery over their symptoms. However, for HA sufferers there may be less desire to alter one's life in order to cultivate a sense of

mastery over their HA, since HA individuals' concerns are often about seeking and gaining medical attention and intervention (Warwick & Salkovskis, 1990). There was recognition that finding the time to practice required a considerable restructuring of their daily schedule. Furthermore, a smaller proportion of the current sample continued to practice regularly post-course than has been reported in samples of depressed patients undertaking MBCT (e.g., Allen *et al.*, 2009; Finucane & Mercer, 2006). Therefore, despite the general findings that MBCT appears acceptable and beneficial for those with HA, it may be that MBCT needs adaptation for different populations in order to help participants overcome such struggles (e.g., devoting more class time to problem-solving difficulties in finding the time for practice).

### *The group format*

One of the beneficial aspects of MBCT was support from the group. The benefit of being in a group has emerged in all of the previous qualitative studies of MBCT (Allen *et al.*, 2009; Finucane & Mercer, 2006; Mason & Hargreaves, 2001; Smith *et al.*, 2007), and highlights the importance of specific and non-specific factors of MBCT. Participants in the current study focussed on feeling supported by the group and echoed Allen *et al.*'s, (2009) participants in noting the de-stigmatizing effects of meeting others with similar problems. The exception was one participant who had felt isolated within the group due to a gender imbalance, and who had found his mild tinnitus to be exacerbated by hearing about other participants' tinnitus symptoms, consequently he expressed a preference for individual therapy. This was the only incident whereby one participant's health concern exacerbated another's. In contrast, Wattar *et al.* (2005) reported having to modify the format of their group CBT because participants experienced increased anxiety as a result of discussions about each other's health concerns. This is important: a potentially serious unacceptable aspect of group treatment for HA did not present itself in the current sample, and suggests that MBCT for HA has the potential to be a more acceptable group treatment than CBT. This may be because MBCT is better described as 'class-based' rather than 'group-based' (Coelho, Canter, & Ernst, 2007), meaning that the environment is more focussed on learning skills rather than discussing individuals' specific HA concerns.

### *Variety and flexibility of MBCT*

Participants reported that the variety of practices was advantageous, since some practices were deemed to be more enjoyable or acceptable than others. In this sense, the flexibility of MBCT could be considered an acceptable and beneficial mechanism of the MBCT approach in that it is likely to increase the chance of participants continuing with MBCT after the course (i.e., for most participants there will at least be some practices that are appealing). However, a 'flexible' approach could have the effect of reducing treatment gains in a number of ways. First, Segal *et al.* (2002) propose that daily practice of a range of both formal and informal practices is essential for treatment gains. This suggests that all of the practices are important and need to be practiced regularly, which may not occur with a more flexible approach whereby participants choose which to practice. Second, since MBCT aims to cultivate an attitude of acceptance to events irrespective of whether they are considered pleasant or unpleasant, choosing to perform only more enjoyable practices could be seen as a form of avoidance of negative experiences. This goes against the MBCT approach and may even potentially maintain assumptions that are fundamental to mood and anxiety disorders (i.e., that avoidance is an acceptable means of coping). Finally, it is unknown whether all components of mindfulness meditation are essential for providing treatment gains (Dimidjian & Linehan, 2003). It could be that the practice of certain forms of meditation is of more benefit than others and thus that the flexible approach of MBCT could lead participants to unknowingly choosing to perform practices that are less effective. Different practices may also be more or less effective for different populations, and it would be advantageous for future research to explore this.

### **Limitations**

The current study brings with it limitations inherent in the qualitative method used, particularly the difficulty in generalizing the findings beyond the current sample since the study explored the lived experiences of individuals with a unique experience (i.e., the same MBCT group). It is noteworthy that the current sample was predominately female and exclusively Caucasian, thus the findings may have limited applicability to more diverse samples. In addition, the retrospective nature of the study also means that participants' accounts of their experiences may have been influenced by factors, such as the social context of the interview and memory biases. For example, the interviewer reflected that, whereas most participants appeared open and even keen to recount their experiences of receiving MBCT, one participant seemed less willing to articulate her experiences, possibly due to a reluctance to disclose personal information to a stranger. Due to these limitations, caution must therefore be exercised in the interpretation and application of the findings from this study.

## Conclusion

Since MBCT was formulated as a treatment for individuals who suffer from recurrent depression but are in remission, this study is important in highlighting the experiences of participants with HA who received MBCT. The findings suggest that the current sample consider MBCT an acceptable and effective treatment in reducing HA. A key finding was that participants' HA in the current sample was not exacerbated through the performance of practices that focused their attention upon bodily sensations and thoughts, since heightened attention to aberrant bodily sensations is considered to be a maintaining factor of HA. This is consistent with suggestions that there may be more than one mode of self-focus (Teasdale, 1999), in that participants in the current study seemed to be able to use MBCT techniques and focus on bodily sensations without being drawn into a ruminative spiral. The study also revealed many struggles that were encountered and noticed by participants in their attempts to achieve psychological change. Thus, the study provides important insight into nine HA participants' experiences of MBCT and highlights areas of MBCT where participants may need additional support and guidance in order to make the treatment more acceptable, maintainable, and ultimately more effective to benefit individuals with HA.

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## References

- Abramowitz, J. S., Deacon, B. J., & Valentiner, D. P. (2007). The short health anxiety inventory: Psychometric properties and construct validity in a non-clinical sample. *Cognitive Therapy and Research*, 31(6), 871–883.
- Allen, M., Bromley, A., Kuyken, W., & Sonnenberg, S. J. (2009). Participants' experiences of mindfulness-based cognitive therapy: "It changed me in just about every way possible". *Behavioural Cognitive Psychotherapy*, 34(4), 413–430.
- American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. Text Revision). Washington, DC: Author.
- Asmundson, G. J. G., Taylor, S., Sevgur, S., & Cox, B. J. (2001). Health anxiety: Classification and clinical features. In G. J. G. Asmundson, S. Taylor, & B. J. Cox (Eds.), *Health anxiety: Clinical and research perspectives on hypochondriasis and related conditions* (pp. 3–21). Chichester, England: Wiley.
- Barnhofer, T., Duggan, D., Crane, C., Hepburn, S., Fennell, M. J. V., & Williams, J. M. G. (2007). Effects of meditation on frontal alpha-asymmetry in previously suicidal individuals. *Neuroreport*, 18(7), 709–712.
- Barsky, A. J., Ettner, S. L., Horsky, J., & Bates, D. W. (2001). Resource utilization of patients with hypochondriacal health anxiety and somatisation. *Medical Care*, 39(7), 705–715.
- Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health*, 21(7), 87–108.
- Coelho, H. F., Canter, P. H., & Ernst, E. (2007). Mindfulness-based cognitive therapy: Evaluating current evidence and informing future research. *Journal of Consulting and Clinical Psychology*, 75(6), 1000–1005.
- Creed, F., & Barsky, A. J. (2004). A systematic review of the epidemiology of somatisation disorder and hypochondriasis. *Journal of Psychosomatic Research*, 56, 391–408.
- Didonna, F. (2009). *Clinical handbook of mindfulness*. New York: Springer.
- Dimidjian, S., & Linehan, M. M. (2003). Defining an agenda for future research on the clinical application of mindfulness practice. *Clinical Psychology: Science and Practice*, 10(2), 166–171.
- Eatough, V., & Smith, J. A. (2008). Interpretative phenomenological analysis. In C. Willig & W. Stainton Rogers (Eds.), *The sage handbook of qualitative research in psychology* (pp. 179–194). London: Sage.
- Elliott, R., & James, E. (1989). Varieties of client experiences in psychotherapy: An analysis of the literature. *Clinical Psychology Review*, 9, 443–467.
- Finucane, A., & Mercer, S. W. (2006). An exploratory mixed-methods study of the acceptability and effectiveness of Mindfulness-Based Cognitive Therapy for patients with active depression and anxiety in primary care. *BMC Psychiatry*, 6, 1–14.
- Flick, U. (1998). *An introduction to qualitative research* (3rd ed.). London: Sage Publications.
- Helbig, S., & Fehm, L. (2004). Problems with homework in CBT: Rare exception, or rather frequent? *Behavioural and Cognitive Psychotherapies*, 32, 291–301.
- Hodgetts, A., & Wright, J. (2007). Researching clients' experiences: A review of qualitative studies. *Clinical Psychology & Psychotherapy*, 14(3), 157–163.
- Jacobson, N. S., Follette, W. C., & Revenstorf, D. (1984). Psychotherapy outcome research: Methods for reporting variability and evaluating clinical significance. *Behavior Therapy*, 15, 336–352.
- Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain and illness*. New York: Delacorte.
- Kuyken, W., Dalgleish, T., Watkins, E., Holden, E., White, K., Taylor, R., & Teasdale, J. D. (2010). *How does Mindfulness-based Cognitive Therapy Work?* Manuscript submitted for publication.

- Macran, S., Ross, H., Hardy, G. E., & Shapiro, D. A. (1999). The importance of considering clients' perspectives in psychotherapy research. *Journal of Mental Health*, 8(4), 325–337.
- Marcus, D. K., Hughes, K. T., & Arnau, R. C. (2008). Health anxiety, rumination, and negative affect: A meditational analysis. *Journal of Psychosomatic Research*, 64, 495–501.
- Mason, O., & Hargreaves, I. (2001). A qualitative study of mindfulness-based cognitive therapy for depression. *British Journal of Medical Psychology*, 74(2), 197–212.
- McManus, F., Grey, N., & Shafran, R. (2008). Cognitive therapy for anxiety disorders: Current status and future challenges. *Behavioural and Cognitive Psychotherapy*, 36, 595–704.
- McManus, F., Peerbhoy, D., Larkin, M., & Clark, D. M. (2010). Learning to change a way of being: An interpretative phenomenological perspective on cognitive therapy for social phobia. *Journal of Anxiety Disorders*, 24(6), 581–589.
- McManus, F., Williams, M. J. G., Surawy, C., & Muse, K. (2010). *A randomised controlled trial of mindfulness-based cognitive therapy for hypochondriasis*. Manuscript in preparation.
- National Institute for Clinical Excellence (2004). *Depression: Management of depression in primary and secondary care (no. CG023)*. London: Author.
- Papageorgiou, C., & Wells, A. (1998). Effects of attention training on hypochondriasis: A brief case series. *Psychological Medicine*, 28(1), 193–200.
- Reid, K., Flowers, P., & Larkin, M. (2005). Interpretative phenomenological analysis: An overview and methodological review. *Psychologist*, 18, 20–23.
- Sadler, M., Stephens, S. D. G., & Kennedy, V. (2008). Tinnitus rehabilitation: A mindfulness meditation cognitive behavioural therapy approach. *Journal of Laryngology and Otology*, 122(1), 31–37.
- Salkovskis, P. M., Rimes, K. A., Warwick, H. M. C., & Clark, D. M. (2002). The health anxiety inventory: Development and validation of scales for the measurement of health anxiety and hypochondriasis. *Psychological Medicine*, 32, 843–853.
- Schulte, D. (2008). Patients' outcome expectancies and their impression of suitability as predictors of treatment outcome. *Psychotherapy Research*, 18(4), 481–494.
- Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*. London: The Guildford Press.
- Smith, J. A. (1995). Semi-structured interviewing and qualitative analysis. In J. A. Smith, R. Harre, & L. van Langenhove (Eds.), *Rethinking methods in psychology* (pp. 9–26). London: Sage.
- Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health*, 11, 261–271.
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage Publications.
- Smith, A., Graham, L., & Senthinathan, S. (2007). Mindfulness-based cognitive therapy for recurring depression in older people: A qualitative study. *Aging & Mental Health*, 11(3), 346–357.
- Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology* (pp. 51–80). London: Sage.
- Teasdale, J. D. (1999). Emotional processing, three modes of mind and the prevention of relapse in depression. *Behaviour Research and Therapy*, 37, S53–S77.
- Teasdale, J. D., Segal, Z., & Williams, J. M. G. (1995). How does cognitive therapy prevent depressive relapse and why should attentional control (mindfulness) training help. *Behaviour Research and Therapy*, 33(1), 25–39.
- Teasdale, J. D., Segal, Z., Williams, J. M. G., Ridgeway, V. A., Soulsby, J. M., & Lau, M. A. (2000). Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *Journal of Consulting and Clinical Psychology*, 68(4), 615–623.
- Thomson, A. B., & Page, L. A. (2007). Psychotherapies for hypochondriasis. *Cochrane Database of Systematic Reviews*, 4, 1–43.
- Warwick, H. M. C., & Salkovskis, P. M. (1990). Hypochondriasis. *Behavior, Research and Therapy*, 28(2), 105–117.
- Wattar, U., Sorensen, P., Buemann, I., Birket-Smith, M., Salkovskis, P. M., Albertsen, M., et al. (2005). Outcome of cognitive-behavioural treatment for health anxiety (hypochondriasis) in a routine clinical setting. *Behavioural and Cognitive Psychotherapy*, 33(2), 165–175.
- Westra, H. A., Dozois, D. J. A., & Marcus, M. (2007). Expectancy, homework compliance, and initial change in cognitive-behavioral therapy for anxiety. *Journal of Consulting and Clinical Psychology*, 75(3), 363–373.
- World Health Organization (1992). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*. Geneva, Switzerland: Author.
- Williams, J. M. G., Teasdale, J. D., Segal, Z. V., & Kabat-Zinn, J. (2007). *The mindful way through depression: Freeing yourself from chronic unhappiness*. New York: Guilford Press.
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health*, 15(2), 215–228.