

Psychotherapeutic practitioners' views of the efficacy of mindfulness for the treatment of Obsessive-Compulsive Disorder: A qualitative key informant analysis

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Abstract

Objectives: A substantial proportion of individuals affected by Obsessive-Compulsive Disorder (OCD) are not experiencing adequate therapeutic outcomes from current standard psychotherapeutic treatments. Mindfulness has had a positive therapeutic impact on many symptoms associated with OCD. This study investigated the views of experienced psychotherapeutic practitioners concerning the potential efficacy of mindfulness as a therapeutic intervention for individuals with OCD.

Method: Six psychotherapeutic professionals experienced in using mindfulness with individuals affected by OCD were interviewed. Data were subjected to thematic analysis. **Results:** Participants reported that engaging in mindfulness enabled people with OCD to experience an altered relationship with their symptoms and self. This new attitude, in conjunction with cognitive behavioural therapy, was perceived as helping individuals to manage their OCD in an effective and healthy way. However, participants were unsure whether an exclusively mindfulness-based treatment would be effective. **Conclusion:** This study indicates the potential for mindfulness practice to constitute a valuable therapeutic resource in helping people to manage their OCD experience. Implications for future research and practice are considered.

Key words: cognitive behavioural therapy; intrusive thoughts, mindfulness;
Obsessive-Compulsive Disorder; thematic analysis.

Practitioner Points:

- This research highlights a natural, non-invasive therapeutic option for the alleviation of OCD, a condition known for its treatment resistance and limited long-term therapeutic outcomes.
- This study supports research on the potential for mindfulness to reduce cognitive biases thought to be responsible for the development of obsessions, and research on the use of mindfulness to enhance CBT protocols.
- This research provides insight into the practical use of mindfulness in individual therapy and draws attention to common constraints experienced when applying mindfulness in a therapeutic environment.

Introduction

Obsessive-compulsive disorder (OCD) has been estimated to be the fourth most common mental health disorder, with a lifetime prevalence of between 1.6% and 2.3% and a point prevalence of approximately 1% of the population (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005; Kessler, Chiu, Demler, Merikangas, & Walters, 2005; Ruscio, Stein, Chiu, & Kessler, 2010; Wittchen & Jacobi, 2005). This heterogeneous condition is characterized by unwanted and intrusive thoughts, obsessions, compulsions or both, accompanied by marked anxiety or distress (American Psychiatric Association, 2013). These can seriously disrupt the day-to-day functioning of affected individuals. For some time, the recommended evidence-based psychological treatment for OCD has been Cognitive Behavioural Therapy (CBT) (National Institute for Health and Care Excellence, 2005). This accessible model of intervention invites individuals to exert conscious attention on their behaviour and thought processes to bring about change (Leary, Adams, & Tate, 2006). It has been effective in diminishing overt compulsions that often occur in response to obsessions (Fairfax, 2008). However it fails to provide a positive treatment outcome for between a third and half of mental health service users with OCD (Schruers, Koning, Luermans, Haack, & Griez, 2005). With a high dropout rate (Mancebo, Pinto, Rasmussen, & Eisen, 2008) and supplementary therapeutic treatment often needed to maintain any therapeutic gains, CBT does not effectively address clinical problems and provide satisfactory outcomes for many people with OCD (Rufer et al., 2005). There is therefore a need to consider and assess alternative and/or additional intervention possibilities.

Mindfulness is an ancient Eastern spiritual construct most usually associated with Buddhism that, at its heart, involves intentionally attending to the present moment with an accepting and non-judgemental stance (Kabat-Zinn, 1994; Nhat Hanh, 2008). In psychological terms, this can be thought of as a metacognitive decentering, with a shift in experiential perspective from within one's subjective experience *onto* that experience. Over the past 20 years, mindfulness has been conceptualized as a set of skills that can be taught and developed independently of any religious system. It has been successfully used in the treatment of various psychological problems, including anxiety (Zhang et al., 2015), recurrent depression (Crane et al., 2014), intrusive images (McManus et al., 2015) and trauma (Kelly, 2015), often within cognitive behavioural approaches (for example, in Mindfulness-Based Cognitive Therapy – Segal et al., 2002). The adoption of mindfulness by psychotherapy has not gone unchallenged, however. For example, there has been an ongoing debate as to whether the promotion of mindfulness as a set of skills rather than a spiritual practice prevents individuals from looking at the spiritual significance of their struggles (Olson, 2003).

In relation to OCD, the focus of a mindfulness-based approach would not be on the symptoms but on an individual's attachment to them. Such an approach would not teach the individual to change their obsessional mode of thinking but would work on the hypothesis that acceptance of one's internal struggle will bring psychological relief (Bishop et al., 2004; Kabat-Zinn, 1994). It is this shift in focus, where individuals become objective observers of the workings of their internal processes, that theorists such as Hanstede, Gidron and Nyklicek (2008) proposed could 'defuse' the cognitive biases thought to be responsible for everyday unwanted thoughts

developing into obsessions. These biases, seen as central to OCD, are referred to as thought-action fusion (TAF) (Rachman, 1997) and thought-fusion fusion (TFF) (Aardema & O'Connor, 2003). In TAF, thoughts are given the same value as or are believed to be determinants of real actions. In TFF, the person is constantly attempting not to have the thoughts that provide evidence that their self is 'dangerous' or 'evil'. However, attempting not to have the thoughts implies to the person that the thoughts are possible. Preliminary research by Hanstede et al. (2008) did indeed show that by practising mindfulness, individuals learned to perceive thoughts without giving them undue meaning or significance. Consequently they were more able to 'let go' of the thoughts without the need for compensatory behaviours.

People with OCD that is treatment-resistant tend to suffer predominantly from obsessions rather than compulsions and/or from depression (Aardema & O'Connor, 2007; Hyman & Pedrick, 1999). Mindfulness has been shown to be effective in reducing the frequency of obsessions and associated distress (Hanstede et al., 2008; O'Sullivan, 2006) as well as having clinically significant effects in alleviating depression (Crane et al., 2014; Ma & Teasdale, 2004; Teasdale et al., 2000). In addition, when integrated with behavioural exposure therapies, mindfulness has been shown to produce a substantial decline in OCD symptoms among those service users seen as 'refractory' to traditional CBT (O'Neill et al., 2013).

Despite the positive impact of mindfulness on many symptoms and conditions associated with OCD, relatively little research has been conducted on the therapeutic

use of mindfulness for OCD. The present study addresses this by qualitatively exploring the views of experienced psychotherapeutic practitioners concerning mindfulness as a treatment option for OCD, including the perceived processes by which mindfulness might alleviate symptoms of OCD and/or render the OCD experience more tolerable for affected persons. Practitioners with substantial experience of using mindfulness to address OCD symptoms can act as ‘key informants’, sharing their own views and experiences and commenting from their informed positions on the views and experiences of others in their field (Gilchrist, 1992).

However, it is important to note that concerns have been raised over whether mindfulness practice could provoke additional distressing anxiety for people who are already highly anxious over the power of their own thoughts. For example, participants in Hertenstein et al.’s (2012) study reported the challenge of applying mindful awareness to ‘highly automatized’ OCD rituals and drew attention to the tendency of people with OCD to turn mindfulness into a compulsive ritual in itself. These concerns have prompted the suggestion that mindfulness might be better introduced for relapse prevention after an individual’s psychological difficulties have been addressed by psychotherapy (Epstein, 2007). Given the heterogeneity of the clinical presentation of OCD, it has also been suggested that a tailored approach to the therapeutic use of mindfulness may be advisable (Wilkinson-Tough, Bocci, Thorne, & Herlihy, 2010). The current study aims to examine experienced psychotherapeutic practitioners’ views about these concerns.

Method

Participants

Psychotherapeutic practitioners were sought who had substantial experience of using mindfulness in their practice (that is, for at least two years) and using it with clients specifically to address symptoms of OCD. Invitations to participate were emailed to members of the British Psychological Society, the British Association for Counselling and Psychotherapy and the United Kingdom Council for Psychotherapy who described themselves as having clinical experience in using mindfulness and in working with clients with OCD. Six participants were recruited who met the stated criteria. A deliberately small sample was recruited to allow detailed engagement with perceptions, understandings and experiences. A sample of six is not unusual in qualitative research with an idiographic focus (for example, see Smith & Eatough, 2016) and is appropriate for the analytic approach used in this study (Clarke & Braun, 2016).

Three participants were male and three female. Their mean age was 42 years (SD 8.4). Four described themselves as White British and two as White European. Three were Counselling Psychologists, two were Clinical Psychologists and one was a CBT Psychotherapist. Their relevant therapeutic trainings had been accredited by one of the bodies through which participants had been recruited. All six participants used CBT as their main therapeutic model. All but one had first encountered mindfulness during their therapeutic training or practice. All had used mindfulness within a CBT framework when working with clients with OCD. All had conducted this work with

individual clients in British National Health Service (NHS) and/or private settings and one had also done so in group settings. All had experience of past or ongoing personal mindfulness practice. Five participants deemed this primarily a well-being practice rather than an explicitly spiritual, Buddhist endeavour.

Procedure

Data were generated through individual semi-structured interviews lasting 30-60 minutes. These were conducted by the first author face-to-face (in five cases) or by phone (in one case). The interview schedule consisted of open-ended questions that asked participants what mindfulness meant to them; how (if at all) they believed mindfulness worked therapeutically for individuals experiencing OCD symptoms; views on debates about the ‘adoption’ or ‘appropriation’ of mindfulness in therapeutic practice; and views on the future role of mindfulness as an intervention for people with OCD. Participants were encouraged to ground their responses in their experience and, in keeping with their role as key informants, in the experience of practitioners with whom they were familiar. Interviews were audio-recorded and transcribed.

Analytic strategy

Transcripts were analysed using a version of thematic analysis that has become popular within psychology and the social and health sciences in recent years due largely to the fact that it is not wedded to any particular theoretical or epistemological position and to its more general flexibility (Braun & Clarke, 2006; Clarke & Braun, 2016). In this study, the data were considered from a critical realist position: the reality of the phenomena under investigation is acknowledged

but the only access available to these phenomena is through the participants' and the researchers' interpretative lenses. Following Braun and Clarke's (2006) phases of thematic analysis, the researchers undertook a process of familiarization with the data, generating initial codes, developing themes, and selecting key data extracts to illustrate the overall story of the analysis, with the researchers checking each other's theme development to guard against idiosyncratic readings of the data.

Findings

Four themes and associated sub-themes were generated. The first theme, 'The processes by which mindfulness engages with OCD symptoms', addresses participants' understandings of the major processes by which mindfulness makes a therapeutic impact on OCD. Participants described diverse ways of introducing mindfulness to clients and adapting it to practitioners' therapeutic approaches. They advanced a shared assumption that individuals presenting with OCD experience severe anxiety because of the loaded meanings they attribute to their intrusive thoughts and feelings, reflecting how they see themselves as moral beings as well as the likelihood of their thoughts turning into reality. Mindfulness was viewed by the participants as being able to remedy this by offering an alternative attitude to symptoms that brought a more compassionate awareness to clients' intrusive experiences.

The theme entitled 'The nature of the OCD condition that influences the therapeutic potential of mindfulness' reflects a common experience reported by practitioners that clients would often use mindfulness as a neutralizing ritual. Subsequently,

participants emphasized the importance of a mindfulness-based treatment approach that is tailored to the individual, alongside constant checking-in with clients to clarify the basic assumptions of mindfulness. That being said, the sub-theme of ‘Mindfulness as an intuitive approach’ addressed what participants perceived as a natural fit between mindfulness and OCD (intervention). The OCD condition was thus perceived as both potentially suiting *and* potentially undermining the implementation of mindfulness as a therapeutic practice and resource.

The third and fourth themes take a broader view of the contexts in which mindfulness is implemented and the impact it has on clients’ therapeutic experience. The third theme, ‘The necessity of CBT for OCD’, relates to the pervasiveness of CBT within the treatment of OCD. It looks at how, rather than being used as a sole intervention for OCD, mindfulness has to be adapted to work alongside a long-standing treatment protocol that takes precedence within interventions. None of the participants described using a purely mindfulness-based approach to treat OCD. The value of mindfulness was perceived to lie in its capacity to add to traditional, evidence-based approaches to OCD. Although it was perceived to have a lot to offer, mindfulness was seen as lacking a (sufficiently complex) psychological understanding of OCD and the behavioural component that was viewed as essential for putting cognitive change into action.

The fourth theme, ‘NHS and research constraints’, reflects participants’ frequent references to the restrictions that they and colleagues/peers experienced when attempting to provide clients with the most contemporary treatment and with ethical and boundaried practice within the NHS. Their main concern was the perceived lack

of a substantial evidence base for mindfulness as a treatment approach that left them questioning the extent to which they and other practitioners would be permitted use mindfulness with their clients. The sub-theme ‘Mindfulness as a way of being or a tool for OCD?’ related to the NHS context where mindfulness was viewed as being promoted as a ‘self-help’ tool that clients could acquire within a few weeks. This conflicted with participants’ understanding that, in its pure and therapeutic forms, mindfulness is essentially a ‘way of being’ that ideally requires an on-going dedication to its practice. Although participants’ talk focused on NHS settings here, their concern reflects broader debates about the nature of mindfulness and its use in therapeutic interventions.

Due to space limitations, only one theme and its sub-themes will be discussed in detail: ‘Processes by which mindfulness engages with OCD symptoms’. This theme was selected on account of its importance in answering a central part of the research question. The other three themes, although valuable, contributed more to expanding the wider picture of using mindfulness in the clinical field. In the data excerpts that illustrate the analysis, text that appears within square brackets has been added for clarification and ellipses indicate a pause in speech.

Processes by which mindfulness engages with OCD symptoms

(i) ‘Observer self’ as an antidote to the intrusive experience/Thought-action defusion

When asked how they thought mindfulness worked therapeutically (if at all) for people with OCD, the emphasis was not on remedying the symptoms but enabling

people to look at them in a different light, from a position of acceptance and neutrality:

It's not about alleviation of the symptoms or the alleviation of anything. It's about altering how we relate to ourselves and our internal stuff. So in OCD obviously a lot of what people have is an internal world that is very marked by worries about intrusive thoughts about what might happen if x, y and z [] Now mindfulness is about cultivating the ability to observe our thought processes from a distance without getting pulled into them, [] recognising that they are not the factual account of the world, they're not reality so one can observe from a distance with less well emotions. (Eric)

Whilst talking about this process, it felt important for this participant to stress that mindfulness was not about effecting change or reducing symptoms of distress. He spoke as if it were a common experience for mindfulness to be misconstrued as a method for 'curing' anxiety and, like other participants, expressed a concern that this misconception worked against the therapeutic processes of mindfulness. Other participants were more open to the idea of clients believing they were using mindfulness to reduce their anxiety levels. This might have been a reflection of participants' differing perceptions of how readily compatible the nature of mindfulness is with its use as a therapeutic resource. Some represented both 'pure' and therapeutic forms as a 'way of being' and 'lived experience' in a manner that queried the therapeutic instrumentalization of mindfulness. Others seemed at ease with the therapeutic use of mindfulness, while, as noted earlier, seeing it as requiring commitment on the part of clients.

An individual's attachment to their intrusive thoughts was identified as the main reason why suffering occurs in OCD. Participants suggested that if an individual could perceive their thoughts, feelings and images from a more removed position, not succumbing to their emotional pull, then a sense of freedom from their obsessive mind could be regained. In reflecting on this, Max drew upon his experience with a client:

It was his ability to disassociate with the thoughts and feelings to detachment, which is the essence of the Buddhist approach-non-attachment, which enabled him to separate himself in situations, whereas previously he would have been caught up. [] It helps clients a lot, particularly the ability to identify obsessive thinking and not to attach to it, to view obsessive thinking unemotionally.

(Max)

Although all participants spoke of the 'pull' of emotions being a core aspect of the development of obsessive thoughts, for some the ability to cultivate the 'observer self' in relation to the thoughts was more of a secondary process in comparison to one's emotions. For example, Sophie said:

So being able to feel in the body is a way to sort of survive the very visceral feeling of anxiety so I guess that's a major way of using mindfulness and the other way has been just be able to stand back from thoughts. (Sophie)

Sophie spoke as though anxiety were key to the development of all OCD symptoms and, if focused on, then other remedying processes would fall into place. In addition, it seemed that those participants who considered mindfulness as a ‘lived’ experience rather than a ‘tool’ were more likely to emphasize the contribution of mindfulness of the body, that is, attending to what the body is feeling in and of itself.

Individuals suffering from OCD were described as getting caught up in the ‘irrational’ meaning that they gave to their obsessive thinking. Mindfulness was said to facilitate a more rational appraisal of the obsessive thoughts that re-established a sense of control for the individual:

Very often you take the meaning out of something [and] it becomes very easy to deal with – because OCD is often about putting unreasonable meaning into things. [] I think they [clients] understand the ability to believe less in the exaggerated and irrational thinking, [] which gives them a sense of control, stops them from obeying obsessive compulsive thinking. (Max)

This relates more specifically to participants’ perception that, through the cultivation of an ‘observer self’, mindfulness can ‘defuse’ the link between an individual’s thought and the value they place on that thought as having a significant impact on reality:

With OCD umm there is the sort of thought-action fusion that causes people to believe that having a thought means that either that action that they’ve been

thinking about is more likely or that having the thought is as bad as acting and so by practising mindfulness they can establish that sort of metacognitive distance. (Lara)

It was apparent from this and many other data extracts that participants mostly described the processes of mindfulness using terms drawn from clinical and cognitive theory. Language drawn from spiritual conceptualisations of mindfulness was seldom used – and then only alongside clinical and cognitive language. This is not surprising, given that most participants had first experienced mindfulness in professional settings, most practised mindfulness themselves not primarily for spiritual reasons, and the interviews were located within a psychological and psychotherapeutic framework. Even allowing for these considerations, questions remain about the scope of participants' conceptual repertoire for thinking about mindfulness and for communicating with clients to elaborate views and understandings of mindfulness in 'pure' and therapeutic forms.

Returning to participants' understandings of relevant therapeutic processes, the shift that mindfulness was seen to produce in individuals' perceptions of their internal processes was held to be crucial. This was seen as challenging the belief held by individuals with OCD that intrusive thoughts are reality-based:

I think it shifts people's um beliefs about about their minds [] that thoughts are just thoughts – they're not facts, they're just mental events...they're transitory and again often people with OCD get very confirmed that their intrusive thoughts [] might actually indicate that they're responsible for

doing something and there's something about the mindfulness approach that I think can counteract that. (Molly)

To challenge such OCD-based assumptions and cultivate an 'observer self', participants reported encouraging clients to sit with their intrusive experience and not do anything other than be curious about and open to it. By noticing that their anxiety can be tolerated, clients were said to be helped to query their fear that something awful might happen:

People can very slowly begin to recognise that actually 'If I just sit with my experience, my intrusive thoughts that are coming in, it's kind of OK. I think nothing bad will happen and actually maybe my anxiety initially really rises – you know, goes up but then actually it does begin to fall and if I am able to sit with intrusive thoughts about harm, let's say, and I don't respond to them in the usual way, actually maybe the terrible thing I thought was going to happen didn't really happen. What does that mean about my intrusive thoughts?'

(Molly)

This links to the sub-theme of 'Mindfulness as enhancing an OCD treatment protocol'. Participants believed that, as a result of the 'defusion' process, clients are able to handle their anxiety in order to engage in CBT exposure experiments:

So you can have the feeling that um 'I absolutely cannot do this because that means I have to feel this unbearable anxiety and there's no way I can tolerate this' and then they might discover that they can still take the action and feel

the unbearable anxiety at the same time but you can kind of divorce the feelings from the action. (Sophie)

From our analytic perspective, it was difficult to see the distinction made by participants between mindfulness of the intrusive experiences and exposure interventions. All participants made it clear that mindfulness was a helpful practice to enable clients to tolerate their anxiety during exposure techniques and yet, when participants spoke of practising mindfulness during therapy, it was described like an exposure exercise – getting clients to face their intrusive thoughts/feelings. This seemed to query participants' perceptions (noted earlier) that mindfulness lacked the behavioural component essential to the treatment of OCD.

(ii) Mediating effect of mindfulness on the self

Participants observed that, as an individual's relationship to their internal world changed, so did their attitude towards their 'self'. A more mindful awareness of the self was said to develop. This was said to allow space for an internalized, more supportive voice to emerge that identified OCD symptoms as separate from an individual's self:

If you change the relationship to the contents of self...um...you're also developing a new compassionate voice so I guess that's, that's kind of feeding another part of self that might have been neglected...um...and the thing – I think the compassionate element of mindfulness I think is quite important.

(Sophie)

Compassion was highlighted as significant by many participants. Yet, as indicated by the pauses in Sophie's account, there was often a lack of definitiveness in their accounts of the processes of mindfulness. This may be due to the intangible and implicit nature of mindfulness.

Not holding so much responsibility for their intrusive thoughts was seen as instrumental in providing an alternative way for clients to experience having OCD:

OCD patients usually have a very strong sense of personal responsibility and they are very self-critical and so mindfulness can help them to develop a less judgemental attitude to themselves. (Lara)

Participants needed to be prompted to discuss their thoughts on perceptions of self in relation to mindfulness and OCD. Although the mediating effect of mindfulness on the self has routinely been seen as the aspect of mindfulness that holds greatest potential to produce lasting therapeutic effects, most participants centred their discussion on the immediate felt experience of mindfulness for their clients. This may indicate a concern with being perceived as embracing mindfulness as a spiritual practice that facilitates a personal 'journey'. Alternatively or additionally, participants may have felt that the therapeutic use of mindfulness was not yet sufficiently established for its long-term impact on an individual's sense of self to be credibly evaluated.

(iii) Mindfulness of the body anchoring the individual during times of high anxiety

All participants spoke of the primary significance of mindfulness in encouraging a metacognitive shift that detoxified intrusive thoughts. However, it was noted that, at least initially, mindfulness of the thoughts may not be suitable for all individuals with OCD. Some participants talked about bringing mindful attention towards the body as a basic grounding practice for individuals whose physical experience of their symptoms was too overwhelming:

The physical symptoms of anxiety, they seem to be – especially maybe for people who have longstanding difficulties – they seem to be quite strong []
There was something to really help me to actually – when I shifted from the cognitive level that mindfulness helps at, that level – to actually concentrate on the physical, to actually start focusing on what happens in your body when these thoughts come in and then to refocus in the sense of ‘Don’t focus on the thoughts, focus on what’s going on in your body first’. (Thomas)

Similarly, another participant emphasized the need for clients with severe symptoms to be anchored first by using the breath before working on their compulsive behaviours:

If I just get them to prevent the response, often I find people really struggle to do that because they just don’t know what to do with themselves. [] The kind of clients that I see are quite severe and they would – often they really struggle to even begin to think how are they even going to start doing that. So mindfulness I have found really helpful – to start having, I suppose, a different

relationship towards one's feelings. So...um...I would start with sort of mindfulness of the breath, if the person is OK with being aware of the breath and the breath and body and help them, give them an anchor to stay in the present moment with their feelings. (Sophie)

If participants' observations are generally legitimate – that mindfulness of intrusive thoughts can be too difficult as a starting point for individuals with severe OCD – this could help explain why individuals suffering predominantly from obsessions have been found to be most resistant to CBT (as was noted earlier). It opens up a discussion as to whether a more informal practice of mindfulness, centred around bringing attention to movement, breathing and daily activities, would be a suitable alternative to traditional 'exposure and response' prevention.

Discussion

Participants' views about the merits of using mindfulness in therapeutic interventions for OCD and about associated therapeutic processes resonated with existing literature on these issues. Their experience-based reflections supported the theoretical rationale that mindfulness works therapeutically through its capacity to query and loosen an individual's attachment to their thoughts and intrusive experiences (Kabat Zinn, 1994; Nhat Hanh, 2008). Their views also echoed work by Hanstede et al. (2008) and Wilkinson-Tough et al. (2010), with participants perceiving mindfulness as 'defusing' the cognitive biases responsible for the development of obsessions. The development of an 'observer self', cultivated through mindfulness, was described as a major contributor to the ability of individuals with OCD to release themselves from obsessive thinking. Participants identified mindful awareness of one's internal world

as significant in producing a more manageable relationship with OCD among affected individuals (see Epstein, 2007). These resonances are not surprising, given that participants had substantial experience of using mindfulness with clients to address symptoms of OCD and so would have encountered at least some of this relevant literature.

From their own and others' clinical experience, participants specifically stressed the potential of mindfulness to remedy unhelpful self-evaluative inferences that individuals made from their intrusive thoughts. They commented on how many clients saw mindfulness as an intuitive intervention to manage their OCD experience effectively. However, they also spoke of how OCD processes seemed to interact with mindfulness in less helpful ways so that, for individuals with more severe obsessions and anxiety, there was the risk of mindfulness becoming an obsessive practice in itself. In response to this, participants advocated using mindfulness of the body, focusing on the breath, to reduce individuals' physical arousal levels before attempting to progress to mindfulness of the thoughts. Mindfulness of the body may be a key intervention to be used to help clients tolerate their anxiety during exposure interventions and to increase the likelihood of retaining clients in therapy. Such considerations point to the importance of a formulation-based approach to assess the relationship of TAF and/or neutralizing behaviours in the maintenance of an individual's condition before mindfulness is introduced (Wilkinson-Tough et al., 2010).

It is noteworthy that all participants concluded that mindfulness was not appropriate as an exclusive treatment approach with individuals with OCD. Participants felt that

key elements of CBT, specifically the psycho-educational and behavioural components, were essential, with mindfulness serving as a protocol enhancer. This ‘middle way’ approach for OCD that can balance the promotion of change (through CBT) and the promotion of acceptance (through mindfulness) accords with research into the use of mindfulness to improve the long-term effects of CBT. For instance, in line with the present study’s findings, Fairfax (2008) proposed that mindfulness, in conjunction with cognitive therapy, could act therapeutically by disconnecting the TAF mechanism as well as helping the individual with OCD to accept the ‘self-as-is’.

Producing an approach that promotes change as well as self-acceptance sounds ideal and, from the accounts of participants’ experiences, the integration seems feasible as well as promising, especially for people whose level of physical arousal makes it difficult for them to remain fruitfully engaged with traditional approaches. There is a need for further ongoing evaluative research on such integrated interventions in order to build a strong evidence base from which recommendations can be confidently advanced. The gaps in the evidence base surrounding outcomes and best practice were reflected in the *ad hoc* nature of participants’ reported experience of integrating mindfulness into their therapeutic approach.

The main limitation of this study is that its findings are drawn a small, ethnically homogeneous sample of practitioners who all used CBT as their main therapeutic model and who were based in Britain. Also those who volunteered to participate may have been positively disposed towards the use of mindfulness and may have been motivated to perform an advocacy role. For these reasons, the transferability of the findings may be limited and further research is required to extend the analytic picture

produced by this study. However, the psychological processes discussed within the theme that was elaborated were not tied to specific cultural or clinical contexts. Instead the data reflected the experiences of key informants and their peers whose practice of working therapeutically with people with OCD opens up questions and areas of consideration that merit further investigation. It would be fruitful to compare other practitioners' perspectives with those obtained in this study, such as those whose main therapeutic approach is mindfulness-based and/or those who have no experience of using mindfulness therapeutically but who have considerable experience of working with individuals affected by OCD. In addition, it is recognized that a key voice, that of the clients receiving treatment for their OCD, is missing and will need to be included in later studies.

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