The effects of Mindfulness Based Cognitive Therapy on patients with chronic anxiety and depression – a pilot study

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Summary

Despite the fact that Cognitive Behavioral Therapy (CBT) can be evidently effective in managing affective disorders, a substantial number of patients struggle with residual symptoms and become long term patients in mental health organizations. Mindfulness Based Cognitive Therapy (MBCT) (Teasdale, Segal, & Williams, 1995) is a group treatment derived from a synthesis of cognitive therapy and Mindfulness Based Stress Reduction (MBSR) developed by Jon Kabat-Zinn and colleagues. Because of its special characteristic, namely, focusing less on control of psychological distress but emphasizing the acceptance of these private events, this new intervention MBCT is assumed to be well suited to be added to existing psychotherapeutic protocol. This study was conducted to get an idea of the effect of MBCT in treating patients with chronic/recurrent depression and/or anxiety disorder in the mental health organization "Dimence" in The Netherlands, Overijssel. In a pilot study with seven participating patients with chronic/recurrent depression and/or anxiety disorder, levels of symptoms, well-being, acceptance and mindfulness were measured before treatment, after three introduction sessions and the end of the eight sessions MBCT. Finally, an evaluation questionnaire was administered. Data was analyzed using individual analysis of reliable change (RC) (Jacobson & Truax, 1991). The aim of the present research was to analyze whether Mindfulness Based Cognitive Therapy (MBCT)(a) affects the depressive symptoms of the target group and significantly decreases symptomatology, (b) affects the anxious symptoms of the target group and significantly decreases symptomatology, (c) promotes the mental health of the target group, (d) fosters acceptance as an alternative strategy to experiential avoidance, and (e) promotes mindfulness of the target group at "Dimence".Furthermore acceptability and feasibility of the training were evaluated. These analyses served to emerge recommendations toimprove the training by approaching the needs of the target group.

This pilot study provides sustainable evidence of the effect of MBCT as a tool to treat patients with chronic anxiety and depression at the mental health organization "Dimence" in Overijssel. The mediating effect of acceptance in fostering well-being and reducing affective symptoms can be supported by this study as well. These results are particularly promising, given the chronic nature of the disorders of the participants. Furthermore, it can be concluded that the training was very well-accepted by the target group.

Preface

This thesis is the result of a pilot study I conducted as a part of my master's study of mental health psychology at the University of Twente, Netherlands.

On all loop ways I made in life I have gained experiences and I learned to trust in my own strength and resources. I am absolutely glad that on my way I met Dr. Ernst Bohlmeijer, who brought me into contact with the models of positive psychology, the third wave behavioral therapies and meditation. For me, this was the best way to complete my studies of psychology at the university. It made my wish to become at psychotherapist even clearer. I learned to be milder to myself and others and I know many more to follow will benefit personally and professionally from the study of positive mental health at the University of Twente.

I want to thank my tutors Dr. Ernst Bohlmeijer and Wendy Pots for this opportunity. Your kindness and openness are winning and encouraging:

"Consciously we teach what we know,

Unconsciously we teach who we are" (Hamachek, 1999)

Contents

1. Introduction

Mindfulness Based Cognitive Therapy (MBCT; Segal, Williams, & Teasdale, 2001)as an alternative strategy to pure Cognitive Behavior Therapy (CBT) in treating clients with anxiety or depression is the central topic of this research. The details are elaborated in the following. First, in the introduction, the individual, societal and clinical relevance of effective treatment approaches against anxiety and depression will be elaborated. Then a summary of CBT and research results of its effectiveness is given. Thereafter the necessity to develop alternative approaches to CBT will be pointed out and MBCT will be introduced.

Efficacious treatment of affective disorders, i.c.depression and anxiety disorders is of general importance on both the individual and the societal level as affective disorders are most prevalent of all psychiatric conditions, accounting for a substantial proportion of the mental health disease burden in Western countries. Both diseases often take a recurring or chronic lifetime course and are associated with significant impairment in social and occupational functioning (Clark & Beck, in press). On the individual level, being affected by anxiety disorders may mean to suffer from impairments by symptoms such as anxious feelings despite the absence of a real threat, increased heartbeat, dry mouth, sleep problems, or irritability (RIVM, 2009a). In the Netherlands, more than 1.7 million people from 13 years upwards suffer from anxiety disorders, with females being twice as often affected as males. It has been expected that the absolute number will rise by almost 5% until 2025 (RIVM, 2009a). Focusing on another affective disorder, namely depression, is of importance as well. According to the RIVM (2009b), the prevalence among the Dutch population was almost 382.300in 2007, considering people from 13 year upwards. A rise by 4% has been predicted until 2025. Both anxiety disorders and depression can be found in the top5 of diseases that cause most *disability adjusted life years (DALY)*, which encompasses the number of lost years due to early death and the number of years characterized by the impairments caused by the disease (Hoeymans et al, 2007).They are also represented in the top3 of disease causing most loss in quality of life (RIVM, 2009b). This ranking holds true for affective disorders in terms of health and direct economic costs (Smit et al., 2006).

Cognitive-behavioral approaches dominate the mental health field, as in recent history of evidence based psychotherapy the focus has been primary on the application of CBT to a growing range of problems (Hayes, Stosahl, & Wilson, 2006; Butler, Chapman, Forman & Beck, 2006). It is a well-established, collaborative and problem orientated approach with clearly defined treatment steps (Clark & Beck, in press; Hofmann & Asmundson, 2008). CBT is based on the theoretical notion that the way in which individuals structure the world mostly determines their affects and behaviors. This theory is founded on four main underlying assumptions: (a) emotions and behaviors are determined by

underlying cognitive schemata; (b) emotional disorders result from negative, maladaptive and unrealistic cognitive schemata and behavior (c) emotional disturbance can be reduced by the modification of these negative, maladaptive and unrealistic schemata (d) emotional disturbance can also be reduced by the modification of maladaptive behavior and the establishment of new more adequate behavior . Thus, the goal of CBT is to enable individuals to think more realistically and handle psychological problems more adaptively using therapeutic techniques that are designed to identify, reality-test, and correct distorted thoughts (Clark & Beck, in press; Hamamci, 2006). CBT has been proven to be an effective treatment for affective disorders (Buttler, Chapman, Forman & Beck, 2006; Simons, 1987). Meta-analytical research of Butler & Beck (2000) and Butler, Chapman, Forman & Beck (2006) support the efficacy of CBT for a variety of disorders with large effect sizes (ES> 0.8) for unipolar depression, generalized anxiety disorder, panic disorder without agoraphobia, social phobia and posttraumatic stress disorder. CBT is among the recommend evidence based treatments for depression and there is a large body of evidence that CBT is effective in management of depression (Baker & Wilson, 1985; Flynn, H., 2010; Mohlman & Gorman, 2005;Teasdale, Segal, Williams, Ridgeway, Soulsby, & Lau, 2000; Rush, Kathami, & Beck, 1975). Properly treated clients with depression have briefer periods of illness, are less likely to relapse, than those who are not or under-treated (Flynn, 2010). Furthermore appropriate treatment with CBT has shown to yield significant as well as maintaining changes in groups of participants with anxiety disorders, like reducing the number and severity of anxious symptoms (Borkovec & Ruscio, 2001; Butler, Chapman, Forman, & Beck, 2006;Covin, Quimet, Seeds, & Dozois, 2008; Gould et al., 1997; Norton & Price, 2007).

Despite the fact that CBT can be evidently effective in managing affective disorders, for a substantial number of patients with depression as well as anxiety disorders, treatment is less than optimal (Craske et al., 2009), leaving them symptomatic (Flynn, 2010; Roemer & Orsillo, 2007; Rapgay, 2009). In clinical trials commonly achieved remission rates for depression (Flynn, 2010) and for example Generalized Anxiety Disorder (GAD) (Roemer & Orsillo, 2007) lay between 40%-60%. Thus, 40%-60% of patients do not fully respond to this treatment, remain in clinical range of psychopathology after treatment and thus do not reach high-end state functioning, which implicates vulnerability for relapse and poor outcome over lifespan (Flynn, 2010; Wetherell et al., 2005, Schurink, 2006).

But, even though a large number of clients does not respond to CBT in a desired degree, and suffer from a recurring or chronic etiopathology, psychotherapeutic guidelines do not offer any specific treatment directions for the treatment of these clients if CBT, medication and other evidence-based treatments such as IPT have not been successful (Timbos-instituut, 2005, 2009). For this reason treatments based on different explanatory models are needed to be evaluated and implemented.

During the last decade there has been growing interest in new psychotherapeutic approaches that are based on notions of meta-cognitive awareness: emphasizing strategies that alter a client´s

relationship to his internal experiences, rather than aiming to directly change the content of these experiences. These treatments focus on acceptance rather than judgment or avoidance and solution orientation rather than cause orientation (Hayes, Strosahl, & Wilson, 1999; Teasdale, Segal, Williams, Ridgeway, Soulsby, & Lau, 2000; Ruiz, 2010; Rapgay, Bystritsky, Drafter, & Spearman, 2009; Roemer & Osillo, 2002; Kim et al., 2010). This by some authors labeled "third wave of behavioral psychotherapy" is based on the notion that mental health is best explained by a two dimensional model where the promotion of mental health is working as resilience enhancing factors against psychological illness. These approaches usually incorporate a practice called "mindfulness", like MBCT.

Mindfulness refers to a process leading to a mental state that is characterized by nonjudgmental awareness of the present moment experience, including one´s sensations, thoughts, bodily states, and the environment, while encouraging openness, curiosity and acceptance (Bishop et al., 2004).

Mindfulness Based Cognitive Therapy (MBCT) was developed by Teasdale, Segal, & Williams (1995) as a successful tool to treat chronic or recurrent depressive patients (Teasdale, Segal, Williams, Ridgeway, Soulsby, & Lau, 2000). They integrated Mindfulness Based Stress Reduction (MBSR) (Kabat-Zinn, 1990), which uses intensive mindfulness-meditation training to treat chronic medical patients, with CBT into an eight week training program. In addition to formal mindfulness exercises and the (informal) training of mindfulness in everyday life the program includes fundamental information about depression and resorts to exercises of CBT that accentuate the connection between thoughts and emotions(Segal, Williams, Teasdale, 2004; Teasdale et al., 2000).

The underlying explanation for the cognitive vulnerability to relapse and the chronic nature of affective disorders is described by Teasdale et al. (2004) in the phenomenon of differential activation hypothesis (DAH). This is based on the assumption that mood-states can strongly influence cognitive information processing (Lau, Segal, & Williams, 2004). Teasdale and colleagues assume that certain negative cognitive processing patterns that are established during early depression or anxiety will be associated with these negative moods. New anxious or depressive mood states reactivate cognitive styles that are connected to earlier episodes of these moods. Teasdale et al. (2004) talk about, "mood induced cognitive reactivity". In this way people that have earlier suffered from depression or anxiety differ from "healthy" people in the way they handle new episodes of these mood-states. Whereas most people are able to ignore periodic anxious or depressive mood states, a slide change of mood in depressive or anxious direction can induce re-activation of extremely negative cognitive processing pattern in people with earlier episode of depression or anxiety(Lau, Segal, & Williams, 2004;Segal, Williams, Teasdale, 2004).

Furthermore emotions and thoughts are presumed to be maintained and even aggravated by the use of a habitual cognitive responding strategy called experiential avoidance (EA) (Hayes, Strohsal & Wilson,1999). This strategy is presumed to be a process that plays an important role in the development and maintenance of different psychological problems and disorders especially of depression and anxiety (Hayes, Strosahl & Wilson, 1999; Kashdan, Barrios, Forsyth & Steger, 2006;, Roemer & Orsillo, 2002; Roemer et.al, 2009). EA is a short-term strategy to deliberately try to control and avoid immoderately negative evaluated and unwanted inner experiences like thoughts, emotions and sensations, called private events. In the process of experiential avoidance the person puts more and more time and energy into the avoidance of sensations that do not form a real threat or cannot be successfully avoided over the long run. Thereby these negative private events are paradoxically strengthened and cognitive and behavioral pattern are narrowed down. EA is thus an ineffective strategy to handle negative evaluated inner private events, in which the person becomes engaged in a self-reinforcing process, which in many cases causes rigidity in functioning and a reduction of positive life experience (Hayes, Strosahl & Wilson, 2006; Sloan, 2004; Kashdan, Barrios, Forsyth & Steger, 2006).

To prevent relapse, MBCT is therefore focused on this avoidance-strategy and fosters as alternative the strategy of acceptance and decentralization as a goals itself (Segal, Williams, Teasdale, 2004).

Unlike pure CBT in MBCT, there is little emphasis on changing the content or specific meaning of negative automatic thoughts but its focus lies on teaching clients to become more aware of thoughts and feelings and to relate to them in a wider, decentered perspective as passing "mental events" rather than as aspects of the self or as necessary accurate reflections of reality (Teasdale, Segal, Williams, Ridgeway, Soulsby, & Lau, 2000).The aim of this training is to enhance awareness, to facilitate the chance to choose a response style in a particular situation instead of (cognitive or behavioral) responding habitually or automatically. This is done by the practice of mindfulness exercises: by practicing to be more aware of how the mind is wondering, and practicing over and over again to intentionally changing the focus of the attention.

Because of its special characteristic, namely focusing less on control of psychological distress but emphasizing the acceptance of these private events, this new intervention MBCT is assumed to be well suited to complement the existing psychotherapeutic protocol.

In the mental health organization "Dimence" in The Netherlands, Overijssel, there is indeed a group of clients that do not respond to classical evidence-based therapies, like CBT and Interpersonal Therapy (IPT). The current treatment protocol of "Dimence", based on the evidence based guidelines, does not offer any specific guidelines to proceed with the treatment for these patients who suffer from chronic or recurrent depression or/and anxiety disorder. For these patients Mindfulness Based

Cognitive Therapy offers an opportunity to enhance mental well-being, reducing symptoms en find a way to handle their vulnerability. Therefore, a pilot study was conducted to evaluate the process and get an idea of the effects of MBCT as a treatment tool for patients with depression but also anxiety who did not respond satisfactorily to evidence based treatments.

2. Aims & research questions

The goal of this pilot study is to evaluate the process and the effects of Mindfulness Based Cognitive Therapy as treatment for clients with chronic/recurrent depressive or anxiety disorder, who did not respond to CGT at the mental health institution "Dimence" in The Netherlands, Overijssel. Therefore, the specific purpose of this pilot study is to answer the following questions:

1. **Is there a significant decrease in symptomatology and level of experimental avoidance in patients after the completion of MBCT?**
    a) Does the therapy influence affective symptoms i.c. depressive symptoms and anxious symptoms of the target group?
    b) Does the therapy influence mental health of the target group?
    c) Does the therapy promote acceptance as alternative strategy to avoidance?
    d) Does the therapy promote mindfulness?

2. **Based on participants´ evaluations, are there any adjustments required in order to improve the design and application of MBCT as offered at the mental health institution Dimence?**
    a) Is the therapy well-accepted and feasible when offered to participants?

3. Procedure

3.1 Recruitment

Patients with chronic/recurrent depression or anxiety disorder that are currently in treatment according to "Dimence" protocol are informed by their therapists of the existence and the content of this new treatment approach (MBCT) at "Dimence". If interested, they are offered to participate in three introduction sessions. In an individual interview after the introduction sessions therapists and patients decided together whether further participation in the training was suitable for the patient at that moment or if there were interfering circumstances that did not allow patients to fully profit from the treatment at that time, like for example problems with understanding the Dutch language probably or taking part in a cognitive behavioral group therapy.

The participating clients are asked if they are willing to participate in the research study as well, i.e. filling out relevant questionnaires before and after treatment. If they do not wish to participate in the evaluation, they are informed to be still allowed to participate in the intervention. Informed consent to for all parts of this study were obtained (appendix 3).

3.2 Design

X_1 O_1 X_2 O_2 X_3

O_1 = Introduction sessions

O_2 = MBCT

X = Measurement

Before treatment starts and after the introduction sessions the participating clients will be asked to fill out a battery of questionnaires about relevant psychological distress. After that, eight or nine therapy sessions, each of two and a half hours duration will follow (O_1).Subsequently, after the last training session, a posttest battery, including same questionnaires as the pretest battery, will be administered to assess whether the treatment was effective and participants were asked to evaluate the therapy based on specific questions (X_3). The conduction of a pilot study is crucial to determine whether the therapy is well-accepted by participants and whether it is effective in strengthening mental health and decreasing affective problems significantly in order to release patients out of second line psychological treatment. It has been acknowledged that this one-group design of this pilot study is

relatively weak in terms of its capacity to evaluate reliability and validity of the method, as control groups are missing. Still, this design has been chosen as it is the most cost- and time- efficient way to get quantitative and qualitative data in order to evaluate the process and get an idea of the effectiveness and acceptability of this method.

3.3 Case study

To get background information about the participants and to be able to set the test-results of this research into perspective, case studies were conducted. For this purpose, participants that were willing to take part in this case study and gave permission to use the information acquired from their dossiers, were included in the case study. The finale selection of three cases that will be presented in a more detailed fashion in the following was made by the author on the basis of their test scores and the participant's willingness to possibly be interviewed on camera.

4. Participants

4.1 Target Group and Inclusion Criteria

The target group of this pilot study are adults (age 18 and older) with chronic/ recurrent depression or anxiety disorder. The patients had earlier been treated with classical evidence-based therapies at "Dimence". They are still symptomatic and in need of psychotherapeutic treatment. Participants have to be well-motivated and willing to spend a minimum of 45 minutes six days per week on practicing formal and informal mindfulness-practices. Participants have insight in their own situation and development and can refrain from their problems and play a part in the training-group.

4.2 Exclusion Criteria

In line with the concept of a pilot study the exclusion criteria are held minimal. To ensure clients to receive all treatments their condition requires as well as to ensure that the measurements are not influenced by disturbing variables some exclusion criteria had to be set: Respondents (a) with present serious axis-I diagnosis (b) with suicidal tendencies (c) with current diagnosis of drug or alcohol dependency (d) with mental retardation (e) with serious social and/or economic problems (f) with learning or reading problems (Dutch language).

4.3 Sample

In the beginning of the introduction eleven clients were participating in the training. Three participants decided in consultation with therapist to stop with the training for different reasons: problems with Dutch language especially metaphoric language (1); interference with participation in another therapy (2); booked vacation (3). Of the eight participants left, one decided not to take part in this research, leaving finally seven participants for this study.

Three men and four women aged 38 to 56 (M= 47.14; SD=6.89) participated in this research. While three participants were married and two were in a relationship, two were single (one of them had been married before). The number of children varied from zero to two (M= 1.7; SD= .49). On the question which philosophy/religion they feel most related to, four participants answered "none", one stated to be catholic, and two felt related to "other" philosophy/religion than listed. The educational level varied from primary school to university of science. Three participants were either self-employed or spend their days on a paid job. One participant stated to do voluntary word as daily activity. One participant stated to be unemployed and two received sickness benefits. Accordingly the financial situation of participants differed as well: two participants stated that they had to make debts, one was

addressing savings, three participants could make ends meet with their monthly income, and one was able to save money (see Table 1)

Table 1: Demography of the sample

n=7	
Gender	
Male	3
Female	4
Age	M=47.14 (SD=6.89)
Min.-Max.	38-56 years
Marital Status	
Married	3
Divorced &single	1
In a relationship	2
Single	1
Number of children	M= 1.7 (SD=.49)
0	2
1	1
2	4
Philosophy/Religion	
Non	4
Catholic	1
Other	2
Education	
Primary school	1
Lower Vocational Education (LBO)	1
10th grade (MAVO)	1
Vocational Education (MBO)	1
University of Professional Education (HBO)	2
University of science (WO)	1
Daily activity	
Paid job/self-employed	3
Voluntary work	1
Unemployed	1
Sickness benefit	2
Finances	
Making debt	2
Address savings	1
Make ends meet	3
Saving possible	1

5. Measures

5.1 Questionnaires

5.1.1 Center of Epidemiologic Studies Depression Scale (CES-D).

The CES-D (Radloff, 1977) is a 20-item questionnaire that measures depressive symptoms in the general population. Respondents rate on a 4-point scale ranging from hardly *ever (less than 1 day) (0) to predominantly (5-7 days) (3)* to what extent they have experienced depressive symptoms in the previous week. Summation of the scores result in a total score ranging from 0-60. A score of 16 or higher is considered indicative of clinically relevant depressive symptoms. A score of 24 and higher is indicative for possible cases of clinical depression. The CES-D showed adequate psychometric properties in a group of elderly people in the Netherlands (Haringsma, Engels, Beekman, & Spinhoven, 2004). The scale shows high internal consistency in their study (α = .88).

5.1.2 Hospital Anxiety and Depression Scale-Anxiety (HADS-A).

The HADS-A (Zigmond & Snaith, 1983) is a 7-item questionnaire that assesses the presence and severity of anxious symptoms. Respondents rate on a 4-point scale ranging from *not at all (0) to often (3)* to what extent they have experienced anxiety symptoms in the previous week. The total HADS-A scores range from 0 to 21. Scores of 8 and higher are indicative of clinical relevant symptoms. Scores of 15 or higher are indicative of possible clinical cases. The Dutch translation showed good psychometric properties in six different groups of Dutch subjects (Spinhoven et al., 1997). Bjelland, Dahl, Haug, & Neckelmann (2002) showed that among the general population and in somatic patients samples an optimal balance between sensitivity and specificity was achieved when cases was defined by a score of 8 or above. The scale showed high internal consistency in this study (α = .83).

5.1.3 Mental Health Continuum (Short Form) (MHC-SF)

The 14- item MHC-SF (Keyes, 2005; 2006; Keyes et al., 2008) is currently seen to be the most complete instrument to measure mental health. Reliabilities (Cronbach´s Alpha) of its three subscales are high (α= .74 to .89) (Westerhof & Keyes, 2008). The total score can be categorized in weak, moderate and good mental health. Respondents are asked about the frequency of feelings within the last month, varying from *never (1) to every day (6).*Summation of the scores result in a total score ranging from 14-84 (Westerhof & Keyes, 2008).

5.1.4 Acceptance and Action Questionnaire-II (Nederlandse Versie) (AAQ-II-Nl).

The AAQ-II-NL (Jacobs, Kleen, de Groot, & A-Tjak, 2008) is a 10 –item measure of EA. The AAQ-II-NL assesses on a 7-point Likert scale ranging from *never true* (1) *to always true* (7) the subject´s unwillingness to be in contact with negative private events, the need to control these events and the

effect of controlling their negative private experiences of their lives. Thus it measures the levels of emotional avoidance and emotion-focused inaction. Summation of the scores result in a total score ranging from 10-70 whereby a higher score indicates higher acceptance and less EA. The Dutch AAQ-II showed a good factor structure in a general and clinical population in the Netherlands and a good internal consistency (α = .86) in a study of Jacobs, Kleen, de Groot, & A-Tjak(2008).

5.1.5 Five Facet Mindfulness Questionnaire (Nederlandse Versie) (FFMQ-(NL))

The FFMQ(Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006) and the here administered Dutch version of the FFMQ (Bohlmeijer, Klooster, Fledderus, Veehof & Baer, 2011) measures the level of mindful awareness using a 39 item, 5-point Likert scale ranging from *never or nearly never true (1) to Very often or always true (5)*. Summation of the scores result in a total score ranging from 39-195. It has demonstrated good internal validity in meditating as well as non-meditation populations (Baer et al., 2008). In the study of Witkewitz et al. they found the internal consistency of the FFMQ as high as α =0.91 (Witkiewitz et al.,2012).

5.1.6 Evaluation questionnaire

This survey is developed by the author to evaluate the therapy package (MBCT) by asking questions about the general satisfaction with different aspect of the training, questions about the sessions, the setting, mindfulness practices, materials, and therapeutic guidance. Components were rated by the respondents on a 3 or 5-point scales. Additionally, open-end questions were asked to get a comprehensive evaluation from each participant of the training.

5.2 Case study

To get an accurate impression of the target group, their etiopathology, their experiences and evaluations of MBCT, additionally to the questionnaire research three cases will be presented in chapter 8.3. For this purpose, participants that were willing to take part in this case study and gave permission to use the information acquired in the interviews in their dossiers, were interviewed two times.

5.2.1 Interview

The first interview was conducted through telephone in the beginning of the treatment. It contained questions about the reason for attendance, symptoms, the quality of life and expectations of the participation in the program and took approximately 25 minutes time (appendix 3). Participants were informed about the voluntary nature of the participation in the interview.

5.2.2 Evaluation-interview

At the end of the treatment an evaluation-interview was conducted through telephone. Questions were aimed to get an idea of the experienced change in symptoms, general appraisal of the therapy, the setting and the experiences with the mindfulness exercises (appendix 4). One interview was conducted in person and was videotaped.

6. Treatment (MBCT)

6.1 The sessions

In the beginning of each of two and a half hour long sessions, participants are informed about the content and the curriculum of the session. The curriculum of the treatment is illustrated in appendix 4. A digital version of the workbook, that was handed out to every participant can be obtained by the author of the study. A maximum of twelve participants can take part in the treatment.

6.1.1 Introduction sessions (I-III)

The training starts with three introduction sessions with the goal to introduce participants to the guidelines of the training and the basic principles of mindfulness. After these three sessions an individual interview takes place. Together with a therapist, participant evaluate the experiences and impression and decide whether further participation in the training is suitable for the patient at that moment or if there were interfering circumstances that did not allow patients to fully profit from the treatment at that time.

6.1.2 Sessions I-IV

The first four sessions are targeted to teach participants how to focus their attention at any moment without judging. For this purpose they learn (1.) to be conscious about the fact that in our daily lives our attention often fades away and our mind constantly changes its focus (2.) to concentrate on one attention-point, by the means of body-focused-mindfulness meditation, when they recognize that their attention is fading (3.) that fading creates space for negative thoughts and emotions.

6.1.3 Sessions V-VIII

The goal of the second phase of MBCT is to teach participants how to handle mood swings by means of the previously learned mindfulness practices. In the following the basic of these techniques will be describes briefly. For more detailed information review: "Aandachtgerichte cognitieve therapie bij depressie- Een op mindfulness gebaseerde methode om terugval te voorkomen" by Segal, Williams, & Teasdale (2006).

When negative thoughts or feelings arise, participants are instructed to first non-judgmentally recognize and accept them as mental events before acting on them with help of specific strategies. These strategies comprise breathing techniques like of focusing the attention on the breathing for a minute and focusing the attention on the bodily sensations. Thereafter they can decide how to react in the best way by either recognizing their thoughts and feelings as mental events and observing them disappear or focusing their attention on the place of their bodily- sensation, using breathing techniques

to open up and trying to just sense or notice these sensations instead of being overwhelmed by them. Last but not least participants will be stimulated to be aware of their own unique alarm system, for upcoming mood swings and develop a specific action plan for this moment.

6.2. Therapists

The instructors are experienced in CBT and have received extensive training in Mindfulness Based Cognitive Therapy (MBCT). They are certified MBCT therapists.

6.3 Mindfulness exercises

6.3.1 Body Scan

The body-scan meditation exercises awareness of bodily sensations in every part of the body one by one, with the aim to prolong the attention span as well as increase concentration, calmness cognitive flexibility and consciousness. This exercise takes approximately 40 to 45 minutes.

6.3.2 Breathing exercise/Meditation focused on breathing

The breathing exercise is one of the first exercises in the program. It creates consciousness about the breath as continuous thread in life that can help to recognize and cope with tensions, anger, pain and stressful situations in daily life. During this 10 to 15 minute long exercise the breath is used as anchoring point to return to, when cognitive wondering is recognized.

6.3.3 Three minute meditation

The 3-minute-meditation is developed by Segal, Williams and Teasdale (2004) as a meditation-tool for participants to generalize and expand learned meditation techniques into daily-life. First participants are asked to practice this meditation exercise on fixed points in the daily agenda (standard). Then participants are asked to practice this exercise not only on fixed points of time but whenever they feel the need to do it (coping).

6.3.4 Sitting meditation

The sitting meditation is a ten minute exercise in which through the focus on breathing (or alternatively on sounds and thoughts) the participant is learning to recognize that old mental pattern are automatically taking over, recognizing the wondering of the mind. Simultaneously participants learn to focus on one thing at a time (namely breath) only.

6.3.5 Moving-meditation

Moving meditations are exercises in which the focus is lying on the sensation occurring while moving the body consciously. These exercises are easy to embed in daily life and especially suited for the ones that feel chased. Goals of these meditations are similar to those of the sitting meditation.

7. Analysis

In order to assess the effects of MBCT, the significance of the difference between pretest and posttest scores will be analyzed using individual analysis of reliable change (RC) (Jacobson & Truax, 1991). This method is a change score approach in which intra-individual comparison are conducted at pre- and post-treatment. For each individual participant it is assessed whether a reliable clinical change or recovery has been established. The standard deviations of pretest for each instrument, necessary for this analysis, are taken from a large clinical sample (n=376) of a study by Martine Fledderus, PhD student of the University of Twente (Fledderus et al., 2012).

Equation:

$RC = (Xpost - Xpre)/\sqrt{2}(Spre\sqrt{1 - \alpha})^2 = Xpost - Xpre/Sediff$

$-1.96 \geq RC \geq 1.96$

If the RC is 1.96 or greater or RC is -1.96 or smaller than the difference is statistically significant.

The data generated by the evaluation-tool was analyzed using descriptive statistics. The analysis is conducted by the use of SPSS 14.

8. Results

8.1 Effect evaluation

8.1.1 CES-D

Analysis of reliable change show that the significant score difference between pre- and post-measure on the Center of Epidemiologic Studies Depression Scale (CES-D) is 7 points (Table 2). The mean score on pretest and posttest measure were respectively M_1=24.3 and M_4= 18.6. The mean of change in score between pre- and posttest measure were M_{4-1}= -5.7 (see Table 3).At pretest all seven participant reached scores above the 16- point cut-off score indicating possible clinical symptoms on the CES-D. Three of them (participants 2, 3 & 10) scored above the 24-point cut-off score. At posttest three participants scored below the 16-point cut-off score; only two scored 24-pionts or higher and two reached scores higher than 16 points. Individual analysis showed that in two cases (participant 4 and 10) there is a significant of clinical change. These participants' scores decreased respectively by 12 and 19 points. Participant 10 being the one with the second highest score at pretest level to the one with the second lowest at posttest level. All scores beside one were decreased at posttest measure. One participant (3) showed a decrease of symptomatology of six points, approaching the significant difference of clinical relevant change of seven points to one point.

Table 2: CES-D

CES-D	
Cronbach's α	0.88
SD	6.6
Sediff	3.2
Significant difference	7

Table 3: CES-D Reliable Change

CES-D	Xpre	Xpost	Xpost-Xpre	RC
Participant				
2	34	31	-3	-0.9375
3	25	19	-6	-1.875
4	23	11	-12	-3.75*
5	18	15	-3	-0.9375
6	18	17	-1	-0.3125
8	20	24	+4	1.25
10	32	13	-19	-5.9375*
M	24.3	18.6	-5.7	

*significant RC

8.1.2 HADS-A

The reliable change analysis of the HADS-A scores showed that the significant score difference between pre- and post-measure here is three points(Table 4).The mean score on pre- and posttest measure were respectively M_1= 9.9 and M_4=7.7. The mean difference between pre- and posttest measure was M_{4-1}=-2.14(see Table 5).At pretest four (participants 2, 4, 8 and 10) of the seven participants scored higher than the 8 point cut-off score for possible clinical symptoms. No participant scored as high or above the cut-off score of 15 points, indicative for possible clinical cases. At posttest, scores of two of these four participants (4 and 10) decreased under the cut-off score of 9 points. All scores beside one (participant 5) were decreased at posttest measure. Individual analysis showed that in two cases (participant 4 and 10) there is significant evidence of clinical relevant change.

Table 4: HADS-A

HADS-A	
Cronbach's α	0.83
SD	2.5
Sediff	1.4
Significant difference	3

Table 5: HADS-A Reliable Change

HADS-A	Xpre	Xpost	Xpost-Xpre	RC
Participant				
2	14	12	-2	-1.43
3	5	4	-1	-0.71
4	11	7	-4	-2.86*
5	7	9	2	1.43
6	7	5	-2	-1.43
8	13	11	-2	-1.43
10	12	6	-6	-4.29*
M	9.9	7.7	-2.14	

*significant RC

8.1.3 MHC-SF

Through analysis of reliable change the significant difference between pre- and posttest measure on the MHC-SF was defined at 13 point (Table 6). Accordingly one participant (10) showed significant change on this instrument after treatment. The mean score on pre- and posttest measure were respectively M_1= 44.7 and M_4=52.4. The mean difference between pre- and posttest measure was M_{4-1}=10.14 (Table 7).

Table 6: MHC-SF

MHC-SF	
Cronbach's α	0.89
SD	10.64
Sediff	6.38
Significant difference	13

Table 7: MHC-SF Reliable Change

MHC-SF	Xpre	Xpost	Xpost-Xpre	RC
Participant				
2	20	25	5	0.78
3	50	53	3	0.23
4	51	61	10	0.77
5	61	60	-1	0.08
6	36	44	8	0.62
8	54	52	-2	-0.15
10	41	72	31	2.38*
M	44.7	52.4	10.14	

*significant RC

8.1.4 AAQ-II

Analysis of the AAQ-II measure showed that an eight point difference is evidence of a reliable change (Table 8). In Table 9it is shown that here participant four, five, eight and six showed significant change between pre- and posttest measure. The mean score on pre- and posttest measure were respectively M_1= 29.3 and M_4=41.7. The mean difference between pre- and posttest measure was M_{4-1}=12.4 (Table 9).

Table 8: AAQ-II

AAQ-II	
Cronbach's α	0.89
SD	8.6
Sediff	4.03
Significant difference	8

Table 9: AAQ-II Reliable Change

AAQII	Xpre	Xpost	Xpost-Xpre	RC
Participant				
2	23	24	1	0.25
3	36	42	6	1.49
4	24	52	28	6.95*
5	28	37	9	2.23*
6	43	50	7	1.74
8	29	37	8	1.99*
10	22	50	28	6.95*
M	29.3	41.7	12.4	

*significant RC

8.1.5 FFMQ

Analysis of reliable change showed that the significant difference between pre- and post-measure on the Five Facet Mindfulness Questionnaire (FFMQ) was 20 points (Table 10). In Table 11 it is apparent that four of the seven participants, namely participants' nr.4, 6, 8 and 10, showed significant change on this scale after treatment. The mean score on pretest and posttest measure were respectively M_1=100.3 and M_4= 133.6. The mean of change in score between pre- and posttest measure was M_{4-1}= 33.9.

Table 10: FFMQ

FFMQ	
Cronbach's α	0.80
SD	15.62
Sediff	9.88
Significant differences	20

Table 11: FFMQ Reliable Change

FFMQ	Xpre	Xpost	Xpost-Xpre	RC
Participant				
2	92	107	15	1.52
3	107	121	14	1.42
4	89	147	58	5.87*
5	128	126	-2	0.20
6	127	164	37	3.74*
8	82	128	46	4.66*
10	77	142	65	6.58*
M	100.3	133.6	33.9	

*significant RC

8.2 Evaluation Questionnaire

8.2.1 General Evaluation

For analysis of the acceptance and feasibility of the training an evaluation- questionnaire was administered after the training. The precise data can be found in appendix 5 and the following. Through analysis of the first part of this evaluation-tool it becomes clear that all seven participants state that they received the help they hoped to receive, that the training fulfilled the expectation they had, that they would recommend the training to a friend, that they are satisfied with the amount of help they received, that the training helped them to cope with problems in a different way, that they are satisfied with of the help they received, and that they would do the training again if necessary. Four participants experienced the sessions as rather short and three participants as rather long. The number of sessions was judged as rather little by six participants and rather numerous by one participant. Overall quality of the training was judged "good" by six of the participants, while one participant finds the training of moderate quality.

8.2.2 Agenda

The agenda of the training was evaluated in the second part of the evaluation-questionnaire (appendix6). Analysis shows that all seven participants appreciated the three introduction-sessions. The opinion about the un-necessity of the evaluation-interview after the three introduction sessions varied. Five participants felt comfortable in the group and would not prefer to do the training individually. One did not feel comfortable in the group and one would rather do the training individually.

8.2.3 Schedule

The schedule of the sessions was evaluated in the second part of the questionnaire as well (appendix 7).Three participants wanted to spend less time on the discussion of the homework. Most of the participants wanted to spend more time on the explanation of homework, breathing exercise, and move-mindfulness exercise and sit-meditation. No participant wanted to spend less time on explanation of homework or mindfulness principles, breathing exercise, move-mindfulness exercises, sit-meditation and discussion over the exercises. Most of the participants were satisfied with the amount of time that was spent on the explanation of the mindfulness principles and use of metaphors, poems and stories.

8.2.4Mindfulness exercises

Number of days per week

The number of days per week participants spent time on formal mindfulness exercises varied from 2-3 days to 4-5 days to 6-7days per week. The number of days per week participants spent time on informal mindfulness varied as well: 28.6% of participants spend 2-3 days per week, 14.3% spend 4-5 days per week and more than half (57,1 %)of the participants spent6-7 days per week or did exercise even more times per day(appendix8).

Evaluation of exercises

All exercises are analyzed on three dimensions: (a) applicability in daily life (b) applicability in problem situations (c) long–term usability.

Three-minute-meditation

The three-minute-meditation was judged to be (very) well-applicable in daily life and (very) useful in the long term. Six participants find this exercise to be (very) well- applicable in problem situations while one participant found it just reasonable applicable. On none of the three dimensions was the three-minute-meditation judged as (very) difficult to apply or to use (appendix 12).

Body-scan

The Body-scan exercise was judged to be reasonable or difficult to apply in daily life as well as in problem situations by most of the participants (see appendix 12). By all participants the long-term usability was judged to be (very) good.

Sit-meditation

Evaluations of the sit-meditation varied: five participants judged the applicability on both dimensions ((a) daily and (b) problem situation) to be "reasonable applicable" or "difficult to apply" (see appendix 12). The long-term usability was judged as (very) good.

Move-meditations

Applicability in daily life as well as in problem situations and long-term usability of move-meditations were judged to be reasonable or difficult by five participants (see appendix 12 table 3.24).Two participants found this exercise to be very usable to influence their mood positively in one year (long-term-usability).

Meditation focused on breathing

The meditation focused on breathing was judged both in daily life and in problem situations as (very) good applicable by three participants (42.9%) and reasonable applicable on both dimensions by four participants (57.1%) (appendix 12 table 3.25).

Relapse-prevention-plan

The relapse-prevention-plan was judged to be difficult to apply in problem situations by three participants. Three participants found it reasonable and one very well applicable in problems situations. Judgments about long term usability varied as well: two participants found it "well usable", three participants found it "reasonable usable" and two judged it as difficult to use (see appendix 12 table 3.26).

Mindful eating and drinking

The informal exercise of mindful eating and drinking was found difficult to apply in daily life by three participants, while respectively two participants found it reasonable applicable or well-applicable.

8.2.5Materials

CD

Six participants agreed that the CD with guidance to meditation was a helpful support for their exercises and lowered the threshold (made it easier) to start with the exercise. (appendix13). The majority of participants expected to use the CD half a year from that moment. All participants found the CD suitable. Usability of the CD to influence their mood positively in problem situation was confirmed by two participants and disconfirmed by two participants, while three participants neither agreed nor disagreed to the statement (question 4.15).

Diary

The diary, was used to keep track of whether and when home exercises were done, was agreed to be a useful help for the exercises by two participants, while five participants did neither agree nor disagree to the statement (appendix 13). The statement that the dairy was lowering the threshold to begin with the exercises was (fully) agreed by two participants and disagreed by one participant. Four participants neither agreed nor disagreed .The majority of participants disagreed to be using the dairy half a year from that moment. Nearly all participants judged the diary to be suitable for them.

Relapse-Prevention-Plan

Four participants found the Relapse-Prevention-Plan helpful to recognize the signals of threatening relapse, while three participants neither agreed nor disagreed on this statement (appendix 13). Three participants indicated they will still use the relapse prevention plan after six months. Three participants neither agreed nor disagreed to be using it in six months; one participant thought he or she will not be using it. The majority of participants evaluated the relapse prevention plan to be suitable for them. Three participants indicated the relapse prevention plan helps them influencing their mood in a positive way.

8.2.6 Guidance/Therapists

Nearly all participants, namely six, evaluated the therapists to be competent, felt understood by them and evaluated the content feedback they gave to be of good quality (appendix 14 table5).

Five participants support the statement that collaboration was good between therapists.

8.3 Cases

Three clients from the MBCT group at "Dimence" were selected for an individual case description. For privacy reasons names were changed.

8.3.2 Participant No. 4

Bruno is a 39-years-old, Caucasian (Dutch), male with a diploma of "hoger beroepsonderwijs" ((HBO) Dutch equivalent to "University of Professional Education"). He has never been married, but has a partner at the time of treatment. The couple lived a long distance relationship (Netherlands – Thailand). He has one child, feels related to a buddhistic view of life, and has most of his life been living on the countryside in the Netherlands. His financial situation was quite tight, as he had to address his savings. Before the treatment, he is diagnosed with recurrent depressive episodes, social phobia and generalized anxiety disorder. He is introverted and anxieties for reaction of others are causing noticeable restrictions and distress in his daily life. Furthermore he suffers from an upset stomach, and alcohol consumption played a steady role in his (social) life as this helped him to become more relaxed. In the first interview in the beginning of the training, he stated that he had suffered from heavy panic attacks that now had nearly disappeared (1 point on a scale from 0-10). He still suffers from stress (3 on a scale from 0-10), fatigue (6 on a scale from 0-10), feeling rushed or hyperactive (5on a scale from 0-10) and depressive episodes (2 on a scale from 0-10). The total burden of his complains on his daily life he perceives as quite low (3 on a scale from 0-10).According to him, this complains are immanent. In the past he participated in an "attention-training" which suited him well until the meditation on his thoughts became too tense and he stop with that training. As his thoughts were quite negative at that time the direct confrontation was overpowering and he stopped with the training halfway. But as he benefited from earlier cognitive behavioral therapy for his panic attacks and social phobia, particularly by managing to reduce avoidance behavior, he was looking forward to start with the training under study. Above all, he stated as goal for this training, to become more relaxed and being able to benefit from this relaxation in the social context (social phobia) and by being able to concentrate easier. He had confidence in the success of the training in reducing his symptoms (7 on a scale from 0-10). During the training, he got the chance to realize his dream to move to his girlfriend in Thailand and start a business there. He had been waiting for required licenses and documents for a while. For this reason he did not attend the last two meetings. In the evaluation interview after the training he explains that his unpleasant thoughts and his feeling of loneliness in company of others are almost no longer present. Sometimes, especially in relational sphere, he still can feel lonely and panicking. If thoughts appear he states to be able to recognize them and concentrate on something different, like things or people around him. He is able to create distance to his feelings and thereby stopping the self-reinforcing cycle of panic or anxiety from pushing through. He states to feel better, both physically and psychologically,

to be more relaxed and to feel happier in general, to have a greater desire to live, to recognize the nice small things in life, and to recognize when he is tired and in need of rest or to do something different. He explains to be less worrying and that specific thoughts have disappeared completely. He repeatedly states that especially the ability of non-judgmentally recognizing his thoughts and feelings give him the opportunity for a wider range of actions, making it possible for him to be more relaxed, more concentrated and less tired and anxious. In his relationship he is able to speak out without exploding; while recognizing the hard work a relationship demands from him, as this is according to him, one of his weak points. Overall he states his complains to be lessened by 60% to 70 %. The first two introduction weeks were quite difficult and ineffective for him, he tells, as he was quite irritated by some of the group members. However, he explains that through the training his acceptance of people in the group and in daily life has grown by the learning of patience and compassion. From the third week on, he liked the training and felt that it began to help. So, whereas in the beginning he felt difficulties to relax in the meditations in front of others (feeling observed), he let this feelings go and was able to enjoy the meditation within the group. The meditation exercise at home, he stated, demands a great deal of discipline. In the first weeks he postponed the meditations exercises at home until he decided to set fixed times at the day to exercise. "Once, engaged, it is well to do", he said. But still he finds it hard to begin to meditate. For this purpose he established a "meditation-song" that he listens to during meditations, making it easier for him to start with the exercise. On the question about the comparison of therapy-experiences of the past and this training he answers: "The whole point of view is different. In previous therapies thoughts were aggressed: true or untrue; reasoning, and so on and so on. Annoyance hereby is: you are already so exhausted and that just adds. This therapy creates calmness; even just the presence in the group was calming. Acceptance of thoughts, noticing, concentrating on something different, the mildness, the patience, all things I have not noticed in previous therapies. I actually think that it is a wisdom that more people should get the hang of. You learn to feel again, just standing still, in the moment."

8.3.3 Participant No. 5

Carl is a 47-year-old Caucasian (Dutch) male with a diploma of "hoger beroepsonderwijs" ((HBO) Dutch equivalent to "University of Professional Education"). He is living together with his wife and his two children. Most of his life he has been living in a city. He does not feel connected to any philosophy or religion. He is independent, has his own company, and his financial situation is quite tight, as he has to make debts at the moment. He is diagnosed with anxiety disorder (NOS), alcohol addiction in complete remission and a single episode of moderate depressive disorder. He is diagnosed with obsessive-compulsive and avoidant traits. He feels the need to live up to perfectionistic goals to prove himself. As his self-esteem is tightly coupled with these perfectionistic goals, he is afraid of

failing. If something goes wrong, he attributes it as his personal failure, creating a negative self-image. This makes him feel worthless. He started to drink alcohol in the evening to "calm down" and to be able to sleep. Twenty-two years ago Carl had, through an electric shock, a near-death experience. He still suffers from flashbacks and avoids things that remind him of this experience. Since 2007 he suffers from heavy anxiety and panic symptoms. His biggest fear is the loss of control. In the first interview, Carl explains that the symptoms of his disorder are a heavy burden: anxiety and panic (10 out of 10), hyperventilation (8on a scale from 0-10) and worrying (9 on a scale from 0-10). He states that they occur abrupt and motiveless, but that he suffers the least when the "situation is relaxed". The symptoms influence his daily functioning on nearly every field. He perceives the impact of his symptoms at his work and in his relation as high (8 on a scale from 0-10). He states that he is just "busy with(in) himself". His goals of this training are to be more relaxed and stay calm, to stop fighting against his anxiety and panic and to be more mindful. He has confidence in the success of the training in reducing his symptoms (8 on a scale from 0-10). In the evaluation interview, after the training, he states that he has made a step in the right direction towards all his goals (be more relaxed and stay calm, to stop fighting against his anxiety and panic and to be more mindful). According to him, the training has helped him noticeably in reducing his symptoms (8on a scale from 0-10). The process leading to anxiety as well as his anxiety and panic itself and his worrying have changed. Even though his self-esteem is not changed yet, he states, he feels more relaxed with(in) him-self, more at ease. He explains that most importantly, he is earlier aware and less worrying, he does not feel the pressure to rapidly do the utmost, but out of the feeling that things resolve themselves he is able to leave things the way they are. On the question "What experience in the therapy was especially important to you?" He answered: " Letting go…I have now experienced several times some feelings or situations that could otherwise cause considerable anxiety or panic attacks and through looking at them now earlier and differently I have noticed that it does not have to get out of hand…this creates peace and I think that I gained more self-confidence in that area." Additionally he tells that in particular the application of learned practices in critical situations has helped him. Furthermore he learned a lot of the exchange of experiences within the group. He explains that, compared to earlier therapy-experiences, where feelings and thoughts were tried to be overshadowed by distraction, in this therapy feelings and thoughts are faced with acceptance and attention, and assure that you have tools that can be applied in a different manner.

8.3.1 Participant No. 10

Anna is a 57-years-old, Caucasian (Dutch), female that has finished primary school. She is divorced and has no new partner. At the time of treatment she was unemployed and she complained about a tense financial situation that restricted her in her everyday life. She has two children and has been living in a small town most of her life. She is diagnosed with recurrent moderate depressive

disorder associated with problems in her social environment. Since the age of 27 she experienced three depressive episodes with interim complete recovery. Besides that she suffers from social phobia since she was 17 years old. To suppress her feelings of depression, in a period of relationship problems during her marriage, she started drinking alcohol after her pregnancy. This gradually led into an addiction. Rehab helped her to stay clean since 1994. In the first interview in the beginning of the training, she stated that feelings of guilt and depression, associated with the fact that she cannot accept the past, get strongest when under pressure in situations she feels she cannot control (social, bureaucratic etc.) or in situations where there is no distraction. She perceives the symptoms as a heavy burden (9 on a scale from 0-10), associated with worrying self-talk and extreme introversion as far as feeling "absent". Consequently these symptoms have high influence on her daily life (8 on a scale from 0-10) as she stated for example to avoid activities by canceling appointments regularly, being "catty" or sad and worrying and thereby difficult in the contact with others, especially her daughter. Her therapy goals were to feel more congruent, to feel less depressed, to feel able to have social contacts and to get back to working-life. She had a high confidence in the success of the training in reducing her symptoms (9 on a scale from 0-10). Appropriately, in the evaluative interview after finishing the training, Anna states the perceived burden of her symptoms to be noticeably decreased (5 on a scale from 0-10 compared to 9 out of 10 in the beginning of the training). She stated to be more positive and attentive and less worrying. She recognizes this improvement in daily life and relationships as she feels calmer, happier, more open and concentrated. She describes that there are fewer moments of feeling absent. She is able to listen and enjoys conversations, feels less tired and is able to keep up her household. Furthermore she is initiating first steps to find work. She gets positive feedback on her change from her environment like for example "having brighter eyes" or "being less negative". According to her, the introduction weeks were the least effective. As she had to get used to the group and the therapists she did not contribute to the conversations. Nevertheless, she appreciated the group setting as well as the time of the appointment. Asked about the duration she found the sessions to be quite long but would like the total duration of training to be longer. She perceived the exercises during the session as pleasant and she stated to become more aware of the restlessness of her body. She states to become more aware of what is happening in her environment and being able to "correct" her perception by taking a more decentered position (she talks about "having more choices"). The release of initial resistance of physical perceptions was especially important to her as well as the resulting change in the physical perception of her body. Overall she states to have made the first steps into the right direction.

9. Discussion

In today's western society depression and anxiety disorder are the most prevalent of all psychiatric conditions. The often recurring or chronic nature of these diseases is the cause for a high individual and societal mental health disease burden (Clark & Beck, in press). Cognitive behavioral therapy (CBT) is among the most significant contemporary forms of treatments in mental health practice. This highly structured and directive method (Rush, Khatami & Beck, 1975) is based on the assumption that emotional disturbance can be reduced by helping individuals to change the content of their thoughts. CBT is proven to be significantly effective in treating anxiety disorder and depression and is therefore included as standard method in the treatment protocols for these disorders in the Netherlands. Still, a substantial number of patients do benefit less than optimal to this treatment, staying in a clinical relevant range of symptoms. For patients at "Dimence" in The Netherlands, Overijssel, who have been treated according to evidence based guidelines for at least two years but still suffer from chronic or recurrent depression or/and anxiety disorder the treatment protocol of "Dimence" does not offer any specific guidelines to proceed. But these patients stay in treatment and are thereby causing substantial financial mental health burden. Furthermore waiting-lists of mental health organizations, like "Dimence", are growing and new patients are usually waiting for month before treatment starts. For this reason the effectiveness of new treatments that are approaching these chronic/recurrent mental health problems from a different point of view need to be explored, and if proven to be evidently effective, to be added to the treatment protocols. Because of its specific characteristics of focusing less on control of psychological distress but emphasizing the acceptance of private events, MBCT was assumed to be well suited to complement the existing psychotherapeutic protocol of "Dimence". Unlike CBT, in Mindfulness Based Cognitive Therapy (MBCT), there is little emphasis on changing the content or specific meaning of negative automatic thoughts but its focus lies on teaching clients to become more aware of thoughts and feelings and to relate to them in a wider, decentered perspective as passing "mental events" rather than as aspects of the self or as necessary accurate reflections of reality (Teasdale, Segal, Williams, Ridgeway, Soulsby, & Lau, 2000).

The purpose of this study was to get an idea of the effect of MBCT in treating patients with chronic/recurrent depression and/or anxiety disorder in the mental health organization "Dimence". Therefore the aim of the present research was to analyze whether MBCT as treatment for clients with chronic/recurrent depressive or anxiety disorder (a) affects the affective symptoms of the target group and significantly decreases symptomatology, (b) promotes the mental health of the target group,(c) fosters acceptance as alternative strategy to experiential avoidance, and (d) promotes mindfulness. For this purpose levels of depression, anxiety, well-being, acceptance and mindfulness were measured before treatment, after three introduction sessions and the end of the eight sessions long MBCT. Seven patients with chronic/recurrent depression and/or anxiety disorder, who were treated according to

"Dimence" treatment protocol for at least two years, and who still suffer from symptoms were participating in this pilot study. Because of the small sample size individual analysis of reliable change was conducted.

In the following, first the research hypothesis will be answered; main findings of this pilot study will be discussed, test-results will be complemented by data from the interviews and cases studies, and the implication will be discussed. Recommendations for future treatment and research will be made. Thereafter, limitations of the design, the method and the instruments of the research will be discussed. Finally, in a critical reflection, conclusions are summarized.

9.1 Main findings

9.1a Symptomatology of affective symptoms

In the beginning of the treatment all seven participant reached scores, indicative for clinically relevant depressive symptoms. Three of these scored above the cut-off score indicating clinical relevant cases of depression. No participant scored above the cut-off score (15 and higher) that is indicative for cases of clinically relevant anxiety (Bjelland, 2002). Four participants (2, 4, 8 and 10) show scores above the cut-off score indicative for clinical symptoms of anxiety (8 points and higher) at pretest measure. After finishing the training this picture has changed: Of the seven participants, four still reached scores indicative for clinically relevant depressive symptoms and two of these reached scores indicative for possible clinical cases of depression. Individual analysis of reliable change reveals that in two cases (participant 4 and 10) there is significant evidence of clinical relevant change. Furthermore one participant (3) showed a decrease of symptomatology of six points, approaching the significant difference of clinical relevant change of seven points. Concerning the anxious symptoms, all scores of the four participants with indicative anxious symptoms at pretest level are decreased at posttest measure. Two of these four participants (4 and 10) show no indication for possible anxious symptoms anymore. Individual analysis showed that these two participants (4 and 10), that also showed significant evidence of clinical relevant change on the depression scale (CES-D), also showed significant evidence of clinical relevant change on the anxiety-measure.

The results on the depression and anxiety measure give rise to a good deal of considerations. One striking observation is the fact that two (no.5 and 6) of the seven participating patients showed no indication of possible clinical cases on the pretest measure of depression and anxiety. Furthermore, both showed no indication for clinical relevant anxious symptoms. Of all participants these two show the lowest scores on the depression measure, indicated a mild form of depressive symptoms. This not only raises the question over the reason of why these participants are still in treatment at "Dimence", but also has an impact on the interpretations of the results. Considering the target group of this study

and the relatively low scores at the pretest measure of these two participants (no. 5 and 6) the new treatment (MBCT) can only be expected to fine-tune the already relatively good scores. Moreover, statistically there is no differentiation of scores of the CES-D (depression measure) and HADS-A (anxiety measure) under the cut-off point for clinical relevant symptoms. Therefore an improvement of scores that are already non-indicative or very close to the cut-off point at pretest level actually cannot be interpreted. This not only concerns scores of participants no. 5 and 6 but also participant no.3, whose scores are not indicative for clinical relevant anxious symptoms at pretest as well.

In contrast to the test-results, the case study of participant 5 depicts a person that really feels that he has benefited of the training. He entered the training after CGT had helped him to reduce his anxiety and depression but he still suffered from the fear for symptoms to return. His goal for the training was to learn to accept his vulnerability and allow negative thoughts and feelings to be, without acting on them directly. He seemingly reached that goal as he explains in the evaluation interview (video is obtainable from the author of the study) that he now is able to encounter his feelings with more acceptance and mildness and that this change has helps him to handle his anxiety and panic. Participant no. 6, like participant no. 5, enrolled for the MBCT after CBT had helped her to reduce her symptoms. Still she was feeling demoralized and had great difficulties to accept her vulnerability and the way her symptoms could influence her life. Her goal of the MBCT was to learn to accept and handle this vulnerability. In the evaluation interview she states that she now is more aware of what she feels and thinks and that she realized that these thoughts and feelings are passing by mental events. Even though she still finds it hard to accept her limitations/vulnerability this training helped her to be milder to herself, she tells. The scores on the depression and anxiety questionnaire are in accordance to her estimation during the interview: out of 10 point (where 1 point is very low and 10 point is very high) she conservatively expected the improvement of her symptoms (3 points). But she estimated the change that she would recommend the training to a friend with similar problems her symptoms to be high (8 points). It is not the symptoms that need to vanish and she wants to continue practicing "acceptance", she states.

In contrast to participants no. 5 and 6. , participants no. 4 and 10 show significant improvement of both depression and anxious symptoms at posttest. These participants both show scores indicative for anxious symptoms. Participant 4 scores are indicative for a high level of depressive symptoms whereas participants 10 scores are the highest of all participants on the depression measure indicating a case of serious depression. Participant 10 has a main diagnose of depression. Participant 4 has a main diagnosis of anxiety disorder. Both seem to benefit significantly from MBCT. Considering the information gathered in the case study both participants literally explain to exhibit a direct effect of the learned practices on their symptoms. Participant 10 states that the release of initial physical resistance was most important to her. She explains that this has created a greater freedom of choice in how she

reacts to her negative thoughts. Participant 4 explains to benefit of decreased cognitive reactivity that interrupts the self-reinforcing process of panic and anxiety. Conclusively, there is initial evidence of the effects of MBCT in reducing symptoms of patients with comorbide anxiety and depression with different main diagnose.

With a look at the results there are three participants left to discuss (participant no. 2, 3 and 8) whose scores do not show significant change on the two symptom measures.

Participant 3 was mentioned earlier in the context of the non-existing symptoms of anxiety at pretest level that can hardly improve and not be interpreted. She does not suffer from anxious symptoms but her scores on the depression measure are indicative for a case of clinical depression. At posttest measures her symptoms improved by 6 points, which indicates a near to significant improvement. In the interview at the beginning of the training she stated that she suffered the most from her lack of concentration, her agitation and some anger that roots back to her past. In the interview her unrest and her lack of concentration are obviously present. In the interview after the training she still seems to have difficulties to concentrate. She states that throughout the MBCT she became aware of the impact of her way of rushing from one task to the other without ever taking a break and rest. She says she now is aware of her "autopilot" and recognizes on time when she needs to stop. "I found a way to stop myself" she states. Since the MBCT she states to suffer from relapse less often.

Participant no. 2 has the highest pretest scores on both depression and anxiety measure indicative for a case of serious clinical depression and with a substantial number of anxious symptoms. Participant no.8 scores are indicative for anxious and depressive symptom but not for clinical cases of these disorders. Participant no. 2 states that the MBCT made all her symptoms worse as she started to focus on her feelings. Furthermore she did not appreciate the therapist of the treatment at all and she felt neglected in her suffering, she states. Participant no. 8 states to have benefited from the body-scan and 3 minute meditation. Ever since the training he can be milder to himself, he says. One striking fact is that these two participant no. 2 and 8 have something in common: they are the only two participants with a diagnosis of personality disorder on the second axis of the DSM diagnosis (Personality Disorder NOS and Obsessive- Compulsive Personality Disorder, respectively). There is a possibility that these persistent, persuasive and rigid patterns of personality traits do interfere with the working mechanism of MBCT and even worsen the symptoms when coping strategies to handle emotions are insufficient. There actually exists an evidence based treatments for patients with personality disorders, which incorporate mindfulness practices as one of the core strategies called "Dialectical Behavioral Therapy". This therapy however simultaneously teaches patients with personality disorders new skills to cope with their emotions in a productive manner. This grows beyond the capacities of MBCT as it was

administered and may be an explanation of the results of participants diagnosed with personality disorder in this study.

Altogether, given the long history of disorder and treatment of the target group these findings provide initial evidence that for some patients with chronic/ recurrent depression and/or anxiety disorder at Dimence, MBCT to could be a useful treatment offer. Furthermore, through case study research and interviews, this pilot study provides information to gain insight in explanatory factors of these test results. Overall, these results are supported by previous studies, which indicated that MBCT can relieve patients , with comorbid depression and anxiety disorder (Green and Beling, 2011), with chronic/ recurrent depression(Barnhofer et al., 2009, Segal, Williams and Teasdale,2004; Teasdale, Segal, Williams, Ridgeway, Soulsby, & Lau, 2000) and with anxiety disorder, from symptoms(Evans et al.,2009, Kim et al., 2010, Williams et al., 2007; Roemer and Orsillio, 2007).

9.1b Promotion of mental health

Out of the notion that mental health is more than the absence of symptoms (illness) (Keyes, 2005; 2006; Keyes et al., 2008) the MHC-SF was added to the test battery. Conform to the results on the depression- and anxiety-scales both participant 4 and 10 show the highest increase in well-being. Here, individual analysis reveals that only the score of participant 10 provides evidence of statistical relevant change. With a look at the results of the findings on the CES-D and HADS-A an interesting pattern is noticed. In cases were after treatment with MBCT only one of the two symptom measures (depression and anxiety) is decreased while the other is increased there is no increase on the well-being measure. Strikingly, participants (no.5 and 8), that show decrease of symptoms on one of the scales (CES-D or HADS-A) but an increase of symptoms on the other scale are the only two, whose scores do not increase on the MHC-SF. This may lead to the hypothesis that only when MBCT accomplishes improvement of symptoms on both dimensions (anxiety and depression), the patient can benefit from promotion of well-being. To falsify this hypothesis future research must include a larger sample of participants with both anxious and depressive symptomatology. The distribution of the main diagnosis should optimally be fifty-fifty. This hypothesis is anyhow based on a non-significant observation of two participants' scores and should be taken with the necessary scientific reserve. There are other possible explanations for this observed phenomenon as well. Both participants (no.5 and 8) report medium to high level of well-being on the MHC-SF already before the training starts. This indicates that both must reach excellent scores to (significantly) increase their well-being at posttest level.

9.1c Promotion of acceptance

The promotion of acceptance as an alternative strategy to experiential avoidance is one of the main goals of MBCT as psychological prophylaxis for relapse (Segal, Williams, Teasdale, 2004). Findings

on the AAQ-II significantly support this effect of MBCT in promoting acceptance for four of the seven participants. Besides one participant (participant no. 2), all participants show near to significant increase of acceptance. Correspondingly, participant 2 shows highest depression and anxiety scores on pretest and posttest. This findings fit the participants own evaluation in the interview after the training. As mentioned above, she feels the focus on her emotions made symptoms worse and she felt that her suffering was not taken seriously by the therapists of the training. Furthermore this patient is diagnosed with a Personality Disorder NOS, which possibly can be a interfering factor as she starts to be more aware of her feelings but fundamental adaptive coping strategies are missing.

Moreover, the possible mediating effect of acceptance in fostering well-being and reducing affective symptoms of the target group can be encouraged by these findings: The highest increase (pretest to posttest) of acceptance is exhibited by participants (4 and 10), who show highest decrease of depressive and anxious symptomatology, as well.

9.1d Promotion of mindfulness

The findings of the analysis of the mindfulness measure FFMQ provide initial evidence for the effectiveness of MBCT in enhancing mindfulness. Individual analysis shows that in four of the seven cases (4, 6, 8 and 10) there is statistical evidence for clinical relevant change. Notable is, that while the score of six of the seven participants rose by at least 14 points, the score of participant 5 decreased non-significantly by two points. This may be explained by the pretest scores of participant 5 that are with 128 points the highest of the whole group.

All in all, it can be concluded that this study provides initial evidence to support a positive effect of MBCT for patients with chronic/recurring depression or/and anxiety disorder. There is supporting evidence for MBCT to decrease symptoms, and increase well-being, acceptance and mindfulness. Two participants (participant 4 and 10) benefited from MBCT in particular with a significant decrease in symptoms. After treatment participant 4, 5, 6, and 10 show scores of nearly no clinical relevant symptoms anymore paired with medium to very high well-being scores. Here the question arises about when to release participants (4, 5, 6 and 10) out of treatment? The combination of low levels of symptoms, good levels of mental health/well-being, acceptance and mindfulness at posttest measure suggest that participants have incorporated good mental resources and coping strategies to handle their vulnerability. These results suggest that therapist and patient could rely on the capacities of patients and release them out of treatment. In fact, after the MBCT at "Dimence", participant no. 4 and 5 are released out of treatment, and it should be mentioned that participant no.4 was released in any case because he was moving away. To benefit from new treatments for chronic/recurrent patients on individual and societal level mental health institutes as "Dimence" should create clear and strict criteria to justify ongoing treatment of these kinds of patients. Initially, MBCT

was designed as a relapse prevention tool for patients with chronic/ recurrent depression. To gain trust in the long term effects of MBCT on symptom levels and mental health for patients of "Dimence" and to create clear guidelines about when to release patients out of treatment, further research is needed.

9.1.2Main findings of the evaluation of acceptance and feasibility of the intervention

Summarizing, it can be concluded that the MBCT administered at "Dimence", Overijsel was well- accepted by the target group of patients with chronic/recurrent depression and/or anxiety disorder. The details of this evaluation will be elaborated below. (All detailed results are illustrated in tables, see appendix 5 and following).

9.1.2a General Evaluation, Setting and schedule

As the treatment was judged positively on nearly all dimensions, these findings contribute to evidence for the well- acceptance of the treatment. All participants were positive about the fact that the treatment started with three introduction sessions. Only one participant was negative about the group-setting (compared to individual therapy).Participants indicated that they wanted to spend equal or more time for all activities besides the discussion of homework. Participants perceived the amount of time for explanation of the mindfulness principles, use of metaphors, stories and poems, and discussion of exercises to be sufficient. Participants feel the need for more time for explanation of the homework, breathing exercises, move and sit-meditations.

9.1.2b Mindfulness exercises

Evaluation shows that the discipline of participants in doing their homework exercises was high. Concerning the applicability especially the 3-minute-meditation is experienced as well applicable in daily life. Judged as less applicable in daily life are mindful eating and drinking and the move-meditation. Overall, as expected, the findings show that participants have to invest some effort to fit the exercises into their daily life. In problem-situations the 3-minute-meditation and the breathing-meditation were rated to be best applicable in problem-situations. Six of the seven participants judged the relapse-prevention plan to be fairly difficult or difficult to apply in problem situations. These findings indicated that four out of six of the exercises are not easily implementable in problem situations. For long term applicability the 3-minute-meditation and the body-scan are judged by all participants to be well usable over one year. Only the long-term usability of the move-meditation and the relapse-prevention-plan are judged to be difficult. In general the findings depict a rather good long-term usability of the trained exercises.

9.1.2c Materials and Therapists

Findings indicate that the CD is a well-accepted and suitable tool with long-term usability. The diary was mostly neutrally rated. It was judged as suitable but the long-term usability is valued to be low. The relapse-prevention-plan was judged to be rather helpful in recognizing the signals of threatening relapse and influencing their mood in a positive way. It was rated as rather suitable, while only three participants agreed to be using it in six months. The therapists were judged to be competent and understanding by six participants. Overall, their content feedback and cooperation with each user was rated to be good, as well. Strikingly one participant completely disagreed on feeling understood by the therapists.

These results provide usable data to fine tune the already well- accepted treatment to patient's needs and preferences. It becomes evident that there is a need of participants to spend more time on certain parts of the training, whereas time could be saved at the discussion of the homework. Furthermore nearly all participants found the number of sessions to be rather limited. This leads to the recommendation of prolonging the treatment if possible. A 'Mindfulness group' could be set up. There,(former) participants of MBCT have the opportunity to exercise meditation together, thereby ensuring that learned techniques and discipline in practicing do subside. Moreover, data shows that the there is a great need of tools that make starting with mediation practices on a regular bases easier. The diary used in this study does not fulfill this property and could for this purpose probably be digitalized and open for all participants to see. Furthermore, the relapse prevention plan, which should play a crucial role in preventing future crisis, is judged with low long-term usability and to be difficult to apply. The generation of this plan should play a central role throughout the training and every participant should leave therapy with an individual well-working relapse-prevention plan. All recommendations based on the data gathered in this study are summarized in Table 12.

Table 12: Recommendations for improvement

Recommendations to improve MBCT to participants needs and preferences
General
• Keep administering MBCT in group setting.
• Spend more time on the explanation of homework, breathing exercise, move-mindfulness exercises and sit-meditation.
• Spend less time on homework discussion.
• Keep pointing out the importance of home practice to "success". Spend time on generating successful strategies to keep practicing regularly.
• For aftercare and relapse prevention establish a "mindfulness group" at "Dimence" where patients and ex-patients can practice mindfulness meditation together under supervision of a meditation-trainer.
Exercises
• Keep body-scan, breathing meditations, three minute meditation and sit-meditation in the program as basic techniques.
• Focus more on strategies to integrate moving-meditations into everyday life.
Materials
• Keep using the CD as basic tool.
• Try to improve the diary in a way that lowers the threshold to start practice regularly and promote the chance of long-term usage. (for example collective online diary)
• Focus on the generation of more applicable (individual) relapse prevention plans.
Therapists
• Keep up good collaboration between therapists.

9.2 Limitations

Focusing on the design, methods and instruments used in this pilot study, future research should put special attention onto the selection and sampling of participants. First and foremost the sample size of this pilot study limits the possibility for statistical analysis of the effectiveness of MBCT to individual analysis of change. Mean scores cannot be used for pretest-posttest comparison (paired sample t-test) to provide more statistical evidence. Furthermore the sample size is too small to implement a two group pretest posttest design with a non-treatment control group. The used design of this investigation is therefore extremely weak in the controlling for intervening variables. Additionally, the recruitment and the sample itself are quite uncontrolled. To be able to draw more unambiguous conclusions about the effect of MBCT on different target groups, structured clinical interviews for DSM could be administered for all participants. Furthermore to get an idea of why MBCT is working for some patients and is not for others, the treatment histories, number of relapses, onset of disorder, lifespan affected by disorder are possible explanatory variables, interesting for further investigation. A longitudinal study could provide statistical evidence for the capacity of MBCT as psychological prophylaxis tool for different target groups. While more definite trials in this area are required, results and limitations of this study give plentiful recommendations to enhance the quality of future research and training.

9.3 Conclusion

Summarizing this pilot study provides initial evidence that for some patients with chronic anxiety and depression at the mental health organization "Dimence" in Overijssel MBCT seems to be a useful treatment offer. Some participants seem to be nearly free of clinically relevant symptom and benefit of medium to very high well-being as protecting factor to relapse after the training. Analyses give a first idea about the mediating effect of acceptance in fostering well-being and reducing affective symptoms. The results are particularly promising, given the chronic nature of the disorders of the participants. Furthermore, it can be concluded that the training was very well-accepted. Besides the individual focused goal to reduce symptoms and foster mental well-being of their patients, on a wider social level the goal of the mental health organization "Dimence" in The Netherlands, was to find an effective treatment to be able to release long term (chronic) patients out of treatment, thereby shorten the waiting lists and make effective treatment available to more people. These goals both seem to be within reach. Further research is needed to support the findings of this pilot study and expand this research to get a better idea of the influencing factors and the long term effect of MBCT at "Dimence". On the basis of the results of this study, and with the two dimensional model of mental health in mind,

the development of new tools to support the decision making process of stopping or continuing with further treatment for patients with chronic mental disease appears to be valuable. Research should be carried out to create carefully considered and justified criteria for this purpose. All in all, the addition of MBCT to "Dimence's" treatment-protocol could be beneficial on both micro and macro level.

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Appendix 1Pretest battery inclusive all information material and confirm consent

Informatie over het onderzoek naar de aandachttraining 'Mindfulness Based Cognitive Therapy'.

De training 'Mindfulness Based Cognitive Therapy'

Mindfulness is een ander woord voor opmerkzaamheid of aandacht. Het betekent volledige aandacht hebben voor alles wat je van moment tot moment ervaart zonder te oordelen en er zo min mogelijk op te te reageren. Mindfulness is een kernvaardigheid waardoor u andere vaardigheden verbetert. Hierdoor kunnen uiteenlopende klachten en problemen verminderd worden. De training is gericht op aandachtsoefeningen. U leert steeds meer momenten van aandacht in te bouwen in uw dagelijks leven. Ook leert u ingesleten gewoonte- en gedachtepatronen te herkennen en zelf keuzes te maken in hoe u met deze patronen omgaat. Op deze manier wordt mindfulness een onderdeel van uw dagelijks functioneren en werkt het door op al uw levensgebieden.

De training heeft een geleidelijke opbouw. U begint met eenvoudige, korte oefeningen. Verder in de training worden de oefeningen uitgebreider en langer. Ook besteden we steeds meer aandacht aan uw klachten en de manier waarop u hier mee omgaat. Onder andere de volgende oefeningen komen aan bod:

(Korte) zitmeditatie

Het ontwikkelen van aandacht bij routine-activiteiten in uw dagelijks leven

Het onderzoek

Dimence wil graag weten of de cursus MBCT helpend is voor mensen die langere tijd last hebben van psychische klachten. Met het onderzoek willen we nagaan of de training invloed heeft op gevoelens van somberheid, spanning en welbevinden.

Voor het onderzoek maken we gebruik van schriftelijke vragenlijsten. Het is van belang dat de vragenlijsten voor en na de training worden ingevuld. Het invullen van de vragenlijst kost ongeveer 30 minuten per keer.

Hoe werkt het onderzoek?

Als u mee wilt doen aan dit onderzoek, wilt u dan bijgaande vragenlijst invullen en met het toestemmingsformulier aan ons retour sturen in ingesloten retourenveloppe.

Deelname aan het onderzoek verplicht u tot niets. U mag op ieder moment (en zonder opgave van redenen) met het onderzoek stoppen.

Door wie?

Het onderzoek wordt uitgevoerd door de Universiteit Twente in Enschede. Het onderzoeksteam bestaat uit de heer dr. E. Bohlmeijer en mevrouw drs. W.T.M. Pots.

Uw privacy

De bescherming van uw privacy is in Nederland bij de wet geregeld. Het is de onderzoekers verboden vertrouwelijke informatie aan derden door te geven zonder uw uitdrukkelijke toestemming. Tijdens de duur van het onderzoek is het noodzakelijk dat de onderzoeker inzage heeft in uw elektronische dossier bij Dimence, alleen voor de zaken die betrekking hebben op het onderzoek. Uw naam, adres, telefoonnummer moeten wij voor de duur van het onderzoek gebruiken om u te kunnen bereiken. Deze zullen in een afgesloten ruimte worden bewaard. Uw persoonsgegevens worden direct na het onderzoek vernietigd.

Het belang van uw bijdrage

Uw bijdrage kan ervoor zorgen dat er goed aanbod beschikbaar komt voor mensen die hun psychisch leed willen verminderen en hun kwaliteit van leven en geestelijke gezondheid willen bevorderen.

Vragen?

Wij hopen u voldoende te hebben geïnformeerd over het onderzoek. Mocht u nog vragen hebben, kunt u contact opnemen de heer E.T. Bohlmeijer, projectleider van dit onderzoek (Universiteit Twente, Afdeling GW/PCGR, Postbus 217, 7500 AE Enschede, tel.: 06 51070348, e-mail: e.t.bohlmeijer@utwente.nl). Ook kunt u bij hem een schriftelijke aanvraag indienen voor inzage van de van u verzamelde onderzoeksgegevens. U hoeft hierbij geen reden aan te geven.

Wendy T.M. Pots

Onderzoeker/ gz-psycholoog
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Toestemmingsformulier voor deelname aan het onderzoek naar de effecten van de training 'Mindfulness Based Cognitieve Therapie'.

Hierbij geef ik toestemming voor deelname aan het onderzoek dat wordt uitgevoerd door de Universiteit Twente.

Ik heb de informatiebrief gelezen en …

- ik heb begrepen dat ik door het ondertekenen van dit formulier aangeef

  vrijwillig deel te nemen aan het onderzoek;
- ik heb begrepen dat de gegevens anoniem en vertrouwelijk worden behandeld

  en na dit onderzoek worden vernietigd;
- ik heb begrepen dat de onderzoeker inzage heeft in mijn elektronische dossier bij Dimence, voor zover betrekking hebbende op het onderzoek, en dat deze gegevens vertrouwelijk worden behandeld;
- ik heb begrepen dat ik altijd kan stoppen met het onderzoek zonder dat dit van invloed is op het doorwerken van de training mindfulness.

Naam: .....

Voorletter(s): .....

Geslacht:.....

Adres: .....

Postcode/plaats: .....

Telefoonnummer(s):.....

Email: ……..

Datum: Handtekening:

…..…../……/…….

Onderzoeksnummer:					

Onderzoek Training 'Mindfulness Based Cognitieve therapie'

Vragenlijst T1 voor deelnemers

University of Twente
Enschede - The Netherlands

Contactpersoon:Wendy Pots

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Beste deelnemer,

Voor u ligt de tweede vragenlijst in het kader van het onderzoek naar de training 'Mindfulness Based Cognitieve Therapie'. De vragenlijst bestaat uit verschillende onderdelen. De lijst bevat algemene vragen, vragen over uw gezondheid, eventuele gezondheidsklachten en kwaliteit van leven.

De vragenlijst is opgebouwd uit verschillende standaardvragenlijsten die veel worden gebruikt in onderzoek. Het kan daarom voorkomen dat twee keer dezelfde vraag wordt gesteld. Deze vragen zijn dan net wat anders geformuleerd. We hopen dat u hier begrip voor heeft en willen benadrukken dat het van belang is dat u op iedere vraag een antwoord geeft. Alleen op deze manier kunnen wij het onderzoek goed uitvoeren.

We willen u erop wijzen dat er bij de meeste vragen naar uw **mening** wordt gevraagd. Er zijn dan ook geen goede of foute antwoorden. Het gaat telkens om uw eerste indruk, dus lang nadenken is niet nodig. Wanneer u twijfelt over het antwoord op een vraag, probeer dan het antwoord te geven dat het best van toepassing is.

Bij veel vragen kunt u uw antwoord aangeven door het gekozen antwoord aan te kruisen. Indien u een man bent dan beantwoordt u de vraag 'Bent u een man of een vrouw?' dus als volgt:

☒ man
☐ vrouw

Als u zich heeft vergist bij het aankruisen, zet u een streep door het antwoord dat u verkeerd heeft aangekruist en vult u als nog het antwoord van uw keuze in. Dus als volgt:

☒ ~~man~~
☒ vrouw

Bij de meeste vragen moet u slechts **één antwoord geven**. Alleen wanneer erbij staat "meerdere antwoorden mogelijk" kunt u meerdere hokjes aankruisen. Ook als u een antwoord moet **omcirkelen**,staat dit aangegeven.

Graag ontvangen wij de vragenlijst binnen een week terug. U kunt hiervoor gebruik maken van de bijgevoegde antwoordenvelop.

Wij danken u alvast hartelijk voor uw medewerking!

Algemene vragen

Datum waarop u de lijst invult:
dag - maand - jaar

dag ☐☐ – ☐☐ – *jaa* ☐☐☐☐

1 Bent u een man of een vrouw?

- ❑ man
- ❑ vrouw

2a Wat is uw geboortedatum?

dag - maand - jaar

☐☐ – ☐☐ – ☐☐☐☐

2b Wat is uw geboorteplaats?

☐

3a Wat is uw burgerlijke staat?

- ❑ gehuwd
- ❑ gescheiden
- ❑ weduwe/weduwnaar
- ❑ ongehuwd en nooit gehuwd geweest

3b *Indien gescheiden, verweduwd of nooit gehuwd geweest:*

Heeft u een partner?

- ❑ nee
- ❑ ja

3c *Indien gehuwd of een partner:*

Woont u met uw echtgenoot/partner?

- ❑ nee
- ❑ ja

4aHeeft u kinderen?

- ❑ nee
- ❑ ja

4b Zo ja, hoeveel kinderen heeft u? ☐

Vul het aantal in.

5 Met welke levensbeschouwing voelt u zich verwant?

- ❑ geen
- ❑ Rooms Katholiek
- ❑ Nederlands Hervormd
- ❑ Gereformeerd
- ❑ Joods
- ❑ Islam
- ❑ Hindoeïsme
- ❑ Humanisme
- ❑ anders, nl ……

6 Wat is uw culturele achtergrond?

- ❑ Nederlands
- ❑ Surinaams
- ❑ Antilliaans
- ❑ Indonesisch
- ❑ Turks
- ❑ Marokkaans

- ❑ Gemengd, namelijk …….
- ❑ anders, namelijk ……..

7 Waar heeft u het grootste deel van uw leven gewoond?

- ❑ grote stad
- ❑ middelgrote stad
- ❑ kleine stad
- ❑ dorp/platteland

8 Wat is de hoogste opleiding die u heeft afgerond?

- ❑ geen onderwijs gevolgd
- ❑ lagere school
- ❑ lager beroepsonderwijs (LBO)
- ❑ middelbaar algemeen voortgezet onderwijs (bijv. (M)ULO, MAVO)
- ❑ een middelbare beroepsonderwijs (MBO, bijv. MTS, MEAO, MHNO, INAS)
- ❑ hoger algemeen onderwijs (HBS, Atheneum, Gymnasium, MMS; wat nu heet HAVO, VWO)
- ❑ hoger beroepsonderwijs (HBO)
- ❑ wetenschappelijk onderwijs (WO)
- ❑ anders, namelijk …….

9 Welke van de volgende omschrijvingen geeft uw belangrijkste dagelijkse activiteiten op dit moment het beste weer?

- ❑ betaalde baan of zelfstandig ondernemer
- ❑ gepensioneerd
- ❑ huishoudelijk werk
- ❑ vrijwilligerswerk
- ❑ (langdurig) arbeidsongeschikt
- ❑ werkloos
- ❑ anders, nl……

10 Hoe is op dit moment de financiële situatie van uw huishouden?

- ❑ moet schulden maken
- ❑ moet spaarmiddelen enigszins aanspreken
- ❑ kan precies rondkomen
- ❑ kan een beetje geld overhouden
- ❑ kan veel geld overhouden

1. Stemming

Zet een kruisje bij de uitspraak dat het beste uw gevoel of gedrag van de afgelopen week weergeeft.

Tijdens de **afgelopen week**:	**Zelden of nooit (minder dan 1 dag)**	**Soms of weinig (1-2 dagen)**	**Regelmatig (3-4 dagen)**	**Meestal of altijd (5-7 dagen)**
1. Stoorde ik me aan dingen, die me gewoonlijk niet storen.				
2. Had ik geen zin in eten, was mijn eetlust slecht.				
3. Bleef ik maar in de put zitten, zelfs als familie of vrienden probeerden me er uit te halen.				
4. Voelde ik me even veel waard als ieder ander.				
5. Had ik moeite mijn gedachten bij mijn bezigheden te houden.				
6. Voelde ik me gedeprimeerd.				
7. Had ik het gevoel dat alles wat ik deed me moeite kostte.				
8. Had ik goede hoop voor de toekomst.				
9. Vond ik mijn leven een mislukking.				
10. Voelde ik me bang.				

11. Sliep ik onrustig.				
12. Was ik gelukkig.				
13. Praatte ik minder dan gewoonlijk.				
14. Voelde ik me eenzaam.				
15. Waren de mensen onaardig.				
16. Had ik plezier in het leven.				
17. Had ik huilbuien.				
18. Was ik treurig.				
19. Had ik het gevoel dat mensen me niet aardig vonden.				
20. Kon ik maar niet op gang komen.				

2. Gespannenheid

Hieronder staan een aantal uitspraken dat door mensen zijn gebruikt om zichzelf te beschrijven. Lees iedere uitspraak en kruis één antwoord aan dat het beste weergeeft hoe u zich gedurende **de afgelopen week** gevoeld heeft.

1. Ik voel me gespannen:

- ❑ Meestal
- ❑ Vaak
- ❑ Af en toe, soms
- ❑ Helemaal niet

2. Ik krijg een soort angstgevoel alsof er elk moment iets vreselijks zal gebeuren:

- ❑ Heel zeker en vrij erg
- ❑ Ja, maar niet zo erg
- ❑ Een beetje, maar ik maak me er geen zorgen over
- ❑ Helemaal niet

3. Ik maak me ongerust:

- ❑ Heel erg vaak
- ❑ Vaak
- ❑ Af en toe maar niet te vaak
- ❑ Alleen soms

4. Ik kan rustig zitten en me ontspannen:

- ❑ Zeker
- ❑ Meestal
- ❑ Niet vaak
- ❑ Helemaal niet

5. Ik krijg een soort benauwdheid, gespannen gevoel in mijn maag:

- ❑ Helemaal niet
- ❑ Soms
- ❑ Vrij vaak
- ❑ Heel vaak

6. Ik voel me rusteloos en voel dat ik iets te doen moet hebben:

- ❑ Heel erg
- ❑ Tamelijk veel
- ❑ Niet erg veel

- ❑ Helemaal niet

7. Ik krijg plotseling gevoelens van panische angst:

- ❑ Zeer vaak
- ❑ Tamelijk vaak
- ❑ Niet erg vaak
- ❑ Helemaal niet

3. Welbevinden

De volgende vragen beschrijven gevoelens die mensen kunnen hebben. Lees iedere uitspraak zorgvuldig door en omcirkel het cijfer dat het best weergeeft hoe vaak u dat gevoel had **gedurende afgelopen maand.**

In de afgelopen maand, hoe vaak had u het gevoel…	**Nooit**	**Eén of twee keer**	**Onge-veer 1 keer per week**	**2 of 3 keer per week**	**Bijna elke dag**	**Elke dag**
1…dat u gelukkig was?	0	1	2	3	4	5
2…dat u geïnteresseerd was in het leven?	0	1	2	3	4	5
3...dat u tevreden was?	0	1	2	3	4	5
4...dat u iets belangrijks hebt bijgedragen aan de samenleving?	0	1	2	3	4	5
5...dat u deel uitmaakte van een gemeenschap (zoals een sociale groep, uw buurt, uw stad)?	0	1	2	3	4	5
6...dat onze samenleving beter wordt voor mensen?	0	1	2	3	4	5
7...dat mensen in principe goed zijn?	0	1	2	3	4	5
8...dat u begrijpt hoe onze maatschappij werkt?	0	1	2	3	4	5
9…dat u de meeste aspecten van uw persoonlijkheid graag mocht?	0	1	2	3	4	5
10…dat u goed kon omgaan met uw alledaagse verantwoordelijkheden?	0	1	2	3	4	5
11...dat u warme en vertrouwde relaties met anderen had?	0	1	2	3	4	5

12...dat u werd uitgedaagd om te groeien of een beter mens te worden?	0	1	2	3	4	5
13…dat u zelfverzekerd uw eigen ideeën en meningen gedacht en geuit hebt?	0	1	2	3	4	5
14…dat uw leven een richting of zin heeft?	0	1	2	3	4	5

4. Controle en Acceptatie

Hieronder vindt u 10 stellingen. Lees iedere stelling en geef aan in hoeverre het u er mee eens bent door het getal te omcirkelen.

	Nooit waar	**Bijna nooit waar**	**Zelden waar**	**Soms waar**	**Dikwijls waar**	**Bijna altijd waar**	**Altijd waar**
1. Het is OK als ik me iets onaangenaams herinner.	1	2	3	4	5	6	7
2. Mijn pijnlijke ervaringen en herinneringen maken het me moeilijk om een waardevol leven te leiden.	1	2	3	4	5	6	7
3. Ik ben bang voor mijn gevoelens.	1	2	3	4	5	6	7
4. Ik maak me zorgen dat ik niet in staat ben mijn zorgen en gevoelens onder controle te houden.	1	2	3	4	5	6	7
5. Mijn pijnlijke herinneringen verhinderen mij een bevredigend leven te leiden.	1	2	3	4	5	6	7
6. Ik heb controle over mijn leven.	1	2	3	4	5	6	7
7. Emoties veroorzaken problemen in mijn leven.	1	2	3	4	5	6	7
8. Het lijkt erop dat de meeste mensen meer controle over hun leven hebben dan ik.	1	2	3	4	5	6	7
9. Zorgen staan mijn succes in de weg.	1	2	3	4	5	6	7
10. Mijn gedachten en gevoelens staan de manier waarop ik wil leven niet in de weg.	1	2	3	4	5	6	7

5. Mindfulness/aandacht

Hieronder staan verschillende uitspraken. Geef voor elke uitspraak aan hoe vaak deze voor u **in het algemeen**waar is door het juiste cijfer te omcirkelen.

	Nooit of bijna nooit waar	**Zelden waar**	**Soms waar**	**Vaak waar**	**Heel vaak of altijd waar**
1. Als ik loop let ik bewust op hoe de beweging van mijn lichaam voelt.	1	2	3	4	5
2. Ik ben goed in het vinden van woorden om mijn gevoelens te beschrijven.	1	2	3	4	5
3. Ik bekritiseer mezelf voor het hebben van onlogische of ongepaste emoties.	5	4	3	2	1
4. Ik neem mijn gevoelens en emoties waar zonder dat ik er iets mee hoef te doen.	1	2	3	4	5
5. Als ik iets aan het doen ben dwalen mijn gedachten af en ben ik in het algemeen snel afgeleid.	5	4	3	2	1
6. Als ik onder de douche sta of in bad lig blijf ik me bewust van het gevoel van water op mijn lichaam.	1	2	3	4	5

7.	Ik kan makkelijk mijn overtuigingen, meningen en verwachtingen onder woorden brengen.	1	2	3	4	5
8.	Ik let niet op wat ik doe omdat ik dagdroom, pieker of iets anders doe waardoor ik afgeleid ben.	5	4	3	2	1
9.	Ik observeer mijn gevoelens zonder dat ik me er helemaal door laat meeslepen.	1	2	3	4	5
10.	Ik zeg tegen mezelf dat ik me niet zo zou moeten voelen als ik me voel.	5	4	3	2	1
11.	Het valt me op hoe voedsel en drinken mijn gedachten, lichamelijke gewaarwordingen en emoties beïnvloeden.	1	2	3	4	5
12.	Het is moeilijk voor me om de woorden te vinden die mijn gedachten beschrijven.	5	4	3	2	1
13.	Ik ben snel afgeleid.	5	4	3	2	1
		Nooit of bijna nooit waar	**Zelden waar**	**Soms waar**	**Vaak waar**	**Heel vaak of altijd waar**
14.	Ik heb soms niet normale of slechte gedachten, die ik niet zo zou moeten denken.	5	4	3	2	1
15.	Ik let op lichamelijke ervaringen, zoals de wind in mijn haar of de zon op mijn gezicht.	1	2	3	4	5
16.	Ik heb moeite met het bedenken van de juiste woorden om uit te drukken wat ik	5	4	3	2	1

	van dingen vind.					
17.	Ik oordeel of mijn gedachten goed of fout zijn.	5	4	3	2	1
18.	Ik vind het moeilijk om mijn aandacht te houden bij wat er op dit moment gebeurt.	5	4	3	2	1
19.	Als ik verontrustende gedachten heb of beelden zie, dan laat ik me daar niet door meevoeren.	1	2	3	4	5
20.	Ik let in het algemeen op geluiden zoals het tikken van een klok, het fluiten van de vogels of het voorbijrijden van een auto.	1	2	3	4	5
21.	In moeilijke situaties kan ik me inhouden zonder onmiddellijk te reageren.	1	2	3	4	5
22.	Als ik iets in mijn lichaam voel, kost het me moeite om de juiste woorden te vinden om het te beschrijven.	5	4	3	2	1
23.	Het lijkt alsof ik op de 'automatische piloot' sta zonder dat ik me erg bewust ben van wat ik doe.	5	4	3	2	1
24.	Als ik verontrustende gedachten heb of beelden zie, voel ik me kort daarna weer rustig.	1	2	3	4	5
25.	Ik zeg tegen mezelf dat ik niet moet denken zoals ik denk.	5	4	3	2	1
26.	Ik merk de geur en het aroma van dingen op.	1	2	3	4	5
27.	Zelfs als ik heel erg overstuur ben kan ik dit op een of andere manier onder woorden brengen.	1	2	3	4	5

28.	Ik doe activiteiten gehaast zonder dat ik er echt aandacht voor heb.	5	4	3	2	1
		Nooit of bijna nooit waar	**Zelden waar**	**Soms waar**	**Vaak waar**	**Heel vaak of altijd waar**
29.	Als ik verontrustende gedachten heb of beelden zie, kan ik ze opmerken zonder iets te doen.	1	2	3	4	5
30.	Ik denk dat mijn emoties soms slecht of ongepast zijn en dat ik ze niet zou moeten voelen.	5	4	3	2	1
31.	Ik merk de visuele aspecten van kunst of de natuur op, zoals kleur, vorm, structuur of patronen van licht en donker.	1	2	3	4	5
32.	Het is mijn natuurlijke neiging om mijn ervaringen in woorden te vatten.	1	2	3	4	5
33.	Als ik verontrustende gedachten heb of beelden zie, merk ik ze op en laat ze los.	1	2	3	4	5
34.	Ik doe mijn werk of taken automatisch zonder dat ik me bewust ben van wat ik doe.	5	4	3	2	1
35.	Als ik verontrustende gedachten heb of beelden zie, veroordeel ik mezelf.	5	4	3	2	1
36.	Ik let op hoe mijn emoties mijn gedachten en gedrag beïnvloeden.	1	2	3	4	5

37.	Over het algemeen kan ik in detail beschrijven hoe ik me op dat moment voel.	1	2	3	4	5
38.	Ik merk dat ik vaak dingen doe zonder er aandacht aan te besteden.	5	4	3	2	1
39.	Ik keur mezelf af als ik onlogische gedachtes heb.	5	4	3	2	1

U bent klaar met het invullen van de vragenlijst.

Zou u nog een keer willen nagaan of u echt alle vragen heeft ingevuld? Dat is voor ons erg belangrijk.

HARTELIJK DANK

Appendix 2 Posttest Evaluation-questionnaire

Enschede, 29.12.2010

Beste cursist,

In december heeft u de training ‘Aandachtgerichte cognitieve gedragstherapie’ afgerond.

Aan het begin van de training heeft u aangegeven mee te willen doen aan het onderzoek. Bijgaand treft u de evaluatie-vragenlijst van het onderzoek naar de aandachtstraining. Aan hand van deze vragenlijst zou in kaart gebracht worden hoe u deze training heeft ervaren. We zijn geïnteresseerd in uw eerlijke mening. Zou u deze vragenlijst willen invullen en **binnen 3 dagen** aan ons willen retourneren middels de meegestuurde enveloppe? (postzegel is niet nodig) Dit is voor ons zeer van belang. Alvast hartelijk dank!

Er zal vertrouwelijk worden omgegaan met uw antwoorden, deze zullen volledig anoniem worden verwerkt. Niemand, behalve onderzoekers aan de Universiteit Twente, krijgt inzage in uw antwoorden.

Als u geïnteresseerd bent in de resultaten van dit onderzoek wil ik uw vragen dit op de vragenlijst aan te geven.

Ik wil u nogmaals hartelijk bedanken voor uw medewerking aan dit onderzoek!

Met vriendelijke groet,

Julia Esser

Wendy T.M. Pots

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Onderzoeksnummer:					

Onderzoek Training 'Mindfulness Based Cognitieve therapie'

Evaluatie vragenlijst voor deelnemer

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Evaluatie vragenlijst MBCT

1.Algemeen

Alle volgende vragen hebben alleen betrekking op de Mindfulness-training die u kort geleden bij Dimence in Almelo heeft afgerond. Kruis het antwoord aan wat het meest van toepassing is.

Wat vindt u van de kwaliteit van de MBCT- training die u heeft ontvangen?			
uitstekend	goed	matig	slecht

Heeft u het soort hulp ontvangen dat u hoopte te krijgen?			
nee,beslist niet	nee, nauwelijks	ja, over het algemeen wel	ja, zeker

In hoeverre heeft de MBCT- training aan uw wensen voldaan?			
aan bijna al mijn wensen voldaan	aan de meeste van mijn wensen voldaan	aan de meeste van mijn wensen niet voldaan	aan geen van mijn wensen voldaan

Stel dat een van uw kennissen dezelfde hulp nodig had, zou u dan de MBCT- training aanbevelen?			
Nee, beslist niet	Nee, ik denk van niet	Ja, ik denk van wel	Ja, zeker

Hoe tevreden bent u met de hoeveelheid hulp die u heeft ontvangen?			
Zeer tevreden	Tamelijk tevreden	Tamelijk ontevreden	Zeer ontevreden

Vindt u dat de lengte van de sessies over het algemeen voldoende is geweest?			
Veel te lang	Tamelijk lang	Tamelijk kort	Veel te kort

Vindt u dat u voldoende sessies hebt gehad?			
Veel te veel sessies	Tamelijk veel sessies	Tamelijk weinig sessies	Veel te weinig sessies

Heeft deze cursus u geholpen om anders met uw problemen om te gaan?			
Ja, het heeft aanzienlijk geholpen	Ja, het heeft wel wat geholpen	Nee, het heeft eigenlijk niet geholpen	Nee , het heeft mijn problemen alleen maar verergerd.

Hoe tevreden bent u over het geheel genomen met de hulp die u heeft ontvangen?			
Zeer tevreden	Tamelijk tevreden	Tamelijk ontevreden	Zeer ontevreden

Zou u de cursus nog een keer doen, als u dat nodig zou hebben?			
Beslist niet	Nee, ik denk van niet	Ja, ik denk van wel	Ja, zeker

Opmerkingen

2.Sessies

Aan welke week of weken van de mindfulness-training heeft u het meeste gehad?
Waarom heeft u het meest gehad aan deze week of weken?

Aan welke week of weken van de mindfulness-training heeft u het minste gehad?
Waarom heeft u het minst gehad aan deze weken?

Hoeveel weken heeft u afgerond van de cursus?
Kunt u de reden aangeven waarom u niet alle weken heeft afgerond? (indien van toepassing)

2.1 Setting

	Helemaal mee oneens	Mee oneens	Noch mee eens, noch mee oneens	Mee eens	Helemaal mee eens
Het was goed om te beginnen met drie introductiebijeenkomsten.					
Het evaluatiegesprek na de eerste drie bijeenkomsten was voor mij niet nodig geweest.					
In de groep voelde ik mij op mijn gemak.					
Ik had de cursus liever als individuele training (niet in een groep) gevolgd.					

2.2 Indeling van de sessie

Aan de volgende onderdelen zou ik in een volgende training …			
	meer tijd willen besteden	evenveel tijd willen besteden	minder tijd willen besteden
Huiswerk nabespreken			
Huiswerk uitleg			
Uitleg mindfulness principes			
Ademoefeningen			
Beweegaandachtoefening			
Zitmeditatie			
Nabespreking oefeningen			
Metaforen/gedichten/verhalen			
Ervaringen delen			

3.Mindfulness oefeningen

Hoe vaak per week heeft u gemiddeld de formele mindfulness oefeningen gedaan?				
1dag of minder	2-3dagen	4-5dagen	6-7 dagen	Meerdere keren per dag
Welke formele oefeningen heeft u regelmatig gedaan? (meerdere antwoorden mogelijk)				

Hoe vaak per week heeft u gemiddeld de informele mindfulness oefeningen gedaan?				
1dag of minder	2-3dagen	4-5dagen	6-7 dagen	Meerdere keren per dag
				o
Welke informele oefeningen heeft u regelmatig gedaan? (meerdere antwoorden mogelijk)				

Hoe toepasbaar vindt u de volgende oefeningen in uw dagelijkse leven?					
	Heel goed toepasbaar	Goed toepasbaar	Redelijk toepasbaar	Moeilijk toepasbaar	Heel moeilijk toepasbaar
3 minuten ademruimte					
Body-scan					
Mindfull eten/drinken					
Zitmeditatie					
Beweegmeditatie					
Meditatie gericht op de ademhaling					

Hoe toepasbaar vindt u de volgende oefeningen, met name in probleemsituaties?					
	Heel goed toepasbaar	Goed toepasbaar	Redelijk toepasbaar	Moeilijk toepasbaar	Heel moeilijk toepasbaar
3 minuten ademruimte					
Zitmeditatie					
Beweegmeditatie					
Terugvalpreventieplan					
Body-scan					
Meditatie gericht op de ademhaling					

Hoe bruikbaar denkt u dat de volgende oefeningen zijn over een jaar, om uw stemming positief te beïnvloeden ?					
	Heel goed bruikbaar	Goed bruikbaar	Redelijk bruikbaar	Moeilijk bruikbaar	Helemaal niet bruikbaar
Body-scan					
Zitmeditatie					
Beweegmeditatie					
Terugvalpreventieplan					
3 minuten ademruimte					

4. Materiaal

4.1 begeleidende CD

De begeleidende CD …					
	Helemaal mee oneens	Oneens	Noch mee eens, noch mee oneens	Mee eens	Helemaal mee eens
…was voor mij een behulpzame ondersteuning bij de oefeningen					
…heeft het makkelijker gemaakt met de oefeningen te beginnen					
…zal ik over een half jaar nog gebruiken					
…is voor mij niet geschikt					
…helpt mij in probleemsituaties mijn stemming positief te beïnvloeden					

4.2 Het dagboekformulier

Het dagboekformulier…					
	Helemaal mee oneens	Oneens	Noch mee eens, noch mee oneens	Mee eens	Helemaal mee eens
…is voor mij een behulpzame ondersteuning bij de oefeningen					
…maakt het makkelijker met de oefeningen te beginnen					
…zal ik over een half jaar nog gebruiken					
…is voor mij niet geschikt					

4.3 Het terugvalpreventieplan

Het terugvalpreventieplan…					
	Helemaal mee oneens	Mee oneens	Noch mee eens, noch mee oneens	Mee eens	Helemaal mee eens
…is voor mij niet geschikt					
…helpt mij in probleemsituaties mijn stemming positief te beïnvloeden					
…zal ik over een half jaar nog toepassen					
…helpt mij de signalen te herkennen als een mogelijke terugval dreigt					

4.4 Gebruikte gedichten, metaforen en verhalen

Welk gedicht, metafoor of verhaal uit de cursus was voor u het minst toegankelijk?
En waarom?

Welk gedicht, metafoor of verhaal uit de cursus heeft de meeste indruk op u gemaakt?
En waarom?

Welk gedicht, metafoor of verhaal uit de cursus helpt u in probleemsituaties uw stemming positief te beïnvloeden ?
En waarom?

5. Begeleiding

	Helemaal mee oneens	Mee oneens	Nog mee eens, nog mee oneens	Mee eens	Helemaal mee eens
Ik vond mijn begeleidsters deskundig.					
Ik voelde me begrepen door mijn begeleidsters.					
Ik vond dat mijn begeleidsters goed inhoudelijk feedback gaven.					
Ik vond de samenwerking tussen de twee begeleidsters goed					

Laatste vraag

Welke aanbevelingen voor de verbetering van de Mindfulness-training heeft u?

Hartelijk bedankt voor uw medewerking!

Appendix 3 Interviews and informed consent

Geachte mevrouw/meneer,

Een paar weken geleden heeft u uw toestemming gegeven voor de deelname aan het onderzoek van de Universiteit Twente naar de effecten van de “Mindfulness Based Cognitive Therapie”. Ik wil u daarvoor nogmaals hartelijk danken.

Afgelopen donderdag (7-10-2010) bent u telefonisch op de hoogte gebracht van enkele nieuwe ontwikkelingen binnen dit onderzoek, waarbij een aantal deelnemers van de cursus zullen worden geïnterviewd. In deze brief wil ik u graag schriftelijk informeren over het interview.

Om een beter beeld te kunnen krijgen over de doelgroep en de effecten van deze training zal er met geïnteresseerde deelnemers twee keer een interview worden afgenomen. Wij willen graag een indruk krijgen van onder andere de aanleiding voor deelname aan de training, de klachten van de cursisten, de invloed van deze klachten op hun dagelijks leven en hun verwachtingen van de training. Het eerste interview is telefonisch, duurt circa 20 minuten, en zal al deze week plaatsvinden. Het tweede interview zal aan het einde van de cursus persoonlijk worden afgenomen.

De in het interview verkregen informatie zal samen met informatie uit uw dossier helpen een beter beeld te schetsen van de training en de effecten ervan op het dagelijks leven van de deelnemers. Deze gegevens zullen anoniem in het onderzoeksverslag worden beschreven.

De deelname aan dit interview is uiteraard vrijwillig en vrijblijvend. Deelname verplicht u tot niets en u mag op elk moment stoppen.

Om de informatie uit het interview te kunnen gebruiken heb ik uw schriftelijke toestemming nodig. Als u bereid bent om mee te doen aan het interview zou ik u willen vragen het bijgevoegde toestemmingsformulier te ondertekenen en zo snel mogelijk in de antwoordenvelop te retourneren.

Met vriendelijke groet,

Julia Esser

Wendy Pots

Onderzoeker/ gz-psycholoog
Universiteit Twente
Faculteit Gedragswetenschappen
Afdeling Psychologie & Communicatie van Gezondheid & Risico (PCGR)
do/vr: Universiteit Twente,
Faculteit Gedragswetenschappen,
Citadel, Toren
Postbus 217,
7500 AE Enschede.
E w.t.m.pots@utwente.nl mailto:w.t.m.pots@utwente.nlT (053) 489 4470

Toestemmingsformulier voor de deelname aan het telefoon interview in het kader van het onderzoek naar de effecten van de training „Mindfulness Based Cognitieve Therapie".

Hierbij geef ik toestemming voor de deelname aan het telefoon interview dat wordt gevoerd in het kader van het onderzoek dat wordt uitgevoerd door de Universiteit Twente.

Ik heb gelezen en…

- ik heb begrepen dat ik door het ondertekenen van dit formulier aangeeft vrijwillig deel te nemen aan het telefoon interview;
- ik heb begrepen dat de gegevens uit het interview anoniem worden verwerkt in het onderzoek verslag;
- ik heb begrepen dat ik altijd kan stoppen met het onderzoek en daarmee de verwerking van de gegevens in het onderzoeksverslag, zonder dat dit van invloed is op het doorwerken van der training mindfulness.

Naam:.....

Voorletter(s):.....

Geslacht:.....

Telefoonnummer(s):.....

Email:.....

Datum: Handtekening:

.....

Telefoon interview I

Opbouw

1. Reden van aanmelding
2. Klachten
3. Qualiteit van leven
4. Verwachtingen
5. (meeting 3 ook process analyse/ evaluatie)

1. Reden van aanmelding

1.4) Welk persoonlijke reden hebben ertoe geleidt dat u mee wilde doen aan de MBCT? (Hulpvraag: Met welk probleem zit u? Lijdensgeschiedenis. Overleiding-> klachten)

1.1.a) Heeft u de beslissing om aan deze training mee te doen met familieleden of vrienden besproken? (om niet direkt op de hulpvraag/klachten te komen)

1.1.b) In hoeverre heeft dit gesprek invloed gehad op u deelname ?

1.2.a) Bent u voor de deelname aan deze training al in aanraking gekomen (literatuur, andere training/therapie/ familie etc.) met het onderwerp "Mindfulness"? (check voorkennis)

1.3.b) Zo ja -> Hoe ? En wat waren u ervaringen/indrukken

2.Klachten

2.1) Wanneer heeft u voor het eerst last gehad van u klachten? Wanneer zijn de klachten begonnen? Idee van oorzaak?

2.2.a) Welke klachten zijn dat precies? Waar heeft u last van?

2.2.b)Op een scale van 1 (niet belastend) tot en met 10 (extreem belastend) hoe belastend ervaart u deze klachten?

2.3) Hoe voelt u zich dan als u last heb van ….(invullen naar gelang antwoord van cliënt)?

2.4) Wanneer heeft u het meest last van u klachten? Is dat in samenhang met bepaalde omstandigheden?

2.5) Wanneer heeft u het minst last van u klachten?

2.6) Welk invloed hebben u klachten op u dagelijkse leven?

2.7)Op een schaal van 1 (niet) tot en met 10 (heel sterk)hoe sterk ervaard u de invloed van deze klachten op u dagelijkse leven/ functioneren?

3.Verwachtingen

3.1)Waaraan zal u het eerst merken dat deze training een positief effect heeft? (Antwoord op de hulpvraag)

3.2)Wat zou moeten veranderen om u beter te voelen?

3.3)Hoe logisch lijkt u de aangeboden training?

1=helemaal niet tot 10 =helemaal

3.4) Wat zijn volgens u de doelen van deze cursus?

3.5)Hoe succesvol is deze training, denkt u, in het verminderen van je symptomen?

3.6)Hoe overtuigt zult u deze training aan een vriend met soortgelijke klachten aanbevelen?)

Appendix 4 Curriculum MBCT Dimence

Bijeenkomst 1
-inleidende aandachtsoefening
-rozijnoefening
- automatische piloot + hoe kan mbct helpen?
- bodyscan
- huiswerk voorbespreken
-afsluitende aandachtsoefening

Bijeenkomst 2
-inleidende aandachtsoefening
-nabespreken huiswerk
-ademhaling anker
- zitmeditatie aandacht ademhaling
- begin drie minuten ademruimte
- huiswerk voorbespreken
-afsluitende aandachtsoefening

Bijeenkomst 3
-inleidende aandachtsoefening
-nabespreken huiswerk
- zitmeditatie, aandacht ademhaling en lichaam
- uitleg 3 minuten ademruimte
- 3 minuten ademruimte
- loopmeditatie
- huiswerk voorbespreken
-afsluitende aandachtsoefening

Bijeenkomst 4
-inleidende aandachtsoefening
-nabespreken huiswerk
- zitmeditatie, geluiden en gedachten
- vragenlijst automatische gedachten
- erbij blijven, drie minuten oefening
- huiswerk voorbespreken
-afsluitende aandachtsoefening

Bijeenkomst 5
-inleidende aandachtsoefening
-nabespreken huiswerk
- voorlezen verhaal koning + drie zonen
- thema accepteren
- 3 minuten ademruimte
- herberg
- voorlezen verhaal geluk (paard)
- huiswerk voorbespreken
-afsluitende aandachtsoefening

Bijeenkomst 6
-inleidende aandachtsoefening
-nabespreken huiswerk
- oefening John loopt op straat (zie inleiding hoofdstuk Teasdale, williams, segal)
- uitleg themna: gedachte zijn geen feiten + gedachtes op andere manier bekijken
- oefening: voor jezelf negatieve gedachtes herkennen
- omgaan met gedachtes 1 + 2
- doodgewaande zoon
- huiswerk voorbespreken
-afsluitende aandachtsoefening

Bijeenkomst 7
-inleidende aandachtsoefening
-nabespreken huiswerk
- plus en min activiteiten. Uitgebreid bespreken wat doet goed
- huiswerk voorbespreken
-afsluitende aandachtsoefening

Bijeenkomst 8
-Inleidende aandachtsoefening
-nabespreken huiswerk
- terugvalpreventieplan. Met name wat staat in deel 1. Wanneer merk je in het begin dat het niet goed met je gaat? Op verschillende domeinen
* persoonlijke verzorging
* sociale relaties
* gezin
* huishouden en administratie
* hobby's
* werk
* eten/drinken
* slapen
Samen naar kijken
- afsluitende aandachtsoefening

Appendix 5 Final interview and inform consent video recoding

Interview therapie evaluatie MBCT

1.Klachten

1.1a)Welke klachten zijn nog niet verandert?

- ➔ b)Welke klachten zijn verandert?

1.2a)Welke doelen zijn nog niet bereikt? (doelen uit het eerste interview)

- ➔ b)Welke doelen zijn bereikt?

1.3)In het verleden was u vaak angstig/depressief/onrustig. Wanneer door de therapie heeft u gemerkt dat het minder werd of helemaal verdween?

1.4)Waaraan herkent u dat u al een stukje minder angstig/ depressief/onrustig bent?

1.5)Wat heeft u bemerkt, dat zich sinds de therapie misschien verbetert heeft? met betrekking op u

- ➔ a)vaardigheiden in het dagelijkse leven
- ➔ b)privéleven/relaties
- ➔ c)beroep

1.6)Welk ervaring in de therapie was bijzonder belangrijk voor u?

1.7)Waaraan merkt, in uw mening, uw omgeving dat de therapie u hebt geholpen?

1.8)Waaraan merkt u zelf dat u en stap verder bij uw therapeutisch doel bent gekomen?

1.9)Op een schaal van 1 (niet belastend) tot en met 10 (extreem belastend) hoe belastend ervaart u uw klachten?

2.Algemeen

(1=helemaal niet tot 10 =helemaal)

2.1)Hoe successvol was dit training ,denkt u, in het verminderen van je symptomen?

2.2)Hoe overtuigt zal u dit training aan een vriend met soortgelijke klachten aanbevelen?

2.3)Hoe veel ,denkt u, zijn u symptomen/klachten verbeteren?

2.4)Welk cijfer zou u de zelfhulpcursus geven op een schaal van 1 (heel slecht) tot 10 (heel goed)?

3.Sessies

3.1)Aan welke week of weken van de cursus heeft u het meest gehad? Waarom?

3.2) Aan welke week of weken van de cursus heeft u het minst gehad? Waarom?

3.3)Wat vindt u van de setting van de cursus ?

- ➔ a)Groep
- ➔ b)Tijdstip
- ➔ c)Duur

3.4)Hoe heeft u de beleiding in de cursus ervaren?

4. Mindfulness oefeningen

4.1)Hoe heeft u de oefeningen gedurende de sessies ervaren?

4.2)Welke ervaring was bijzonder belangrijk voor u?

4.3)Wat vond u van de oefeningen thuis?:

4.3a)Welke ervaringen heeft u gemaakt?

4.5)Welke ervaring was bijzonder belangrijk voor u?

4.6) In vergelijking met therapieën die u al eerder heeft gedaan: Wat was anders?

5.Eind

5.1) Wat , dat u tot nu toe nog niet heeft bereikt, zal u nog graag bereiken?

Toestemmingsformulier voor de deelname aan de video opname van het evaluatie-interview van de training „Mindfulness Based Cognitieve Therapie".

Hierbij geef ik toestemming dat het evaluatie interview dat plaats vindt in het kader van het onderzoek naar de effecten van MBCT bij Dimence, op video wordt opgenomen.

Ik heb de informatiebrief gelezen en…

- ik heb begrepen dat ik door het ondertekenen van dit formulier aangeef vrijwillig deel te nemen aan het onderzoek;
- ik heb begrepen dat de gegevens anoniem en vertrouwelijk worden behandeld en na dit onderzoek worden vernietigd;
- ik heb begrepen dat de opgenomen video alleen door de betrokken onderzoekers van de Universiteit Twente en de psychologen van Dimence bekeken mag worden.

Naam:……

Voorletter(s):……

Geslacht:……

Adres:……

Postcode/plaats:……

Telefoonnummer(s):……

Email:……

Datum: Handtekening:

……

Appendix 6 General Evaluation

1. General evaluation

1.1 Wat vindt u van de kwaliteit van de MBCT- training die u heeft ontvangen?			
uitstekend	goed	matig	slecht
0	85.7% (6)	14.3% (1)	0

1.2 Heeft u het soort hulp ontvangen dat u hoopte?			
nee, beslist niet	nee, nauwelijks	ja, over het algemeen wel	ja, zeker
0	0	85.7% (6)	14.3% (1)

1.3 In hoeverre heeft de MBCT- training aan uw wensen voldaan?			
Ja, bijna aan al mijn wensen voldaan	Ja, aan de meeste van mijn wensen voldaan	Nee, aan de meeste van mijn wensen niet voldaan	Nee, aan geen van mijn wensen voldaan
28.6% (2)	71.4% (5)	0	0

1.4 Stel dat een van uw kennissen dezelfde hulp nodig had, zou u dan de MBCT- training aanbevelen?			
Nee, beslist niet	Nee, ik denk van niet	Ja, ik denk van wel	Ja, zeker
0	0	28.6% (2)	71.4% (5)

1.5 Hoe tevreden bent u met de hoeveelheid hulp die u heeft ontvangen?

Zeer tevreden	Tamelijk tevreden	Tamelijk ontevreden	Zeer ontevreden
71.4% (5)	28.6% (2)	0	0

1.6 Vindt u dat de lengte van de sessies over het algemeen voldoende is geweest?

Veel te lang	Tamelijk lang	Tamelijk kort	Veel te kort
0	57.1% (4)	42.9% (3)	0

1.7 Vindt u dat u voldoende sessies hebt gehad?

Veel te veel sessies	Tamelijk veel sessies	Tamelijk weinig sessies	Veel te weinig sessies
0	14.3% (1)	85.7% (6)	0

1.8 Heeft deze cursus u geholpen om anders met uw problemen om te gaan?

Ja, het heef aanzienlijk geholpen	Ja het heeft wel geholpen	Nee, het heeft eigenlijk niet geholpen	Nee, het heeft mijn problemen alleen maar verergerd
28.6% (2)	71.4% (5)	0	0

1.9 Hoe tevreden bent u over het geheel genomen met de hulp die u heeft ontvangen?

Zeer tevreden	Tamelijk tevreden	Tamelijk ontevreden	Zeer ontevreden
71.4% (5)	28.6% (2)	0	0

1.10 Zou u de cursus nog een keer doen, als u dat nodig zou hebben?

Beslist niet	Nee, ik denk van niet	Ja, ik denk van wel	Ja, zeker
0	0	28.6% (2)	71.4% (5)

Appendix 7 Setting

2.1 Setting

	Helemaal mee oneens	Mee oneens	Noch mee eens, noch mee oneens	Mee eens	Helemaal mee eens
2.11 Het was goed om te beginnen met drie introductiebijeenkomsten.	0	0	0	71.4% (5)	28.6% (2)
2.12 Het evaluatiegesprek na de eerste drie bijeenkomsten was voor mij niet nodig geweest.	0	28.6% (2)	57.1% (4)	14.3% (1)	0
2.13 In de groep voelde ik mij op mijn gemak.	0	14.3% (1)	14.3% (1)	28.6% (2)	42.9% (3)
2.14 Ik had de cursus liever als individuele training (niet in een groep) gevolgd.	14.3% (1)	57.1% (4)	14.3% (1)	14.3% (1)	0

Appendix 8 Schedule

2.2 Session Schedule

2.2 Aan de volgende onderdelen zou ik in een volgende training …			
	meer tijd willen besteden	evenveel tijd willen besteden	minder tijd willen besteden
2.21 Huiswerk nabespreken	28.6% (2)	28.6% (2)	42.9% (3)
2.22 Huiswerk uitleg	71.4% (5)	28.6% (2)	0
2.23 Uitleg mindfulness principes	28.6% (2)	71.4% (5)	0
2.24 Ademoefeningen	85.7% (6)	14.3% (1)	0
2.25 Beweegaandachtoefening	71.4% (5)	28.6% (2)	0
2.26 Zitmeditatie	71.4% (5)	28.6% (2)	0
2.27 Nabespreking oefeningen	42.9% (3)	57.1% (4)	0
2.28Metaforen/gedichten /verhalen	14.3% (1)	71.4% (5)	14.3% (1)
2.29 Ervaringen delen	28.6% (2)	57.1% (4)	14.3% (1)

Appendix 9 Discipline

3.1 Frequency of homework

3.11 Hoe vaak per week heeft u gemiddeld de formele mindfulness oefeningen gedaan?				
1 dag of minder	2-3 dagen	4-5 dagen	6-7 dagen	Meerdere keren per dag
0	28.6% (2)	42.9% (3)	28.6% (2)	0
3.12 Hoe vaak per week heeft u gemiddeld de informele mindfulness oefeningen gedaan?				
1 dag of minder	2-3 dagen	4-5 dagen	6-7 dagen	Meerdere keren per dag
0	28.6% (2)	14.3% (1)	42.9% (3)	14.3% (1)

Appendix 10 Applicability in daily life

3.2Applicability in daily life

Hoe toepasbaar vindt u de volgende oefeningen in uw dagelijkse leven?					
	Heel goed toepasbaar	Goed toepasbaar	Redelijk toepasbaar	Moeilijk toepasbaar	Heel moeilijk toepasbaar
3 minuten ademruimte	57.1% (4)	42.9% (3)	0	0	0
Body-scan	0	28.6% (2)	57.1% (4)	14.3% (1)	0
Mindfull eten/drinken	0	28.6% (2)	28.6% (2)	42.9% (3)	0
Zitmeditatie	14.3% (1)	14.3% (1)	42.9% (3)	28.6% (2)	0
Beweegmeditatie	14.3% (1)	14.3% (1)	28.6% (2)	42.9% (3)	0
Meditatie gericht op de ademhaling	28.6% (2)	14.3% (1)	57.1% (4)	0	0

Appendix 11 Applicability in problem situations

3.3 Applicability in problematic situation

Hoe toepasbaar vindt u de volgende oefeningen, met name in probleemsituaties?					
	Heel goed toepasbaar	Goed toepasbaar	Redelijk toepasbaar	Moeilijk toepasbaar	Heel moeilijk toepasbaar
3 minuten ademruimte	28.6% (2)	57.1% (4)	14.3% (1)		0
Zitmeditatie	14.3% (1)	14.3% (1)	28.6% (2)	42.9% (3)	0
Beweegmeditatie	14.3% (1)	14.3% (1)	57.1% (4)	14.3% (1)	0
Terugvalpreventieplan	14.3% (1)	0	42.9% (3)	42.9% (3)	0
Body-scan	0	0	85.7% (6)	14.3% (1)	0
Meditatie gericht op de ademhaling	28.6% (2)	14.3% (1)	57.1% (4)	0	0

Appendix 12 Long-term usability

3.4 Long-term usability

Hoe toepasbaar vindt u de volgende oefeningen, met name in probleemsituaties?					
	Heel goed toepasbaar	Goed toepasbaar	Redelijk toepasbaar	Moeilijk toepasbaar	Heel moeilijk toepasbaar
3 minuten ademruimte	42.9% (3)	57.1% (4)	0	0	0
Zitmeditatie	28.6% (2)	28.6% (2)	42.9% (3)	0	0
Beweegmeditatie	28.6% (2)	0	57.1% (4)	14.3% (1)	0
Terugvalpreventieplan	0	28.6% (2)	42.9% (3)	28.6% (2)	0
Body-scan	14.3% (1)	85.7% (6)	0		0

Appendix 13 Exercises

3.21 Evaluation 3 minute meditation

3.21a Hoe toepasbaar vindt u de oefeningen in uw dagelijkse leven?

Heel goed toepasbaar	Goed toepasbaar	Redelijk toepasbaar	Moeilijk toepasbaar	Heel moeilijk toepasbaar
57.1% (4)	42.9% (3)	0	0	0

3.21b Hoe toepasbaar vindt u de oefeningen, met name in probleemsituaties?

Heel goed toepasbaar	Goed toepasbaar	Redelijk toepasbaar	Moeilijk toepasbaar	Heel moeilijk toepasbaar
28.6% (2)	57.1% (4)	14.3% (1)	0	0

3.21c Hoe bruikbaar denkt u dat de oefeningen zijn over een jaar, om uw stemming positief te beinvloeden?

Heel goed bruikbaar	Goed bruikbaar	Redelijk bruikbaar	Moeilijk bruikbaar	Heel moeilijk bruikbaar
42.9% (3)	57.1% (4)	0	0	0

3.22 Body-scan

3.22a Hoe toepasbaar vindt u de volgende oefeningen in uw dagelijkse leven?

Heel goed toepasbaar	Goed toepasbaar	Redelijk toepasbaar	Moeilijk toepasbaar	Heel moeilijk toepasbaar
0	28.6% (2)	57.1% (4)	14.3% (1)	0

322b Hoe toepasbaar vindt u de volgende oefeningen, met name in probleemsituaties?

Heel goed toepasbaar	Goed toepasbaar	Redelijk toepasbaar	Moeilijk toepasbaar	Heel moeilijk toepasbaar
0	0	85.7% (6)	14.3% (1)	0

3.22c Hoe bruikbaar denkt u dat de volgende oefeningen zijn over een jaar, om uw stemming positief te beinvloeden?

Heel goed bruikbaar	Goed bruikbaar	Redelijk bruikbaar	Moeilijk bruikbaar	Heel moeilijk bruikbaar
14.3% (1)	85.7% (6)	0	0	0

3.23 Zitmeditatie

Hoe toepasbaar vindt u de volgende oefeningen in uw dagelijkse leven?

Heel goed toepasbaar	Goed toepasbaar	Redelijk toepasbaar	Moeilijk toepasbaar	Heel moeilijk toepasbaar
14.3% (1)	14.3% (1)	42.9% (3)	28.6% (2)	0

Hoe toepasbaar vindt u de volgende oefeningen, met name in probleemsituaties?

Heel goed toepasbaar	Goed toepasbaar	Redelijk toepasbaar	Moeilijk toepasbaar	Heel moeilijk toepasbaar
14.3% (1)	14.3% (1)	28.6% (2)	42.9% (3)	0

Hoe bruikbaar denkt u dat de volgende oefeningen zijn over een jaar, om uw stemming positief te beinvloeden?

Heel goed bruikbaar	Goed bruikbaar	Redelijk bruikbaar	Moeilijk bruikbaar	Heel moeilijk bruikbaar
28.6% (2)	28.6% (2)	42.9% (3)	0	0

3.24 Beweegmeditatie

Hoe toepasbaar vindt u de volgende oefeningen in uw dagelijkse leven?

Heel goed toepasbaar	Goed toepasbaar	Redelijk toepasbaar	Moeilijk toepasbaar	Heel moeilijk toepasbaar
14.3% (1)	14.3% (1)	28.6% (2)	42.9% (3)	0

Hoe toepasbaar vindt u de volgende oefeningen, met name in probleemsituaties?

Heel goed toepasbaar	Goed toepasbaar	Redelijk toepasbaar	Moeilijk toepasbaar	Heel moeilijk toepasbaar
14.3% (1)	14.3% (1)	57.1% (4)	14.3% (1)	0

Hoe bruikbaar denkt u dat de volgende oefeningen zijn over een jaar, om uw stemming positief te beinvloeden?

Heel goed bruikbaar	Goed bruikbaar	Redelijk bruikbaar	Moeilijk bruikbaar	Heel moeilijk bruikbaar
28.6% (2)	0	57.1% (4)	14.3% (1)	0

3.25 Meditatie gericht op de ademhaling

Hoe toepasbaar vindt u de volgende oefeningen in uw dagelijkse leven?

Heel goed toepasbaar	Goed toepasbaar	Redelijk toepasbaar	Moeilijk toepasbaar	Heel moeilijk toepasbaar
28.6% (2)	14.3% (1)	57.1% (4)	0	0

Hoe toepasbaar vindt u de volgende oefeningen, met name in probleemsituaties?

Heel goed toepasbaar	Goed toepasbaar	Redelijk toepasbaar	Moeilijk toepasbaar	Heel moeilijk toepasbaar
28.6% (2)	14.3% (1)	57.1% (4)	0	0

3.26 Terugvalpreventieplan

Hoe toepasbaar vindt u de volgende oefeningen, met name in probleemsituaties?

Heel goed toepasbaar	Goed toepasbaar	Redelijk toepasbaar	Moeilijk toepasbaar	Heel moeilijk toepasbaar
14.3% (1)	0	42.9% (3)	42.9% (3)	0

Hoe bruikbaar denkt u dat de volgende oefeningen zijn over een jaar, om uw stemming positief te beinvloeden?

Heel goed bruikbaar	Goed bruikbaar	Redelijk bruikbaar	Moeilijk bruikbaar	Heel moeilijk bruikbaar
0	28.6% (2)	42.9% (3)	28.6% (2)	0

3.27 Mindfull eten/drinken

Hoe toepasbaar vindt u de volgende oefeningen in uw dagelijkse leven?

Heel goed toepasbaar	Goed toepasbaar	Redelijk toepasbaar	Moeilijk toepasbaar	Heel moeilijk toepasbaar
0	28.6% (2)	28.6% (2)	42.9% (3)	0

Appendix 14 Material

4.Material

4.1 Evaluation CD					
De begeleidende CD …	Fully agree	Agree	Neither agree, nor disagree	Disagree	Completely disagree
4.11…was voor mij een behulpzame ondersteuning bij de oefeningen	57.1% (4)	28.6% (2)	14.3% (1)	0	0
4.12…heeft het makkelijker gemaakt met de oefeningen te beginnen	57.1% (4)	28.6% (2)	14.3% (1)	0	0
4.13…zal ik over een half jaar nog gebruiken	42.9% (3)	28.6% (2)	14.3% (1)	0	14.3% (1)
4.14…is voor mij niet geschikt	0	0	0	42.9% (3)	57.1% (4)
4.15…helpt mij in probleemsituaties mijn stemming positief te beïnvloeden	14.3% (1)	14.3% (1)	42.9% (3)	28.6% (2)	0

4.2 Evaluation Diary					
Het dagboek formulier …	Fully agree	Agree	Neither agree, nor disagree	Disagree	Completely disagree
4.21…was voor mij een behulpzame ondersteuning bij de oefeningen		28.6% (2)	71.4% (5)	0	0
4.22…heeft het makkelijker gemaakt met de oefeningen te beginnen	14.3% (1)	14.3% (1)	57.1% (4)	14.3% (1)	
4.23…zal ik over een half jaar nog gebruiken	0	14.3% (1)	14.3% (1)	71.4% (5)	0
4.24…is voor mij niet geschikt	14.3% (1)	0	0	57.1% (4)	28.6% (2)

4.3 Evaluation Relapse-Prevention-Plan					
Het terugvalpreventieplan …	Fully agree	Agree	Neither agree, nor disagree	Disagree	Completely disagree
4.31…helpt mij de signalen te herkennen als een mogelijke terugval dreigt	0	57.1% (4)	42.9% (3)	0	0
4.32…zal ik over een half jaar nog gebruiken	0	42.9% (3)	42.9% (3)	14.3% (1)	0
4.33…is voor mij niet geschikt	0	14.3% (1)	14.3% (1)	28.6% (2)	42.9% (3)
4.34…helpt mij in probleemsituaties mijn stemming positief te beïnvloeden	0	42.9% (3)	57.1% (4)	0	0

Appendix 15 Guidance/Therapists

5. Guidance/Therapists

5.Evaluation guidance/ therapists					
	Completely agree	Agree	Neither agree, nor disagree	Disagree	Completely disagree
5.1 Ik vondt mijn begeleidsters deskundig	28.6% (2)	57.1% (4)	0	14.3% (1)	0
5.2 Ik voelde mij begepen door mijn begeleidsters	28.6% (2)	57.1% (4)	0	0	14.3% (1)
5.3 Ik vondt dat mijn begeleidsters goed inhoudelijk feedback gaven	0	85.7% (6)	0	14.3% (1)	0
5.4 Ik vondt de samenwerking tussen de begeleisdsters goed	0	71.4% (5)	14.3% (1)	14.3% (1)	0