The experiences of parents in mindfulness-based cognitive therapy

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Abstract
Mindfulness-based cognitive therapy (MBCT) is a relatively new intervention that has been developed to help people with recurrent depression stay well in the long term. Although there is evidence that depression impacts negatively on parenting, little is known regarding MBCT’s potential impact on parenting. This study used a qualitative design to explore how parents with a history of recurrent depression experience their relationships with their children one year after MBCT. We interviewed 16 parents who had participated in MBCT as part of a randomized controlled trial (RCT) (Kuyken et al., 2008). Thematic analysis was used to identify prevalent themes in parents’ accounts, including: (i) emotional reactivity and regulation; (ii) empathy and acceptance; (iii) involvement; (iv) emotional availability and comfort; and (v) recognition of own needs. Based on these exploratory findings, we suggest that some components of MBCT may help parents with a history of depression with emotional availability, emotion regulation and self-care and set out avenues of further research.

Keywords
depression, mindfulness-based cognitive therapy, MBCT, parenting, thematic analysis

Parental depression can have a negative impact on parent–child relationships and child development (Brennan, Hammen, Katz, & Le Brocque, 2002; Hammen & Brennan, 2001; Lewinsohn, Olino, & Klein, 2005; Miller, Warner, Wickramaratne, & Weissman, 1999). The few studies that consider recurrent parental depression indicate that recurrence is associated with worse outcomes for children (Frye & Garber, 2005; Murray, Woolgar, Cooper, & Hipwell, 2001; Shaw et al., 2006; Silk, Shaw, Skuban, Oland, & Kovacs, 2006; Spence, Najman, Bor, O’Callaghan, & Williams, 2002). Despite these findings, treatments tend either to target depressive symptoms or parenting practices (Murray, Cooper, Wilson, & Romanuk, 2003). To what extent do treatments for parental depression also target parenting behaviour?

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Current treatments for parental depression targeting symptoms

In the UK, The National Institute of Clinical Excellence (NICE, 2007) recommends self-help, non-directive counselling, cognitive behavioural therapy (CBT) and interpersonal therapy for the treatment of single-episode depression in mothers in the pre- and post-natal period. However, the only longitudinal study of non-directive counselling, routine primary care, CBT and psychodynamic therapy in mothers diagnosed with post-natal depression (PND), found that these interventions had only short-term benefits on early relationship difficulties (Murray et al., 2003) suggesting the need for new treatments that can help parents with recurrent depression. From a US perspective, England and Sim (2009) also highlight the lack of research and evidenced-based treatments to address depression and depressive relapse in parents and its impact on children in their recent review.

Current treatments targeting parenting practices in relation to parental depression

Interventions aimed at improving parenting practices tend to be based on behavioural and attachment theories and focus on the parent–child relationship and child behavioural, emotional and cognitive development. These approaches do not typically address parental depression directly. Where researchers have measured current parental depression, they have found that it is associated with poorer engagement in and response to behavioural parent training (Baydar, Reid, & Webster-Stratton, 2003; Reid, Webster-Stratton, & Hammond, 2003). In two attachment-based studies, one reported positive outcomes for children (Cicchetti, Rogosch, & Toth, 2000), while the other found that maternal depression moderated the effects of interventions (Robinson & Emde, 2004) – however, maternal depression was found to recur in both.

Developmental research has linked negative outcomes for children to certain behavioural patterns exhibited by some parents currently experiencing depression, such as criticism, unresponsiveness and unsupportiveness (Cicchetti, Rogosch, & Toth, 1998; Garstein & Fagot, 2003; Marmostein & Iacono, 2004; Milgrom, Westley, & Gemmill, 2004; Murray et al., 2001; Nelson, Hammern, Brennan, & Ullman, 2003). However, studies have also found an added independent negative impact for parental depression, over and above parents’ interaction styles (Murray, Woolgar, Cooper, & Hipwell, 2001), especially when depression recurs (Murray et al., 2006; Nelson et al., 2003; Nolen-Hoeksema, Wolfson, Mumme, & Guskin, 1995). This suggests the need to address parents’ depression and emotional well-being in addition to providing parent training or targeting the parent–child relationship. There is also a need to examine parents’ experiences, as the longitudinal or observational methods used in developmental studies focus on parent–child interaction and child outcomes and do not provide information about the experiences of parents, which may inform treatments for parents.

Mindfulness-based cognitive therapy (MBCT), recurrent depression and parenting

MBCT is a relatively new intervention, derived from cognitive therapy and mindfulness-based stress reduction (MBSR) (Kabat-Zinn, 2006; Segal, Teasdale, & Williams, 2002). It teaches people with a history of recurrent depression to become aware of the bodily sensations, thoughts and feelings associated with depressive relapse and relate constructively to these experiences. MBCT aims to cultivate mindfulness and compassion so that people can be more responsive to stress and sad
mood and thereby “nip in the bud” depressive relapse (Segal et al., 2002). It has been found to reduce depressive relapse in three randomized-controlled trials (RCTs) (Ma & Teasdale, 2004; Kuyken et al., 2008; Teasdale et al., 2000). There is now also evidence that MBCT works through the mechanism of increasing mindfulness and self-compassion and attenuating cognitive reactivity (Kuyken et al., 2010).

Kabat-Zinn and Kabat-Zinn (1997) articulate an account of how mindfulness can enhance parenting by helping parents become more aware of their feelings and needs and more responsive in interactions with their children. That is to say the mechanism being targeted in MBCT for recurrent depression (cognitive reactivity) may also be equally valid in parenting (reactive parenting). Intervenional research with couples and parents suggests that mindfulness interventions do positively affect relationship functioning (Carson, Carson, Gil, & Baucom, 2004; Singh et al., 2006). Carson et al. (2004) found that happy, non-distressed couples reported increased satisfaction, closeness and acceptance and reduced relationship and psychological distress following a mindfulness-based group intervention. Singh et al. (2006) found that a mindfulness-based intervention improved maternal satisfaction in parenting skills and parent–child interaction in dyads of healthy mothers and children diagnosed with autism displaying challenging behaviours. However, the nature of the changes in the parent–child relationship remains to be explored.

While the primary focus of MBCT is to help people with a history of recurrent depression prevent depressive relapse, qualitative research with people who have been through MBCT groups suggests that its effects are more broad ranging and include the cultivation of mindfulness skills that are applied in everyday life (Mason & Hargreaves, 2001; Smith, 2004). Qualitative approaches are particularly interesting in this context – not only because they are well suited to exploratory research in fields that are so far relatively unchartered, but also because of their emphasis on people’s subjective experiences. It is this particular emphasis that seems pertinent for understanding the therapeutic significance of MBCT since mindfulness-training is directed at people’s subjective experiences of their thought processes, emotions and bodily sensations (see also Allen, Bromley, Kuyken, & Sonnenberg, 2009). However, to date neither quantitative nor qualitative research has focused explicitly on parents going through an MBCT programme and the programme’s potential effect on parenting remains unexplored.

The current approach

As suggested above, whilst a small number of studies indicate that mindfulness may have a positive effect on relationships (Carson et al., 2004; Singh et al., 2006) and that MBCT is effective in reducing depressive relapse and recurrence (Ma & Teasdale, 2004; Kuyken et al., 2008; Teasdale et al., 2000) through increasing mindfulness and self-compassion (Kuyken et al., 2010), to date research has not examined both areas concurrently. In addition, while existing research provides an understanding of the outcomes and benefits of mindfulness, it does not provide an understanding of how this occurs or the way in which this may occur for parents who have experienced recurrent depression. There is thus a need to define and describe parents’ experiences to lay the groundwork for the development of further theory, research and treatment (Barker, Pistrang, & Elliot, 1994). This exploratory interview study therefore sought to examine how parents with a history of recurrent depression describe their experiences regarding their relationships with their children one year after MBCT. In doing so, its broader objective was to contribute to our understanding of the potential impact of MBCT on parenting practices.
**Methods**

*Study context and interventions*

This interview study was part of a randomized controlled trial (RCT) for people with a history of recurrent depression (Kuyken et al., 2008). In brief, the trial was a parallel two arm study comparing MBCT with maintenance antidepressants. The trial was approved by the UK National Health Service North and East Devon Research Ethics Committee and was conducted in line with national ethical guidelines for psychologists. To enable participants to have gathered some experience with mindfulness practices in their everyday lives, interviews were conducted one year after completion of the MBCT programme.

*MBCT and antidepressant tapering/discontinuation*

MBCT was delivered to groups of 9–14 participants, in two-hour sessions over eight consecutive weeks with four subsequent follow-up sessions spread out over a year. Sessions followed the MBCT manual (Segal et al., 2002) and included: (i) guided mindfulness practice; (ii) enquiry into participant’s experiences of practice; (iii) weekly homework reviews; and (iv) CBT skills (see Segal et al., 2002). Parents were drawn from one of five MBCT groups led by one of two different MBCT therapists (see Kuyken et al., 2008). The MBCT content, adherence and therapist competency checks are described fully in Kuyken et al. (2008).

*Participants*

The sample for the present study consisted of all the parents (N = 16) who had been in the MBCT arm of the RCT and had at least one child living at home. Participants’ details are summarized in Table 1. As can be seen, some of the parents had older children, but parents in the study had a history of depression stretching back over many years (see Kuyken et al., 2008), so those with older children may have established patterns of parenting influenced by chronic experience of depression.

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Marital status</th>
<th>Number of children</th>
<th>Age of children at time interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary</td>
<td>Divorced</td>
<td>3</td>
<td>18 (2 older not at home)</td>
</tr>
<tr>
<td>Jack</td>
<td>Married</td>
<td>2</td>
<td>24, 28</td>
</tr>
<tr>
<td>Ellen</td>
<td>Married</td>
<td>1</td>
<td>20</td>
</tr>
<tr>
<td>Sarah</td>
<td>Divorced</td>
<td>2</td>
<td>22, 26</td>
</tr>
<tr>
<td>Rebecca</td>
<td>Married</td>
<td>2</td>
<td>2, 6</td>
</tr>
<tr>
<td>Julie</td>
<td>Divorced</td>
<td>2</td>
<td>19, 20</td>
</tr>
<tr>
<td>Jenny</td>
<td>Married</td>
<td>2</td>
<td>3, 8</td>
</tr>
<tr>
<td>Laura</td>
<td>Divorced</td>
<td>3</td>
<td>11, 18, 20</td>
</tr>
<tr>
<td>Donna</td>
<td>Married</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Peter</td>
<td>Married</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Joyce</td>
<td>Married</td>
<td>4</td>
<td>14, 16, 19, 21</td>
</tr>
<tr>
<td>Sally</td>
<td>Married</td>
<td>3</td>
<td>13 (33, 36 not at home)</td>
</tr>
<tr>
<td>Angus</td>
<td>Married</td>
<td>2</td>
<td>9, 17</td>
</tr>
<tr>
<td>Lily</td>
<td>Married</td>
<td>2</td>
<td>7, 7</td>
</tr>
<tr>
<td>Lisa</td>
<td>Widow</td>
<td>2</td>
<td>18 (22 not at home)</td>
</tr>
<tr>
<td>Anne</td>
<td>Divorced</td>
<td>3</td>
<td>13, 14 (18 not at home)</td>
</tr>
</tbody>
</table>
As wide a population as possible of people with recurrent depression in primary care was screened for the trial (White, Holden, Byng, Mullen, & Kuyken, 2007). The RCT sample can be characterized as a group of people with recurrent depression, treated pharmacologically in primary care, who following a referral from their primary care physician were interested in a psychological group-based approach that included tapering/discontinuing their maintenance antidepressant treatment. All participants in the study met the Diagnostic and Statistical Manual IV (American Psychiatric Association, 2000) criteria for recurrent depression, either in full or partial remission. Exclusion criteria were: co-morbid diagnoses of current substance dependence; organic brain damage; current/past psychosis, including bipolar disorder; persistent anti-social behaviour; persistent self-injury requiring clinical management/therapy; inability to engage with MBCT or formal concurrent psychotherapy.

**Interview schedule and data collection**

Interviews were conducted by two research officers employed on the RCT, using a semi-structured interview schedule that allowed participants to explore new areas but also provided a consistent interview structure. The interview focused on participants’ relationships with their children following MBCT (e.g., “Can you tell me about your relationship(s) with your children, following the mindfulness course?”). Parents were encouraged to relate recent emotionally charged encounters with their children (including sadness, anger and happiness) and then reflect on these encounters with minimal prompts (e.g., “Can you bring to mind some times when you became angry or frustrated with your child recently?” If yes: “What happened? And after it was over? Is this different from before you took part in the mindfulness course? If so, how?”). The interview schedule was developed by the first author and refined in response to preliminary analysis of initial interviews, which is in keeping with the broader iterative and reflective principles outlined by Strauss and Corbin (1998). Interviews were transcribed and analysed by the first author who, at the time, was a trainee on a clinical psychology doctoral programme. The interview schedule is available by request from the corresponding author.

**Analytical strategy and procedure**

Interview transcripts were analysed following Braun and Clarke’s outline of thematic analysis (Braun & Clarke, 2006). Like other qualitative methods, thematic analysis is well suited to an inductive, data-driven approach. However, it allows for a greater degree of flexibility than other methods – both with regard to sampling and its underlying epistemological assumptions, especially concerning the nature of language (Braun & Clarke, 2006). Thematic analysis allows for the identification of themes at a semantic level of meaning (Braun & Clarke, 2006). This is in keeping with the realist stance adopted in this analysis which assumed that participants’ experiences could be accessed through their verbal accounts of these experiences.

Data analysis comprised two phases. The first phase involved reading (and re-reading) transcripts and highlighting segments of text that specifically referred to children and the parenting role. For each transcript, data-driven codes were then produced to thematically describe these segments. These codes, together with the corresponding extracts, were subsequently compiled in a separate document (a list of codes). This provided a record of the context in which each code or theme had arisen. Some extracts were summarized under several codes.

During the second phase, the presence and absence of themes across all interviews were recorded. Due to the large number of emerging themes, only those that were prevalent across the entire data set and key – in terms of past research, the research question and clinical experience – were retained.
Clinical Child Psychology and Psychiatry

(see Braun & Clarke, 2006). Codes or themes were then examined for their commonalities and differences. This resulted in themes being re-grouped according to their similarities or differentiated further to capture subtle differences in meaning. During the analysis, sample scripts were audited to ensure the credibility and coherence of the analysis (Elliott, Fischer, & Rennie, 1999). Four independent researchers (clinical psychology doctoral programme trainees) analysed relevant portions of sample transcripts. This provided initial support for the coding framework as these researchers generated consistent codes and themes. In addition, the two interviewers, the second author and an independent analyst with expertise in qualitative methods (third author) read the transcripts, commented on all the themes and provided general feedback to the first author. Although the analysis is presented as linear, it was cyclical in practice and involved moving back and forth between these two phases (Braun & Clarke, 2006).

This study was informed by the second author’s observations, through the experience of running MBCT groups, that parents often described applying mindfulness skills to their parenting and the first author’s experiences with a Special Parenting Service, which involved using behavioural methods with parents experiencing depression and other difficulties in Sure Start centres, as well as with personal experience of mindfulness. Rice and Ezzy (1999) note that qualitative researchers should constantly take stock of their actions and role in the research process and subject these to the same critical scrutiny as the rest of the data. To facilitate this process, reflective journal and memo writing were used to develop an awareness of the influence of a variety of theories, models and clinical experiences on the analysis, with regular supervision and discussion of these reflections and the analysis process with the third (independent) author. These influences are evident in the choice of some labels, such as reactivity and escalation of anger (from the attachment literature) and terms, such as “attributions” (from cognitive models). Thus, while the researcher tried to base the results of the analysis on parents’ descriptions of their experiences, the influence of the researcher and the influences on the researcher, which inevitably shape the analysis, are acknowledged.

Findings

Over the year, 15 of the 16 parents continued to practise mindfulness and reported various changes in their emotional relationships with their children. The degree of similarity in parents’ descriptions of changes from pre-MBCT patterns of interaction to new ways of interacting was striking. Only one parent (who did not practise mindfulness) described experiencing no changes in her emotional relationship with her children.

Within each pattern of change, the analysis will first focus on how parents described their pre-MBCT patterns of behaviour and interaction followed by their accounts of their post-MBCT patterns of behaviour and interaction and then parents’ descriptions of how they felt they achieved these changes (see Table 2).

Theme 1: Emotional reactivity and regulation

One of the most prevalent themes within parents’ accounts related to dealing with their negative emotions in challenging situations, which had impacted on their children. This theme included three aspects: irritability, reactivity and escalation of anger and sadness and giving-in.

Irritability. For 14 parents, the start of a depressive episode was signalled by an increase in irritability, which, in turn, commonly became directed towards their children. This involved the ease with which parents were triggered by situations in daily life. Jack explained:
If I got stuck in a traffic jam or a queue at the check-out, or something delayed me, I was … a Mr. Angry … I’d shout [laughs] and get annoyed with my wife and the kids. (Jack, children aged: 24, 28)

Twelve parents described how the use of the 3-Minute Breathing Space (a tool taught in MBCT) reduced this irritability. Lily illustrated:

During the day, when the girls ... are killing each other … and the phone’s ringing and lots of things, the television is on in the house … it’s good to just, sit in the garden, and just, sit quietly, and do your breaths … it’s like an empty feeling, all the chaos is gone … it feels as if your mind’s empty, you just go back in, and you face each thing then … until it happens again, and you get all full up. (Lily, twins, aged: 7)

While the irritability aspect of emotional reactivity and regulation related to general situations in daily life, reactivity and escalation of anger and sadness and giving-in specifically involved the ways in which parents described managing their emotions in interactions appraised as challenging with their children. Before MBCT, parents described two patterns of responding, namely with anger (reactivity and escalation of anger) and sadness (sadness and giving-in).

Reactivity and escalation of anger. For 13 parents, some changes occurred in managing the reactivity and escalation of anger in challenging interactions with their children. Parents described a similar pre-MBCT pattern of responding to interactions they perceived as challenging: this involved overreacting or feeling overwhelmed by parenting demands, which, in turn, led to emotional escalation and anger directed towards the child, and resulted in rumination, guilt and self-blame. This pattern involved two components: reactivity and escalation. Rebecca described the change in reactivity:

I wasn’t … triggered by … them mucking about … or they weren’t doing what I was saying … or they were being naughty … I had more of a relaxed, approach to them ... rather than a preoccupied ... “We’ve

<table>
<thead>
<tr>
<th>Main themes</th>
<th>Patterns of change</th>
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| 1. Emotional reactivity and regulation | Changes in management of negative emotions in challenging situations with children, includes 3 sub-themes:  
1.1 Irritability: Using the 3-Minute Breathing Space to manage irritability arising from general stress, previously directed at children  
1.2 Reactivity and escalation of anger: Changes in the management of reactivity and the escalation of anger in incidents previously appraised as challenging with children  
1.3 Sadness and giving-in: Changes in the management of sadness and the tendency towards ruminating and giving in to children following incidents previously appraised as challenging with children |
| 2. Empathy and acceptance    | Changes in the appraisal of children and or their behaviour                         |
| 3. Involvement               | Changes in the ability to fulfil parenting duties, be physically available to children and participate in pleasurable activities |
| 4. Emotional availability    | Changes in availability to provide comfort, manner of providing comfort and communication about emotions |
| 5. Recognition of own needs  | Changes in parents’ recognition, understanding and ability to communicate their own emotional support needs |
got to get out of the house!” or “We’ve got to do this!” ... it was much more, “Well ok, so we’re going to be late. Fine. Let’s get on with ... ” … nothing was so much of a big deal. (Rebecca, children aged: 2, 6)

Lisa portrayed the escalation element before she participated in MBCT:

I probably would have been hysterical about it … and would have gone on, and on, and on about it. (Lisa, child aged: 18)

Nine parents described using MBCT to develop a different pattern of responding and using a variety of elements from the course, including practice, imagery and the focus on the present moment. For Laura, the use of imagery and practice reduced the escalation of anger:

Now I think … hang on a minute … just stop, and come away and do something else, and then think about it, and then go back, and I think that’s the 3-Minute Breather type of thing ... to stop … getting off on a waterfall … he [therapist] talks about waterfalls and getting out before you go over the waterfall ... really, taking a step back and looking at it objectively. (Laura, child aged: 11)

Angus described using the focus on the present moment:

I was more controlled about what I said to him, the things I said. I didn’t fly off the handle, I didn’t get angry ... I made a point of not dredging up ... errors and mistakes from the past … and focus purely on what was happening now and what the problem was and what he had to do to sort it out. (Angus, child aged: 17)

Nine parents, who used mindfulness to reduce reactivity and escalation of anger in interactions, explained that practice had provided them with cognitive clarity, perspective, ability to reason, calmness, patience and tolerance in these situations. They explained that their children seemed to have responded to this reduction in their levels of anger and were increasingly willing to approach them about difficult issues, which they would not have done before. Anne explained:

I am calmer, so therefore they are not so worried about telling me … things ... such as, “Oh, I’ve broken a plate”. (Anne, children aged: 13, 14)

Six children spontaneously commented on the reduction in their parent’s level of anger. Rebecca recalled:

… he said “Oh, it’s really nice mum, you haven’t been cross for ages”. (Rebecca, child aged: 6)

In summary, parents described how different aspects of mindfulness increased their ability to regulate anger and reduced the irritability they associated with depression, which had been expressed in parent–child relationships. The parents, who used the 3-Minute Breathing Space, described how it had helped to reduce reactivity. However, only some parents reported reduced overall irritability and no or fewer incidents. These parents reported engaging in the longer practices on a daily basis and using other elements of MBCT, such as imagery. Parents reported that reductions in anger and irritability seemed to have led to increased approaches by their children. Some parents described a different way of responding to challenging interactions with their children, described under sadness and giving-in.
Sadness and giving-in. Three parents described a pattern of reacting to interactions appraised as challenging (pre-MBCT) by becoming sad, self-blaming and then giving in to their child. Jenny portrayed the pre-MBCT sadness pattern of responding:

I am just more aware really ... And not letting it, take control of me ... or them or just being so sad ... that I’ll let them get away with anything ... because that’s happened in the past ... when I have been very sad and low. (Jenny, children aged: 3, 8)

During the year following MBCT, these parents described a change in this pattern of responding. They explained that they had recognized what they needed to do, communicated this to their child and used the 3-Minute Breathing Space to help them stand by their decision. This resulted in a sense of self-awareness, control, acceptance of the outcome and perspective rather than self-blame and a spiral into depression. Jenny explained how she had managed her emotions when her child challenged her, and offered her child a choice of responses without becoming overwhelmed and giving in to her child:

There would have been times when I might have turned away, and crying a bit, because … I didn’t feel in control and now I would say that ... I am back … in control. (Jenny, child aged: 8)

These parents used the 3-Minute Breathing Space to reduce rumination after interactions with their children. Instead of feeling overwhelmed by sad feelings, they described an increased sense of control, decreased rumination, an ability to consider options and to abide by decisions. The degree of change parents reported in managing irritability, anger and sadness in their relationships with their children related to and overlapped with another main theme, empathy and acceptance.

Theme 2: Empathy and acceptance

Eight parents described how they had experienced an increased ability to see that there were a number of reasons for their child’s behaviour. This seemed to be related to increased empathy and acceptance towards themselves and their children. This ability to adopt a broader perspective seemed to evolve from different, sometimes overlapping, mechanisms, including reduced child- and self-blame, acceptance, mindfulness practice and the understanding that “thoughts are not facts”.

Three parents explained how they blamed themselves less for becoming depressed, as they had realized that depression was common and an illness and that this had led to increased acceptance and less child-blaming. Parents described becoming more accepting of child behaviours (as normal and age appropriate) and how this led to increased emotional control and kindness in handling previously challenging situations. Angus explained:

I am a bit over fussy about ... putting things away and tidying up and … to be totally honest, with two lads, of their ages, they don’t do that kind of thing … and I’ve been more inclined to give ... on all these kind of things. (Angus, children aged: 9, 17)

A further change for Angus was his acceptance of his older son’s attitude to work, which differed markedly from his own, and had been an area of friction. He clarified:

There has been a difference in the way, that I have responded to ... his attitude … I’ve been … firm and pretty forthright about it, but, not in an aggressive, irritable kind of a way … and I think he’s appreciated that ... and he’s actually responded pretty well.
Two parents of children with special needs explained how acceptance had led to increased empathy and relationship improvements. Sally reported how her acceptance of her child’s difficulties and feelings had changed the way in which she spoke to him, as she now regarded his feelings of hurt, before her own feelings of annoyance:

I accept it easier now, I used to get cross before … “You stupid child!”’, then walk away … whereas now, I just think, I’ll say it again in a minute. (Sally, child aged: 13)

Only two parents (who did not or were unable to practice) described continuing difficulties in relating to a child, because the child was seen as dissimilar. These parents continued to find it easier to relate to children they viewed as similar to themselves. Jack noted:

I unfairly pick on the older one, because he seems to be, well, I said, he’s not like me. (Jack, child aged: 28)

In summary, some parents described changes in empathy and acceptance. They described being better able to accept their children as independent, different people to themselves, without their own fears, expectations and needs obscuring their view of their children. These changes seemed to occur through different pathways, including acceptance, reduced blame and increased practice. Parents linked increased empathy and acceptance to an increased closeness to their children. However, this did not occur for all parents as some continued to experience difficulties in the way in which they perceived their children. Some parents linked changes in empathy and anxiety to increased involvement with their child, which led to further bonding.

Theme 3: Involvement

Six parents described increases in their degree of involvement with their children over the year. They explained how this had occurred through reduced social avoidance and improved emotion regulation.

Parents described how the use of the 3-Minute Breathing Space had reduced their anxiety. This had led to decreased anxiety and avoidance, which had a positive impact on parent–child relationships. Parents described becoming more able to fulfil parenting duties, such as the school run, drive on their own, take part in outings and be involved in supporting their child’s sporting and educational activities. Peter illustrated:

When she was at nursery and ... counting ... I wouldn’t bother at all. Even drawing pictures, I couldn’t be bothered. But I make things with her now. Whenever we go out, she has a treasure bag, a plastic bag, and she will put bits of wood in it and when we get home, we make things ... with it. (Peter, child aged: 5)

Other parents related their increased involvement to their increased ability to regulate their emotions (described within reactivity and escalation of anger). Mary observed:

I think they enjoy me being around, much more ... because I am not... hysterical and shouting anymore. (Mary, child aged: 18)

Parents suggested that increased involvement in their children’s lives had led to increased bonding and a closer, more positive relationship. A number of parents explained how changes in irritability and anger, and for some, increased empathy and involvement, had altered their relationship patterns in terms of emotional availability and comfort.
Theme 4: Emotional availability and comfort

Five parents described changes in their ability to be emotionally available to their children, in the manner in which they provided comfort and communicated about emotions. These parents explained how their children had been more inclined to approach them for help and comfort during the year. Parents related this to a reversal of roles or their increased ability to regulate their emotions (described under emotional reactivity and regulation).

Parents explained that they had approached their children for emotional comfort before participating in MBCT and described how these roles had reversed. These parents explained how they now provided their child with comfort, whereas before their child had needed to seek comfort elsewhere as the parent was not emotionally available. Laura described how her son acted pre-MBCT:

He would have probably ... kept it in... and he wouldn’t have said anything. He would have ... got grumpy … but he’s… willing to say now, things are upsetting him.

Laura felt that this occurred because:

I am more open ... so I will [say] ... “Ohh, that really annoys me, because ... ” or “You really upset me there ... because .. ”, so he knows ... because I know it’s all right for him to do ... rather than [him thinking], “Must n’t upset mummy” … we didn’t used to talk about it and ... if you are sad, you must talk about it and if you don’t talk to mummy, then you can talk to [sister], but more often than not he will come to me now. (Laura, child aged: 11)

The reversal of roles did not always occur in this direction. Some single mothers of older daughters described asking for more support from their children in dealing with depression, including help in recognizing triggers, encouragement to practise and communicate about emotions. Both mothers and daughters felt that this had led to increased closeness and improved relationships.

Three parents described changes in the manner in which they provided comfort, modelled dealing with difficult emotions and in the content of their communication with their children. This change involved naming and explaining their child’s feeling, why their child was experiencing the feeling and how these feelings would change and could be managed. Anne explained:

Before it would just be, “Oh well … never mind, come on, let’s just have a kiss and a cuddle”, and … “We’ll get over this”, but now … if I can explain to him how he is feeling … and why he is feeling this … (Anne, child aged: 13)

In summary, some parents described changes in their degree of emotional availability. Children were more likely to seek comfort from parents and parents were more likely to provide comfort rather than seek it from their children. Some felt that the quality of comfort and support had changed and that they provided more information to their children about feelings and managing feelings. This was not always the case as some parents also turned to older children for comfort.

Theme 5: Recognition of own needs

Seven parents referred to an increased understanding and recognition of their own needs and ability to communicate these needs to their children. A quote from Mary illustrates her need for time-out for nourishment and its benefits:
… because I was relaxed, I realized … I’d be much more clear minded about things … and then I could go off and have a rest, and say what I was doing, and at what time we’d meet, and expect to be listened to … and plan … ahead. It just made everything fall into place a lot better. (Mary, child aged: 18)

The ability to recognise what they needed and share this with their children was associated with increased openness and involvement and led to what these parents considered an improved relationship. However, three mothers of younger children were not able to communicate their needs and continued to experience feelings of frustration, while two parents of older children illustrated a continued inability to ask for help and an expectation that the child would intuit what the parent wanted. These parents felt that they had experienced few changes in their relationships with their children.

In sum, parents who reported changes in being able to recognize and communicate their needs, linked this to improved relationships with their children, while those who did not, reported minimal changes.

**A different pattern of change.** One parent described responding to challenging interactions with her child, using the reactivity and escalation of anger pattern pre-MBCT. In the year following MBCT, however, she did not use MBCT to reduce and regulate anger. Instead, she described using mindfulness to reduce rumination following incidents, in a similar manner to parents who described responding with the sadness and giving in pattern. This pattern of dealing with emotions was echoed in the way in which she advised her daughter to deal with emotions:

She now understands that a temper is a split second thing … you don’t have to carry it around with you, you can fire off whatever you need to fire off in a temper and you’ve got to walk away. You don’t carry on … you walk away, you take a few breaths, you put a smile on your face and go back. Because, by the time you’ve done that, whoever you’ve been shouting and hollering at has forgotten about it all anyway. You don’t need to be miserable all the time. (Donna, child aged: 9)

This account illustrates that MBCT can be applied in unanticipated ways and suggests that interventions targeting parenting practices may need to focus on the way in which mindfulness can be used in challenging interactions with children.

**Discussion**

This study explored parents’ experiences of their relationships with their children one year following MBCT. One parent did not practise MBCT and this parent described experiencing no changes in her emotional relationship with her children. Parents who continued to practise MBCT described patterns of change in their emotional relationships with their children, which they ascribed to MBCT. These patterns of change will be discussed below in relation to current theory and research.

The most widely reported change was in irritability. Parents described using the 3-Minute Breathing Space to better manage irritability. A smaller number of parents experienced further changes in other areas. These parents reported using more elements of MBCT, undertaking the longer practices daily and related these changes to increased practice and use of MBCT. This is consistent with reports of a dose-response relationship in quantitative (Carson et al., 2004; Singh et al., 2006) and qualitative studies (Mason & Hargreaves, 2001).

Parents also described changes in emotional reactivity and regulation during challenging interactions with children. Such incidents had previously resulted in reactivity and the escalation of
anger or sadness that was linked to giving in to their children. Parents described using MBCT to regulate their emotions and gain a sense of control, clarity and perspective instead of being overwhelmed by their emotions. Jenny, for instance, described using MBCT to regulate her emotions and then being able to choose to apply a parenting strategy. These descriptions of changes in emotional regulation are consistent with mindfulness research (Davison et al., 2003; Mason & Hargreaves, 2001; Smith, 2004) and theory, which suggest that mindfulness may prevent relapse by helping participants disengage from automatic patterns of responding (Segal et al., 2002).

Some parents described changes in empathy and acceptance, involving attributions of child-blame, self-blame and child intent. They described an increased ability to appraise behaviour as related to other factors, such as child age, special needs or personality, and were better able to accept the behaviour. They ascribed these changes to reduced self-blame and increased practice and acceptance. Participants in qualitative MBCT studies have also reported changes in attributions, empathy and acceptance of self and others (Mason & Hargreaves, 2001; Smith, 2004).

Some parents reported increased involvement with their children and the positive impact of this on their relationships. Parents described becoming more emotionally available to their children. They felt that children approached them more frequently in times of distress, that they were more able to provide comfort and provided comfort in a different manner. This is of interest as maternal depression has been associated with reduced sensitivity and responsivity to child sadness and fear (Easterbrooks, Bieseckr, & Lyons-Ruth, 2000; Shaw et al., 2006) and increased risk of insecure attachment (Cicchetti et al., 1998; Radke-Yarrow, Zahn-Waxler, Richardson, Susman, & Martinez, 1994; Robinson & Emde, 2004). However, parents also described recognizing their own needs, the benefits of taking the time for self-care and communicating their needs to their children. From a theoretical point of view, we speculate that MBCT might enable parents to become aware of their own mental states as well as the mental states of their children, referred to by some theorists as mentalization (Allen, 2003; Fonagy, 1999; Fonagy & Target, 1997). This would explain why parents appeared more able to view their children as separate individuals, rather than being preoccupied by their own difficulties, and why they described themselves as more empathic, accepting and emotionally involved.

A striking aspect of parents’ accounts was the different ways in which the mindfulness skills learned in MBCT were used to regulate emotion. One parent used MBCT to down-regulate rumination following interactions, rather than regulate anger before and during interactions. This suggests that mindfulness can be applied in multiple ways, and in this one case was used as a way of not reflecting on problematic interaction styles. This suggests the importance of discerning not only how but also when to apply the skills learned in MBCT.

Mindfulness training is more than learning ‘how and when’. It is also about taking a wider perspective and seeing more deeply. In this case, discerning what brings happiness and unhappiness to themselves and others in their lives – a deeper understanding of the relationship between their reactions to what is happening and the consequences – may be necessary to motivate Donna to apply mindfulness to regulate anger.

Duncan, Coatsworth and Greenberg (2009), in a recent paper, subsequent to this analysis, outline a model of mindful parenting that emphasizes “qualities of listening with full attention when interacting with their children, cultivating emotional awareness and self-regulation in parenting, and bringing compassion and nonjudgmental acceptance to their parenting interactions” (p. 255). The themes derived in this study converge with this model even though the intervention in this study did not directly target parenting.
Limitations and implications

This study set out to explore the experiences of parents with a history of depression who had undergone an MBCT programme. Given the exploratory nature of the study, and its methodological approach, there are several limitations to bear in mind. In general, qualitative methods are not geared towards examining causality, and we therefore cannot draw any direct conclusions regarding the mechanisms of change underlying MBCT. Moreover, parents’ accounts of their experiences of change may have been influenced by factors beyond those explored by this study such as their awareness, level of the developmental stage of their children, their levels of depression, the passage of time or non-specific factors, such as taking part in group therapy (Dimidjian & Linehan, 2003; Lau & McMain, 2005). However, the study’s aim was to assess parents’ perceptions and it will be for future research to examine the quantitative robustness of the constructs that emerged in our analysis (e.g., through the development of psychometric measures of these constructs and testing these with a more homogeneous sample and an attention control group). The current findings are thus unavoidably circumscribed and should therefore be interpreted with these limitations in mind.

Nonetheless, this study provides an important platform for future studies. First, MBCT appears to relate to processes that indirectly affect parenting. It will be important to examine whether MBCT has quantifiable impacts on parenting and child outcomes and whether bespoke mindful parenting programmes might generate such outcomes. Second, the findings provide an initial indication of a possible dose–response relationship between the extent of mindfulness practice and the degree of experienced psychological change which can be explored in quantitative terms. Third, as change did not seem to be experienced to the same degree by all parents, there is the need to further explore for whom changes occurred and under what circumstances; that is to say, there is a need to examine the moderators of psychological change. Fourth, it remains to be established whether children benefited from the changes reported by parents. Such research will need to consider particular developmental windows such as infancy versus early childhood. Fifth, there is the question of whether changes in the parent–child relationship occur concurrently with reductions in depressive relapse, as concurrent changes in parental depression were not tracked. Again, well designed process-outcome studies with time lagged measurement of the key constructs from this analysis could begin to explore this issue. Finally, it is striking that there were relatively few parents with young children in the trial sample which raises the possibility that the commitment of time and energy to MBCT may pose barriers for parents of young children. Any treatment development work should explore not just the efficacy but also the accessibility of any new intervention.

Conclusions

This exploratory study found that many parents reported changes in their emotional relationships with their children in the year following MBCT. Parents described an increase in their ability to manage their emotions and recognize and communicate their needs. This, in turn, seemed to increase their ability to be emotionally available to their children and also led to greater involvement, acceptance, empathy and ability to comfort and teach their children how to manage emotions. Future studies might consider building on these findings and further explore the links between MBCT, recurrent parental depression, emotional availability and the parent–child relationship reported by parents.

Conflict of interest

The study was conducted as part of a registered trial (ISRCTN12720810) funded by the UK Medical Research Council (TP 72167). This qualitative analysis was undertaken by the first author as part of her doctoral thesis.
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Notes

1. Frequencies have been used to indicate the prevalence of a theme, but should not be regarded as statistical indicators.
2. Information regarding the age or ages of the child or children to whom the parent refers in each data extract has been supplied in brackets, with the parents’ pseudonym.

References


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