Author’s response to reviews

Title: “I am getting something out of this, so I am going to stick with it”: Supporting participants’ home practice in Mindfulness-Based Programmes

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Author’s response to reviews:

Reviewer 1: In general, I think the manuscript is a useful resource for practitioners or teachers of mindfulness interventions. The statement of aims of the article on p 5 was clear and helpful. The structure of the article is clear and easy to follow, consisting of conceptual review, discussion of mindfulness literature, interview examples, and suggestions for teachers. I thought the discussion of the planning factor in ways congruent with mindfulness training was important and helpful, showing how goal planning might be discussed without contradicting the approach advocated by developers of the mainstream mindfulness approaches.

We thank the reviewer for these positive comments on our work.

I thought the discussion of a supportive physical environment for practice on p 13 would be better placed in the discussion of the planning/commitment factor, as is does not fit with the rest of the discussion of social support.

We thank the reviewer for this restructuring suggestion. The rationale for including the supportive physical environment on p13. is because we believed this fits the COM-B factor, “Opportunity” (see Behaviour Change wheel – Grey outward category where Opportunity falls into the “Environmental/Social Planning category)

The references are incomplete in some cases, or in a strange form. See particularly the WHO references.

We apologise for the errors in our referencing. Our Endnote library has been updated and the references have been corrected.

I also am not sure about the value of Figure 1, and don't think it adds to the article, so perhaps should be deleted. Figure 2 is helpful, however.

We have now removed Figure 1 and only include Figure 2.
Reviewer 2: This is an interesting and useful addition to the literature bringing together theory and participant experience to explore how MBPs might be working. I have a few comments and questions:

We thank the reviewer for this overall positive assessment, and are pleased to have the opportunity to correct the issues raised.

1) Participant quotes are used, but it is unclear if permission was obtained to use these. Please explain how these were collected, and from whom, and if IRB approval was obtained (or waived). Further, the paper would benefit from a description of who the interviewees were, who did the interviewing, what the context was, and how the quotes were chosen.

We have added a paragraph to address these issues, copied below. We also include an ethics statement at the end of the manuscript. The sources of the quotes have been described throughout the manuscript and we now include the time-points when JM obtained these (i.e., week number, post-course etc.).

‘Interviews were conducted by JM and participants were drawn from general public groups. The participant age range age was from 28-60 years and 6 were female and 3 were male. The interviews with course participants were at three points, halfway through (4 weeks), at the end of the programme (8 weeks), and two to three months after the programme finished. One person dropped out after 3 weeks, so only one interview was conducted with this individual. The interviews were recorded and permission was obtained to use quotes for this article, which is based on a Master’s thesis conducted by JM, as part of the MSc in Mindfulness-Based Cognitive Therapies at the University of Exeter. Quotes were chosen to illustrate points derived from the literature and are not considered to be a data primary source.’

There is a vast literature on qualitative data, and following some of its guidelines may enhance the readability and quality of this paper.

We thank the reviewer for this comment. We have now added a paragraph to explain our method more fully. We note here, and in the limitations section of the discussion (also copied below) that we do not intend manuscript as a formal qualitative study.

‘Our approach was informed and shaped by our experiences as mindfulness practitioners, teachers and researchers. In reviewing the literature, we took a narrative approach, selectively considering highly-cited articles from the fields of behaviour change, mindfulness and Buddhist literature. We used the key terms ‘home practice’, ‘practice’, ‘mindfulness’ ‘Mindfulness-Based Stress Reduction, ‘Mindfulness-Based Cognitive Therapy’, ‘engagement’, ‘compliance’ and ‘adherence’.’ (then section above, continuing below)

‘The 25 interviews with the MBPs participants started with open-ended questions (What helped/hindered you in developing and sustaining a mindfulness practice?) and then developed into a more in-depth dialogue to understand the factors that were key for those individuals.
The iterative process of a focused literature review, an examination of participant interviews and dialogue among the authors took place over 2 years. We note that the present review is not intended as a systematic literature review, nor as primary qualitative research, rather a discussion of factors around mindfulness practice that we consider to be key. Finally, we use one widely-established model, the COM-B model (Capability, Opportunity, Motivation and Behaviour; Michie, van Stralen, and West (2011) as an organising framework to consider the factors identified through the literature review. These factors can be examined further in qualitative research, with a larger-scale approach to participant interviews, and with a systematic literature search.’

2) How were the seven factors determined? Was there a longer list that was considered? How do these specifically come from or derive from the COM-B model? This needs to be explained more.

We have added further explanation of the process in the paragraph above. In brief, the first author began with an initial narrative literature review, and hand-coded significant themes noted in these articles. When reviewing the interview notes, these themes were echoed in the points raised by participants. We use quotes as illustrations, but we now explain in several places that this is not a formal qualitative study. We refer to these themes as ‘factors’. We use the COM-B model to organise the factors, to provide a coherent comparative framework for the reader. We hope we have fully clarified the process undertaken.

3) Why was the COM-B model chosen? What other models were considered, and how did this serve as the best for describing MBPs? For example, there are many models and frameworks that have been applied to health-related behaviors.

We considered only the COM-B model, because this is arguably the most-cited recent behaviour change framework that we are aware of (more than 3737 citations as of June 2020). We agree, however, that this is a limitation, and that other models could be considered. We note this in the discussion section, as follows:

‘We acknowledge, however, that there are many models of health behaviour change that we have not considered here (for a recent review, see Nilsen, 2020).’

4) For each of the factors, it would be helpful to see how impactful they have been in behavior change. For example, action and implementation plans are theoretically helpful, but it is unclear how much these contribute individually to actual behavior change. Please add examples and references from previous literature showing that the seven factors are associated with actual behavior change (beyond theory).

We have now added the suggested examples for each of the 7 factors, including meta-analytic evidence, where possible. These examples have been added to each section, along with a brief explanation, as follows:

1. ‘Meta-analyses have found medium to large effects of ‘if-then plans’ on goal achievement across a wide area of behaviours (Bélanger-Gravel, Godin, & Amireault, 2013; Gollwitzer & Sheeran, 2006).’
2. Social support can be defined as an individual’s perception or experience of affection, care, value, belonging, or assistance in connection with others or networks of others (Taylor, 2010). The stress-buffering effect of social support is arguably amongst the most tested impacts of social relationships on health (Holt-Lunstad, 2018). Perceived levels of social support have been associated with numerous physical health markers, especially in mid-adulthood, in large-scale life span analyses (Yang et al., 2016). Social support falls within “Opportunity” in the COM-B model, whereby the individual’s physical (see above) and social environment can facilitate or prompt practice behaviour.

3. Social support has been found to be correlated with people’s engagement in a range of health behaviours such as physical exercise (Fowles, Stang, Bryant, & Kim, 2012) and healthy eating habits (Fowles et al., 2012). A recent meta-analysis provided evidence for a robust association between social support and positive sleep outcomes (Kent de Grey, Uchino, Trettevik, Cronan, & Hogan, 2018). Furthermore, improving social support may also improve health outcomes: a 2019 meta-analysis reported that interventions directly targeting social support networks had significant, positive effects on a range of health behaviours and health-related outcomes (Hunter et al., 2019). Social support, in various forms such as family and the group setting, is likely to be important in MBPs as well. Most people learn mindfulness practices in a peer group, and that group can provide significant support.

4. For individual psychotherapy, meta-analytic evidence indicates a robust, predictive association between the therapeutic alliance and therapy outcomes (Flückiger, Del Re, Wampold, & Horvath, 2018). However, establishing a causal role for the therapeutic alliance in outcomes is methodologically challenging and studies to date have been observational, and have not attempted to directly manipulate the therapeutic alliance (Cuijpers, Reijnders, & Huibers, 2019).

5. For physical activity, experimental evidence suggests that specifically targeting feelings of enjoyment during exercise can increase activity adherence (Jekauc, 2015). Across psychological therapies, early symptom improvement has been identified as a strong indicator of overall treatment outcome across a range of disorders (e.g., Lutz et al., 2014; Turner, Bryant-Waugh, & Marshall, 2015). Such findings suggest, albeit indirectly, that experiencing the benefits of treatment might be helpful in overall patterns of change and improvement.

6. Self-efficacy is one of the clearest correlates of health behaviours such as physical activity in adults according to a large-scale review of reviews (Bauman et al., 2012). Furthermore, there is experimental evidence that changes in self-efficacy can mediate the effects of a behaviour change intervention on increases in physical activity (Darker, French, Eves, & Sniehotta, 2010).

7. Further, there is a well-established phenomenon in clinical trials where participants do better if they find the treatment they are given plausible or credible (Williams & Silverton, 2017). If a treatment or intervention seems plausible, this can motivate participants to engage and there is evidence from other health domains for the efficacy of changing treatment beliefs on subsequent treatment-related behaviour. For example, one trial directly targeted beliefs about treatment for asthma using personalised messages and showed subsequent improvements in self-reported treatment adherence (Petrie, Perry, Broadbent, & Weinman, 2012).
8. ‘There is emerging evidence suggesting that health-promoting preventative self-care interventions show promise in increasing the well-being of healthy people (Perera & Agboola, 2019). For chronic illness, self-care interventions have a more established evidence-base (Powers, Olsen, Oddone, & Bosworth, 2009).’

5) Social support is a broad and important category, yet there are few references for this section (some dating back to 20 years ago). This would benefit from more description.

We have entirely re-written this section, drawing primarily on newer, large-scale studies and meta-analyses. We have now included two paragraphs describing current understanding of social support effects on health relevant to the current manuscript, as follows:

‘Social support can be defined as an individual’s perception or experience of affection, care, value, belonging, or assistance in connection with others or networks of others (Taylor, 2010). The stress-buffering effect of social support is arguably amongst the most tested impacts of social relationships on health (Holt-Lunstad, 2018). Perceived levels of social support have been associated with numerous physical health markers, especially in mid-adulthood, in large-scale life span analyses (Yang et al., 2016). Social support falls within “Opportunity” in the COM-B model, whereby the individual’s physical (see above) and social environment can facilitate or prompt practice behaviour.

‘Social support has been found to be correlated with people’s engagement in a range of health behaviours such as physical exercise (Fowles, Stang, Bryant, & Kim, 2012) and healthy eating habits (Fowles et al., 2012). A recent meta-analysis provided evidence for a robust association between social support and positive sleep outcomes (Kent de Grey, Uchino, Trettevik, Cronan, & Hogan, 2018). Furthermore, improving social support may also improve health outcomes: a 2019 meta-analysis reported that interventions directly targeting social support networks had significant, positive effects on a range of health behaviours and health-related outcomes (Hunter et al., 2019). Social support, in various forms such as family and the group setting, is likely to be important in MBPs as well. Most people learn mindfulness practices in a peer group, and that group can provide significant support.’

Further, the use of a quote from Thich Nhat Hanh as representative of "contemporary mindfulness teachers" and then a single line from the "the Buddha" may be observed as selectively and/or superficially picking something to back up a personal point of view. In addition describing ‘three refuges' without even naming these may confuse an uninformed reader. This entire section would benefit from a more thorough and less selective review of the literature if it is to be informative for more than the initiated.

We thank the reviewers for their helpful feedback on this and have now given more contemporary Buddhist sources. We expand on the sources, as below and in additional places throughout the ms:

‘Contemporary Buddhist teachers also emphasise social support. For example, Thich Nhat Hanh (1996), global spiritual leader and Zen teacher who in 1966 founded the Buddhist Order of
Interbeing at Plum Village in France, says ‘The presence of those who practice mindful living is a great support and encouragement to us…getting in touch with an existing sangha [community] or setting up a small sangha amount to a very important step’ (p.146; Hanh, 2006). Similarly, Ajahn Sucitto (1988), former Abbot of the first monastery of its lineage in the UK (1992-2014) the Cittaviveka Buddhist Monastery says: ‘Meditating with a few friends at regular times can be a great support towards constancy of practice’ (p. 22; Sucitto, 1988).

Indeed, the importance of social support in establishing and maintaining a meditation practice was recognised as far back as the original Connected Discourses (Samyutta Nikaya), where the Buddha stresses the importance of companions and friends on the path of practice (Bodhi, 1997).

We have also explained the three refuges of Buddhism more comprehensively:

‘Central to Buddhist practices are the ‘Three Refuges’; the word ‘refuge’ is used to denote a safe metaphorical ‘place’ to practice and come to understand the causes of our stress. The first refuge is in the Buddha – either in the teacher or in the qualities of wisdom and clear-sightedness within the teacher. The second refuge is in the Dharma – the teachings and practices that lead to wisdom, which can also be understood as ‘the truth of the way things are’. By observing phenomena in our mindfulness practice, we come to understand features like impermanence and the futility of clinging to what will inevitably change, and the painful pointlessness of resisting our experience. The third refuge is in the Sangha – the spiritual community as a necessary support for the practice (Accessstoinsight.org, 2017b).

In secular mindfulness literature, Santorelli (1999 p.47) also highlights the power and emotional support offered by the group: ‘Thirty strangers. Thirty different reasons for being here. Yet in our differences, we are drawn together around a common intention: to learn to care for ourselves and be alive to our living; to look deeply into our own lives and to do so collectively.’ He then goes on to say, ‘My mother died during the fourth week of class. Often, I felt deeply nourished by the caring offered, mostly in silence, by the patients, as if I were their patient’ (p. 47).

Minor:

1) It would be helpful to have more of a description of the participants, and some background to set the context for them (e.g. what type of course were they taking, when were the quotes obtained [if during a course, what week etc]).

We have added a full methodology paragraph, as set forth above. The sources of the quotes have been more clearly described, including the time-points provided (e.g., week number, post-course).

2) p5: the authors report deliberately considering the most impactful and highly-cited papers, but do not state more than this. It would be helpful to know what criteria they used to determine this.

We have added a more thorough description of our literature review, noting its non-systematic nature, and state that ‘We carried out searches using the terms ‘home practice’, ‘practice’
adherence, compliance, engagement and related terms, and ‘mindfulness’, MBCT/MBSR. We have added this to our method section.

3) Throughout the paper, sources are not clearly described (e.g. Khema being listed as a "Buddhist source."), which combined with selective quotes, may detract from the message the authors are trying to deliver.

We have now provided additional details on where each Buddhist source is derived, and important contextual details on each Buddhist teacher, with some of their achievements and numbers of publications. All are eminent teachers in the field of mindfulness and meditation.

We have made an extended effort to explain the context and importance of Buddhist sources included, and to connect these to the reviewed secular literature. We understand however the reviewer’s concern. We are willing to remove the pieces on Buddhist teachers, if the editor and reviewer still believe that these confuse or disrupt our central messages.

References


