



Research in brief

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A qualitative study into the experience of individuals involved in a mindfulness group within an acute inpatient mental health unit

Introduction

Mindfulness based therapeutic interventions in mental health services are increasingly proving to show high levels of efficacy. Mindfulness involves intentionally developing an awareness of moment-to-moment experience through meditation exercises, reflecting upon the findings and gaining insight into the cognitive, emotional and physical internal processes which underlie our experience of the world.

A mindfulness group within acute inpatient mental health services in the Plymouth Teaching Primary Care Trust was established in March 2005 as part of an increased psychotherapeutic response within service delivery. Recent acute inpatient care guidance (Department of Health 2002) established the provision of therapeutic experiences for people whilst in hospital as a major area for development. The National Institute for Mental Health in England (NIMHE 2003) report that many service users have extremely negative experiences of hospital, finding the hospital environment stressful rather than therapeutic. The Department of Health (2002) found that high therapeutic intervention environments diminish disturbance, violence and boredom, and enhance recovery. It is further suggested that each inpatient service needs to have a clear focus on the timetabled accommodation of therapeutic activity for service users, the implementation of effective ward groups being of great value.

Background

Day & Horton-Deutsch (2004) argue that finding effective interventions for the treatment of mental illness is a major concern. Increasingly, innovative

psychotherapeutic forms of treatment are being used with individuals experiencing serious mental illness (Segal *et al.* 2002). The use of mindfulness techniques originates from over two millennia ago in the meditation traditions of Asia and has been increasingly developed as a tool in the West over recent years. Mindfulness has found its way into physical and mental health settings over the last two decades.

Mindfulness-based therapeutic interventions have been shown to relieve distress for a wide range of psychiatric conditions and there is a growing evidence base to substantiate this. Ma & Teasdale (2004) found that mindfulness-based cognitive therapy reduced the incidence of relapse from 78% to 36% in patients with three or more previous episodes of depression. Individuals suffering from subjectively distressing psychosis have also been shown to benefit from the use of mindfulness techniques (Chadwick *et al.* 2005). A study of 35 community mental health team clients with a range of psychiatric diagnoses that had used mindfulness-based therapy found significant reductions in global distress, anxiety and depression, and improvements in well-being (Soulsby & Williams 2004). A qualitative study of mindfulness-based cognitive therapy involving mental health service users found that mindfulness skills were seen to play a key role in the development of change (Mason & Hargreaves 2001).

The use of mindfulness within acute inpatient mental health is still very much in its infancy. This study aimed to explore the experiences of individuals involved in the mindfulness group within Plymouth acute inpatient mental health services in order to evaluate its efficacy within this setting.

The mindfulness group

The group met on a weekly basis, consisting of two facilitators and an average of five participants who were inpatients of the unit. The sessions lasted for

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1 h with individual follow-up from facilitators between groups if required. A number of mindfulness techniques were explored in order to cultivate concentration and awareness of internal physical and mental processes through the use of sitting and walking exercises, mindfulness of breathing being a core technique.

Using the mindfulness-of-breathing technique as an example, participants were instructed to sit comfortably with eyes closed and spine straight and to direct their attention to their breathing. When thoughts, emotions, physical sensations or external stimuli arose, participants were encouraged to simply accept them, creating a space for them to come and go without judging or getting lost in them. When their attention had drifted from the focus of the breath and became identified with thoughts and feelings, participants were instructed to simply and gently bring it back to the breathing and continue with the exercise. Importantly, participants were reminded that it is okay and natural for thoughts and sensations to arise and for their attention to follow them. The technique involves gently bringing the attention back to the breath (or alternative focus of awareness) no matter how many times this occurs.

Group reflection on the experiences of using the technique would follow each practice session in order to explore how newly acquired mindfulness skills may be used to work with problematic cognitive and behavioural patterns experienced by participants within the group. The group facilitators were mental health professionals with significant training in using mindfulness techniques and, importantly, having their own personal mindfulness practice. It is essential for a mindfulness facilitator to have a direct personal experience of the techniques involved in order to translate the often difficult concepts used within mindfulness. An important aspect of the group was to equip the individual participants with the skills to develop a personal mindfulness practice to use in their daily lives after discharge, lessening dependence on the group itself.

Method

Given the experiential and subjective nature of mindfulness-based approaches, a qualitative research design seemed the most appropriate response to the research objectives (Holloway & Jefferson 2000). Semi-structured interview sched-

ules (Sapsford & Jupp 2006) were devised based upon a thorough literature review. The open-ended nature of the interviews aimed to facilitate the emergence of the individual's essential experience of mindfulness and possible themes that arose out of the process. Eight individuals involved in the group (four male and four female patients) were interviewed in depth. The average interview length was 35 min and all interviews took place within the unit. The range of psychiatric diagnoses within the group included bipolar affective disorder, depression, borderline personality disorder, paranoid schizophrenia and substance misuse. Admissions to the inpatient unit were for varying periods of time and therefore more structured, long-term courses were not appropriate. On average, participants attended five mindfulness groups. Participants were selected as having attended such groups two or more times. Interviews were recorded (with consent) and transcribed.

The chosen method for analysing the data was thematic analysis (Denzin & Lincoln 2000). The transcripts were analysed by the researcher to generate categories, themes and patterns which emerged (Marshall & Rossman 1999). Once identified, these areas were coded and cross-referenced in order to exhaustively draw out the findings (Mason 1997). Researcher bias was evaluated and interpretation of the data was confirmed by a peer review. The results have also been made available to participants to ensure consensus and validity. Confidentiality was protected at all times and approval was obtained for the project from the Plymouth TPCT Data protection team. All names used in participant quotes are pseudonyms to protect anonymity. The study adhered to the Royal College of Nursing (1998) guidance on research ethics and was approved by the South West Devon Research Ethics Committee and sponsored by Exeter Primary Care Trust.

Results

Ten clear themes emerged as a result of the study. The following is a reflection of these findings.

Cognitive changes

Most participants reported that mindfulness had led to changes in thought patterns and in the attitude one holds towards thoughts. One mindfulness facilitator mentioned that 'being able to distance

from their thoughts, being able to de-centre from their thoughts and feelings has been something that's been commented on'. Accounts of increased insight into thought patterns were also reported: '[people] can start to think about perhaps where their thoughts are coming from, where their patterns are coming from . . . like negative self talk or things like that' (Kate). Some participants also discussed an ability to rest in the present moment. Paul explained, 'Its given me freedom from my initial thoughts . . . I think it has helped in the way I think about things . . . I was thinking of things in the moment, not thinking of [the] past'.

A number of participants found that bringing awareness to thoughts and feelings and labelling them, as opposed to identifying with them as 'self', encouraged the realization that they may not be an accurate representation of reality. The breakthrough seemed to occur when they learned to observe the experience of a difficult thought or feeling such as depression as just a thought or feeling as opposed to a representation of self, avoiding the leap to I AM depressed: 'I can still totally identify with my feelings, with the painful feelings . . . which was fuelling the whole business, you know – the addiction, the behaviours, the avoiding strategies . . . I'm not saying it's easy, but there is a glimmer now . . . by seeing feelings as events rather than completely identifying with them . . . I'm having feelings of anxiety rather than I AM anxious . . . so that is the difference – breaking the identification . . . there are moments, particularly in sitting or walking meditation when I can actually see outside the frame' (Jason).

Concentration

A few participants described a new sense of focus as a result of using mindfulness. One reported an increased ability to focus on one thing at a time without getting lost in thought. Julie commented, 'I think it's a brilliant method for pinpointing your mind if that's the correct expression'.

A sense of peace and relaxation

Although mindfulness is not strictly a relaxation technique, all participants reported an experience of peace and relaxation: 'there was a feeling of peacefulness in the room' (Rob). One mindfulness facilitator said, 'in practice the word that comes up most often is *relaxing*. Interesting that they use that

word . . . this is a kind of new different experience for them . . . some people use the words calm, peaceful or slowed down'. Other participants described how this peacefulness has a positive effect on their problematic symptoms: 'by going into a form of meditation like say a body scan, I find it can relax me . . . I can find it useful for reducing anxiety' (Kate). Helen also described a therapeutic effect: 'I find it very calming, very peaceful. You feel at ease afterwards, in touch with sensations rather than just lost in thought . . . [I had] feelings of suicide and self-harm and I wanted to find a spiritual peace but I found a peace in the feelings and sensations of meditation . . . feeling aware distracts from my pain inside'.

Acceptance

Some participants described finding new more gentle responses to uncomfortable, problematic thoughts and feelings. Kate reported a 'noticing of the here and now without judgement . . . I find that a useful technique because it allows me not to go straight into my emotions'. Participants further discussed allowing difficult thoughts and feelings to simply be there, developing a more kindly and accepting reaction as opposed to a struggle: 'It allows you just a little bit of breathing space, room to move around . . . you can come back to your breath and can just say to yourself – this is my reality at the moment, these are my cards, this is it, you know?' (Jason). One of the mindfulness facilitators commented that 'people notice how self-critical they are, how they judge themselves all the time'.

Exposure to problem thoughts, feelings and beliefs

A number of participants discussed experimenting with sustained, non-judgemental observation of difficult feelings, without attempting to avoid them: 'I was very anxious and sitting with that . . . watching the anxiety . . . experiencing a bit of it and then coming back to the breathing, then a little bit more anxiety then coming back to the breathing' (Jason). Julie reported: '[I was] just really feeling disturbed and all this whirling going around in my head, things like that . . . but I felt I was using the mindfulness technique with it and then I sort of progressed from there'.

Exposure techniques are common in cognitive behavioural approaches, but mindfulness training does not deliberately induce the problematic symptoms. In the mindfulness group, participants were instructed to observe these sensations non-judgementally when they naturally arose: 'I went to the group and I really didn't want to be doing it, I really didn't want to sit with those feelings . . . but I did because that is what you do in mindfulness. That was a really important lesson to come away with actually, my other strategies obviously aren't working any more . . . the lesson to sit with the discomfort, that I should be willing to sit with the discomfort, I should be willing to sit even though I did not want to sit' (Jason).

Awareness

Two participants described a heightened state of awareness as a result of using mindfulness techniques. One participant discussed a feeling of being grounded in and more aware of his body: 'you take it (your body) for granted until someone points it out to you, you don't realize you've got this body here, you just get up in the morning and carry on and don't give it two thoughts'(Dan). Helen described a positive effect of this increased awareness: 'being aware of your presence . . . its calm . . . looking at the sky or feeling the wind on my face. Being aware of the present and forgetting the turmoil'.

Self-management – taking responsibility

Most participants reported using mindfulness techniques outside of the group: 'Yeah it's really got me through; it was really good . . . a lot of the time I have just had to sort of use mindfulness on my own' (Julie). With regard to mindfulness, one of the facilitators stated that 'I think it's [an approach] that encourages quite a lot of self-reliance in terms of people using it outside the sessions'. One participant explained how she uses mindfulness at night as it helps her relax, clears her thoughts and aids sleep. A number of participants described setting time aside daily for mindfulness practice: 'with the pressure these days and stress, you don't have time to stop and think . . . it's only ten to twenty minutes a day (mindfulness practice). We should stop and think what we are doing . . . it's taught me to do that' (Dan).

The use of mindfulness after discharge

The majority of participants expressed a desire to continue to practise mindfulness after discharge from hospital. One issue that came forward was the lack of provision of a mindfulness group in the community: 'People will probably come to one, two, possibly three sessions and then be discharged with no follow-up group in the community as yet' (Mindfulness facilitator). Jason confirmed that 'if there was one (group) in the community I would definitely attend weekly or bi-weekly'. There was evidence, however, that some participants would develop their own practice: 'well it's just got me through so much, you know? I'll carry on with it even if it's at home on my own' (Julie).

Negative experiences and misunderstandings in mindfulness

A few participants expressed difficulty in understanding some concepts within mindfulness. One common difficulty was the assumption that mindfulness involved controlling thought as opposed to observing thought: 'I was trying to control my mind but it was difficult to control my mind . . . you can't control your mind' (Rob). Another difficulty which arose for some participants was holding prior expectations regarding the outcomes of mindfulness practice and experiencing frustration at perceived failure: 'One frequent response is – I can't do it, or – I'm not doing it properly' (Mindfulness facilitator). One participant commented that 'when people go there [the group] for the first time, like everybody they want a quick fix. They want the answer. They want to sit down for an hour and not think about the past or their problems, and it will not work. You really have to go there with an open mind' (Paul).

Mindfulness and psychiatric medication

Only one participant discussed his medication, a person who was being prescribed an atypical antipsychotic medication. This person stated that he believed that mindfulness can be used in conjunction with this type of drug and that he had been able to access the group and techniques adequately. Reports from the facilitators indicate the use of psychiatric medication causing sedation can sometimes make it difficult to engage in mindfulness practice for some participants.

Discussion

The results indicate mindfulness to be a useful therapeutic addition to the acute inpatient environment. The use of mindfulness appears to allow participants to make significant cognitive changes. The reported ability to identify less with problematic thoughts and feelings as opposed to adopting them as 'self' could usefully be applied within a variety of psychiatric experience. Adopting this new self-schema may, however, create a friction with the usual use of psychiatric diagnoses. Mental health service users are often given a diagnosis that becomes an identity health professionals may collude with (e.g. 'I AM/YOU ARE depressed/anxious/psychotic'). The use of mindfulness could be an opportunity for service users to develop a more holistic self-view.

Reports of increased concentration could offer an opportunity to aid an individual's process of reflection through the ability to focus on one aspect of experience at a time without becoming enmeshed in thought and feeling. It is noteworthy that all participants described a sense of peace and relaxation as a result of mindfulness practice, often whilst having to manage highly disturbing symptoms and within the acute inpatient setting, which can often be a difficult and stressful environment. This phenomenon could prove highly beneficial in such settings and deserves further exploration. It was noted how articulately and openly the participants expressed their experiences. Inpatients experiencing high levels of distress or low mood can sometimes be mistaken as lacking competence and thereby unable to engage in more complex forms of therapeutic interaction (Bunsfield 1989), an assumption quite clearly disproved by this particular sample group.

Participants' acceptance of problem thoughts, feelings and beliefs, and a willingness to expose themselves to these has been shown to be a useful approach within this study. This approach could at times conflict with an acute inpatient environment, where controlling symptoms through the use of medication and developing strategies to avoid thought and feeling labelled as 'negative' can be the norm (Berke *et al.* 2002). Such friction could lead to a useful debate as to whether perceived 'bad' thoughts are something to be suppressed and eradicated or accepted and understood.

The ownership that participants took of their mindfulness practice was noteworthy. As opposed

to being passively treated pharmacologically or collaboratively with a therapist, mindfulness seems to offer the rare opportunity for the individual to become his/her own therapist and develop an expertise of his/her own unique internal process. This movement towards working with individual subjective experience rather than an abstract system of diagnoses may prove an interesting development within acute psychiatry. The evidence that participants wished to continue their use of mindfulness after discharge was also encouraging. The use of mindfulness has been shown to lessen impulsive and reactive behaviours and enable individuals to engage in new coping responses, thus lowering the likelihood of relapse and re-admission to hospital (Ma & Teasdale 2004).

Conclusion

Mindfulness appears to have a useful part to play within an increasingly psychotherapeutic response to acute mental health inpatient needs. It appears that within the processes that create the sense of self and conditioned experience of the world, the development of mindfulness can allow the letting go of maladaptive thought processes and beliefs, thus providing a space in which new healthier responses to the environment can be experimented with.

In a setting such as acute inpatient mental health services, where prolonged chemical sedation is widely utilized as a response to mental distress, mindfulness offers a markedly different approach. As opposed to concentrating on specific problematic cognitive patterns mindfulness offers an opportunity to change the individual's relationship with the whole panorama of emotion, thoughts and feelings. An approach resulting in reports of cognitive changes, peacefulness and relaxation as described by participants in this study certainly deserves further exploration.

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