Doctoral Portfolio In

Counselling Psychology

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A portfolio submitted in partial fulfilment of the requirements of the University of Wolverhampton Practitioner Doctorate in Counselling Psychology

Award: D.Couns.Psych

July 2016
ABSTRACT

Background: Research has shown that mindfulness-based interventions (MBIs) can be effective in the treatment and management of a variety of psychological and physical health conditions. Whilst under researched, there is growing evidence to support the use of MBIs with individuals with intellectual disabilities (IDs) who may require adaptation to existing MBIs as a result of cognitive or other impairments.

Method: This research dossier describes the development of an 8-week mindfulness group for adults with IDs. Two mindfulness groups were delivered by community practitioners. Participants completed self-report measures of anxiety and depression pre-intervention, post-intervention and at follow-up. Participants were interviewed for their experience of the group and assessed for their ability to understand and engage with the basic concepts of mindfulness.

Results: Participants reported a decrease in anxiety post-intervention which continued to decrease at follow-up five weeks after the final session of the mindfulness group. Self-reported depression also decreased post-intervention, however there was a slight increase at follow-up although this remained lower than baseline. The decrease in self-reported depression from pre-intervention to post-intervention was statistically significant. Participants were able to engage with, understand, enjoy and benefit from the mindfulness group and appreciated having the opportunity to meet with similar people with similar experiences.

Conclusion: Results indicate that the mindfulness group had some positive effect on self-reported anxiety and depression states. Participant feedback coupled with the researcher’s own reflections offer direction for further adaptations that could be made to the mindfulness group and support the need for further research in this area.
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ACKNOWLEDGEMENTS

During my training I have had the fortune to meet some incredible people; none more so than those participants who kindly, and somewhat bravely, took part in this research. Thank you for being so open and honest. Your involvement in this research was fundamental and I hope the findings go some way in improving mental health services for other people with intellectual disabilities too.

I would like to thank my research supervisors Dr. Darren Chadwick and Dr. Wendy Nicholls for being a constant source of support and encouragement. I have so appreciated working with you both and have learnt so much about what it means to be a psychologist and a researcher.

I would also like to thank Professor Kenneth Manktelow and Dr. Lee Hulbert-Williams for their enthusiasm during the initial stages of the research and their encouragement to pursue this particular area of research.

I would like to thank Dr. Alison McGarry for co-facilitating the mindfulness groups (I don’t think either of us were prepared for how enormous a task this turned out to be) and Dr. Joy Davis for being hugely inspirational and supportive from my very first day as an assistant psychologist right through to my very first day as a qualified counselling psychologist.

I feel privileged to have studied at the University of Wolverhampton and will look back proudly at the things I have achieved with the support of the course team and my cohort.
CONFIDENTIALITY

The contents of this Doctoral Portfolio has been appropriately anonymised in order to ensure participant confidentiality and anonymity. All identifiable information has been removed including participant names which have been replaced with pseudonyms.
# ABBREVIATIONS

Below is a list of abbreviations frequently used throughout this doctoral portfolio.

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<td>Acceptance and commitment therapy</td>
</tr>
<tr>
<td>ADHD</td>
<td>Attention deficit hyperactivity disorder</td>
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<td>ASD</td>
<td>Autistic spectrum disorder</td>
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<td>BPS</td>
<td>British Psychological Society</td>
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<tr>
<td>CLDT</td>
<td>Community Learning Disability Team</td>
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<tr>
<td>DBT</td>
<td>Dialectical behaviour therapy</td>
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<tr>
<td>HCPC</td>
<td>Health and Care Professions Council</td>
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<tr>
<td>ID</td>
<td>Intellectual disability</td>
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<td>IDs</td>
<td>Intellectual disabilities</td>
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<td>MBCBT</td>
<td>Mindfulness-based cognitive behaviour therapy</td>
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<td>MBCT</td>
<td>Mindfulness-based cognitive therapy</td>
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<td>MBI</td>
<td>Mindfulness-based intervention</td>
</tr>
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<td>MBSR</td>
<td>Mindfulness-based stress reduction</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<td>NICE</td>
<td>National Institute for Clinical Excellence</td>
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<tr>
<td>RCT</td>
<td>Randomised control trial</td>
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<td>SoF</td>
<td>Meditation on the Soles of the Feet</td>
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## WORD COUNT SUMMARY

Each word count includes titles and in-text references and excludes tables and diagrams.

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### Research Dossier

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| TOTAL                                    |          | 47,424     |
| TOTAL                                    |          | 64,534     |
DECLARATION

This work, or any part thereof, has not previously been presented in any form to the University or to any other body whether for the purposes of assessment, publication or any other purpose, unless otherwise indicated.

Other than the expressed acknowledgements, references and/or bibliographies cited in the work, I confirm that the intellectual content of the work is the result of my own efforts and of no other person.

The right of Sarah Croom to be identified as author of this work is asserted in accordance with ss.77 and 78 of the Copyright, Designs and Patents Act 1988. At this date copyright is owned by the author.

Date: July 2016
PREFACE

The following portfolio has been completed as part of the University of Wolverhampton’s Practitioner Doctorate in Counselling Psychology. Comprised of three sections – the Academic Dossier, Therapeutic Dossier and Research Dossier – this portfolio describes my development as a reflexive and autonomous counselling psychologist and scientist-practitioner (Health & Care Professions Council (HCPC), 2012) with a special interest in intellectual disabilities (IDs). A Confidential Attachment containing a process report, client study, personal journal summaries, assignment feedback sheets and raw research data has been submitted separately to the Doctoral Portfolio and will remain confidential.¹

The Academic Dossier consists of two essays, both completed during the second year of doctoral training. The first was submitted in fulfilment of the requirements of the Therapeutic Issues and Ethics module and the second in fulfilment of the requirements of the Psychodynamic Approach module. The Therapeutic Dossier also consists of two essays – one completed for the Professional Issues module and the second for the Supervised Practice module. Both were completed during the third year and towards the end of the taught aspects of the course. These four essays are presented as they were originally submitted in order to reflect my development in terms of academic writing, reflective thinking and the ability to integrate personal and professional experiences and learning in the formation of a professional identity and apply this learning to a clinical context. The third section of the portfolio, the Research Dossier, begins with a review of the research area of interest, ¹ In order to maintain confidentiality throughout the doctoral portfolio, all identifying material has been removed or replaced with pseudonyms. This is discussed in greater depth in the Research Dossier.
followed by the empirical study and finally a critical review of the research process.

Submitted for the Therapeutic Issues and Ethics module and titled ‘An exploration of issues regarding the routine use of psychometric assessment within the ID population: Considerations for counselling psychologists’ the first essay to make up the Academic Dossier highlights ethical concerns associated with the diagnosis of IDs. I particularly enjoyed writing this essay and felt I had been successful in providing a thought provoking and compelling argument for the critical evaluation of the social construction of intelligence, IDs and the methods by which we measure and diagnose IDs. I was afforded the opportunity to write about something of which I felt passionate and to think critically about how my values influence my clinical work and how these values are challenged by factors additional to the therapeutic relationship, such as the demands of the service and the social construction of IDs.

The second essay included in the Academic Dossier is titled ‘Working psychodynamically with individuals with IDs’. In this essay I explore how the key features of the psychodynamic approach may present within the therapeutic relationship with adults with IDs. I highlight potential challenges for counselling psychologists, such as the need to maintain the fidelity of the psychodynamic approach whilst recognising and responding to the client’s individual needs and adapting the approach to suit (The Royal College of Psychiatrists, 2004). I also highlight potential challenges for the individual with IDs, such as the pervasive assumption that they do not possess the skills necessary to engage with and benefit from psychological therapy and subsequent barriers to accessing this support.

Both of the essays included in the Academic Dossier are relevant to my work as a trainee
counselling psychologist within community-based psychological services for adults with IDs. They integrate academic learning and clinical practice and illustrate the reflective and evaluative process required to achieve this. On reflection, I appreciated the opportunity to advocate for the people with whom I worked, to challenge assumptions and stereotypes, to highlight the underrepresented needs of an underrepresented population, and to do so creatively and with passion and enthusiasm.

The essays included in the Therapeutic Dossier are compulsory components of the Doctoral Portfolio. The first, submitted in fulfilment of the Professional Issues module in the final year of training, provides a reflective and personal account of my development as a counselling psychologist and the values and philosophy that inform my clinical practice. I discuss my transition from assistant to trainee psychologist and the need to balance the demands of the doctoral course with the often competing demands of employment. I highlight some of the challenges I have experienced as a trainee counselling psychologist working within the NHS, such as the potential for incongruence between my person-centred, relational approach to therapy versus service and structural demands resultant from a medical model approach. Establishing an identity as a counselling psychologist and developing a strong sense of my own personal values has been vital to how I have been able to manage such demands.

The second essay included in the Therapeutic Dossier is a ‘Placement Portfolio’ focusing on my clinical experience and the competencies and skills I have developed thus far. I outline my varied role within the NHS which includes direct client work in a variety of contexts with a variety of clinical and ethical issues, working independently and as part of a multi-disciplinary team, developing individual therapeutic relationships and working systemically with families, paid caregivers and service management, administering and evaluating
psychometric measures, engaging in service development and facilitating therapeutic groups. I also consider context issues specific to working with people with IDs within the NHS and draw on client examples to illustrate the scope and variety of issues with which clients present to the service. Bringing all of this together allowed me to think critically about how my experiences and learning have shaped and influenced my development as a counselling psychologist, scientist-practitioner, researcher and leader.

My interest in working therapeutically with individuals with IDs, my dedication to the clients with IDs with whom I work, the realisation that relatively little is known about the work of counselling psychologists within ID services (Jones, 2013) and that the emotional wellbeing of (Arthur, 2003) and psychological interventions for people with IDs has largely been ignored (Reed, 1997), influenced my assignments and ultimately my doctoral research. ‘The Development and Evaluation of a Mindfulness Group Intervention for People with IDs’ forms the Research Dossier component of the doctoral thesis. The process of developing a mindfulness group for people with IDs, adapting and developing materials, data collection, analysis and interpretation are described and critically evaluated. I used a mixed methods design drawing on transformative and social constructionist principles and engaged in a continued process of reflexivity in line with the ethos of counselling psychology, qualitative data collection methods and thematic analysis. The primary research aims were to explore the feasibility of adapting mindfulness techniques to successfully meet the needs of individuals with IDs, to consider the participants’ experiences of attending the mindfulness group and engaging in mindfulness exercises, and to establish whether the mindfulness group could lead to beneficial outcomes. The Research Dossier can be seen as a culmination of my learning and development throughout the course of doctoral training, however it is also the beginning of what I hope will be a long and rewarding career as a Chartered Counselling Psychologist,
dedicated to providing effective and compassionate psychological support within ID services.

References:


Research Dossier

The Development & Evaluation of a Mindfulness Group Intervention for People with Intellectual Disabilities

By Sarah Croom
Chapter 1 – Literature Review

A review of the literature regarding the application of mindfulness with people with

Intellectual Disabilities and those who care for them

1.1 Introduction

1.1.1 The present study

This study presents the development and outcomes of a community-based mindfulness group for adults with Intellectual Disabilities (IDs). Relatively little is known about the potential benefits of mindfulness for people with IDs and there remains a gap in service provision for those with IDs and additional mental health needs. The aim of this study was to address the gaps in knowledge, research and service provision, explore the potential benefits of mindfulness for individuals with IDs and report on the feasibility of developing a mindfulness group for individuals with IDs. An extensive review of the existing literature regarding the use of mindfulness-based interventions (MBIs) with people with IDs informs this research. The literature review, presented below, begins with a definition of the term ‘IDs’². Existing interventions are outlined and reviewed. The process of conducting the literature review is described; the results of which are presented in three sections. The first is concerned with the direct use of MBIs with individuals with IDs. The second and third are

² The term ‘Intellectual Disability’ has been used as it is considered less offensive to people with disabilities than previously common place terms, is being increasing used internationally and is consistent with current professional practices focused on functional behaviours and issues of context and environment (Schalock, 2011). It has been shortened to ‘ID’ or ‘IDs’ (plural) due to word restrictions.
concerned with the indirect impact the mindfulness practice of parents, caregivers and professionals may have on those individuals with IDs whom they support. A critique of the existing literature concludes the review.

1.1.2 Intellectual Disabilities, emotional need and therapeutic intervention

The term ‘Intellectual Disability’ (ID) does not refer to a homogenous group (The British Psychological Society (BPS), 2000; Inglis, 2013) but is a socially constructed concept (Jones, 2013a; Rapley, 2004) referring to a group of individuals with differing practical, emotional and cognitive needs (and indeed strengths) who possess a number of features which have become widely accepted as indicative of an ID. People with IDs should be considered “people first” (The Department of Health, 2001; p.14) and people-first language has been adopted throughout this thesis (Snow, 2008).

Individuals must meet three specific criteria in order to meet the threshold for a diagnosis of IDs and therefore access to specialist services. These criteria are: impairment in the ability to understand new or complex information (impaired cognitive functioning) and an impairment in the ability to cope independently (impaired social and adaptive functioning); both of which must have presented in childhood and have predicted lifelong effects (The Department of Health, 2001). Current estimates suggest that in England there are around 1,191,000 individuals with IDs including 286,000 children and young people and 905,000 adults (Emerson et al., 2011). The life-expectancy of people with IDs has increased significantly over the past 50 years (Strydom et al., 2010) which may be the result of advances in healthcare, medicine, science, education and technology (World Health Organisation, 2000) alongside a shift in the way in which society views people with disabilities.
“Incompetence” and “inability” are dominant in the discourse surrounding IDs (Baum, 2007; p.8). It can be argued that the definition of IDs is reductionist and based on a deficits model with the focus being on what the individual cannot do rather than what the individual could do if they were appropriately supported or lived in a society in which they were better enabled rather than disabled. Inglis (2013) suggests that many of the difficulties experienced by those with IDs are not as a result of the disability itself, but rather inequalities in access to services imposed by a society which views those with disability as ‘different’. Similarly, Kroese (1998; p. 320) suggests that individuals with IDs are “more disabled by the external, material and political barriers that are put in their way than by their inherent disabilities”.

It is widely accepted that people with IDs are at an increased risk of emotional, financial and sexual exploitation, whilst research suggests that incidences of mental-ill health are greater within the ID population compared to that of the general population (Cooper, Smiley, Morrison, Williamson & Allan, 2007). It may therefore be assumed that given the number of people in England with IDs, the fact that this is a growing population, and the increased likelihood of individuals with IDs experiencing mental ill-health, that psychological support would be widely available for people with IDs. Taylor and Knapp (2013) list a number of factors contributing to the continuing inequality in access to mental health services including a lack of knowledge and awareness regarding the mental health and emotional needs of people with IDs, a lack of evidence to guide practice, and difficulties “making an economic case in increasingly challenging fiscal context” (p.2).

The use of therapeutic approaches with people with IDs remains under-researched. Psychodynamic therapy, for example, remains largely unavailable for people with IDs (O’Driscoll, 2009) due to barriers in accessing such services, whilst having a diagnosis of IDs
is often cited as an exclusion criteria for some psychological therapies and mental health services (The Royal College of Psychiatrists, 2004). It would seem Freud’s suggestion that the success of therapy is in some way reliant on client intelligence (Freud, 1904) has been pervasive (Brown & Peddler, 1979) alongside more recent suggestions that people with IDs lack the language or cognitive skills necessary to understand therapy or that the presence of a cognitive impairment implies emotional impairment also (Hodges, 2003). As such, the emotional lives of people with IDs have been neglected (Arthur, 2003).

Talking therapies were historically considered inappropriate for people with IDs (Hodges, 2003) and applied behaviour therapy was, until relatively recently, the most frequently employed therapeutic intervention for people with IDs (Johnson, Mason & Withers, 2003) with the focus being on the measurement of cognitive functioning, the assessment and modification of maladaptive behaviour and the treatment of ‘challenging behaviour’ (Arthur, 2003). Bender (1993) refers to a history of institutionalised ‘therapeutic disdain’ based on prejudice towards those with disability which has led to their exclusion from psychological interventions. With the focus being on behaviour modification rather than emotional wellbeing, the therapist, arguably, is able to maintain some degree of distance and so avoid engaging with their own feelings regarding disability (Hodges, 2003). However, therapeutic disdain can no longer be justified (Taylor & Knapp, 2013) and changes in social attitude and service reforms mean that these historical practices are being challenged. As Arthur (2003; p.31) states “there is now sufficient evidence to show that people with [IDs] have emotional lives with emotional difficulties, need help with these problems and can benefit from psychological techniques”.
1.1.3 Mindfulness as a therapeutic intervention

Baer, Smith, Hopkins, Krietemeyer and Toney (2006) identified five facets of mindfulness: non-reactivity to inner experience, acting with awareness, observing, describing and non-judging of experience. Common definitions of mindfulness also include the ability to orientate oneself to the present moment, often employing the breath as an anchor between the inner experience of the body and mind, and the outer experience of the external world. Physical sensations, thoughts and emotions are explored with a degree of curiosity and compassion, and are ultimately accepted for what they are, as they are. They are not challenged, evaluated or judged.

Mindfulness is present in most religious and spiritual traditions (Shapiro, 2009) however the Western understanding of mindfulness is perhaps associated most strongly with the work of Jon Kabat-Zinn, the founder of mindfulness-based stress reduction therapy (MBSR). Contemporary psychological approaches have adopted mindfulness as a tool for managing emotional distress and maladaptive behaviours through the promotion of increased awareness and the ability to respond skillfully to individual thought processes (Bishop et al., 2004); although there has been much debate around the definition of mindfulness within a clinical context (for example Bishop et al., 2004) and the need for a cross-cultural sensitivity which takes into account differing philosophical, spiritual, cultural and intellectual traditions (Shapiro, 2009). Kabat-Zinn (2003; p.147) for example states “the challenge is to find a fit that honours the integrity of what may be different but complimentary epistemologies”.

Although no universal definition of mindfulness exists, psychological literature tends to refer to mindfulness as a state, a trait, a process and an outcome (Singh, Lancioni, Wahler, Winton & Singh, 2008a). Bishop et al. (2004) describe mindfulness as a two-component model involving the self-regulation of attention so that thought processes might be recognised in the
present moment, in addition to the adoption of curiosity, openness and acceptance to personal experiences. They consider mindfulness to be a state and a psychological process, which can be practiced. Kabat-Zinn (2003; p.143), however, opts for the following operational definition and states that mindfulness is “the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment”.

Much of the interest in the use of mindfulness as an aid to alleviating existential suffering resulted from Kabat-Zin’s (1982) MBSR program for the treatment of chronic pain conditions. Various MBIs were born out of MBSR research (Cullen, 2011) including mindfulness-based cognitive therapy (MBCT), mindfulness-based cognitive behaviour therapy (MBCBT), acceptance and commitment therapy (ACT) and dialectical behaviour therapy (DBT). There is now substantial evidence to suggest that MBIs can be beneficial for a variety of clinical and non-clinical groups (Shapiro, 2009) such as those experiencing depression (Segal, Williams & Teasdale, 2002; Williams, Teasdale, Segal & Kabat-Zinn, 2007) with current National Institute for Health and Clinical Excellence (NICE) guidelines recommending MBCT for adults with three or more previous episodes of depression who are at risk of relapsing (NICE, 2009). MBIs have also been shown to improve mood and alleviate symptoms of stress in cancer patients (Speca, Carlson, Goodey & Angen, 2000), improve symptoms of depression in coronary heart disease patients (O’Doherty et al., 2015) and improve the working memory of military personnel and mediate the effects of stress on functional impairments (Jha, Stanley, Kiyonaga & Gelfand, 2010).

A recent meta-analysis found that MBIs “showed large and clinically significant effects in treating anxiety and depression” with benefits maintained at follow-up (Khoury et al., 2013;
Similarly, a review of empirical literature concluded that findings from clinical intervention, correlational and laboratory-based experimental studies all indicate that “mindfulness is positively associated with psychological health, and that training in mindfulness may bring about positive psychological effects” (Keng, Smoski & Robins, 2011; p. 1052).

As with other therapeutic interventions, the use of mindfulness with people with IDs is under-researched (Robertson, 2011) despite the fact that Uma, Nagendra, Nagarathna, Vaidehi and Seethalakshmi (1989) reported on the use of mindful relaxation techniques in the form of yoga practices for children with IDs over two decades ago. This lack of research may be explained by the findings above regarding assumptions about the lack of appropriateness of talking therapies for people with IDs and subsequent exclusions from talking therapies. The need for specialist outcome measures for use with individuals with IDs and difficulties obtaining valid and reliable self-reports from those who may have difficulties with communication or self-expression may also be contributing factors.

Existing research suggests mindfulness can be used alongside the behavioural model historically employed with people with IDs, however it can also be used as an alternative to this approach (Harper, Webb & Rayner, 2013) either on its own or in conjunction with talking therapies to improve quality of life, emotional wellbeing and behaviours that challenge. Taking into account the cognitive capabilities of people with IDs and the historical treatment of people with IDs, there would appear to be various qualities to mindfulness approaches which might make them particularly acceptable to people with IDs. For example, mindfulness is experiential and skills-based; it does not require reading or writing. Mindfulness can be practiced, repeated and internalised so that it becomes instinctual and is...
more easily generalised to different environments or situations. It can also be practiced and delivered in groups or on a one-to-one basis depending on the needs and preferences of the individual. Mindfulness promotes quality of life and an acceptance of personal difficulties and individual differences. Mindfulness is an internal process and does not rely on external intervention and prompting; mindfulness is therefore something a person can do for themselves rather than something which is done to or for them.

Hastings (2013) has speculated that mindfulness can be empowering for people with IDs and their carers as it can help them to develop the skills and resilience required to manage their own environments (rather than being dependent on others to do this for them) and to cope with novel or ongoing challenges. Possible explanations for how and why mindfulness might be beneficial for people with IDs are discussed throughout this literature review alongside descriptions of the existing research in this area.

Given the lack of research in this area, the potential for mindfulness to be particularly useful for people with IDs and consistently positive findings regarding mindfulness and the general population, the use of mindfulness with people with IDs deserves further exploration.

1.2 Search strategy

In December 2014 the databases MEDLINE and PSYCHinfo were searched for publications relating to mindfulness and IDs. Search terms included ‘mindfulness’ / ‘mindful’ / ‘relaxation’ / ‘meditation’ and ‘intellectual development disorder’ / ‘mental retardation’ / ‘intellectual disabilities’ / ‘learning disabilities’. The author also checked the reference lists from journal articles identified via the literature search and requested that colleagues, clinical
and research supervisors share any additional publications they may have been aware of. Searches were conducted from inception to present day.

1.2.1 Inclusion and exclusion criteria

To be included in this review, the research paper had to report an original empirical study with original data. Further, the research paper needed to describe a study in which either one or more individuals with IDs or their caregivers engaged in some form of MBI.

Papers were excluded from the literature review if they involved participants with a developmental condition (such as autism spectrum disorder (ASD)) but no ID. Papers were also excluded if they considered the impact of the MBI on family or professionals but not the individual with IDs themselves, or employed mindfulness as only a component part of a wider intervention such as ACT or DBT.³

In an extension of previous review papers, this review includes studies considering the psychological and/or emotional impact of MBIs in addition to those which focus on behaviour change (Harper, Webb and Rayner (2013), in their review, chose to focus solely on behaviour change). Studies relating to family or professionals were also included only if they considered the impact of the MBI on individuals with IDs. A previous review paper by Hwang and Kearney (2013) excluded studies relating to the families and carers of those with IDs and focused on the value of mindfulness practice for the individuals with IDs themselves. Given the lack of agency typically afforded individuals with IDs, maintaining the focus of the

³ Harper, Webb and Rayner (2013) point to a lack of research regarding the clinical and academic impact of such approaches and the exact role of mindfulness within these approaches. Such approaches therefore require further research in their own right.
research on the individual is clearly important, however the author recognises the benefits of working systemically and engaging with the systems within which the individual operates. Arguably, it is only by engaging with these systems that allied health professionals can influence the ways in which people with IDs are treated within wider society (Kroese, 1998; Singh et al., 2013c).

1.3 Narrative review

1.3.1 Overview of the studies

22 published journal articles were identified and grouped into the following areas of concern: studies evaluating MBIs for people with IDs (N=17), studies evaluating MBIs for professionals working with people with IDs (N=3) and studies evaluating MBIs for parents whose children have IDs (N=2). These studies will now be reviewed and following this a critical appraisal of the extant literature will be presented. An overview of the studies is presented in Appendix 1.

1.3.2 Mindfulness-based interventions for people with Intellectual Disabilities

13 of the 17 studies regarding the direct use of MBIs with people with IDs employed the ‘Meditation on the Soles of the Feet’ (SoF) technique described by Singh, Wahler, Adkins and Myers (2003) in which the individual diverts attention from the emotionally arousing thought, situation or other stimulus to a neutral part of the body, such as the soles of the feet. Singh et al. (2003) state that interventions aimed at addressing aggressive behaviour in individuals with IDs are predominantly externally controlled by, for example, a behavioural therapist or other professional. They go on to suggest that since such interventions have apparently had little success with those who are repeatedly readmitted to institutions,
interventions should be offered which allow the individual a greater degree of meaningful involvement in their own treatment; such as mindfulness meditation.

Research in which the individual is the focal point of the MBI tends to take the form of case studies. Such methodology raises issues regarding generalisability, however the potential benefits of mindfulness on the behavioural presentation and emotional and psychological wellbeing of participants is evident. For example, in the case study described by Singh et al. (2003), a 27-year-old man with mild IDs had previously been deemed too aggressive to secure a community placement. The man participated in a ‘SoF’ MBI and went on to live in the community independent of the two psychotropic medications he was previously prescribed. In a follow-up study, the same individual taught the same mindfulness technique to three of his peers in order to help them control their anger and aggressive behaviour (Singh et al., 2011a). Self-reported anger and incidences of aggressive behaviour were compared with the reports of others who were present during an incident of aggressive behaviour. An overall reduction in anger and aggressive behaviour suggested that the individual with IDs who taught the ‘SoF’ intervention was “an effective therapist who could produce treatment outcomes...essentially similar to those produced by clinicians...” (Singh et al., 2011a; p.2694). The fact that he was able to successfully share his knowledge with others suggests he had engaged at a meaningful level in the management of his behaviour and that this was successful where previous externally controlled interventions were not.

In a further study considering the use of ‘SoF’ in the treatment of anger and aggression, Singh et al. (2007a) report on three individuals with mild IDs at risk of losing their community placements due to aggressive behaviour. Despite initial difficulties understanding
the procedure, the introduction of role play allowing the recreation of past anger inducing situations lead to a reduction in aggressive behaviour in the community for at least two years. Adkins, Singh, Winton, McKeegan and Singh (2010) considered whether such positive outcomes could be achieved when the ‘SoF’ training was delivered by a community therapist rather than experienced researchers (as for Singh et al. (2007a)). Three adults with IDs and additional mental health needs were given written and individual instruction in ‘SoF’. They received one hour of training five days a week with the therapist and were encouraged to practice at least twice a day. This intervention period lasted between two and five weeks depending on how quickly participants felt confident to perform the technique on their own or with staff support. Incidences of aggression decreased and the three participants maintained their community placements. The authors conclude that the ‘SoF’ technique can be successfully taught by a community therapist.

‘SoF’ has also been employed as a technique for reducing anger and aggression in forensic and in-patient settings in two studies again carried out by Singh and his colleagues. The first study (Singh et al., 2008b) focused on six male offenders with mild IDs from a forensic mental health facility. All had a history of physical aggression and were referred for treatment as their aggressive behaviour had caused injury to staff, had failed to be controlled through other means, and was jeopardising any future chance of a community placement. At baseline, the mean number of physically aggressive behaviours occurring each month ranged from 1 to 2.6 for each participant. During the 27 months of mindfulness training (which involved practicing ‘SoF’ twice a day and whenever triggers for aggression occurred) the number of aggressive behaviours for all participants fell to zero. Verbal aggression also decreased and there were no staff injuries or any physical restraint. The intervention appeared to be cost-effective as staff took fewer days off work due to injury and associated medical
costs were reduced. Despite this success, the authors highlight the need for extensive practice of the ‘SoF’ technique before positive outcomes may be observed. It took participants several months of practice and engagement with the technique before incidences of physical aggression feel to zero and for this to be sustained for all participants over a period of six months towards the end of the study.

Three of the participants (all of whom had committed a sexual offence) took part in a second study considering the impact of ‘SoF’ and a ‘Mindful Observation of Thoughts’ meditation on their ability to manage their “deviant sexual arousal” (Singh et al., 2011c; p.165) when shown images aimed to induce sexual arousal. Although participants reportedly found it difficult to use such techniques for this purpose due to their emotional attachment to the sexual thoughts, self-reported sexual arousal levels reduced for all three participants. Participants commented that previous interventions requiring direction from others were not as good as the mindfulness intervention since mindfulness required them to take responsibility for their own behaviour. The fact that participants had practiced mindfulness previously may have had some impact on the positive outcomes observed. The small sample size, in-patient setting and use of self-report data which was not validated by additional measures raise issues regarding the generalisability of results.

Chilvers, Thomas and Stanbury (2011) consider the impact of a ward-based mindfulness program on observed aggression. 15 female residents with IDs in a medium secure facility in the UK took part in a 30-minute mindfulness group session, twice a week for approximately six months. A combination of participation, observation and description exercises were taught and practiced. Following the intervention there was a decrease in the number of observed incidents of aggression, physical intervention and seclusion, which the authors
conclude supports the efficacy of group MBIs in forensic ID settings. Nursing staff who attended the mindfulness sessions said they found the sessions enjoyable, enlightening and fun (Thomas, 2013) whilst patients reported using mindfulness to help with a range of symptoms, such as managing thoughts and feelings regarding self-harm (Thomas, 2012). Chilvers, Thomas and Stanbury (2011) highlight a relevant point about the nature of group work which may have had an impact on outcomes. That is, the group was intended to be an enjoyable experience and so may have influenced the mood of those who attended the groups which may in turn have influenced overall ward dynamics and patient-staff interactions.

It is possible then that factors other than mindfulness may have had an impact on outcome. A control or treatment as usual group might have facilitated the identification of potential confounding variables as would a multiple baseline design in the case series. Behavioural observations, in addition to self-report measures, could have been made of those who did not participate in the mindfulness group so that comparisons could be made between those who received mindfulness training and those who received treatment as usual. However, since the 15 participants constituted all residents on the ward during the study, the implementation of a control or treatment as usual group would have meant withholding a potentially effective intervention for some of those resident on the ward which has ethical implications.

Yildiran and Holt (2014) provide insight into how people with IDs understand mindfulness and the benefits and difficulties associated with attending a weekly relaxation and mindfulness group at an inpatient assessment and treatment unit for people with IDs and additional mental health diagnoses. Six semi-structured interviews were analysed using thematic analysis. The identified themes suggest participants doubted their ability to learn the mindfulness techniques however they were able to form an understanding of mindfulness
even if this differed from the explanations of mindfulness provided by the group facilitators. Participants’ understanding of mindfulness appeared to be in relation to relaxation; perhaps because relaxation was a familiar concept, or because the group combined mindfulness and relaxation techniques. The authors note that it would be interesting to repeat this study with a mindfulness group that does not incorporate elements of relaxation. When two interventions are combined, it is not clear which lead to the positive outcomes observed or whether there was a cumulative effect.

In addition to Chilvers, Thomas and Stanbury (2011) and Yildiran and Holt (2014) seven further studies examine the effectiveness of MBIs within a group setting, however all took place within the community. Idusohan-Moizer, Sawicka, Dendle and Albany (2015) evaluate a nine week structured MBCT group program adapted for individuals with IDs, anxiety and/or depression and a history of self-harm. 15 participants attended one of two MBCT groups and completed pre-intervention, post-intervention and six-week follow-up self-report measures; one of which measured depression and anxiety and the other compassion. Neither of the two self-report measures were developed for use with people with IDs, however the measure of compassion was shortened. Scores for anxiety and depression were significantly lower post-intervention and were maintained at follow-up. Conversely, scores for compassion were significantly higher post-intervention and were also maintained at follow-up. All participants felt they were treated with respect, kindness, understanding and interest, however some found the amount of paperwork overwhelming and two carers felt that the program did not meet the needs of people with moderate IDs, with one suggesting that a ‘one size fits all’ approach was not effective given the diversity amongst people with IDs.
Beauchemin, Hutchins and Patterson (2008) also explored the feasibility of running a community mindfulness-based group intervention for people with IDs and report on the findings of a five-week mindfulness meditation intervention attended by 34 adolescents with IDs aged between 13 and 18 years. The authors were interested in the high levels of anxiety and school-related stress experienced by adolescents with IDs and whether mindfulness might have a positive impact on anxiety, social skills and academic performance. Outcome measures including self-reports from the students and ratings from their teachers showed significant improvement in the students’ social skills and academic performance, and a decrease in state and trait anxiety. The authors highlight the lack of a comparable control or waiting list control group; a criticism made of much of the existing literature in this area (Harper, Webb & Rayner, 2013).

Whilst Beauchemin, Hutchings and Patterson (2008) question the ethics of withholding therapeutic intervention, Singh et al. (2013b) demonstrate the feasibility of randomised controlled trials (RCTs) in ID research in their paper regarding the use of a mindfulness-based group intervention in the treatment of physical and verbal aggression for people with mild IDs living in the community. 34 participants were assigned to either an experimental or waiting list control group. There was a 12-week baseline phase for both groups followed by a 12-week intervention phase and then a 12-week follow-up phase. The only difference for those in the waiting list control group was an additional 12-week waiting list control phase after the initial 12-week baseline phase. The mindfulness training was delivered by parents and support staff who practiced with participants five times a week, 15-30 minutes a time. The trainers followed a 12-week training program (Singh, Singh, Adkins, Singh & Winton, 2011e) including mindful observation of the breath and ‘SoF’. Results showed a significant reduction in physical and verbal aggression for those in the experimental condition when
compared to the control group despite there being no differences in physical or verbal aggression between both groups at baseline. The control group also showed a significant reduction in physical and verbal aggression following the MBI with further significant reductions observed for both groups during the follow-up period. The use of a control group is a particular strength for this study; just two other studies identified in this review employed a control group (Singh et al., 2014; Neece, 2014).

A further two studies, again conducted by Singh and his colleagues and employing the ‘SoF’ technique, consider the impact of group-based mindfulness training on individual smoking behaviour. In the first study (Singh et al., 2013a) three adult men with mild IDs aged between 23 and 31 who lived together in rented accommodation engaged in a mindfulness-based smoking cessation program. Participants were taught ‘SoF’ and a mindful observation of thoughts exercise. They were encouraged to verbalise their intention to stop smoking in a self-affirming manner. All three participants showed a decline in the number of cigarettes smoked during the intervention period which reduced to zero during the maintenance period and remained at zero during the follow-up period. Despite this success the authors highlight the fact that participants lived together and likely provided social support and reinforced and encouraged each other to stop smoking. The benefits resulting from the mindfulness intervention cannot therefore be disentangled from the potential benefits of social support.

The second study regarding the use of a mindfulness-based smoking cessation program for individuals with IDs (Singh et al., 2014) used a RCT to assign 51 adults with mild IDs to either an experimental or control group. Those assigned to the control group received treatment as usual such as motivation, behaviour and nicotine replacement therapies. Those assigned to the experimental group engaged in a smoking cessation program replicating the
three interventions used by Singh et al. (2013a). Training was delivered via Skype, individually or in small groups by a trainer experienced in service provision for people with IDs and personal meditation practice. Of the participants who completed the intervention, 100% of those in the experimental condition stopped smoking entirely compared to 38.89% of those in the treatment as usual group. The authors conclude that the mindfulness-based smoking cessation program was beneficial in supporting individuals with IDs to stop smoking and to maintain this for up to a year.

Both the Singh et al. (2013a) and Singh et al. (2014) group intervention studies were preceded by a case study by Singh et al. (2011d) in which a 31-year-old male with mild IDs engaged in a mindfulness-based smoking cessation program and reduced his smoking to zero during a 12-month maintenance period and a three year follow-up period. Although all three of these studies provide evidence for the beneficial effects of mindfulness in supporting smoking cessation, the addition of a measure of participants’ mindfulness pre and post intervention would add further support to the assumption that it is an increase in mindfulness that leads to a decrease in smoking behaviour. Singh et al. (2014) note that they were unable to measure participants’ mindfulness due to the absence of a psychometrically validated mindfulness rating scale appropriate for use with people with IDs.

Singh and colleagues have also considered the benefits of mindfulness group training for individuals with Prader-Willi syndrome. Following a mindfulness-based health wellness program including physical exercise, food awareness training, mindful eating and ‘SoF’, three adolescents with mild IDs and Prader-Willi syndrome were able to reach their goal weights and maintain this weight for three years (Singh et al., 2011b). In an earlier case study, one adolescent with mild IDs and Prader-Willi Syndrome following a similar program
was able to lose weight and manage his food-seeking behaviours (Singh et al., 2008c).

Although both studies observed positive outcomes, mindfulness was delivered alongside additional interventions and so it is unclear which aspects of the mindfulness-based health wellness program lead to the positive outcomes observed, or whether there was a cumulative effect. Singh et al. (2008c) note that the most consistent changes occurred when the individual received mindfulness training combined with healthy eating and exercise compared with healthy eating or exercise alone, however the contribution of the individual component parts has not been assessed (Singh et al., 2011b). The program is, however, referred to as “a lifestyle-change intervention” focusing on multiple components so as to enable participants to manage their long-term health (Singh et al., 2011b; p.102). It could therefore be argued that for these individuals with Prader-Willi syndrome, mindfulness alone may not have been enough to sustain long-term change and that mindfulness in addition to an increase in physical exercise and food awareness training was necessary for this to happen.

Chapman and Mitchell (2013b) highlight the paucity of research regarding the use of MBIs within a community environment and focus on the experiences of people with IDs and their carers who attended a one-off mindfulness workshop. These workshops were intended to provide an introduction to mindfulness and to promote an awareness of mindfulness amongst people with IDs. 171 people attended 12 workshops, of which approximately 114 people had IDs and the remaining 57 were family, carers and staff. Participants were asked to take part in a 20-minute body scan and were given a brief easy-read questionnaire to complete. Six participants were interviewed; all of whom said they attended the workshops to help them

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4 The ‘body scan’ is a guided meditation exercise in which the individual is encouraged to focus a ‘spotlight’ of awareness on different parts of the body (Williams & Penman, 2011). Individual mindfulness exercises are described in greater detail in Chapter 2.
cope with stress, anxiety and depression. The workshops were generally well received and demonstrated that those who attended were able to participate in mindfulness exercises and provide constructive criticism regarding the accessibility of the information and the language used. The authors conclude that it is feasible to run mindfulness-based workshops within a community setting with people with IDs and that mindfulness could be beneficial in terms of psychological wellbeing and quality of life due to the considerable sources of stress in the lives of people with IDs.

1.3.3 Mindfulness-based interventions for the families/parents of people with Intellectual Disabilities

There is some support for the exploration of MBIs for parents of children with IDs and the potential impact on parental psychological adjustment. Bazzano et al. (2013) for example report increases in mindfulness, self-compassion, psychological wellbeing and a reduction in stress for parents and caregivers of children with IDs who attended a MBSR program.

There are, however, only two published studies to date regarding the impact of parental involvement in mindfulness training on outcomes for children with IDs; both of which comment on the impact of mindfulness training on child behaviour. In a replication of a previous study in which parents of children with ASD were able to mindfully attend to their children’s challenging behaviours after receiving mindfulness training (Singh et al., 2006b), Singh et al. (2007b) consider the impact of parental mindfulness training on aggression and social behaviour in children with IDs. Four African-American mothers recruited via a day care centre for children with developmental disabilities participated in a 12-week mindfulness training program followed by a 52-week practice phase. Observations of the children and self-report measures completed by the mothers showed decreases in child aggressive
behaviour and parental stress and increases in positive child-sibling interactions and parental satisfaction. The mothers commented that with consistent practice they were able to respond to their children in a calm and positive manner.

One strength of this study is that it combined both objective and subjective measures so that parental accounts of their child’s behaviour could be validated by behavioural observations. The addition of a control group would have supported the argument that the parental mindfulness training was superior to other parental training programs, however the mothers’ qualitative accounts suggest they preferred the mindfulness training over other training programs they had attended previously. They said the mindfulness training differed greatly as they were required to focus on themselves rather than specific behavioural techniques or rules which in hindsight appeared narrow and restrictive. They also appreciated the opportunity to utilise their own knowledge, skills and intuition.

In the second study Neece (2014) considers the link between parental mental health and child behavioural difficulties. 46 parents of children with developmental delays and significant behavioural difficulties (excluding children with severe intellectual impairments) aged between 2.5 and 5 years were randomly assigned to either an immediate treatment group or a waiting list control group. Parents in the immediate treatment group participated in an eight-week MBSR program based on that described by Kabat-Zinn, Massion, Kristeller and Peterson (1992). Parents in both groups completed self-report assessments before and after the MBSR intervention for the immediate intervention group, however the waiting list control group did not receive any intervention during this time. At the point of the second assessment, parents in the immediate treatment group reported significantly lower levels of stress and depression, and significantly more life satisfaction than parents in the waiting list.
control group. Further, they reported a significant reduction in their child’s Attention Deficit Hyperactivity Disorder (ADHD) related symptoms and a significant decrease in the extent to which they considered their child’s behaviour to be problematic. Results suggest that a reduction in parental stress can lead to an indirect reduction in child behaviour problems, however due to the lack of a treatment control group it can only be concluded that the MBSR intervention was superior to no treatment. Further, the study relied on potentially biased self-report measures and may have benefited from additional outcome measures, such as observations of child behaviour (as in Singh et al. (2007b)).

Both Neece (2014) and Singh et al. (2007b) therefore report benefits for both parents and their children when the parents are taught mindfulness techniques. Neither intended the MBI to directly change the child’s behaviours, yet change was observed as an indirect result of changes made within the parents and consequently the ways in which they interacted with their children. A review of the literature regarding the application of mindfulness with parental and professional caregivers highlights the interconnectivity between those who practice mindfulness and those they care for (Hwang & Kearney, 2014) and suggests that such cross-over effects may work both ways. Neece, Green and Baker (2012) suggest the relationship between child behaviour difficulties and parental stress may be bidirectional, i.e. child behavioural difficulties increase parental stress which in turn increases child behavioural difficulties. Thus, the positive outcomes reported by parents who engage in MBIs in terms of stress reduction and improved psychological wellbeing may also lead to beneficial outcomes for the child in terms of a reduction in challenging behaviour. Neece (2014) highlights a number of factors intrinsic to mindfulness training and practice which may go some way in explaining this positive effect. For example, mindful parents may be more
sensitive and responsive to their child and less reactive to their challenging behaviour thereby creating increased calmness for both the parent and their child.

One critique of both the Singh et al. (2007b) and Neece (2014) studies is that both provide evidence for the positive impact of parental mindfulness training on children with IDs, but neither consider the impact on adults with ID. It cannot be assumed that parental mindfulness training would lead to similar outcomes for adults with IDs who may live independently of their family, though the relationship may hold for adults with ID living in the family home. However, generalising findings from research with children with IDs to adults with IDs is problematic as it fails to challenge paternalistic attitudes towards adults with IDs and perpetuates their continued infantilisation and associated inequality within society.

1.3.4 Mindfulness-based interventions for professionals working with and supporting those with Intellectual Disabilities

Three studies were identified relating to the use of MBIs with professionals employed within ID services, all of which were carried out by Singh and his colleagues. The first (Singh et al., 2004) examined whether the happiness levels of three men with profound IDs and complex physical health conditions could be improved by increasing the mindfulness of their caregivers. Each of the men were supported by two carers. One carer from each of the three sets of carers engaged in 8-weeks of mindfulness training followed by 16-weeks of mindfulness practice, whilst the remaining three carers received eight-weeks of training in behavioural methods followed by a 16-week practice period. Observations of happiness levels for the three men with IDs were taken during the baseline, training and practice periods with levels of happiness measured in terms of facial expressions and vocalisations typically indicative of happiness among people without disabilities as well as those specific to each
individual. Observed happiness levels increased substantially for all three men when supported by those caregivers who had received the mindfulness training, whilst there was no significant change in happiness levels when supported by the three caregivers who had not received the mindfulness training. Whilst this suggests that happiness increased for the men when supported by caregivers who had engaged in mindfulness training, this happiness did not appear to extend beyond the time they spent with the mindful caregivers. The positive effects are not prolonged and would appear specific to the person and direct contact with that person.

The second study (Singh et al., 2006a) considered the ability of mindful staff to increase learning and reduce aggression. 15 members of staff supporting 18 individuals with severe and profound IDs across three care homes engaged in a five-day behavioural training program and later a five-day mindfulness training program. Non-significant changes were recorded in the number of staff interventions for aggressive behaviour and the number of learning objectives mastered by the individuals with IDs following the behavioural intervention, whilst the mindfulness training was followed by clinically significant improvements in both of these areas (i.e. the number of staff interventions decreased and learning improved). Staff were observed to be more responsive, patient, creative and adaptable during their interactions with the individuals with IDs whom they cared for, and there were substantial increases in staff satisfaction. The authors suggest that these changes may have been the result of an attitudinal transformation on behalf of the staff, an unconditional acceptance of those with IDs whom they cared for, and an increased ability to instil a sense of peace and calmness in both themselves and others. However, given that the mindfulness training was preceded by behavioural training, it is not possible to isolate the effects of one intervention from the other nor to assume that outcomes can be solely
attributed to the mindfulness intervention. It is possible that outcomes may have been the result of the accumulation of skills developed by staff through their involvement in both training programs.

In the third study by Singh and colleagues (Singh et al., 2009) 23 members of staff supporting 20 individuals with mild to profound IDs across four group homes participated in a 12-session mindfulness training program. As the mindfulness training progressed, incidences of verbal and physical aggression decreased, the occurrence of residents being physically restrained by staff decreased, as did the administration of immediate or as required (‘Stat’) medications and the number of staff and resident injuries. The authors provide a number of potential explanations for this (such as the ability of staff to engage in calm attention and non-judgemental acceptance) and highlight the correlation between changes in staff behaviour and subsequent changes in the behaviour of the residents.

Interestingly, the authors note that on occasion ‘floating’ staff were required to cover holidays, sick leave, etc. and that their presence correlated with an increase in the use of restraint and Stat medication. As with the Singh et al. (2004) study this would suggest that the positive outcomes observed are specific to the mindful staff and are not sustained in their absence. There are many explanations for this; perhaps the change in staff was anxiety provoking for residents and lead to an increase in aggression, or perhaps the staff who had not received mindfulness training were more reliant on restraint and Stat medications as a means of managing this aggression. It is also possible that mindful staff may have behaved in a way that promoted certain behaviours in the people with IDs whom they supported whereby medication and restraint were less likely to be required.
In essence, the existing literature in this area is interested in whether the behaviour and emotional wellbeing of carers and other professionals can have an impact on the behaviour and emotional wellbeing of those individuals with IDs whom they support. They advocate for an improved quality of life for individuals with IDs and suggest that this can be achieved by shifting the expectation of change from the individual with IDs to the professional (Singh et al., 2004). This follows a social model of disability in which quality of life is promoted through good quality support and an understanding that it is the environment that needs to change rather than the individual (Rapley, 2004). Further, Singh et al. (2006a) suggest that the cultivation of unconditional acceptance, a notion at the heart of mindfulness practice, might enable carers and other professionals to accept the individual with IDs for who they are, regardless of their behaviour, whilst the concept of non-judgemental acceptance requires a reinterpretation of these behaviours so that they are no-longer considered in either positive or negative terms. Noone (2013) suggests that an increased willingness on behalf of the professional to sit with personal discomfort may result in the increased frequency and quality of their interactions with those with IDs whom they support. It has also been suggested that mindful staff with an increased ability to be aware of and pay attention to their immediate surroundings might be better placed to respond to the unspoken needs of those with IDs who may be dependent on others to act on their behalf (Noone & Hastings, 2010). Reiss (2000) suggests that professionals in general need to adopt a more mindful approach to IDs. He asserts that in the adoption of a mindful definition of IDs, professionals can learn to appreciate the importance of the individuality, personality and social needs of those with IDs and not allow these factors to become overshadowed by diagnosis.
1.4 Summary and conclusions

An extensive search of the literature identified 22 published journal articles regarding MBIs and people with IDs. A similar search carried out by the author in early 2012 identified just nine. Although this suggests there has been an increase in the number of published articles over recent years, it would appear a relatively small number considering the current popularity of mindfulness within research for the general population and the consistent finding that mindfulness is positively associated with psychological wellbeing (Keng, Smoski & Robins, 2011).

Findings from the literature review suggest mindfulness can be a useful tool for individuals with IDs and their caregivers for a range of psychological and health concerns including anger, ‘challenging behaviour’, anxiety and smoking cessation. Mindfulness has been shown to be both feasible and beneficial when delivered on a one-to-one basis and in groups, in community and in-patient settings, by practitioners with many years’ experience in mindfulness, as well as practitioners, care staff and parents trained in mindfulness, and in one case an individual with IDs. Individuals with IDs benefitted indirectly through the increased mindfulness of their caregivers and directly through their own personal mindfulness practice. In some cases these benefits were sustained over several years (for example, Adkins et al., 2011; Singh et al., 2011b). The apparent success of ‘SoF’ and other mindfulness techniques indicates that mindfulness can be a beneficial tool for both the prevention and self-management of target behaviours and emotional states.

The current publications provide valuable knowledge for future research in terms of the adaptation and application of existing mindfulness materials and interventions. For example, Idusohan-Moizer et al. (2015) found 67% of participants felt overwhelmed by the amount of
paperwork, they preferred meditation on the breath to ‘SoF’ and it was suggested that more repetition and more role play would be beneficial. Chapman and Mitchell (2013b) received feedback suggesting that the language used was not accessible for all participants and that greater guidance and support was required for the body scan.

Although many of the papers included in this literature review describe small scale studies such as case studies, Chapman and Mitchell (2013b) demonstrate the feasibility of delivering group interventions which can be replicated so as to include a larger number of participants. Their use of questionnaires and interviews highlights the complexity of measuring MBIs and their outcomes, whilst also demonstrating the feasibility of gathering qualitative information from individuals with IDs. Chapman and Mitchell (2013b) and Yildiran and Holt (2014) demonstrate the feasibility of conducting qualitative interviews which can later be analysed. Others, such as Idusohan-Moizer et al. (2015) gathered quantitative self-report data from participants. However, none of the studies included in this literature review sought to gather self-report data directly from participants with IDs regarding their own mindfulness practice. This may be explained by the lack of a self-report measure of mindfulness that has been psychometrically validated for use with an ID population (Singh et al., 2014). Idusohan-Moizer et al. (2015) gathered self-report data regarding compassion. Compassion may be considered a component of mindfulness but compassion alone does not constitute mindfulness. Whether individuals with IDs can become more mindful following a MBI therefore remains unknown.

The perspectives of people with ID on the process of mindfulness interventions is, thus far, fairly absent in the research literature. Chapman and Mitchell (2013b) have however
acknowledged the importance of the voice of people with ID in discerning the utility of interventions that may require some adaptation.

Despite positive outcomes there are methodological weaknesses and other limitations in the existing literature. For example, of the 22 articles included in this review, 16 are attributed to Nirbhay Singh and his colleagues from the American Health and Wellness Institute and the Research Institute in Virginia. Just six were published in the UK. Differences in culture and service provision therefore need to be taken into account. Harper, Webb and Rayner (2013) highlight potential generalisability issues and point specifically to the similar methods used by Singh and his colleagues across their research and the repeated use of ‘SoF’. How mindfulness exercises designed for the general population may have been adapted for use with people with IDs is generally absent from the existing literature. Chapman and Mitchell (2013b) also draw attention to the fact that Singh usually delivers the mindfulness training in his and his colleagues’ research. Since the characteristics of the individual delivering the mindfulness training are reported to be crucial to outcomes (Segal, Williams & Teasdale, 2002) it cannot be assumed that the positive outcomes observed are the result of something intrinsic to the mindfulness intervention itself and not the individual skills, personality and teaching style of the mindfulness trainer. This has implications for both replicability and validity and raises the following questions: 1. If the study was repeated with a different mindfulness trainer, would results be consistent? 2. What is being measured; mindfulness or a variable that has not been accounted for? A number of studies delivered mindfulness alongside other interventions such as relaxation (Yildiran & Holt, 2014) and physical exercise (Singh et al., 2011b); both of which may have had some impact on results ether in addition to or despite of the mindfulness intervention. Similarly, Chilvers, Thomas and Stanbury (2011) suggest that being involved in a group may have had some influence for
some participants, whilst Singh et al. (2013a) highlight the potential for social support to influence outcomes. Other variables might include participant motivation for change and levels of staff training. The question of fidelity, or what is being measured, is further complicated when the diversity of definitions for mindfulness are taken into account (as discussed in section 1.1.3).

Future research in this area will need to control for confounding variables (such as the characteristics of the mindfulness trainer and the component parts of the MBI) and explore in greater detail the extent to which positive outcomes can be attributed to the MBI. There is a need to identify which aspects or component parts of MBIs are the ‘unique essence’ of the intervention and which make MBIs particularly relevant to people with IDs and set them apart from other interventions. The ‘unique essence’ of mindfulness (i.e. the conditions necessary to constitute a MBI) are dependent on how mindfulness is understood and defined. Despite the lack of a universal definition of mindfulness, mindfulness is broadly understood as the practice of developing a non-judgemental awareness and acceptance of moment-to-moment experiences facilitated through a number of breathing exercises, such as the Body Scan and the 3-Minute Breathing Space. Wahbeh, Goodrich, Goy and Oken (2016) identify a number of mechanistic pathways by which mindfulness might lead to positive outcomes such as slowed breathing resulting in increased parasympathetic activation and a normalisation of stress hormones. Slowed breathing and resultant physiological changes might therefore contribute to positive outcomes for people with IDs, as might a reduction in stress (Neece, 2014) or increased acceptance (Singh et al., 2009).
Why mindfulness might lead to positive outcomes and the processes by which this might happen need further consideration, as do the experiences and opinions of those with IDs who participate in MBIs. Future research will also need to develop and agree upon a robust and measurable definition of mindfulness so that measures of mindfulness appropriate for use with individuals with IDs can be developed. Much of the previous research in this area has focussed primarily on the outcomes of the therapeutic interventions without fully exploring and accounting for the processes undertaken, how these processes map onto the outcomes and how these have been adapted for people with IDs. This argument will be taken up further in Chapter 2.
Chapter 2 – Research Report

2.1 Introduction

People with IDs are more likely to develop mental ill-health compared to the general population (Cooper et al., 2007) yet they have historically been excluded from talking therapies and there remains continued inequality in the provision of mental health services for people with IDs (Taylor & Knapp, 2013) perhaps due to the false assumption that they may be unable to engage or understand. This research addresses this continued inequality in service provision and does so from the basic belief that people with IDs are people first, have the right to live their lives with the same opportunities and responsibilities as any other, and deserve dignity and respect (Department of Health, 2009). It therefore follows that people with IDs should have the same access to mainstream health services as those without disability (Department of Health 2001). The existing research suggesting mindfulness can have beneficial effects for people with IDs and their carers therefore deserves further attention.

Psychological interventions for people with IDs have traditionally focused on behavioural change and independent living, often at the expense of emotional wellbeing (Reed, 1997). In recent years, alternative interventions such as mindfulness have become increasingly popular and there is a growing body of research supporting the efficacy of mindfulness with people with IDs. There are various definitions of mindfulness, however the definition commonly used (Cullen, 2011) is that of Kabat-Zinn (1994; p.4) who describes mindfulness as “paying attention in a particular way: on purpose in the present moment, and non-judgementally”.

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Lew, Matta, Tripp-Tebo and Watts (2006; p.2) discuss DBT for individuals with IDs and ask the question “Why should persons with IDs be denied a potentially effective treatment?” The same can be asked of mindfulness when basic mindfulness research with people with IDs is lacking despite rapid and widespread interest in mindfulness approaches (Hastings & Manikam, 2013). Lew et al. (2006) go on to discuss elements of DBT relevant for individuals with IDs, many of which are applicable to MBIs as DBT itself incorporates elements of mindfulness. For example, MBIs often include psycho-educational elements, are skills-based, positive in nature, non-blaming and encourage the individual to advocate for themselves and take control of their own mental or physical health. Further, MBIs “may have an especially important role to play in situations that do not lend themselves to easy solutions” (Noone, 2013; p.217) such as lifelong disability. Mindfulness has also been shown to improve working memory and attention span and enhance brain function associated with self-awareness, empathy and self-control (Burch & Penman, 2013) – areas of difficulty for many individuals with IDs. Emotion regulation (another area of potential difficulty for individuals with IDs) may also be developed through mindfulness since mindfulness facilitates distance between the individual’s internal and external experiences (Hayes & Feldman, 2004).

Emotion regulation can be described as a set of processes by which the individual can “seek to redirect the spontaneous flow of their emotions” (Koole, 2009; p.6) – a description which echoes a mindful understanding of emotions and thoughts as temporary and fleeting mental events.

As noted in Chapter 1, existing research suggests individuals with IDs can benefit from mindfulness in relation to a variety of psychological and health concerns, across in-patient and community settings when delivered by a variety of trainers including community staff and experienced mindfulness practitioners. MBIs have been shown to reduce incidences of
aggression within community (Adkins et al., 2010) and inpatient settings (Chilvers et al., 2011), reduce anxiety and depression (Idusohan-Moizer et al., 2015) and improve social skills and academic performance (Beauchemin, Hutchins & Patterson, 2008). MBIs have been successful when delivered in groups (for example, Beauchemin, Hutchins & Patterson, 2008) and individually (for example, Singh et al., 2011d).

MBIs and interventions of which mindfulness is a component part, such as ACT and DBT, have been adapted to meet the needs of individuals with IDs. ACT is activity oriented and experiential in nature, allowing the individual to reframe cognitions via mindful and experiential exercises rather than verbal reasoning (Brown and Hooper, 2009). DBT can be adapted to include pictorial cues, film and music to facilitate participation from individuals who cannot utilise written materials, despite primarily being a cognitively based intervention (Lew et al., 2006). Other interventions, such as ‘SoF’ (Singh et al., 2003) have been designed specifically for use with individuals with IDs. Reviews of the literature suggest MBIs need to be accessible to people with IDs, use clear instruction and concrete examples, and involve role play and regular practice (Chapman et al., 2013a).

Some effort has been made to gather the views of participants with IDs regarding their involvement in MBIs. For example, Yildiran and Holt (2014) interviewed six participants regarding their involvement in a weekly relaxation and mindfulness group and found that participants were able to form an understanding of mindfulness even if this differed from that provided by the group facilitators. However, relatively little is known about what individuals with IDs actually think about mindfulness. Establishing what individuals understand of mindfulness and how they can be supported to make sense of the relatively abstract concepts associated with mindfulness may go some way in supporting the development of effective
MBIs for individuals with IDs (Singh et al., 2013c). Recent research examining the experiences of individuals with IDs who attended a cognitive behaviour therapy (CBT) group indicated that participants appreciated having the opportunity to talk and to have others talk with them. The authors state that it is “imperative” that appropriate qualitative methodology be developed in order to support the voices of those with IDs to be heard (MacMahon et al., 2015; p.343). Such thinking highlights a change in attitude towards people with IDs following a history of exclusion, with the perspectives of people with IDs often overlooked and seldom elicited.

A previous study by Chapman and Mitchell (2013b) ran a number of one-off mindfulness workshops within a community setting. 76 people with IDs and 30 carers completed questionnaires about their experience of the workshop. Six people with IDs were interviewed. Participants said the workshops helped them to relax, that they benefitted from knowing other people experienced similar difficulties, and that they felt other people would also benefit from mindfulness. When asked about the positive aspects of the workshops, participants commented on the opportunity to share experiences, talk about feelings and learn new skills. Participants also suggested the workshops could be longer or that there could be more of them. Some participants found aspects of the workshop difficult to understand and another suggested a manual or toolkit could be helpful. One participant felt mindfulness could be accessible to people with IDs, commenting that “it’s not the information that’s the problem, it’s actually the way it’s been given” (p.174). The authors conclude that mindfulness could help people with IDs cope with the various sources of stress they experience and that people with IDs can engage with group workshops and mindfulness exercises such as the body scan. They suggest future research focus on developing a manualised mindfulness program drawing on what is already known about making adaptations for people with IDs.
Drawing on prior research findings the present study was devised. It comprised an evaluation of two mindfulness groups attended by nine individuals with IDs who were referred to a community learning disability team (CLDT) for psychological support. Each mindfulness group consisted of eight 1.5hr sessions held over eight weeks. Participants took part in interviews and group discussions in order to gather their views about the Mindfulness Group and whether they felt they had experienced any positive benefits as a result of their involvement with the group. This qualitative data was supplemented with quantitative measures which included self-reported anxiety and depression states pre-intervention, post-intervention and at follow-up, and observations of participants understanding of and engagement with the mindfulness practice.

The present research investigation was designed with three primary questions in mind:

1. Can mindfulness techniques be successfully adapted to meet the needs of people with IDs, and can people with IDs understand and engage with these techniques?

2. How do participants experience mindfulness and their involvement in the Mindfulness Group intervention?

3. Does involvement in the Mindfulness Group lead to beneficial outcomes?

Given the recommendations from previous research, the investigation makes explicit how the mindfulness exercises were adapted (including how they were presented, practiced and communicated) and how participants’ IDs influenced these adaptations. How well the mindfulness exercises were received and whether participants’ experienced positive outcomes following their involvement with the Mindfulness Group are also discussed. A mixed methods design employing both qualitative and quantitative methods was deemed appropriate to capture the broad spectrum of data required to address the research questions.
The author takes an interactionist approach and recognises that people with IDs are often disabled not only by their disability, but also by the world around them. The author believes it is the therapist’s responsibility to promote understanding and engagement and that this will likely require some adaptation and flexibility on behalf of the therapist. A failure to make “reasonable adjustments” in response to literacy and communication difficulties has been identified as an organisational barrier contributing to health inequalities for people with IDs (Emerson & Baines, 2010; p. 9).

Although much of the previous research in this area is based on case studies or single-subject experimental designs (such as Singh et al., 2011d; Singh et al., 2008c), social support has been cited as having the potential to enhance the benefits of MBIs (Singh et al., 2013a). Delivering mindfulness within a group setting allows for the study of social influence on mindfulness engagement. It also allows for an increased sample size for research and, in practice, an opportunity to decrease waiting lists for therapeutic intervention. Group designs may be better placed to inform general clinical practice, can consider the effects of different mindfulness exercises on different behaviours and different individuals with varying degrees of cognitive impairment (Singh et al., 2013c). Cullen (2011; p.191) states that “group support is often key in providing scaffolding for the learning and accountability for the [mindfulness] practice” whilst groups can help people with IDs to feel accepted and safe amongst peers, and to recognise that they are not alone (Mishna & Muscat, 2004). For these reasons, this research study employed a group approach.

Whilst existing research in this area has shown that mindfulness can be beneficial for people with IDs and their carers, relatively little is known about why or how these beneficial effects have been observed. There would appear to be many contributing factors, such as the group
environment and associated social support (Singh et al., 2013a), the accumulation of learning from mindfulness and additional behavioural-based interventions (Singh et al., 2006a), the component parts of the mindfulness intervention (such as relaxation (Yildiran & Holt, 2014) and physical exercise (Singh et al., 2011b)) and the characteristics of the mindfulness trainer (Segal, Williams & Teasdale, 2002). There are also different processes by which mindfulness may lead to positive outcomes, such as a reduction in stress (Neece, 2014), an increased ability to engage in calm and non-judgmental acceptance (Singh et al., 2009), an attitudinal transformation (Singh et al., 2006a) or simply enjoying the intervention (Chilvers, Thomas and Stanbury, 2011).

Establishing theoretical accounts of the mechanisms (or components) of mindfulness through which the positive effects of mindfulness practice are mediated is cited as the greatest challenge for researchers in the field of mindfulness (Brown, Ryan & Creswell, 2007). However, literature suggests that these mechanisms may include attention, intention and attitude (Shapiro, Carlson, Astin & Freedman, 2006); exposure to strong emotive states and anxiety or pain related sensations, cognitive change such as changes in thought patterns or attitudes towards one’s thoughts, improved self-management and coping responses, relaxation and acceptance (Baer, 2003); insight into desires, needs and values and the fleeting nature of thoughts and emotions, exposure to unpleasant or challenging emotional states leading to desensitisation and a decrease in emotional reactivity, the promotion of nonattachment versus desire and craving, greater health and enhanced mind-body functioning (Brown, Ryan & Creswell, 2007). Baer et al. (2006) have also proposed five facets of mindfulness: observing, describing, acting with awareness, non-judging of inner experience and non-reactivity to inner experience (these facets are explored in greater detail in section 2.2.5.2.5 of the Methodology).
Hölzel, Lazar, Gard, Schuman-Olivier, Vargo and Ott (2011), in a review of the existing literature, identify four components to mindfulness mediation which they suggest describe much of the mechanisms through which mindfulness leads to positive outcomes. These are: attention regulation, body awareness, emotion regulation and a change in perspective of the self.

Focusing on participants’ perceptions and experiences, this research attempts to explore the mechanics of mindfulness and considers the many factors which constitute a MBI intervention and the possible influence of these factors on outcome. Given the multifaceted nature of mindfulness and MBIs, the primary researcher was keen to explore the processes and influential factors within her own practice as part of the research study.

It is anticipated that findings from this research will go some way in addressing inequalities in service provision for individuals with IDs and will provide valuable insights for practitioners working in this field.
2.2 Methodology

2.2.1 Approach

During the initial stages of the research design, the qualitative approach was considered ontologically consistent with the primary research aim to explore participants’ individual experiences and to address the question ‘How do participants experience mindfulness and their involvement in the Mindfulness Group intervention?’ It was anticipated that qualitative research methods would afford participants the opportunity to tell their own story in their own words and promote a sense of empowerment. This was considered particularly important given the potential for power imbalances within the therapeutic or ‘client-professional’ relationship and those resulting from the societal positioning of people with IDs. Further, the inductive nature of qualitative research facilitates an explorative approach, driven by participants’ contributions rather than any pre-existing theoretical framework or hypotheses. The importance of investigating social interaction within context, learning about the meanings people make of their experiences, and reporting results in the everyday language of participants are a few of the main characteristics of qualitative research (Morrow & Smith, 2000) and which underpin this research project.

The primary researcher, who has undertaken this project as part of a Professional Doctorate in Counselling Psychology, recognises the overlap between the principles of qualitative research and the values and ethos of counselling psychology. Qualitative research methods can, for example, promote counselling psychology’s social justice agenda. Individuals with IDs have historically been marginalised and silenced; a qualitative approach which engages with participants and creates conversations between participants and researchers may prove empowering and provide knowledge that could not be gathered without this level of participant engagement (Morrow, 2007). A further parallel is highlighted by McLeod (2001;
p.16) who states that the “activity of doing qualitative research (identifying and clarifying meaning; learning how the meaning of aspects of the social world is constructed) is highly concordant with the activity of doing therapy (making new meaning, gaining insight and understanding, learning how personal meanings have been constructed)”.

Whilst it was recognised that qualitative methods could provide rich and detailed accounts of participants’ individual experiences, it was felt that such an approach would not adequately and objectively address the research question ‘Does involvement in the Mindfulness Group lead to beneficial outcomes?’ The researcher was keen to select the most appropriate data collection methods based on the demands of the initial research questions therefore addressing the question of clinical outcome whilst also exploring the potential meaning of and developing an understanding of this data.

Research methods were therefore chosen in order to acquire knowledge and to advance knowledge, however it was also recognised that quantitative data may carry more weight in terms of informing service development and justifying service provision, and that mixed methods may be more likely to lead to social change (Mertens, 2007). A mixed methods design was therefore considered necessary in order to address the research questions as well as the needs of an underrepresented population (Hanson, Creswell, Plano Clark, Petska & Creswell, 2005) who have historically been afforded little power within research and who have been disenfranchised on the grounds of disability (Mertens, 2007).

Mixed methods can provide a more complete picture of the area of study than may be possible with a single method (Mertens, 2012). In this instance, the quantitative data provides an indication of whether the Mindfulness Group leads to positive outcomes in terms of
reduced anxiety and depression and increased mindfulness. The qualitative data however casts light on how or why the Mindfulness Group might lead to positive outcomes. It was therefore anticipated that a qualitative exploration would add richness to the quantitative data (Morrow, 2007).

Qualitative and quantitative methods are often considered alternative and competing paradigms with established ideological and epistemological positions, yet qualitative researchers do not necessarily reject the use of quantitative data (Todd, Nerlich & McKeown, 2004). Those who take a transformative approach, for example, have argued for the necessity of mixed methods in order to address issues of social justice (Mertens, 2007).5

Quantitative methods have clear benefits in terms of evidence-based practice and can be exploratory, empathic, and consider ethical and interpersonal issues as well as meaning, context and culture (Yardley, 2000) yet may be criticised for losing sense of the person at the heart of the research. It can also be argued that the objective nature of quantitative research creates a divide between the researcher and the researched, however the reflexive quality of qualitative research, focused on understanding rather than measuring, bridges this gap (Todd, Nerlich & McKeown, 2004) and fits well with the values of counselling psychologists who are taught to continually develop their skills as reflexive practitioners.

The use of a mixed methods design appears to fit within the current understanding of counselling psychology as a person-centred, explorative discipline with a focus on advancing knowledge and research. The dynamic and contextually responsive nature of counselling

5 The transformative approach is discussed in more detail in section 2.2.9.1, ‘Epistemological Reflexivity’.
psychology (Hemsley, 2013) allows for some creativity, whilst selecting the method to suit the participant, rather than expecting the participant to conform to the chosen method, adheres to a person-centred approach.

2.2.2 Participants

2.2.2.1 Inclusion and exclusion criteria

Individuals were eligible to participate in the research and the Mindfulness Group if they had IDs, had been referred to the CLDT and might benefit from support regarding anxiety, low mood or anger as assessed by the CLDT. Those already engaged in psychological intervention from another practitioner were not eligible. Neither were those deemed to pose a risk to themselves or others, or those who required immediate psychological intervention or alternative support. If it was decided the individual lacked capacity to provide informed consent (as assessed by the CLDT), they were not asked to participate in the group or the research.

2.2.2.2 Sampling and recruitment

Participants were selected from referrals to the CLDT for whom the primary researcher was employed. During referral meetings held by the team, clients who fulfilled the inclusion criteria were identified. Prior assessment processes conducted at receipt of referral would have confirmed firstly that the individual had an ID, secondly their mental health and required support, and thirdly that the CLDT was the most appropriate service. When the Mindfulness Group was identified as an option for therapeutic intervention, facilitators met with the individual to discuss the nature of the group. Before the individual decided whether they would like to participate in the group, facilitators made a clinical judgement as to whether they believed the group to be appropriate. When making this decision, facilitators
considered the client's level of ID, their current level of psychological need, their capacity to consent to the research and potential vulnerabilities or Safeguarding issues. In order to establish capacity to consent, the primary researcher and second facilitator consulted with their clinical supervisor, the wider multi-disciplinary team and other professionals involved with the individual’s care. Once the group was deemed appropriate, the individual was required to give explicit consent in accordance with ethical guidelines (BPS, 2009, p. 12) to participate in both the Mindfulness Group and the research.

Decisions regarding sample size took into account the client waiting list and client demand, the presenting needs of participants and corresponding demands on the facilitators, and the number of facilitators available to support the researcher in the running of the group. As a result, five participants were recruited to attend Mindfulness Group 1 (of which all five attended) and eight were recruited for Mindfulness Group 2 (of which one opted out before the group started, one opted out after attending one session and one was unable to attend due to a deterioration in health).

2.2.2.3 Participant details

Participant demographic details are provided in Table 2.1. Nine participants took part in the research. Participant 1 (P1)\(^6\) attended Group 1 and Group 2. The remaining eight participants attended either Group 1 or Group 2. Participants were aged between 19 and 56 years (Mean =

\(^6\) In order to maintain confidentiality participants have been given a number from 1 to 9. Participant 1 is referred to throughout as P1. Participant 2 is referred to as P2, and so forth.
34.1, SD = 12.05) and all identified as White British. Seven were male and two were female.\textsuperscript{7} Participants missed an average of 1.5 out of the eight sessions. Reasons for missed sessions included attending a funeral, feeling unwell and going on holiday. On occasion participants ran late for sessions citing difficulties with transport.

2.2.3 Procedure

Two Mindfulness Groups were delivered consecutively during 2014. Each group ran for eight sessions over eight weeks. Each session ran for 1.5 hours.

Participants for Mindfulness Group 1 met with the group facilitators approximately one week prior to the first session of Mindfulness Group 1. Participants were provided with an easy-read information sheet (Appendix 2) and consent form (Appendix 3) targeted at the ID population. Both were read through with each participant, signed by each participant and signed by the group facilitators. There was opportunity for questions and discussion. Once participants had provided consent, they were asked to complete two quantitative measures: the Glasgow Anxiety Scale for people with ID (GAS-ID; Mindham & Espie, 2003) and the Glasgow Depression Scale for people with ID (GDS-ID; Cuthill, Espie & Cooper, 2003). The GAS-ID and GDS-ID were administered verbally and answers noted down by the facilitators. Visual aids consisting of bars of varying height reflecting the varying intensity/frequency of symptoms were available for participants as required. One week later, participants attended the first session of Mindfulness Group 1.

\textsuperscript{7} One other female was invited to attend but declined; a second opted out after one session. At the time of recruitment, there were no further female clients open to the service who met the inclusion criteria.
Table 2.1: Participant Demographic & Background Information

<table>
<thead>
<tr>
<th>Participant No.</th>
<th>Age (years)</th>
<th>Gender</th>
<th>Primary diagnoses</th>
<th>Referrer</th>
<th>Reason for referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>56</td>
<td>F</td>
<td>Mild ID</td>
<td>Psychiatrist</td>
<td>Depression</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Depressive illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>29</td>
<td>M</td>
<td>Mild ID</td>
<td>Self-referral</td>
<td>P2 had attended previous groups and asked that he be invited to future groups</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Autism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>43</td>
<td>F</td>
<td>Mild-Moderate ID</td>
<td>Social Worker</td>
<td>Anxiety, depression, low self-esteem linked to history of abusive relationships</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>40</td>
<td>M</td>
<td>Mild ID</td>
<td>Psychiatrist</td>
<td>For consideration for the Mindfulness Group</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ASD</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Schizophrenia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>19</td>
<td>M</td>
<td>Mild ID</td>
<td>Community Nurse</td>
<td>Anxiety linked to eating disorder</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ASD</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Anorexia Nervosa</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>26</td>
<td>M</td>
<td>ID</td>
<td>Social Worker</td>
<td>Anger, relationship difficulties</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Williams Syndrome</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dyslexia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>33</td>
<td>M</td>
<td>Mild-Moderate ID</td>
<td>Clinical Psychologist</td>
<td>Anger, excessive drinking, relationship difficulties with family</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ADHD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>41</td>
<td>M</td>
<td>Mild ID</td>
<td>Psychiatrist</td>
<td>Anxiety</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>20</td>
<td>M</td>
<td>Mild ID</td>
<td>Psychiatrist</td>
<td>Low mood, loss of interest in things, reduced appetite linked to relationship difficulties</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ADHD</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
During the final session of Mindfulness Group 1, participants were invited to take part in an optional audio-recorded group discussion. Group facilitators explained the rationale behind the group discussion, i.e. that they wanted to know what participants thought about the Mindfulness Group and that their opinions were important in terms of the research and service development. Participants were informed that the group discussion would be audio-recorded and the reason for this was explained. All participants agreed to participate. The task of the facilitators was to steer the discussion, maintain focus and to encourage participants to respond to and comment on each other’s contributions (Willig, 2008). In order to encourage contributions from all participants, participants were asked to hold a stress ball when talking and to pass this on when finished.

One week following the final session of Mindfulness Group 1, facilitators met with participants individually to administer the questionnaires for a second time. Four weeks later, facilitators met with participants individually to administer the questionnaires for a third and final time and to conduct an audio-recorded semi-structured interview. Scores on the GAS-ID and GDS-ID therefore provide a baseline measure, a post-intervention measure and a measure of the extent to which any potential change had been maintained in the short-term post intervention.

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Cambridge and McCarthy (2001) outline the benefits of group discussion with people with IDs such as the opportunity to identify collective observations and to develop a safe, nonthreatening and non-intimidating environment. Group discussion can also provide peer support and validation, build individual confidence, and facilitate the participation of those who may otherwise be excluded from research due to their literacy skills.
Interviews took place either in the participant’s home or in clinic rooms depending on which location was deemed most appropriate. If, for example, it was thought there may be interruptions or a lack of privacy within the home then the interview was held in a clinic space. However, a number of participants requested interviews take place at home. Interviews were conducted by either one or both of the group facilitators. As with the group discussion, facilitators explained the rationale behind the interviews and that the interviews would be audio-recorded. Facilitators avoided using the term ‘interview’ as it was felt such terminology might create an atmosphere of expectation, rather than the informal sharing of ideas that was preferred. It was also felt that the term ‘interview’ did not adequately reflect the informal nature of the meetings and did not fit comfortably with the rapport or therapeutic relationship that had been developed between participants and facilitators. However, the fact these discussions were audio-recorded for the purpose of later transcription and analysis was made explicit so as to avoid unintended exploitation of the informal feel to the meetings. Facilitators were mindful that they should not encourage participants to share more than they felt comfortable with (Willig, 2008).

The process described above was repeated for participants attending Mindfulness Group 2. At the conclusion of the study all participants were debriefed (Appendix 4) and continued psychological support was offered if required.

2.2.4 Group facilitators

The primary researcher was supported by a second facilitator in the process of establishing and running the group, recruiting participants and collecting data. The primary researcher was studying for a Practitioner Doctorate in Counselling Psychology and had both a personal and professional interest in mindfulness. She had completed an eight-week mindfulness for stress
course delivered by ‘Breathworks’ and attended regular mindfulness group sessions, day
retreats and training events. She used mindfulness in her clinical practice and had worked
within psychological services for people with IDs for approximately five years at the time of
the research. The second facilitator was a colleague of the primary researcher and a qualified
clinical psychologist. Again, she had both a personal and professional interest in mindfulness
and used mindfulness in her clinical practice. The mindfulness exercises were led by both the
primary researcher and the second facilitator.

2.2.5 Development of the Mindfulness Group intervention

The development of the Mindfulness Group intervention was an ongoing process which
continued throughout delivery. An overview of the intervention and preliminary development
and decision making is presented below.

2.2.5.1 Materials used in the Mindfulness Group intervention

2.2.5.1.1 Development of the written materials

Documents such as the information sheet (Appendix 2), consent form (Appendix 3), debrief
form (Appendix 4) and GP information letter (Appendix 5) were written by the primary
researcher, reviewed by the research supervisors and approved by the University and NHS
ethics committees. All written materials were designed with the client population in mind
taking into account existing literature regarding the development and requirements of easy-
read materials for people with IDs (for example, Department of Health (2010)).

9 It is generally accepted that practitioners delivering mindfulness training should actively
engage in sustained personal mindfulness practice (Kabat-Zin, 2003).
2.2.5.1.2 Development of the Mindfulness Group intervention content and session plans

Both groups adhered to an eight-week structured program created by the primary researcher in consultation with the second facilitator (See Table 2.2 in Results Section A for an overview of the session plans, Appendix 6 for a more detailed overview and Appendix 7 for an example session plan). This was based on pre-existing eight-week mindfulness programmes\(^{10}\) and the researcher’s and facilitator’s clinical practice, experience and knowledge of mindfulness and the client population. Specific examples of how the exercises were adapted are provided in Table 2.3 in Results Section A.

2.2.5.1.3 Development of the Mindfulness Group CD and ‘Mindfulness To Go’ workbook

‘Mindfulness To Go’ workbooks containing worksheets and written scripts for the mindfulness exercises used in the Mindfulness Groups were given to all participants (Appendix 8). Each workbook included a CD with audio-recordings of the scripts for these exercises. The CD was voiced by the primary researcher who led the majority of the mindfulness exercises. It was anticipated that hearing the primary researcher’s voice on the audio CD might serve to orientate participants back to the Mindfulness Group and therefore support memory and recall. To aid memory and recall further and to promote active engagement in the home practice, participants in Group 1 were invited to record an introductory segment for the CD during which they took turns to introduce the listener to the CD and explain its purpose. Due to time constraints this recording did not take place with Group 2.

\(^{10}\) Primarily that described by Williams and Penman (2011) in their book ‘Mindfulness: A Practical Guide to Finding Peace in a Frantic World’.
During the first session of each Mindfulness Group participants were invited to draw a picture of something that represented them or that told others something about them. This was initially intended as an ice-breaker exercise, however the drawings were later featured on the covers of the ‘Mindfulness To Go’ workbooks and CDs. Again, it was hoped this might aid memory as participants would be reminded of the other group members. It was also hoped that the use of participants own drawings might promote a sense of ownership over the materials and thus encourage active engagement with them.

2.2.5.2 Data collection materials

2.2.5.2.1 Interviews and group discussions

When developing the schedules for the semi-structured interviews (Appendix 9) and group discussions (Appendix 10) it was important to consider the research questions and to think also about the nature of qualitative research and the emphasis on participant experience and meaning making. Primarily the researcher was interested in participants’ subjective and individual experience of the Mindfulness Group. The schedules were therefore used as a tool to elicit discussion and were not administered prescriptively. Questions were missed if asking them would break the flow of discussion or if the question had already been addressed. Whilst the interviewer may have guided discussion, the aim was to provide a space in which participants could discuss freely and in their own words their experience of the Mindfulness Group. The interviewer was open to the possibility that such open discussion may be as likely to generate novel insights as challenge the researcher’s hope that the group had been a positive and beneficial experience.

The interview schedule was developed collaboratively by the primary researcher and one of her research supervisors. The final version included questions regarding the course content,
participants’ understanding of and experience of the group, any changes they may have experienced during or after attending the group and how they felt about the future. Where possible, questions were open-ended and explorative rather than leading. Some questions were descriptive (‘Did you miss any of the sessions?’), structural (‘How would you describe the group to other people?’) or evaluative (‘How do you feel now that you have been to the group?’) (Spradley, 1979).

The schedule for the group discussion was developed by the facilitators. Questions were designed to elicit discussion around what participants were hoping to gain from the group, what they enjoyed or found helpful, what they thought about mindfulness and how they understood it, whether they learnt anything from the group and whether they would continue to practice mindfulness at home. It was considered important to carry out group discussions in addition to the individual interviews so that data might be collected regarding the dynamics of each of the Mindfulness Groups and the nature of interactions that took place between group members.

During the interviews and group discussions, materials from the Mindfulness Group were used to aid memory and participants were encouraged to reflect on their experience of the group in general. Facilitators were mindful of the significant events which had taken place during the course of the group such as conversations around, for example, disability and discrimination, any personal disclosures that and been made, incidences of significant learning or personal development and any difficulties that had been experienced. Facilitators referred to these events as a means of reminding participants of the things they had done during the course of the group and to provide examples to illustrate the questions.
2.2.5.2.2 *The Glasgow Anxiety Scale for People with an Intellectual Disability (GAS-ID)*

The GAS-ID is a 27-item self-report measure of anxiety (including worries, specific fears and psychological symptoms) developed for use with people with IDs. Each item is scored from 0 to 2 with a total score of 13 or above indicative of an anxiety disorder (however it is recommended this cut-off point be regarded tentatively) (Mindham and Espie, 2003). The GAS-ID has good internal consistency with a reported Cronbach alpha coefficient of between .954 and .959 (Mindham & Espie, 2003). In the current study, the Cronbach alpha coefficient was .881 when administered pre-intervention, .920 post-intervention and .951 at 4-week follow-up. Questions include ‘Do you worry when you are doing something new?’ and ‘Do you feel scared meeting new people?’

2.2.5.2.3 *The Glasgow Depression Scale for People with an Intellectual Disability (GDS-ID)*

The GDS-ID is a 20-item self-report measure of depression, again developed for use with people with IDs. Each item is scored from 0 to 2 with a total score of 13 or above indicative of depression, however such a score would not be sufficient for a clinical diagnosis (Cuthill, Espie & Cooper, 2003). The GDS-ID has good internal consistency with a reported Cronbach alpha coefficient of between .89 and .91 (Cuthill, Espie & Cooper, 2003). In the current study, the Cronbach alpha coefficient was .712 when administered pre-intervention, .635 post-intervention and .872 at 4-week follow-up. A value of .70 or above is usually considered acceptable (DeVellis, 2003). A score of .635 post-intervention highlights potential issues with reliability. Questions include ‘Have you felt sad?’ and ‘Have you found it hard to make decisions?’ Participants are asked to think about these questions in relation to the past week only.
2.2.5.2.4 The Distress Thermometer: Checking in and checking out

In order to assess the immediate impact of each session and the mindfulness exercises practiced within each session, participants were asked to ‘check in’ at the beginning of each session and ‘check out’ at the end of each session. This process required participants to rate how they felt ‘right now’ on a scale of 1-5 ranging from ‘very relaxed’ to ‘very tense and stressed’. This scale was presented pictorially in the form of a thermometer. Participants were invited to add their names to the corresponding point on the thermometer. If participants reported feeling tense or stressed they were asked why they felt this way and their answers were noted down by the primary researcher on the ‘Check In’ form (Appendix 11). Whilst ‘checking out’ participants were asked what they liked about the session and what they did not like or found difficult. Their answers were noted down by the primary researcher on the ‘Check Out’ form (Appendix 12). The quantitative ratings were used to provide a ‘snap shot’ of how beneficial each session was and how successfully the mindfulness exercises were delivered, whilst the qualitative feedback informed the ongoing and future development of the Mindfulness Group.

2.2.5.2.5 Five Facet Mindfulness Questionnaire (FFMQ) – Facilitator Observation Form

Based on the Five Facet Mindfulness Questionnaire (FFMQ) (Baer et al., 2006) and a similar measure informally trialled within the CLDT, the ‘FFMQ Facilitator Observation Form’ (Appendix 13) was created by the primary researcher in consultation with the research supervisors and was used to measure facilitators’ observations of participants’ engagement with and understanding of the five facets of mindfulness: observing, describing, acting with awareness, non-reactivity to inner experience and non-judgment of inner experience. Facilitators completed the ‘FFMQ Facilitator Observation Form’ for each participant after each session. This involved rating each participant for their understanding of and engagement
with the five facets of mindfulness on a scale or 1 to 5 where 1 indicates no understanding or engagement and 5 indicates full understanding or engagement. Additional notes and reflections were made on these forms.\(^{11}\)

Singh et al. (2014) comment on the limitations of their study regarding the efficacy of a mindfulness-based smoking cessation program and refer specifically to the absence of a mindfulness rating scale psychometrically validated for use with people with IDs which would have allowed for the measurement of changes in mindfulness pre and post intervention. Thus far, the direct impact of MBIs on people with IDs has been assessed through an examination of changes to the dependent variable (Singh et al., 2013c). The present study assesses both impact on anxiety and depression (via the GAD-ID and GDS-ID) and makes an attempt to measure participants’ mindfulness. Measuring participants’ mindfulness after each session of the Mindfulness Group provides an indication of how successful each session was in terms of promoting mindfulness, whether participants were able to engage with and understand mindfulness, and whether participants were able to develop mindfulness over time.

2.2.5.2.6 Facilitator reflections

Following each session facilitators met to debrief. They completed evaluation forms (Appendix 15) designed to capture the content of the session, any observations made, any

\(^{11}\) An adapted version of the FFMQ (Appendix 14) was trialled in order to gather self-report data. This was abandoned when it became apparent that the adaptations intended to make the items more accessible to people with IDs had been unsuccessful. Participants struggled to understand the questions and as such it felt unethical to administer the questionnaire. The ‘FFMQ Facilitator Observation Form’ was developed in response to this difficulty.
successes or areas of difficulties and any further reflections. They also considered actions to be completed before the following session, such as further development of the materials or following-up on disclosures. These reflections were about both the effectiveness of the intervention and participants’ engagement with, understanding of and overall presentation during each session.

2.2.6 Data analysis

2.2.6.1 Analysis of the qualitative data

Seven semi-structured interviews and two group discussions were completed. Each were audio-recorded and transcribed. Before transcription, recordings were listened to in full in order to develop a familiarity with their content and emotional context. Audio-recordings were transcribed verbatim by the primary researcher. Non-verbal cues such as laughter, pauses and para-linguistic fillers were noted, as were any interruptions or distractions, such as participants leaving the room or talking amongst themselves. All identifying material was removed. Each transcript was read through at least once whilst listening to the corresponding audio-recording in order to check for the quality of the initial transcription.

The qualitative analytical method of thematic analysis offered a framework to which the transcripts could be coded and overall themes established. Thematic analysis was chosen as it was felt important to take an inductive, data driven approach, focusing on participants’ personal experiences, their meaning making and general understanding of the group process and content. Thematic analysis has also proven useful in other studies exploring mindfulness with people with IDs (Chapman & Mitchell, 2013b; Yildiran & Holt, 2014). Although the identification of themes was an interpretive act focused on the subjective experiences of the
participants, thematic analysis leans towards a positivist epistemological stance as assertions need to be supported by the data (Guest, MacQueen & Namey, 2012).

Thematic analysis is a versatile approach applicable to mixed methods research. In this context, the process of thematic analysis allowed for the extraction of information about participants’ experiences regarding their involvement with the Mindfulness Group, but also allowed for the analysis to focus on other aspects of importance such as whether the Mindfulness Group was feasible and what participants thought about the adaptations made to the mindfulness exercises. Given the number of research questions and breadth of information gathered including data from both qualitative and quantitative measures, thematic analysis, rather than interpretative phenomenological analysis (IPA), was considered most appropriate for this research study. Hefferon and Gil-Rodriguez (2011) describe IPA as the ‘default’ option for many students resulting in poorly constructed, descriptive projects which are not reflective of good-quality IPA. “Simply describing is not enough” and students who lack training in qualitative research methods or who do not fully understand the intricacies of IPA risk failing to “develop the analysis to a sufficient interpretive level” (Hefferon & Gil-Rodriguez, 2011; p.757). Given then the broad scope of this research project (using a mixed methods design to consider experience, process and outcome) and resultant demands on the researcher, developing sufficient knowledge and understanding of IPA may have proven challenging within the timeframe allowed for the completion of this research.

There are advantages to using thematic analysis, such as its accessibility to novice researchers (Braun & Clarke, 2006), the opportunity to work flexibly and to discover unanticipated insights in the research area of concern (Yildiran & Holt, 2014) and the opportunity to incorporate quantitative data into the analysis. The process of thematic analysis followed the
six stages outlined by Braun and Clarke (2006): (i) transcription and familiarisation with the data; (ii) generating initial codes; (iii) searching for themes; (iv) reviewing themes; (v) defining and naming themes; and finally, (vi) producing the report. Initial codes and themes generated and identified by the primary researcher were reviewed by the research supervisors and the second facilitator.

2.2.6.2 Analysis of the quantitative data

To test the research question regarding whether involvement in the Mindfulness Group might lead to decreases in self-reported anxiety and depression states, mean scores on the GAS-ID and GDS-ID at pre-intervention, post-intervention and follow-up were calculated and compared. Friedman analyses were carried out on the data followed by Wilcoxon Signed Rank post-hoc analyses.

To establish whether participants were able to develop mindfulness over time, Friedman analyses were carried out on the ‘FFMQ Facilitator Observation Form’ data to identify any statistically significant differences in participants’ understanding of and engagement with the five facets of mindfulness over time.

To establish whether participants were better able to understand or engage with some facets of mindfulness over others, further Friedman analyses were carried out comparing mean scores for understanding and engagement across the five facets of mindfulness to identify whether there were statistically significant differences in participants’ understanding of and engagement with each of the five facets. A Spearman Rank Order analysis was carried out to establish whether there was a correlational relationship between understanding and
engagement for each facet, i.e. whether increased understanding is related to increased engagement.

In order to establish whether participants experienced any immediate benefits as a result of their involvement with the Mindfulness Group, mean scores on the ‘Distress Thermometer’ were calculated and compared. Friedman analyses were conducted to establish whether scores on the ‘Distress Thermometer’ at the end of each session were significantly lower than scores at the beginning of each session. These were followed with Wilcoxon Signed Rank post-hoc analyses.

Non-parametric statistics were used due to the relatively small sample size and violations of the general assumptions that apply to parametric techniques, such as the assumption that data is obtained from a random sample of the population. Non-parametric statistics are, however, less powerful than parametric statistics and may lead to a Type 2 error, i.e. failing to reject the null hypothesis. This has been considered in the interpretation of the data.

2.2.7 Validity

Willig (2008) describes validity as a problematic concept for qualitative researchers and points to a number of ways in which validity issues can be explored within qualitative research. For example, participants could challenge the researcher’s assumptions around the meaning and relevance of the research (in this case through the interviews and group discussions) and the researcher engaged in a process of reflexivity in which she continually scrutinised the research and the role she played within the research. The primary researcher follows the school of thought that “different people have different, equally valid perspectives on ‘reality’, which are shaped by their context, culture and activities” (Yardley, 2008;
p.235). However, in the absence of one true perspective on reality, evaluating the validity of a piece of research is challenging. Yardley (2000) suggests that the quality of qualitative research can be assessed through four principles: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. Although primarily developed for qualitative research, these principles can be applied to quantitative research (Yardley, 2008) so are applicable to a mixed methods design.

2.2.7.1 Sensitivity to context

The extensive literature review provided a background to the research and gave context to the research questions. The literature review detailed existing knowledge regarding the use of mindfulness with people with IDs and identified gaps in the research. The primary aim of the research project, which was to explore the experiences of an underrepresented minority group, highlights a contextual sensitivity underpinning the research.

The researcher is an experienced practitioner within ID services and has an awareness of the socio-cultural influences on the service within which she works and the individuals who access this service. Normative, socioeconomic and historical influences on, for example, the beliefs and expectations of individuals with IDs and the beliefs and expectations others have of them have been considered throughout the research process. As an example, one of the driving forces behind the research was a recognition of the difficulties individuals with IDs often have in accessing healthcare. These difficulties are put into context when a history of institutionalisation and social exclusion is taken into account.

The research was participant focused with the content, format and process designed to best meet the needs of the individual participants. The semi-structured interviews, for example,
were flexible and open-ended and created a forum for participants to discuss what was of most significance to them in relation to the Mindfulness Group, rather than being led by the researcher’s preconceived ideas or interests. Transcribing these interviews verbatim allows for participants’ experiences to be contextualised, which gives a greater degree of meaning to the findings.

2.2.7.2 Commitment and rigour

The researcher demonstrated her commitment to the research and the client population through her prolonged engagement with the research topic and her continued employment within ID services. This resulted in the continued development of competence, skill and knowledge and required a considerable degree of personal investment. The researcher demonstrated her commitment to the research participants through the development of the Mindfulness Group and the various materials associated with this, such as the CD and workbook. She also sought to create an environment in which participants felt respected, appreciated and validated and took the time to thank participants for their involvement.

Rigour is demonstrated through the extensive literature review and commitment to contextual sensitivity. It is also evident in the quantity of data collected, the accurate transcriptions of the audio-recordings and the in-depth analysis of this data. All results and any conclusions drawn were checked and discussed with research supervisors and rigorously justified. Further, efforts were made to ensure any conclusions or interpretations drawn from the analysis were embedded within the data and representative of the data. The process of thematic analysis is in itself one of rigour and commitment as it requires a period of in-depth familiarisation with and immersion in the data.
2.2.7.3 Transparency and coherence

In line with the principles of thematic analysis and counselling psychology which promote transparency and reflexivity, the researcher has sought to provide as much information as possible regarding the research process and the collection and interpretation of results. The researcher provides epistemological and personal reflexive accounts (Section 2.9) and has considered the influence she may have had on the research. Clear documentation at all stages of the research process (from the submission of the initial research proposal to the coding of transcripts for the interviews and group discussions) provides clarity and transparency. The researcher has been clear in her intention to present the experiences of the participants and to advocate for them as best she can.

The decision to use a mixed methods design in order to appropriately address the research questions demonstrates a degree of coherence to the methodology and overall design of the research project. The process of data collection required coherence in order to ensure quality and consistency, as did the process of thematic analysis which followed the six stages outlined by Braun and Clarke (2006). The results chapter is divided into three sections in order to address each research question individually.

2.2.7.4 Impact and importance

The introduction and literature review highlight a gap in the research and consequently a gap in service provision for people with IDs. The research questions, concerned with outcome and experience, address the process of developing a mindfulness group for people with IDs and the potential benefits experienced by those involved. As such, this research provides valuable information regarding the feasibility of developing a mindfulness group for people with IDs and the potential for such a group to have positive outcomes. It is hoped that
findings will inform service development and the further development of MBIs for people
with IDs.

2.2.8 Ethical considerations

The research was carried out in accordance with the BPS Code of Human Research Ethics
(2010) and Code of Ethics and Conduct (2009) in addition to the Health and Care Professions
Council (HCPC) Standards of Conduct, Performance and Ethics (2012). It was anticipated
that neither the research process nor the intervention would violate the ethical principles of
respect, competence, responsibility and integrity (BPS, 2009). Despite this, ethical
considerations specific to the participant selection process, the client population, and the
group-based nature of the intervention needed to be considered.

2.2.8.1 Avoiding harm

The group was only offered as a therapeutic intervention where clinically appropriate. In
order to ensure this happened, facilitators liaised with colleagues within their direct and wider
multi-disciplinary teams. People with IDs often possess specific vulnerabilities and group
therapy can potentially expose participants to a variety of experiences from a variety of
people. Given the therapeutic nature of the group, it was not always possible to control the
nature of discussion and the nature of the information brought to the group from participants.
Facilitators took each participant’s particular vulnerabilities into account when deciding
whether the group would be an appropriate intervention. Should participants have required
additional support as a result of the content of discussion within the group, facilitators and/or
other qualified practitioners were available for individual consultation sessions.
The importance of participants keeping themselves safe by, for example, not disclosing personal information which they or other participants might find uncomfortable or inappropriate, was discussed during the group. Whilst no risk to physical health was anticipated, it was acknowledged that individuals with IDs are at increased risk of psychological difficulties (Smiley, 2005). If it became apparent that a participant was experiencing mental health issues more severe than previously acknowledged, appropriate steps were taken to ensure their needs were met via individual work or referral on to additional services. In addition, facilitators received regular supervision throughout the course of the research. Supervision was provided by the Lead Psychologist for the service.

In terms of potential burden, participants were asked to take part in one audio-recorded interview and one group discussion, complete a number of questionnaires, attend eight sessions of the Mindfulness Group and practice mindfulness at home. The benefits included potential improvement in clinical symptoms of anxiety and low mood, and an increase in self-awareness. It was anticipated that participants might feel empowered by the opportunity to participate in the research, with the outcomes of which being used to shape future service provision.

2.2.8.2 Ethical approval

Ethical approval was granted by the University of Wolverhampton’s Ethics Committee (Appendix 16), the NHS Research and Development office (Appendix 17) and the National Research Ethics Committee (NREC) (see Appendix 18 for the conditional approval and Appendix 19 for confirmation of favourable opinion).
2.2.8.3 Informed consent

Facilitators met with each participant to read through the information sheet and consent form and answer questions. Whilst going through the information sheet and consent form with participants, facilitators asked questions about the information contained within these documents in order to check for understanding and retention of information. The information sheet was left with each participant as this contained information about the Mindfulness Group and the research which they could refer back to or share with others if necessary. The information sheet also contained contact details for the service and guidance on how to report concerns. Once consent had been established, the research operated a process of ongoing consent confirmed by participants’ continued attendance of the sessions. Consent was checked again prior to initiating the group discussions and interviews.

Group facilitators were mindful of the indicators for consent outlined by Cameron and Murphy (2006). Negative indicators for consent suggesting that the individual may not have understood the presented information include a lack of eye contact, appearing indifferent or overly acquiescent, and ambivalent non-verbal responses such as negative facial expression. Positive indicators include eye contact, verbalisation of the willingness to participate, and positive non-verbal responses such as nodding.

2.2.8.4 Right to withdraw

During the first session of the Mindfulness Group a contracting exercise took place including discussion around confidentiality and the option to opt-out of either the group or the research (BPS, 2009, p. 14) without this effecting participants’ right to participate in future therapeutic intervention. It was arranged that should a participant choose to opt-out of the research, they would have the option to continue to attend the group without being a part of the research. If
a participant chose to opt-out of both the research and the group but wished to engage in individual therapeutic support, this was available also.

2.2.8.5 Debriefing

Following involvement in the Mindfulness Group and the research, participants were debriefed and a collaborative decision made as to whether they required ongoing support. This process involved going through the debrief form (Appendix 4) with each participant. The debrief from outlined the nature of the research and who participants should contact should they have had any concerns. Participants had the opportunity to ask the facilitators questions about, for example, the group, the research, or the potential for ongoing support.

2.2.8.6 Confidentiality

Group facilitators complied with the principles outlined by the Department of Health (2003) including the accurate and consistent recording of patient information, and ensuring patient information is kept private and physically secure and is used and disclosed appropriately. Clinical notes and all identifying information was stored securely in each participants’ NHS files. These NHS files were stored on NHS property and all confidential participant information was dealt with according to NHS information governance procedures.

Copies of interview transcripts and questionnaires stored in the primary researcher’s home for analysis were appropriately anonymised and stored securely. All identifying information was either removed or replaced with pseudonyms. Sources of data can be identified only by number.
Audio-recordings were downloaded from the recording device onto the primary researcher’s personal computer and a second copy saved onto an external hard drive as backup. All recordings were stored securely and confidentially in the primary researcher’s home. Recordings were used for qualitative analysis and were not listened to by anyone other than the primary researcher. Recordings will be destroyed when the research is completed and has been assessed.

2.2.9 Reflexivity

2.2.9.1 Epistemological reflexivity

An important feature of thematic analysis is that the researcher identifies and makes explicit their theoretical position and epistemological assumptions and acknowledge the impact these may have on the analysis and interpretation of the research data (Braun & Clarke, 2006; Caelli, Ray & Mill, 2003). Similarly, qualitative research methods require methodological reflexivity, whilst the counselling psychology ethos promotes a commitment to personal reflexivity (Orlans & Scoyoc, 2009). In accordance with these expectations and in order to contextualise the research, the researcher describes below her theoretical assumptions and ‘analytic lens’ (i.e. her methodologic and interpretive assumptions and how she has thought about and engaged with the data (Caelli, Ray & Mill, 2003)).

Due to a lack of existing knowledge regarding the application of mindfulness within the ID population, the researcher did not seek to falsify existing claims or theories. The researcher did not therefore follow the hypothetico-deductivism theory of knowledge which forms the basis of mainstream experiential psychology (Willig, 2008). Rather, she took an explorative, content driven approach combining aspects of both interpretivism and positivism. The process of thematic analysis allows for an interpretation of the data, however these
interpretations should be inductive in nature, i.e. embedded within the data and derived directly from the data (Guest, MacQueen & Namey, 2012) and not moulded or selected to fit a pre-existing coding frame or the researcher’s preconceptions of the analysis (Braun & Clarke, 2006). This is to ensure that any interpretations made by the researcher remain valid and true to the participant. The researcher chose to analyse the qualitative data at a semantic level. This required the identification of themes within the explicit or surface meanings of the data followed by an interpretation of the data, considering the significance of any patterns in the data and potential meanings and implications (Braun & Clarke, 2006). Given the lack of agency typically afforded people with IDs and the researcher’s strong belief that this research should be a reflection of the real life experiences of participants, the researcher was keen to avoid either over interpreting or misinterpreting participants’ words. However, the researcher recognises the active role she took in the identification of themes and the impact her own personal experiences, values and beliefs may have had on this process. As explained by Braun and Clarke (2006), themes do not passively ‘emerge’ but are identified, selected and reported by the researcher and are the result of the ways in which she has thought about and understood the data.

Of the four predominant research paradigms (positivism/postpositivism, constructivist, transformative and pragmatic (Mertens, 2005)), the researcher identifies most strongly with the transformative paradigm. Of particular appeal is the transformative paradigm’s focus on issues of power and subsequent implications for social justice (Mertens, 2007). From an onotological point of view, the transformative paradigm assumes that there are multiple socially constructed realities (Mertens, 2007) which are shaped by social, political, cultural, ________________

12 It was felt that a thematic analysis at the latent level, which might involve examining underlying ideologies and assumptions, would go beyond the scope of this research.
economic, ethnic, gender and disability values (Mertens, 2005). Due to its situation within social and historical contexts, knowledge (or what is perceived to be real) should be critically examined for its potential role in the perpetuation of existing oppressive societal structures and policies (Mertens, 2005). In terms of epistemology, the relationship between the researcher and participant should be one of empowerment with the research leading to recommendations that will support the empowerment of those who are considered to be lacking in power (Mertens, 2005). Further, this relationship should be interactive, built on trust and understanding, with an acknowledgement of potential power imbalances (Mertens, 2007).

The researcher recognised her position of relative power in comparison to those with IDs with whom she works. It was hoped that the development of the Mindfulness Group might begin to address inequalities in service provision, whilst an evaluation of the Mindfulness Group (informed by and focused on participants’ individual voices and experiences) might go some way in challenging this power imbalance and prove an empowering experience for participants. In giving participants the opportunity to comment on the processes inherent to the mindfulness intervention, participants were instrumental to the future shaping of the intervention.

The transformative paradigm shares similarities with social constructionism (Mertens, 2005). Both are anti-essentialist in nature and assume that there is no one true, objective reality and that there are in fact multiple realities of equal validity. What differs is that the transformative paradigm acknowledges an imbalance of power across these realities. Whilst the transformative paradigm argues that these realities should be subject to critical analysis with regards to these power differentials (Mertens, 2007) social constructionism allows for the
deconstruction of these realities and an examination of how these realities could have been alternatively constructed (Cromby & Nightingale, 1999).

Burr (2003; p.6) states that much of the opposition to essentialism is because “essentialism traps people inside personalities and identities that are limiting for them and are sometimes pathologised by psychology”. It can therefore be argued that essentialism may maintain oppression. The researcher therefore rejects the essentialist nature of traditional psychological research in an effort to avoid the further pathologising, categorising and defining of an already marginalised population with a history of oppression and discrimination. This ability to challenge dominant categories and associated practices highlights the potential for social constructionism to be an empowering approach (Willig, 1999). Similarly, the transformative paradigm provides a framework for addressing issues of social injustice (Mertens, 2007).

This research project draws on a social constructionist worldview and has its foundations in the four key assumptions outlined by Burr (2003). As such, the researcher takes a critical stance towards taken for granted knowledge, recognises the importance of historical and cultural specificity and believes that knowledge is sustained by social processes and that knowledge and social action go together. As a therapist working within ID services the researcher is a witness to the destructive power of normative thinking and the human tendency to categorise and create divisions (as is evident when one considers the historical treatment of people with IDs). She attempts to “become aware of the greyness of such categories” (Burr, 2003; p.3) and challenge the assumption that such categories reflect real divisions. She is invested in the idea that people can change how they think and what they do, but recognises that this potential for change and personal growth may be impacted on by the very nature of the individual’s IDs in addition to societal influences and constraints. The
version of social constructionism most relevant to this particular research project is described by Burr (2003) as ‘micro’ social constructionism which focuses on the social construction which occurs between people during every day discourse. This research is in essence focused on participants’ personal and individual experiences and how they construct their understanding of mindfulness within a group context. Whilst the researcher is mindful of wider societal influences, the experiences of the individual participants remains the focus of the research.

2.2.9.2 Personal reflexivity

The author has worked within community mental health services for people with IDs for over six years. Prior to this, she completed an undergraduate degree in Human Psychology. This was a four-year course including one year on placement within adult mental health services. During this placement year she co-facilitated a mindfulness group and was witness to the positive effects involvement in this group had on both clients and professionals. After graduating she secured an Assistant Psychologist post within the CLDT and was keen to build on the skills she learnt on this placement year. As she became more aware of the health inequalities experienced by people with IDs and the various barriers to accessing appropriate healthcare, developing a mindfulness group similar to that she was involved with previously seemed like the logical next step to improve access to mental health services. This initial idea was further bolstered as mindfulness became increasingly popular within both the research

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13 ‘Macro’ social constructionism which “acknowledges the constructive power of language but sees this as derived from…material or social structures, social relations and institutionalised practices” (Burr, 2003; p.22) is beyond the scope of this research project and was not a primary driver in terms of research topic.
literature and popular culture and research began to emerge suggesting that MBIs could be adapted to meet the needs of individuals with IDs.

The author felt an affinity with counselling psychology ethos, hence her application to the University of Wolverhampton. The values promoted by counselling psychologists, such as the importance of engaging in anti-discriminatory practice, empowering rather than controlling, and respecting the validity of individual experiences (BPS, 2005) echoes those values promoted by ID services. Counselling psychology is a relatively new and emerging discipline (Jones, 2013a) with the potential to have a significant impact in many contexts (Burr, 2006). Counselling psychologists are well equipped to work with individuals with IDs due to their own minority group status and can identify with the experience of disempowerment, discrimination and the struggle to develop an identity (Jones, 2013a).

As a white British woman with no disabilities nor physical health concerns, the author is not of a minority group yet has experienced discrimination and has felt stigmatised; often in relation to her gender or appearance. Fortunately, she is in the relatively privileged position of being able to speak out against those who discriminate against her. It is the author’s experience that people with IDs rarely have this privilege, particularly those who may have additional mental health needs or whose cognitive and emotional impairments cause them to be reliant on others for their everyday care needs. In her position as therapist and researcher, the author has the opportunity to reach a wider audience and highlight the experiences of those with whom she works. This may be interpreted as a need to ‘save’ or to ‘rescue’; a characteristic perhaps many in the healthcare profession can identify with. If this is a characteristic held by the author and one which drives her continued professional development, this is balanced by her belief that all are experts of their own experience and
that her role as therapist is to validate, accept and facilitate personal growth and change. Therapy can be an empowering experience, however this ‘empowerment’ is not a gift from the therapist; it is the result of a strong collaborative therapeutic relationship based on trust, equality and respect. The author’s hope is that those who participated in this research felt empowered by the process.
2.3 Results

The results are presented in three sections in order to address the three research questions as follows:

1. Section A: Can mindfulness techniques be successfully adapted to meet the needs of people with IDs, and can people with IDs understand and engage with these techniques?
2. Section B: How do participants experience mindfulness and their involvement in the Mindfulness Group intervention?
3. Section C: Does involvement in the Mindfulness Group lead to beneficial outcomes?

2.3.1 SECTION A: Can mindfulness techniques be successfully adapted to meet the needs of people with Intellectual Disabilities, and can people with Intellectual Disabilities understand and engage with these techniques?

2.3.1.1 Overview

This section outlines the course content and adaptations made to the mindfulness exercises. The success of these adaptations and implications for practice are discussed. ‘Success’ is considered in terms of whether participants were able to understand and engage with the core concepts of mindfulness and whether this understanding and engagement developed over time as participants attended more sessions and developed their practice. Variations in participants’ ability to understand and engage with each of the core mindfulness concepts is also discussed. Facilitator reflections, participant comments and data gathered from quantitative measures inform this section of the findings.
2.3.1.2 The Mindfulness Group Session Plans

Each session began by setting an agenda, ‘checking in’ and discussing home practice. To aid assimilation and learning this was followed by a discussion regarding the content of the previous session. Dependant on time constraints, two to three mindfulness exercises were practiced per session. In a typical mindfulness exercise participants were asked to focus their attention on their breath, observe their thoughts and practice ‘letting go’ of these thoughts (Williams & Penman, 2011). Each mindfulness exercise was followed by discussion during which facilitators used guided discovery and Socratic questioning (Padesky, 1993) to support participants to reflect on their experiences and to generate answers and learning for themselves. Each session ended by ‘checking out’. Psychoeducation around, for example, emotional intelligence and cognitive distortions, was incorporated into each session to support the mindfulness exercises. See Table 2.2 for itemised session plans for Mindfulness Groups 1 and 2. See Appendix 6 for a more detailed outline of the session plans and Appendix 7 an example session plan.

Despite claims that the cognitive aspects of some mindfulness interventions, such as MBCT, may be unsuitable for some individuals with IDs, research suggests that the skills-based, experiential components of MBIs can be easily adapted to meet the needs of the ID population (Robertson, 2011). Individuals with IDs can be taught “simple, highly effective, mindfulness-based relaxation practices through the use of modelling and experiential exercises based on everyday activities such as breathing, exercising and playing” (Robertson, 2011; p.50).
### Table 2.2: Session Plans for Mindfulness Groups 1 and 2

<table>
<thead>
<tr>
<th>Group 1</th>
<th>Group 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Session 1</strong></td>
<td><strong>Session 1</strong></td>
</tr>
<tr>
<td>Consent forms</td>
<td>As Group 1</td>
</tr>
<tr>
<td>Ice-breaker exercise</td>
<td></td>
</tr>
<tr>
<td>‘Mindfulness of the Breath Exercise’</td>
<td></td>
</tr>
<tr>
<td>Contracting</td>
<td></td>
</tr>
<tr>
<td>‘Raisin Exercise’</td>
<td></td>
</tr>
<tr>
<td><strong>Session 2</strong></td>
<td><strong>Session 2</strong></td>
</tr>
<tr>
<td>‘Mindfulness of the Breath Exercise’</td>
<td>As Group 1, minus ‘The Body Scan’</td>
</tr>
<tr>
<td>Practical exercises targeted at understanding physical sensations of</td>
<td></td>
</tr>
<tr>
<td>the body associated with mental states such as anxiety.</td>
<td></td>
</tr>
<tr>
<td>‘The Body Scan’</td>
<td></td>
</tr>
<tr>
<td><strong>Session 3</strong></td>
<td><strong>Session 3</strong></td>
</tr>
<tr>
<td>‘The Body Scan’</td>
<td>As Group 1</td>
</tr>
<tr>
<td>‘Mindful Movement’</td>
<td></td>
</tr>
<tr>
<td>Practical exercises around self-care and feeling good</td>
<td></td>
</tr>
<tr>
<td>(mindfulness concept: gratitude)</td>
<td></td>
</tr>
<tr>
<td>‘The Three Minute Breathing Space’</td>
<td></td>
</tr>
<tr>
<td><strong>Session 4</strong></td>
<td><strong>Session 4</strong></td>
</tr>
<tr>
<td>‘The Three Minute Breathing Space’</td>
<td>As Group 1</td>
</tr>
<tr>
<td>Practical exercises designed to develop an awareness of thought</td>
<td></td>
</tr>
<tr>
<td>processes</td>
<td></td>
</tr>
<tr>
<td>‘The Three Minute Breathing Space’</td>
<td></td>
</tr>
<tr>
<td><strong>Session 5</strong></td>
<td><strong>Session 5</strong></td>
</tr>
<tr>
<td>‘Walking Meditation’</td>
<td>As Group 1, minus the ‘Mindfulness of the Breath Exercise’</td>
</tr>
<tr>
<td>Practical exercises based on the ‘Turning Towards Difficulties’</td>
<td></td>
</tr>
<tr>
<td>exercises outlined in Williams and Penman (2011)</td>
<td></td>
</tr>
<tr>
<td>‘Mindfulness of the Breath Exercise’</td>
<td></td>
</tr>
<tr>
<td>Identifying sources of support</td>
<td></td>
</tr>
<tr>
<td>‘The Three Minute Breathing Space’</td>
<td></td>
</tr>
<tr>
<td><strong>Session 6</strong></td>
<td><strong>Session 6</strong></td>
</tr>
<tr>
<td>‘The Three Minute Breathing Space’</td>
<td>As Group 1</td>
</tr>
<tr>
<td>Practical exercises focused on emotions and memories</td>
<td></td>
</tr>
<tr>
<td>Practical exercises based on the befriending meditation (Williams and</td>
<td></td>
</tr>
<tr>
<td>Penman, 2011) (mindfulness concept: compassion)</td>
<td></td>
</tr>
<tr>
<td>‘The Three Minute Breathing Space’</td>
<td></td>
</tr>
<tr>
<td><strong>Session 7</strong></td>
<td><strong>Session 7</strong></td>
</tr>
<tr>
<td>‘The Three Minute Breathing Space’</td>
<td>As Group 1</td>
</tr>
<tr>
<td>Recap on previous sessions and topics covered</td>
<td></td>
</tr>
<tr>
<td>Discussion around changes participants may have made over the past 7</td>
<td></td>
</tr>
<tr>
<td>weeks</td>
<td></td>
</tr>
<tr>
<td>Mindfulness exercise(s) of group’s choice</td>
<td></td>
</tr>
<tr>
<td><strong>Session 8</strong></td>
<td><strong>Session 8</strong></td>
</tr>
<tr>
<td>Mindfulness exercise(s) of group’s choice</td>
<td>Group discussion</td>
</tr>
<tr>
<td>Group discussion</td>
<td>Mindfulness exercise(s) of group’s choice</td>
</tr>
<tr>
<td>Practical exercises based on the befriending meditation (Williams and</td>
<td>(mindfulness concept: compassion)</td>
</tr>
<tr>
<td>Penman, 2011) (mindfulness concept: compassion)</td>
<td></td>
</tr>
</tbody>
</table>
Lindsay et al. (2013, p.72) state that “a conscious effort is needed to adjust the style of presentation to take account of...limited information processing abilities” in order to work effectively with an individual with IDs. They identify four cognitive domains (intellect, emotional literacy, memory and executive function); deficits in which have implications for therapy as they affect specific processes such as verbal and non-verbal understanding and reasoning, emotional vocabulary, memory recall and working memory. These factors were taken into account when developing and delivering the course materials. For example, facilitators used a combination of verbal and non-verbal communication when engaging with participants and delivering the course content. Facilitators were mindful of using short sentences containing a single concept and two-syllable words in their verbal and written communication (Lindsay et al., 2013). They used reminders, prompts and frequent repetition to aid assimilation and memory recall and continually checked for understanding by asking questions about what had been discussed and asking participants to explain what they had been asked to do. Key points from verbal discussions were noted down on flip chart paper. Facilitators were mindful of the potential for acquiescence or compliance if participants did not understand what was being asked of them. Where appropriate, course content was shared with carers who were prompted to support the individual to engage with mindfulness practice at home. Psychoeducation was used to support learning and understanding. As an example, in order to explore how mindfulness techniques might be drawn on to manage feelings of stress, anxiety or anger it was necessary to explore what is meant by the terms ‘stress’, ‘anxiety’ and ‘anger’. It was also necessary to explore what an emotion is and how this differs from a thought, as well as the physiological impact of different emotional states. Before practicing mindfulness, it was necessary to explore the breath, what this is and why it is important. Interactive activities (such as the use of balloons to demonstrate the breath entering and leaving the body, and stress balls and exercise equipment to demonstrate the physical effect
of stress and tension) were used to deliver the psychoeducational components of the course content and participants were invited to engage in discussion around how the concepts might apply to them (Singh et al., 2013c). Participants were supported to remember specific incidents and concrete examples of times when they felt worried, for example, to explore why they felt worried, what thoughts they had, how this emotion manifest in the body, to recall how they reacted to or managed this situation and to think about how mindfulness techniques might have helped.

Specific example exercises will now be presented and evaluated with illustrative comments from participants to indicate the acceptability of the component.

2.3.1.3 The Mindfulness Exercises

Singh and his colleagues have published a number of studies regarding the application of ‘SoF’ in a variety of settings for a variety of presentations. For example, ‘SoF’ and MBIs of which ‘SoF’ is a component part have shown positive effects for people with IDs living in the community in terms of smoking cessation (Singh et al., 2014; Singh et al., 2013a), managing aggression (Singh et al., 2013b; Singh et al., 2011a; Adkins et al., 2010; Singh et al., 2007a; Singh et al., 2003) and managing the effects of Prader-Willi syndrome (Singh et al., 2011b; Singh et al., 2008c). Positive outcomes have also been observed in in-patient settings in terms of offenders with IDs controlling their ‘deviant sexual arousal’ (Singh et al. 2011c) and aggression (Singh et al., 2008b). Given that ‘SoF’ has already proven useful and the technique has been thoroughly developed to include a training manual for teaching ‘SoF’ as a method for managing anger (Singh et al., 2011e) this research focuses instead on existing mindfulness exercises which are commonly practiced by people without IDs, but of which little is known regarding their potential effectiveness with people with IDs. Identifying the
nature of the adaptations that need to be made to existing mindfulness exercises may go some way in informing the future development of appropriate MBIs for people with IDs.

Scripts for the mindfulness exercises practiced can be found in the ‘Mindfulness To Go’ pack in Appendix 8. Mindfulness exercises often required individualisation according to the cognitive capabilities of each participant (Singh et al., 2013c) and facilitators were conscious of the need to adapt the exercises in order to promote understanding and engagement whilst maintaining the integrity of the exercises (Lindsay et al., 2013). Brief descriptions of the mindfulness exercises are provided in Table 2.3 alongside an indication of how these exercises were adapted and how successful these adaptations were. This discussion is informed by participant comments and facilitator observations and reflections noted down during and after each group session. Due to word restrictions, an effort has been made to present comments which are most representative of participant feedback and facilitator observations and reflections. It should be noted that not all participants commented on all exercises.
Table 2.3: A description of the mindfulness exercises, how they were adapted, and how they were received

<table>
<thead>
<tr>
<th>Purpose and description</th>
<th>Adaptations</th>
<th>Participant/facilitator comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mindfulness of the Breath</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduction to mindfulness practice. Focus on the breath.</td>
<td>Adapted from exercise by Vivyan (2009) which compares the breath to the concrete and familiar image of a balloon inflating and deflating as the breath enters and leaves the body. Terms such as ‘inflate’ and ‘deflate’ replaced with ‘bigger’ and ‘smaller’ and ‘abdomen’ replaced with ‘tummy’ or ‘stomach’. Guidance expanded to allow for more repetition and prompting.</td>
<td>Participants described the exercise as relaxing, peaceful and “weird”. Some described the physical sensation of the breath flowing in and out of the body. Others noted difficulties concentrating or “switch[ing] off”. P1 felt tearful - she said she had become aware of her emotions during the exercise. P8 pretended to be asleep – perhaps an indication of how relaxed he felt, or a strategy to avoid discussion.</td>
</tr>
<tr>
<td><strong>The Raisin Exercise</strong></td>
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</tr>
<tr>
<td>Focus attention on the act of eating a raisin and notice how paying attention changes the experience of everyday activities.</td>
<td>Due to the practical and interactive nature of the exercise it required little adaptation. Participants encouraged to notice the texture of the raisin by looking at and touching the raisin. Encouraged to smell, taste and eventually swallow the raisin. The use of prompts throughout maintained engagement and supported guided discovery.</td>
<td>Participants commented that the exercise took patience and practice and that they felt able to practice something similar at home.</td>
</tr>
</tbody>
</table>
**Table 2.3 Continued**

<table>
<thead>
<tr>
<th>Purpose and description</th>
<th>Adaptations</th>
<th>Participant/facilitator comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Body Scan</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reintegrate the mind and the body and to experience in the present moment how thoughts and emotions can create tension in the body (Williams &amp; Penman, 2011).</td>
<td>Adapted from Williams and Penman (2011) who refer to a ‘spotlight’ of attention focusing first on the toes working up the body until it reaches the neck, face and head. Participants encouraged to imagine the spotlight of a torch shining on different parts of the body. The exercise was shortened by focusing on fewer and less specific parts of the body. During Group 1 participants practiced in silence however it was unclear whether they were following instruction and it was not possible to check for understanding. The exercise was further adapted for Group 2 - participants were asked to hold, touch or point to each area of the body as they focused their attention.</td>
<td>P9 found the exercise nice, relaxing and he felt able to “let everything go.” P1 commented on physical sensations (such as feeling the arthritis in her legs) and being able to observe her breath entering and leaving her body. She said it felt nice and that it helped to “get rid of distress”. Facilitators struggled to gather everyone’s attention to begin the exercise and queried how engaged participants were and whether they understood the relevance of the exercise.</td>
</tr>
</tbody>
</table>
### Mindful Movement

<table>
<thead>
<tr>
<th>Purpose and description</th>
<th>Adaptations</th>
<th>Participant/facilitator comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observe and experience the physical manifestation of stress through a series of stretches; “involves anchoring awareness in the moving body” (Williams &amp; Penman, 2011; p.118).</td>
<td>Adaptations made to the language and sentence structure of the exercise described by Williams and Penman (2011). The sequence of four interlinked stretches was followed including the use of imagery. One facilitator modelled the exercise whilst the other provided verbal instruction.</td>
<td>Participants said they felt relaxed. Facilitators noted participants appeared more engaged with the practical and interactive exercises, such as mindful movement, where they were able to leave their chairs and practice as a group.</td>
</tr>
</tbody>
</table>

### The Three-Minute Breathing Space

<table>
<thead>
<tr>
<th>Purpose and description</th>
<th>Adaptations</th>
<th>Participant/facilitator comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three steps: becoming aware of the inner experience (thoughts and emotions), gathering and focusing attention on the breath, and expanding the field of awareness to include the whole body.</td>
<td>The language and sentence structure in the guidance provided by Williams and Penman (2011) were adapted and the core concepts maintained. Imagery of a torch shining on the mouth or breath and then the whole body was also used.</td>
<td>Participants said the exercise was relaxing. Some could imagine the torch whilst others pictured a beach scene. P8 said the torch helped him focus on his breathing. P6 commented on the sound of birds outside. He imagined himself as a bird flying over a canyon, commented on physical sensations and noted his thoughts could be distracting. After a few practices P5 volunteered to lead the exercise. Facilitators noted participants engaged well and they observed noticeable changes in participant’s pace and depth of breathing. The exercise was particularly successful in terms of engagement and reported benefits – possibly as it was shorter.</td>
</tr>
<tr>
<td>Purpose and description</td>
<td>Adaptations</td>
<td>Participant/facilitator comments</td>
</tr>
<tr>
<td>-------------------------</td>
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<td>---------------------------------</td>
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<tr>
<td>The Walking Meditation</td>
<td>Adapted from Williams et al. (2007). Group 1 completed the exercise in silence whilst one facilitator modelled the exercise and the other provided verbal guidance. However, facilitators could not assess participant understanding of and engagement with the exercise. Group 2 were encouraged to engage in an observational commentary of the exercise, commenting on how different parts of their body felt as they moved.</td>
<td>Participants appeared to struggle. Rather than take their usual sized steps but at a much slower pace, some took very tiny steps whilst others walked quickly. It was unclear whether participants appreciated the relevance of the exercise or understood the relatively abstract nature of prompts such as “tell me how your legs feel” with one participant jokingly asking his legs how they were feeling.</td>
</tr>
</tbody>
</table>
2.3.1.4 The effectiveness of the individual sessions in promoting wellbeing and facilitating engagement with and understanding of mindfulness

The success of the adaptations made to the mindfulness techniques and acceptability of the component parts of the mindfulness intervention as described above have been explored through an examination of participants scores on the outcome measures, specifically the ‘Distress Thermometer’ and the ‘FFMQ Facilitator Observation Form’.

At the start and end of each session participants rated their mood on the ‘Distress Thermometer’. Mean scores on the ‘Distress Thermometer’ are presented in Figure 2.1.

![Figure 2.1: Participants’ mean scores on the Distress Thermometer for sessions 2-8](image)

Note: The ‘Distress Thermometer’ was not completed for Session 1. A rating of 5 indicates ‘very tense and stressed’ and 1 indicates ‘very relaxed’. 
On average, participants rated themselves as feeling most relaxed following session 8 (M = 1.63) and least relaxed following sessions 2 (M = 2.57) and 7 (M = 2.56). The greatest reduction in scores was recorded following session 8 (M = -1.12) followed by session 3 (M = -.57). This suggests sessions 8 and 3 were most successful in terms of promoting relaxation and decreasing stress levels and thus the mindfulness exercises and overall content of these sessions (see Table 2.2 for details) may have been the most well received. There was no difference between before and after scores following session 7 suggesting that perhaps the content of this session was not as well received and may require further adaptation.

After each session the ‘FFMQ Facilitator Observation Form’ was used to rate participants on their engagement with and understanding of five core mindfulness concepts as described by Baer et al. (2006). Scores provide an indication of how successful each session appeared to be in terms of participants’ engagement with and understanding of these mindfulness concepts. Mean scores on the FFMQ Facilitator Observation Form are presented in figures 2.2 – 2.6.
Figure 2.2: Participants’ mean scores on the FFMQ Facilitator Observation Form, Facet 1: Observing

Note: Participants were not rated after session 1 as this was primarily focused on introductions. Participants were not rated after session 8 as this was primarily focused on the group discussion and endings. A score of 5 indicates full engagement or understanding and score of 1 indicates no engagement or understanding. A score of zero was given if it was not possible to score a participant on their engagement with or understanding of the particular facet of mindfulness.
Figure 2.3: Participants’ mean scores on the FFMQ Facilitator Observation Form, Facet 2: Describing

Figure 2.4: Participants’ mean scores on the FFMQ Facilitator Observation Form, Facet 3: Acting with awareness
Figure 2.5: Participants’ mean scores on the FFMQ Facilitator Observation Form, Facet 4:
Non-judging of inner experience

Figure 2.6: Participants’ mean scores on the FFMQ Facilitator Observation Form, Facet 5:
Non-reactivity to inner experience
Figures 2.2 – 2.6 show that participants were consistently rated higher for engagement compared to understanding across all five facets of mindfulness and across all sessions. For sessions where participants were given lower scores for their understanding of and engagement with a particular facet, further adaptations could be made. For example, understanding of and engagement with Facets 1 and 2, ‘Observing’ and ‘Describing’, were rated lowest following session 3. During session 3 participants practiced the Body Scan, Mindful Movement and the Three-Minute Breathing Space. They also participated in a discussion and practical exercises related to self-care. Future groups might consider adapting session 3 so that it places a greater emphasis on developing participants’ skills in observing and describing. This might require further adaptation to the mindfulness exercises or reducing the number of exercises practiced during this session.

2.3.1.5 The effectiveness of the Mindfulness Group intervention in supporting participants to develop and build on their mindfulness over time

Scores on the ‘FFMQ Facilitator Observation Form’ (as discussed above) provide an indication of how successful each session was in terms of addressing and allowing opportunity to learn, practice and demonstrate the five facets of mindfulness as described by Baer et al. (2006). However, scores on the ‘FFMQ Facilitator Observation Form’ also provide an indication of whether participants were able to develop a greater understanding of and engagement with the five facets of mindfulness over time.

Freidman analyses were carried out on the ‘FFMQ Facilitator Observation Form’ data in order to establish whether participants’ ability to understand and engage with each of the five facets increased over time; the prediction being that understanding and engagement improve over time as participants attend more sessions, become more familiar with mindfulness and
develop their practice. Results indicate however that there was no statistically significant difference across the 6 time points (sessions 2, 3, 4, 5, 6 and 7) for understanding of ($\chi^2$ (5, n = 2) = 5.65, $p > .05$) and engagement with ($\chi^2$ (5, n = 2) = 6.96, $p > .05$) the facet ‘Observing’, understanding of ($\chi^2$ (5, n = 2) = 7.54, $p > .05$) and engagement with ($\chi^2$ (5, n = 2) = 5.61, $p > .05$) the facet ‘Describing’, understanding of ($\chi^2$ (5, n = 2) = 3.75, $p > .05$) and engagement with ($\chi^2$ (5, n = 2) = 5, $p > .05$) the facet ‘Acting with Awareness’, understanding of ($\chi^2$ (5, n = 2) = 2.93, $p > .05$) and engagement with ($\chi^2$ (5, n = 2) = 3.91, $p > .05$) the facet ‘Non-judging of Inner Experience’, and understanding of ($\chi^2$ (5, n = 2) = 7.45, $p > .05$) and engagement with ($\chi^2$ (5, n = 2) = 6.8, $p > .05$) the facet ‘Non-reactivity to Inner Experience’. Results therefore suggest that participants’ understanding of and engagement with the five facets of mindfulness as measured by the ‘FFMQ Facilitator Observation Form’ did not significantly change during the course of the Mindfulness Group.

2.3.1.6 Were some aspects of mindfulness easier or more difficult to engage with and to understand than others?

Participants’ mean scores for understanding of and engagement with the five facets of mindfulness as measured by the ‘FFMQ Facilitator Observation Form’ are presented in Table 2.4. A Friedman analysis comparing mean scores for understanding indicates there was a statistically significant difference in participants’ overall ability to understand the different facets ($\chi^2$ (4, n = 6) = 9.92, $p < .05$). Similarly, a Friedman analysis comparing mean scores for engagement indicates there was a statistically significant difference in participants’ overall ability to engage with the different facets ($\chi^2$ (4, n = 6) = 9.71, $p < .05$).
Table 2.4: Participants’ mean scores on the ‘FFMQ Facilitator Observation Form’ for 'understanding' & 'engagement’

<table>
<thead>
<tr>
<th></th>
<th>Observing</th>
<th>Describing</th>
<th>Acting with awareness</th>
<th>Non-judging of inner experience</th>
<th>Non-reactivity to inner experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean Understanding</strong></td>
<td>1.67</td>
<td>4.25</td>
<td>3.08</td>
<td>3.58</td>
<td>2.42</td>
</tr>
<tr>
<td><strong>Mean Engagement</strong></td>
<td>1.83</td>
<td>4.08</td>
<td>2.92</td>
<td>3.92</td>
<td>2.25</td>
</tr>
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</table>

Inspection of the mean ranks indicates participants scored on average lowest on their understanding of the facet ‘Observing’ (M=1.67) followed by ‘Non-reactivity to Inner Experience’ (M=2.42). On average they scored highest for understanding of the facet ‘Describing’ (M=4.25) followed by ‘Non-judging of Inner Experience’ (M=3.58). This pattern is mirrored exactly for participants’ ability to engage with the five facets scoring on average lowest for the facet ‘Observing’ (M=1.83) followed by ‘Non-reactivity to Inner Experience’ (M=2.25) and highest for ‘Describing’ (M=4.08) followed by ‘Non-judging of Inner Experience’ (M=3.92).

This indicated a potential correlational relationship between understanding and engagement. As such, Spearman Rank Order Correlation analyses were carried out on the data. There was a strong, positive correlation between understanding of and engagement with the facet ‘Observing’, \( r = .9, n = 6, p < .05 \); a strong, positive correlation between understanding of and engagement with the facet ‘Describing’, \( r = 1, n = 6, p < .01 \); a strong, positive correlation between understanding of and engagement with the facet ‘Acting with Awareness’, \( r = .94, n = 6, p < .01 \); and a strong, positive correlation between understanding of and engagement with the facet ‘Non-judging of Inner Experience’, \( r = .9, n = 6, p < .05 \). There was no significant correlation between understanding of and engagement with the facet ‘Non-
reactivity to Inner Experience’, $r = .75$, $n = 6$, $p > .05$. Results suggest that for the facets of mindfulness, excluding ‘Non-reactivity to Inner Experience’, understanding and engagement are intertwined and that increased understanding leads to increased engagement and vice versa.
2.3.2 SECTION B: How do participants experience mindfulness and their involvement in the Mindfulness Group intervention?

2.3.2.1 Overview

Section B presents the results of the thematic analysis carried out on the transcripts of seven interviews and two group discussions. Initial codes were identified, named and reviewed and finally organised into five master themes. A table of master themes and subthemes is provided below (Table 2.5). Quotes extracted from the transcriptions were used for the master theme headings in order to emphasise the central role participants played in the research.

Master theme 5 “Without this group I wouldn’t really exist” is presented and discussed in Section C of this results chapter as it goes some way towards answering the third research question addressing the positive outcomes reported by participants as a result of involvement with the Mindfulness Group. The four remaining themes are presented below in an order chosen to promote fluidity of narrative and support a coherent discussion. Due to restrictions on the word limit many supporting quotes could not be reported. Whilst every effort has been made to select quotes which are representative of the thoughts, opinions and experiences of the participant group as a whole, the researcher’s belief that all realities are equally valid has allowed for the inclusion of quotes of particular significance or poignancy. Quotes are presented verbatim with minimal interpretation on behalf of the researcher. This is to ensure an accurate representation of participants’ experiences.
Table 2.5: Master Themes and Subthemes

<table>
<thead>
<tr>
<th>Master Themes</th>
<th>Subthemes</th>
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<tbody>
<tr>
<td>1. “We have coffee and biscuits but it’s more than that”</td>
<td>1. Enjoyment and fun</td>
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<td></td>
<td>2. Engagement in meaningful activity and gaining a sense of purpose</td>
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<td></td>
<td>3. The therapeutic nature of the group</td>
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<td>2. “You didn’t feel sort of the odd one out”</td>
<td>1. Socialisation and sharing</td>
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<td></td>
<td>2. Friendship, bonding and support</td>
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<td>3. “I think you two have probably helped”</td>
<td>1. Group facilitator qualities</td>
</tr>
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<td></td>
<td>2. Participant-facilitator relationships</td>
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<td>4. “It gets rid of stress and it relaxes you”</td>
<td>1. Understanding of mindfulness</td>
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<td></td>
<td>2. Experience of mindfulness and the mindfulness exercises</td>
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<td></td>
<td>3. Demonstrating the five facets of mindfulness</td>
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<td></td>
<td>4. Difficulties with mindfulness and the mindfulness exercises</td>
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<tr>
<td>5. “Without this group I wouldn’t really exist”</td>
<td>1. Impact on mental health/psychological wellbeing</td>
</tr>
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<td></td>
<td>2. Impact on quality of life</td>
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<td></td>
<td>3. Looking to the future – ongoing impact</td>
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2.3.2.2 Master Theme 1: “We have coffee and biscuits but it’s more than that”

2.3.2.2.1 Overview of the theme

Master Theme 1 offers insight into participants’ personal and collective experience of the group. Participants discuss the fun they had attending the group and the significant role having fun played in their enjoyment of the group and their ability to form a group bond. Participants’ focus on fun and enjoyment may reflect a misunderstanding of the purpose of the group, however it might also highlight a component of the group that was necessary in order to facilitate an environment in which participants felt safe, supported and accepted so that they were able to engage with the intervention. Further, experiencing the group as an enjoyable activity may have positively influenced participants’ motivation to attend. Motivation, engagement in a meaningful activity and gaining a sense of purpose are all explored in Master Theme 1, as are the participants’ experience of the therapeutic aspects of the group.

2.3.2.2.2 Subtheme 1: Enjoyment and fun

Whilst facilitators hoped the group would be a positive experience for participants, the purpose was not primarily to provide enjoyment and fun. The group content was designed to be engaging and to promote discussion and it was hoped participants would benefit from their involvement with the group. A number of participants commented directly on their enjoyment of the group. For example, P2 said “I've been enjoying the sessions” (Group Discussion 1, 179)\(^{14}\) and P6, “It was really fun as well” (Interview with P6, 65). It seems participants’ active engagement in the practical exercises promoted this sense of enjoyment.

\(^{14}\) Transcripts are provided in the Confidential Attachment which has been submitted separately to the Research Dossier. Here, 'Group Discussion 1, 179’ indicates that the quote can be found on line 179 of the transcript for the first group discussion.
and fun. For example, P8 recalls an exercise in which he volunteered to lie on a large piece of paper whilst P7 drew around him:

(...)“I think we like need a volunteer” you said. (...) because yeah it’s going to have to be me isn’t it! [group laughter] You know! [group laughter] Only me! (Group Discussion 2, 153-155)

Participants were invited to draw and write on the outline of P8’s body in order to create a picture of physiological responses to emotions such as stress and anxiety. It is unclear whether participants remembered the purpose of this exercise:

Group Facilitator 2 (GF2): So why did [P2] draw around you?

P4: [laughs] I dunno. (Interview with P4, 36-37)

Primary Researcher/Group Facilitator 1 (R/GF1): You lay down (...) and [P2] drew around you. (...) we drew lots of things on to that didn’t we?

P4: Yeah. What we liked. Our hobbies.

R/GF1: Ah so that was another exercise (...). We talked about (1) things that we enjoy doing. (Interview with P4, 43-48)

However, it is evident that the exercise was remembered fondly:

P8: Both of us was absolutely in- in hysterics laughing. (Group Discussion 2, 143-145)

---

15 (...) indicates that due to word constraints some of the text from the original transcript has not been included here.

16 (1) indicates a pause of one second. (2) indicates a pause of two seconds and so forth.
By having fun together a group bond, or identity, was forged. P7 remarks “Oh we had some fun times” (Group Discussion 2, 256) and positions himself as being part of the group. This group identity was characterised by humour and a shared enjoyment of the group and of each other’s company:

P8: Let ladies go first.
P9: Who are you referring to? [laughs]
P8: P1! [group laughter] You look like a lady!
P9: [group laughter] Hey come here then! (Group Discussion 2, 8-12)

At times the group identity was strengthened by directing this humour at the facilitators or using humour as a means of excluding them:

P1: ‘Cause [R/GF1] was getting really bright red and I could see on [her] face as if to say “listen to me” [laughs]. And we all kept going “shush, listen to [R/GF1] (...) We’re supposed to be relaxation. Concentrate.” [laughs] And we all started laughing.
(Second Interview with P1, 58-60)

Fun and enjoyment became an integral aspect of the group and there was an expectation that facilitators would support this jovial atmosphere. For example, when asked what the facilitators could do differently when running another group, P7 suggested:

(...) a little bit more (...) funny things and more entertainment. (Group Discussion 2, 705-707)

This experience of the group as being somewhere to have fun went on to define the nature of the group for some:

P1: We come here to be happy and try to be cheerful. (Group Discussion 2, 34)
Whilst this comment might be understood as a reference to the group’s position within Psychological Services and subsequent focus on improvements in psychological wellbeing and mental health, it might also be interpreted as a misunderstanding of the nature of the group. The group was not intended to promote happiness (or provide entertainment) but was intended as a space to explore emotions, with the expectation that this might involve difficult emotions such as sadness and anger. However, it seems this experience of the group as being a place to have fun and be cheerful helped P1 to recognise and challenge her own emotions. She was able to consider her emotional state in comparison to others, put this into perspective and change her pattern of thought:

‘Cause sometimes when I get down it can last for a long time. But then (...) everybody started laughing I think oh for goodness sake cheer yourself up P1, stop being so miserable. (Group Discussion 2, 719-721)

Having fun then not only defined and shaped the group but also facilitated change.

2.3.2.3 Subtheme 2: Engagement in meaningful activity and gaining a sense of purpose

Each group quickly developed a set of routines and participants assigned themselves certain roles or tasks:

P5: Good thing is I got to make cups of tea for people (...) (Interview with P5, 13)

The task of making tea and coffee at the start of each session was a collaborative one and symbolic of the care and kindness of the facilitators and participants:

P2: I know you’re k- You’re very kind, and you are, ‘cause I made you drinks. We make each other drinks. (Group Discussion 1, 189).
There was a sense that attending the group provided participants with a meaningful and valued activity. P1, for example, said the group gave her motivation; something to get up for:

\[
I \text{ had the motivation to get up and- and looking forward to doing something (Group Discussion 1, 198)}
\]

This was confirmed by her advocate:

\[
\text{Advocate: You enjoyed getting up to come here as well though didn’t you?}\\
P1: Yes, it was sort of motivation. (First interview with P1, 576-579)
\]

P1 also said the group gave her motivation to do more things that she enjoyed outside of the group:

\[
\text{But it’s just so so nice I find my- like I said my knitting and crocheting. You’ve gave me encouragement to carry on to do that, so I find I’m into that more. (Group Discussion 1, 119-121).}
\]

With the support of her advocate P1 was motivated to make practical changes that might have a beneficial impact on her quality of life. She spoke of going for walks, meeting friends and redecorating her flat. P1 expressed her disappointment that the group had come to an end as she felt she was just beginning to make positive changes:

\[
P1: \text{ ‘Cause when [the group] stopped I thought “Oh, just, sort of getting somewhere”.}\\
\text{Advocate: You missed it didn’t you? Yeah.}\\
P1: And I thinking well, it’s given me motivation to do something instead of just being lazy, ‘cause it’s a big effort at the moment for me to get that motivation, to keep it going. (First Interview with P1, 913-919).
\]
Similarly, P5 spoke of his disappointment at the group coming to an end as it had given him a reason to leave the house:

_I am [disappointed] yeah. ‘Cause it got me- got me out of the house for a bit and stopped me being bored that’s the main thing._ (Interview with P5, 26)

Participants’ motivation to attend the group suggests they perceived the group as meaningful and worthwhile. Participants spoke positively about the group with P1 going as far as to say “_I think without this group I think I just (1) wouldn’t really exist_” (Group Discussion 1, 563). She appears to attribute much of the positive change she has experienced to her involvement in the group, however she also acknowledges the hard work and determination she has invested in this:

_Gradually more happy but I’m still not- but it’s a slow thing but I, er, I know that I will get there and I’m not giving up._ (Group Discussion 1, 16)

P1 therefore perceives the group as having played a significant role in her progress and development. Indeed, she states she attended the group because of the way she was feeling and a sense that she needed something:

_I find (1) because (1) the way I (2) the way I was that I needed something._ (Group Discussion 2, 30)

Similarly, P3 attended the group because she was “_quite stressed out_” (Group Discussion 1, 24) and “_needed to calm down a bit_” (Group Discussion 1, 129). P2 said he attended the group “_To achieve. To get something out of it_” (Group Discussion 1, 94) whilst P4 said he was “_interested_” (Group Discussion 1, 2) and “_needed it_” (Group Discussion 1, 4). Some were motivated to attend the group in the hope of making friends:
R/GF1: I’m wondering what (...) you were hoping to get out of the group.

P4: (7) Make new friends. (Group Discussion 1, 97-98)

P7: (...) came to the- the group to make new friends, to try and get everything out of my system. Bit upset. Make me laugh. New friends like P8, P1 and P9. Really good, cracking people. (Group Discussion 2, 175-179)

P8: Just (1) make (1) new friends, like P7, P1 and, erm, P9. (Group Discussion 2, 114)

Some felt nervous about attending the group, particularly at the thought of meeting new people. P2, for example, recalled feeling nervous before the first session, however there was something about the group or his own ability to regulate his emotions which enabled him to overcome this:

When I first came I was a bit nervous but I thought I can- I wasn’t gonna do the group. I thought that. But as soon as I came, I picked myself up and knew it would (2) but (2) er. I liked the group. (Interview with P2, 167-170)

For P8, the fact he was able to attend the group despite initial hesitation lead to a sense of achievement and pride:

[GF2] said “how would you like to come along [to the group]?” And I said “oh, well I’ll come- I’ll probably maybe come along for the first week”. Then I like, came along for the first week. Erm. Then I come around for the second week. Now look, I’ve come round for the third week. (Group Discussion 2, 133-135)
P5 illustrates a process of positive change in which he is able to reflect on how he felt when he first joined the group and the progress he has made since then:

*Well, I found it a little bit nervous coming ‘cause I was meeting new people but then, gradually, as you go along you progress through different (1) erm, bits on the Richter scale. You go up one, you go up one and you go up one. But (...) as soon as that progresses you’re halfway there already (1) so I (1) finally realised for myself that I was doing the right thing by coming to this group, getting out of the house and doing what I needed to do.* (Interview with P5, 44-48)

2.3.2.2.4 Subtheme 3: The therapeutic nature of the group

Subtheme 3 focuses on references made to the therapeutic nature of the group and participants’ ability to use the group as an opportunity to talk openly about their difficulties.

Whilst subtheme 1 ‘Enjoyment and Fun’ highlights the enjoyable aspects of the group, fostering an atmosphere for therapeutic change goes beyond enjoyment and fun and in many ways challenges the perception of the group as a place for enjoyment and fun. Indeed, when asked about what they did not like about the group, both P1 and P9 said they did not like feeling “down” (*Group Discussion 2, 555 and 549*). Both had experienced difficulties with relationships during the course of the group and were supported to talk about this within the group. It is possible that talking about these difficulties may have initially exacerbated their feeling ‘down’, however the hope of any therapeutic intervention is to progress from the discussion of facts and exploration of emotions to positive change, growth and development. Whilst diversion to an alternative topic of conversation or distraction with an enjoyable task might have felt less challenging in the short term, the basis of mindfulness is awareness. By encouraging participants to become aware of their feelings, the facilitators were modelling mindfulness. P1 sums up the divergent aspects of the group when she says:
And we have laughs and as I said we- we have, um, coffee and biscuits and- but it’s more than that. (...) instead of thinking, well this is something that I have to deal with all on my own at least other people try to comfort each other. And that’s really nice. (Group Discussion 2, 803-807)

Whilst the facilitators were welcoming of therapeutic discussion and actively encouraged this where appropriate, mindfulness was key to their interactions with participants. As such, they attempted to model mindful awareness, acceptance, non-judgement and compassion during these discussions and referred back to mindfulness concepts when, for example, problem solving with participants or thinking about different ways of coping. Both P3 (Interview with P3, 67-68) and P6 said they found it helpful to talk about feelings, with P6 referring specifically to the problem solving potential of these discussions:

And just (1) figuring out who, what or how the problem got there. Or just erm (1) just being there for each other really. (Interview with P6, 8-10)

However, for P1 it seems there was not a clear link between these discussions and the rest of the course content:

[The things we talk about have] nothing to do with what’s going on with the actual group – it’s what we’re feeling and what we’re thinking. (First Interview with P1, 782-784).

2.3.2.2.5 Summary

The quote used to illustrate master theme 1 “We have coffee and biscuits but it’s more than that” suggests there was a greater depth and meaning to the group that went beyond the coffee and biscuits, enjoyment and fun. This sense of there being something more about the
group, something with greater meaning and significance, is perhaps difficult to put into words. Participants’ comments suggest they viewed the group as a meaningful activity and one which they were motivated to attend despite reservations about meeting new people. Due to difficulties some had experienced with, for example, low mood or anxiety, finding the motivation to attend the group may be considered a significant achievement in itself. This motivation spilled-over from the Mindfulness Group and many participants reported being able to engage in more meaningful activities within their personal lives. Although it is unclear whether the mindfulness exercises themselves had a direct impact on participants’ ability to motivate themselves and begin making changes within their personal lives, there may have been a combination of factors at play, including the opportunity to socialise and enjoy themselves and talk about their difficulties within a compassionate and accepting environment. Although encouraging, the positive regard with which participants viewed the group may be better understood alongside a consideration of participants personal lives, amount of appropriate support (or lack there of) and the kinds of activities they might tend to engage in. Against a backdrop of social isolation and limited activity, the Mindfulness Group may have provided a significant source of social contact and stimulation.

2.3.2.3 Master theme 2: “You didn’t feel sort of the odd one out”

2.3.2.3.1 Overview of the theme

Master theme 2 “You didn’t feel sort of the odd one out” focuses on the group dynamics and relationships formed between participants. The opportunities participants had to socialise, share experiences, learn from each other and to develop friendships are considered, as is the impact of these friendships on participants’ overall experience of the group.
2.3.2.3.2 Subtheme 1: Socialisation and sharing

Participants seemed to appreciate meeting with and getting to know each other:

   P5: (...) it was really good to like interact with other- other people and like er, get to
   know them. (Interview with P5, 6)

Some felt accepted within the group and were able to talk openly without feeling criticised:

   P1: I could be (1) quite- quite open. (...) I’m not put down or criticised. And (1)
   everybody’s just accepted me, the way I am. (Group Discussion 1, 623-627)

This acceptance and freedom to be herself facilitated a sense of belonging and inclusion:

   P1: (...) you didn’t feel sort of the odd one out thinking, oh everybody’s saying oh pull
   yourself together, don’t be stupid. (Group Discussion 2, 199)

Participants were compassionate towards each other and showed empathy for each other. For example, P8 recalls a story P1 had told some weeks previously about a woman who would not let her sit down on the bus:

   (...) and this like woman wouldn’t move for [P1]. Do you remember that? (Group
   Discussion 2, 674)

As P1 told her story others were able to empathise and identify with her experience. In return, P1 found she was able to identify with them and could see aspects of her own experiences as they spoke about their difficulties:

   There’s a lot of us (...) we’ve got a lot- quite a lot in common. We can connect. I’m
   thinking “Yes, that’s how I feel in that situation. That’s what I feel”. (First Interview
   with P1, 374)
An experience confirmed by P1’s advocate:

Advocate: You felt that some of them were the same as you, didn’t you?

P1: Yes.

Advocate: When you came back you said “oh” you could relate to that ‘cause that’s how you felt, didn’t you?

P1: Yes. Quite a lot. (First Interview with P1, 345-352)

Finding people with shared experiences who they could identify with lead to a sense of normalisation:

P7: Everyone goes through like a bad patch and everyone goes through a good patch.

(Group Discussion 2, 669)

This process of normalisation in which participants were able to realise that they were not alone in feeling the way they did, provided a degree of comfort:

P1: (…) they all said “Oh, we’ve all been through that.” (Second Interview with P1, 209)

P1: (…) It’s nice to know we all- we all felt the same and- and we all- we all get sad days. (Group Discussion 2, 32-34)

Participants were able to normalise experiences for each other and in doing so offer comfort, support and compassion:

P9: (…) last night I was thinking about [ex-girlfriend] again, but, it’s gonna happen.

P1: That’s just a natural thing when you’re close to somebody. (Group Discussion 2, 108-111)
P1 “wanted to talk to them and to help them” (First Interview with P1, 342) but seemed surprised by her own ability to do this. As someone with IDs who receives support with activities of daily living, P1 may be more familiar with the role of ‘supported’ rather than ‘supporter’:

(...) they said I helped them and I’m thinking ‘have I?’ (Second Interview with P1, 281)

The Mindfulness Group therefore provided an environment in which participants could share their experiences, offer each other comfort and support, and also learn from each other and think about themselves in relation to others. For example, P1 discovered P6 did not share her views on body image. Rather, she found that he could talk about weight with ease whilst she found such conversations particularly difficult:

I know [P6 has] got to talk about it but please don’t because (...) I’m trying to get rid of these things but then they come back. But- but I thinking, well, that’s the way he handles it. (Second Interview with P1, 171-173)

Similarly, P1 found P7’s use of language difficult and his tendency to make comments which she felt were inappropriate:

P7: [inaudible] sex change then! [laughs]
P1: Oh, P7. Will you stop saying things you shouldn’t say? (Group Discussion 2, 73-74)

By drawing attention to P7’s comments, P7 received a brief lesson in social norms and how to behave in social situations thus demonstrating the opportunity for socialisation within the Mindfulness Group. Although P1 did not appreciate P7’s use of language and experienced him as being different from herself – not, perhaps, someone she would ordinarily socialise
with outside of the Mindfulness Group – P1 made efforts to understand their differences and reflected on her childhood and the role this might play in how she relates to P7:

(...) I can’t understand what he says and then- then I thinking P7 did you- did you just say a word you-. ‘Cause- ‘cause I suppose it’s the way I been brought up and I thinking this is a hard situation, but he knows. He says (...) excuse my language but-

(Second Interview with P1, 144-146)

There were also opportunities for P1 to learn from others. Being the only woman in the second group meant that generalisations about the other sex were unlikely to go unnoticed:

P1: (...) typical of men. They never smile or-

P7: Ey, ey, ey! [group laughter] Oi! Oi! You can’t say that we’ve got men here.

P1: But- but this one was really, really nasty. (Group Discussion 2, 679-682)

Participants responded to P1’s comments with humour, however her assumption that all men are the same was challenged. She corrected herself and acknowledged that it was one man, not all men, that was “really, really, nasty” (Focus Group 2, 682). It seems that being in a group with men challenged P1 to think differently as she realised that she could relate to the men in the group:

I find it’s difficult (...) if it’s a man. I find it rather embarrassing but (...) well, they need cheering up. They just human like us. (Group Discussion 2, 65-69)

P1 reflected on this again during a later interview:

It sounds a bit embarrassing all- all men in the group but I thinking well, funny enough, some women can connect with- with men more than just though- just ladies

(Second Interview with P1, 156-159)
2.3.2.3 Subtheme 2: Friendship, bonding and support

The Mindfulness Group was a social experience for participants in which relationships were formed which could be maintained outside of the group context:

P5: ‘Cause I always see quite a lot of other people from the group while I’m out in town a lot. (Interview with P5, 8-10)

These relationships were an important aspect of the group process:

R/GF1: So what would you say (1) you liked the most about coming to the group? (2) So the things that we did, or the people, or the fact that it was-

P4: The people. (Interview with P4, 153-154)

Participants tended to view these relationships as friendships rather than therapeutic relationships; not ones that might be time limited, bound to the Mindfulness Group:

P7: Everybody stuck together- stuck by like each other, like a group of good friends.

(Group Discussion 2, 125)

There was a sense that the Mindfulness Group created an atmosphere in which these friendships could be formed as participants felt safe to disclose information about themselves and were able to get to know each other and provide support for each other:

P6: (...) just being there for each other really. Erm. And getting to know each other. And (1) trying to make friendship groups as well (...) (Interview with P6, 8-10)

P2 felt pride in his ability to form these relationships and felt secure in the knowledge that he could share as much or as little as he felt comfortable with:
I’ve been enjoying the sessions, but I’ve- I’m really proud of meeting friends, who I can really trust and bond with. And stick in with the group and, go out and say, as much as you want. (Group Discussion 1, 179-183)

Whilst P1 trusted group members to validate rather than dismiss her experiences:

(...) even if you did burst into tears I don’t think anybody (...) would say, oh don’t be so silly. And I think (...) would just say, oh are you alright? (Group Discussion 1, 706-708)

Her comment “oh don’t be silly” (Focus Group 1, 708) is reminiscent of something a parent might say to their child or, perhaps, comments that have been made to P1 previously. The tendency of some to infatalise adults with IDs or to engage in paternalistic relationships with them appeared to be the antithesis what P1 valued about the Mindfulness Group:

(...) everybody’s patient with one another. We don’t put each other down. We don’t say oh you shouldn’t be dressed like this. Look at you. Look at this and that. And that- and that is really nice. (Group Discussion 2, 799-803)

Cleary P1 felt that her peers were addressing her as their peer. She felt included in this peer group and felt that her contributions were valued and respected:

I’ve found somewhere where I feel (1) not the odd one out. I feel I’m not being criticised. Not being called stupid. (...) Or you don’t know what you’re talking about. (Second Interview with P1, 206)
Far from criticise each other, participants offered moral support and were keen to bring their perspective to any difficulties other group members may have been experiencing. Here, for example, P7 attempts to boost P1’s confidence and encourages her to challenge herself:

\[
P1: (...) why do I bring everybody else down? It’s my problem nobody else’s.
\]

\[
\]

Others were keen to voice their support for P1 also:

\[
P6: (...) we’re all there for [P1]. (Interview with P6, 169)
\]

Whilst the exchange below reflects the depth of the relationships forged within the group:

\[
P1: [Others in the group are] feeling exactly the same. And I thinking, how do they know I was thinking that? How do they know? [group laughter]
\]

\[
P8: Because we know you too well P1, that’s why! (Group Discussion 2, 658-664)
\]

During the second interview with P1 the primary researcher commented on her experience of the group as being one in which group members were supportive of each other and genuinely wanted to help each other. P1’s response highlights again the significance of the relationships formed within the group and the positive impact these relationships had:

\[
It was a relief. ‘Cause I thinking “Oh. This is just a relief” and I thinking “Why couldn’t I have people like this before?” (Second Interview with P1, 201-203)
\]
P1’s comments suggest there was a real need for a group such as this and that the Mindfulness Group was able to provide something which had previously been absent from P1’s life.

Although the group was reportedly positive in the main, perhaps as a result of the strong group bond and group identity which was formed, P1 pointed to some difficulties in the groups, specifically around maintaining a sense of self within the group context. P1 felt that another member of the group was dominating the conversation and discussing things which she felt were unrelated to the Mindfulness Group. She wanted to say something but seemed unsure whether she was in a position to do this:

*And I think “well it’s not my place”. I can’t- I don’t like to say anything ‘cause I’m not the sort of person to be nasty or- or to upset anybody.* (First interview with P1, 742-745)

The difficulty P1 describes may reflect a failing on behalf of the facilitators to better manage the dynamics of the group; however it might also reveal something about the opportunities people with IDs have to develop a strong sense of self. Research suggests that people with IDs struggle to construct a self-identity due to difficulties in understanding themselves and others and in the interpretation of social situations and interpersonal relationships (Zolkowska & Kaliszewska, 2014). Societal expectations of people with IDs also play a role in individual self-concept and thus a fluidity in individual self-concept is likely depending on the context within which the person finds themselves and the attributes others use to define them.
2.3.2.3.4 Summary

Master theme 2 “You didn’t feel sort of the odd one out” highlights the importance of the relationships formed within the Mindfulness Group. These relationships facilitated a group bond and sense of group identity. They also facilitated an environment in which participants felt able to talk openly about their difficulties and know that their experiences would be both validated and respected. Participants tended to think of these relationships as friendships, perhaps due to the personal nature of some of the difficulties discussed and the subsequent degree of intimacy. Pockney (2006) identifies four elements necessary for a relationship to develop into a friendship: intimacy, autonomy, equality and reciprocity. Although participants did not choose who they would attend the Mindfulness Group with, there were opportunities (during the tea break for example) to develop individual friendships and participants had autonomy over who they chose to spend this time with. Further, there was no indication of hierarchy or inequality between participants with each engaging in peer-to-peer interactions with each other. There also appeared to be a degree of reciprocity within these relationships, particularly in relation to the giving and receiving of support. It is perhaps no surprise then that these relationships quickly developed into friendships.

2.3.2.4 Master theme 3: “I think you two have probably helped”

2.3.2.4.1 Overview of the theme

When asked what he liked about the Mindfulness Group P8 replied “Everything. Including you” (Group Discussion 2, 409-412) which raises the question: how much of his experience of the group was attributable to the facilitators’ own unique style or rapport with group members? Presumably, his experience of the group would have been different had the group been lead by different facilitators. This is not to presume that it would have been better or worse, more beneficial or less beneficial, but different. Master theme 3 reports on the
particular qualities of the facilitators which were identified by participants as being particularly helpful and offers insight into the relationships that were formed between facilitators and participants. There are also some suggestions of things facilitators could have done differently which might be useful to consider when running future groups.

2.3.2.4.2 Subtheme 1: Group facilitator qualities

P1 experienced the facilitators as a comforting, kind and loving presence in the group:

\[ GF2 \text{ has] got a very smiley face and [R/GF1 is] always smiling and happy. (...) You always say do you want a drink or- or, are you alright? And- and find it very comforting and kind. And- and- and loving and what you say is really confidential \]

\( (...) \) (Group Discussion 1, 700-704)

Her suggestion that the facilitators needed to be patient with her casts light on her perception of herself and her own difficulties. Perhaps she is referring to difficulties associated with having an ID:

\[ P1: \text{[The facilitators] are very kind and very patient. They have to be really patient with us.} \] (Group Discussion 2, 799)

However, P1 may also be referring to the difficulties experienced by the facilitators gathering everyone’s attention and focusing on the topic at hand. It was often difficult for facilitators to respond to the needs of participants whilst following the session plans and managing the time. P1 was clearly aware of these difficulties:

\( (...) \text{it’s not easy for you} (...) \text{‘Cause it’s very difficult to, sort of, erm, ‘cause you’ve got kind and gentle voices and- and- and- and some people can’t take it when you say} \)
something like “no”. They- they- it sounds like you don’t mean it but you do mean “no”. (First Interview with P1, 765-767)

P1’s comments suggest the facilitators’ calm voices meant they weren’t always listened to or that their requests were not always taken seriously. It seemed participants wanted the facilitators to have some authority, when necessary, in order to manage difficult situations:

P1: I don’t like it when it gets a bit, heated, as I call it. A bit too- and I’s thinking, if [the facilitators] calm the situation down a little bit. (Group Discussion 1, 208-210)

P1 made suggestions as to how the facilitators might have better managed the group dynamics:

If you can just say (...) “Can you give somebody else a chance?” Or “Excuse me, I’d like to say something to the group.” (First Interview with P1, 720-722)

The implication being that facilitators needed to be more assertive and ensure equity of opportunity for contribution across the group members:

Advocate: You’re not assertive enough. [laughs]

P1: I’m like that. (...) I couldn’t actually tell somebody off (...) (First Interview with P1, 771-776)

Overall, however, P1 appreciated the relaxed style of the facilitators and the fact that, in her eyes, they did not take their role too seriously:

And I was thinking, this is just what I need. Because I don’t like it if I go to a group and the person that’s taking it is too- takes things too seriously. (Second Interview with P1, 430)
2.3.2.4.3 Subtheme 2: Participant-facilitator relationships

P5 thought the facilitators had been “really good supporting me” (Interview with P5, 149) whilst P1 commented on the facilitators’ positive presence in the group:

[The facilitators] cheer me up even if I’m feeling a bit- ‘cause they’ve always got smiles and being happy and I thinking, how do they keep that motivation (...) (Group Discussion 1, 200-202)

There are many examples of positive exchanges between facilitators and participants throughout the interviews and focus groups. These positive exchanges were often characterised by humour and highlight the importance of building and maintaining rapport:

R/GF1: It wouldn’t have been the same without you and your cups of tea!
GF2: [laughs] Definitely.
P5: Yeah. (...) It’s always about that isn’t it? (Interview with P5, 159-163)

Participants felt comfortable enough to joke with and tease the facilitators. For example, when asked what the facilitators could do differently when running another Mindfulness Group, P8 responded with gentle sarcasm:

Erm. Let me think. [group laughter] (Group Discussion 2, 699)

Participants felt able to correct or challenge facilitators if they made a mistake:

P4: You said I missed [a session] but I’m- I’m sure I didn’t. (...) I thought I came to every single one, but you said I missed one. (Interview with P4, 172-180)

Participants also felt able to ask the facilitators questions and in doing so transform the interviews and focus groups into discussions in which there was a sense of reciprocity
between participants and facilitators. Participants’ questions provided opportunities for self-disclosure on the part of the facilitators, which in turn provided moments of connection between facilitators and participants:

\[ R/GF1: I (...) thought it would be a good idea to run the group because (...) similar to GF2] I find things stressful (...) \]

\[ P1: That’s exactly the same as what I- I get really stressed out and I can’t cope with it and it makes me feel (...) very vulnerable (...) (Group Discussion 1, 67-68) \]

However, there was some indication that the relationships within the Mindfulness Group and the therapeutic context within which they were formed were not always distinguished from friendships and an opportunity for social contact. Rather than seeing the Mindfulness Group as primarily being an opportunity to learn about and to practice mindfulness, participants often saw the group as a place to have fun and explore their new formed friendships:

\[ P1: We weren’t taking a blind bit of notice of what [R/GF1] was saying! [laughs] And I kept saying “shush, I think we ought to be concentrating on what [R/GF1] is saying”. (...) and then somebody started [laughing] and I thought “oh no” [laughs] (Second interview with P1, 377-383) \]

Although P1 tries to empathise with the facilitators she is caught up in the moment and joins in with the group laughter. By referring to herself and the other group members as ‘we’ she makes a distinction between the group members and the facilitators and further cements the group bond. At times the facilitators experienced this as a teacher-pupil dynamic in which they found themselves in the unintended position of imparting knowledge and exerting control. This is an experience echoed by P1:
It was sort of like a, um, teacher saying “No you- now children be quiet and concentrate on what I am writing on the blackboard” [laughs] We were just giggle giggle giggle. (Second interview with P1, 71-73)

By using this metaphor of the teacher and the child, P1 reveals something about the roles she assumes in everyday life. Indeed, P1’s advocate referred to the Mindfulness Group as a “class” (First Interview with P1, 370). It also suggests the intended role of the facilitators had in some way been miscommunicated. This is evident when participants challenge the boundaries of what might be considered appropriate behaviour for their relationship with the facilitators. For example, P1 talks about cuddling and loving the facilitators. She suggests that if they were to attempt to maintain their preferred therapeutic boundaries she would interpret this as rejection:

Well, give [the facilitators] a cuddle and a love ‘cause I don’t think they’ll say “oh get off me” and push me away. I- I think they’re thinking “Oh, that’s nice”. (Second interview with P1, 293)

Similarly, P7 expressed a desire to engage with the facilitators in play activities; however, he recognised that this might be inappropriate:

I was gonna jump on [R/GF1] (...) I got a ball and I was gonna chuck it at her but I thought no I can’t do that [laughs] (Group Discussion 2, 726)

Others such as P5 appeared to have a greater understanding of the roles of the facilitators within the wider service and how their professional boundaries might shape the type of contact they are able to provide:
You’ve always been there for me when I’m down or need to talk (...). ‘Cause you’re from the psychology department obviously. So you know, if I have problems I- I can er (1) come talk to you or I can, er, phone you up (...). (Interview with P5, 57-62)

Despite attempts to foster a sense of equality and reciprocity within the group, the facilitators’ professional roles within the service and need to maintain professional boundaries meant that relationships between facilitators and participants would never be ones of true equality as may be experienced within a friendship. Inevitably, the facilitators would always know more about the participants than they would know about the facilitators:

P1: I like [the facilitators]. I think (1) I get on quite well. I don’t know what they think of me but (...) everybody’s got their points of view. (Second Interview with P1, 39)

Participants therefore formed their understanding of the facilitators based on their experience of them within the group context. Perhaps in an attempt to compensate for this missing information P1 attributed characteristics to the facilitators which did not always sit well with their own appraisal of themselves and their position within the Mindfulness Group:

Sometimes I think [R/GF1 is] thinking “why isn’t anybody taking any notice of me?” [laughs] (...) [GF2] just sits there quite calmly as if to say “not my problem!” [laughs] (Second Interview with P1, 255-257)

Similarly, P1 attributed thoughts and opinions to the facilitators which again were not always representative of their genuine thoughts and opinions:

How do you think of- of me or any of us? What do you think? (...) I mean it’s just pure guesswork but I think- I think you’re thinking P1 talks to much. Don’t give anybody
else a chance [laughs] ‘Cause I know it’s (...) happened before (...) (Group Discussion 1, 735)

In the absence of further knowledge about the facilitators P1 appeared to project her own insecurities onto the facilitators and used their actions to confirm her beliefs:

R/GF1: The idea is that if you’re holding the [stress ball] it’s your turn to talk. Is that OK? (...)

P1: In other words, be quiet P1 [laughs] (Group Discussion 1, 423-424)

It may be that in trying to manage the dynamics of the group and ensure everyone had an opportunity to speak and feel heard, P1 was unintentionally offended. However, P1 was able to frame the facilitators’ comments within the context of her existing knowledge and experience of them:

(...) they’re nice people. They want to know. They won’t know what to do or- or how to handle me or- or how to put things without upsetting me. (First Interview with P1, 336)

2.3.2.4.4 Summary

From the above accounts it appears that the individual characteristics of the facilitators had some impact on the participants’ experience of the Mindfulness Groups. Participants found the facilitators to be comforting, kind, patient and supportive. Overall participants appeared able to engage in adult-to-adult interaction styles with the facilitators, however on occasion facilitators found themselves operating from the parent or teacher state which did not sit comfortably with their preferred therapeutic styles. Facilitators had a difficult role to fulfil in which there appeared to be many competing demands. They were required to ‘teach’
mindfulness concepts, guide mindfulness practice, engage in therapeutic relationships and carry out the many tasks that conducting research requires. They were conscious of the potential for a blurring of boundaries given the many roles they took on. It is possible that participants viewed their relationships with each other and with the facilitators as more akin to friendships rather than professional relationships, which raises ethical concerns in terms of managing the ending of the Mindfulness Group and subsequent ending of these relationships. It is also possible that the social aspects of the group and the friendships formed as a result of feeling safe and accepted may have resulted in distraction and a lack of attending to the therapeutic purpose of the sessions. The social aspects may then have been counterproductive to the primary goal of the sessions despite appearing to facilitate engagement and motivation to attend.

2.3.2.5 Master theme 4: “It gets rid of stress and it relaxes you”

2.3.2.5.1 Overview of the theme

Master theme 4 focuses on participants’ understanding of mindfulness, how they experienced the mindfulness exercises and whether they demonstrated or engaged with any of the core mindfulness concepts as defined by Baer et al. (2006). References to and demonstrations of these core concepts were interspersed throughout the interviews and focus groups and are discussed here.

2.3.2.5.2 Subtheme 1: Understanding of mindfulness

Participants appeared to have little understanding or awareness of mindfulness before attending the group. When asked if he had an idea of what mindfulness was before he came to the first session P4 replied “not a thing” (Group Discussion 1, 155) whilst P2 said he “didn’t have a clue” (Group Discussion 1, 175). Both P3 (Group Discussion 1, 127) and P4
(Focus Group 1, 6) said they expected it to be about relaxation whilst P1 thought it was “supposed to do (...) with the mind and with the body” (Group Discussion 1, 117). She also drew comparison between the relaxing aspects of mindfulness and the relaxing aspects of tai chi:

It’s a bit like, erm (2) tai chi and things like that (...) you can relax and the same when- when you do exercise you can- you can relax but this is more, er, what’s the word, um, (1) very relaxing. (Group Discussion 1, 117).

P6 was the only participant to share that he had some prior awareness of mindfulness:

R/GF1: You already had an idea of what mindfulness was. (...) Your dad practices Buddhism, so he does some mindfulness.

P6: (...) with doing Buddhism, it helps (1) to know (1) it’s like ying and- ying and yang really. You have your dark bit and you have your goo- very very good bit, really. (Interview with P6, 209-215)

Participants’ answers to the question ‘how would you describe the Mindfulness Group to other people?’ provide insight into their understanding of mindfulness. P3, for example, said the group was about “fulfilment in life” (Interview with P3, 60) perhaps referring to aspects of the group which promoted quality of life, such as discussions around activities that participants enjoyed and that made them feel good. Participants were encouraged to do more of the things they enjoy and were supported to find means of coping with the things that caused them stress or anxiety. P5 referred to this emphasis on learning different ways of coping in his description of the Mindfulness Group:

Basically it’s just (...) discussing, like, different emotions and feelings and stuff like (...) how to cope with everyday life. (Interview with P5, 94)
Many of the participants spoke about mindfulness in terms of relaxation. P1 referred to the Mindfulness Group as “the relaxation group” (First interview with P1, 840) and commented that she found the mindfulness exercises “very relaxing” (Group Discussion 1, 117). P2 also said they were “relaxing” (Interview with P2, 50). P1 appreciated having some “me time” where she could “just chill out with a cup of tea and just (…) relax” (Group Discussion 1, 578-582). Similarly, P4 thought the group would be about “relaxing” (Group Discussion 1, 6) and when asked what he thought was the most helpful part of the group he replied “just the relaxation” (Group Discussion 1, 598). When asked how they would explain the Mindfulness Group to other people, P4 replied “it gets rid of stress and it relaxes you” (Group Discussion 1, 671) while P7 said “you feel more relaxed” (Group Discussion 2, 849). It is possible that relaxation was a term and a concept participants were more familiar with and had experience of prior to attending the Mindfulness Group (P2, P4, P5 and P7 had all attended a relaxation group previously). It is also possible that participants’ understanding of mindfulness as a relaxation technique may have been reinforced by those supporting them if they too had little prior knowledge of mindfulness.

Following their involvement with the Mindfulness Group some participants appeared to struggle to explain what the group was about. For example, P6 said he would like group members to keep in contact and to set up an online mindfulness group using social media “so it means you can chat if you have a problem” (Interview with P6, 140). He wanted the group to stay in contact with each other as:

(...) I think [mindfulness] gives a sense of mind. And other people’s- other’s minds as well. (Interview with P6, 156-158)
It may have been that participants struggled to explain what mindfulness was as they were interviewed approximately five weeks following the final session of the Mindfulness Group and may have forgotten during this time:

\[ P2: \textit{Mindisfull (sic) was, er} \ (2) \textit{Oh.} \ (4) \textit{I’ve forgotten now.} \ (\textit{Interview with P2, 189}) \]

P2’s mispronunciation of ‘mindfulness’ conjures up the image of a mind which is literally full, perhaps with thoughts, anxieties, memories or regrets. One possible interpretation of this is that P2 may have viewed mindfulness as the antithesis of this full mind; a way of emptying this full mind.

2.3.2.5.3 Subtheme 2: Experience of mindfulness and the mindfulness exercises

Participants were introduced to a variety of mindfulness exercises. On the whole participants seemed to find these exercises enjoyable. For example, P7 said the walking meditation was “funny” (Focus Group 2, 437), P9 said the raisin exercise was “funny” (Focus Group 2, 498), P4 compared an exercise in which participants stretched individual parts of their body to the “hokey cokey” (Interview with P4, 95) and P6 found the mindful breathing exercises fun:

\[ I \text{ think the concentration bits always the funnest (sic) bit because it always- you have to know to just “shush” and concentrate.} \ (\textit{Interview with P6, 251-253}) \]

Others were able to engage with the exercises at a deeper level. For example, both P1 and P8 commented on their use of visualisation during the mindful breathing exercises:

\[ P1: \textit{When- when I listened to the CD it just remind me of (...) the seaside and I could see it.} \]

\[ P8: \textit{Of the waves don’t it.} \ (\textit{Group Discussion 2, 608-611}) \]
Similarly, P3 also commented on her use of visualisation. She was also able to describe the physical act of creating tension and release in her muscles and subsequent experience of relaxation:

*You do different exercises. Like (4) you tense up and then you relax and everything. And then you- you pretend (4) er, you’re somewhere else (…) you could pretend you’re (5) I dunno, in Majorca or somewhere? (Group Discussion 1, 681-689)*

P1 explained how she used the mindful breathing exercises as a way of ‘letting go’ of certain emotions:

*(…) you can let your (2) feelings by breathing air in and then- then let your feelings-bad feelings- let- let them go. (First interview with P1, 80)*

P6 used the exercises as a way of ‘training’ himself to be quiet. He demonstrates insight and self-awareness and the ability to self-regulate when given the opportunity to observe himself and his actions and the time to think before engaging in his usual pattern of behaviour:

*(…) I loved that because (…) it was like training yourself to be quiet. (…) And I just- I just chatter all the time. You know, just “blah blah blah blah blah” (Interview with P6, 260-265)*

Although participants engaged in little or no formal mindfulness practice at home, many provided numerous examples of informal practice, i.e. examples of mindfulness in everyday life. P7, for example, was able to incorporate mindful observation and awareness into his existing hobbies and interests:
(...) when you go night fishing, I tell you what, everything is nice and peace and quiet about half five in the morning, everything’s just relaxing. Sun’s just coming up nicely.

(Group Discussion 2, 771-773)

Similarly, P1 described going for a walk and paying attention to things she would not ordinarily notice:

The best thing is (...) if you can distract yourself by looking at something and focus on something out the window. Even if it’s something that’s (1) not important. Or if you (...) go in a park and just sit in the lovely sunshine. And just (...) go for a walk and just- just sort of switch off that way and look around at different things. I find that’s really helpful. (...) And hear- hear things that you haven’t even took much notice of.

(Group Discussion 1, 72-84)

Although mindfulness is not about distraction, as this implies an aim and does not allow for awareness, P1’s description of making a conscious effort to enjoy and to notice her surroundings suggests that a higher level of mindfulness is not yet present, but that she is going through the behaviours associated with increased mindfulness.

2.3.2.5.4 Subtheme 3: Demonstrating the five facets of mindfulness

Participants appeared to have some awareness of their difficulties prior to attending the group. Some, such as P1 were able to talk in detail about their difficulties and appeared to have incorporated these into their own sense of self or self-identity. P1 described herself as “a happy, cheerful person” (First Interview with P1, 617) who is “sensitive (...) towards other people’s feelings” (First Interview with P1, 692) and has problems “trying to look after myself” (First Interview with P1, 473). She was able to accept “well this is- this is me” (First Interview with P1, 692).
Interview with P1, 401). Similarly, P3 described herself as “a good person” (Group Discussion 1, 610) who can sometimes “blow things out of proportion” (Group Discussion 1, 491). Others needed more support to develop their self-awareness and insight into their own difficulties. During the Mindfulness Group participants were encouraged to develop their emotional awareness. Each session participants rated how they felt on a scale of 1-5 from ‘very relaxed’ to ‘very tense and stressed’. Participants were asked to observe how they felt and reflect on why they might feel this way. P5 provides insight into his understanding of the purpose of this exercise:

The checking out piece of paper was quite (...) well thought up. ’Cause (...) that’s a good reason to also check how you’re feeling, how like your emotions are playing with you and how to see if you’re OK, if you’re not OK, etcetera, etcetera. (Interview with P5, 106-113).

By checking how he is feeling P5 can develop a greater awareness of his own emotions. Once he is aware of how he is feeling and why, he may be more likely to make informed decisions with regards to the management of these emotions and any difficult situation he may find himself in. He might notice if his emotions are ‘playing’ with him and might be more likely to think rationally about the situation and to respond, rather than react. Below, P6 refers to a recent bereavement. He has an awareness of his emotions and an acceptance of what has happened:

But I didn’t wanna feel (4) sad about it. (2) ’Cause it felt like (...) just one of those difficult- difficult things. (Interview with P6, 181-183).
Similarly, P1 demonstrated an awareness of her difficulties and the impact of these on her overall wellbeing. She stated “I think I’ve got an eating disorder” (First Interview with P1, 377) and went on to explain:

[People put food] in front of you and say “you’ve got to”. (...) It’s more than just mind over matter. It just takes over and that’s what- that’s what’s happened. That’s why I’m not eating properly and I must admit that. (...) perhaps that’s what my problems are. (First Interview with P1, 393)

However, she also had a tendency to judge herself and to think negatively about herself:

I’m always putting myself down (...) People that know me, they say “you’re not what you say you are” and I thinking “well I’m not going to argue with you. I disagree. I think I am” (First Interview with P1, 869-871)

Although she may have found it difficult to accept the opinions of others if these contradicted her own beliefs, she was aware of this pattern of thinking and the negative impact it had on her mental health:

And it’s not nice (...) criticising myself (...) but it’s something (1) that (1) I erm, I think to myself no ‘cause it’s not true. (Group Discussion 1, 520-530)

(...) it doesn’t help my depression and it doesn’t help me get strong and better not really (Group Discussion 1, 632)

Learning to be more compassionate towards herself perhaps enabled P1 to be more compassionate towards others:
(...) it’s a bit contradicting myself because I think, shouldn’t put other people down

but I’m- put myself down. (Group Discussion 1, 629)

Similarly, P3 was also aware of the judgements she made of herself and expressed a desire to change this pattern of thinking. Her comments suggest she had developed a degree of compassion and acceptance towards herself:

I’ve just got to learn not to say nasty things about myself. And learn, to say nice things. (Group Discussion 1, 511-514)

Although developing an awareness forms the basis for the mindfulness concept of acceptance, mindfulness is also about being in the present moment; focusing on the here and now rather than ruminating on the past. Despite an awareness of her tendency to digress, P1 struggled to remain in the present moment and to identify why she might find this difficult:

I know I, um, go on to something totally different and I don’t know why I do that. (Second interview with P1, 332)

However, it is possible there may have been an element of avoidance to P1’s actions and that this may have been a coping strategy she had relied on for some time:

It’s best in the group for us not to dwell on what’s wrong with us and things ‘cause I thinking, I could go on forever (Second interview with P1, 203)

2.3.2.5.5 Subtheme 4: Difficulties with mindfulness and the mindfulness exercises

At times participants did not appear to understand the purpose of the mindfulness exercises. For example, P1 said she did not understand what was expected of her during the raisin exercise:
(...) That was a bit difficult and then when you say “oh you can chew it now” and (…)
I didn’t quite un- understand and I didn’t chew it (…) (Group Discussion 2, 479)

In this case the difficulty may have resulted from the way in which the exercise was
presented. Similarly, P1 struggled during the mindful movement exercise in which the
primary researcher provided verbal instructions and second facilitator modelled the exercise:

My legs was shaking trying to keep up with [GF2] and I- and I thinking where-
where’s [GF2] gone? [laughs] ‘Cause you was quite ahead of me and I’s thinking,
where? What? [laughs] What’s going on? I’m so- I’m just in my own little world just
sort of standing still [laughs] (Group Discussion 2, 459-465)

Some participants demonstrated a surface level understanding of the purpose of the
mindfulness exercises. For example, P4 referred to the raisin exercise as “the tasting”
exercise (Interview with P4, 12) and said he remembered this exercise because “it was tasty”
(Interview with P4, 27). He did not make reference to mindfulness concepts however he did
remember that the exercise involved bringing the focus of attention to the taste of the raisin.
Similarly, P2 remembered he “played with raisin” (Interview with P2, 4) and that “It was
something to do with taste wasn’t it?” (Interview with P2, 29). When asked what was the
most useful part of the group P2 replied “listening to the noises on the radio” (Group
Discussion 1, 649), whilst P3 commented “I liked the exercises and I liked, er, (4) the birds”
(Group Discussion 1, 18). During this exercise, a selection of sounds were played including
the noise of a crowd, birds singing and the ringing of an alarm clock. The purpose of the
exercise was to demonstrate that different noises can elicit different physiological and
psychological reactions. When asked what they were trying to find out by listening to the
sounds P3 replied “what was noisy (1) and what wasn’t” (Interview with P3, 11).
At times participants found it difficult to focus their attention on the mindfulness exercise. During one exercise in which participants focused their attention on different parts of their body, P1 seemed preoccupied with the physical sensations in her body:

(...) I thought, ooh my legs are going (...) they’re shaking and I’m thinking shush be quiet P1 and concentrate on what [the facilitators] are saying, shut up [laughs]

(Group Discussion 1, 226-232)

Here P1 is preoccupied with thoughts about what she should be doing and is unable to fully engage with the mindfulness exercise. Contrary to the non-judgemental nature of mindfulness and emphasis on acceptance, P1 appears to judge herself and engage in an inner dialogue or conflict. P1 also struggled with a befriending exercise in which participants were encouraged to look in a mirror and say positive affirmations to themselves, such as ‘may I be happy’, ‘may I be healthy’ and ‘may I be kind to myself’:

I don’t know what came over me (...) this feeling was saying no ca- can’t look at myself put [the mirror] down quick I can’t do it. (Group Discussion 1, 275)

This exercise was based on the befriending exercise described by Williams and Penman (2011) and inspired by P3 who told the group she looks in a mirror and says kind things to herself when feeling low. However, P1 clearly found this exercise difficult. Facilitators had asked her to challenge the long held beliefs she had about her appearance; beliefs which she was likely heavily emotionally invested in and may have carried since childhood. Mindfulness meditation promotes the idea that thoughts are transient; they come and go and are not “real” (Williams & Penman, 2011; p. 11). P1 struggled to accept that her thoughts might not be an accurate reflection of reality and that other people might see her differently to
how she sees herself. However, she demonstrated some awareness of her key role in creating this truth for herself:

*R/GF1*: (...) we were talking about thoughts and (...) that just because we have a thought doesn’t mean that it’s true?

*P1*: But I- I- I’ve convinced myself that it was. It’s hard to (1) reverse it and I thinking no I’m not gonna (1) listen to what [the facilitators] were saying ‘cause I know it’s not true. (Group Discussion 1, 290-293)

Participants also had difficulty practicing mindfulness at home. When asked whether she had practiced at home P1 replied “No I tend to forget.” (Group Discussion 2, 574) which was confirmed by her advocate: “We just haven’t had time” (First interview with P1, 4). When asked whether he had looked at the ‘Mindfulness To Go’ pack or listened to the CD P2 said “I think it’s in my room somewhere” (Interview with P2, 233) whilst P4 said the resources had been “put aside” (Interview with P4, 231). P5 said he had not “had chance to listen to [the CD] yet” (Interview with P5, 119) and P9 explained that “having stuff on my mind doesn’t let me do it” (Group Discussion 2, 568). Facilitators were careful not to describe home practice as ‘homework’ due to possible associated negative connotations. Instead, they emphasised the importance of home practice for personal development and were keen for participants to understand that they would be engaging in home practice for their own benefit and that although recommended, it was not prescriptive. This was in order for the facilitators to distance themselves from the role of teacher imparting knowledge and support participants’ self-determination. However, P1’s comments “I know you keep telling me [to practice] but I- I never think about [it]” (Second interview with P1, 110-112) and “No, naughty, no [laughs] I’ve got to [practice] really” (Group Discussion 2, 563-565) might
suggest she thought of the home practice as something she should be doing rather than something she could see the potential benefits of doing.

Facilitators experienced ongoing difficulties keeping participants focused on the discussion or exercise taking place at that moment in time. Whilst analysing the transcripts the primary researcher referred to these incidences as ‘story telling’. ‘Story telling’ or divergence from the topic of discussion might be understood as a feature of the individual’s IDs or associated diagnosis. One might also consider how often participants had the opportunity to talk and feel listened to or to engage in conversation with peers outside of the Mindfulness Group. Facilitators were keen to support the perception of the group as being a safe place for discussion, however they also needed to manage the timing and pacing of each session and ensure that quieter individuals did not feel excluded from discussion. They were also keen to acknowledge participants’ contributions to discussion and not to dismiss genuine concerns which may have been intruding on their ability to attend to the session. P3, for example, was concerned about a recent news story: “This plane has just went off the face of the earth” (Group Discussion 1, 346). Facilitators attempted to direct participants back to the original topic of conversation by drawing on mindfulness techniques and reminding participants of the mindfulness concept of focusing attention on what is happening in the here and now. Although this provided an opportunity for mindfulness practice within a real world context, it also highlighted the difficulties participants had in focusing their attention on and existing in the moment.

2.3.2.5.6 Summary

Participants tended to speak about mindfulness in terms of relaxation. Some appeared to struggle to articulate their understanding of mindfulness, whilst others said mindfulness was
about fulfilment in life, feeling less stressed, discussing different emotions and learning how to cope with everyday life. Overall, participants found the mindfulness exercises enjoyable and some were able to discuss their use of visualisation.

Participants engaged in little or no mindfulness practice at home and were more likely to engage in informal rather than formal practice. This suggests participants may have had difficulty generalising mindfulness practices into everyday life and may have benefitted from support and prompting from family or caregivers.

Participants’ difficulties keeping on topic, perhaps due to a lack of social opportunities outside of the Mindfulness Group, has implications for therapy. Without adequate opportunity for social contact in everyday life people with IDs when in a supportive therapeutic context may utilise the space to get this social need met rather than fully engage with the content and primary purpose of the group.
2.3.3 SECTION C: Does involvement in the Mindfulness Group lead to beneficial outcomes?

2.3.3.1 Overview

The original research question ‘Does involvement in the Mindfulness Group lead to beneficial outcomes?’ has been addressed through consideration of the following questions:

1. What did participants say about any benefits/positive changes experienced?
2. Did participants experience immediate benefits following their involvement with the Mindfulness Group?
3. Are benefits evident when pre and post-intervention scores are compared?
4. Can these benefits be sustained over time?

These questions are discussed below drawing on a range of data sources.

2.3.3.2 What the Participants Thought, Master Theme 5: “Without this group I wouldn’t really exist”

2.3.3.2.1 Overview of the theme

Master Theme 5 “Without this group I wouldn’t really exist” focuses on the positive outcomes experienced by participants following their involvement with the Mindfulness Group. These outcomes relate to psychological wellbeing and quality of life. The on-going impact of the Mindfulness Group is also discussed.

2.3.3.2.2 Subtheme 1: Impact on mental health/psychological wellbeing

P1 (First interview with P1, 909-911), P2 (Interview with P2, 211-212), P6 (Interview with P6, 192) and P9 (Group Discussion 2, 104) said they found the Mindfulness Group helpful.
P3 said the group had “calmed me down’ (Focus Group 1, 480) whilst P4 said the group had helped in in terms of relaxation (Interview with P4, 225) and reducing feelings of “stress and tension” (Group Discussion 1, 470). Interestingly, P7 said the Mindfulness Group had helped him to improve his golf. A friend had told him that he was not getting as stressed as he used to and that this was having a positive impact on his performance:

[He] knew it straight away. He was like, yeah (...) you’re not getting stressed, not going over the top with it, your golf’s getting better and better (...) (Group Discussion 2, 854)

P1 felt the Mindfulness Group had helped her to manage her negative thoughts:

(... because of my depression and what’s (1) wrong with me I find, er, positive and negative thoughts about myself that wasn’t very nice, they seem to have gone away and then, and I don’t want them to come back so I can move on. (Group Discussion 1, 14)

She states she has been feeling more relaxed and has successfully substituted the negative thoughts with more positive ones. She gives credit to the Mindfulness Group for her improved mental health:

[The group has been] very helpful to me to help me to get better. I think without this group I think I just (1) wouldn’t really exist. I mean it sounds dreadful but (1) I might not even (1) be here, ’cause that’s how I (1) felt but now (...) I’m more relaxed and I’m moving on. I’ve got to move on. So I don’t think about nasty things anymore, I think about happy things. (Group Discussion 1, 563-569)
It is unclear exactly what P1 means when she says that without the Mindfulness Group she would not exist. Had she been having suicidal thoughts prior to attending the group, or did the group give her a sense of purpose, a clearer sense of who she is or a reason to exist? Either way it is clear that her involvement with the Mindfulness Group helped her to feel more motivated and better able regulate her own emotions, and to become more aware of her negative thoughts and how to challenge these:

(...) just move on and (...) just go for a little walk. Even if it’s not very far and you distract yourself ‘cause I find my mind goes racing on and then I’ve got to come down to a- a level which I find hard. ‘Cause I couldn’t (1) do that before and now I thinking “I can do that”. (First interview with P1, 854-856)

P1’s advocate agreed she had made positive changes stating “You’re a lot more positive aren’t you? (First Interview with P1, 305). She also felt P1 was “a lot better”, “not as stressed” and “not so uptight” (First Interview with P1, 277-279).

2.3.3.2.3 Subtheme 2: Impact on quality of life

P1: I feel a lot happier doing- doing something (...) everybody’s always going out to work (...) or even when they go home they got their family (...) or peoples got- always got something to do. (First Interview with P1, 951)

The above quote suggests that without a job or a family living with her, P1 felt she did not have enough to do. Going to work and looking after a family can provide a sense of purpose and become a part of a person’s identity; how they define themselves. It is possible that, for some, involvement with the Mindfulness Group provided a meaningful activity in the absence of employment, family support or regular social contact. In this sense the Mindfulness Group may have contributed to an improvement in quality of life, particularly if
participants were able to use the Mindfulness Group as an opportunity to evaluate their lives and make changes that might have a lasting impact. P1, for example, said she had “more (...) get up and go” (Group Discussion 2, 878-880) and had been sorting out her flat and throwing old things out, buying herself flowers (First Interview with P1, 213-214), baking cakes for the church (First Interview with P1, 425), going for walks (First Interview with P1, 641), doing her washing (First Interview with P1, 936), knitting and crocheting (First Interview with P1, 925) – all of which she had previously enjoyed:

\[
I \text{ sort of lost interest in that. (...) it's really really helpful 'cause you're gaining more, confidence again to go for walks again, instead of just, sort of, shutting meself (sic) away, which is- which is really good. So I'm (...) doing that a lot more. (Group Discussion 1, 125)}
\]

P7 made changes that helped him to manage conflict within the community. He described an incident with someone in the pub who had drank too much alcohol. Rather than get into an argument or physical altercation as he may have done previously, P7 said “See ya later” and “Walked off” (Group Discussion 2, 339-241). This signalled a significant shift in P7’s ability to manage conflict and to regulate his behaviour and his emotions. Similarly, P1 felt the group had helped her to manage situations in the street in which she might feel judged by others or might feel judgemental towards others:

\[
This \text{ group’s helped me not to be- I think, oh well, don’t say anything. They want a reaction. (Group Discussion 2, 313-315)}
\]

As such, both P1 and P7 learnt to manage situations in the community in which they might be vulnerable.
2.3.3.2.4 Subtheme 3: Looking to the future – ongoing impact

Participants’ intention to continue practicing mindfulness provides some indication of the group’s ongoing impact. When asked what he was going to continue after the group P4 replied “the exercises” (Group Discussion 1, 590). P5 described when and why he practiced mindfulness at home:

*Usually in the afternoonish (sic) (...) when I’ve got nothing to (...). I just pop [the CD] on and have a chill for twenty, twenty-five minutes with it.* (Interview with P5, 131-133)

Whilst P8 was able to describe in detail the breathing exercise which had become a part of his daily routine:

*I have to like take three deep breaths. Erm. Stretch out feet and toes. Erm. Stretch out legs. Erm. Stretch out fingers. And I have to pull my shoulders up to your ears and I have to also scrunch up your face, you know. But I have to do that for like 10 seconds. I think it- you know. And it does help.* (Group Discussion 2, 396-404)

In terms of future Mindfulness Groups, P2 (Interview with P2, 214), P3 (Interview with P3, 74), P4 (Interview with P4, 217) and P6 (Interview with P6, 194) said the group would be helpful for others. P2 asked “Is there any more groups going on, do you know?” (Group Discussion 1, 192) and said he would like to “do another group like this again” (Group Discussion 1, 558). P1 added that “it would be a shame (...) if there’s, suddenly nothing.” (Group Discussion 1, 194-196) and said she would like the group to continue indefinitely:

*I’d like it to be a- a permanent thing because (...) I can’t speak for everybody but, myself, I thinking, I needed that somewhere.* (Second Interview with P1, 428)
Others wanted to keep in touch after the group had finished. P6 suggested setting up a Mindfulness Group using social media (Interview with P6, 133) or starting a mindfulness band (Interview with P6, 340) (both P8 and P9 enjoyed playing the harmonica during sessions). Similarly, both P7 and P9 wanted to maintain the relationships they had made:

P9: *I don’t want us to die away.*

P7: *Nah, nah, nah. I don’t want to either.* (Group Discussion 2, 871-872)

Wanting to keep in touch suggests participants valued the relationships they had made whilst their desire to attend more groups suggests they enjoyed and benefitted from the Mindfulness Group. However, their reluctance to accept the ending of the group might also point to a lack of motivation or ability to engage in self-led mindfulness practice and a perception that they needed ongoing support to do this. It may also suggest ongoing difficulties which had either not been addressed or had not yet subsided. For example, P6 states:

*The money situation’s always a stressful thing for me to think about because it is stressful* (Interview with P6, 219-221)

P6’s continued difficulties with money highlights one of the limitations of the Mindfulness Group. Practicing mindfulness did not and could not have a direct impact on P6’s finances. Whilst mindfulness may help him to acknowledge and manage some of his worries, this alone could not have any direct impact on the political, societal and financial systems within which he functions. P4’s wish to do more things he enjoys, such as working in the local kennels (Interview with P4, 260), P7’s difficulties at work (Group Discussion 2, 818) and P1’s tendency to spend too much money on food (First Interview with P1, 247) are not health related. These are social concerns indicative of current policy and how well the individual is supported in the community.
Although some difficulties may not have improved, there was evidence of some positive change:

   P3: I don’t get, wound up as easily as I used to but it’s like (2) I do (2) sometimes, you know? (Group Discussion 1, 129-131)

Here P3 recognises that she no longer gets as wound up as she used to, but this is work in progress. Similarly, P1 describes a journey towards improved mental health which is both physically and mentally demanding:

   I know that I shall get there and I’m going to get there but I feel it physically and mentally very, draining (Group Discussion 1, 454)

   I’m learning not to have all these (1) horrible negative thoughts. They really, really took over and I’m just beginning to realise, but it’s hard (...) (Group Discussion 1, 636)

Although this is a gradual journey and one which is not yet complete, P1 seems determined that this positive change will continue:

   (...) I still got (1) issues, but (1) they’re- they’re gradually just going. (Group Discussion 1, 236)

   I’ve got to think (1) that I can (1) and I will, be a lot more happier. (Group Discussion 1, 450)

P1 perhaps sums up the impact of Mindfulness Group when asked what one thing she was going to continue with:
I’ve, erm, more confidence in myself. (...) trying to (1) be (1) very strong, physically and mentally. And not letting things get to me. And not be so clumsy, tripping over things [laughs] and doing daft things. (...) And stop moaning [laughs] (Group Discussion 1, 538-552)

Whilst feeling more confident and emotionally resilient may be considered anticipated outcomes, being less clumsy and not tripping over things might be individual to P1. Clumsiness, perhaps breaking or spilling things out of carelessness, walking quickly or rushing through activities without paying attention, may be considered examples of mindlessness (Brown & Ryan, 2003).

2.3.3.2.5 Summary

Overall, participants reported experiencing some positive outcomes following their involvement with the Mindfulness Group such as feeling calmer, less stressed and more motivated to engage in daily activities. Some, such as P1 and P7, found they were better able to manage difficult situations, which meant they were less likely to find themselves in vulnerable or risky situations. P1 appeared to develop a greater awareness of her thought processes, which enabled her to make informed decisions as to whether she wanted to engage with these thoughts. Both P1 and P7 experienced some unanticipated gains – P1 found she was less clumsy (perhaps as a result of engaging more mindfully with her surroundings) and P7 felt less stressed, which had a positive impact on his performance at golf. Some difficulties remained, such as financial concerns for P6 and difficulties at work for P7. It is possible that participants developed a greater awareness of their difficulties as a result of their engagement with the Mindfulness Group. It is likely that the Mindfulness Group alone was
not sufficient to address some of these ongoing difficulties. To facilitate greater change, the facilitators may have worked closer with participants’ established support networks.

2.3.3.3 Did participants experience immediate benefits following their involvement with the Mindfulness Group?

Results on the ‘Distress Thermometer’ (as discussed in Results Section A) provide an indication of how successful each session was in terms of reducing self-reported stress and tension so that sessions requiring further development can be identified. However, scores on the ‘Distress Thermometer’ also provide an indication of whether participants experienced any immediate benefit following each session. A lower score at Time 2 (‘check out’) compared to Time 1 (‘check in’) would suggest participants felt less stressed and more relaxed immediately following the session. Mean ‘check in’ and ‘check out’ scores on the ‘Distress Thermometer’ are provided in Table 2.6. Scores reduced from ‘check in’ to ‘check out’ for all sessions apart from session 7 where there was no change. This suggests that on average participants rated themselves as feeling more relaxed and less stressed following all but one of the sessions.

<table>
<thead>
<tr>
<th>Session No.</th>
<th>n</th>
<th>Check In</th>
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<tr>
<td>2</td>
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<td>3</td>
<td>2.57</td>
<td>-0.43</td>
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<td>7</td>
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<td>2.44</td>
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</tr>
<tr>
<td>8</td>
<td>8</td>
<td>2.75</td>
<td>1.63</td>
<td>-1.12 *</td>
</tr>
</tbody>
</table>

*difference was significant at the .05 level
Due to this trend in the expected direction, i.e. scores appeared to reduce at ‘check out’, Freidman analyses were conducted in order to identify whether the reductions from ‘check in’ to ‘check out’ were statistically significant. No statistical differences between ‘check in’ and check out’ scores were found for session 2 ($\chi^2(1, n = 7) = 1, p > .05$), session 3 ($\chi^2(1, n = 7) = 1, p > .05$), session 4 ($\chi^2(1, n = 8) = 2.67, p > .05$), session 5 ($\chi^2(1, n = 6) = 1, p > .05$), session 6 ($\chi^2(1, n = 9) = 0, p > .05$) or session 7 ($\chi^2(1, n = 9) = 1, p > .05$). However, a statistically significant difference between ‘check in’ and ‘check out’ scores was found for session 8 ($\chi^2(1, n = 8) = 5, p < .05$) suggesting that participants experienced the most improvement in terms of reduced stress following session 8.

Due to the significant difference between ‘check in’ and ‘check out’ scores for session 8, Wilcoxon Signed Rank post-hoc analyses were also carried out on the data. Again no statistical differences between ‘check in’ and ‘check out’ scores were found for session 2, $z = -.74, p > .05$; session 3, $z = -1.3, p > .05$; session 4, $z = -1.08, p > .05$; session 5, $z = -1, p > .05$; session 6, $z = -.39, p > .05$; or session 7, $z = .0, p > .05$. However, a statistically significant difference was found for session 8, $z = -2.12, p < .05$.

2.3.3.4 Changes in wellbeing: Anxiety and depression

2.3.3.4.1 Changes in self-reported anxiety following the Mindfulness Group intervention

Participant scores on the GAS-ID at pre-intervention, post-intervention and follow-up are presented in Table 2.7. If the suggested cut-off score of 13 (Mindham & Espie, 2003) is applied to the data it would appear all participants met the clinical threshold for anxiety at pre-intervention and almost all met this threshold post-intervention, with just one participant scoring at a sub-clinical level at follow-up. It may be worth noting that for the majority of participants, a move into sub-clinical levels of anxiety would require a significant decrease in
self-reported anxiety scores from pre-intervention. Participant 4, for example, scored 44 on the GAS-ID at pre-intervention; significantly higher than the cut-off score of 13.

Table 2.7 Participant scores on the GAS-ID at pre intervention, post intervention and follow-up17

<table>
<thead>
<tr>
<th>Participant</th>
<th>Pre</th>
<th>Post</th>
<th>Follow-up</th>
<th>Difference (pre to post)</th>
<th>Difference (pre to follow-up)</th>
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<td>-1</td>
<td>-7</td>
</tr>
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<td>7</td>
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<td>20</td>
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<td>-3</td>
<td>-10</td>
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<td>35</td>
<td>32</td>
<td>-9</td>
<td>-12</td>
</tr>
<tr>
<td>P5</td>
<td>29</td>
<td>18</td>
<td>17</td>
<td>-11</td>
<td>-12</td>
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<td>25</td>
<td>22</td>
<td>-</td>
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<tr>
<td>P7</td>
<td>17</td>
<td>16</td>
<td>15</td>
<td>-1</td>
<td>-2</td>
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<tr>
<td>P8</td>
<td>-</td>
<td>26</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<td>P9</td>
<td>19</td>
<td>13</td>
<td>10</td>
<td>-6</td>
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</table>

A Freidman analysis was carried out on participants’ scores on the GAS-ID at pre intervention, post intervention and follow-up. Results indicate there was no statistically significant difference in scores across the three time points ($\chi^2 (2, n = 8) = 4.71, p > .05$). Inspection of the mean ranks, however, suggests there was a decrease in scores from pre-

17 A dash (-) indicates missing data. Both P6 and P8 cancelled appointments in which the pre-intervention measures would have been completed. Group facilitators offered to complete the measures with P8 during and/or immediately following session 1, however P8 requested to complete these at home with his family’s support. These were not returned. Due to personal difficulties relating to the health of a close family member, it was deemed inappropriate to meet with P8 to complete the post-intervention measures. P6 did not attend session 1 so was given the pre-intervention measures to complete at home with the support of his support workers. Again these were not returned.
intervention (2.56) to post-intervention (1.94) and a further decrease at follow-up (1.5). A Sign test indicated that overall participants scored lower at post-intervention compared to pre-intervention ($Z = 1.78, p = .075$), lower at follow-up compared to pre-intervention ($Z = 1.2, p = .231$) and lower at follow-up compared to post-intervention ($Z = .49, p = .623$).

Since the Friedman analysis approached significance ($p = .095$) and there was a trend in the predicted direction (i.e. participants generally reported a decrease in anxiety post-intervention and at follow-up), a Wilcoxon Signed Rank post-hoc analysis was carried out on the data. However, results revealed no significant reductions in self-reported anxiety when pre-intervention and post-intervention scores were compared, $z = -1.78, p > .05$, when pre-intervention and follow-up scores were compared, $z = -1.21, p > .05$, and when post-intervention and follow-up scores were compared, $z = -.42, p > .05$. However, the median score on the GAS-ID decreased from pre-intervention ($Md = 26$) to post-intervention ($Md = 20.5$) and increased slightly from post-intervention to follow-up ($Md = 21.5$).

2.3.3.4.2 Changes in self-reported depression following the Mindfulness Group intervention
Participant scores on the GDS-ID at pre-intervention, post-intervention and follow-up are presented in Table 2.8. Of the 8 participants measured for depression pre-intervention, 6 exceeded the cut-off score of 13 putting them in the clinical range for a potential diagnosis of depression (Cuthill, Espie & Cooper, 2003). Of the 10 participants measured for depression post-intervention just 3 exceeded the cut-off score of 13 and scored within the clinical range. At follow-up, self-reported depression states appeared to increase slightly (remaining lower than at pre-intervention for most) with 4 of the 8 participants measured exceeding the cut-off score of 13 and scoring within the clinical range.
A Friedman analysis was carried out on participants’ pre-intervention, post-intervention and follow-up scores on the GDS-ID. Results indicate there was no statistically significant difference in scores across the three time points ($\chi^2 (2, n = 8) = 5.23, p > .05$). Inspection of the mean ranks suggests there was a decrease in scores from pre-intervention (2.56) to post-intervention (1.44) followed by an increase at follow-up (2), however scores at follow-up remained lower than at pre-intervention. A Sign test indicated that overall participants scored lower at post-intervention compared to pre-intervention ($Z = 2.38, p = .017$), lower at follow-up compared to pre-intervention ($Z = 1.27, p = .205$) and lower at follow-up compared to post-intervention ($Z = 1.12, p = .261$). It would appear that overall participants experienced a decrease in depression post-intervention, but that this was not maintained at follow-up.

**Table 2.8: Participant scores on the GDS-ID at pre-intervention, post-intervention and follow-up**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Pre</th>
<th>Post</th>
<th>Follow-up</th>
<th>Difference (pre to post)</th>
<th>Difference (pre to follow-up)</th>
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</table>

Since the Friedman analysis approached significance ($p = .073$) and the pattern of a decrease in depression at post-intervention followed by a slight increase at follow-up may be expected following psychological intervention, a Wilcoxon Signed Rank post-hoc analysis was carried out on the data. Results revealed a statistically significant reduction in depression from pre-intervention to post, $z = -2.38, p < .05$, with a large effect size ($r = .6$). No statistically
significant reductions in depression were seen when pre-intervention scores were compared to follow-up scores, $z = -1.27, p > .05$, and when post-intervention scores were compared to follow-up, $z = -1.12, p > .05$. The median score on the GDS-ID decreased from pre-intervention ($Md = 18$) to post-intervention ($Md = 10.5$) and increased from post-intervention to follow-up ($Md = 13$).

### 2.3.3.4.3 Case Example

Participant 1 attended both Group 1 and Group 2. Her pre-intervention, post-intervention and follow-up scores for attendance in Group 1 are labelled in Tables 2.7 and 2.8 as ‘P1’. Her scores for attendance in Group 2 are labelled as ‘P1.2’. Anxiety and depression states for Participant 1 were therefore measured at 6 different time points across the course of the research. These scores are presented in Table 2.9.

**Table 2.9: GAS-ID and GDS-ID scores for Participant 1**

<table>
<thead>
<tr>
<th></th>
<th>Group 1</th>
<th>Group 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-intervention</td>
<td>Post-intervention</td>
</tr>
<tr>
<td>GAS-ID</td>
<td>37</td>
<td>40</td>
</tr>
<tr>
<td>GDS-ID</td>
<td>29</td>
<td>27</td>
</tr>
</tbody>
</table>

Participant 1’s scores on the GAS-ID increased following Group 1 when measured at both post-intervention and follow-up. However, there was a drop in self-reported anxiety prior to starting Group 2 followed by further decreases at post-intervention and follow-up. There are various potential explanations for this. Perhaps Participant 1 experienced an increase in anxiety following her involvement with the first Mindfulness Group as she had developed a greater awareness of her emotional states but had not yet reached a point where she was able to make active changes. Attending the second Mindfulness Group may have provided the opportunity to make these changes. It is also possible that Participant 1 benefitted from
attending an increased number of sessions; more sessions meant more time to practice the mindfulness exercises and increased repetition. This may also explain why Participant 1’s self-reported depression states as measured by the GDS-ID continued to decrease throughout the course of the research. This data may therefore support the argument for an increased number of sessions in future Mindfulness Groups for people with IDs.

2.3.3.5 Participant follow-up

The success of the intervention and its potential to lead to ongoing and sustainable benefits can be further determined by an examination of what happened to participants after the conclusion of the study. This information is provided in table 2.10.

From this information it can be inferred that the majority of participants did not require ongoing psychological support (N=6), however most required ongoing psychiatric support to monitor their medication (N=6) and three went on to attend additional groups ran by the CLDT. Although the primary aims of each of these groups differs, all provide opportunity for social contact and peer support. The walking group for example, promotes physical activity but also provides a valuable opportunity for social contact. The fact participants asked to be considered for future groups despite no-longer requiring individual therapeutic support might further support the themes discussed in Results Section B regarding the importance of the social aspects of the Mindfulness Group. For those participants for whom ongoing psychological support was required, this support took the form of consultation with other professionals and training for staff teams, rather than therapeutic work with the individual.
Table 2.10: What happened next? Participant follow-up

<table>
<thead>
<tr>
<th>Participant</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>Provided with information regarding current CLDT groups but chose not to attend these. No further input required. Discharged from Psychological Services. Continued to attend out-patient appointments with Psychiatry.</td>
</tr>
<tr>
<td>P2</td>
<td>Provided with information regarding current CLDT groups. Went on to attend a walking group ran by the CLDT. Discharged from Psychological Services. Continued to attend out-patient appointments with Psychiatry.</td>
</tr>
<tr>
<td>P3</td>
<td>GF2 provided training to P3’s support staff. P3 went on to attend a healthy eating group ran by the CLDT and a further group around recognising and coping with difficult emotions ran by Psychological Services.</td>
</tr>
<tr>
<td>P4</td>
<td>Went on to attend a walking group ran by the CLDT. Discharged from Psychological Services. Continued to attend out-patient appointments with Psychiatry.</td>
</tr>
<tr>
<td>P5</td>
<td>Continued to attend out-patient appointments with Psychiatry. Received ongoing support from Community Nursing and Psychological Services regarding training for support staff.</td>
</tr>
<tr>
<td>P6</td>
<td>No further input required. Discharged from Psychological Services and the CLDT.</td>
</tr>
<tr>
<td>P7</td>
<td>Continued to attend out-patient appointments with Psychiatry. Psychological Services continued to liaise with family and other professionals whilst P7 moved out of the family home. P7 expressed an interest in attending more groups, however he was unable to do this due to an increase in work commitments.</td>
</tr>
<tr>
<td>P8</td>
<td>No further input required. Discharged from Psychological Services. Continued to attend out-patient appointments with Psychiatry.</td>
</tr>
<tr>
<td>P9</td>
<td>No further input required. Discharged from Psychological Services and the CLDT.</td>
</tr>
</tbody>
</table>
2.4 Discussion

This research study addresses inequalities in psychological service provision for people with IDs and builds on existing literature concerning the potential benefits of mindfulness for individuals with IDs. Nine participants with IDs took part in two eight-week Mindfulness Groups. They were assessed for anxiety and depression pre-intervention, post-intervention and at follow-up. They were invited to participate in group discussions and interviews. Observations regarding participants’ understanding of and engagement with key mindfulness concepts were recorded. Mindfulness exercises are clearly documented in an effort to address concerns regarding fidelity raised by existing reviews of the literature (Hwang & Kearney, 2014). Similarly, ethics protocols have been described in an effort to convey the researcher’s care and respect for participants.

Scores on the GAD-ID and GDS-ID indicate that on average self-reported anxiety decreased following involvement in the Mindfulness Group and continued to decrease at follow-up. Similarly, self-reported depression decreased following involvement in the Mindfulness Group, however there was a slight increase at follow-up although still lower than at baseline. The decrease in self-reported depression from pre-intervention to post-intervention was statistically significant. Results therefore indicate that the Mindfulness Group had some positive effect on self-reported anxiety and depression states. Scores on the ‘Distress Thermometer’ suggest that the Mindfulness Group also had some immediate positive effect on mood in terms of reduced stress and increased relaxation. These findings are consistent with existing literature suggesting mindfulness can have positive effects on symptoms of depression (Segal, Williams & Teasdale, 2002; Williams, Teasdale, Segal & Kabat-Zinn, 2007) and anxiety (Khoury et al., 2013; p.769) within the general population and also within the ID population (Idusohan-Moizer et al., 2015).
Results indicate participants were able to engage with mindfulness techniques and practice mindfulness within a group context, thus challenging the notion that individuals with IDs do not have the cognitive capacity to understand and practice mindfulness (as cited by Hastings & Manikam, 2013). Participants experienced the group as a meaningful activity which they were motivated to attend. They reported feeling calmer, less stressed and more motivated to engage in meaningful activities away from the group. They appreciated the opportunity to socialise and relationships formed within the group were of great significance. They felt respected and able to talk openly within the group. Findings regarding participants’ appreciation of the social aspects of the Mindfulness Group, including the apparent significance of the relationships formed within the group and between participants and facilitators, are consistent with previous research regarding group therapeutic interventions for individuals with IDs (for example, MacMahon et al., 2015).

Participants were able to develop their own understanding of mindfulness which tended to be framed by concepts typically associated with relaxation, however it is unclear whether they were able to maintain their understanding of mindfulness over a prolonged period of time. This is consistent with previous research by Yildiran and Holt (2014) who reported that participants who attended a mindfulness group for people with IDs appeared to understand mindfulness in relation to relaxation, possibly due to prior experience of relaxation and mindfulness being a new skill.

Scores on the ‘FFMQ Facilitator Observation Form’ suggest participants’ understanding of and engagement with the five facets of mindfulness did not improve over the course of the Mindfulness Group as might be predicted. However, there were statistically significant differences in participants’ understanding of and engagement with each of the five facets.
Participants were rated lowest for their understanding of and engagement with the facet ‘Observing’ and highest for their understanding of and engagement with the facet ‘Describing’. This suggests that participants found it difficult to notice or attend to “internal and external experiences, such as sensations, cognitions, emotions, sights, sounds, and smells” but felt relatively comfortable “labelling internal experiences with words” (Baer et al., 2008; p.330).

However, it should be noted that assumptions regarding participants’ understanding of and engagement with core mindfulness concepts are not based on self-reports but on observations. It is possible that participants both understood the concept of observation and were able to engage with the process of observation, but that this was an internal process which could not be easily observed by facilitators. It is also possible that participants may have lacked the technical vocabulary to explain the concept to others and that this was interpreted by the facilitators as a lack of understanding or engagement. ‘Describing’ typically involved actively engaging in discussion following the mindfulness exercise and sharing with the group a description of these observations and as such may have been easier to observe and score. Participants also scored lower on the facet ‘Non-reactivity to Inner Experience’ suggesting they had difficulty allowing “thoughts and feelings to come and go, without getting caught up in or carried away by them” (Baer et al., 2008; p.330). This may be explained by a lack of inhibition (as may be experienced by individuals with IDs) or a degree of emotional reactivity perhaps associated with anxiety, depression or other emotional vulnerabilities.

Research considering the relationships between the five facets of mindfulness and symptoms of anxiety and depression suggest that acting with awareness, being observant and non-
judging of inner experience are particularly important for the alleviation of anxious and depressive symptoms (Raphiphatthanna, Jose & Kielpikowski, 2015). The results of this study indicate which of the Mindfulness Group sessions were particularly relevant to these three facets and which sessions might need further adaptation in order to promote an increased understanding of and engagement with these particular facets. Whilst there was no control group, previous research has already shown MBIs to be more effective than treatment as usual (for example, Singh et al., 2014) and no treatment (for example, Singh et al., 2013b) and scores on the ‘FFMQ Facilitator Observation Form’ provide information regarding the effectiveness of individual sessions, thereby going some way to identifying the effective components within the intervention.

Results from this study support the assumption that individuals with IDs can self-report and that these self-reports can be valid and reliable (Kroese, 1998). Evidently, some participants appeared more able than others to self-report on their emotional states. This is clear when considering the scores on the ‘Distress Thermometer’. For example, on 11 out of 12 occasions P3 rated herself as feeling ‘OK’ and on all occasions P9 rated himself as feeling ‘very relaxed’. Whilst these ratings may simply be reflective of how the individual actually felt in that moment, they may also reflect difficulties with self-reporting, deficits in emotional intelligence or in recognising and verbalising emotions. Historically it has been assumed that individuals with IDs do not have the emotional skills necessary to explore their difficulties (Hollins & Sinason, 2000). However, there is evidence to suggest that although individuals with IDs have difficulty recognising emotions, these skills can be learnt (McKenzie, Matheson, McKaskie, Hamilton & Murray, 2000).
Schutte and Malouff (2011) make links between the core aspects of mindfulness and emotional intelligence and suggest that mindfulness may support the ability to regulate emotions and to accurately perceive and understand own and others’ emotions, whilst a greater awareness may “facilitate the timely harnessing of emotions” (Schutte & Malouff, 2011; p.1117). They also suggest that emotional intelligence may act as a mediator between mindfulness and subjective wellbeing, with mindfulness facilitating the development of emotional intelligence and emotional intelligence facilitating greater wellbeing. During the Mindfulness Group participants were supported to develop their emotional intelligence and broaden their emotional vocabulary through the use of psychoeducational materials. Participants demonstrated the ability to identify what was causing them difficulty and articulate this to the group. Given the opportunity to talk about their difficulties and what had brought them to the Mindfulness Group, all were able to speak about their experiences and how they felt about them.

As might be expected with such a diverse group, there was some variability across participants in terms of how much they engaged with and benefitted from the group. Whilst some of this variability may be the result of differing cognitive abilities, some had attended groups previously and may therefore have felt more comfortable with the group context, some appeared to have greater levels of support than others, and some experienced changes in relationships and other environmental factors during the course of the group.

It is also possible that participants’ motivation may have had some influence on outcomes (Harper, Webb & Rayner, 2013). Just one participant referred himself to the CLDT. Others were referred by psychiatrists, social workers, a clinical psychologist and a community nurse. It might be assumed that those who referred themselves may have been more motivated to
engage with the intervention (Harper, Webb & Rayner, 2013) whilst those who were referred by others may have been less motivated. However, just one participant dropped out of the Mindfulness Group after attending one session, whilst two others did not attend any of the sessions. The continued attendance of the nine remaining participants indicates level of engagement. Given that the majority of participants relied on others to make the referral for them, it was necessary to promote the intervention and raise awareness of mindfulness and its potential benefits within the multi-disciplinary team.

It can be assumed that deficits in understanding and reasoning, emotional literacy, memory and executive functioning associated with IDs (Lindsay et al., 2013) may have had some impact on how participants experienced, engaged with and understood the mindfulness intervention and the basic mindfulness concepts. Impairments in executive functioning, for example, effect three areas of skill: the ability to monitor own behaviour using working memory, the ability to inhibit impulsive responding, and the ability to initiate actions (Lindsay et al., 2013). Deficits in the ability to monitor or regulate own behaviour may present as a shortened attention span; something which often manifest during the mindfulness groups as ‘storytelling’ or difficulty keeping on topic.

Similarly, some of the participants’ tendency to be quite impulsive meant they often struggled to remain on task and might present for the session having experienced a crisis during the previous week due to (on occasion) difficulties with self-control. Alongside the psychoeducational component to the Mindfulness Group, time was spent exploring such crises and supporting participants to develop behavioural self-control skills. Where appropriate, facilitators promoted the use of mindfulness techniques for improved self-control
such as focusing on the breath during times of stress or confrontation, or engaging in regular mindfulness practice so that participants might feel generally calmer and more in control.

Difficulties with initiation might mean the individual struggles to generate ideas or engage in discussion. This may be compounded by a fear of answering incorrectly or getting things wrong. Although facilitators worked hard to promote autonomy and the sense that the Mindfulness Group was a collaborative enterprise, it was often necessary to take a more directive role by, for example, suggesting topics for discussion and suggesting alternative points of view where participants struggled to generate these. It was noted that participants often waited to be told what to do during the sessions, perhaps as a result of repeated experience of directed interactions (Lindsay et al., 2013). Whilst challenging this through the use of, for example, Socratic questioning, facilitators sought to provide a sense of much needed safety and security by maintaining certain boundaries such as timekeeping and ensuring that discussion remained relevant and focused.

Deficits in memory can affect an individual’s ability to assimilate new information (Lindsay et al., 2013). When interviewed, participants initially struggled to remember the mindfulness exercises however visual reminders and verbal prompts appeared to support memory recall. People with IDs may have deficits in prospective memory, i.e. remembering to do things (Lindsay et al., 2013) such as home practice. It is generally accepted that ongoing, regular mindfulness practice is vital to the development of mindfulness and that increased practice leads to increased benefits. Carmody and Baer (2008), for example, found that time spent practicing formal mindfulness exercises at home was correlated with increases in psychological well-being and most facets of mindfulness (as measured by the FFMQ). Since participants in this research study reported engaging in little or no home practice it seems
important to identify why this might be and for future research to put measures in place to support home practice. Due to this lack of home practice it is likely the mindfulness exercises were not internalised, nor were they practiced to the point of automaticity (Singh et al., 2013c).

Singh et al. (2003) describe a ‘SoF’ intervention in which a 27-year-old man with mild IDs engaged in a 30-minute supervised practice session twice a day for five days following admission to an inpatient psychiatric ward. Despite the authors noting that the individual appeared able to internalise the ‘SoF’ technique, such an intensive intervention would be difficult to replicate in a community setting. An alternative might be to work systemically with the individual and their support networks. Individuals with IDs may require support when learning, practicing and employing a new skill and are likely to require social support and reinforcement to engage in homework (Singh et al., 2013c). It is therefore possible that participants may have been more likely to engage in home practice had the facilitators engaged more closely with the networks within which each participant functioned. Singh et al. (2013c; p.260) go as far as to state that “attending to the multiple systems in which the individual functions...is critical to the outcome of the support provided”.

One of the aims of the Mindfulness Group was, however, to promote personal agency and to support participants to develop their own individual and personalised methods of coping with day-to-day stressors. Mindfulness can be used as a tool for emotion regulation and self-management of one’s own behaviours and can enable individuals to achieve goals which they have selected for themselves (Singh et al., 2013c). Working systemically could risk losing ‘the voice’ of the individual (Baum, 2007) however it would not necessarily challenge the person-centred approach if the individual remained the focus of the intervention.
The researcher tends to draw on systemic ways of working in her general practice, considering the individual and their presenting need in relation to the people around them (Baum, 2007) and identifying relational and environmental factors which may be detrimental to the individual, sustaining or working to relieve the difficulty. However, many factors made working systemically difficult in this instance, such as the number of participants who attended each group. Individuals with IDs are likely to be supported by various networks, each of which may be compartmentalised and have limited contact with one another (Pockney, 2006). This might include family, day centres, support staff, work placements and advocates. To engage with each of these networks for each participant and within a restricted time frame was not feasible. Future mindfulness groups may benefit from asking each participant to identify one individual who could be the point of contact for the facilitators. The facilitators could meet with this point of contact to discuss the premise of the Mindfulness Group, to explore what mindfulness is, to practice mindfulness and to establish how they could best support the individual with IDs to practice mindfulness at home. This intervention might also include psychoeducation around emotional awareness in order to promote the shift from a behavioural to a psychological focus and facilitate a greater understanding of the emotional wellbeing of the individual with IDs. The chosen point of contact with their expertise and knowledge of the individual becomes a ‘therapist’ (Singh et al., 2013c) who can support the individual to reinforce and sustain their skills in mindfulness long after the group has finished. Monthly follow-up sessions might also prove beneficial in terms of facilitating generalisation and adoption of long term practice.

Although consideration of the participants’ IDs and subsequent areas of need was a significant aspect of the research in terms of the identification of the necessary adaptations required to create and run a mindfulness group for people with IDs, participants should not be
defined by their ID nor should they be considered a homogenous group. Just as the personal qualities and characteristics of the individual facilitators had an impact on process and outcomes, so too did the personal qualities and characteristics of the individual participants. Whilst the results of this research may therefore be seen to provide rich accounts of diverse experiences, the individual and personal nature of these accounts make generalisation of the findings more challenging. As identified by Jones (2013b) the themes identified are particular to the experiences of this particular group of participants. However, it is hoped that through the rich descriptions and accounts herein decision making regarding the transferability of the findings is facilitated.

McCown (2013) highlights the lack of research regarding the relationships between participants and between the participants and the mindfulness trainer and suggests that the demands of research, controlling for therapist effects, have neutralised the therapist’s role in the mindfulness intervention. This is despite the fact that the characteristics of the mindfulness trainer are thought to be crucial to outcomes (Segal, Williams & Teasdale, 2002) and that existing studies (such as Singh et al., 2009) have been criticised for providing little information regarding the mindfulness trainer (Hwang & Kearney, 2014). Rather than deny the role of the therapist, this research acknowledges the potential for the therapist to have a significant influence on those whom she supports. During the interviews and group discussions participants were asked to share what they thought about the facilitators and their approach; participants described the facilitators as comforting, kind, patient and supportive. It is likely these factors will have influenced participants’ experience of the group however the extent of this influence is unknown.
In the development of a manualised MBI for individuals with IDs, there lies the risk of overlooking the importance of individual trainer characteristics. McCown (2013; p.29) describes this as the “opposed yet potentially complementary needs for fidelity to a protocol and integrity in responding authentically in the moment”. The primary researcher was conscious of the need to maintain the fidelity of existing mindfulness techniques and to follow a process which could be replicated for future research and future groups. However, she was also influenced by her counselling psychology training which emphasises the importance of empathy, congruence and unconditional positive regard (Rogers, 1957). These person-centred concepts share common features with mindfulness and highlight the potential for mindfulness meditation and psychological intervention to complement one-another (Baer, 2003).

Mindfulness itself might be considered a common factor across psychological interventions (Martin, 1997). The need to remain authentically in the moment, to be genuine and empathic might mean straying from preconceived scripts, programs or manuals. The author therefore suggests that any manualised MBIs be delivered with some flexibility and take into account the individual characteristics and qualities of the therapist, as well as those of the participants. The participants who attended the mindfulness groups in this study were not “isolated individuals” but rather “a co-created and sustained community” (McCown, 2013; p. 28); how one replicates such phenomena remains unknown. If the aim is, however, to create a manualised, replicable MBI, there needs to be an agreed operational definition of mindfulness. As there remains no universal definition of mindfulness, selecting and developing appropriate measures of mindfulness was problematic, particularly when combined with the participants’ communication and cognitive impairments related to their ID. The use of the ‘FFMQ Facilitator Observation Form’ does however go some way in
providing a clear and measurable definition of mindfulness and makes this study the first of its kind to quantifiably measure the ability of individuals with IDs to engage with and understand mindfulness concepts.

Identifying an agreed operational definition of mindfulness might also support the identification of the unique aspects of MBIs, i.e. the conditions which must be necessary in order to constitute a MBI. The FFMQ identifies five key features of mindfulness, however in addition one might also expect MBIs to promote compassion for self and others and the ability to focus on the present moment, undeterred by anxieties about the past or the future. Through the identification of the unique aspects of mindfulness, researchers might begin to identify why or how mindfulness might lead to positive outcomes for people with IDs. It can of course be argued that these ‘unique aspects’ of mindfulness are present in other psychological interventions and approaches. Compassion Focused Therapy, person-centred approaches and indeed counselling psychology share many common elements with MBIs. If, however, there is to be an investment of resources in research regarding mindfulness and people with IDs, it is necessary to consider what it is about MBIs that distinguish them from existing interventions and whether there are sufficient unique qualities to MBIs that provide beneficial outcomes that go above and beyond these existing interventions.

Existing research has pointed to the mechanisms through which mindfulness may lead to beneficial outcomes (for example, Baer, 2003; Bear et al., 2006; Brown, Ryan & Creswell, 2007; Shapiro, Carlson, Astin & Freedman, 2006) and has suggested that mindfulness may be particularly beneficial for people with IDs for a number of reasons. For example, mindfulness might have positive effects on emotion regulation (Hayes & Feldman, 2004) and working memory, attention span and brain function associated with self-awareness, empathy and self-
control (Burch & Penman, 2013) – areas of difficulty for many with IDs. MBIs may also be empowering for people with IDs as they offer the individual a degree of meaningful involvement in their own treatment (Singh et al., 2003) and the individual is encouraged to develop the skills and resilience necessary to manage their own environment rather than relying on others to do this for them (Hastings, 2013). Further, mindfulness is a skills-based, positive and non-blaming approach (Lew et al., 2006) which asks the individual to accept themselves as they are, rather than trying to change or deny oneself and one’s difficulties. Research has suggested carers might benefit from MBIs through a reduction in stress (Neece, 2014), an attitudinal transformation (Singh et al., 2006a) or the increased ability for calm and non-judgmental acceptance (Singh et al., 2009).

Participants who attended the Mindfulness Group said they found the mindfulness exercises relaxing and enjoyable. Some used visualisation, were able to incorporate mindful attention and awareness into daily activities, and described a sense of release (such as letting go of tension in muscles and letting go of thoughts). Some appeared able to develop their self-awareness (perhaps as a result of the observational element of mindfulness practice) whilst others appeared to develop a greater sense of compassion towards themselves and others and an acceptance of individual differences. According to participants then, the elements of mindfulness which may have had the greatest significance were perhaps acceptance, awareness and compassion. Baer (2003; p.139) suggests that MBIs, whilst consistent with existing empirically supported psychological interventions, “provide a technology of acceptance to complement the technology of change”. Developing an awareness of one’s own strengths and difficulties may provide the means of cultivating acceptance and indeed change, whilst learning to develop compassionate relationships with oneself and others facilitates the sense of loving kindness at the heart of mindful practice.
2.5 Study Limitations

The potential for facilitator characteristics to influence outcomes and the significance of relationships within the group could be considered confounding variables. Social desirability, memory deficits, recency effects, anxiety and comprehension (Kroese, 1998) also need to be taken into account when considering the validity of data collected via self-report measures. It should be noted that interviews and group discussions were carried out by the facilitators, one of whom was the primary researcher. A general reluctance to give critical feedback (Kroese, 1998) may have been exacerbated by this fact and participants may have been more likely to respond positively than had they spoken with an independent interviewer who was not inextricably linked to the Mindfulness Group (Chapman et al., 2013a). However, it is also possible that the relationships participants had with facilitators may have reduced social desirability, anxiety and incomprehension (Kroese, 1998) and that familiarity may have facilitated trust and therefore honesty. Further, the facilitator observations and their felt experience of the group, in addition to the positive feedback from all participants suggest that participants genuinely found the Mindfulness Group to be a positive experience. However, the question remains, was it mindfulness that lead to the positive outcomes or something else? Could this ‘something else’, be it trainer characteristics or social influence, ever be fully accounted for? Teasdale, Segal and Williams (2003) note that mindfulness delivered by Western researchers and clinicians is done with the understanding that mindfulness is not “an end in itself” (p.159) but rather a component part of a wider intervention. Thus, psychoeducation, development of a therapeutic relationship, being part of a group, etc. might be understood as necessary components of a wider MBI (necessary in order to aid comprehension and engagement) and not as interfering variables which detract from the fidelity of the intervention.
Due to the strong and growing enthusiasm to deliver MBIs in a range of contexts with diverse populations, adequate monitoring of the integrity of the MBI and the standards and competence of the mindfulness trainer is required (Crane, Kuyken, Williams, Hastings, Cooper & Fennel, 2012). Whilst the researcher has sought to provide clear documentation pertaining to the content of the MBI presented herein (including the session plans and a description of the adaptations made to the mindfulness exercises in order to promote their acceptability to people with IDs) the fidelity of the intervention offered may have been alternatively addressed with the inclusion of a method of monitoring whether the intervention was delivered as intended. The MBCT Adherence Scale (Segal, Teasdale, Williams & Gemar, 2002) and the Mindfulness-Based Relapse Prevention Adherence and Competence Scale (Chawla et al., 2010) have been developed for this purpose, i.e. to measure the mindfulness trainer’s adherence to treatment protocols. Although both are model specific which raises concerns regarding their utility in different contexts with different MBIs (Crane et al., 2012) it may be possible to develop a similar scale perhaps more applicable to a broader definition of what constitutes a MBI. The MBCT Adherence Scale (Segal, Teasdale, Williams & Gemar, 2002) assesses group cohesion and asks “To what extent did the therapist’s actions facilitate the cohesiveness and shared identity of the treatment group?” (p.137). It also assesses homework setting (“To what extent does the therapist assign homework to group participants?” (p.137)), relating to experience through acceptance rather than aversion (“To what extent does the therapist introduce the differences between relating to one’s experiences from a standpoint of acceptance as opposed to aversion?” (p.137)) and pleasure and mastery (“Did the therapist encourage the client to engage in activities which would be pleasurable to the client from which the client would obtain a sense of accomplishment?” (p.138)). Promoting group cohesion, setting homework, encouraging acceptance and an engagement in pleasurable, rewarding experiences were all relevant to the
Mindfulness Group described and could be included in a scale developed for the assessment of the group facilitators’ adherence to both the session plans and the theoretical and philosophical assumptions underpinning mindfulness. Further ethical approval would need to be sought in order to video record each session of the Mindfulness Group so that an independent assessor could observe the presence or absence of the identified core features of the intervention (as is the process for the MBCT Adherence Scale (Segal, Teasdale, Williams & Gemar, 2002)). Identifying these core features and incorporating them into detailed session plans would not only allow for the assessment of integrity to the treatment protocol, but would also facilitate the evaluation of whether a mindfulness intervention has occurred and/or been delivered, and support the development of a standardised and replicable intervention.

Singh et al. (2011c) have also addressed the need to measure fidelity to the treatment protocol and have developed monitoring forms to assess how well the mindfulness trainer follows the instructions detailed in the ‘SoF’ training manual. If, as the authors suggest, how well someone is able to learn, teach or use ‘SoF’ is in part dependent on how well they were taught the procedure, trainer adherence to treatment protocols is key to outcomes.

Another potential concern relates to the relatively small sample size; 7 of which were male and all identified as White British. Due to service demands it would not have been possible for more than two practitioners to be freed from their usual clinical work in order to dedicate the time necessary to develop the Mindfulness Group, prepare for and deliver each session and then debrief and write clinical notes afterwards. They would also need to be available for follow-up sessions and to complete the interviews, group discussions and psychometric measures. Due to the nature of the work and the demands of the client group it was agreed that no more than five to six participants would attend each group. It should also be noted that
due to external influences, such as events in participants’ personal lives, it was not possible to complete assessment measures for all participants, thus effectively reducing the sample size further. If future research studies wish to recruit a greater number of participants, it is recommended that more practitioners are employed to run the groups or that (if time allows) more than two groups are ran (however it will remain difficult to control for external events in the lives of those who may be likely to experience crises during the course of the research). Increasing the number of participants would potentially improve the generalisability of results, whilst delivering to multiple groups would demonstrate replicability, enable the inclusion of a waiting list control comparison group and contribute towards the development of a manualised approach.

At the time of recruitment, there were no further clients open to the service who met the inclusion criteria. Participants who took part in the research were therefore reflective of the client population open to the service and awaiting therapy at that point in time. Whether this is reflective of the UK population is unknown as there remains no conclusive record of the number of people with IDs, however estimates for England suggest that a greater number of men than women are diagnosed with IDs (Emerson et al., 2011). The primary researcher chose not to put the Mindfulness Groups on hold until a greater diversity of participants were available as it was deemed unethical to ask clients to wait for the intervention; this also prevented the inclusion of a waiting list control group. The primary researcher was also mindful of time constraints associated with the research.

2.6 Future Directions

As highlighted in section 2.5 Study Limitations, future research might consider developing a procedure for ensuring adherence to the treatment protocol and ensuring that the mindfulness
intervention is delivered as intended. Further adaptations could also be made to the FFMQ Facilitator Observation Form (Appendix 13), the trialled adaptations to the original FFMQ (Appendix 14) and the Facilitator Evaluation Form (Appendix 15). In its current form, practitioners other than the groups facilitators involved with this research study may struggle to use the FFMQ Facilitator Observation Form due to the lack of detail regarding what the group facilitators were actually observing when scoring participants on each of the facets. Replicability would be supported by the inclusion of a brief description of each facet and a list of key indicators of participants’ understanding of and engagement with each facet. For example, Baer et al. (2006; p.330) describe the facet ‘observing’ as “noticing or attending to internal and external experiences, such as sensations, cognitions, emotions, sights, sounds, and smells”. This description could be added to the FFMQ Facilitator Observation Form along with a list key of behaviours or discussion points which might indicate the participant has been able to successfully understand and/or engage with the facet ‘observing’. These could be based directly on items from the original FFMQ. For example, items 1 (‘When I’m walking, I deliberately notice the sensations of my body moving’), 20 (‘I pay attention to sounds, such as clocks ticking, birds chirping, or cars passing’), 26 (‘I notice the smells and aromas of things’) and 36 (‘I pay attention to how my emotions affect my thoughts and behaviour’) on the FFMQ could translate into the following key indicators to be included on the FFMQ Facilitator Observation Form: participant comments on physical sensations; participant comments on environmental sounds; participant comments on smells or scents; participant comments on the interconnectedness of their emotions, thoughts and behaviour.

Further adaptations are required to the FFMQ (Appendix 14) in order to ensure the items are acceptable to and can be understood by people with IDs. The adaptations trialled in the early stages of this research project were not successful and as such there remains the need for the
development of a self-report measure of mindfulness for use with people with IDs. It is possible that due to its length and extensive number of items, the FFMQ is not appropriate for adaptation for this client population. There exist shorter self-report measures of mindfulness, such as the 15-item Mindful Attention Awareness Scale (MAAS; Brown & Ryan, 2003) which has been validated for use with college students and adults within the community and takes approximately five minutes to complete. Items on the MAAS such as ‘I forget a person’s name almost as soon as I’ve been told it for the first time’ and ‘I snack without being aware that I’m eating’ may require little or no adaptation.

Adaptations could also be made to the Facilitator Evaluation Form (Appendix 15), again to aid replicability. This form was intended for use by the group facilitators in order to evaluate their own contribution to each of the Mindfulness Group sessions including their reflections on things that went well or not so well, areas for improvement (of the session plans or adaptations, for example) and actions to be completed. The Facilitator Evaluation Form is focused on process rather than outcome and is therefore distinct from the FFMQ Facilitator Observation Form which was intended as an evaluation of participants’ contribution to each of the Mindfulness Group sessions in terms of their engagement with and understanding of mindfulness and the mindfulness exercises practiced. This distinction could be made clearer on the Facilitator Evaluation Form to ensure it remains focused on process and remains a useful tool for the facilitators to draw on in order to monitor and improve their own practice.

With regards to the process of obtaining informed consent, future research should think critically about how people with IDs are expected to provide consent and whether the demands of the research and the process of gaining ethical approval ever compromise the best interests of the participant. As her first major research project, the researcher perhaps lacked
the confidence in her own clinical knowledge to challenge the expectations of others that various clauses be included in the information sheet and consent form (so that they might meet the requirements of research ethic boards) which did not sit comfortably with her person-centred approach. For example, the inclusion of a space for carers to sign the consent form on behalf of the individual with IDs raises issues regarding informed consent and reinforces the historical assumption that people with IDs are unable to advocate for or make decisions for themselves. In practice, had a carer needed to sign the consent form on behalf of the individual, this would have indicated that the individual was not able to provide informed consent and thus they would not have been included in the research. Some adaption is therefore required to the consent form and information sheet. The space for carers to sign could be removed, and consent for participation in the research and consent for participation in the Mindfulness Group should be more clearly differentiated. If it is apparent the individual lacks capacity to consent to take part in the research, ideally there should be some way of determining whether the individual has capacity to take part in the Mindfulness Group. Individuals who lack the capacity to consent to the research should not be denied a potentially effective treatment intervention and all possible reasonable adjustments should be made in order to facilitate their involvement.

It may also be possible to remove items pertaining to the need to access medical records. It is NHS procedure that clinicians directly involved in the individual’s care will have access to medical records. Access to these medical records was not required by any other professional involved in the development, implementation and write-up of this research project, other than the two group facilitators (one of whom was the primary researcher). Other than reason for referral and existing diagnoses, no information was required from participants’ medical records for the purposes of the research. It is recommended that this item either be removed
from the consent form or be explained in greater detail in the information sheet. Items contained in the consent form need to map more clearly onto the information sheet in order to ensure that participants have understood exactly what they are giving consent to and why and that issues of best interest are clear. In this case, it is in participants’ best interests that clinicians directly involved in their care have access to their medical records, but participants have a choice as to whether any information contained within their medical records is included in the research. Such issues could be addressed in greater depth in the information sheet and consent form.

One method of addressing the limitations of the information sheet, consent form and data collection tools might be to involve people with IDs and their carers in the research design phase. Inclusive research in which researchers work collaboratively with service users in the design and management of the research, the collection and analysis of the data and the dissemination of the findings has the potential to address power imbalances between the researcher and the researched (The National Institute for Health Research (NIHR) Research Design Service (RDS); Gilbert, 2004); something which is particularly relevant to research involving people with IDs.

The term ‘inclusive research’ covers a range of research approaches traditionally referred to as ‘participatory’ or ‘emancipatory’ (Walmsley, 2001). Participatory research tends to focus on the experiences of people with IDs and enlists the help of people without IDs to support the involvement of people with IDs in the research process, whereas emancipatory research has a clear aim to promote social change, putting people with IDs in control of the research process (Gilbert, 2004). Stalker (1998) outlines the three core beliefs shared by both participatory and emancipatory approaches. Firstly, inequality is maintained when the
researcher is viewed as the expert and the participant the object of study; secondly, people have the right to be consulted and involved in research which has an impact on their lives; and thirdly, the quality and relevance of research is improved as a result of the involvement of people with disabilities in the research process.

There are difficulties associated with involving people with IDs in the research process which have been explored in the research literature (such as the protectiveness of others resulting in ‘gatekeeping’ and exclusion from research involvement, inaccessible and inappropriate research materials, complex ethical approval processes, the impaired cognitive and communication skills of the individual (Crook, Tomlins, Bancroft & Ogi, 2015) and a lack of organisational support (García Iriarte, O'Brien & Chadwick, 2014)). It is important to ensure that such difficulties are recognised and addressed so that the involvement of people with IDs in the research process is not tokenistic and does not compromise the best interests of the individual.

Given these difficulties, people with IDs can be involved at different stages of the research process and with differing levels of involvement. This can range from a consultative role (such as in the identification of priority areas for research (Northway et al., 2014)) to participatory action research in which the individual with IDs has an active role in the research process, identifying areas of difficulty, collecting and interpreting the data and using the results of the study to facilitate action (Kramer, Kramer, García Iriarte & Hammel, 2011). Stages at which people with IDs have been involved in research include the identification of topics of interest, participant recruitment, data collection, data analysis, report writing and dissemination of the research findings (García Iriarte, O'Brien & Chadwick, 2014).
How people with IDs could be involved in future research regarding mindfulness should be considered. Here, participant consultation during the research design phase would have allowed for a review of the proposed materials and data collection tools to ensure their suitability for the client population (NIHR RDS). Any issues could therefore be identified and addressed prior to commencement of the research. Mertens (2012) suggests that, under the transformative paradigm, involving participants in initial discussions regarding the research focus provides important insights into issues of power and social justice. Involving participants in the research design phase also allows for participants to comment on the relevancy of the research focus and the potential impact the research might have on their day-to-day lives. Whilst this research presents an overview of participants’ understanding of and engagement with the mindfulness exercises and has provided comment where exercises were not as well received as others, future research might seek to involve participants in the development of the mindfulness exercises in order to ensure their acceptability to people with IDs. This might also have the effect of promoting participant ownership over the exercises and a greater sense of empowerment and awareness of own capacity for self-advocacy (Kramer, Kramer, Garcia Iriarte & Hammel, 2011). Any future research regarding mindfulness and seeking to employ people with IDs as researchers or as contributors to the research process might benefit from the involvement of ‘research supporters’ who can “[bridge] the gap of accessibility”; something which is thought to be crucial to ensuring people with IDs are kept informed of the research process and do not drop out of the research process (García Iriarte, O’Brien & Chadwick, 2014; p.152).

This research looked at the experiences of individuals with IDs and did not formally seek to gather information on the experiences of those who support them, such as their family or care providers. In addition to addressing the limitations outlined above, future studies might also
consider inviting family or care providers into the group and consider the effect their involvement might have on outcome and generalisability of mindfulness into participants’ everyday lives. The presence of family or care providers may compromise the therapeutic aspects of the group, however it is possible their presence may lead to greater benefits due to the continued support they can offer the individual between sessions and after the group has finished.

This study did not adequately monitor the amount and quality of home practice participants may or may not have engaged in between sessions. Given the importance of continued and repeated practice of the mindfulness exercises, future studies might benefit from engaging further with family or caregivers and seeking their support in the monitoring of and facilitation of a greater amount of home practice. This might provide some indication of whether participants can generalise mindfulness across settings.

Many of the carers who supported participants to attend the Mindfulness Groups in this study developed an informal support group and met in the café at the hospital where the Mindfulness Group took place. It is possible that they may have been open to the idea of attending a mindfulness group for parents delivered in parallel with the mindfulness group for their adult children. Lunsky, Robinson, Reid and Palucka (2015) evaluated a ‘Coping with Stress’ mindfulness-based group intervention for parents of children with IDs. Parents reported feeling isolated and appreciated the opportunity to talk with other parents in similar situations. Further, self-reported stress levels reduced significantly. Given that the relationship between child behaviour difficulties and parental stress may be bidirectional (Neece, Green & Baker, 2012) a reduction in parental stress may have a positive effect on the children and adults whom they care for.
Future research might also compare the outcomes of a mindfulness group against the outcomes of a one-to-one mindfulness intervention. This might reveal something about the extent to which simply being in a group influences outcomes. Future studies might also benefit from running more or longer sessions and facilitating a greater amount of home practice. The benefits observed during this study might be increased with greater time for practice, repetition and assimilation. It is possible that the Mindfulness Group facilitated mindful awareness but without sustained practice was not enough to facilitate significant and ongoing change. There also remains the need to develop a widely accepted operational definition of mindfulness. Having such a definition would support the development of a psychometric tool appropriate for use with people with IDs to reliably and consistently measure agreed facets of mindfulness. Such a tool would support future research into the effectiveness of mindfulness interventions with people with IDs and may facilitate the development of a manualised approach.

2.7 Conclusion

The researcher has attempted to provide an accurate portrayal of participants’ experience of a mindfulness group intervention and their understanding of mindfulness. This was achieved through a mixed methods approach combining quantitative and qualitative measures. The quantitative measures indicate that self-reported anxiety and depression states decreased during the course of the mindfulness intervention and that this was maintained at follow-up, whilst the qualitative measures have facilitated a discussion of participants’ experience of their involvement in the group. The process of developing and running the group has been discussed, as have the successes and difficulties experienced and suggestions for future research in this area. Participants were able to engage in and benefit from a group format in terms of friendship and support, and socialisation and sharing. They were able to practice
mindfulness in a group and were able to demonstrate some understanding of mindfulness concepts. Overall, participants reported that they enjoyed the group and that they benefitted from their involvement with the group.

Whilst there remains a need for a clear and measurable definition of mindfulness and a means of collecting self-report data regarding mindfulness which is appropriate for use with people with IDs, this study shows that a mindfulness group can be delivered in a community setting by community practitioners, that people with IDs can learn, understand and engage with mindfulness practice and mindfulness concepts, and that engagement in a mindfulness group can have a beneficial impact on self-reported anxiety and depression. Further, this study is novel in its attempt to measure mindfulness in people with IDs and to map these measurements onto an eight-week session plan in order to identify the component parts of the mindfulness intervention which were most beneficial and consequently those that require further development.

This study has included the voices of people with IDs and gained their perspectives on the process of the mindfulness intervention; something which has thus far been seldom reported in the research literature. The participants were central to this study and it is their voices which will help to shape future development of MBIs for people with IDs.
Chapter 3 – Critical Appraisal of the Research Process

I present below a critical appraisal of the research process and reflect on some of the challenges and successes experienced along the way. I describe my personal and professional development and consider how my experiences have shaped my research and clinical practice.

In 2009, after completing an undergraduate degree in Human Psychology, I secured a post as an assistant psychologist within psychological services for people with IDs. My initial excitement was quickly met with the realisation that other than the odd lecture, I had studied very little regarding working therapeutically with people with IDs. Whilst it can be argued that in the interests of promoting equality and anti-discriminatory practice, working with someone with IDs should be no different to working with someone without IDs, such a viewpoint effectively dismisses individual differences and does not recognise the adaptations that may need to be made on behalf of the therapist in order to provide the most appropriate and effective service for the individual. Rather, individual differences should be acknowledged and embraced and the therapist should be ready to adapt her approach in order to best support the individual. To quote Jones (2013b; p.199) there is “a need to recognise the rich and vast differences that exist between people regardless of the presence of disability”.

Taking on the post of assistant psychologist was then the beginning of a process of continued learning and development. By the time I enrolled on the Practitioner Doctorate in Counselling Psychology I had already decided that my career would be within ID services and within the NHS. I continued working within the ID service and dropped my hours to accommodate my
studies. Whilst I recognised the merit of the modules studied and, in the most part, enjoyed the work, I could not help but notice that much of the work was focused on adult and child mental health with very little reference to working with people with IDs. This is not a criticism of the university, nor counselling psychology, but is perhaps a reflection of the strong history of applied behavioural models and psychopharmacological approaches in the ‘treatment’ of individuals with IDs (Jones, 2013a). The assignments I completed through the doctoral course (many of which focused on working therapeutically with people with IDs) and later this doctoral portfolio might be considered a reaction to this; an attempt to highlight and address inequalities in service provision, raise the profile of psychological services for people with IDs and to encourage further research in this area.

The doctoral research was not without its difficulties. Being new to research, the process of ethical approval was long and complicated. I was invited to attend a meeting with the National Research Ethics Committee which, although stressful and added a great deal to my workload, was ultimately a rewarding and confidence building experience. Despite having a clear rationale and detailed plan for the research, the practicalities of implementing the mindfulness intervention and conducting the research were also met with difficulties. For example, my intention was to gather self-report data regarding mindfulness as this had not been done previously with people with IDs. The FFMQ (Baer et al., 2006) was adapted so that it might be more accessible to people with IDs and trialled with participants attending Mindfulness Group 1. The failure of these adaptation lead to the development of the ‘FFMQ Facilitator Observation Form’. Although this provided some indication of participants’ understanding of and engagement with the core facets of mindfulness, this was from the facilitators’ perspectives and as such there remains a need to develop a self-report measure of mindfulness which is appropriate for use with individuals with IDs.
I had also intended to implement a waiting list control design in which participants would be randomly assigned to an immediate treatment group or a waiting list control group.\(^{18}\) This design would have addressed ethical concerns regarding lack of treatment for control arms of RCTs, as both groups would have received the intervention and potentially beneficial treatment would not be withheld from any participants. Unfortunately, a number of participants assigned to Group 2 decided against attending the group and one could no longer attend due to a deterioration in physical health. Other participants were referred to the service in the weeks prior to the commencement of Mindfulness Group 2 and could not therefore participate in the waiting list control stage of the research. As such, a waiting list control design could not be implemented at the time of the research. Challenges such as these meant the research had to evolve and I had to be ready to work flexibly and adapt the research to suit what was feasibly possible at that point in time.

Further difficulties were met during the implementation of the mindfulness intervention. These were often in relation to my ability to maintain boundaries and to communicate these boundaries to others whilst fulfilling multiple roles and addressing competing demands. Research suggests that practitioners are likely to modify the therapeutic boundaries when working with individuals with IDs (Jones, 2013b). This might be to facilitate reassurance, put the client at ease and to develop a “friendlier relationship” so that they might be more likely to engage in the therapeutic relationship (Jones, 2013; p.197b). A flexible approach to boundaries such as being friendlier and less rigid about adhering to session times is

\(^{18}\) All participants would complete psychometric measures at baseline. Participants in Group 1 would attend the 8-week Mindfulness Group whilst participants in Group 2 receive no treatment. After the 8-weeks, all participants would be assessed for a second time, after which Group 2 then attend the second 8-week Mindfulness Group.
recommended (The Royal College of Psychiatrists, 2004). On occasion, however, I found it challenging to maintain what felt like an ever-decreasing line between professional and personal relationships. That is, what I considered a professional relationship (although different to that which might develop during one-to-one therapy) was often misconstrued as friendship on behalf of the participant. Although it was made explicit that the Mindfulness Group was time limited (with follow-up available if required) this raises ethical issues regarding power dynamics, participant expectations and ending therapy which would need to be considered further when running future groups. Unfortunately, not long after the second Mindfulness Group, I moved to a different locality within the ID service. This means I am unable to offer follow-up interventions to those participants who may be re-referred to the service in the future. Although the second facilitator continues her work with this service, my departure signalled the ending of my relationships with the clients who access this service and highlights my personal concern that the ending of the Mindfulness Group and my departure may have been experienced by participants as a repeated pattern of relationships being formed and later broken; particularly given past experiences of rejection, staff turnover and participants’ likelihood of seeing the therapeutic relationship as one of friendship. However, the Mindfulness Group was intended as a short-term psychological intervention with a clear beginning and ending. The hope is that the relationships formed become internalised and that the individual carries with them an internalised version of the therapeutic relationship long after the intervention has ended.

I also experienced a tension between my therapeutic approach (informed by person-centred theory), a desire to promote participants’ sense of agency and the felt need to exert some control over the group (in terms of guiding the discussion and managing time) whilst being mindful of falling into a teacher-pupil dynamic or paternalistic interaction style. Further, I
often felt torn between the requirement to direct the mindfulness exercises and my desire to support and promote personal agency. Learnt helplessness, previous life experiences (such as the high or low expectations of others) and difficulties initiating tasks may go some way in explaining why some participants appeared reluctant or unable to take responsibility for themselves and their own mental health and appeared to need to be told what to do. Others, such as P1, appreciated the autonomy they had in the group and commented on the fact they were not put down, criticised or told what to do.

There are, of course, particular demands associated with working therapeutically with people with IDs. Jones (2013b) suggests that therapeutic work with people with IDs can be particularly energy consuming as the therapist may burden herself with the success of therapy. Further, therapeutic work may be slow and progress slight, the therapist may experience a sense of futility and question the likelihood of improvements being maintained after therapy. The psychoeducational component of the mindfulness intervention highlights the need for preparatory work which may have a detrimental effect on the rate of progress or change, as might the cognitive abilities of individuals with IDs and the need for repetition and practice.

Working therapeutically with people with IDs can also be emotionally demanding given the likelihood of the individual having experienced traumatic life events. The therapist may also experience frustration; perhaps with the pace of therapy or an apparent lack of change or improvement, frustration with herself for her difficulty engaging with the individual or of making herself understood, or frustration with the environment within with the person lives and the manner in which others behave towards them. There is an acceptance that therapeutic change can only be maintained if the coping skills the individual has learnt during therapy are
acceptable to others (and supported by others) and if the individual “enters into a reasonable world” post therapy (Kroese, 1998; p. 319). It must also be ensured that the individual “lives in a world where human rights are respected and where self-determination is encouraged” (Kroese, 1998; p. 320). Given the positioning of people with IDs within society, is this then a further role for the therapist; to advocate for the individual and promote a social justice agenda? The role of the therapist is therefore complicated; as was my role in the running of the Mindfulness Group. I was in effect taking on numerous roles in the lives of participants - researcher and therapist, teacher and facilitator, friend and advocate.

In terms of my role as mindfulness ‘teacher’ or ‘trainer’, there were further demands resulting from the expectation that I engage in continued mindfulness practice. It is generally accepted that the mindfulness practice of the clinician is “a critical variable in the training and delivery of mindfulness interventions and...outcomes for individuals with ID” (Singh et al., 2013c; p. 261). Throughout the development and implementation of the Mindfulness Group, I sought to develop my mindfulness practice as it was my belief that this would have a positive impact on my ability to deliver the mindfulness exercises, promote the philosophy of mindfulness and relate to participants from a mindful perspective. Undertaking this research project has, however, been an incredibly demanding experience. Whilst I am confident that I have done all I could at this point in time, this is not without the acknowledgement that had demands been fewer, I may have been more emotionally available and able to dedicate more time to my practice. As it was, the demands of the research (including the development and implementation of the research and the mindfulness intervention, and gaining ethical approval), the demands of the doctoral course (such as completing assignments for other modules), the requirement to complete personal therapy and maintain clinical practice, were often met with a fear that mindfulness meditation may be self-indulgent (Burch & Penman,
2013) and that time may be better spent elsewhere. This has been an ongoing battle and one I have sought to address by challenging my priorities and making a conscious effort to set time aside to engage in mindfulness practice and thus attend to my own emotional wellbeing.

I have also spent time reflecting on the proposal that one must have completed a certain number of years of personal mindfulness practice before one can ‘teach’ mindfulness. I have attended numerous mindfulness training events and workshops, perhaps most notably an evening of mindfulness in Coventry Cathedral at which Davinder Panesar, founder of Mindfulness-Based Business Management (MBBM), gave a presentation on mindfulness as a process for regaining health and wellbeing. I felt challenged by his statement that being taught mindfulness by someone without five years of personal mindfulness practice is like being taught to swim in the ocean by someone who learnt to swim in a paddling pool (Panesar, 2015).

Whilst I acknowledge that ongoing mindfulness practice is essential for the mindfulness teacher, my intention was not to ‘teach’ mindfulness, but to share my knowledge and experience with others and to explore, collaboratively, the potential for mindfulness to have a positive impact on the emotional lives of those who attended the Mindfulness Group. If I had waited a few more years, would I have felt any more confident in my mindfulness practice, or would I have failed to offer those with whom I work a potentially beneficial and effective intervention? As I understand mindfulness, there is no goal nor perfect meditation; mindfulness practice is ongoing and cannot be perfected. It is a process and the transformation is in the trying. It is highly likely that I will never feel that I have ‘succeeded’ at mindfulness nor reached a point of optimum practice.
What I have learnt from the Mindfulness Group and from those who participated in the research has served to develop my practice significantly and will continue to have a positive influence on both my personal and professional development. Further, the philosophy of mindfulness is one of inclusivity and acceptance and should therefore be available to people with IDs, particularly given the significant research base supporting the use of mindfulness within the wider population. My hope is that this research encourages others to further develop research and knowledge regarding mindfulness and people with IDs and that mindfulness can continue to be viewed as an inclusive practice which transcends religious, cultural and societal boundaries.

Despite the difficulties, I have not lost my enthusiasm for this research. It has been a challenging yet rewarding experience and I am excited to share my findings with others. I am confident that this research provides interesting and novel insights regarding mindfulness and IDs that will be useful to practitioners in informing their practice. I have done my best to advocate for the participants who took part in this research and to present truthfully, and with respect, their voices and experiences. I plan to continue working within psychological services for people with IDs, to further develop the use of mindfulness within community ID services, and to use this research as the basis for continued research and development in this area.
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## Appendix 1: Outcome of the Literature Review

Table 1: Mindfulness-based interventions for people with IDs

<table>
<thead>
<tr>
<th>Study</th>
<th>Study type</th>
<th>Aims</th>
<th>Sample</th>
<th>Settings and duration</th>
<th>Content</th>
<th>Method</th>
<th>Instructor</th>
<th>Outcomes measured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Singh et al. (2003)</td>
<td>Single participant</td>
<td>Teach a MBI, Meditation on the Soles of the Feet, to reduce aggressive behaviour</td>
<td>27y/o male with Mild ID. Inpatient in psychiatric hospital.</td>
<td>Psychiatric hospital Intervention - 5 days Follow up – 12 months</td>
<td>Meditation on the Soles of the Feet</td>
<td>Individual training 30min role play and practice, twice a day for 5 days 1 week of home practice</td>
<td>-</td>
<td>Staff reported ad self-reported incidences of physical and verbal aggression</td>
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<tr>
<td>Soles of the Feet: a mindfulness-based self-control intervention for aggression by an individual with mild mental retardation and mental illness</td>
<td>5 month baseline</td>
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<tr>
<td>Singh et al. (2007a)</td>
<td>Multiple baseline at 3, 5 and 10 weeks</td>
<td>Teach a MBI, Meditation on the Soles of the Feet, to reduce aggressive behaviour in order to maintain community placement</td>
<td>3 adults aged 27, 39 and 43. 2 of which were male and 1 female. All had moderate ID and mental health issues</td>
<td>Group home 35 weeks</td>
<td>Meditation on the Soles of the Feet</td>
<td>Individual training with 1 week of guided meditation</td>
<td>First author</td>
<td>Staff reported incidences of physical aggression</td>
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<tr>
<td>Mindfulness training assists individuals with moderate mental retardation to maintain their community placements</td>
<td>Intervention at 35 weeks</td>
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<tr>
<td>Beauchemin et al. (2008)</td>
<td>Pre-post no control</td>
<td>Reduce anxiety, improve social and academic</td>
<td>34 adolescents with IDs</td>
<td>Classroom 5 week</td>
<td>Focusing on breathing</td>
<td>Modelling Discussion</td>
<td>Primary investigator</td>
<td>Social Skills Rating System</td>
</tr>
</tbody>
</table>
Mindfulness meditation may lessen anxiety, promote social skills, and improve academic performance among adolescents with learning disabilities.

<table>
<thead>
<tr>
<th>Singh et al. (2008b)</th>
<th>Multiple baseline at 3, 5 and 7 months</th>
<th>Effectiveness of Meditation on the Soles of the Feet to reduce physical aggression</th>
<th>6 male offenders with mild ID</th>
<th>Forensic mental health facility 27 months of mindfulness training</th>
<th>Meditation on the Soles of the Feet</th>
<th>Practice twice a day for 27 months</th>
<th>Individual training with guided meditation</th>
<th>Therapist</th>
<th>Physical aggression</th>
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</thead>
<tbody>
<tr>
<td>Clinical and benefit-cost outcomes of teaching a mindfulness-based procedure to adult offenders with IDs</td>
<td>Singh et al. (2008c)</td>
<td>ABCD design – baseline, exercise alone, exercise plus food awareness, exercise plus food awareness plus mindfulness.</td>
<td>Lose weight A 17y/o male with Prader-Willi syndrome and mild ID</td>
<td>Home 5 years</td>
<td>Mindful eating Visualising and labelling hunger Meditation on the Soles of the Feet</td>
<td>Not stated Use of a cartoon character Individual training for a week</td>
<td>Participant’s mother was the ‘primary therapist’, assisted by the senior author via email</td>
<td>Mean weight</td>
<td>Physical aggression</td>
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<tr>
<td>Study</td>
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<td>Intervention Details</td>
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<tr>
<td>Adkins et al. (2010)</td>
<td>Multiple baseline</td>
<td>Reduce verbal and physical aggression among adults aged 22, 25, and 42, and those living in the community.</td>
<td>Meditation on the Soles of the Feet, individual training for 1 hour/day, 5 days/week, practice twice daily, practice when triggers are present.</td>
<td>4-8 weeks follow up</td>
<td>Individual training, multiple baseline procedures.</td>
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<tr>
<td>Chilvers et al. (2011)</td>
<td>Repeated measures</td>
<td>Impact of mindfulness group sessions on aggressive behaviour among women with mild/moderate ID.</td>
<td>A 30-minute mindfulness group session twice a week in a ward environment for approx. 6 months.</td>
<td>No follow up</td>
<td>The impact of mindfulness group sessions on recorded aggression.</td>
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<tr>
<td>Singh et al. (2011a)</td>
<td>Multiple baseline design</td>
<td>Reduce aggressive behaviour, control anger among adult males with mild ID.</td>
<td>Meditation on the Soles of the Feet, workplace setting.</td>
<td>3 years follow up</td>
<td>Incidences of aggression.</td>
<td></td>
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<tr>
<td>Author(s)</td>
<td>Title</td>
<td>Design</td>
<td>Intervention</td>
<td>Setting</td>
<td>Outcomes</td>
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<tr>
<td>Singh et al.</td>
<td>A mindfulness-based health wellness program for individuals with Prader-Willi syndrome</td>
<td>A changing criterion design.</td>
<td>Lose weight</td>
<td>Home</td>
<td>Physical exercise, food awareness, mindful eating, visualising and labelling hunger, meditation on the Soles of the Feet</td>
<td>A therapist-guided remote treatment study with interventions personalised via email. The mother of each participant was trained by a therapist with experience in mindfulness. The mothers became the primary therapists</td>
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<td></td>
<td>(2011b)</td>
<td>Baseline, intervention, 3yr maintenance period</td>
<td>3 adolescent males with mild ID and Prader-Willi Syndrome</td>
<td>36 months including baselines and maintenance period</td>
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<tr>
<td>Singh et al.</td>
<td>Can adult offenders with intellectual disabilities use mindfulness-based procedures to control their deviant sexual arousal?</td>
<td>Multiple baseline</td>
<td>Control deviant sexual arousal</td>
<td>Forensic mental health facility</td>
<td>Meditation on the Soles of the Feet, mindful observation of thoughts, use of pictures to induce sexual arousal and shift attention to soles of the feet, individualised instruction, home practice, discussion with the therapist</td>
<td>2 therapists, including one with extensive experience in mindfulness practice</td>
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<td>(2011c)</td>
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<td></td>
<td>3 adult male offenders aged 23, 25 and 34 with ID and mental health issues</td>
<td>60 weeks</td>
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<td>All had participated in Singh et al (2008b)</td>
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<tr>
<td>Singh et al.</td>
<td>Effects of a mindfulness-based smoking cessation program for an adult with mild intellectual disability</td>
<td>Single subject changing criterion design</td>
<td>Cease smoking</td>
<td>A 31 y/o male with mild ID</td>
<td>mindful observation of thoughts, meditation on the Soles of the Feet, discussion with group home staff, observation of desire to smoke, role play and self-practice of meditation on the soles of the feet</td>
<td>Therapist with extensive experience in mindfulness practice</td>
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<td>(2011d)</td>
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<td>82 days</td>
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<td>Number of cigarettes smoked, interviews with staff, observations at work, informal enquiries with neighbours</td>
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<tr>
<td>Singh et al. (2013a)</td>
<td>Changing criterion design</td>
<td>Cease smoking</td>
<td>3 adults with mild ID</td>
<td>Approximately 4yrs</td>
<td>Basic concentration meditation</td>
<td>Delivered in a group format</td>
<td>As Singh et al. (2011d)</td>
<td>Number of cigarettes smoked</td>
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<td>A mindfulness-based smoking cessation program for individuals with mild intellectual disability</td>
<td>10 day baseline, 12 month maintenance period, 3yr follow up</td>
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<td></td>
<td>Daily intention</td>
<td>20min practice each morning, and 30min training twice a day for 5 days followed by 10 days of practice assignments</td>
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<tr>
<td>Singh et al. (2013b)</td>
<td>Participants in the SoF group – 12 week baseline phase, 12 week mindfulness training phase, 12 week follow up phase</td>
<td>Reduce physical and verbal aggression</td>
<td>24 adults with mild ID assigned to two conditions</td>
<td>36 – 48 weeks</td>
<td>Meditation on the Soles of the Feet</td>
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<tr>
<td>Mindfulness-based treatment of aggression in individuals with mild intellectual disabilities: A waiting list control study</td>
<td>Participants in WL control group – 12 week baseline phase, 12 week WL control condition, 12 week mindfulness training phase, 12 week follow up phase</td>
<td></td>
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<td>Encouraged to use Meditation on the Soles of the Feet during incidents that could lead to aggression</td>
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<tr>
<td>Chapman and Mitchell (2013b)</td>
<td>Post intervention measures – no pre, baseline or</td>
<td>Explore the experiences of people with ID and their carers</td>
<td>171 people attended the 12 workshops, of which 114</td>
<td>The duration of each workshop was 1-1.5hrs</td>
<td>Easy read leaflet and mindfulness CD</td>
<td>A questionnaire survey and qualitative interviews with</td>
<td>Majority of workshops facilitated by certified MBSR</td>
<td>A questionnaire survey</td>
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<td>325</td>
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</tr>
<tr>
<td>Study Title</td>
<td>Methodology</td>
<td>Intervention</td>
<td>Sample Description</td>
<td>Outcome Measures</td>
<td>Findings/Interpretation</td>
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<tr>
<td>Mindfully valuing people now: An evaluation of introduction to mindfulness workshops for people with IDs</td>
<td>follow-up</td>
<td>people had ID and 57 were family, carers and staff</td>
<td>20min body scan</td>
<td>6 people with ID</td>
<td>teacher with experience of running mindfulness groups. One workshop facilitated by 2 community ID nurses.</td>
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<tr>
<td>Singh et al. (2014)</td>
<td>RCT</td>
<td>51 adults with ID across two groups (mostly males)</td>
<td>Community setting</td>
<td>Daily intention Mindful observation of thoughts</td>
<td>Thematic analysis of 6 interviews</td>
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<tr>
<td>A randomized controlled trial of a mindfulness-based smoking cessation program for individuals with mild intellectual disability</td>
<td>Post intervention measures – no pre, baseline or follow-up</td>
<td>Explore people with IDs understanding of mindfulness, including the benefits and difficulties they experienced in their use of the mindfulness exercises</td>
<td>Participants attended between 2 and 23 sessions</td>
<td>Exercises included the raisin exercise, muscle tension and relaxation, the body scan and meditating on the breath</td>
<td>Trainee and assistant clinical psychologists</td>
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<tr>
<td>Yildiran &amp; Holt (2014)</td>
<td>Post intervention measures</td>
<td>6 participants with mild or moderate IDs and additional diagnoses aged between 21 and 64y/o 4 women, 2 men</td>
<td>Weekly relaxation and mindfulness group</td>
<td>Trainee with long standing personal meditation practice ad 35 year history of service provision to people with intellectual and developmental disabilities</td>
<td>Mean number of cigarettes smoked</td>
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<tr>
<td>Thematic analysis of an inpatient mindfulness group for adults with intellectual disabilities</td>
<td></td>
<td>Participation measures</td>
<td>Pre, post and follow-up self-report measures</td>
<td>Evaluate the effectiveness of mindfulness as a ‘stand alone’ therapy for</td>
<td>Thematic analysis of 6 interviews</td>
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<tr>
<td>Idusohan-Moizer, Sawicka, Dendle &amp; Albany (2015)</td>
<td></td>
<td>15 adults with borderline, mild or moderate IDs and a diagnosis or either</td>
<td>Community setting</td>
<td>Loosely based on Segal et al (2002) manualised MBCT for</td>
<td>Qualified clinical psychologists with training in mindfulness — Anxiety Depression Self-</td>
<td></td>
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<tr>
<td>Mindfulness-based cognitive therapy for adults with intellectual disabilities: an evaluation of the effectiveness of mindfulness in reducing symptoms of depression and anxiety</td>
<td>adults with IDs. recurrent depression, anxiety or both and a history of deliberate self-harm</td>
<td>6 week follow-up depression and included mindfulness of the breath, basic yoga stretches, raisin exercise, diary of pleasant and unpleasant events. Modified exercises on self compassion. Meditation on the Soles of the Feet. Metaphors and analogies from ACT.</td>
<td>based therapies, an assistant psychologist and a two trainee who had attended mindfulness workshops. Compassion for others</td>
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</tbody>
</table>
### Table 2: Mindfulness-based interventions for families/parents of people with IDs

<table>
<thead>
<tr>
<th>Study</th>
<th>Study type</th>
<th>Aims</th>
<th>Sample</th>
<th>Settings and duration</th>
<th>Content</th>
<th>Method</th>
<th>Instructor</th>
<th>Outcomes measured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neece (2014)</td>
<td>Waiting list control group</td>
<td>Evaluate the effectiveness of MBSR in reducing parenting stress and whether decreases in parenting stress lead to reductions in behaviour problems their in children with developmental disabilities</td>
<td>46 parents. Children aged 2.5-5yrs with ‘developmental delay’ and behaviour problems.</td>
<td>8 week course, 2hr group session once a week</td>
<td>Mindfulness Awareness for Parenting Stress (MAPS) Project. The MBSR intervention followed the manual outlined by Kabat-Zinn et al. (1992)</td>
<td>Parent self-report measures completed pre and post intervention</td>
<td>Instructor with 20yrs experience practicing mindfulness and teaching MBSR</td>
<td>Parents stress, depression, distress, satisfaction with life.</td>
</tr>
</tbody>
</table>
### Table 3: Mindfulness-based intervention for professionals working with and supporting those with IDs

<table>
<thead>
<tr>
<th>Study</th>
<th>Study type</th>
<th>Aims</th>
<th>Sample</th>
<th>Settings and duration</th>
<th>Content</th>
<th>Method</th>
<th>Instructor</th>
<th>Outcomes measured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Singh <em>et al.</em> (2004)</td>
<td>Alternating treatments embedded within a multiple baseline across subjects design</td>
<td>The effect of mindfulness training for paid caregivers on levels of happiness for adults with profound multiple disabilities</td>
<td>6 female African-American carers across four group homes, 3 males with profound ID and complex physical health conditions</td>
<td>8 weeks of mindfulness training followed by 16 weeks of mindfulness practice</td>
<td>Meditation exercises on observing the mind, emptiness, single pointed meditation on an object, being in the present moment, the beginner’s mind, being the activity</td>
<td>Each participant supported by two carers, one of which was given mindfulness training.</td>
<td>The senior investigator</td>
<td>Happiness</td>
</tr>
<tr>
<td>Singh <em>et al.</em> (2006a)</td>
<td>Multiple baseline design across group homes</td>
<td>Investigate whether mindful staff can increase learning and reduce aggression</td>
<td>15 care staff aged between 22 and 38yrs. 10 men, 5 women. Staff were responsible for 18 individuals with severe of profound IDs across 3 homes.</td>
<td>4 week baseline. 5 days behavioural training. 5 days mindfulness training.</td>
<td>Didactic instruction, practice in meditation, mindfulness-enhancing exercises</td>
<td>Staff provided with behavioural training and then mindfulness training</td>
<td>-</td>
<td>Staff intervention for aggression, learning objectives performed independently, use of emergency physical restraints, socially integrated activities, physical integrated activities, staff work satisfaction, social validation of staff behaviour</td>
</tr>
<tr>
<td>Singh et al. (2009)</td>
<td>Multiple baseline design</td>
<td>Effect of training staff members in mindfulness on their use of physical restraints</td>
<td>23 staff working in 4 group homes for 20 people with ID</td>
<td>3-5 week baseline phase, 12 weeks of mindfulness training followed by a mindfulness practice phase</td>
<td>Mindful practice on observing the mind, breathing, arousal, being in the present moment, beginner’s mind, being one with the individual, non-judgemental acceptance, letting go and loving kindness.</td>
<td>Delivered in a group format to staff on morning and afternoon shifts separately.</td>
<td>-</td>
<td>No. of potential and actual incidents of physical/verbal aggression</td>
</tr>
</tbody>
</table>
Appendix 2: Participant Information Sheet

Participant Information Sheet

An Evaluation of a Mindfulness Group for People with Intellectual Disabilities

My name is Sarah Croom. I am a student and a Trainee Counselling Psychologist.

I would like to invite you to join a Mindfulness group and take part in a research study. Before you decide I would like you to understand why the research is being done and what it might involve for you.

I will go through the information sheet with you.

Please ask me if you have any questions.

_____________________________________________________________________

What is Mindfulness?

• Mindfulness is about paying attention to what is happening right now
• In the group we will practice exercises that help us to relax, feel calm, and worry less about the past or the future
• Mindfulness can help us to enjoy life and help us to be kind to ourselves.

You have been invited to join the Mindfulness Group and take part in the research because:

• You have been referred to Psychological Services for People with Learning Disabilities
• The Mindfulness Group may be helpful to you.
I am trying to find out:

- If it is possible to run a mindfulness group
- If it is helpful
- What you think about the group.

You do not have to take part if you do not want to

- If you would like to join the Mindfulness Group and take part in the research I will ask you to sign a consent form
- You can choose not to join the Mindfulness Group or take part in the research
- You can choose to leave the Mindfulness Group and the research at any point. Your standard of care will not change.

What will happen if you take part?

You will be asked to join a Mindfulness Group:

- The Mindfulness Group will meet every week for 8 weeks
- We will meet at [name of location]
- Each meeting will last 1 hour and 30 minutes
- We will talk about lots of things, like stress, relaxation, relationships and looking after ourselves. We will talk about this more during the first session.

You will be asked to take part in the research:

- I will meet with you for 2 interviews. One interview will be 1 week before the first Mindfulness Group session. The other interview will be 4 weeks after the last group session
- The interviews will be audio recorded
- You will also be asked to fill in 3 questionnaires
- I will use what you tell me in the interviews and the questionnaires to help write the research
- I will be writing a report about the group. This might be published in the future.
Possible risks

- It is important that you look after yourself
- If you have any worries during the group, please tell me
- If we are talking about something you find upsetting or do not want to talk about, please tell me
- If you have any questions, please ask me.

Possible benefits

- I hope that you will find the Mindfulness Group helpful and enjoyable
- By being in the group and talking to me, you will help me and my research
- By being in the group and talking to me, you will help other professionals, like me, to better understand how mindfulness can be used to help people.

Confidentiality

- Everything you talk about in the group will be kept confidential. This means that I will only talk to my supervisors and the other people running the group about what happens in the group
- I will write a letter to your GP and other health professionals supporting you, just to let them know that you are taking part in the group and the research
- I might need to talk to other people if you say something that makes me think you or someone else might get hurt
- The consent form, questionnaires and the all recordings will be stored with your confidential file
- The questionnaires and recordings will be used to help my research
- When I write up the research, I will not use your real name
- I might like to talk to your carers or other people supporting you to find out if you found the group helpful. I will only do this if you agree that this is OK.
Complaints

If you are not happy about the research, the group, or the people running the group please talk to me or my clinical supervisor:

• You can phone us on:
• Or write to us at:

If we cannot answer your questions, you might choose to contact the university

• You can speak to my academic supervisor, on:
• Or write to him at:

If you are still unhappy after speaking with my supervisors, they will be able to put you in touch with the relevant people to continue your complaint.
Appendix 3: Consent Form

Centre Number:
Study Number:
Patient Identification Number:

CONSENT FORM

Title of Project: An evaluation of a mindfulness group intervention for people with intellectual disabilities

Name of Researcher: Sarah Croom

Please initial all boxes

1. I have read and understand the information sheet dated ________ (3rd version) for the above study. I have met with the people running the group and have been able to ask them questions.

2. I understand that it is my choice to join the group and take part in the research. I understand that I can stop coming to the group at any time and do not have to give a reason for this. If I decide to stop coming to the group, but still need some other support, this will be available.

3. I understand that relevant sections of my medical notes and data collected during the study may be looked at by other professionals in the Learning Disability Team, from regulatory authorities, or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these people to have access to my records.

4. I agree to my GP or other health professionals supporting me being told that I will be taking part in the group and the research.
5. I agree to take part in the above study and would like to join the Mindfulness Group.

Client Name:__________________________________________________
Signature:____________________________________________________
Date:________________________________________________________

Parent/Carer Name (if required): __________________________________
Signature:____________________________________________________
Date:________________________________________________________

Name of person taking consent:____________________________________
Signature:____________________________________________________
Date:________________________________________________________
Appendix 4: Debrief Form

The Mindfulness Group

What was this study about?

Thank you for taking part in this study and for joining the Mindfulness Group. I hope you found the group helpful.

By being in the group and talking to me, you have helped me and my research a lot. I wanted to find out if the group was helpful for you, and if it might be helpful for other people.

I hope the research I write will help other professionals, like me, to better understand how mindfulness can be used to help people.

If you are feeling worried about the group or the study, or have any questions, please let me know.

Please remember that I won’t show anyone the recordings and I will not mention your name in the research.

If you think you still need help from the psychology team, please let me know, or contact us on [phone number].

Thank you for taking part.

Sarah Croom, Trainee Counselling Psychologist
Appendix 5: GP Information Letter

[Trust logo]

[date]

[GP address]

Dear [GP name],

Re. [client name, address and date of birth]

I am writing to inform you that [client name] will be attending a Mindfulness Group. This group will be run by myself and a colleague for eight weeks and forms part of a research project. As the principal researcher, I will be working under the supervision of both a clinical supervisor and research supervisors. The research forms part of a doctoral training programme.

As part of the research, [client name] will be required to take part in an audio recorded interview, complete a series of questionnaires, and attend the Mindfulness Group.

[Client name] has provided consent to take part in the research and attend the group.

If you would like further information regarding the Mindfulness Group or the research, please do not hesitate to contact me on [researcher’s work contact number].

Yours sincerely,

Sarah Croom, Trainee Counselling Psychologist
Under the supervision of [name removed], [title]

Cc: [client]
    [main carer, if required]
    [other professionals involved]
    File
Appendix 6: The Mindfulness Group Session Plans

Mindfulness Group 2, Session 1
10.30am  WELCOME. Introductions. Agenda.
10.40am  Consent forms.
10.50am  Getting to know you exercise.
11am  Description of mindfulness and what course facilitators hope group members might get out of the group.
11.05am  **Short mindfulness exercise (no.1)** to demonstrate what mindfulness is. Describe the exercise. Emphasis that group members should try to “go with it” and not worry about feeling silly. Follow with discussion.
11.25am  TEA BREAK
11.35am  Contracting – write up on flip chart paper rules everyone agrees on, inc. confidentiality, looking after ourselves and others, being careful what of we say, etc.
11.45am  **Raison mindfulness meditation (no.2)** followed by discussion.
11.55am  Checking out. Answer any questions. Run through homework. Give out handouts.
12noon  END.

Mindfulness Group 2, Session 2
10.30am  Introduce any new members that may have missed the first session. Ask them to add to the group members’ sheet and recap on agreed contract Recap on last session
10.40am  Check in cards
10.50am  Discuss homework. Did group members try any of the exercises at home? If yes, what was it like? If no, what stopped them? What did people discover about themselves?
10.55am  **Mindfulness exercise**: Repeat breathing mindfulness exercise (no.1) from session 1, followed by feedback and discussion
11.05am  Topic for today: **THE BODY**. Group discussion around the purpose of breathing, sensations in the body and how our bodies feel when we experience certain emotions (e.g. stress, fear, worry, etc.)

11.25am  TEA BREAK

11.30am  Explanation of/discussion around the effect mindfulness can have on our bodies. Engage in exercise in which we tense certain parts of the body (e.g. hand) and let go. Does this tension and release create any kind of pain relief/feeling of relaxation?

11.40am  **Mindfulness exercise**: Muscle stretching and relaxing exercise, followed by feedback and discussion

11.50am  Checking out. Answer any questions. Run through homework

12noon  END

---

**Mindfulness Group 2, Session 3**

10.30am  Check in

Recap on last session

Discuss home practice

10.45am  **Mindfulness exercise**: Shortened and adapted body scan (no.4), followed by discussion

10.55am  **Mindfulness exercise**: Mindful movement (no.5), followed by discussion

11.05am  Topic for today: **MAKING TIME TO FEEL GOOD**. Group discussion around what makes us feel good, what we enjoy doing and what we might like to do more of. Encourage each group member to identify at least five things that make them happy about their lives and/or that they are grateful for (‘Gratitude Exercise’)

11.30am  TEA BREAK

11.40am  **Mindfulness exercise**: The 3-minute breathing space (no.6), followed by discussion

11.50am  Checking out. Answer any questions. Run through homework (‘Habit releaser’ – making time to do something enjoyable (e.g going for a walk) or doing something differently (e.g. watching less TV, or sitting in a different chair). Give out handouts.

12noon  END
Mindfulness Group 2, Session 4

10.30am  Check in
Recap on last session

10.45am  Discuss homework (‘Habit Releaser’). Did group members manage to try any of the exercises at home? If yes, what was it like? If no, what stopped them? What did people discover about themselves?

10.50am  **Mindfulness exercise**: 3-minute breathing space (no.6), followed by discussion

11am  Topic for today: **THINKING**. Exercise: Group to be encouraged to notice what they are thinking. Discussion around what people are thinking, whether thoughts have meaning, and where thoughts might come from. Key points to get across are that thoughts do not necessarily have any meaning, that thoughts do not equal reality, and that what we think does not make us a good/bad person. Thoughts come and go. Thoughts are not facts. Normalise the experience of having thoughts.

11.25am  TEA BREAK

11.30am  **Sounds exercise**: Play various sounds and ask group members to share how each sound makes them feel/what each sound reminds them of.

11.45am  **Mindfulness exercise**: 3-minute breathing space (no.6), followed by discussion

11.55am  Checking out. Answer any questions. Run through homework (inc. ‘Habit releaser’ and practising exercises at home). Give out handouts.

12noon  END

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Mindfulness Group 2, Session 5

10.30am  Check in
Recap on last session

10.40am  Discuss ‘Mindfulness To Go’ (‘Habit Releaser’). Did group members manage to try any of the exercises at home? If yes, what was it like? If no, what stopped them? What did people discover about themselves?

10.45am  **Mindfulness exercise**: Walking meditation (no.7), followed by discussion

10.55am  Sound exercise from last week.
11.10am  Topic for today: **FINDING THINGS HARD (“TURNING TOWARDS DIFFICULTIES”)**. Exercise (sharing experiences): Group discussion around things that group members find hard, difficult, or struggle with. Encourage group members to identify what it is about certain situations that is difficult for them and to think about how they feel in these situations.

11.20am  Continue discussion from earlier, focusing now on **sources of support** (e.g. family members, friends, etc.) and things that help us to feel better/help us feel able to cope.

11.35am  TEA BREAK

11.40am  **Mindfulness exercise**: 3-minute breathing space (no.6) followed by discussion

11.50am  Checking out. Answer any questions. Run through homework (inc. ‘Habit releaser’ and practising exercises at home). Give out handouts.

12noon  END

**Mindfulness Group 2, Session 6**

10.30am  Check in
        Recap on last session
        Discuss home practice

10.45am  **Mindfulness exercise**: 3-minute breathing space followed by discussion

10.55am  Topic for today: **EMOTIONS and MEMORIES**. Exercise using the emotion cards. Encourage group discussion and sharing of experiences. Make links between emotions, thoughts and physical sensations. Explore how mindfulness could help in difficult situations.

11.15am  TEA BREAK

11.25am  **Mindfulness exercise**: Exercises based on the befriending mediation

11.45am  **Mindfulness exercise**: 3-minute breathing space followed by discussion

11.55am  Check out. Answer any questions. Run through homework (inc. being kind to self and others and practising exercises at home). Give out handouts.

12noon  END
Mindfulness Group 2, Session 7

10.30am  Check in
         Recap on last session
         Discuss home practice

10.45am  Mindfulness exercise: 3-minute breathing space followed by discussion

10.55am  Recap on previous sessions and topics covered

11.15am  TEA BREAK

11.20am  Discussion: CHANGES

11.40am  Mindfulness exercise: Exercise of group’s choice

11.55am  Check out.

12noon  END

Mindfulness Group 2, Session 8

10.30am  Check in
         Recap on last session
         Agenda for today – the group discussion, mindfulness exercises of group’s choice, befriending exercises, arranging follow-up appointments, saying goodbye

10.45am  Audio recorded group discussion

11.10am  Mindfulness exercises: Exercise(s) chosen by group

11.25am  TEA BREAK (during which, arrange appointments for home visits next week)

11.30am  Mindfulness exercise: Exercises based on the befriending mediation members

11.50am  Check out

12noon  END
Appendix 7: Example Session Plan

**Mindfulness Group 2, Session 2**

10.30am  
Introduce any new members that may have missed the first session. Ask them to add to the group members’ sheet and recap on agreed contract.
Recap on last session

10.40am  
Check in cards

10.50am  
Discuss homework. Did group members try any of the exercises at home? If yes, what was it like? If no, what stopped them? What did people discover about themselves?

10.55am  
**Mindfulness exercise:** Repeat breathing mindfulness exercise (no.1) from session 1, followed by feedback and discussion

11.05am  
Topic for today: **THE BODY.** Group discussion around the purpose of breathing, sensations in the body and how our bodies feel when we experience certain emotions (e.g. stress, fear, worry, etc.)

11.25am  
**TEA BREAK**

11.30am  
Explanation of/discussion around the effect mindfulness can have on our bodies. Engage in exercise in which we tense certain parts of the body (e.g. hand) and let go. Does this tension and release create any kind of pain relief/feeling of relaxation?

11.40am  
**Mindfulness exercise:** Muscle stretching and relaxing exercise, followed by feedback and discussion

11.50am  
Checking out. Answer any questions. Run through homework

12noon  
**END**

**Resources**

- Pre-intervention forms for those not yet completed (inc. Information sheet, consent form, GAS-ID, GDS-ID, FFMQ-ID)
- Marker pens and flip chart paper
- Flip chart paper notes from session 1
- Balloons
- Mirrors
- Stress balls and muscle toning exercise equipment
- Balloon exercise handouts
- Raisin exercise handouts
- Body scan handout
- Fight/flight response hand out
- Tea, coffee, milk, sugar, biscuits
- Teapots, cups, spoons
10.30am **Introduce new members**  
Ask new members to add to the ‘getting to know you’ group members sheet  
Run through agreed ‘agreements’ from last week  
Run through ‘what mindfulness is’ notes from last week

Key points to discuss: “Mindfulness is about paying attention. To be mindful we need to pay attention to whatever we choose to attend to.

Mindfulness is about being in the present moment. The reality of being in the here and now means that we need to be aware of the way things are, as they are now. It is about our own experiences.

Mindfulness is about being non-reactive. Normally when we experience something we automatically react to it without really thinking. Mindfulness encourages us to think before we respond. A reaction is automatic; a response is a deliberate and thought out choice. For example, if someone says something horrible to us, we might react by getting angry. But if we had time to think things through, we might think, “Oh, they’re having a bad day today, they don’t mean it” and leave the situation feeling better than had we just got angry.

Mindfulness is also about being openhearted. By this I mean being open to new experiences. And being kind, caring, warm and welcoming to new experiences. But the best way to explain what Mindfulness is, is to practice it. So we’re going to do a short Mindfulness exercise.”

10.40am **‘Check in’** – introduce idea of checking in at the beginning of each session and checking out at the end of each session.  
Complete check in cards and ask group members to put their initials or name next to corresponding point in the check in thermometer sheet

10.50am **Homework** – did anyone manage to try any of the exercise we did last week at home, such as mindful eating?

10.50am **Repeat Mindfulness ‘balloon’ exercise** from last week.

   e.g. “I would like everyone to sit in their chair, with their feet flat on the floor and their hands resting on their knees. The most important thing is to be sitting comfortably. We’re all going to sit quietly, and I’m going to read out loud to you all. Don’t worry if you feel silly. Just try to go with it. Try to relax. I’ll let you know when we’ve finished.”

Run through following script: “Sit comfortably, with your eyes closed and your back upright.

Notice how your body feels in the chair. Maybe your legs feel heavy. Maybe your arms feel heavy. [pause]"
Bring your attention to your breathing. Notice yourself breathe in, and breathe out. Breathe in, and breathe out. [pause]

Imagine that you have a balloon in your tummy. Every time you breathe in, the balloon gets bigger. Every time you breathe out, the balloon gets smaller.

Bigger and smaller.

Breathe in, and breathe out. [pause]

Notice the feelings in your stomach as the balloon gets bigger and gets smaller.

Bigger and smaller.

Breathe in, and breathe out. [pause]

Your stomach is rising when you breathe in, and falling when you breathe out.

Bigger and smaller.

Breathe in, and breathe out. [pause]

Perhaps there are thoughts coming into your mind, and that’s okay, because that’s just what the mind does. Thoughts come, and then they go. Simply notice those thoughts, then bring your attention back to your breathing. [pause]

Perhaps you are also hearing sounds around you. Perhaps you can hear the ticking of the clock, or the birds outside, and that’s OK. [pause]

You might be able to feel physical feelings in your body and again, that’s OK. Just bring your attention back to your breathing. [pause]

You might be able to feel emotions. Maybe you are feeling, happy, sad, worried or excited. [pause]

Thoughts, sounds, feelings in your body, emotions; they all come and go. Notice them, and let them wash over you. [pause]

You don’t have to follow those thoughts or feelings. Try not to think badly of yourself for having them, or think about what they may mean. It’s okay for the thoughts to be there. Just notice those thoughts, and let them drift on by, bringing your attention back to your breathing. [pause]
Whenever you notice that your attention has drifted off and is becoming caught up in thoughts or feelings, simply note that your attention has drifted, and then gently bring it back to your breathing. [pause]

It's okay and natural for thoughts to come into your mind, and for your attention to follow them. No matter how many times this happens, just keep bringing your attention back to your breathing. [pause]

Breathe in, and breathe out. [pause]

Breathe in, and breathe out. [pause]”

DISCUSSION
Ask questions to tap into the FFMQ domains **observing, describing, acting with awareness, non-judging of inner experience, and non-reactivity to inner experience**. For example,
- How did you find that?
- What was I asking you to do?
- How do you feel now? (emotions and body)
- Why did we do that exercise? / How do you think that exercise might be helpful?

[Space for writing client responses]
11.05am ‘The Body’. Draw outline of a body on flipchart paper. Ask questions like ‘what does your body feel like when you are scared/worried/anxious/stressed?’ Draw responses on the outline of the body.

Ask if people can share what things make them feel this way (e.g. fears like dogs, spiders, etc. or stressful situations like meeting new people, going to new places, etc.)

Use suggestions to facilitate discussion around the **fight or flight response**

Notes to facilitate discussion:

What happens during fight or flight response:
- Heart beats faster (to supply the body with more energy)
- Face looks pale or flushed
- Digestion slows down or stops (so body can concentrate on reacting to the threat)
- Muscles tense (to provide the body with extra speed and strength)
- Pupils dilate (to help see things more clearly)
- Relaxation of bladder
- Auditory exclusion (loss of hearing)
- Tunnel vision (loss of peripheral vision)
- Shaking
- Sweat more (to prevent overheating)

11.25am TEA BREAK

11.30am Practical exercises using stress balls, hand grips, etc. to demonstrate the physical sensation of tensing and relaxing muscles.

11.40am **Mindfulness exercise** – Run through muscles tensing and relaxing exercise, followed by discussion.
DISCUSSION
Ask questions to tap into the FFMQ domains **observing, describing, acting with awareness, non-judging of inner experience**, and **non-reactivity to inner experience**. For example,

- **How did you find that?**
- **What was I asking you to do?**
- **How do you feel now? (emotions and body)**
- **Why did we do that exercise? / How do you think that exercise might be helpful?**

[Space for writing client responses]

11.50am Check out

Home work – to listen to CD (Track 1)

12noon End.
Appendix 8: ‘Mindfulness To Go’ Pack

Mindfulness To Go
Dear [participant name],

Thank you for taking part in the Mindfulness Group.

In this pack we have put together all of the exercises we did. We hope that these will help you to practice the exercises at home. You can also listen to these exercises on the CD that we gave you at the start of the course.

We would like to thank you for taking part in the group and wish you all the best for the future.
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What is Mindfulness? Page 4

The Mindful Thermometer Page 5

The Balloon exercise Page 6

The 3 Minute Breathing Space Page 9

The Body Scan Page 10

Mindful Movement Page 12

The Walking Meditation Page 14

The Raisin Exercise Page 16
Mindfulness is about paying attention. To be mindful we need to pay attention to whatever we choose to attend to.

Mindfulness is about being in the present moment. The reality of being in the here and now means that we need to be aware of the way things are, as they are now. It is about our own experiences.

Mindfulness is about being non-reactive. Normally when we experience something we automatically react to it without really thinking. Mindfulness encourages us to think before we respond. A reaction is automatic; a response is a deliberate and thought out choice. For example, if someone says something hurtful to us, we might react by getting angry. But if we had time to think things through, we might think, “They’re having a bad day today, they don’t mean it” and leave the situation feeling better than had we just felt angry.

Mindfulness is also about being openhearted. This means being open to new experiences and being kind, caring, warm and welcoming to new experiences.

When might we practice Mindfulness?

- When we feel stressed, worried or angry
- Before we feel stressed, worried or angry
- When we want to relax or feel good
It is important to think about how we feel and what is making us feel this way. In the Mindfulness Group we did this at the start and the end of each session by “checking in” and “checking out” using the Mindful Thermometer. You might find it helpful to carry on doing this.

The Mindful Thermometer

5. Very tense and stressed
4. A little bit tense and stressed
3. OK
2. A little bit relaxed
1. Very relaxed
Mindfulness Breathing Exercise

Sit comfortably, with your eyes closed and your back upright.

Notice how your body feels in the chair. Maybe your legs feel heavy. Maybe your arms feel heavy.

...

Bring your attention to your breathing. Notice yourself breathe in, and breathe out. Breathe in, and breathe out.

...

Imagine that you have a balloon in your stomach. Every time you breathe in, the balloon gets bigger. Every time you breathe out, the balloon gets smaller.

Bigger and smaller.

Breathe in, and breathe out.

...

Notice the feelings in your stomach as the balloon gets bigger and smaller.

Bigger and smaller.
Breathe in, and breathe out.

...

Your stomach is rising when you breathe in, and falling when you breathe out.

Bigger and smaller.

Breathe in, and breathe out.

...

...

Perhaps you are noticing thoughts coming into your mind, and that’s okay, because that’s just what the mind does. Thoughts come, and then they go. Simply notice those thoughts, then bring your attention back to your breathing.

...

Perhaps you are also noticing sounds around you. Perhaps you can hear the ticking of the clock, or the birds outside, and that’s OK.

...

You might notice physical feelings in your body, or emotions such as sadness or happiness. Again, that’s OK. Just bring your attention back to your breathing.

...
Thoughts, sounds, physical feelings, emotions; they all come and go. Notice them, and let them wash over you.

...

You don’t have to follow those thoughts or feelings, don’t judge yourself for having them. It’s okay for the thoughts to be there. Just notice those thoughts, and let them drift on by, bringing your attention back to your breathing.

...

Whenever you notice that your attention has drifted off and is becoming caught up in thoughts and feelings, simply note that your attention has drifted, and then gently bring your attention back to your breathing.

...

It’s okay and natural for thoughts to enter into your awareness, and for your attention to follow them. No matter how many times this happens, just keep bringing your attention back to your breathing.

...

Breathe in, and breathe out.

...

Breathe in, and breathe out.
This exercise is called the three minute breathing space. It is a quick way to be mindful and tune into our bodies. The three minute breathing space is made up of three steps.

To start, sit comfortably in your chair with your back upright. Make sure that your feet are resting on the floor and your hands resting on your lap.

**Step 1:** Notice what thoughts are going through your mind. As best you can, be OK with the thoughts that you are having. They are not good or bad; they are just thoughts. Thoughts do not have to mean anything.

Now notice your feelings, or emotions. What are you feeling? Again, try to be OK with these feelings. They are not good or bad; they are just feelings.

Now notice how your body feels. Maybe you notice an uncomfortable feeling in your body, or perhaps your body is feeling relaxed and loose. Again, try to be OK with these feelings. Try not to change them.

**Step 2:** Now, focus on your breath. Imagine the room going black and shining a torch on your mouth so that you can only see your breath moving into your body and moving out again. Notice how your stomach gets bigger as you breathe in and smaller as you breathe out.

**Step 3:** Now, imagine the light from the torch getting bigger and bigger so that it is shining on the whole of your body. Notice your breathing, how you are sat in the chair, the expression on your face. Imagine that the whole of your body is breathing. If there is any discomfort or pain in your body, imagine breathing into this feeling.

When you are ready, slowly open your eyes and bring your attention back to the room.
Find somewhere quiet and comfy to sit. Somewhere where you will not be disturbed. Sit comfortably, with your eyes closed and your back upright.

Notice how your body feels in the chair. Maybe your legs feel heavy. Maybe your arms feel heavy. Notice how your clothes feel on your skin. Notice how your feet press into the ground.

Bring your attention to your breathing. Notice yourself breathe in, and breathe out. Breathe in, and breathe out. Picture the balloon filling with air as you breathe in and emptying of air as you breathe out.

With each out breath, let yourself sink a little deeper into your chair. Let yourself feel a little heavier. Let yourself feel a little more relaxed.

Now, as if your attention were like a torch, shine your attention on your toes and feet. Think about each of your toes. Wriggle them gently. Notice how your socks or shoes feel on your toes. Are they comfy, warm, tingly, or numb? Maybe you can’t feel anything in your toes and in your feet. This is OK. Allow your toes and your feet to be just as they are.

Now, move your attention up your body. Shine the torch on your thighs, knees and lower legs. Notice how your legs feel. Are they heavy or light? Warm or cold? As you breathe in, imagine your breath filling your lungs. As you breathe out, imagine your breath travelling down your legs and leaving your body through the tips of your toes.
In the same way as before, move your attention up your body. This time, shine the torch on your stomach. Notice how your stomach feels. Notice how it changes when you breathe in and when you breathe out. Does your stomach feel comfortable, or does it feel uncomfortable? As you breathe in, imagine your breath filling your lungs. As you breathe out, imagine your breath travelling down to your stomach and then your legs, before leaving your body through the tips of your toes.

In the same way as before, move your attention up your body. This time, shine the torch on your shoulders. Notice how your shoulders feel. Are they tense or relaxed? Do you notice any pain or discomfort? Try to 'let go' of your shoulders. Feel them getting heavier and more relaxed. As you breathe in, imagine breathing into your shoulders. Imagine your breath filling your shoulders. As you breathe out, imagine your breath travelling down through your stomach, your legs and then leaving your body through the tips of your toes.

Now try to think of the whole of your body. The body is made up of lots of parts – toes, feet, legs, stomach and shoulders. All of these parts come together to make you. As you breathe in and breathe out, think about how your body feels as a whole. Think about how it sits in the chair. How it holds you up and keeps you steady.

Continue breathing in and breathing out, noticing how your body feels. Imagine the balloon getting bigger and getting smaller as you breathe in and breathe out.
Find somewhere to stand in the room where you have plenty of space. Stand with your feet hip-width apart and your knees relaxed – perhaps slightly bent. Notice yourself breathe in and then breathe out.

Pay attention to your breath moving into your body – perhaps through your nose – and then leaving your body – perhaps through your mouth.

On your next in breath slowly and mindfully raise your arms out to your sides (so that they are parallel to the floor). Breathe out and, as you breathe in again, slowly raise your arms higher. As your arms move through the air, see if you can be fully aware of what is happening in your muscles as they work to lift your arms.

Continue breathing in and out as you move your arms up higher above your head. Stretch your arms upwards and gently point your fingers towards the sky. Keep your feet firmly planted on the ground. Take some time to think about how your muscles feel stretching like this. Take some time to think about how the rest of your body feels – your joints, bones, feet, legs, stomach, shoulders, arms, hands and fingers.

As you hold this stretch think about what is happening to your breathing. Allow your breath to flow freely in and out of your body. Notice any changes in your breathing. Maybe you are starting to feel uncomfortable, if so, remember not to hurt yourself but to be gentle with your movements.

When you are ready, breathe out and slowly – very slowly – allow your arms to move back down. Lower them slowly and notice how they start to feel different. Perhaps you can notice the fabric of your t-shirt or jumper moving on your skin. Carry on lowering your arms slowly until they are resting at your sides, hanging from your shoulders.
If your eyes have been open, you may want to gently close them at this point. Carry on thinking about your breath, noticing how it moves in and out of your body.

Now, open your eyes and mindfully and slowly stretch one arm up above your head as if you are picking fruit from a tree. The fruit is out of your reach so you need to stretch quite far. Stretch your fingers out towards the fruit. Allow one of your feet to come off the floor so that you can stretch further. Look up to the fruit and the sky beyond your fingers. Notice how this stretch feels in the whole of your body. Now, slowly let go of this stretch. Allow your foot to rest back on the floor. Slowly lower your arm and watch your fingers as you do this. Let your arm rest by the side of you. Notice how your body feels after this stretch.

Now, slowly raise your other hand up towards the sky as we did before. Try to pick that fruit again, stretching to reach it. And again, slowly lower your arm down to rest by the side of your body. Notice how your body feels now after this second stretch.

Now I am going to ask you to put your hands on your hips. As you breathe out, bend your body slightly to the side. As you breathe in, come back to standing up right. Again, as you breathe out, bend your body slightly to the other side. As you breathe in, come back to standing.

Finally, let your arms dangle at your sides. Let them feel limp. As you do this, roll your shoulders forwards, and then backwards. Push your shoulders forwards as far as they will go, and then push them backwards as far as they will go. Do this as smoothly and mindfully as you can.

Now that we have finished the exercises, you might like to shake your body slightly – your legs, your arms; shake out the stretches. Let your body be loose and relaxed.
This exercise is about really noticing what it feels like to walk. That means noticing how your body moves, what is happening around you and what you are thinking. When practicing mindful walking, you might find it helpful to follow these steps:

1. Stand on the spot with your feet firmly on the ground. Relax your legs. Let your arms hang loosely by your sides.

2. Bring your attention to the soles of your feet. Notice how the weight of your body pushes down on your feet. Imagine the weight of your body pushing through the soles of your feet and into the ground. Think about what your body needs to do to keep you standing. Our muscles work together to keep us standing like this, but this is something we don’t usually notice.

3. Lift your left foot very slowly off the floor. Notice how the muscles in your leg feel. Notice how the weight of your body shifts to your other leg. Slowly move your foot through the air and carefully place it on the ground in front of you. Notice how the weight of your body shifts again as your right foot begins to slowly lift off the floor.
4. Continue slowly lifting your right foot off the floor. Notice how the muscles in your leg feel. Notice how the weight of your body shifts to your other leg. Slowly move your foot through the air and carefully place it on the ground in front of you. Notice how the weight of your body shifts again as your left foot begins to slowly lift off the floor.

5. Continue walking in this way, moving slowly across the room.

6. Remember to pay attention to your body. How do the soles of your feet feel when they touch the ground? How do the muscles in your legs feel as they move through the air?

7. Also think about your breathing. Notice as you breathe in and breathe out. How does your breath feel on your lips, or nose?

8. When you reach the other side of the room, stop. Stand for a moment and focus your awareness of just standing here. Slowly turn around, noticing how your body moves to do this. Then, continue walking slowly and mindfully as before.

9. As you walk, you might notice things around you. Your view of the room changes as you walk.

10. When your thoughts wander away from you and you start thinking about other things, gently bring your attention back to the exercise.

11. Remember to take small steps during this exercise. You don’t have to look at your feet—do what is best for you.

You can do this exercise for as long as you want to. You could also try mindful walking outside, perhaps walking at your usual speed but paying extra attention to all the things around you.
The Raisin Exercise

- Pick up a raisin and hold it in the palm of your hand. Look at it. Examine it. Describe the raisin.
- What does it look like?
- What colour is it?
- How would you describe the texture?
- Now, feel the raisin in the palm of your hand. What does it feel like against your skin?
- Pick it up with your other hand. What does it feel like in your fingers?
- Squeeze it softly. What do you feel?
- Smell the raisin. Describe how it smells.
- Put the raisin in your mouth, but do not eat it. What does it feel like on your tongue?
- What does the texture feel like now?
- How does it taste? How does the taste compare to the way it smelled?
- Move it around in your mouth and notice everything about the raisin.
- Bite the raisin and think about what you taste.
- Now how does the raisin feel in your mouth?
- Finish chewing and eat the raisin. How did it taste?
- Describe the experience of the raisin.
Appendix 9: Interview Schedule

Setting up the interview
- Introductions (if necessary)
- Outline purpose and nature of the interview
- State issues around confidentiality
- Explain that there are no right or wrong answers
- State that the interview will be audio recorded
- State that participant can end the interview at anytime
- Clarify consent

Course content
Was there anything about the group you particularly liked?
Was there anything about the group you didn’t like?
What did you learn about:
  - Mindfulness?
  - Feelings and emotions?
  - Yourself?
  - Other people?

Experience of the group
Who was in your group?
  - Did you like them?
  - Did you have any difficulties with them?
What did you think about course facilitators?
  - Did you feel able to talk to them?
  - Did you feel comfortable around them?
Did you miss any of the sessions?
  - If so, why?

Understanding of the group
Have you talked to anyone about the group?
  - If yes, what did you tell them?
- If no, why was this? What stopped you from telling other people?

How would you describe the group to other people?
What do you think was the purpose of the group?
Do you think the group might be helpful for other people?
- If yes, who? And Why?
- If no, why?
Would you recommend the group to other people?
If you had the chance to, would you attend the group again?

Changes
Think back to before you started the group. Can you tell me how you were feeling? What was life like for you then?
When you went to the first session, can you remember how you were feeling or what you were thinking?
How do you feel now that you have been to the group?
Has anything changed?
- Has your mood changed?
- Do you feel more/less stressed/anxious/angry/etc.?
- Have any of your relationships changed?
- Have your parents/friends/carers noticed any changes? What do they say?
Do you practice any of the mindfulness techniques we learnt in the group at home?
- If you do, are they helpful?
- What time of the day might you practice them?
- In what situations do you practice them?
- How are you feeling when you practice them
- If you do not practice them at home, why is this?

The future
What did you think about the future before you started the group?
Do you feel any differently about the future now that you have finished the group?

Questions
Do you have any questions for me?
Appendix 10: Group Discussion Schedule

Setting up the group discussion

• Outline purpose and nature of the group discussion
• State issues around confidentiality
• Explain that there are no right or wrong answers
• State that the group discussion will be audio recorded
• Clarify consent

General discussion

• Would anyone like to share why they came to the group?
• How were you hoping the group would help / what were you hoping to get from the group?
• Tell me about the group in general – what did you like? Not like? Enjoy? Not enjoy?
• What was helpful?
• Have you used any mindfulness at home?
• Was it good to meet in a group? Why?
• Was there anything we could have done differently?

Pass the ‘talking stick’ around:

1. Tell me one way the group has helped you.
2. Tell me one thing you are going to carry on with after the group?
3. Tell me what was the most useful part of the group for you.
4. What would you tell someone else about the group / how would you explain what the group is about to other people?

Questions

Do you have any questions for me?
Appendix 11: Distress Thermometer – Check In

Check In

How are you feeling right now?

1. Very relaxed
2. A little bit relaxed
3. OK
4. A little bit tense and stressed
5. Very tense and stressed

If you are feeling tense and stressed, why do you feel this way?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Appendix 12: Distress Thermometer – Check Out

Check Out

How are you feeling right now?

1. Very relaxed
2. A little bit relaxed
3. OK
4. A little bit tense and stressed
5. Very tense and stressed

What did you enjoy about today?

________________________________________________________________________

________________________________________________________________________

Was there anything you found difficult or did not like?

________________________________________________________________________

________________________________________________________________________
Appendix 13: FFMQ Facilitator Observation Form

Date: ___________________________  Session Number: ______
Participant Name: ___________________________
Form completed by: ___________________________

**Observing** Did the participant seem to understand the concept of observing? Did they demonstrate this understanding through mindfulness practice?

<table>
<thead>
<tr>
<th>No Understanding of concepts</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Full understanding of concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Engagement with practice</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>Full engagement with practice</td>
</tr>
</tbody>
</table>

**Describing** Did the participant seem to understand the concept of describing? Did they demonstrate this understanding through mindfulness practice?

<table>
<thead>
<tr>
<th>No Understanding of concepts</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Full understanding of concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Engagement with practice</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>Full engagement with practice</td>
</tr>
</tbody>
</table>

**Acting with awareness** Did the participant seem to understand the concept of acting with awareness? Did they demonstrate this understanding through mindfulness practice?

<table>
<thead>
<tr>
<th>No Understanding of concepts</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Full understanding of concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Engagement with practice</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>Full engagement with practice</td>
</tr>
</tbody>
</table>

**Non-judging of inner experience** Did the participant seem to understand the concept of non-judging? Did they demonstrate this understanding through mindfulness practice?

<table>
<thead>
<tr>
<th>No Understanding of concepts</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Full understanding of concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Engagement with practice</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>Full engagement with practice</td>
</tr>
</tbody>
</table>

**Non-reactivity to inner experience** Did the participant seem to understand the concept of non-reactivity? Did they demonstrate this understanding through mindfulness practice?

<table>
<thead>
<tr>
<th>No Understanding of concepts</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Full understanding of concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Engagement with practice</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>Full engagement with practice</td>
</tr>
</tbody>
</table>
### Appendix 14: Trialled adaptations to the FFMQ self-report questionnaire

Items from the FFMQ (Baer et al., 2006):  
(Blank)

<table>
<thead>
<tr>
<th></th>
<th>FFMQ</th>
<th>FFMQ-ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>When I’m walking, I deliberately notice the sensations of my body moving.</td>
<td>I notice how my body feels when I move.</td>
</tr>
<tr>
<td>2</td>
<td>I’m good at finding words to describe my feelings.</td>
<td>I’m good at using words to tell people how I feel.</td>
</tr>
<tr>
<td>3</td>
<td>I criticize myself for having irrational or inappropriate emotions.</td>
<td>I feel bad about myself when I have feelings that seem silly or wrong.</td>
</tr>
<tr>
<td>4</td>
<td>I perceive my feelings and emotions without having to react to them.</td>
<td>I don’t have to react to my feelings and emotions.</td>
</tr>
<tr>
<td>5</td>
<td>When I do things, my mind wanders off and I’m easily distracted.</td>
<td>My mind wanders off and I’m easily distracted.</td>
</tr>
<tr>
<td>6</td>
<td>When I take a shower or bath, I stay alert to the sensations of water on my body.</td>
<td>I feel the water on my body when I have a shower or bath.</td>
</tr>
<tr>
<td>7</td>
<td>I can easily put my beliefs, opinions, and expectations into words.</td>
<td>It is easy for me to use words to tell people about myself and the things that are important to me.</td>
</tr>
<tr>
<td>8</td>
<td>I don’t pay attention to what I’m doing because I’m daydreaming, worrying, or otherwise distracted.</td>
<td>I daydream, worry, or get distracted and that makes it hard for me to pay attention to things.</td>
</tr>
<tr>
<td>9</td>
<td>I watch my feelings without getting lost in them.</td>
<td>I don’t get lost in my feelings.</td>
</tr>
<tr>
<td>10</td>
<td>I tell myself I shouldn’t be feeling the way I’m feeling.</td>
<td>I tell myself my feelings are wrong.</td>
</tr>
<tr>
<td>11</td>
<td>I notice how foods and drinks affect my thoughts, bodily sensations, and emotions.</td>
<td>I can see how food and drink change my thoughts and emotions, and the way that my body feels.</td>
</tr>
<tr>
<td>12</td>
<td>It’s hard for me to find the words to describe what I’m thinking.</td>
<td>It’s hard to use words to tell people what I am thinking.</td>
</tr>
<tr>
<td>13</td>
<td>I am easily distracted.</td>
<td>I mind wonders off a lot.</td>
</tr>
<tr>
<td>14</td>
<td>I believe some of my thoughts are</td>
<td>Some of my thoughts are strange or bad. I don’t think I should have these thoughts.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>abnormal or bad and I shouldn’t think that way.</td>
<td>I notice things like the sun on my face and the wind in my hair.</td>
<td></td>
</tr>
<tr>
<td>15. I pay attention to sensations, such as the wind in my hair or sun on my face.</td>
<td>I notice things like the sun on my face and the wind in my hair.</td>
<td></td>
</tr>
<tr>
<td>16. I have trouble thinking of the right words to express how I feel about things.</td>
<td>I find it hard finding the right words to tell people how I feel about things.</td>
<td></td>
</tr>
<tr>
<td>17. I make judgments about whether my thoughts are good or bad.</td>
<td>I decide if my thoughts are either good or bad.</td>
<td></td>
</tr>
<tr>
<td>18. I find it difficult to stay focused on what’s happening in the present.</td>
<td>I find it hard to think about what is happening right now and nothing else.</td>
<td></td>
</tr>
<tr>
<td>19. When I have distressing thoughts or images, I “step back” and am aware of the thought or image without getting taken over by it.</td>
<td>When I have upsetting thoughts, I can “stop” before the thoughts take over.</td>
<td></td>
</tr>
<tr>
<td>20. I pay attention to sounds, such as clocks ticking, birds chirping, or cars passing.</td>
<td>I notice sounds around me, like clocks ticking, birds singing, and cars driving by.</td>
<td></td>
</tr>
<tr>
<td>21. In difficult situations, I can pause without immediately reacting.</td>
<td>I can “stop” before doing something when I feel stressed, angry or annoyed.</td>
<td></td>
</tr>
<tr>
<td>22. When I have a sensation in my body, it’s difficult for me to describe it because I can’t find the right words.</td>
<td>I find it hard to use words to tell people how my body feels.</td>
<td></td>
</tr>
<tr>
<td>23. It seems I am “running on automatic” without much awareness of what I’m doing.</td>
<td>Sometimes it’s like I’m “running on automatic”.</td>
<td></td>
</tr>
<tr>
<td>24. When I have distressing thoughts or images, I feel calm soon after.</td>
<td>I can calm down quickly after I get upset.</td>
<td></td>
</tr>
<tr>
<td>25. I tell myself that I shouldn’t be thinking the way I’m thinking.</td>
<td>I tell myself not to think the way that I do.</td>
<td></td>
</tr>
<tr>
<td>27. Even when I’m feeling terribly upset, I can find a way to put it into words.</td>
<td>I can use words to tell people how I feel, even when I am really upset.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>28. I rush through activities without being really attentive to them.</td>
<td>I rush things and don’t pay attention.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>29. When I have distressing thoughts or images I am able just to notice them without reacting.</td>
<td>I notice my upsetting thoughts without reacting to them.</td>
</tr>
<tr>
<td></td>
<td>30. I think some of my emotions are bad or inappropriate and I shouldn’t feel them.</td>
<td>Some of my feelings are bad or wrong. I don’t think I should feel them.</td>
</tr>
<tr>
<td></td>
<td>31. I notice visual elements in art or nature, such as colors, shapes, textures, or patterns of light and shadow.</td>
<td>When I look at art I see lots of detail, like colours, shapes and patterns.</td>
</tr>
<tr>
<td></td>
<td>32. My natural tendency is to put my experiences into words.</td>
<td>I usually talk to people about the things that I have experienced.</td>
</tr>
<tr>
<td></td>
<td>33. When I have distressing thoughts or images, I just notice them and let them go.</td>
<td>I notice upsetting thoughts and let them go.</td>
</tr>
<tr>
<td></td>
<td>34. I do jobs or tasks automatically without being aware of what I’m doing.</td>
<td>I do things without noticing what I’m doing.</td>
</tr>
<tr>
<td></td>
<td>35. When I have distressing thoughts or images, I judge myself as good or bad, depending what the thought/image is about.</td>
<td>When I have upsetting thoughts, I think I must be either good or bad.</td>
</tr>
<tr>
<td></td>
<td>36. I pay attention to how my emotions affect my thoughts and behavior.</td>
<td>I notice how my feelings change my thoughts and the things that I do.</td>
</tr>
<tr>
<td></td>
<td>37. I can usually describe how I feel at the moment in considerable detail.</td>
<td>I can tell people how I am feeling right now.</td>
</tr>
<tr>
<td></td>
<td>38. I find myself doing things without paying attention.</td>
<td>I do things without thinking what I am doing.</td>
</tr>
<tr>
<td></td>
<td>39. I disapprove of myself when I have irrational ideas.</td>
<td>I think badly of myself when I have ideas that seem silly.</td>
</tr>
</tbody>
</table>

Scoring:
1 = never or very rarely true
2 = rarely true
3 = sometimes true
4 = often true
5 = very often or always true
Appendix 15: Facilitator Evaluation Form

**Mindfulness Group**

<table>
<thead>
<tr>
<th>Date:</th>
<th>Session Number:</th>
<th>Group 1 / 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Attended:**

Content:

Observations:

Successes:
Areas of difficulty:

Reflections:

Actions:
Appendix 16: University of Wolverhampton Ethical Approval Confirmation

8 August 2013

To Whom It May Concern

Counselling Doctorate Student:

Supervisors:

Study Title: An Evaluation of a Mindfulness Group Intervention for People with Intellectual Disabilities

This research is sponsored by the Research Institute for Healthcare Science (RIHS) at the University of Wolverhampton. Its scientific soundness was assessed and confirmed and ethical approval has been granted by the School of Applied Sciences Ethics Committee.

Yours faithfully

Deputy Vice-Chancellor (Research & External Engagement)
Appendix 17: Confirmation of NHS Research and Development Approval

10 February 2014

Project Title: an evaluation of a mindfulness group intervention for people with ID
R&D Ref: PAR010813
REC Ref: 13/EM/0443

I am pleased to inform you that the R&D review of the above project is complete, and NHS permission has been granted for the study at Coventry and Warwickshire Partnership NHS Trust. The details of your study have now been entered onto the Trust’s database.

The permission has been granted on the basis described in the application form, protocol and supporting documentation. The documents reviewed were:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>REC Favourable Opinion Letter</td>
<td>-</td>
<td>02/01/2014</td>
</tr>
<tr>
<td>Protocol</td>
<td>V2</td>
<td>24/11/2013</td>
</tr>
<tr>
<td>Participant Information Sheet</td>
<td>V3</td>
<td>09/01/2014</td>
</tr>
<tr>
<td>Consent Form</td>
<td>V2</td>
<td>24/11/2013</td>
</tr>
<tr>
<td>GP Letter</td>
<td>V2</td>
<td>24/11/2013</td>
</tr>
<tr>
<td>5 facet m questionnaire-1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>debrief sheet</td>
<td>V2</td>
<td>24/11/2013</td>
</tr>
<tr>
<td>five facet questionnaire</td>
<td>V2</td>
<td>-</td>
</tr>
<tr>
<td>Glasgow anxiety depression questionnaire</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Glasgow depression questionnaire</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

All research must be managed in accordance with the requirements of the Department of Health’s Research Governance Framework (RGF), to ICH-GCP standards (if applicable) and to NHS Trust policies and procedures. Permission is only granted for the activities agreed by the relevant authorities.

All amendments (including changes to the local research team and status of the project) need to be submitted to the REC and the R&D office in accordance with the guidance in IRAS. Any urgent safety measures required to protect research participants against immediate harm can
be implemented immediately. You should notify the R&D Office within the same time frame as any other regulatory bodies.

It is your responsibility to keep the R&D Office and Sponsor informed of all Serious Adverse Events. All SAEs must be reported within the timeframes detailed within ICH-GCP statutory instruments and EU directives.

In order to ensure that research is carried out to the highest governance standards, the Trust employs the services of an external monitoring organisation to provide assurance. Your study may be randomly selected for audit at any time, and you must co-operate with the auditors. Action may be taken to suspend Trust approval if the research is not run in accordance with RGF or ICH-GCP standards, or following recommendations from the auditors.

You will be sent an annual progress report which must be completed in order to ensure that the information we hold on our database remains up to date, in line with RGF requirements.

I wish you well with your project. Please do not hesitate to contact me should you need any guidance or assistance.

Yours sincerely

Cc:
Appendix 18: National Research Ethics Service (NRES) Confirmation of Conditional Favourable Opinion

Study title: An evaluation of a mindfulness group intervention for people with Intellectual Disabilities (ID)
REC reference: 13/EM/0443
IRAS project ID: 124383

The Research Ethics Committee reviewed the above application at the meeting held on 16 December 2013. Thank you for attending to discuss the application.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager, NRES Committee East Midlands - Nottingham 2, or 0115 8839695.

Ethical opinion

- The chair thanked you for attending.
- The committee asked you if you are conducting interviews at home is there a lone worker policy. You stated there was and this will be followed as you work in a community setting.
- The committee asked you to clarify the process for the interviews and recordings. You explained you will meet with the participant for 2 interviews. One interview will be one week before the mindfulness group session and the other interview will be 4 weeks after the last group session. The interview will be audio recorded. You then stated that you later came up with the idea that you would like to record the group session as well. The committee informed you the possible disadvantage of that is if someone in the group session does not want the group session recorded then you would not be able to record it. You stated you will only record the group session if everyone in the group agreed to it.
- The committee informed you they do not understand mindfulness so could you explain this to them. You explained to the committee mindfulness is paying...
attention to present surroundings, what is happening around the person, what emotions they are feeling and attention to detail.

- The committee asked you to clarify if the groups you are running are already in place or are they setting up new ones. You explained it is a combination as you have done individual groups already, but you will be working alongside a colleague to set up these mindfulness group sessions.
- The committee asked you to clarify the level of learning disability a person may have. You explained this will be varied as some people have more disability than others and you need to ensure they can consent. If their disability affects their ability to consent then they will not be able to take part. The committee asked what will be used to assess consent. You stated this is very much based on clinical judgement, her colleague is a psychologist and you will assess consent together.
- The committee asked you to clarify if you will be conducting the interviews and running the mindfulness group sessions, and asked if there was a potential conflict. You explained the plan is you will conduct the interviews and run the mindfulness group sessions but would consider whether someone else could help, but if you weren't there for the group sessions then this may affect how participants respond. The committee asked you for the name of your supervisor and asked had this been discussed with them. You stated your supervisor is a counselling psychologist and the issue had not been discussed with her.
- The committee asked you if the questionnaires were suitably modified. You explained there was an issue with the original five-facet one but this has now been reworded and reviewed by the supervisor and the speech and language therapy team who agree it has been reworded in a way that reflects the original.
- The committee asked you to clarify the sponsor. You explained it is the University of Wolverhampton. The committee informed you A4 of the IRAS form had not been completed and a Senior Lecturer had signed D2 which needs clarification if they are authorised to sign as the sponsor.
- The committee asked you to clarify why there is a space on the consent form for a parent/carer to sign. You explained you put this there if required as some participants may have a carer or support worker with them. The committee informed you this information is not on the participant information sheet and suggested it be added. You agreed it can be added.
- The committee asked you to clarify the aspects which are part of normal service provision and which are part of the research. You explained you will run the group as part of your professional commitments whilst the research will be the interviews. The committee asked if the NHS managers were supportive of this approach. You confirmed their on-going support.
- The committee asked you to clarify how you will handle the different levels of learning disabilities in the group sessions. You explained you would like a mixed group ensuring the group suits the individuals. There is an element of selection, no-one will be involved if they cannot consent and everyone will be on an equal level with similar issues such as low mood. This will also depend on how many people have been referred to the service and how many people are on the waiting list.
- The committee asked you if you had any questions for the committee. You stated you did not, but commented that you were very nervous about attending.
- The committee thanked you for attending and answering their questions.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

**Ethical review of research sites**
NHS Sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see “Conditions of the favourable opinion” below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

The Participant Information Sheet

1. Add the title of the study
2. Add the details that you will speak with carers after the study to find out if the participant benefited from it.
3. Add the following paragraph to the introductory section: “Mindfulness is about paying attention to what is happening right now. In the group we will practice exercises that help us to relax, feel calm, and worry less about the past or the future. Mindfulness can help us to enjoy life and help us to be kind to ourselves.”
4. Add the university complaints details.

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at [http://www.rdforum.nhs.uk](http://www.rdforum.nhs.uk).

Where a NHS organisation’s role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).
There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact [catherineblewett@nhs.net](mailto:catherineblewett@nhs.net); the HRA does not, however, expect exceptions to be made.

Guidance on where to register is provided within IRAS.

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved at the meeting were:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covering Letter</td>
<td></td>
<td>25 November 2013</td>
</tr>
<tr>
<td>Evidence of insurance or indemnity</td>
<td></td>
<td>19 July 2013</td>
</tr>
<tr>
<td>GP/Consultant Information Sheets</td>
<td>2</td>
<td>24 November 2013</td>
</tr>
<tr>
<td>Investigator CV</td>
<td></td>
<td>15 November 2013</td>
</tr>
<tr>
<td>Letter from Sponsor</td>
<td></td>
<td>08 August 2013</td>
</tr>
<tr>
<td>Other: SSI Form 124383/523219/6/617/191061/284935</td>
<td></td>
<td>15 November 2013</td>
</tr>
<tr>
<td>Other: Participant Debrief</td>
<td>2</td>
<td>24 November 2013</td>
</tr>
<tr>
<td>Other: Proof of Personal Indemnity Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: CV Wendy Nicholls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participant Consent Form</td>
<td>2</td>
<td>24 November 2013</td>
</tr>
<tr>
<td>Participant Information Sheet</td>
<td>2</td>
<td>24 November 2013</td>
</tr>
<tr>
<td>Protocol</td>
<td>2</td>
<td>24 November 2013</td>
</tr>
<tr>
<td>Questionnaire: Glasgow Depression Scale for People with LD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Questionnaire: Glasgow Anxiety Scale for People with LD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Questionnaire: 5 Facet Mindfulness Questionnaire</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Questionnaire: 5 Facet Questionnaire - Proposed Adaptations for an Intellectual Disability Population</td>
<td>2</td>
<td>24 November 2013</td>
</tr>
<tr>
<td>REC application</td>
<td>124383/527636/1/970</td>
<td>15 November 2013</td>
</tr>
</tbody>
</table>

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research
Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

13/EM/0443 Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members’ training days – see details at http://www.hra.nhs.uk/hra-training/

With the Committee’s best wishes for the success of this project.

Yours sincerely

[Email: NRESCommittee.EastMidlands-Nottingham2@nhs.net]

Enclosures:

List of names and professions of members who were present at the meeting and those who submitted written comments “After ethical review – guidance for researchers” [SL-AR2]

Copy to:
Committee Members:

<table>
<thead>
<tr>
<th>Name</th>
<th>Profession</th>
<th>Present</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Martin Hewitt</td>
<td>Consultant Paediatric Oncologist</td>
<td>Yes</td>
<td>Chair</td>
</tr>
<tr>
<td>Ms Gill Bumphrey</td>
<td>Clinical Trials Pharmacist</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Miss Shamim Byrne</td>
<td>Gynaecologist/Obstetrician</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Dr Frances Game</td>
<td>Consultant Physician</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Dr Asam Latif</td>
<td>Research Pharmacist</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Mrs Veronica Lyon</td>
<td>Lay member</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Dr Simon Roe</td>
<td>Consultant Nephrologist</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Dr John Shaw</td>
<td>Lay Member</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Miss Catherine Shenton</td>
<td>Lay Member</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Mrs Sally Ann Smith</td>
<td>Retired Audit Manager</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Ms Margret Vince</td>
<td>Translator</td>
<td>Yes</td>
<td></td>
</tr>
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</table>

Also in attendance:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position (or reason for attending)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wendy Rees</td>
<td>REC Manager</td>
</tr>
</tbody>
</table>
Appendix 1: National Research Ethics Service (NRES) Confirmation of Favourable Opinion

15 January 2014

Study title: An evaluation of a mindfulness group intervention for people with Intellectual Disabilities (ID)
REC reference: 13/EM/0443
IRAS project ID: 124383

Thank you for your letter of 9th January 2014. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 02 January 2014.

Documents received

The documents received were as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covering Letter</td>
<td></td>
<td>09 January 2014</td>
</tr>
<tr>
<td>Participant Information Sheet</td>
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<td>09 January 2014</td>
</tr>
</tbody>
</table>

Approved documents

The final list of approved documentation for the study is therefore as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Covering Letter</td>
<td></td>
<td>25 November 2013</td>
</tr>
<tr>
<td>Covering Letter</td>
<td></td>
<td>09 January 2014</td>
</tr>
<tr>
<td>Evidence of insurance or indemnity</td>
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<td>19 July 2013</td>
</tr>
<tr>
<td>GP/Consultant Information Sheets</td>
<td>2</td>
<td>24 November 2013</td>
</tr>
<tr>
<td>Investigator CV</td>
<td></td>
<td>15 November 2013</td>
</tr>
<tr>
<td>Letter from Sponsor</td>
<td></td>
<td>08 August 2013</td>
</tr>
</tbody>
</table>
You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor’s responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

Please quote this number on all correspondence

13/EM/0443

Yours sincerely

Liza Selway

REC Manager

E-mail:

Copy to: