

**Investigation of the effectiveness of a  
mindfulness intervention with  
vulnerable young people**

**by**

**Anna Abdullahzadeh**

**A thesis submitted to Manchester Metropolitan  
University in fulfilment of the requirements for the  
degree of Doctor of Philosophy**

Department of Psychology, Faculty of Health,  
Psychology and Social Care

**March 2017**

## Acknowledgements

Many people have played a part in this project. Firstly I am grateful to Salford University for introducing me to mindfulness especially to lecturers Tim Duerden and Annette Dunn. Mindfulness proved to be something very useful and I was able to use this very effectively with some of the young people attending CAMHS on an individual basis. I am grateful to all those young people and I hope they continue to use the '*present moment*' to good effect. The difficulties of supply and demand raised the idea of a better method of helping young people. Mindfulness could potentially be a very effective way to help a number of people. Being a research project would also give validity to the process. I am grateful to my CAMHS colleagues who gave me support and encouragement: Sarah, Caroline, Gemma and Kirsty and especially Eric Barker and Debbie Garner. The next step was to find a university with an interest in mindfulness and I am very grateful to MMU and especially to Professor Christine Horrocks who took the trouble to meet with me in the first place and subsequently offered on-going support throughout the process which at times has been difficult. I am grateful to Dr Jo Ashby who has also been very supportive and encouraging. I am grateful to 'Marcia', 'Bethan', 'Jane' and 'Leila', the young people who took part in the pilot group which helped shape what later became the main project. I am also grateful for the help, support and encouragement of colleagues throughout this process: in particular Dr Vasu Balaguru and the Psychology Department, Dr Petra Gwilliam and Psychology students Mary, Candice and Graham who helped out and also to Dr Viji Janarthanan. I am grateful to Vasu for planting the idea to take the project into education when things became problematic. Anne Pye Brown (the Head) was both welcoming and enthusiastic about mindfulness. I should like to thank her and all the staff but particularly 'Christine' and 'Mary' who took part in the group and I hope continue to benefit. I would like to give special thanks to all the young people and their families who took part in the research. Finally I would like to thank the University staff for providing the administrative support without which this could not have gone ahead.

## **Abstract**

Mindfulness is an ancient Buddhist tradition which has found a place in the West especially as a therapeutic intervention. The evidence base continues to expand but most of the previous work has been undertaken with adults, with relatively limited research involving children and young people.

The study was conceived, devised and designed within a CAMHS setting and therefore much attention has been paid to this aspect. However circumstances necessitated change and the main mindfulness sessions were finally delivered in a special educational establishment. The young participants were vulnerable young people who were essentially similar to the clinical population for which it was initially envisaged. As such the study has some similarity to the mindfulness in schools programme but with a different population.

The aim was to deliver a mindfulness-based intervention to no more than ten vulnerable young people in a group format giving consideration to how this might impact on them.

The research was approached from a relativist social constructionist stance but was essentially one of mixed methods. The study was to be evaluated in a number of different ways. These were a focus group held with the young people, individual interviews with their parents and outcome measures delivered in the form of self-report questionnaires (mainly those in regular use in Child Mental Health). These questionnaires were completed before and after the sessions in a single case evaluation method. The pilot group was held within CAMHS and contributed to the format of the main group where eight sessions of mindfulness meditation practices and psycho-educational information were delivered to the young people.

The study found that the process was well received by the young people with some favourable results and reports of less overall stress in some of the young people. The position of parents proved to be important in terms of their support and interaction with mindfulness. Those young people whose parents engaged with them in mindfulness did better. Future projects would do well to focus on

more inclusion of parents. The findings also showed that not everybody would benefit and it would seem to be important for participants to opt in to the project.

The eight sessions of intervention were comparatively short considering some other therapeutic interventions. Thus it can be cost effective and not too difficult to deliver providing that clinicians have the implementation skills. There would seem to be potential to develop the method in terms of treatment for future service delivery with vulnerable young people in a number of settings. The study will be of interest to clinicians and others working with vulnerable young people and also may draw the attention of service providers as a potential way to capitalise on a treatment initiative. Additionally it will be of interest to those within education settings, particularly those in special education seeking to promote the emotional health of their students.

# Table of Contents

<b>Acknowledgements</b> .....	<b>ii</b>
<b>Abstract</b> .....	<b>iii</b>
<b>1. Putting mindfulness on the map</b> .....	<b>1</b>
1.1 Overview.....	1
1.2 Exploring Buddhist roots in order to appreciate ‘mindfulness’.....	1
1.3 Core concepts: the ‘Noble Truths’.....	2
1.4 A different view.....	4
1.5 Mindfulness intertwines with Buddhist thought.....	5
1.6 Explanations of mindfulness.....	6
1.7 Freeing ourselves from old habits.....	9
1.8 Mindfulness meditation practice: ‘waking up’ to what is there.....	10
1.9 Developing ‘compassion’ as a necessary aspect of mindfulness.....	11
1.10 ‘Transplanting’ mindfulness.....	13
1.11 Mindfulness: impact on the West.....	13
1.12 Scientific perspectives.....	15
1.13 The medical model.....	18
1.14 Who knows how the brain works?.....	18
1.15 Mirror neurons.....	19
1.16 Mindfulness in therapy.....	20
1.17 Psychological evidence base.....	24
1.18 Neurological evidence base.....	28
1.19 Mindfulness with young people.....	29
1.20 Work that has been done.....	30
1.21 Inclusion of parents.....	33
1.22 Practical tasks.....	33
1.23 Stories and their appeal to many.....	34
1.24 Summing up.....	35
1.25 Research aims.....	37
<b>2. Child mental health</b> .....	<b>39</b>

2.1 Overview .....	39
2.2 Environmental influences impacting on children’s health and well-being	40
2.3 The stress of modern life .....	40
2.4 The inter-woven influences .....	42
2.5 Promoting healthy child rearing.....	44
2.6 Parenting.....	44
2.7 Attachment and parenting style.....	48
2.8 Risk and resilience .....	50
2.9 Safeguarding children’s rights.....	52
2.10 Does every child matter? .....	55
2.11 Educating children to their potential .....	56
2.12 Mindfulness in Schools .....	58
2.13 Mental health services for vulnerable children and young people .....	62
2.14 Brief history of child mental health .....	62
2.15 Current structure of CAMHS .....	65
2.16 Child and Adolescent Mental Health Services (CAMHS) .....	66
2.17 The gaps in service provision.....	69
2.18 Is the problem mental health, behaviour or culture? .....	70
2.19 Can mindfulness help? .....	71

### **3. Towards developing a methodology ..... 73**

3.1 Overview .....	73
3.2 Research framework.....	73
3.3 Understanding ‘reality’? .....	74
3.4 The philosophies .....	75
3.5 Quantitative and qualitative .....	77
3.6 Linking to research aims .....	77
3.7 The research design .....	78
3.8 Justification for the methods .....	79
3.9 Focus groups with young people .....	80
3.10 Interviews with parents.....	80
3.11 Single case evaluation .....	81
3.12 Analysing the qualitative data .....	85

3.13 Thematic approach .....	86
3.14 Thematic analysis .....	88
3.15 Codes and themes .....	89
3.16 Identifying themes .....	90
3.17 Ways to progress coding to themes .....	91
3.18 The quantitative outcome measures used .....	93
3.19 Strengths and Difficulties Questionnaire (SDQ) .....	94
3.20 The Children’s Global Assessment Scale (CGAS).....	97
3.21 The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) .....	99
3.22 Freiburg Mindfulness Inventory (FMI) .....	101
3.23 Summary.....	102

#### **4. Setting the research in a methodical and contextual framework104**

4.1 Overview .....	104
4.2 CAMHS issues.....	104
4.3 Background to CAMHS .....	105
4.4 Supply and demand .....	108
4.5 The idea for the research.....	109
4.6 The CAMHS structure when the research was planned .....	111
4.7 The planning stage for the research .....	114
4.8 The first approach .....	115
4.9 Research with children.....	116
4.10 Consideration of age appropriate research methods .....	117
4.11 Understanding the process .....	117
4.12 Consent.....	118
4.13 The best time to do the research .....	119
4.14 Considering a ‘control group’ .....	120
4.15 The mindfulness context .....	121
4.16 Reviewing Ethics.....	122
4.17 Buddhist foundation - ethical overlaps .....	122
4.18 Wider ethical considerations .....	123
4.19 Do no harm .....	125

4.20	Justifying the research .....	127
4.21	The influence of research protocols .....	128
4.22	The paradox of definitions.....	128
4.23	Pulling the plan together .....	129
4.24	Outline plan of the research protocol .....	129
4.25	Participant selection .....	131
<b>5.</b>	<b>The research continues .....</b>	<b>133</b>
5.1	Overview .....	133
5.2	How hard can it be? .....	133
5.3	The NHS process and the novice researcher .....	133
5.4	The climate within the Trust .....	136
5.5	The structure of the initial project .....	139
5.6	Questionnaires used as outcome measures .....	140
5.7	Modifications .....	140
5.8	Ethics revisited.....	142
5.9	Informed consent .....	142
5.10	Confidentiality .....	143
5.11	Anonymity .....	143
5.12	Codes of conduct, patients' rights and protocols.....	144
5.13	Preparing to redesign.....	145
5.14	Making the best of the situation .....	146
5.15	Pulling together a group.....	148
5.16	The pilot group .....	149
5.17	The 'control group' .....	150
5.18	Conclusions and new pathways.....	150
5.19	New decisions.....	150
5.20	A sideways step .....	152
5.21	Approvals and modifications .....	154
5.22	The new recruitment process.....	155
<b>6.</b>	<b>The research pilot, the new group and the outcomes.....</b>	<b>156</b>
6.1	Overview.....	156



6.2 The pilot group .....	156
6.3 Participant and adult views about the effect of the sessions .....	157
6.4 The control group .....	159
6.5 Outcome measures for the pilot and ‘control’ groups .....	159
6.6 SDQ Outcomes of the ‘pilot group’ .....	161
6.7 SDQ Outcomes of the ‘control group’ .....	162
6.8 HoNOSCA and CGAS .....	164
6.9 The outcomes of the control group .....	165
6.10 The outcomes for the pilot group .....	166
6.11 The new mindfulness group .....	167
6.12 Individual Profiles .....	168
6.13 The plan for delivering the sessions.....	171
6.14 The content of the sessions .....	171
6.25 Questionnaires .....	174
6.26 The Perceived Stress Scale (PSS) .....	174
6.27 The results of the outcome questionnaires .....	175
6.28 Results from the SDQs .....	176
6.38 Incomplete questionnaires .....	181
6.39 Reflections on the outcomes of the ‘new group’ .....	183
6.40 The Children’s Global Assessment Scale (CGAS).....	186
6.41 The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) .....	188
6.42 The Perceived Stress Scale scores .....	189
6.43 Freiburg Mindfulness Inventory (FMI) .....	191
6.44 Summary.....	194

## **7. The focus group and emerging themes ..... 195**

7.1 Overview .....	195
7.2 Correlation and causation .....	195
7.3 The young participants.....	197
7.4 The focus group .....	197
7.5 Transcription .....	199
7.6 Emerging themes.....	200

7.7 The young people's views .....	201
7.8 Expectations .....	202
7.9 Practising Mindfulness .....	204
7.10 Challenges .....	206
7.11 Benefits .....	208
7.12 Education and Mindfulness .....	210
7.13 Environment .....	211
7.14 Future Groups .....	212
7.15 Teacher Interviews .....	213
7.16 Personal evaluation .....	213
7.17 Challenges .....	214
7.18 Continuing practice .....	215
7.19 Mindful eating .....	216
7.20 Student challenges .....	216
7.21 Future group .....	218
7.22 Other points .....	220

## **8. The parents' stories and their perspectives of the research ...224**

8.1 Overview .....	224
8.2 Young people in today's economic and political climate .....	224
8.3 Nature, nurture and attachment dynamics .....	226
8.4 The constituents of good mental health .....	227
8.5 Risk and resilience and other interactions .....	228
8.6 Including parents in mindfulness .....	229
8.7 The parent interviews .....	229
8.8 Katie's parents' interview: exclusion and misunderstanding .....	230
8.9 Matthew's parent interview: supported beginnings .....	236
8.10 Jessica's parent interview: seeking inclusion .....	239
8.11 Jack's Parent Interview: family engagement .....	247
8.12 Emily's parent interview: promoting engagement .....	254
8.13 Rounding up .....	260
8.14 Experiences of mindfulness .....	261
8.15 Continuing practice .....	261

8.16 Benefits .....	261
8.17 Talking to parents .....	262
8.18 Mindfulness in schools.....	263
8.19 School issues.....	263
8.20 Different families' different stories .....	263
<b>9. Cultivating a milieu for mindfulness.....</b>	<b>265</b>
9.1 Overview.....	265
9.2 Approaching conclusion: reviewing the steps .....	265
9.3 Reviewing the research question and objectives .....	266
9.4 Family inter-dependence in developing mindfulness skills.....	268
9.5 Bringing mindfulness into schools.....	271
9.6 Unrealistic expectations? .....	273
9.7 Mindfulness meditation practice.....	276
9.8 Promoting discussion .....	277
9.9 Evaluating mindfulness with questionnaires .....	277
9.10 Considerations for further study.....	279
9.11 Including parents.....	282
9.12 Final thoughts, contribution to knowledge and points for further research.....	283
<b>References .....</b>	<b>286</b>
<b>Appendix 1 .....</b>	<b>328</b>
Introductory Session Plan .....	328
Snow globe .....	329
Session 1 .....	330
Ideas to help you let go of your thoughts .....	334
The Old Mule in the Well.....	343
Session 2 .....	344
Fight or Flight? Video Clip.....	345
Instructions for mindful breathing hand-out.....	346
Session 3 .....	347
Illusions.....	348
The story of the boy under the magic tree .....	352

Session 4 .....	353
The Gruffalo’s Child faces his monster .....	354
Sai and the horse.....	354
Know Your Orange activity .....	355
Eating a raisin Mindfully .....	355
What’s in the box? .....	355
Waves.....	356
Watching different cloud formations.....	357
Session 5 .....	358
Selective Attention Test .....	359
The voice in your head.....	359
Session 6 .....	360
How to make a paper dart.....	361
Session 7 .....	363
The Man who was shot by a poisoned arrow .....	364
The balance between reasonable, wise and emotional .....	364
Session 8 .....	365
The Serenity Prayer .....	366
The Park .....	366
<b>Appendix 2 .....</b>	<b>367</b>
Basic Information Sheet.....	367
Information Sheet - Young Person.....	370
Information Sheet - Parent.....	372
Young person’s consent form .....	374
Parent’s consent form .....	375
Young person’s assent form .....	376
<b>Appendix 3 .....</b>	<b>377</b>
SDQ parent.....	377
SDQ young person .....	379
The Children’s Global Assessment Scale .....	381
The Health of the Nation Outcome Scores for Children and Adolescents...	382

The Perceived Stress Scale.....	383
Interview Schedule - Parents .....	385
Outline Schedule for Focus Group.....	386
Certificate of attendance at the sessions .....	387

## List of Tables and Figures

Table 1 Timescale of the research.....	84
Table 2 FMI scores .....	159
Table 3 Collective outcome scores .....	160
Table 4 SDQ outcomes for the pilot group.....	161
Table 5 SDQ outcomes for the control group.....	163
Table 6 CGAS results .....	165
Table 7 Collective results .....	175
Table 8 Emotional distress scores .....	176
Table 9 SDQ results from mindfulness group .....	177
Table 10 SDQ scores for incomplete questionnaires .....	181
Table 11 CGAS scores .....	187
Table 12 PSS scores .....	190
Table 13 FMI scores .....	192
Figure 1 The referral process.....	113
Figure 2 'Control group' .....	164
Figure 3 'Pilot group' .....	164
Figure 4 HoNOSCA Results.....	187

# 1. Putting mindfulness on the map

## 1.1 Overview

The aim of the research was to investigate whether mindfulness could be a useful intervention to help vulnerable young people manage the challenges in their lives. Thus a view of mindfulness and something of its essence seemed to be a necessary first step. This chapter firstly considers the Buddhist roots of mindfulness and something of its '*psychology*'. Mindfulness is a difficult concept, especially for those who have not experienced it, and thus the somewhat overlapping of concepts and language are then explored referring to the varied literature and the different aspects. The chapter moves on to consider the impact of mindfulness in the West. Mindfulness has both a religious perspective and a scientific one and it is the scientific view that is considered next. Focus is given to a medical viewpoint and something of the workings of the brain before beginning to consider the therapeutic uses and the evidence base. Specific applications of mindfulness are discussed together with their stated benefits to particular populations. Both physical and psychological aspects are discussed. Finally the chapter looks at mindfulness with young people considering work that has been done, ways of making it '*child friendly*' and the inclusion of parents. The chapter sums up considering the potential for work with vulnerable young people and concludes by outlining the specific aims of this research project.

## 1.2 Exploring Buddhist roots in order to appreciate '*mindfulness*'

This section gives some of a flavour of the Buddhist roots of mindfulness. What is presented here can thus only be an overview. However, although mindfulness as it exists in the West is fundamentally not part of any religious belief, we cannot deny its Buddhist roots and its sound ethical values. Indeed these fit well with the medical ethic of 'do no harm'. Barash (2014) suggests that Buddhism itself fits with scientific principles and compares Darwin's evolutionary theories to the Buddhist view of nature. One might describe this as a sort of '*mother nature*' approach – the natural order of things that come and go. Germer (2005:13) claims to have

recognised from reading early Buddhist texts that Buddha was '*essentially a psychologist*'.

### **1.3 Core concepts: the 'Noble Truths'**

Teasdale and Chaskalson (2013) provide two interesting chapters on the four Noble Truths of the Buddhist concept. It is interesting that they explain that these '*truths*' are presented as guides to be explored, tested and checked out within individual experience. This is in contrast to many religions. When one considers what these '*truths*' are, there is a certain resonance with what we might have postulated that '*Noble Truths*' might be – at least with the first two. Firstly, there is suffering or *dukkha* (which is the original Pali word) in the world. Gunaratana (2002:145) translates *dukkha* as 'unsatisfactoriness'. He is himself a Buddhist Monk and has written about mindfulness. His 2002 publication is titled 'Mindfulness: in plain English'. This is indeed the style in which the book is written making it more accessible to non-Buddhists who might otherwise struggle with some of the terminology. Tanaka (1994:161) refers to *dukkha* as 'a bumpy road'. Maex (2013) speaks of *dukkha* as the first '*Noble Truth*' and uses the word suffering but clarifies that it does not mean that all is suffering. It is more of an observation of a '*generic*' reality which is not specifically linked to any particular condition or disease. Teasdale and Chaskalson (2013:90) say that *dukkha* covers a wide range of experience – from '*intense anguish*' to the '*subtlest sense of the word*' – such as weariness or unease. Thus the challenges and difficulties faced by people in their daily lives could be thought of as experiencing *dukkha* and thus potentially may benefit from a mindfulness intervention. In this context it is important to acknowledge that in the field of mental health not everything will go in the desired way. This is a step forward in overcoming obstacles. Life is not all pleasant experiences. The English word '*suffering*' apparently is insufficient to fully explain the term (Gilbert & Choden 2013).

The second noble truth is that there is a reason for *dukkha*. Teasdale and Chaskalson (2013) name this reason '*tanha*' another Pali word which is often used as there is no suitable English equivalent. It has the notion of unquenchable thirst, a craving or attachment. This point emphasises the more negative aspects of humans in their strivings for possessions – the greed aspects and the failure to

develop compassion. However it is not so much the experience that is the problem than it is our relationship to it. Teasdale gives an example of this (Teasdale and Chaskalson 2013:95). He was working on a lecture about the second '*Noble Truth*' and had been thinking about this a lot. He found himself awake in the early hours of the morning and became annoyed that he was awake and tried to get rid of this unwanted wakefulness. He realized that the problem was his need not to be awake rather than the wakefulness itself. On reaching this conclusion he soon dropped off to sleep again. The third '*Truth*' is that this '*suffering*' can end – when one is able to be less materialistic the ability to develop higher qualities comes forth. This involves developing a different mind-set. Steve Taylor (2010) gives some good examples of how different cultures develop different mindsets over different time periods. Imagine a nomadic American Indian way of life. There would be no need for striving to obtain possessions – no territorial ownership. Their needs would be to have the ability to move from place to place carrying their few possessions with them. Co-operation with others would be the norm rather than competition. Seeing things from the Indian's perspective might make us realize just how much time and effort most Westerners put into acquisition. Mindfulness helps us develop the ability to see things as they are without building on them – dwelling on the past or living for the future. If we can accept the moment as it is this helps with our acceptance of whatever difficulties we face and gives us more clarity to think things through. Learning to be comfortable in our own skin. Thus cultivating mindfulness helps us realise the third '*Truth*'. The fourth '*Truth*' describes a path from which to escape *dukkha* and is about further developing qualities of mindfulness. As Teasdale and Chaskalson (2013:119) explain, seeing experiences as independently existing objects rather than unfolding processes, and identifying with experiences as though they are personal ('*why me?*') rather than impersonal phenomena that arise as a function of certain conditions, only adds to the suffering. Possibly the latter two '*Truths*' require more of what might be termed '*faith*' than is perhaps common in the average person in Western culture as the concepts are somewhat different. Although a certain amount of '*faith*' might be needed to engage with mindfulness this would translate better as '*confidence*'. If one does not accept that there can be an end to the '*suffering*' one is not likely to embark on a path to achieve this. One has to have some



'*confidence*' that things will work. In Western society we are more used to having concepts backed by evidence. While we can easily accept that there is '*suffering*' (for want of a better word) in the world and there are some reasons for this it is perhaps a step too far to be sure that such suffering can be overcome. Accepting that there is a way to do this would seem to be a further step. Gunaratana (2009) makes the point that all religion depends on some kind of faith – which in effect is nothing more than provisionally accepting something without its yet having been verified for oneself.

#### **1.4 A different view**

Olendzki (2013:55, in his work entitled '*The construction of mindfulness*', presents a different approach from those already mentioned. He discusses '*wholesome*' and '*unwholesome*' states of mind and the different processing levels. Emotions such as compassion and patience would be considered '*wholesome*' whilst emotions such as anger and hate would presumably be considered '*unwholesome*'. Thus more positive emotions are considered with more negative ones. He identifies six types of consciousness corresponding to the five sense organs (ear, eye, nose, tongue and body) with the sixth being the mind. Experiences are episodes of cognition within one of the six, occurring again and again in a temporal series which is referred to as the '*streams of consciousness*' (p.57). He emphasises the constant movement and the impermanence of things. The idea is that in meditation experience will be brief glimpses towards the desired outcome of developing wisdom. Gilbert and Choden (2013) explain that wisdom is neither mysterious nor mystical. It is simply knowledge plus experience which thus gives rise to insight. Over time mindfulness practice develops wisdom.

Gunaratana (2002:33) explains that the Pali word for mindfulness is *Vipassana bhavana* often referred to just as *Vipassana*. *Vipassana* is composed of the word for '*perceiving*' together with a prefix roughly meaning '*in a special way*'. *Bhavana* means '*cultivation*'. Thus Vipassana means looking into something with clarity '*to perceive the most fundamental reality of that thing*'. The emphasis is on different feelings – different states of mind - although some may be close to others. It is the nature of the emotion that leads to the different states of mind. Olendzki (2013:60) further suggests that '*any practice*' that encourages relaxation is '*inherently*

*healthy*'. Thus mindfulness (or '*Vipassana*') in so far as it assists to reduce the restlessness of the mind is in itself beneficial. Further benefits of mindfulness practice notwithstanding, this point alone would appear to be worth cultivating. Olendzki (2013:65) also states that it is possible to experience '*purification of the mind stream*' without a detailed understanding of the process. This is about emotions and feelings rather than parts of the brain. An interesting analogy was presented by Cutler (1999). As an American psychiatrist he was tasked to write a book about the views of the Dalai Lama on everyday human problems based on a series of interviews with him. This comparison of Buddhist Eastern culture with Western psychology is illustrated by the following example. The Dalai Lama's approach is akin to '*pulling the arrow out*' whereas modern psychology is more about discovering '*who shot the arrow*'. In this instance the 'arrow' may possibly be low self-esteem as a result of adverse criticism '*shot*' by parents in early years. It seems to be a valid point that in the West our primary concern tends to be directed towards the how and why rather than a more holistic look at what is actually happening now.

### **1.5 Mindfulness intertwines with Buddhist thought**

It is difficult to talk about mindfulness without referring to Buddhist terms and concepts although it is not necessary to be Buddhist to gain the benefits. Kabat-Zinn (1994:3) identifies mindfulness as '*an ancient Buddhist practice*'. Mindfulness as it is known in the West, however, is largely devoid of the Buddhist cultural backdrop where one is a member of a meditating community. Kabat-Zinn (1994) makes the point that it is all the more important to have some '*vision*' about our own personal reasons for meditating as cultural support is mainly lacking. However, starting from the Buddhist tradition there is immediately a problem. Translation of the ideas is not just a matter of language; the concepts do not easily follow. Dunne (2013) writes about two challenges emerging from Buddhist traditions, one being the right terms to interpret mindfulness and also recognising there are different strands of Buddhism which may throw up some contradictions.

The culture is basically different and thus to understand one has not only to encounter a strange word but a different concept. However this is what we might expect after two and a half millennia. The origins of this movement were written in

the ancient languages of Sanskrit or Pali. Mace (2008:7) highlights the Pali word '*appamada*' explaining that it is translated by Thera (1974:180) as '*ever present watchfulness or heedfulness in avoiding ill or doing good*' but as '*non-negligence or absence of madness*' by Gunaratana (2002:145), while in modern texts the word may be translated as mindfulness.

Kabat-Zinn and Williams (2013) consider different perceptions on mindfulness, both from the point of view of Buddhist religion and from a psychological and therapeutic focus (which will be returned to later in the chapter). Fennell and Segal (2013) consider whether in the evolving of mindfulness-based cognitive behaviour therapy (MBCT) anything has been lost from the tradition of cognitive behaviour or the Buddhist tradition. They refer to this as a marriage which has '*so far*' prospered. There is increasing evidence of a meeting of the two traditions. As early as 2003 the Dalai Lama met with scientists at the Massachusetts Institute of Technology to engage in discussion about Buddhism and the Bio-behavioural Sciences as reported in Scientific American Mind (Fields 2006).

## **1.6 Explanations of mindfulness**

Watt (2012:1) describes mindfulness as one of the oldest skills known. She compares it to '*re-discovering the taste of fresh water*'. The quality which mindfulness evokes is something that is always there but often we just do not notice. Being so busy with our hectic lives we fail to notice what is actually there – almost as if we are 'sleep walking' (Watt 2012:9). To explain mindfulness adequately one needs to have some experience of it. Although explaining mindfulness is not the same as practising mindfulness, by practising one begins to better appreciate what it is. Being mindful increases engagement with the present moment and allows for a clearer understanding of how thoughts and emotions can impact on our health and quality of life. Siegel (2007) presents a useful acronym COAL - curiosity, openness, acceptance with love - to identify what mindfulness is. This is the mindset that mindfulness develops. One is merely curious about things that are happening, not getting overly involved and open to what comes; being open to what is there without trying to avoid unpleasant thoughts – if that is what arises - not seeking out positive experiences. An accepting and loving attitude is

required in an attempt to avoid making judgements about things. This is the mindset that is cultivated and develops through meditation practice.

It is maintained that being mindful can help people feel calmer and more fully alive (Mace 2008). One is neither '*trapped*' in the past or the future but more aware of the present and in a position to make better decisions uncluttered by emotional baggage. Hasson (2013) states that mindfulness keeps you grounded and centred – you feel less pressured by what is going on around you. Hanh (2012) comments that there is little point sitting in a peaceful forest when one's mind is in the city. The concept is that one merely is – living in the moment and fully experiencing whatever is happening without bias. As Williams and Penman (2014:78) phrase it '*awakening to the ordinary moments of living*'.

From the point of view of someone who has never tried mindfulness before the challenge may seem difficult. It is something that we usually don't do unless we deliberately stop and try to cultivate this frame of mind. As Williams and Penman (2011:1) put it, we are usually '*chasing our tail*': so busy with what we have to do and things that we ought to do and even things that we did or should not have done that there appears to be little room for this '*breathing space*'. Wenk (2013) blames evolution for our difficulty in being able to '*switch off*' this '*thought chatter*' (as Taylor 2010 calls it). Wenk (2013) explains that our brains like stimulation and when there is not enough stimulation our minds go into '*default mode*' or as Wenk calls it '*daydreaming*'. The tendency to do this is what makes it difficult to meditate. Shapiro & Shapiro (2011) list a number of points which people have said makes it difficult for them to meditate. These include not having enough time, minds wandering or finding it uncomfortable to sit for long. However there are things that do make it easier. One important thing is to be committed to try and also to accept whatever is: your mind will wander – just gently bring it back. If it is always '*too noisy*' then accept the noise but don't '*go with it*'.

Davis and Thompson (2015:46) define mindfulness as 'the ability of the mind to hold its object and not float away from it'. It increases the capacity to live in the present moment allowing for a better understanding of the impact of our emotions. Kabat-Zinn (1994:4) defines mindfulness as '*paying attention in a particular way,*

*on purpose, in the present moment, and non-judgementally*'. This is perhaps the most quoted definition of mindfulness. The main difficulty is that mindfulness is something which needs to be experienced – it is not something that you can give to someone. Gunaratana (2002) also states that mindfulness requires regular effort and practice. Hasson (2013:6) points out that mindfulness *'isn't about getting anywhere'* but a matter of *'knowing you're already there'*. People have to experience it for themselves. In this way it may be easier to describe what *'mindlessness'* is. Being mindless is the opposite of being mindful where one is aware minute by minute. We have all been mindless – being too occupied with what has happened in the past or may happen in the future. We are so preoccupied with these thoughts, *'thought chatter'* as Taylor (2010) terms it, that we may drive to our destination without realising how we got there. Hasson (2013) gives examples of how we can get so caught up in our thoughts and feelings that we go on *'auto pilot'* not even realising what is happening right now. Mindfulness is about the present – the now. Being aware of what is happening within and around us without judging it or criticising ourselves or anyone else for what is actually there. Teasdale and Chaskalson (2013) describe mindfulness as maintaining a focus of attention on the body and the breath, recognising when the mind has drifted off and gently guiding it back to refocus on the task.

Again this may sound easy but can be incredibly difficult. It is really a different mode of being which takes willingness (or faith for want of a better word) to try it out and stick with it long enough to see some benefit. Siegel (2010:125) makes a useful analogy. He describes *'day vision'* when our eyes *'will be adjusted to large amounts of photons bombarding them'* and contrast this with *'night vision'* where you permit,

*'a shift in perception as you relax your intense focus and let the patterns of subtle light falling upon your retina at the back of your eye take hold.'*

In this way what seemed like a black sky becomes filled with sparkling stars. It is claimed that mindfulness practice is accumulative (Mace 2008, Gunaratana 2009) and thus with practice we can build on this ability.

## 1.7 Freeing ourselves from old habits

Mindfulness creates a space where we can see things as they really are without getting tied up into pre-conceived notions of what should be. We are all influenced by our individual life experiences. Krashen (1981:22) writes of learning a second language through a '*socio-affective filter*' i.e. the perceptions formed about how language '*should*' be spoken. We form value judgements. Some ways of talking are '*right*' and some are '*wrong*'. This is perhaps why adults learning a second language often continue to pronounce it in their '*normal*' ('*right*'?) way of speaking. The same sort of thing occurs as we mature – we learn to make judgements. It is this value base which sometimes blinds our efforts to see what is really there. Thus our '*conditioning*' – our previous patterns of thinking - colours how we view the world. Mace (2008) describes not being able to see the stars clearly because of light pollution. As Siegel says (2010 mentioned above), it is a question of allowing our eyes to re-focus. In other words we need to just be aware of what is there rather than striving to direct our minds. We just notice if we lose focus and bring our minds gently back. Mindfulness attempts to provide us with this '*breathing space*' so that we can see the world as it is without judgement. Siegel (2007) describes the physical reality of the link between mind and body via the anterior cingulate cortex. This organ plays a crucial role in the process of attention and is influenced by mindfulness meditation (Nataraja 2008). Intuition is also a part of this, with a need to attune to others, developing empathy and insight. Other components of mindfulness are to calm fears and pause before any action, all within a moral framework. Stanley (2015:98) states that morality is a prerequisite for meditation. Mindfulness would seek to assist the individual to be in more of an observer role – freeing them from previous conditioning (Hasson 2013, Gilbert and Choden 2013, Saltzman and Goldin 2008).

The value of mindfulness appears to lie in its essence of being - you have to be there. It is an experiential entity somewhat divorced from our left-brain logical language. Sometimes poetry and stories make it clearer than simple explanations ever could. Indeed Shapiro and Carlson (2010) point out that writing about mindfulness in an academic way is '*antithetical*' to the nature of mindfulness as it is essentially experiential. However, accepting mindfulness into Western culture

demands at least some transliteration. As previously explained, the concepts of mindfulness are most often associated with Buddhism; however its phenomenological nature is embedded in most religious and spiritual traditions as well as Western psychological schools of thought. Barash (2014) finds parallels in Buddhism, Western psychology and the natural order of things. This principle of a '*common sense*' approach holds appeal and may be part of the reason for the current interest in mindfulness. Buddhist culture encourages questioning of principles, accepting them only when one knows from one's own experiences that the concept is valid. This contrasts with the view of many religions which require that their subjects follow their doctrines without question. Thus mindfulness in some way appears empowering. Perhaps this aspect contributes towards its current popularity.

### **1.8 Mindfulness meditation practice: 'waking up' to what is there**

Gunaratana (2002) states that we normally tune out 99% of the sensory input we receive - almost as if we are '*sleepwalking*' - focusing on mental objects in a habitual, pre-programmed way. In his subsequent book '*Beyond Mindfulness*' Gunaratana (2009:33) extends his descriptions and clarifications on the Buddhist way of mindful practice. He makes an important point, stating that the experience of meditation is not a competition and there is no '*time table*' pointing out that people make the mistake of trying too hard and that something of a sense of humour is necessary. Stahi and Goldstein (2010) regard their work as a '*playbook*' with a message that we should not take ourselves too seriously. Gunaratana (2002:33) also emphasises another Buddhist tradition that you have to learn things for yourself by your own experience, not by what others say you ought to believe. He states that the benefits of mindfulness are more like '*side effects*' and that the calm that one may seek from it is illusive: '*The irony is that real peace only comes when you stop chasing it*'. Siegel (2010:109) describes mindfulness meditation – what he calls '*Mindsight skills*':

*'Sitting with a straight back, let the sounds around you fill your awareness as you let your body find its natural state. Let your awareness ride the waves of the breath, in and out, as it finds its natural rhythm ... Let the breath go into the background ... noticing whatever*

*arises in your field of consciousness just sit back and take it all in. Whatever sensations, images, feelings or thoughts, whatever outside perceptions, memories, dreams or worries, just let them arise and fall like ripples on a pond'.*

One might imagine that there are those to whom these actions would be extremely difficult. Those, for example, who were unduly concerned (perhaps for good reason) about events surrounding them, would be likely to find this difficult. Mindfulness-based cognitive therapy (MBCT) is recommended for those who have recovered from previous episodes of depression (Segal et al 2002). However this research was aimed at those who, although having some level of difficulty, were not evidently overwhelmed by them.

To practise mindfulness you have to meditate but usually mindfulness is of a shorter duration and does not usually involve long hours in formal meditation. '*Vipassana*' trains the meditator to notice things - '*attentive listening*', '*mindful seeing*' and '*careful testing*' - and this is the type of meditation that is encouraged in mindfulness. It would seem that translation of the concept is difficult thus using the original word is sometimes preferred. Senses are finely tuned and we learn to listen to our own thoughts without being caught up in them. The object is to realise the impermanence of everything, the '*unsatisfactoriness*' and '*selflessness*' of it all. Realising these points will help us to develop, in Buddhist terms, the third '*Noble Truth*' – that there is a way to overcome difficulties. Gunaratana (2002) states that while we may think we are fully aware, in reality often we are not paying enough attention to our lives to even notice that we are not paying attention. Mindfulness slowly helps us to recognise things as they really are. The approach should be to disregard what we may have been taught or told to believe. To disregard theories or prejudices but to experience things for oneself and not to just accept what others have said. Cultivating meditation in this way is called mindfulness.

### **1.9 Developing 'compassion' as a necessary aspect of mindfulness**

Magill (2003:78) states that '*In order to see the truth we need to view ourselves with compassion*'. Thus, an important aspect of compassion would seem to be compassionate to oneself. Gilbert (2013), one of the pioneers of the Compassion



Focused Therapy (CFT) movement, was himself influenced by his interest in Buddhism as well as an interest in attachment theory. His continuing interest in mindfulness is witnessed in his work with Choden (Gilbert and Choden 2013) referenced below. Welford (2012) author of *'The Compassionate Mind'* has a whole section on mindfulness. Clearly there is an overlap of the same basic idea. Ciarrochi et al (2013) identify self-compassion as a combination of experiential acceptance, mindfulness, perspective taking and values. By this they mean recognizing that sometimes you *'beat yourself up'*, recognizing that you are doing this, putting it into some kind of perspective based on the situations of others and *'putting kindness into play'* in your own life. Too often people are very harsh with themselves – too self-critical - and when they learn not to blame themselves too much this helps with their equanimity and becomes part of the healing process. Gilbert and Choden (2013) emphasize the role of compassion as being fundamental to the development of mindfulness. Without a compassionate attitude to oneself one could not easily tolerate any negative thoughts that arose during mindfulness and thus the essential non-judgmental aspect would not develop. However they also point out that modern society makes this a difficult task with its emphasis on the *'drive system'* and the pursuit of material goods. They state that even organisations which seek to be compassionate find difficulty in doing this due to the focus on efficiency. They also cite the number of popular video games which do not engender a compassionate frame of mind but nevertheless engage our youngsters in playing them.

Feldman and Kuyken (2013) cite the role of compassion in MBCT. Although not directly a part of the teaching, nevertheless it becomes something that is learned. Many authors have meditations on loving kindness (Eastoak 1994, Bays 2011, Willard 2010). Kaiser Greenland (2010:66) has an inspirational story called *'the Kind and Gentle Princess'*. Salzberg (2013:177-182) devotes her article to *'mindfulness and loving kindness'*. Thus in mindfulness it is important to first of all be compassionate towards oneself and then extend that capacity towards others. One cannot maintain a *'non-judgmental attitude'* if one is being too hard on oneself. Maex (2013) gives an interesting account of how he discovered that participants who had attended an eight-week mindfulness course had become

kinder to animals. They related such tales of saving spiders which they would have previously just stomped on.

### **1.10 ‘Transplanting’ mindfulness**

Bodhi (2013) makes the point that practitioners of mindfulness in the West are more likely to be dressed in ‘*street clothing*’ rather than ‘*ochre robes*’. He speaks of mindfulness as having been transplanted into a secularised culture. Likewise mindfulness is taught, not necessarily to help people release from the cycle of birth and death (as is the aim in Buddhist culture when people seek enlightenment), but towards alleviating other strains and stresses in life be they psychological, connected with relationships or just everyday stresses. This is somewhat at odds with the spirit of mindfulness which is about acceptance of what is but nevertheless the side effects of mindfulness do assist in alleviating stresses and no doubt this is a large part of its appeal to many. Bodhi (2013) mentions the possibility of ‘*diluting*’ the religious effect but concludes that people should be welcome to make use of mindfulness in a spirit of generosity and sharing. Gunaratana (2002) explains that meditation is a word and words can be used in different ways by different speakers. He also points out that there are overlapping traditions in the Judeo-Christian and Islamic faiths by way of the traditions of prayer and contemplation. These result in a sense of peace and wellbeing – a deep calm and a physiological slowing down. However Buddhist meditation introduces the further element of awareness. Gunaratana (2002), states that this is an aim that all the various Buddhist traditions strive to develop. He describes various ways in which this may be achieved depending on the particular Buddhist tradition being followed.

### **1.11 Mindfulness: impact on the West**

A few years ago not many people had heard of mindfulness and yet today it is gaining increasing attention from many perspectives with the literature on mindfulness growing alongside the interest which it has created. Black (2014) charts the number of publications from 1982. In 1982 and in 1983 he notes one publication for each year but thereafter a steady growth until by 2011 there were 397 and in 2012 477 publications. Looking at the volume of publications that has

emerged reflects the growing interest which has developed. There would seem to be two often overlapping underpinnings to mindfulness. One is from the perspective of Buddhist culture (Hahn 1988, 1991, 2012, Gunaratana 2002, 2009) which has been discussed above and the other from Western scientific enquiry, specifically looking at psychology and particularly at alleviating stress (Kabat-Zinn 1990, 1994, 2009, 2013, Williams et al 2007, Williams and Penman 2014, Shapiro and Carlson 2010). However, before considering the scientific aspects a brief reflection is given to the similarities in the general aims of both viewpoints. Science would seek to alleviate distress while the Buddhist philosophy seeks enlightenment. The main interest in mindfulness that has arisen in the West would seem to be due to its potential ability to help with stress as well as other emotional or physical difficulties.

Considering the similar concepts found in mindfulness and also in many therapies may be part of the reason for the current interest in mindfulness. In some way it echoes what has previously found to be therapeutic. For example one aspect of mindfulness is that it emphasises the point of '*distancing oneself*' – giving things space. This is also a common theme in many therapeutic disciplines, for example allowing the client to go at their own pace (Biestek 1957). Saltzman and Goldin (2008) illustrate this concept as not '*marching*' with the parade. It is as if one is an observer, watching the parade as it were, rather than getting caught up with thoughts and marching with them. Killingsworth and Gilbert (2010:932) state that a '*wandering mind is an unhappy mind*'. Bateson (1979) introduced the concept of '*externalisation*', that is thinking of a problem as being outside of oneself e.g. 'anger is the problem' not 'I have a problem with anger'. Levels of communication were all important including communication which could be regarded as '*unhealthy*' or gave a '*double message*'; such things as non-verbal body language giving a different message to what was being said. All contribute to influence individuals. Karl Tomm (1989) developed this idea further in narrative therapy allowing for different perspectives. For example talking to a young person while the father '*eavesdropped*' on the conversation provided a space for the father to be allowed a different perspective, one in which he was not required to respond to what his son was saying. All this resonates with the non-judgemental stance of

mindfulness, just noticing but not being carried away with ideas and developing compassion. Narrative therapies seek to reconstruct a different (often more positive) narrative. For example Zimmerman and Beaudoin (2002) relate a retelling of the '*life story*' of a boy who was previously less well regarded promoting a better outcome for him. Narrative therapies add emphasis on meaning and language as '*a vehicle*' to create perspectives within family scripts (Dallos 2007). For example in a family where it seemed that discussions were devoid of feelings merely commenting on this could open up a new channel for the family to acknowledge these possibly painful feelings. Mindfulness allows another perspective – away from the normal chatter of our thought processes. People fall into ways of being which may lead to the creation of problems. It is this '*conditioning*' which steers the individual in particular directions. Some cultures may judge certain behaviours as acceptable while others are not. Gilbert and Choden (2013) explain that how others relate to us can have a major impact on how we relate to ourselves; people from '*difficult*' backgrounds would usually find it much harder to like themselves (Gilbert 2013). Andersen (1987) used a reflecting team approach in which a team of professionals observed a family interview and reflected on it. White (1995) describes the '*outsider witness*' position. All of these present a different focus allowing for a different depth of perception which creates scope for the '*breathing space*' required to grasp what is happening in a different way and therefore create a space to move forward. Aspects of this are what others have advocated for some time. Omar (2004:37) advises not to respond in the moment but to '*strike when the iron is cold*'; thereby giving some space for reflection.

### **1.12 Scientific perspectives**

A scientific evidence base for mindfulness continues to develop. Brain scans have been undertaken on experienced meditators as well as scans on those who are relatively new to the method. It has been established that mindfulness practice brings about changes in the brain (Davidson 2004). Siegel (1999) gives a very clear example of how the brain tends to follow routes that have already been established. Repeated activation of a particular neural network engrains patterns of neural firing. He gives an analogy of a grassy field with a pond at the bottom. A

person wanting to get to the pond would make a path through the vegetation. They would be likely to take the same route back up. The next person seeing this '*path*' would tend to follow it. Others would observe an area that was more trodden down and thus the path would become established. Hebb's axiom (1949) states '*what fires together wires together*' meaning that neurons which are repeatedly activated together tend to become embedded in a sequential pattern. Repeated exposure to similar stimuli re-enforces the patterns. This goes some way to account for the '*conditioning*' process which we are all subject to.

Gilbert and Choden (2013) describe how, by the process of evolution over thousands of years, we are '*left with*' what our brains have become. Rather than being designed for purpose the species has evolved from what was there before. Nature makes use of what is there. Patterns are copied again and again. We share 98-99% of our genes with chimpanzees (Gilbert and Choden 2013). The next time you see a frog look closely at its hands. There would appear to be a pattern that has been copied in the formation of the hands. Thus as Gilbert and Choden (2013) describe it, we have an old brain and a more modern '*smart*' brain which has been added to it. It is our '*smart*' brain which gives rise to such things as imagination, reflection, rumination planning and self-identity which sometimes lead to problems. They identify three emotional systems: the drive system which motivates us to pursue our aims, the threat system - the fight or flight system which becomes so necessary to keep us safe - and the soothing system which comforts us. This is also the model employed in compassion therapy (Gilbert 2013). The soothing system is something we all need to maintain our equilibrium throughout our lives and is especially important when raising a child to be a healthy, well-functioning individual. It is the balance between the three systems that keeps us healthy. However these emotional systems can take over when we don't want them to. Mindfulness and compassion contribute to the soothing system.

Sara Lazar (2013) has used MRI scanners on the brains of people who meditate and those who do not. Her results show an increase in the hippocampus of meditators and a decrease in the size of the amygdala (sometimes called the fear centre). These changes were not observed in non-meditators. Nataraja (2008:32)

explains that a person who is under stress '*is in a state of permanent arousal*', ready for '*fight or flight*'. In such a case the body maintains high levels of the stress hormone cortisol, such is the inter-relationship between the mind and the endocrine system. Stress also affects the amount of another hormone, serotonin, in the brain and '*a happy state is associated with increased serotonin levels*' (Nataraja 2008:34). This is sometimes called the feel-good hormone. Nataraja also explains that meditation (or mindfulness practice) begins with the intention to clear the mind. This intention leads to an increase in activity in the area of the brain in the frontal cortex associated with paying attention. While in this area activity increases, at the same time areas within the frontal cortex surrounding this area decrease in activity. Thus the focused attention filters out any unimportant information and, as attention is drawn to the experience of the '*here and now*', a shift to the right side of the brain is triggered – the region associated with comprehension and emotional inflection. Thus this links in with statements about the difficulty in describing mindfulness. Namely that mindfulness mainly takes place in the non-language processing area of the brain - a sense of feeling it, experiencing it but difficult to explain in words. There is a sort of dissolving of the self/non-self-boundary which is reflected by a decrease in activity in the right parietal lobe. This chain of events leads to activation of structures in the limbic system - the parietal lobes orientation association area and the hippocampus. A decrease in the former results in the activation of the latter which in turn stimulates the amygdala. The hippocampus and the amygdala are responsible for assigning emotional significance to our experiences. The process is complex requiring co-operation between the various parts of the brain. Clearly scientists have studied the process to be able to explain the functioning in this way.

However, Nataraja does qualify her above description by stating that experiences of meditation differ considerably as it is a highly individual and subjective experience. Thus perhaps the most appropriate understandings of the process of mindfulness (or meditation) are the psychological ones which refer to the activation of the soothing system.

### **1.13 The medical model**

The scientific approach to treating illness including emotional difficulties has tended to follow the medical model. Nataraja (2008:35) has described this as *'founded on the tradition of dissecting the human body into its constituent parts and targeting malfunctioning components for treatment'*. Although this can be effective in disease management it fails to address the root cause of the disease. Also, whilst this may be very appropriate for physical conditions, it does not exactly fit for psychiatry (Timimi 2002). Timimi (2009:2) suggests that it is not helpful to *'jump straight to the assessment, diagnosis, treatment approach'* which is advocated by the medical model, and advocates a wider approach to health care. Nataraja (2008:18) further states that the *'Western approach to health care is inherently flawed and incapable of meeting current demand'*. She goes on to discuss the relationship between the body and the mind and the inter-connectedness of this. This is in fact a Buddhist concept. Kabat-Zinn (1994) has termed the worst aspects of this practice (i.e. the *'medical model'*) as *'disease care'*. Eastern approaches to illness are much more holistic taking into account both mind and body. Wade and Halligan (2004), in the British Medical Journal, suggest that the current medical models cannot explain all illness and this would seem to be particularly true of psychiatry. Mindfulness, while not a *'treatment'* in the sense of a medication, presents a different stance. It does help people become calmer and can assist in helping with any number of conditions (Kabat-Zinn et al 1986, Davidson et al 2003, Baer et al 2006, Shapiro et al 2008, Siegel 2010, please see later in this chapter). However, people have to engage with mindfulness and experience it for themselves. Germer et al (2005) in fact say that mindfulness cannot adequately be described as it is mostly experienced. Later we consider the value of mindfulness in this field.

### **1.14 Who knows how the brain works?**

Siegel (2007:23) begins his description of the workings of the brain with an anecdote. He asked a group of eminent psychiatrists *'Who knows how the brain works?'* The answer from one famous doctor was *'None of us do'*. This illustrates just how difficult it is to fully understand the workings of the brain and thus the realisation that what we do know is only partially understood. Thus, he states, we

*'need to be very humble'* in explaining the brain's role in mindfulness. Neural connection is influenced from our very first years of life. Our experiences make an impact. When neurons become active their connections to each other grow. He explains that roughly 100,000,000 neurons on average are linked by 10,000 synaptic connections in the human brain. Nature and nurture play a part in how the brain develops but changes can take place in the brain as a result of experience. Siegel (2007) states that mindfulness is a form of experience that seems to promote *'neural plasticity'*. Davidson (2004) found that with mindfulness meditation the degree of left-brain shift indicated a correlation with the degree of positive immune function. Siegel (2007) also points out that the brain is linked to our evolution. The brain stem, the earliest part of the brain, sometimes called the *'reptilian brain'*, carries out basic processes such as regulating the heart and respiration systems. With the evolution of mammals the limbic brain developed. This is concerned with attachment, memory, finding meaning in things and emotions. An important part of this system is the hypothalamus, the *'master hormone regulator'* and thus the endocrine connection with the brain's influence on the immune system and the interconnection between the brain and the body. This region, together with the brain stem and the sub-cortical areas, influence the drives in our lives. The cortex (the outer part of the brain) allows for more complex processing of stimuli. In this region there are many lobes carrying out different functions – for example seeing and hearing. Essentially it is a region composed of grey and white matter arranged in layers with many folds. The areas are connected to each other and it is this linkage that has developed our cortical capacity. The frontal lobes, which are more developed in primates, become more complex with social living.

### **1.15 Mirror neurons**

The cortex is also the region where there are *'mirror neurons'* that enable us to take in the emotions of others. An article by Daniel Lametti (2009) describes how certain neurons *'observe'* the actions of others and *'mirror'* them firing in a similar way to the actions being observed. For example if you see someone stub their toe you might wince. Thus it is hypothesised that they constitute a brain system responsible for our ability to understand the actions of others. Siegel (2007)



suggests that these may play an important role in mindfulness awareness. The side and middle regions generally work together as a team. Good neural integration seems to be promoted by secure attachment. Siegel (2007) hypothesises that some preliminary data on mindful awareness suggests that mindfulness may also promote neural integration by way of intrapersonal attunement. Hence the awareness of one's direct experiences creates an opportunity to accept oneself as things are. Suggesting large-scale interconnectivity is at the heart of relational well-being. Co-ordination means that we can monitor and then influence what reactions take place and develop a well-functioning whole. There are somewhat different functions within the left and right hemispheres of the brain. The right is better at seeing context – the whole picture - while the left pays more attention to detail - more of an in-depth analysis. The left side is linguistic, logical and literal while the right is non-verbal, holistic and along with a number of other qualities. Siegel (2007) suggests that the co-ordination between the left and right brain in shaping our overall emotional tone may be an important dimension of how mindfulness awareness alters our effective style. He believes that creativity arises from the integration of both sides of the brain. Integration of both hemispheres helps us make sense of the world. In mindfulness we focus on bodily movement and function. Shifting to this bodily aspect may involve a shift from linguistic processing to the right hemisphere. Lazar et al (2005) identified an increase in thickness in the middle prefrontal and right insular area. Attention to the present moment, as in mindfulness, may be influenced by on-going communication with other activities within our own brain.

### **1.16 Mindfulness in therapy**

Although mindfulness is an inherent human capacity that has been examined introspectively for millennia (at least within the Buddhist culture), scientific interest in mindfulness is now burgeoning in the fields of medicine, psychology, social work and business, as well as other areas (Boone 2014, Hamer 2006, Gelles 2015, Chaskalson 2011, Nghiem 2015 Shapiro and Carlson 2010, Kashdan and Ciarrochi 2013, McCracken 2011 and Dobkin 2015). Thus being more commonly used in the helping professions led to consideration of whether it would be something that would be useful to vulnerable young people. Essentially the

mindfulness-based therapies involve educating people about how to meditate as the practice of doing this leads to the benefits. To recap, mindfulness is a quality of human consciousness characterised by an accepting awareness of and enhanced attention to the constant stream of lived experience. Garland and Fredrickson (2013:30) title their work '*Mindfulness broadens awareness and builds meaning at the attention-emotion interface*'. It is claimed that being mindful increases engagement with the present moment and allows for a clearer understanding of how thoughts and emotions can impact on our health and quality of life. Shapiro and Carlson (2010:36) say that mindfulness teaches us to stop struggling against our experience, and accept what is there. Thus this creates an opportunity to realistically view the present circumstances and respond with '*greater clarity and freedom*' and also '*wisdom*'. Kabat-Zinn (1994) explains 'mindlessness' as what the Buddhists call '*ignorance*' – not being aware. Mindfulness therefore equates to '*wisdom*', that is being aware. Mindfulness is said to require experience over time to cultivate it through meditation practice. Gunaratana (2002:154) emphasises the necessity of patience stating that the '*process cannot be forced and it cannot be rushed. It proceeds at its own pace*'. Hasson (2013:6) states that '*Mindfulness enables you to experience and appreciate your life*' contrasting with the more usual frame of mind in which we rush around '*trying to be somewhere else*'. The concept is that one merely is – living in the moment and fully experiencing it without bias.

Shapiro and Carlson (2010) emphasise knowing the state of your own mind just as it is right now without judging or evaluating it or trying to change it. This is the attitude that is the essence of mindfulness and being able to cultivate this state of mind, over a period of time, brings the benefits. Mace (2008) in his publication '*Mindfulness and Mental Health*' provides a comprehensive view of different aspects of mindfulness and examines other effects which may come from mindfulness. He presents a significant new model of how mindful awareness may positively influence different forms of mental suffering.

Mace (2008) surveys the relationships between mindfulness practice and established forms of psychotherapy. He introduces evaluations of recent clinical work where mindfulness has been used with a wide range of psychological

disorders. These therapies reflect the main mindfulness-based interventions: MBSR, MBCT, acceptance and commitment therapy (ACT) and dialectical behaviour therapy (DBT). He considers the future contribution to positive mental health that mindfulness may make with reference to vulnerability to illness, adaptation and the flourishing of hidden capabilities.

As mentioned above mindfulness-based therapies contain some element of mindfulness practice, however some vary in content. Mindfulness-based therapies involve compassion or '*loving kindness*' – such concepts as not reprimanding yourself if your mind drifts away from the focus you are trying to give it – just notice if it does - accept what is there. Bays (2010:9) describes using mindfulness to heal people's relationship with food. She states '*the mindfulness diet assumes self-love and kindness towards yourself*' and also she devotes space to describing how the food marketing industry promotes '*unhealthy*' foods. Again the theme is to avoid self-critical concepts recognizing that these are unhelpful.

Mindfulness has an established evidence base. MBCT (Segal et al 2002) and MBSR (Kabat-Zinn 1994) are perhaps the most well known methods. These are standardised interventions which have been shown to be effective in helping individuals with various issues (Baer 2006, Hayes et al 2005, Shapiro et al 2008). NICE (2009) recommends the consideration of MBCT for depression. Jon Kabat-Zinn could be regarded as one of the first pioneers to develop the mindfulness tradition in the West with his MBSR programme delivered at the University of Massachusetts Medical School in 1979. This was designed to help people with a wide range of problems, both physical and mental health issues, and it continues to date. This is now one of the four most established mindfulness-based interventions. MBSR is delivered in a group format and involves mindfulness meditation, body scanning and simple yoga postures. The '*body scan*' involves directing one's attention to various parts of the body sequentially and just noticing what feelings and/or thoughts are there. The focus is on becoming aware of just how things actually are without either adding to or detracting from them. MBCT (Segal et al 2002) is an intervention with a proven effectiveness for people who have previously suffered from two periods of depression. Much of the content of MBCT has developed from cognitive behavioural techniques such as the

questioning of automatic thoughts. It is delivered in a manualised programme which lasts over a period of eight weeks but also requires regular '*homework*' and the method includes patients learning to recognise their thoughts without reacting to them, learning about depression and about the impact these can have. It has an element of education recognising that if people understand the process they are more able to deal with low mood. '*Education about depression is essential if people are to deal with it*' (Segal et al 2002:203).

Mindfulness is one aspect of DBT which is an established therapeutic intervention currently in use and also approved by NICE (2009). DBT is particularly useful for those suffering from Borderline Personality Disorder (BPD) (Linehan 1993) but some of the content is also useful for those struggling with difficult emotions. For example McKay, Wood and Brantley's (2007) publication is more of a '*self-help*' manual. DBT includes learning skills of '*distress tolerance*', interpersonal effectiveness and emotional regulation. Thus not only is the focus on developing skills in mindfulness, which in itself holds benefits, but also learning some other important skills. Essentially, social skills may have been previously overlooked by those who develop personality disorder and knowing how, for example, to make a simple request in a way that is more likely to achieve its objective, is a useful skill to acquire for those who would otherwise be ineffective in this aspect of social interaction.

ACT (Hayes et al 2005) is particularly helpful for those suffering from chronic pain conditions. ACT encourages accepting feelings as they are and seeing the self in the context of what is happening rather than part of the thoughts or feelings. Frequently people are tied up with what we might call '*emotional baggage*'. This is likely to be something that they have acquired at some point in life and they have come to believe is reality. Mindfulness, it is claimed, allows one to see beyond this emotional charge to '*dispel the fog*' (Kabat-Zinn 2009). There are often two '*darts of pain*' (Feldman and Kuyken 2013): the first '*dart*' of pain – which is the pain or injury itself and then the second '*dart*' which is the thought overlay which people may place upon it such as '*why do I have this pain?*', '*I was a fool to not look where I was going*', '*why did this happen to me?*' and any number of negative statements which do nothing except to make the misery worse. ACT also

promotes people to realise their goals and values and identify the behaviours which are most likely to achieve these aims. ACT contains aspects of behaviour analysis but focuses on getting people to just notice their thoughts. Noticing thoughts without the emotional involvement is cultivated in mindfulness practice thus one comes to accept that thoughts are not necessarily true and therefore avoid some of the more negative thoughts taking hold. ACT also aims to make the distinction between people's thoughts and their identities and promotes recognition of their values. Steger et al (2013) state the desirable outcomes of ACT are to bring behaviour in line with people's values. They regard mindfulness as a tool to this end.

These are the main mindfulness-based interventions which have an established evidence base. However mindfulness has been found useful in a number of different situations. Baer et al (2006) describe a number of different mindfulness-based treatments with different populations, including older adults, children, work-based interventions, interventions for enhancement of relationships with couples and mindfulness-based approaches to eating disorders.

### **1.17 Psychological evidence base**

Lee et al (2009) integrate their ideas about '*body-mind-and-spirit*' work into what appears to be basically mindfulness practice. They have evaluated their treatment strategies in cases of female breast cancer and with colo-rectal cancer patients. In both studies improvements were noted in the general well-being of the patients.

Koerner and Linehan (2000) reviewed the research to date on Dialectical Behaviour Therapy compared with treatment as usual. The results were mainly positive in that the less desirable behaviour – including para-suicide - diminished. Mind (2014) claim that DBT can help reduce various aspects of negative behaviour. They include intense negative emotions, impulsive behaviour, unstable relationships, feelings of emptiness, mood swings, suicide attempts and self-harming. DBT remains the treatment of choice for BPD (NICE 2009). DBT addresses specific treatment targets in hierarchical order. The first priority is to decrease life-threatening behaviour, then behaviours that interfere with accessing treatment. Next the focus is on behaviours that have a detrimental effect on the

patient's quality of life and lastly the focus comes to be on increasing skills in more positive forms of behaviour. DBT has been perceived as a way to improve services specifically for this patient group. One major advantage is that it can be undertaken on an outpatient basis thus preventing the involuntary hospitalisation of chronically suicidal patients.

ACT has a '*small but growing database of support*' (Forman et al 2007:1). A number of outpatients (101) suffering from moderate to severe levels of anxiety or depression were randomised to CBT or ACT interventions. Although participants in the study in both groups displayed improvement, the mechanisms of action appeared different. Overall the results suggest that ACT is a viable treatment. Hayes et al (2006) consider the models, processes and outcomes in ACT and conclude that, although there have not been enough well-controlled trials to firmly conclude that ACT is generally more effective than more traditional therapy, the data so far seems promising.

Segal et al (2002) have evaluated their mindfulness interventions in situations, focusing their efforts on preventing relapse in recovered patients who were formerly depressed. They claim the results of these appear promising with the studies appropriately conducted and researched. The conducted randomised controlled trails took place over three different centres where the authors were based. They recruited a total of 145 patients who had recovered from two or more previous episodes of depression. Comparing patients who had MBCT with those who had treatment as usual they discovered that those who had three or more previous depressive episodes and had completed MBCT had a relapse rate of 37% compared with the treatment as usual group's 66% relapse rate. However MBCT was not as effective for patients with only two previous episodes. These were indeed heartening results. The practices mentioned above remain the practices which are most prominent and are the most researched. Baer (2006) discusses these most established practices and considers their mainly positive effectiveness.

Segal et al (2002), Lee et al (2009), Semple (2010), Dahl and Lundgren (2006), Roemer et al (2006) all identify positive outcomes. Segal et al (2002) uses MBCT

with people who have had more than one previous episode of depression. Lee et al (2009) have a broader, more eclectic approach. However their programme contains essentially the same focus as mindfulness interventions integrating the mind and the body in the present. They describe a number of treatment populations, for example breast cancer patients, depressive disorders and trauma survivors. Semple (2010:218-229) also uses MBCT but with adaptations for children. Her article is entitled 'promoting mindful attention to enhance social-emotional resiliency in children' which is effectively the aim of her study. Dahl and Lundgren (2006), employ ACT with a population of people who suffer chronic pain. Roemer et al (2006) use a combination of elements of MBCT, ACT and DBT with an adult population suffering from generalised anxiety disorder. In the author's personal clinical experience mindfulness techniques have helped young people coming to a child and adolescent mental health facility. However the evidence base for young people is less than exists for the adult population. Some aspects of the work that has been done with children are covered later in this chapter. Davis and Hayes (2011) have considered the benefits of mindfulness and identify that mindfulness protects against the stressful effect of emotional relationship conflicts. Additionally therapists who themselves practice mindfulness increase their skills in empathy, compassion as well as their actual counselling skills.

Garland and Fredrickson (2013) assert that mindfulness may facilitate access to positive emotions disrupting any negative downward spirals therefore nudging the emotional balance in a more upward direction. Others have considered measures of evaluation in the form of self-report questionnaires. The Freiberg Mindfulness Inventory (FMI) is a 30-point self-report questionnaire which questions the participant's level and experience of mindfulness (Buchheld et al 2001). There is also a shortened version (Walach et al 2006) consisting of 14 questions which may be more suitable for young people. Such questions as '*I am open to the experience of the present moment*' and asking participants to score how true this statement is for them. This is considered to be one of the better options although Mace (2008) considers others - such as the Mindful Attention and Awareness Scale (MAAS Brown & Ryan 2003) and the Kentucky Inventory of Mindfulness

Skills (KIMS Baer et al 2004) which have also been fully validated. However Nataraja (2008) summarises that there are difficulties in studying meditation. It is difficult to assess how strictly participants adhere to the programmes and how committed they are to individual meditation. Nevertheless with the increased focus on mindfulness in recent years research into the benefits of meditation has increased. Resultantly a number of clear health benefits have emerged. Meditation appears to reduce stress, improve the immune system and generally improve the quality of life for people – even those who may be suffering from such conditions as cancer.

Other studies have been undertaken to quantify the effectiveness of mindfulness methods. Lau and Yu (2009) outline a number of recent studies focused on mindfulness-based treatments. These include a description and validation of a trial of the Toronto Mindfulness Scale (TMS) and an investigation of whether mindfulness practice between sessions assists the improvement of symptoms. The Toronto Mindfulness Scale (Lau et al 2006) was designed for use with people suffering specifically from emotional disorders. This is a 10-item scale designed to be completed after each mindfulness session. The questions relate to such things as awareness of internal sensations or thoughts – thus measuring how mindful people were. The scores have been shown to fluctuate from session to session but overall there was a tendency for scores to rise as the mindfulness sessions continued. Shapiro and Carlson (2010) state that there is a growing number of controlled studies which demonstrate that mindfulness meditation increases the ability to direct as well as sustain attention. Miller, Fletcher and Kabat-Zinn (1995) undertook a three-year follow-up of patients who had been suffering from anxiety disorders and who had undergone a mindfulness-based stress reduction course. Of the 22 patients in the study, 20 of them showed a clinically and statistically significant improvement in both subjective and objective symptoms of anxiety.

The following studies have all witnessed some positive results:

- Psychological studies showing that regular meditators are happier and more content (Ivanowski and Malhi 2007, Shapiro et al 2008, Shapiro et al 1998, Siegel 2010)



- Positive emotions link to a longer and healthier life (Fredrickson and Joiner 2002, Fredrickson and Levenson 1998, Tugade and Fredrickson 2004)
- Anxiety, depression and irritability decrease with regular meditation (Baer et al 2006)
- Memory improves, reaction times become faster, mental and physical stamina increase (Jha et al 2007, Tang et al 2007, McCracken and Yang 2008, Ortner 2007, Brefczynski-Lewis et al 2007)
- Better and more fulfilling relationships (Hick and Bien 2008)
- Reduces the key indicators of chronic stress including hypertension (Low et al 2008)
- Reduces the impact of serious conditions such as chronic pain (Kabat-Zinn et al 1986, Morone et al 2008, Grant and Rainville 2009)
- Reduces the impact of serious conditions such as cancer (Specia et al 2000, Lee et al 2009)
- Helps relieve drug and alcohol dependence (Bowen et al 2006)
- Bolsters the immune system and helps fight off colds, flu and other diseases (Davidson et al 2003)

### **1.18 Neurological evidence base**

There exists a body of evidence to suggest that mindfulness can be effective (Mace 2008, Segal et al 2002, and Shapiro and Carlson 2010). There are a number of empirical studies which support a physical evidence base for mindfulness-based interventions. Dunn et al (1999), Davidson et al (2003) and Lazar et al (2005) have all evidenced physical changes in the brain. The brains of regular meditators were compared with those who did not meditate and differences were noted. Interestingly some people with a relatively recent practice in meditation were also found to show some pattern similarity in the same areas of the brain as those of the regular meditators, indicating that it does not necessarily require long years of meditation and some benefits can sometimes materialise

quite quickly. Dunn et al (1999) set out to define differences in three mindsets with electroencephalographic (EEG) technology – relaxation, concentration and mindfulness. The analysis was carried out over alpha, beta, delta and theta wave bands. It showed strong mean amplitude frequency differences over numerous cortical sites in respect of concentration and mindfulness when compared with relaxation. Further significant differences were found between concentration and mindfulness at all bandwidths. This establishes that mindfulness is a different mindset from the other two and they conclude that therefore it is not merely a higher degree of relaxation. Davidson et al (2003) undertook a controlled study of brain activation on people who had undergone an eight-week mindfulness training programme (MBSR). They assessed the brain's electrical activity by computer analysis and identified more activity in the left frontal lobe – an area associated with positive emotions. Thus they concluded MBSR increases left-sided cortical activation and stress reduction correlates with changes in the amygdala. Lazar's (2005) controlled study was anatomical rather than a physiological one in which possible links between the thickness of the brain cortex and meditation was examined. The subjects were mindfulness practitioners. Measurements of cortical thickness were compared with controls who had no previous experience of mindfulness. The brain cortices of meditators were found to be consistently thicker in several areas, namely in the prefrontal cortex, but it was less clear whether these differences were more pronounced in the right or left prefrontal cortex.

### **1.19 Mindfulness with young people**

Although most of the literature relates to adults some literature does specifically relate to young people and some of this seemed particularly relevant to the idea of a mindfulness group intervention. Burke, (2010) considers that mindfulness based work with children is '*in its infancy*'. She suggests that further robust research be undertaken to enhance the empirical evidence. Kaiser-Greenland (2010:206), states that '*Mindful awareness with kids is still uncharted territory*'. Considering the literature regarding children and young people, Coholic (2010:28) states that mindfulness practices are '*just beginning to emerge*'.

## 1.20 Work that has been done

Semple et al (2006) designed their mindfulness-based cognitive therapy for children (MBCT-C) based on the adult programme although modified to be suitable for children. There are clearly important differences between adults and children. As they state *'We found that adults rarely (if ever) use their meditation mats to construct forts'* (Semple et al 2006:143). They emphasise three points that contribute to the sessions being more accessible to children. Repetition enhances learning experience and therefore they began each session with a review and group discussion of the previous week and also a discussion of their home practice. They add that variety increases children's interest and for this reason they introduced several different exercises within each session. Finally they state that most of their exercises require active participation. The sessions are a formalised, highly structured programme which involves a 12-week group practice. A brief outline of the content of the sessions is shown below.

Session 1 – Developing community and orientation to mindfulness

Session 2 – Introduction to mindfulness of the breath exercise

Session 3 – Differentiating thoughts, feelings and body sensations

Session 4 - Mindful hearing

Session 5 - Mindful hearing (continued)

Session 6 - Mindful seeing

Session 7 - Mindful seeing (continued)

Session 8 – Mindful touch

Session 9 – Mindful smell

Session 10 – Mindful taste

Session 11 – Mindfulness in everyday life

Session 12 – Generalising mindfulness

Thus there was a focus on experiencing things and learning to accept without judgement.

Others have also described '*child-friendly*' ways of approaching mindfulness. Saltzman and Goldin's (2008) method is adapted from the adult MBSR but with certain modifications. For example they had a higher ratio of instructors to participants and the environment and exercises were made more child friendly – such as sitting on cushions on the floor, receiving stickers for their weekly attendance and shorter meditations. Their programme runs over eight sessions and contains the themes of that of Semple et al (above) but some different emphasises. It consists of the following themes:

Session 1 - mindfulness practice introduction

Session 2 - formal and informal ways of practising mindfulness meditations

Session 3 – continues to deepen meditations with attention on the body

Session 4 - examines thoughts, feelings and perceptions

Session 5 – examines resistance and how self and others are viewed

Session 6 – enhances skills of observing thoughts and feelings

Session 7 - covers mindfulness during difficult times and begins loving kindness practice

Session 8 – focuses on developing the capacity to send and receive love and looks at the issue of mindfulness in daily life.

Kabat-Zinn's (1994) usual 45-minute practice seemed too long for children to remain quietly seated. For example, Saltzman and Goldin's (2008) '*seaweed practice*', which allows for children's natural tendency to need to move about, and their '*Thought Parade Exercise*', where the children develop their ability to '*watch*' their thoughts go by without joining the parade. Kaiser Greenland (2010) includes '*star fish stretch*' and rocking a teddy to sleep with breathing in her programmes.

Willard (2010:56) refers to his early experience of mindfulness practice as watching clouds with his father and trying to direct their movement. He also gives an interesting and useful section of practices '*for mental clarity and creativity*'. Examples of these are awareness of sound and awareness of contact. He describes a group activity called '*know your orange*'. In this young people are asked if they could tell one orange from another. They then '*get to know*' their orange by examining it very closely before putting it back in the fruit basket. The young people then pick out '*their*' orange from the pile. He also presents stories which illustrate various points – such as '*Sai and the horse*'. This is a story about supposedly '*good luck*' which turns out to be '*bad luck*' and vice versa. The point is not to be quick to prejudge a situation which could well turn out to be other than expected. He also recites a story of a boy under a '*magic tree*' who comes to believe his own fantasies and finally gets '*gobbled up*' by his own monstrous creation.

Young people may be more likely to respond more to practical meditations where they are focused on something in particular. Bays (2011) suggests using the non-dominant hand to do tasks – such as cleaning teeth or brushing hair. The unfamiliarity in using the hand requires that more attention is paid to the task and therefore it is easier to keep the mind specifically on the task. Hooker and Fodor (2008) also emphasise the need to have shorter periods of meditation (suggesting perhaps a five minute period) as well as recognising that although children need clear concrete instruction, they also have greater powers of imagination and creativity whilst still requiring clearer guidance. Goodman and Kaiser-Greenland (2009:425) use the term '*Scram*' which they practice when fear arrives: '*stop and slow down, calmly breathe through the fear and remember fear is just visiting*'. Kaiser-Greenland (2010) gives an example of how she used a snow globe to illustrate how, when allowed to, the mind settles, helping her children focus and calm down. Hanh (1988) describes a similar analogy in the telling of an encounter with a young child. The Monk (Hanh) was charged with looking after the youngster and had prepared some fresh apple juice (made from real apples). The young girl's glass was poured from the bottom of the jug and appeared cloudy. She did not wish to drink it and the apple juice was left for a while on a windowsill while

she went out to play. A while later she returned to find that it had settled and was beautifully clear and now *'delicious'*. Hanh explained to her that this was similar to how the mind settles in meditation.

### **1.21 Inclusion of parents**

Saltzman and Goldin (2008) advocate including parents because of the young people's emotional dependency and need for support and guidance. Mace (2008) notes that it is helpful if parents are also involved as they can then act as co-facilitators in the process. Carmody (2009) discusses the issue of explaining mindfulness to participants. Where parents are also strategic players, explanations to children require some reflection. If parents are fully informed and understand the process they can better assist their children as they too learn the skills. Conversely it may be that the *'child'* has a better grasp of the concepts and can explain these to the adult. Also if parents developed their own practice *'their children would benefit'* (Saltzman and Goldin 2008:158). Singh et al (2010) maintain that mindfulness training for the parents increases compliance in their children. Semple et al (2006:158) record an interesting case example of a boy called *'Nathan'* and his mother who was deeply involved with her son's mindfulness practice.

*'She made sure that Nathan attended every session and accompanied him to and from them. At home she reviewed the contents of his travel folder and allocated time each day to practice the mindfulness exercises with him.'*

Dumas, (2005), MacDonald, (2010) Bögels (2008) and Phelps (2010) all include parents in their programmes. Thus the position of parents remains a significant factor.

### **1.22 Practical tasks**

Mindfulness is about being aware. Several authors have advocated undertaking specific tasks such as doing the washing up mindfully (Hanh 1991, Gunaratana 2002, Hasson 2013). Although this does not seem something that would be of obvious appeal to young people there are plenty of other *'routine'* tasks that can

be done mindfully. Saltzman and Goldin (2008:157) discussed class format with their participants. '*The children suggested more movement and less talk*'. Kaiser-Greenland (2010:55) comments that '*some are better with music, some with art, and some with movement*'. Mindful walking is an activity which involves movement as well as mindful focusing. Combined with observing nature this can also prove to be an interesting '*mindful task*' for young people. Mace (2008) considers ways in which mindfulness might be cultivated and harnessed. He lists some practices under the categories of formal and informal. The formal ones include formal sitting practices and moving practices – such as walking meditation or yoga stretches and there are also formal group practices. These would normally be led and include a guided discussion of the experiences of the group. The informal ones would include mindful activities such as mindful eating, cleaning or drawing for example. These very much reflect the formal moving practices but in this case centre on a daily activity. There are structured exercises where one can direct one's thoughts and disperse them or create a breathing space for oneself. Also included in the informal category are the contemplative practices. Klinger-Lesser (1994:67) illustrates how '*The Bell of Mindfulness*' is a tool that one family use. They ring it to create a moment for mindfulness and then move on in their day.

### **1.23 Stories and their appeal to many**

Much of mindfulness concerns feelings and emotions. This has been linked to poetry and stories. Buddhist tradition uses stories to illustrate various points and this seemed very relevant to young people. Many of the stories relate to learning better ways of coping with the stresses of life. There are also koans – paradoxical sentences which require reflection – for example the '*sound of one hand clapping*'. Stories have a wide appeal and this does not just apply to young people. Civilizations have handed down their history in the form of stories. The tales of Mullah Nasruddin (the so-called '*wise old fool*') have perpetuated in Iran and Turkey and have extended well beyond. Aesop's fables have been around since somewhere around 600 BC conveying moral tales. Muth (2005) retells an old story about two monks who observed a fine lady stranded by a muddy puddle. One of the monks carried her across the puddle. She was rude, gave no thanks at all for

the help that the older monk had given her and yet he set her down safely on dry land. However, his companion, who had been brooding on this for some hours, finally raised it with his master. How rude she was. The monk replied I set her down hours ago. Why are you still carrying her?

Poetry and aesthetic experiences are two aspects which resonate with mindfulness. Mace (2008:116) includes Rumi's poem '*The Guest House*' in his chapter. Basically this is a poem about accepting the '*guests*' (thoughts and feelings) who may arrive treating them with dignity for even the 'difficult' ones may have some positive future purpose. '*He may be clearing you out for some future delight*'. Also in his chapter Mary Oliver's poem '*Wild Geese*' is quoted '*You do not have to be good*', '*You do not have to walk on your knees*' (Mace 2008:117). This illustrates Gunaratana's (2009) ideas about not forcing things and this point is also reflected by Kabat-Zinn (1994). Eastoak (1994) includes many inspirational poems, stories and practical actions in her edited book.

Nataraja's (2008) ideas about left and right brain function with the right being more involved in mindfulness and Siegel's (2007) concepts about the integration of things seem to reflect well with this more '*poetic*' view. In effect we should not seek to overanalyse or divide mindfulness up into too many parts. Doing this we might just miss the whole point of mindfulness. This appeared to reflect the sentiments of Gunaratana (2009) when he advocates that mindfulness is not something that should be forced. One should let it develop naturally at its own pace.

### **1.24 Summing up**

From its Buddhist roots *mindfulness* has encompassed many of the concepts employing them in therapeutic contexts to the benefit of people in the West. Although Buddhists may be seeking '*enlightenment*' we are happy to reap the benefits of calmness, better clarity and positive health benefits. Mindfulness is interwoven with Buddhist ideas but without the need for the religious aspects. It may be difficult to explain mindfulness as it seems to primarily be a right-brain function (Nataraja 2008) but nevertheless benefits are real. We are often restricted by our conditioning and worrying thoughts often swamp our ability to make good choices. As Gunaratana (2002) states most of the sensory input we



should receive is '*tuned out*' by what is going on in our heads. Mindfulness creates a space for us to do this. Compassion, especially self-compassion is an important part of this and has become a therapeutic intervention in its own right (Compassion focussed therapy, Gilbert 2013). Often we are too self-critical which does not assist the healing process. There are similarities between the concepts of mindfulness and various therapeutic interventions and a number of therapies have developed combining mindfulness with other established practices for example MBCT (Segal et al 2002). The main mindfulness-based interventions remain, MBSR (Kabat-Zinn 1994), MBCT, ACT (Hayes et al 2005) and DBT (Linehan 1993). However new aspects and combinations continue to develop. The scientific evidence base for mindfulness has been established both in neurology and psychology.

There are common threads running through the different interventions as well as differences. There is a Buddhist and a scientific perspective but both reflect similarities. MBSR and MBCT both emphasise lengthy meditation whereas the emphasis in DBT and ACT is on shorter and less formal meditation. Some interventions are in a group format whereas others originally developed as individual therapy. DBT has both group and individual aspects. ACT and DBT both include many behaviour change strategies. MBCT and DBT were initially developed to treat a particular disorder whereas ACT and MBSR developed to treat a wide range of problems. As is reflected by the ever growing literature more interventions are developing or being modified from existing ones.

Considering the number of mindfulness-based interventions that have been discussed above, as well as the very positive benefits that appear to result from the practice, it seemed logical to think about a project which would be of benefit to 'vulnerable' young people. Thus some clarification of 'vulnerable' is necessary.

Dogra et al (2009:118) explains that 'vulnerable' young people are considered vulnerable 'because they have certain attributes or have had past or present experiences or are growing up in the face of adversity'. She states that they 'are at increased risk of developing mental health problems'. However it is not always entirely clear what 'vulnerable' involves.

A government research report (Walker & Donaldson 2011) entitled 'Intervening to improve outcomes for vulnerable young people', mentions the word vulnerable 87 times but gives no definition. However, it does state that 'all young people are likely to be vulnerable at some time or other' (p.8). Arora et al's (2015;194) concept of vulnerability is 'the ones who are more exposed to risks than their peers'.

Brown (2015) writes about the use of vulnerability issues as used in welfare and other services. She discusses the understanding of vulnerability based on a survey of the views of 49 interviewees. Of these 15 related vulnerability to 'risk' (the highest number). The next largest groups (all containing five interviewees) reported a range of different understandings: 'lack of support', 'behaviour and activities', 'easily exploited' and 'poor outcomes'. Other views varied. Clearly it becomes difficult to be exact as people may be vulnerable for a range of issues and circumstances both past and present.

'Vulnerable' in this research refers to young people who struggled with the challenges that life presented because they were at some disadvantage. Some may have had mental health issues including such things as being prone to anxiety or perhaps having low self-esteem, as well as other health problems. Some may have suffered from conditions such as ADHD or Autistic Spectrum Disorders (ASD) or have some form of learning difficulty or adverse life circumstances. The main point being that they were not starting from an even playing field. This project sought to develop better resilience in those young people who were already at some disadvantage and were in some way vulnerable.

The development of a '*child friendly*' programme included consideration of the points identified above as well as some of the work that has been done with young people.

### **1.25 Research aims**

Thus considering mindfulness and the extensive literature focusing on the therapeutic benefits led to the development of the idea for the research. The main aim was to investigate how mindfulness might be used with vulnerable young people, exploring their engagement, forms of support and the impact. It seemed a

group format would provide an alternative to individual therapy and would potentially be more cost effective as well as more time limited. Additionally it could offer group support to the young people. If in fact the intervention could promote healthier outcomes for young people then there would be a potential to offer this as a future treatment for other young people. Mindfulness seemed to offer much that could be useful.

### **Objectives**

1. To design and deliver a mindfulness programme suitable for work with vulnerable young people
2. To evaluate the experiences of young people engaged with the mindfulness programme
3. To gain a better understanding of how parents might support and interact with mindfulness interventions for vulnerable young people
4. To enable a better understanding of how a mindfulness intervention might be used as a therapeutic strategy with vulnerable young people including those in special educational settings
5. To consider the impact that mindfulness may have in terms of potential future interventions.

## 2. Child mental health

### 2.1 Overview

Having discussed mindfulness, its roots and some applications, before continuing with the process of the project, various aspects which impact on young people's lives are considered here. The subject of child mental health has an interesting history. The approach has modified over the years as has the general view of health. Situating the research within the context that has evolved provides a backdrop against which mindfulness provides another perspective.

Firstly this chapter considers aspects which may impinge on people's lives and affect mental health. A discussion about what is currently felt to constitute healthy childrearing gives emphasis on parenting and attachment issues although risk and resilience factors, either negative or positive, are important components. The section on safeguarding considers the main legislation which protects children and young people within the current political framework including education matters and those that affect young offenders. The chapter goes on to consider the theme of '*Every Child Matters*' and how this translates in today's society. Next child mental health services are considered, firstly looking at the historical aspects and progressing to the current structure within CAMHS and how this serves vulnerable young people in identifying and treating mental health issues. The difficulties of service provision in the current economic climate with the issues of supply and demand highlight the need for cost effective interventions – of which mindfulness may prove to be valuable. The support needs of children and young people who are vulnerable and need support to reach their potential are considered, including something of an historical overview of their treatment.

The inter-relationship between mental health, behaviour and culture is addressed in the next section. Finally the chapter concludes with a discussion considering the potential for mindfulness to be an effective intervention for vulnerable young people.

## **2.2 Environmental influences impacting on children's health and well-being**

This section looks at physical and societal aspects of life with an attempt to begin to understand the differing components which may create the experiences of young people affecting how they manage their mental health issues. Children develop as they grow and adverse environmental influences can make an impact on their development. In human life there are always factors that will overlap (for example relationships and material conditions) and to some extent it is difficult to establish which are most influential in people's lives. It is frequently a combination of circumstances which create the environment. Good child mental health is dependent on many factors. These points are relevant in putting into context the many variables which may impact. However, the benefits of mindfulness extend through multiple dimensions and have been shown to help in many different situations as outlined in Chapter 1.

## **2.3 The stress of modern life**

In today's modern society stress is a common problem affecting many people. Modern life with all its conveniences is somehow more stressful. Twenge (2000) states that the average stress levels in young people today resemble what would have been clinical levels in the 1950's. Cohen and Janicki-Deverts (2012) undertook a study over three time periods (1983, 2006 and 2009) using the Perceived Stress Scale (PSS, Cohen 1983) levels showed a general increase over the period for all groups but with some reduction in the stress levels of those who had higher educational achievement and better economic status. Bor et al (2014) also identified increasing levels. Perhaps this is an indication of how more complicated and stressful life has become. In turn this is often claimed to be mitigated by resilience factors (such as better education and financial circumstances as evidenced by Cohen and Janicki-Deverts above). Where there is an absence of 'risk' factors this alone becomes a mitigating factor (see later in this chapter). There are a known number of risk factors contributing to poor mental health. The World Health Organisation (2012) groups these into three main areas affecting mental health and well-being. These are:

- Individual attributes and behaviours
- Social and economic circumstances
- Environmental factors.

The individual difficulties may include such things as low self-esteem or poor cognitive or emotional maturity. The social factors may include neglect or exposure to violence and the environmental factors may be injustice and discrimination or events such as war or disasters. One may be negatively influenced by such things as learning difficulties or by poverty and cultural inequalities or by a poor environment. Hackett et al (2011) state that problems with children have a multidimensional presentation. '*Problems*' do not always lead to categorisation within a psychiatric diagnosis. Hackett et al (2011) identify that needs are usually complex and may include social, familial and educational aspects. There are also vulnerability factors – such as physical illness or parental mental health issues – but also protective factors. More positive influences in the child's life provide a balance. For example an adverse life history may be greatly compensated for by a close and loving relationship with a family member. Thus some situations which may otherwise result in poor mental health do not necessarily have this outcome. However there is no doubt that modern life is stressful and gaining respite can be a challenge. Mindfulness may have a place in this as it can help to create the opportunity for such a respite.

It is hard to define which influences may contribute to mental health problems and which do not as every individual is a unique combination of genes and individual make up which then interact with care-giving and family influences in a wider environment which may present with any number of challenges. All this and the experiences which one encounters shape the whole person and some cope better than others. Here of note is the parenting experience (see Section 2.6 below) which is of great significance but a number of other threads draw together in this tapestry of experience. These are mentioned briefly below.

## 2.4 The inter-woven influences

Culture (either with a small or capital C) does affect how we view things and can be relevant to a family, a city or a country. Pavord, Williams and Burton (2014) refer to culture as a combination of shared cultural traits and a shared group history. It provides a sense of belonging. Dogra et al (2002) comment that humans are essentially social; thus a definition of self is necessary in the context of relationships with others. To a large extent our behaviour is culturally defined. Gilbert and Choden (2013) propose that self-identity is the way we co-ordinate the multicultural influences that have shaped us and the values we have acquired. They suggest a hypothetical situation: if we were to be kidnapped as babies and brought up in violent drug gangs – that would be our reference point – ‘our culture’ which we would be likely to defend as our identity. Unless we were able to step outside that ‘culture’ we would have no way of choosing to be different. This point was also relevant to delivering a mindfulness intervention. There may be some who were not able to ‘escape’ their culture although it also seemed that such individuals would not be likely to opt for a mindfulness group.

Brentnall and Sanders (2009:v) in the introduction to Timimi’s (2009) work, state that *‘Much of which is written and spoken about emotional distress or mental health problems implies that they are illnesses.’* Sometimes this is not the case and much will depend on how we view emotion. What does our culture tell us about expressing emotions? Mindfulness, however, allows us the ability to ‘escape’ the confines of this giving room for a clearer view of things. Culture can also create differences and divisions. Divisions amongst people can tend to promote conflict - us and them - and there are even members of the same religion who can feel hostility towards members of their own religion - Catholics and Protestants, Sunni and Shia. Children and young people are influenced by their culture and that needs to be taken into account as we live in a multicultural society. Therefore the ethnic experience of any group needs to be considered when any intervention is planned to ensure that all could fairly benefit. Mindfulness develops qualities of compassion and a non-judgemental attitude and thus mitigates against any potential cultural conflicts which may arise.

Additionally there are other factors beyond culture influencing development. Life circumstances also affect people and influence development. Gilbert and Choden (2013) state that people born into poverty have a lesser life expectancy than those who are better off. Rutter (2005) makes a distinction between what he terms '*distal*' risks and '*proximal*' risks. Thus a child in poverty may be at a '*distal*' risk of a mental health disorder because poverty made parenting more difficult. To be at a '*proximal*' risk of mental health problems would involve family malfunction rather than poverty alone. Thus there is more involved than economic circumstances with an interrelationship between the two.

People with inadequate housing and living facilities are clearly facing more stress than those not in this position. There is a clear hierarchy of human needs (Maslow 1943) and where needs remain unmet difficulties may arise. Hatch et al (2011) identified that the prevalence of common mental health problems were twice as high in an inner-city area of London compared with the national average for England. Offord et al (1987) identified, in an Ontario study, that the prevalence of psychiatric disorder was significantly higher in urban rather than rural areas. A survey carried out in 1999 on behalf of the Department of Health identified that there were no significant differences in the prevalence rates for any mental health disorder between metropolitan and non-metropolitan areas. The Department of Health (1999) concluded that this was an unexpected finding and suggested that socio-demographic and socio-economic classification were a better indicator of regional trends. In fact using the ACORN geo-demographic targeting classification they found that group 'F' – who lived in low income areas and were termed '*striving*' - had the highest proportion (13%) of children with any sort of mental health difficulty. A 42nd Street report (a Manchester charity) in 2001 stated that inner-city children are at a 25:10% risk of developing significant mental health problems compared with rural children. On 25/02/14 The Guardian published an article by Benedictus quoting German research which established that inner-city dwellers coped less well with stress than more rural inhabitants. However it would seem that Rutter's (2005) distinction between '*distal*' risks and '*proximal*' risks (as outlined above) may make more sense if factored into the equation. Howe



(2011:52) comments on countries where particularly disadvantaged ethnic groups experience greater poverty.

*'However we need to understand that even in harsh circumstances some parents continue to show resilience, their children do well and are secure'.*

There is clearly a complicated inter-relationship between mental health issues, life experiences, poverty and hardship. As Teasdale and Chaskalson (2013) state it is not so much the circumstances but our reaction that leads to the problem.

Mindfulness allows the opportunity to just accept what is there – avoiding the second '*dart of pain*' when we begin to feel shame or guilt for our situation. The amount of material hardship people suffer and the environmental stresses they encounter does make a difference but there would also seem to be familial factors involved, as discussed in the next section.

## **2.5 Promoting healthy child rearing**

In addition to the points raised above, individual and family differences can influence child development. Clearly genetic makeup and constitutional factors are a part of this but family influences (which also include cultural and environmental factors) also have an impact. Such is the interwoven nature of child development.

## **2.6 Parenting**

As parents' views were to be included in this research it was important to reflect on this aspect. Current Western parenting trends are largely a matter of individual family choice although individuals' own experience of how they were parented is likely to have an impact. As a television advertisement for baby food says, '*you have no experience ... but the job's yours anyway*'. People largely follow what they believe to be correct. Baumrind as early as 1967 described three basic parenting styles: Authoritarian, Authoritative, and Permissive. MacCoby and Martin (1983) later identified a fourth style termed '*uninvolved*' or sometimes '*neglectful*'.

Authoritative parenting is characterised by high levels of nurturance, involvement, sensitivity, reasoning and encouragement of autonomy. Authoritarian parents exhibit highly directive behaviours, high levels of restriction and rejection and

power-asserting behaviour; parents who direct the activities and decisions for their children. Baumrind (1991:62) identifies that these parents '*are obedience- and status-oriented, and expect their orders to be obeyed without explanation*'. The two other types of parenting may be regarded as indulgent or indifferent. Permissive (indulgent) parenting is characterised by making few demands, exhibiting non-controlling behaviours and using minimal punishment - for example, parents who do not establish rules and guidelines. Neglectful or '*uninvolved*' parents leave little to advocate their style of parenting and often their children will be the subjects of state intervention. However there are obviously different degrees of 'neglect'. The NSPCC website (March 2016) defines '*neglect*' as an '*on-going failure to meet a child's basic needs*' and thus if the situation cannot be remedied the state is likely to take action. In general, an authoritative parenting style emphasising both responsiveness and demandingness is thought to be the most healthy. Not all may have access to the more positive styles but other influences could help offset disadvantage and mindfulness practice may potentially be one of these influences. Different aspects of parenting are discussed below to illustrate the breadth of the issue.

Miller (1991) cites previous parenting beliefs influencing childrearing such as a belief that wilfulness in the child was essentially harmful and should be driven out. She terms this '*poisonous pedagogy*' and further explains that parents' experiences of rejection from their own childhood if not successfully worked through, are likely to be passed on to their own children. She quotes from a book published in 1858 by Dr Schreber, widely popular at the time. The philosophy was that if the parent became '*master*' over the child the child would be protected and by this '*instilled obedience*' be spared from long periods of '*agitation*.' Spock (1969), comments on the Victorian era and its insistence on manners and modesty and the subsequent need to be strict in matters of childrearing. He talks of the '*revolution*' in thinking philosophy and of the '*doubts*' of some parents and the '*mixed-up-ness*' of others. Should they not follow the parenting patterns of their childhood? Fontana (1996) comments that parents commonly have little or no parent training. He advocates developing basic understanding and common sense with love and goodwill plus a genuine interest in the child. Aspects of parenting

with regard to this research are further discussed in Chapter 8. Sunderland (2006:159) emphasises that getting discipline '*right*' develops a child's '*social, moral and emotional intelligence*'. She counsels against disciplining through criticism and points out that smacking only teaches children that it is okay to hit. Lask et al (2003) outline the need to be positive and supportive but not to take over.

Robinson et al's (2004) study found a correlation between inconsistent punishment and delinquency, thus underlining the overlap between parenting and child behaviour. Maughan (2005) suggests that biological, psychological and social factors contribute to the development and maintenance of conduct disorder. Hill (2005) Scarr and McCartney (1983) illustrate how the child's own part in selecting adverse environments may be important in understanding the development of problematic situations. '*Difficult Children*' may thus evoke negative responses from parents - which become the '*norm*' for them. Troublesome adolescents may seek out delinquent peers – which become the '*norm*' for them. Moffitt (1993) suggests that neuro-psychological defects such as a lower I.Q. or poor speech and language skills or other impairments of executive functioning may increase vulnerability to conduct problems. Social disadvantage may also play a part. Maughan (2005) suggests that these troublesome child behaviours are more likely to develop in adverse family and social circumstances although some inheritable component is evident. Whether this is genetic or as a result of learned behaviour is not clear.

Carter and McGoldrick (1998) discuss the family life cycle. Particular parenting styles, whether or not influenced by genetic links, personal experiences or personal traits (and to what extent), have been associated with conduct problems. Patterson (1982) cites some parents as being less likely to pre-empt problems, less likely to follow through and likely to get caught in escalating spirals of confrontation. Sometimes these patterns shade into harsh treatment or abuse and the effective quality of parent/child relationship is compromised. It would seem important to consider parenting as an aspect of child mental health but it would be difficult to legislate that particular patterns should be followed. Omer (2004) advocates '*non-violent resistance*' and '*parental presence*' as being key factors

which help overcome difficulties. Where a parent has the motivation and consistency to carry this through his views would seem sensible. This presents a parallel in terms of parental support in a mindfulness intervention.

*'Failing parents'* may be putting in more effort per unit reward than *'successful'* parents to reduce the traits and troublesome consequences (Hamer 2006:11). What is considered to be *'failing'* and what is *'successful'* parenting will depend very much on society's view and cultural norms. A family's explanatory model of the difficulties will depend on cultural and professional backgrounds (e.g. some religious people may believe the child has been possessed by a djin<sup>1</sup>) – colleagues from other disciplines may have other explanatory models as will other families. It is a good idea to ask if others have expressed views about the child's behaviour (he's just like his father) – are there any accusations or scapegoating? One parent complained that her boy *'could not keep still'* and yet the evidence presented by the boy was that he could in fact *'keep still'* and was well behaved. The parent who was distracted by other things going on in her life had failed to notice. It is important to dispel myths – should a seven year old be accused of being *'immature'*? Siegel and Hartzell (2003) advise parents to be fully present and mindful with their children as when we are preoccupied or worried by the past or the future we are not present for our children. This also has significance with the comments of Hill (2005:189) who identifies that adult mental health disorders are generally associated with an increased risk of discord for the young person. Psychological disorders in a parent can compromise development of healthy mental health. On the one hand there is the additional burden placed on the child who is placed in the position of having to give care to the adult but *'emotional dependency is especially pernicious'*.

Bowlby (1997) places much significance on the mother in the child's development. However Rutter (1972) shows that children have multiple attachment figures. He suggests that separation is not always the crucial factor in emotional disturbance, family dysfunction may be more influential on the child's development.

---

A djin is a class of spirit particularly in Islamic mythology which is thought may influence human beings either for good or ill.

## 2.7 Attachment and parenting style

Rees (2005) states that disordered parental attachment frequently underlies mental health problems. The Department for Education (2015) produced a document providing advice to schools. Secure parental attachment was listed as a protective factor for child mental health whereas attachment disorders were listed as mental health problems. Clearly between the two extremes there are different levels affecting young people. Most parents would want the best for their children but there are different styles of parenting and culture. Time period and family experiences affect which styles families adopt. There is also an interrelationship between parents and young people. Some youngsters are more difficult to parent than others. Howe (2011:203) states that *'temperamentally easy children are easier to parent'* and the converse is also true. Iwaniec (2004) also comments on *'easy'* and more difficult children to parent. For example some children may have particular sensitivities – children who will only eat certain foods are hard to manage in a family environment with siblings who have no such issues, thus making the parenting task more difficult.

However it is not to suggest that parenting is the only significant factor in child development either in a positive or more negative direction, although it does provide an important basis. Burton (2014:60) comments on Baumrind's (1991) parenting styles:

*'An authoritative style of parenting acts as a protective factor and is the most predicative of positive child outcomes'.*

There are a number of aspects to the issue of parenting and how relationships can facilitate more positive outcomes. Such relationships include basic attachment patterns (Ainsworth et al, 1978, Main, 1991, Bowlby, 1997, Howe, 1995 and 2011, Dallos, 2007).

*'Attachment is an adaptive biological process serving the needs of the child for protection and nurture' (Dogra et al 2002:97).*

It is an interactive process although it may be influenced by genetic and other factors – for example a depressed parent may find it very difficult to respond to

his/her infant and thus the relationship might not develop as it otherwise might. The security of the attachment to the caregiver is of primary importance. Ainsworth et al (1978) describe three main patterns of attachment: secure attachment, anxious/resistant attachment and anxious/avoidant attachment. A secure attachment gives a child a better chance of a healthy mental life. A fourth attachment pattern was later identified termed '*disorganised attachment*' which predicts less than positive outcomes (Main and Soloman 1986). Attachment research consistently shows that early experiences impact on later capacity (Grossman, Grossman and Walters 2005). Thus the quality of early relationships are of great importance. As stated by Siegel and Hartzell (2003) it is the transaction between the individual and the environment including the relationship with parents. Iwaniec (2004) writes about poverty of environment adversely affecting infant development. This sometimes occurred in institutions before maternal deprivation theories became commonly known (Bowlby et al 1965). Failure to thrive as well as emotional disturbance resulted.

Attachment '*figures*' are vital to a child's healthy development but it is differences in the caregiving environments that can give rise to the various patterns of attachment (Howe 2011:201). It is an interaction between the individuals, their genes and the environment. Differences and distribution of attachment patterns do occur, in general, however (Belsky and Fearon 2008), the greater the poverty and the harsher the life the more insecure the patterns.

*'Parents whose lives are blighted by poverty and environmental deprivation will experience more stress. All of us under stress tend to be less sensitive. Less sensitive parenting increases the likelihood of an insecure attachment'*. Howe (2011:52)

Additionally how parents themselves have been parented and their environmental experiences will affect how they parent their own children (Siegel and Hartzell 2003, Dallos 2007, Prior and Glaser 2006, Howe 2011).

A number of parenting courses exist to assist parents. For example the Webster-Stratton programme (1992) is a popular parent management programme for 3-6 year olds which is still widely used. The '*Incredible Years*' website (Caroline

Webster-Stratton's own website 2015) lists a number of states in the US where the programme is available (and is also available in Canada). A number of areas in the UK also run this course for parents including Salford City Council. The Oregon Social Learning Centre (OSLC) programme is for children aged 3-12 and is based on the work of Patterson (1975). A more recent programme, similar to the Webster-Stratton programme in some respects but only focusing on positive parenting (i.e. no examples of bad parenting are included), is the Parenting Plus Programme (Sharry 1999). Omer (2004:1) advocates a philosophy of '*non-violent resistance*' based on the principals that Mahatma Ghandi applied which seems very useful for '*violent and self-destructive children and young people*'. Prior and Glasser (2006) describe a successful intervention delivered to '*irritable infants*'. A follow up after 18-24 months showed a significantly higher level of acceptance in the mothers and fewer behaviour difficulties with the infants compared to those of the control group (Van den Boom 1994). Thus interventions such as parenting courses can be helpful.

## **2.8 Risk and resilience**

Graham (2000) states that mental health problems have risen over the last 50 years. He states family circumstances – such as inadequate parenting, emotional, physical and sexual abuse in the family, family violence and discordant marital relationships as being risk factors. However there are many children who have such negative experiences and yet do not go on to develop mental health problems. Hill (2005:180) also states that only some children exposed to such risks will develop a psychiatric disorder. He suggests that those that succumb will have vulnerability factors but conversely '*those that escape*' will have protective factors such as high self-esteem. He further suggests that the more that is known about vulnerability and protective factors the better informed a preventative approach will be.

Pearce (1993) defined the risk/resilience model which supplements other theories of child development. He defined three areas within which risk or resilience could present. These were environmental situations, family and factors within the individual young person. Environmental factors would include such factors as poor socio-economic conditions and other adverse factors that impact on the

young person – disasters for example. Family risk factors include parental conflict and hostile or rejecting relationships. Child factors would include genetic influences - the child's genetic endowment, his/her temperament and physical health, brain dysfunction and learning difficulties. Such adverse factors increase the likelihood of developing a mental health problem. The relationships between parent and child, the wider family, the culture and immediate environment are as important as the individual makeup of the people involved. Risk factors are not the only factors to consider. Young people are exposed to any number of influences as they grow up and some may be more prone to face difficulties than others. Individual differences may be accounted for by nature – that is their constitution and genetic makeup but their basic attachment pattern is of primary importance. Also resilience factors are very important. Burton (2014) gives the example of Mo Farah, the famous British athlete, who from a disadvantaged background overcame the odds – one very important resilience factor was the attention his PE teacher gave to his athletic talent which facilitated his sporting prowess. Resilience may also present in an ability to manage stressful situations more easily and mindfulness has an established evidence base in helping to overcome stress – for example MBSR Kabat-Zinn (1994).

Velez, Johnson and Cohen (1989) suggest that low socio-economic status – especially where the mother had a low educational achievement – was a risk factor for all externalising disorders and for separation anxiety. Unmarried families and parental sociopathy were risk factors for both conduct and oppositional disorders. Problems during pregnancy were a risk factor for all types of psychopathology. Costello et al (1996) evidenced that the impact of family and social adversity factors may differ in different cultural groups. For example Cherokee children had a slightly lower prevalence of disorders than white children. They were less likely to be exposed to family risk factors but more likely to experience social adversity.

Verhulst and Van der Ende (2004) identify that refugee children are more likely to live in families under stress than children with the same level of difficulty but in well-functioning families. Richardson and Joughin (2000) confirm that refugee and asylum-seeker children have many problems to face. There is most often



separation from their family and a new culture and language to contend with. Coupled with this are uncertainties about their future, dealing with strange officials and policies and likely racism. New languages, new social norms and new expectations are a lot for most adults. For unaccompanied children this must be a very daunting experience.

Russo and Beidel (1994) reviewed the association between familial psychopathology and childhood psychiatric diagnosis. They stress that the relationship does not necessarily imply biological causality and may be the result of shared genetic makeup, social learning or environmental influences. A number of studies have established that positive self-concept and school achievement are factors that promote resilience. Thus there are many things that influence positive mental health and mindfulness may be one of these. Mindfulness offers a respite from our usual ways of thinking, which may be self-defeating and provides a space where we can learn to be kinder to ourselves (Gilbert and Choden 2013).

## **2.9 Safeguarding children's rights**

The Local Authority may intervene in circumstances where the child's living situation is the cause of his/her mental health problem, and where the authority can be reasonably certain that what they offer is better. Many children in care have mental health problems and all aspects need to be considered. Lindsey (2000) states that young people in the care system have a much higher rate of mental health problems. McCann et al (1996) showed that two thirds of children looked after by an Oxfordshire authority had significant psychiatric disorders. While it is unlikely at present that a young person would be accommodated because of mental health problems, a young person may be '*beyond parental control*' and the family may abandon the child to Social Services. Neglected children frequently exhibit behavioural difficulties and thus the overlap with mental health issues.

As a part of the wider society, children are raised in cultures which are affected by the political features of that particular place within that time period. Laws may include the rights of the individual and other safeguards. In our current society in the UK there are safeguards to protect children but this was not always the case as we shall see later in the section on the history of child mental health.

Two major pieces of legislation affect children and adolescents in respect of mental health – the Mental Health Act (1983) (as amended in 2007) and the Children and Young Persons Act (2008). However, in practice, the latter is rarely used (Royal College of Psychiatrists website March 2016). The Mental Health Act does not stipulate a minimum age and there were no specific provisions for children detained in hospital under the 1983 Act. There is now a duty on hospital managers to ensure that children are detained in an age-appropriate environment. Further safeguards were put in place and from April 2013, the detaining authority had to notify the Care Quality Commission of any instances where a child had been admitted onto an adult ward for more than 48 hours (Bradley 2013). However adolescent beds are scarce and often children are detained in some other '*inappropriate*' way - for example, on a paediatric ward while awaiting a bed in an adolescent facility or being placed far away. There is a continuing need to develop new ways of working with young people and hopefully prevent deterioration into a mental state requiring hospitalisation.

For someone to be detained in a psychiatric hospital or even '*accommodated*' (i.e. in a voluntary capacity) the condition must be serious. The Mental Health Act stipulates that the person is suffering from a mental health problem and is a '*danger to*' him/her '*self or others*'. Under section 2 (admission for assessment), a number of people need to agree to the admission. Two doctors, one of whom should be familiar with the patient (often the GP) and a doctor who is familiar with mental health issues (usually a psychiatrist). Originally it was necessary for the nearest relative, or an Approved Social Worker, to certify this (Olsen 1984). The Approved Social Worker role changed with the 2007 Act to become the Approved Mental Health Practitioner (AMHP) although essentially it remained the same task (Community Care, Barcham 2008). In practice the professional tends to take this responsibility rather than the nearest relative, as a relative signing has wider implications. The amendments made in the 2007 Act extend the role of professionals (Mental Health Act, Chapter 2 page 5). Particular procedures apply under different sections, for example Section 4 is an emergency procedure, and Section 3 involves a formal procedure for a treatment order. The difference in

respect of children comes in the area of '*Gillick Competence*'.<sup>2</sup> Section 131 (2) of the Act (1983:100) states that any 16 or 17 year old '*capable of expressing his own wishes*' can be admitted to a psychiatric hospital '*irrespective of their parent's wishes*' (i.e. on a voluntary basis). Assistance of the court may be sought where a '*non-Gillick Competent*' child's parents are '*unavailable*'. Interestingly where a '*Gillick Competent*' child refuses to enter a psychiatric hospital or refuses treatment, their choice can be overridden by their parents or the court (Revised Code 1999). This remains unchanged under the 2007 Act.

A young person detained on a secure accommodation order incurs serious restriction of liberty and strict criteria apply. The young person has to have a history of absconding and if '*he absconds he is likely to suffer significant harm*' (Government website 21.07.14) It is significant that in such situations while the welfare of the child is important it is not paramount. The making of such an order requires a court application under section 25 of the Children Act 1989.

Other legislation is also relevant to children exhibiting mental health problems. The Education Acts relate to provision for children with difficulties. Until 2000 the 1933 Children and Young Persons Act still applied in high profile cases involving serious crime (such infamous names as the killers of James Bulger, Venables and Thompson). The 1933 Act was consolidated into the powers of Criminal Courts (Sentencing) Act 2000 but did not change the effect of the previous legislation; children may be restricted by Section 92 of the 2000 Act – detained '*at Her Majesty's pleasure*'. An article in Community Care quotes

*'Our failure to take sufficiently seriously the increase in mental health problems in children and young people sufficiently perpetuates our ability to*

---

<sup>2</sup> Gillick competency refers to a legal ruling set by the House of Lords (Gillick v West Norfolk and Wisbech Health Authority and Another [1986] 1 AC 112a). The case looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year-olds without parental consent. Since then it has been used more widely to assess whether a child has the maturity to make their own decisions and to understand the implications.

*deal with both the causes and the consequences of crimes by and against children'* (Harker 2002:22).

## **2.10 Does every child matter?**

Cunningham and Tomlinson (2006:177) write about the '*crisis*' that affects our children. They state that this is due to their being brought up in '*the most desperate circumstances*'. Child poverty in Britain had increased more than almost any other developed society. An article in The Observer (Doward and Helm 20.06.15) claims that child poverty in Britain has risen since the 1990's. The Child Poverty Action Group (March 2016) claim that although there was a reduction in child poverty in previous years, since 2010 the number of children in poverty has '*flat lined*' increasing by 0.5 since 2010, signifying that a problem still exists. There was increasing concern about the younger generation and a concern that society had stopped setting boundaries (Phillips 2002). From this emerged a '*dichotomy of care and control*' (Cunningham and Tomlinson 2006:177). To some extent this is still a factor in today's society affecting how we view young people with problems.

Cunningham and Tomlinson (2006) make the point that although the government promoted the '*Every Child Matters*' agenda (launched in 2003) some children apparently do not matter. They cite children affected by the criminal justice system where young people are detained in less than ideal circumstances. Refugee children, whose parents have been refused asylum, are effectively denied basic rights or threatened with being taken into care away from their parents if the situation persists. Jamie Doward in an article in the Observer (26th April 2014) cites incidences of children being separated from their parents whilst being held at a detention centre awaiting deportation. Although there may be valid reasons for this overall it would seem to be a somewhat draconian policy. Others awaiting decisions from the Home Office about the legality of their status in the UK may be adversely affected by the lengthy time this takes. Richardson and Joughin (2000:64) comment that those who have the status of refugee no longer fear deportation but: '*Those awaiting decisions are in limbo*'.

Laura Penketh (2010) writes about the emergence of the Welfare State '*born*' at the end of World War Two. One aspect of this was in providing school meals,

designed to help the poor and disadvantaged move to a better life experience. More recently the policy regarding school meals has been linked to '*efficiencies*', with schools encouraged to select cheaper food options (or otherwise face cuts in other aspects) which are thus not likely to be of the best quality. Despite the known facts that those in poverty enjoy a shorter life expectancy and of the knowledge of health problems associated with the cheaper '*junk foods*', 37p per day per pupil was the allocated amount set. Jamie Oliver (the famous chef) started his '*half a quid a kid*' campaign. The Government responded by providing guidelines on the use of processed food but no extra money (Penketh 2010). Elsewhere Joughin and Morley (2007:27) cite the necessity for sufficient quantities of fatty acids such as omega 3 to counteract commercially produced foods such as cakes and crisps which affect the brain's ability to use these vital nutrients. Gesch et al (2002) noted that improvements in the diet of 231 young offenders showed a decrease in antisocial behaviour and a 37% decrease in violent offences.

## **2.11 Educating children to their potential**

One important point regarding children who have emotional and behavioural difficulties lies in the way that they are managed. This can make the difference between a successful outcome or a more difficult one. Thus the role of education must be considered in this respect. Health and Education Authorities have a duty to identify special educational needs but '*it was not until the 1970 Education Act that all children were considered educatable*' (Cameron & Sturge-Moore 1990:5). However the Education Act 1944 did make some provision for what was then termed '*ineducable*' children. This led to a protest, both from the aspect of mistaken reality and the terminology, subsequently resulting in provision under the 1959 Mental Health Act requiring children suffering from '*a disability of mind*' to be assessed, a report provided and with provision for review. The Education Act 1981 directed authorities to provide a Statement of Needs. Subsequent Education Acts have reinforced this. The Code of Practice on the identification and Assessment of Special Educational Needs (1997), although it did not categorise children with mental health problems, highlighted that children with emotional and behavioural difficulties may have experienced abuse, neglect or have mental health problems. This appeared to underlie some rethinking away from measures to control such

children to a more welfare approach. In 2001 the policies for assessing children changed with resources being concentrated in the schools. Effectively this meant that the funding mainly came from the school – in a climate where funds were all too scarce it perhaps became more difficult to identify young people who were struggling – especially those who quietly sat at the back of the class. Rutter et al (1979) underline the significance of school time by entitling their work '*Fifteen Thousand Hours*' –the average amount of time pupils spend in school. Aspects of mental and emotional health are, therefore, very relevant in schools thus a need for support services. A number of projects such as the SEAL project (Social and Emotional Learning) (see Durlak et al 2011) are already operating in schools.

Donaldson (1987) argues that in compelling our children to attend school we effectively make them '*conscripts*'. It is a fact that the law requires children to attend school and where their needs are not met it can be an arduous process. Griffin and Tyrrell (2004) advocate the Law of 150 – which they claim to be the optimum number for a community. If this is the case are we perhaps putting stress on both pupils and teachers by the size of our present schools? However Robinson (1990) concluded that class size or pupil/teacher ratio had no consistent association with pupil success. This has been an on-going debate. Some results indicating '*insufficient*' evidence to warrant any large-scale changes (Hanushek 1998). A BBC news item (2005) maintained '*small classes do no better*' but it would seem that it is a point to be considered. These points highlight increasing stresses impacting on young people pointing to the necessity of finding ways to alleviate these stresses. Mindfulness may prove to be one method which may be helpful.

Cole, Daniels and Visser (2005:117) argue that teaching staff have an opportunity to 'create school systems and cultures that foster children's emotional well-being'. However this opportunity is sometimes not grasped nor supported by colleagues in the health service. Goodman and Scott (2002:10) explain how psychometric testing can identify problems which are risk factors for various psychiatric problems which may 'sadly have gone undetected in school'. One young woman had got to year nine in her school career when another service identified that she had an intelligence quotient on the first centile. Her Special Education Needs Co-

ordinator (SENCO) had not known of her difficulties and it had never been picked up that she had any problem.

## **2.12 Mindfulness in Schools**

In 2007 UNICEF reported that British pupils were amongst the unhappiest in the Western world. In their 2007 study on child well-being six areas including material well-being, health and safety, educational well-being and subjective well-being were considered. The UK ranked 18.2 at the bottom of the list. The US only just managed to do better with a score of 18.0. In 2015 the Organisation for Economic Co-operation and Development (OECD) undertook a world-wide study of basic educational skills within different populations. Singapore, Hong Kong, South Korea, Japan and Taiwan took the first 5 places. The UK took the 20<sup>th</sup> position but in this case beat the US who came 29<sup>th</sup>. Interestingly the 6<sup>th</sup> place went to Finland and our near neighbour Ireland scored 15. One wonders what it is about the British educational system that places us behind many of our neighbours. Also could it be just coincidence that Buddhist countries are ahead when it comes to basic education? Perhaps it is the culture that influences how pupils perform. Still, this does not explain why Finland, who had a score of only 7.5 on the UNICEF chart, has done so well. Clearly more investigation is needed to understand the processes which contribute to these results.

There has been an increasing concern that schools should consider the well-being of pupils as well as their academic education. Perhaps since Daniel Goleman (1996) popularised the theme of emotional intelligence the government has been concerned with the social and emotional aspects of learning. In 2010 the Department for Children Schools and Families introduced SEAL into secondary schools (Humprey, Lendrum and Wigelsworth 2010).

Interest began to grow into ways of supporting young people develop qualities to help them cope with the challenge of secondary education. Kempson (2012) suggests that pupils '*in British schools*' are overwhelmed by all the challenges. Huppert & Johnson (2010) also identify this concern. In 2009 a Mindfulness in Schools Project (MiSP) was established as a not-for-profit company by Richard Burnett and Chris Cullen, both schoolteachers and mindfulness practitioners. Their

belief was that the young people in their classrooms could benefit from learning mindfulness skills. Since that time mindfulness in schools has developed leading to a number of research projects being undertaken. Kempson (2012) evaluated the experiences of a number of pupils who had undergone a mindfulness programme. The pupils included both boys and girls and were from two different schools: a fee-paying boys' school and a state co-education school. Kempson's was a mixed method study and included focus groups, interviews and questionnaires. The results were interesting in that the majority of pupils found mindfulness at least moderately helpful and this finding was consistent across both schools and for both boys and girls. However, he identified that girls seemed to perceive mindfulness to be more helpful in managing their emotions than boys did. He also considered some of the barriers to mindfulness practice. These included aspects which he grouped under two main headings – the course content in general and the actual techniques. Length of the course was a factor which some participants identified as a barrier in that they felt it was too short. Other barriers listed were forgetfulness and lack of time. Difficulties with techniques included lack of ability and difficulty in sustaining concentration. Huppert and Johnson (2010) also undertook to evaluate the results of a short mindfulness programme which was delivered to 155 schoolboys. The boys were selected from 11 religious education classes; 6 of these were delivered mindfulness sessions by mindfulness practitioners, 5 other classes taught by other teachers continued their usual religious education and acted as controls. Most pupils reported that they had enjoyed the programme and felt that they had benefited. Huppert and Johnson found that psychological outcome measures positively related to the amount of individual mindfulness practice that the boys had engaged in.

Burnett (2009) considered various aspects involved in teaching mindfulness to pupils in his class. He firstly reviewed the literature and then compiled a questionnaire about mindfulness issues putting various questions to leading figures in this field, including such people as Mark Williams, Christina Feldman, Michael Chaskalson, John Teasdale and Jon Kabat-Zinn. He compared and contrasted Buddhist and secular approaches and differentiated between clinical and non-clinical contexts. Burnett (2009:24) states that school pupils being taught



mindfulness are '*in the as yet undefined middle-ground between mindfulness as clinical application and mindfulness as spiritual practice*'. In this respect this research differs in that it was intended as a clinical application hoping to assist the young people develop better emotional functioning.

Weare (2013) looked at a number of '*good quality*' studies of mindfulness with young people (including that of Huppert and Johnson (2010) mentioned above). She concluded that mindfulness is capable of improving the mental health and well-being of young people and it appears to be acceptable to staff and students alike. However, she identified that many of the groups she considered were pilots with a small number of participants. There was little use of control groups or random allocation with no standardised measures. There was reliance on self-report and a bias towards having participants who volunteered rather than being chosen. In this research the author considered that it was necessary to select those who showed an interest and volunteered, indeed the nature of the research dictated that principle be maintained.

Based on current literature (Huppert and Johnson 2010, Wisner et al 2010, Kempson 2012, Zelago and Lyons 2012) from the point of view of educationalists, mindfulness appears to be a good answer to many of the problems that arise within the field of secondary education. Kempson (2012) emphasises the value of mindfulness in developing attentional skills which is of obvious importance to young people in an educational setting, although more research is still required. However the question is raised as to why it is that our secondary schools have such a large number of young people with mental health problems?

Mindfulness, however, is not something that can be forced nor is it something that you can give to someone. Possibly there is something about the culture that should change. Neale (2011:1) refers to '*something being lost in the translation*'. He argues that the background culture within which mindfulness exists in the East is mainly missing in the West. People do not necessarily identify with the values and understandings that are a fundamental part of the Buddhist way of life. It would seem that mindfulness is sometimes seen as a '*band aid*' something to cover up a more serious problem. Young people in Kempson's study seemed to

practise mindfulness when they felt under stress rather than a routine habitual action. However if secondary school is so stressful perhaps we should begin to think about the system. Mindfulness can be very effective but should we not also endeavour to promote a culture which values positive qualities? Hence schools could be well placed to promote such values as compassion and inclusion, which are fundamental to mindfulness practice.

One further point needs to be considered. The language used in the studies just outlined appears to suggest a different perspective from that of mindfulness. Use of terms such as *'teach'* and *'lesson'* do not fit with the concept of mindfulness. As discussed in Chapter 1 mindfulness has an experiential quality. Teaching mindfulness as a lesson goes against the Buddhist view of *'not forcing it'* (Gunaratana 2002). There is an essentially individual nature to mindfulness practice and the individual's own volition is fundamental.

Kempson (2012: 138) mentions the issue of delivering mindfulness to those who have not volunteered and refers to those from a *'normal' population who do not see themselves as having any difficulties to resolve'*. Weare (2013:7) uses the word *'conscripts'*. Huppert and Johnson (2010) comment that programmes on social and emotional learning are mandatory in the UK. This tends to suggest that mindfulness may go the same way. These concepts do not seem to fit within the ethics of mindfulness but also would seem to be highly problematic in research ethics. Burnett (2009:18) acknowledges that *'In a classroom we must remember that none of the children have chosen to be there and most of them would probably rather be somewhere else'*. This needs to be considered as it contrasts with the adult model for delivering mindfulness where no one is made to attend. Also it is highly unlikely that people who were not really interested would benefit as has been discussed earlier.

The MiSP website states that it does not purport to deliver mindfulness as therapy – merely to deliver a taste to the pupils, as Burnett (2009:41) says *'dipping their toes in the pool'*. However, this particular research was not with mainstream pupils although the main intervention was carried out in an educational setting. It was with a vulnerable *'clinical'* population and aimed to be therapeutic.

Possibly for mindfulness to be most effective it needs to become more mainstream. If the whole school were able to step back and focus on the now rather than the forthcoming exam or the past performance of their students they might have time to begin to take in the benefits that mindfulness can bring. How possible is this in our current climate? Nevertheless mindfulness can bring benefits and if the school also takes on board some of the concepts and values it can only encourage a more nurturing environment.

### **2.13 Mental health services for vulnerable children and young people**

This section considers aspects of child mental health services for the more vulnerable children and young people firstly through a historical perspective. Understanding of health issues has evolved but there remains a difference between physical and mental health conditions and thus mental health is bounded by social and cultural conditions. Nowadays we have a health and social service where all are entitled to benefit although some will not require as high a level of support. These are discussed later in this chapter.

### **2.14 Brief history of child mental health**

Firstly it should be stated that child mental health was not recognised as such until Rutter et al (1975) undertook their epidemiological study and interest in the subject began to grow. Wilson (2011) states that before that date the idea of child mental health '*sat uncomfortably*' with people and where difficulties were identified it was social and economic welfare issues, education and issues of protection that were the focus. Thus the history of mental health is primarily about adults although it must be borne in mind that '*children*' grew up much earlier in the past as confirmed by a notice in a reconstructed '*pub*' in a museum '*Persons must be 13 years or older*' in order to be served. The history of mental health treatments seems hardly credible in our present society. Mental health problems were poorly understood. In the Middle Ages often people suffering from mental ill health would be burned as witches. According to Hall (1965:319) in the 19th century '*lunatics*' were sent to asylums. In 1890 the Lunacy Act was passed making provision for the proper certification, care and control for persons of '*unsound mind*'. Up until that date it was not only people with a serious mental health condition that came into this

category but also people who had learning difficulties or were classed as '*moral defectives*'. Having an illegitimate child would be reason enough to warrant detention in an asylum. This law remained in force until the Mental Health Act of 1959. The '*new*' Mental Health Act '*released*' large numbers of people from '*asylums*'. Many had lived in institutions for years and knew no other way of life. Over the next two decades the process of reintegration into the community continued, with a parallel move to prevent long in-patients stays.

The evolution of children's services reflected the movement away from large institutions. This trend followed in the establishment of child guidance clinics. The first child guidance clinic opened in Chicago in 1909. This was associated with the Chicago juvenile court and their attempt to deal with juvenile delinquency (Hall1965). Shortly after it was realised that the methods would help other difficult or disturbed children and the concept spread. The first such child guidance clinic was set up in the UK in 1927 (Hall1965). Traditionally there were strong links with the School Psychological Service and professional staff combined in a team approach, usually including Educational Psychologists, Psychiatric Social Workers and Psychiatrists. Pioneering work in the establishment of '*child guidance*' clinics was frequently undertaken by voluntary organisations. As the value of their work became recognised some local education authorities established their own clinics. By 1945 LEA's were responsible for more than 73% of clinics. The 1946 Health Service Act made provision for hospitals or local authorities to set up child guidance clinics as part of the National Health Service. Child guidance clinics existed throughout Britain up into the 1990's, although unequally distributed. Thomas and Hardwick (1989:14) indicate [clinics] '*seeming to develop idiosyncratic referral patterns*'.

The service became overloaded with referrals, and the waiting periods involved became disproportionate. The medical profession became more conscious of the need to safeguard mental health.

Service development was piecemeal. Where there was an established Children's Service, a Young People's Unit attached to a Psychiatric Hospital, or a particular service, resources were good. '*The provision of such specialist facilities varied*

*considerably in different authorities*' (Brown 1976:88). *'The demand for psychiatric social workers ... for child guidance clinic work, far exceeds the supply'* (Hall 1965:140). This statement highlights the shortage of trained personnel transcending the decades.

The concept of health and illness, as understood in the West, has a whole empirical history. Year by year progress is made in understanding the causes of disease and cures advanced to treat these. The method has been a scientific one. The aetiology of the disease is established and evidence-based treatments are applied. Mental health also follows this medical model. This was a term first used by Laing (1971) to describe the procedures which doctors are trained to follow. They include an examination often involving tests of one sort or another, a history of the complaint followed by a diagnosis and treatment. The latter is not always successful as there are limitations to what is currently possible in medical science. However over the years treatments have developed for many medical conditions with many successful outcomes. Psychiatry has also progressed but there is a difference between a physical and an emotional condition and respectively in the treatment programmes. In most cases physical illnesses have an aetiology which can be confirmed by tests or other examinations for example blood tests. As Dogra et al (2002:18) explain, mental health is to some extent a culturally-bound concept and there is a continuum between well-being and mental illness with the *'cut off between normal and abnormal being hard to define'*.

At this stage of psychiatric understanding it is just not possible to confirm mental health problems by physiological methods. The medical model depends heavily on identification of an illness – as can be categorised in diagnostic manuals such as ICD-10 and DSM-IV. These describe particular sets of symptoms describing what doctors refer to as conditions. Thus diagnosing a mental health problem is a matter of taking a careful history and observing behaviour. It is very much subjective although clinicians trained for the task are very aware of this and will have developed a certain objective stance. Some questionnaires can also be said to be subjective – e.g. the children's global assessment scales (CGAS Shaffer et al 1983) and the health of the nation outcome scales for children and adolescents (HoNOSCA Gowers et al 1998), therefore training is given to attempt some

standardisation. However working closely with a group of youngsters who have problems can, over a period of time, perhaps skew one's view about what is '*normal*' in the average population.

Mental health services in the past have mainly concerned adults and child mental health stems from the adult medical model. Williams and Kerfoot (2005:13) state that '*the psychiatric disorders of children do not feature in the early history of psychiatry*'. One difficulty when it comes to child mental health is the developmental stage and an essential aspect of childhood is change and adaptation. Whatever problems are experienced, there is always the possibility of overcoming the challenges without psychological input. Emotional distress does not always equate to mental illness. There is much confusion about what is an '*illness*' and what may be termed '*distress*'. In the end it would seem it is how things evolve for the young person over a time period. Another point is that some '*conditions*' or '*illnesses*' are merely descriptions of what is observed – such as '*pervasive developmental disorder not otherwise specified*' (PDDNOS). Goodman and Scott (2002) in describing school refusal make an interesting point. School refusal is regarded as a mental health issue but there is no such condition called '*shopping refusal*' and yet many young people resist this task. Mental health issues are tied in with what is required socially in our culture.

## **2.15 Current structure of CAMHS**

The Health Advisory Service (HAS 1995) set out to look at issues of children's mental health services and resources available. Their model remains very much the same structure we have today. Their definition of mental health was extremely wide and covered a range of interventions. A survey of community-based resources (amounting to 94%) yielded an 81% response, revealing that the greatest change in the previous 3 years had been the loss of social workers in 30% of the units. Educational Psychologists had been largely withdrawn by 1990.

A number of relevant points were made by the Health Advisory Service:

- Child protection issues dominate the agenda of social workers (Working Together 1991 has two paragraphs on CAMHS - advice to

be aware of Child Protection procedures with a focus on the child's needs)

- Need to develop a multidisciplinary approach towards training, with better funding and inter-sectorial understanding of the mental health needs of children in special schools and residential care.
- 'Matters such as the placement and treatment of children on adult psychiatric wards, and the uncontrolled behaviour of young people in residential care' (p2) need to be addressed.
- A filtering model was developed through discussion and a four-tier model was proposed.
  1. Primary or direct contact services
  2. Interventions offered by individual specialist CAMHS professionals
  3. Interventions offered by teams of staff from specialist CAMHS services
  4. Very specialised interventions and care

This represents the four-tier system which is still the model practised to date. There are a number of both local and national initiatives aimed at young people with mental health issues. In 2001, 42nd Street (a Manchester charity) undertook a review of local services with various recommendations. Unfortunately the present picture is not as good as many of these services are no longer in existence having been pushed out by the economic dictates of the current climate. For example O'Hara (2014:22) explains how austerity led to cuts in local authorities and '*the resulting cuts in funding to local charities*'. Mallin (2013:65) quotes an article by Sullivan describing how the government tax cap adversely affected charities.

## **2.16 Child and Adolescent Mental Health Services (CAMHS)**

The structure envisaged by the 1995 HAS document is largely the structure which is in place today. Mental health services for young people are primarily a part of the National Health Service although a number of other providers (mainly

charities) exist which supplement the work. Practitioners will consider the issues affecting the young person in an initial interview (the process is explained more fully in Chapter 4). A number of mental health conditions can affect young people and the way in which these are assessed is considered below. Goodman and Scott (2002), before describing the main disorders found in child and adolescent mental health, present three sections on important aspects for consideration.

These are

- assessment,
- classification and
- epidemiology.

They identify five key questions as being important for the assessment. These include the symptoms, the impact these are making, the risk factors, the strengths that the individual may have and the expectations of the family. Thus there are immediately more factors involved in diagnosing child and adolescent mental health problems than merely identifying the symptoms. They explain that it is the impact that the diagnosis makes on the individual rather than the diagnosis per se. In their view to have a diagnosis of a psychiatric disorder there should be a substantial impairment over four domains in the child's life. Thus: family life, classroom learning, friendships and leisure activities should all be affected. A second important point would be to consider levels of distress, both for the child as well as any disruption for others. They warn against labelling all 'deviants' as psychiatrically ill.

Dogra et al (2002:41) state that a successful assessment interview '*depends on the professional thinking very carefully about appropriate engagement with the young person and the family*'. Both may hold views which help to clarify the essence of the difficulties. Older adolescents may prefer to be seen on their own, nevertheless their parents views are often helpful. Sometimes parents underestimate the child's emotional distress – in any event even conflicting stories will add to the knowledge of the condition. Also somatic problems may have an emotional cause. For example a child who gets stomachaches on a Monday



morning may be having difficulties with school; in which case it would seem more appropriate to focus on school aspects.

Evaluating developmental delays is quite complicated. Development itself complicates assessments for young people. Goodman and Scott (2002:5) give an analogy: an adult height of one metre is small whereas a childhood height of one metre may be '*small average or large*'. Clearly this depends on the age and particular developmental trajectory of the individual child. They advise that parents and teachers are rarely concerned without good reason. Dogra et al (2002) make reference to the mental state examination; such things as general observation, speech (pitch and volume) mood (both how the professional views this and the young person's thoughts and those of the parent. Motor skills and scholastic attainments (reading, writing, arithmetic and spelling) are also important. Attention should be paid to milestones and the general development trajectory. When assessing children's difficulties in social relationships there is a need to take into account whether it is a concern for the child or for others. A child may have some mild difficulty – such as with developmental delay - and be facing social prejudice. For example a child's speech may be delayed but the child is made fun of.

Identification of a single cause for a child psychiatric disorder is rarely scientifically justifiable. The causes may be a dietary allergy, lack of discipline, bad genes, poor teaching, hypothalamic damage, unresolved infantile conflicts and a number of other variables which may come into the mix. Dogra et al (2009:33) identify that '*poverty and socio-economic disadvantage is strongly co-related with development of mental health problems*'. There are risk factors which increase the likelihood of a psychiatric condition and resilience factors which protect. There are predisposing factors – for example a family history of such a condition and, perpetuating factors which mitigate against overcoming difficulties. Our current understanding of the aetiology of mental health takes into account that children inhabit three different social worlds – family, school and peers. Events which happen in any of these '*social worlds*' may influence a young person: a teacher scapegoating a child who has difficulty, peers bullying, adverse life events, chaotic family life style, social adversity, physical and psychological under lying unrecognised problems (such as

low IQ or specific learning difficulties) all can contribute to the child's mental health.

Also there are '*conditions*' within child mental health which, one may argue, are merely descriptions of the way things are – for example '*oppositional defiant disorder*'. Another condition which is also highly subject to speculation is attention deficit hyperactivity disorder (ADHD). Timimi (2005) is highly sceptical of this as a condition and blames it on our modern way of life and current expectations of young people. Today's culture appears to promote multi-tasking – can we wonder that more youngsters are developing this way. Is evolution progressing in this direction? Gilbert and Chodden (2013:165) refer to needing '*Affiliation and slowing down in the culture of speeding up*'

Barker (1971) lists causes of childhood psychiatric disorders, constitutional factors, effects of physical disease and environmental factors as being important. It would seem that his main focus on environmental factors centres on the immediate family with little emphasis on other relationships although he does mention the school environment and neighbourhood groups. Further, not only do physical problems influence a young person's propensity to develop mental health problems, but so do other less well defined issues – such as specific learning difficulties. Dyslexia and dyscalculia are two such examples which may make great impact on the learning experiences of individuals who may otherwise be of generally high intelligence.

### **2.17 The gaps in service provision**

Whatever the resilience factors of the young people there still remains a big gap in service provision where neither the legislation nor the policies make impact. For example, the Department of Health's Framework for Assessment (2000) did not provide the placements nor the workers to ensure that identified needs were met (Calder 2003). The NHS Health Advisory Service in 1995 published '*Together We Stand*'. This was a report and a manual which summarised a philosophy and a strategic approach to policy for CAMHS services in England and Wales. To achieve good mental health children need decent homes and decent schools. Children with behavioural problems should not be excluded from school for bad

behaviour, nor should a disturbed child be placed somewhere that is likely to make matters worse. Limited funding or time limited funding also does not help. If these children are our future we all need to work together and invest properly. Local experience often runs contrary to this with budget constraints taking precedence.

Despite government intentions, children's services were never uniform and different areas developed different service provisions - some of which are excellent, some less so. This is as true of local authority provision as it is of health provision. The House of Commons report (published in 2011:43) stated '*some local authorities will inevitably perform better than others*'. Dinsdale (2001) identified a primary shortage of trained staff and too few resources. The Young Minds website (2014) reported the lack of skilled staff as a problem. Thus this is not a new problem. Agencies now seem to have a focus on economising and cutting back. This is hardly a climate to develop services. Timimi (2009:17) states '*Rates of diagnosis of psychiatric disorders and prescriptions of psychotropic medication to children have increased dramatically over recent years*'. Wong et al (2004) analysed prescribing trends in nine countries between 2000 and 2002. Increases were common with Germany at the lowest being 13% while the UK recorded the highest at a 68% increase. Does this reflect the fact that it is easier to '*pop a pill*' rather than spend time to address the problems or could it be that the drug companies are doing a better job at marketing? Heckman and Krueger (2003) explain the cost effectiveness of early intervention. John Bowis (2005:v) (previous Minister of Health in the UK) writes in the forward to Williams and Kerfoot's 2005 Child and Adolescent Services, '*Child and adolescent mental health is one of the scandals of inadequate provision by health services across the world.*' Belfer (2014) states that resources to ensure child mental health have been eroded rather than being developed over the past 59 years.

## **2.18 Is the problem mental health, behaviour or culture?**

In considering what a mental health problem is, there is immediately a problem. Not all young people who have difficulties with their mental health receive any help although some are seen by CAMHS. ICD-10 and DSM-IV list 'conduct disorder' as a mental health condition, however many would dispute that it is a mental health issue. Many young people having this '*disorder*' go down the criminal justice route

(Teplin et al 2002, Richardson & Liabø 2007, National Collaborating Centre for Mental Health 2013) thus changing the emphasis from mental health to being fully responsible for their actions. Hackett et al (2011) identified that of young people attending pupil referral units (PRU's) in Manchester, a larger proportion appeared to require professional help from mental health services than were receiving such services. Thus not every mental health difficulty is seen as such. Children and young people with pervasive developmental disorders are likely to go down routes supported by the disability services. Again it can be argued that these are not '*mental health problems*'; they are developmental issues. Children with neurological disorders have high rates of psychiatric disorder (Cadman et al 1986, Rutter et al 1970a). Often children and young people who experience adverse living situations will '*act out*' some of their frustrations in their behaviour. Some of these young people will be taken into the care system. Many have mental health problems but it could well be argued that it is their living situation which has contributed to this. The behaviour can in fact sometimes be understood as a coping mechanism to adverse conditions. Thus people may become vulnerable due to coping with adverse conditions.

'*Difficult*' behaviour is not always recognised as a mental health issue. Apart from actual child mental health services there are two other main systems which come into contact with those youngsters displaying this '*difficult behaviour*'. These are the criminal justice and the social service systems. There is also the nurture nature argument about how young people are influenced by either nurture or nature but most probably both. Gilbert and Choden (2013) clearly state that if they had been brought up by drug dealing gangs they would probably not have written a book about mindfulness and compassion. Humans depend on a balance of the drive system, the fight or flight system and the nurturing system - it is the balance which keeps us healthy.

## **2.19 Can mindfulness help?**

In conclusion it is clear that a whole host of factors contribute to child mental health - both good and bad mental health. In the current economic climate resources are limited and it tends to be only the most severely affected who get a service. There is a continuing need to develop and extend services which will be

helpful to young people thus the development of a mindfulness-based programme of intervention seemed worthwhile.

Although mindfulness is potentially helpful to all, for those who live in disadvantaged situations this could be quite a challenge. Just being in the present moment without being preoccupied by past or future can provide some respite if people can let go of their concerns for long enough to realise it. However this may be easier said than done. Gilbert and Chodden (2013:106) point out that to benefit from mindfulness one needs self-compassion. Being angry or anxious can block compassion. Thus for some, who may have had very difficult life experiences this may make it almost impossible to develop mindfulness.

To be mindful one needs to tune in to emotional states. Some people may not be in a good mind-set to proceed with mindfulness. Experiencing intense rage and accepting that it is there is difficult. Both the fear of the emotion and the shame in admitting it is likely to block it. For those who can manage it, mindfulness provides a different way to better cope with some of life's challenges. It does not change circumstances but creates the space for us to calmly view where we are and make better decisions. Mindful compassion helps us wake up to what we are caught up in (Gilbert and Choden 2013:23).

This chapter has considered various aspects of child mental health and influences which might impact on this with insufficient resources to deliver services to vulnerable young people. In Chapters 4 and 5 consideration is given to methods of how best to take forward the idea of a mindfulness intervention which would benefit the young people.

## 3. Towards developing a methodology

### 3.1 Overview

This chapter considers the research framework taking into account the Buddhist roots of mindfulness before considering the question of 'reality'. Moving on, more philosophical research concepts are considered. Qualitative and quantitative aspects of research are then addressed linking to the research aims. The chapter moves on to the justification of research methods and a consideration of methods that provide some measure of triangulation. Focus groups and the parental interviews are explained in some detail. Single case evaluation methods are discussed as an appropriate way in which to identify any changes in the emotional functioning of the participants. Consideration is then given to analysing the data and selecting a method of analysis. The approach to analysis will be considered in relation to the qualitative approach. Reflection is given to selecting codes and themes with an open mind. Reviews and reappraisals are an integral part of the process which concludes when a logical '*story line*' can be identified and the analytical process is clear. The chapter concludes with a detailed description of the outcome measures used in the research forming the basis for the single case evaluation. These were the questionnaires completed before and after the mindfulness sessions. The continuation of the research project, how this evolved and the resultant modifications are outlined in Chapters 4 and 5.

### 3.2 Research framework

Guba (1990:18) states that all paradigms can be characterised by the '*way their proponents respond to three basic questions*'. These he lists as ontology, epistemology and methodology. Ontology concerns the nature of reality – how we see things - the theory one has about how the world is. For example - is it real and set in stone or malleable and changing? Our view or 'ontic' clearly links in with our experiences, our culture and our environment. Epistemology '*refers to the philosophical theory of knowledge - how we can know what we know*' (Seale 2007:507). Methodology refers to a system of methods used in a study for investigation.

Guba and Lincoln (1994) state that a number of basic belief systems are involved in deciding any approach to research which contribute to the paradigm. Mackenzie and Knipe (2006) identify that paradigms and methodology work together to form a research study. Detailed consideration was given to this aspect and indeed Mertens (2007) suggests that the definition of research is influenced by the researcher.

Thus from the viewpoint that things are not fixed and considering that the young people were facing challenges, it seemed logical to introduce a strategy which may change their view of the challenges allowing some space for better decisions. This was a study involving young people and their views and thus it presented a qualitative approach. However, to establish whether any progress had been made would involve measurement and thus a more quantitative aspect to the research.

Taking into account the Buddhist roots of mindfulness it seemed appropriate to consider the paradigm within that tradition - hence the traditional Buddhist paradigm. As already outlined, Buddhism speaks of the four noble truths: that there is suffering in the world, that there is a reason for it, it can be overcome and there is a way to do this (Gunaratana 2009, Gilbert and Choden 2013, Bays 2011). Mindfulness is about accepting things as they are without getting too caught up in our worries. Mindfulness practice develops awareness seeing things as they are without adding or subtracting from them. Perhaps this is what Silverman (2007) meant in his account of becoming a good ethnographer. Therefore collection and analysis of the data should bear in mind this viewpoint.

### **3.3 Understanding 'reality'?**

To some extent everyone creates their own reality, including researchers, and it is the interrelationship that forms the experience. Bryman (2008) states that social research does not exist in a 'bubble'. Fishbein and Ajzen (1975) point out that the views of other people may influence individuals – probably more so in group situations - thus the social constructionist ideas are relevant here. Carter and McGoldrick (1998) describe the family life cycle and how individuals view things differently from different stages in their life. For example the views of a young single person are likely to be very different from that of a parent. Timimi (2002:7)

highlights how different disciplines tend to view problems through the perspectives of their own establishments. This resonated with the experience of this research. The researcher role sometimes became somewhat blurred with the role of a therapist rather than a researcher. There are many ways of viewing the world and not least is through the role of language. The Sapir-Whorf Hypothesis (Wardhaugh 1986, Trugill 1974) has the view that people are shaped by the language they speak. Chomsky (2006) identifies '*elaborated codes*' of language which some do not have access to thus suggesting a hierarchy. Walker (2003) illustrates how different terminology can result in different perspectives. However even using the same word in the same language can have different meanings – for example the word 'Asian' in the UK denotes people or objects of mainly Indian or Pakistani origin but in Australia '*Asian*' denotes Chinese or Indonesian.

### **3.4 The philosophies**

Paradigms or world views have different contexts and can have a very wide or a much narrower view. The word paradigm has a more specific scientific meaning: a term first referred to by Thomas Kuhn in his work *The Structure of Scientific Revolution* (Guba & Lincoln 1994). From this viewpoint a paradigm contains all of the commonly accepted views about how research should relate to a subject. Paradigms change over time periods as new understanding of materials evolves. A good example of this is within the world of physics where new understandings of the way things work have opened new perspectives. Niglas (2001:3), states that there are several different ways to consider the relationship between methodology and philosophical paradigms. She identified the '*two big paradigms*' as positivism and '*something which denies positivism*' which she states is named differently by different authors. Powers and Knapp (2011:140) state that the postpositive environment is of greater variation and cite '*constructivist, post-empiricist and feminist*' as examples of this. The number of different paradigms seems to have developed from that of '*two*' commonly extending to four. Niglas (2001) however extends her list of paradigms to six: positivism, post positivism, pragmatism, phenomenology, hermeneutic and critical realism. She also suggests that other things come into the mix – including linguistics and anthropology. King and Horrocks (2010) make a distinction between approaches focused on language and



those more concerned with content. Sobh and Perry (2006) list four paradigms: positivism, constructivism, critical theory and realism. Creswell (2014) lists four world views: post-positivism, social construction, advocacy/participatory and pragmatism. These will be outlined before going on to consider the most appropriate of these views for this research.

Firstly positivism (as clearly this seems to have come before post-positivism and therefore requires some explanation) involves the ontological view that there is a '*real*' world out there that is objective and is therefore knowable. The epistemological view is objective and the results '*true*'. Considering how '*real*' things can be is perhaps highlighted by Siegel (2010:104) who defines the scent of a rose as '*in fact a neural firing pattern or mental sensation of a rose's scent – not the scent itself*'. From such a perspective the question of '*reality*' has many dimensions. Taylor and Medina (2013) make a fishing analogy describing the positivist fisherman as standing on the river bank observing the fish. This approach tends towards quantifiable methods. The post-positivist fisherman however wears a wet suit and jumps in to study the fish. Thus, the post-positive approach is rather more critical in the ontology with results regarded more as '*probably true*' rather than '*true*' per se. The methods of such research may include both qualitative and quantitative methods. Social Construction takes a more relative view – '*truth*' is constructed by humans within a social context. The researcher and the participants are linked in this '*construction of knowledge*'. The methods generally are qualitative and involve dialogue. Advocacy/participatory paradigms can have a varied ontology. In this approach there is a breakdown in the researcher/participant positions and a high value placed on participant's knowledge. Methods tend to focus on empowerment and move towards positive social or cultural change. The pragmatic paradigm may have a varied ontology with more of a focus on what works rather than '*truth*'. The epistemological approach comprises many different viewpoints and the methods focus on the ones that seem the most appropriate for the task at hand. A further paradigm view is one named critical theory. This view owes much to the post-positivist approach but includes a historical perspective. Reality is seen as constructed through historical issues and power. Also knowledge is relatively mediated through the researcher's

perspective. Methods tend to be focused on uncovering knowledge and linking this to social critique. There would seem to be an expanding field of views with variations in approaches continuing to develop.

Considering the different views there seemed to be multiple realities rather than one '*truth*' influenced by a number of variables. Our life experiences and inter relationships count for a good part of these influences (Buddhists would argue that past lives also come into this): our physical makeup, including emotions, which vary from time to time, the society in which we live and the evolutionary stage individuals are at. This has a strong societal basis (Fishbein and Ajzen 1975) but individuals can vary. Not all members of more primitive societies share exactly the same beliefs and if Columbus had gone along with his compatriots, maybe we would still have feared falling off the edge of the world. Why should one person see a jewelled lattice work when another sees only a menacing spider web?

### **3.5 Quantitative and qualitative**

Sobh and Perry (2006) make the point that many researchers are concerned with the choice between qualitative and quantitative methodology. Harding (2013) points out that quantitative research usually tends to involve larger numbers of respondents while qualitative research involves more details from smaller numbers of participants. This research was designed to be undertaken with a small number of participants and their parents and thus fell mainly within the qualitative field. However this was a mixed methods study as a number of quantitative measures were used. These took the form of questionnaires completed before and after the sessions (see later in this chapter for a full description). Sale et al (2002) comment that combining qualitative and quantitative methods is useful in health care settings and thus using mixed methods seemed appropriate.

### **3.6 Linking to research aims**

The research aims were to deliver a mindfulness intervention to vulnerable young people and evaluate their experiences. Mindfulness encourages just accepting things as they are, acknowledging thoughts but not running with them. The views of the participants were considered to be their own although each of us is

subjected to our own '*conditioning*' with the effects of our upbringing and our local community having a considerable influence.

Thus the research was approached from a relativist social constructionism stance (Harper 2012), considering the research aim was to understand '*the complex world of lived experience*' (Schwandt 1994:118) – what the participants' views were. This led to an interpretive and constructivist viewpoint as the focus was on what '*we have contact with*' (Harper 2012:91). Consideration was also given to the Advocacy/Participatory view as there was a certain aspect of empowerment as the mindfulness sessions hoped to place the participants in a better position to manage their challenges. However the aims of the research included evaluating the mindfulness programme as well as a quantitative analysis of the questionnaires. Additionally the research aimed to gather a better understanding in order to develop a therapeutic strategy with a view to future service delivery. Thus advocacy was not the primary aim.

A further aspect of the study included in the aims was the position of the parents - the views of the young people would also be supplemented by those of their parents. Additionally consideration was given to whether there would be any further ways of evaluating the research. Certain questionnaires used before and after sessions (and in regular use in CAMHS) seemed appropriate for this purpose. Such research questionnaires completed '*before*' and '*after*' interventions lie within the quantitative positivist paradigm and are regarded as '*true*' (or at least '*maybe true*' if one comes from another perspective). Simons and Lathlean (2010) note an interest in mixed method designs in health research and it also seemed logical to include outcome questionnaires which would be familiar to clinicians in the field of child mental health.

### **3.7 The research design**

Research - to be worthy of the name - has to have some logical basis to it: some methods that can be followed through to some conclusions. Seale (2007:8) refers to methodology as the '*conception of its subject matter and how that subject matter might be investigated*'. Having considered the paradigms attention was focused on ways forward. The first objective was to design a suitable programme

in which the mindfulness sessions could be delivered. Of equal importance was the consideration of how this should be investigated and how to evaluate the impact of the sessions. Seale (2007) outlines '*validity*', which he explains derives from the '*truth-value*' of a research project and reliability, which is a concept more concerned with dependability. In other words the research project needs to have validity and be something that could be repeated to maintain similar results if undertaken in a similar way. Thus how the research is undertaken and then analysed needs to be clear. Harding (2013) suggests that the methodology section should include discussion of all the stages of the research process.

### **3.8 Justification for the methods**

Linking to the idea that there are multiple realities it seemed logical to combine as many aspects as possible in this research and thus it became one of mixed methods. A number of mindfulness programmes have been delivered (Segal 2002, Semple et al 2006, Williams and Penman 2014) and have proved effective in contributing to positive change. These typically were delivered over a period of about eight sessions. Thus this was the timescale envisaged which also fitted in well with other time constraints (outlined in Chapter 4). As the work was to be with vulnerable young people emphasis was put on making the sessions '*child friendly*'. (Examples of this have been discussed in Chapter 1 and Chapter 7 gives details of the content of the sessions which included some of these '*child-friendly*' methods.) Much of the work that has been done is with adults although Semple et al's (2006) work was with clinical populations of children. However their evaluation methods seemed to be based more on evaluation questionnaires rather than specific measures linked to emotional functioning. This particular research was planned for a clinical population and as such it seemed pertinent to use the regular measures employed within CAMHS to assess any progress. The mindfulness in schools programme (MiSP) has also advocated the use of SDQs to assess functioning, however the MiSP is not directed at clinical populations. Approaching the research required a pragmatic approach of mixed methods both qualitative and quantitative. There were three aspects to the study which offer a certain measure of triangulation, a technique advocated by Denzin (1978) for validating data. Triangulation was originally a geographical term allowing geographers to pinpoint

a location based on three different measurements (Topping 2010). In this research three sets of data were gathered, the focus group, the parent interviews and the questionnaires completed before and after the sessions using a single case evaluation method – the latter providing more of a quantitative aspect. Indeed Parahoo (2006) states that triangulation is sometimes referred to as a mixed method. This '*triangulation*' would be derived not only from the separate analysis of the questionnaires but also from the different accounts of parents, young people and teachers, providing '*methodological rigor*' (King and Horrocks 2010).

### **3.9 Focus groups with young people**

One of the advantages of a focus group is that it allows people to interact with others exploring and clarifying experiences (Goodman and Evans 2010). Parahoo (2006) also makes a similar point. The choice of this method fitted with the day-to-day experience of the students who participated in this research. They were used to meeting as a class and potentially would be more comfortable voicing their experiences with other classmates. The sessions themselves were delivered in a group format and this method seemed a logical progression of this. The use of an auto tape recorder simplified gathering the data from the conversation. (The interview schedule for the focus group can be found in Appendix 3).

### **3.10 Interviews with parents**

As this research was to be with young people the views of their parents would also be important. Parents' views give a wider perspective of the young person's functioning (Dogra 2002) and it was considered important to obtain as wide a view as possible. If mindfulness were to be an effective intervention then parents may have noticed some positive differences in their young people. Interviews with parents were planned to be undertaken individually. This was for a number of reasons. The logistics of getting the parents together would be difficult but this aside there was the matter of parents feeling free to discuss their child with others present as well as issues of confidentiality. Time constraints were also issues if the interviews were to be constructed in a group format. Some may want to talk less some more. Goodman and Evans (2010:406) cite the '*risk of individual participants dominating the group discussion*' to the exclusion of the contribution of others.

Individual inputs may have been diluted by the group – on the other hand this may have encouraged discussion. While this can work quite well in some situations it was an unknown - especially as the group would only come together for this purpose and the parents were not previously known to the researcher. It seemed better to provide the opportunity for parents to hold their interviews individually. As an experienced mental health practitioner the researcher was used to talking to parents about how their young people were progressing and therefore this seemed to be the right atmosphere in which to conduct these interviews. These were to be semi-structured interviews. This is discussed further in Chapter 8 and the format for the interview schedule can be found in Appendix 3.

The NHS Ethics Committee had asked for a list of potential questions to be drawn up and thus this was the structure followed (see Appendix 3) although there was plenty of scope for parents to make their own contributions and also scope for the researcher to ask other questions if clarification was needed.

Therefore the evaluation of the experiences of the young people (as presented in the focus group), the interviews with parents and the outcomes measures were the data collection methods for this research. These, it was hoped, could be used to discern whether there had been any beneficial impact.

### **3.11 Single case evaluation**

The process of completing questionnaires before and after the mindfulness sessions is similar to the single case evaluation method (Kazi and Wilson 1996). The size of the group was not large and the design needed to '*evaluate client progress*' (Kazi and Wilson 1996:700). Rizvi and Nock (2008:499) state that '*sometimes only one participant is needed*'. Kazi and Wilson (1996) discuss two questions that single case evaluation may address. Firstly whether change has occurred in the target group and secondly whether it was the intervention that led to any changes. Kazi and Wilson (1996) describe a number of designs, design 'AB' being the most basic, records the changes during a course of '*treatment*' (or other intervention). In this model the baseline 'A' (i.e. assessment before treatment) was made at a point where the intervention had not started. In such a

case it was possible to state if improvement had occurred within the '*treatment*' period. Thyer (1993) has termed the evaluative 'AB' as experimental.

Other models of the single case evaluation are available. For example the 'ABAB' involved two periods of '*treatment*' with a period of '*no treatment*' in between. This would highlight any differences that the '*treatment*' period produced. However with mindfulness it would seem that the results are cumulative (Mace 2008, Gunaratana 2009) and thus any periods in between may not make any difference. Another model is the 'ABABC' design where the '*treatment*' is given, to be followed by a '*no treatment*' period and then a different '*treatment*'. As this was to be a single series of sessions with only one intervention period, neither of these models fitted the requirements of this research.

Rubin and Babbie (2008) outline the elements of a simple case design - one of these is to specify the target problem. In this research there was no single individual problem as such. The young people all had some level of difficulty which contributed to their levels of emotional stress. Thus it was anticipated that mindfulness may be a factor contributing to better mental functioning. What was to be measured was somewhat different. Rather than focusing on individual problems it considered the impact of the mindfulness intervention on the general emotional functioning of the participants. It was not a matter of counting the number of times of a young person attending or not attending school, (as described by Kazi & Wilson 1996).

Behaviours and emotions are complex and the questionnaires used were ones commonly in use for clinical populations. The points measured covered a number of different aspects of behaviour and emotions each with a scale range of its own. Thus it was not thought likely that it would be possible to put the information into a simple line graph such as is frequently employed in the single-case evaluation design. Gunaratana (2009) states that the benefits of mindfulness are more like '*side effects*' and that the calm that one may seek from it is illusive. However using rating scales before and after the sessions offered the single case design an acceptable way to consider the intervention.

Wong (2010) identifies that the original purpose of single case designs had a prime objective of producing definite proof of a causal relationship. This could not clearly be established as other variables could not be ruled out. Kazi and Wilson's (1996) model measures the targeted behaviour at different intervals over a time period. In this case the measures were only employed at the beginning and end of the sessions. Ratings could only be compared on the conclusion of the sessions. However although no hard and fast '*evidence*' would be certain it was felt that any trends that might indicate improvement might be encouraging. Thus it was not entirely possible to say whether in this research any changes would be solely – or even partly - the result of the mindfulness sessions.

Table 1 below attempts to track the timescales of the research before moving on to discuss analysing the qualitative data.



**Table 1 Timescale of the research**

<b>Timescale</b>	<b>Activity</b>	<b>Tools</b>	<b>Details</b>	<b>Aims</b>
<b>2011</b>	Program development	Years of professional experience working with CAMHS Personal Knowledge of mindfulness & mindfulness literature		Meets first aim
<b>2012</b>	Seek support from university  Begin ethical process	Single Case Evaluation  Outcome Measures HoNOSCA CGAS SDQs PSS FMI  Parent interviews Focus Group Thematic Analysis evaluation		Meets first aim
<b>2013</b> May  August  September  October  December	Ethical amendments Final NHS approval  Organisational change  Pilot Group starts  Pilot Group concludes	      The above tools were used with this group	     Pilot Group were young people open to CAMHS	     Contributes to meeting the first 3 aims
<b>2014</b> January    April  July	No longer viable to conduct this research  Decision to relocate research  New approvals sought  Main mindfulness group starts  Main mindfulness group concludes	     The above tools were used with this group including analysis	    Main Mindfulness group were vulnerable young people attending a special education unit	Contributes to meeting the first 3 aims  The final project contributed to meeting all aims

### 3.12 Analysing the qualitative data

Bernard (2011) states that analysis is the search for patterns in the data.

Therefore it follows that the way in which the material is analysed needs to be clear. Auerbach and Silverstein (2003) state that there is no single right way to analyse a data set. Matthews and Ross (2010) advise that decisions should be made with reference to the research question. To establish this, methods to evaluate the project needed to be considered to decide which methods would fit with the particular research. The quantitative sections of the study required an analytical format that fitted with this. Consideration of how best to do this so as to yield a more robust evaluation of the outcomes is addressed below.

Silverman (2007:145) concludes that research studies should be '*methodologically inventive, empirically rigorous, theoretically alive but with an eye to practical relevance*'. Thus the aim in this research was to attempt to explain the process of analysis in such a way that it would be both accurate as well as of interest to the reader in the justification of the analytical process. Attride-Stirling (2001) states that qualitative researchers need to be clear about what they are doing and why. Also the '*how*' section needs to be explained. The aim of this analysis was to present the findings in as clear and comprehensive a manner as possible. There has been much debate over the validity of qualitative analysis (Kelle 2000) and thus it was important to select a method which would be both valid and clear in evaluation. In any project, whether of a qualitative or quantitative nature, analysis of data is important as it gives further interpretation of the findings. Sanders and Liptrot (1993) define analysis as taking things apart to see how they fit together.

Harper (2012) emphasises choosing the most appropriate method of analysis to fit the research question. Saldaña (2013:2) observes that in the pragmatic process he is '*yet to find a single satisfactory book that focuses exclusively on the topic*'. Harper (2012) points out that this is a central concern for academics. There are many publications that cover various aspects of the qualitative analytical process. King and Horrocks (2010:211) recommend a wide reading before determining how analysis will be carried out – not merely a '*cook book approach*'. Seale (2007) emphasises that practising researchers should find what is of value in each approach.

Elliot (2012) comments that research in mental health, psychology and related fields originally fell into two divisions - outcome and process. Outcome relates to how much people change over the course of treatment whereas process looks at what occurs within the treatment sessions. Notwithstanding the importance of the process itself, this research aimed to look at outcomes. The research question was whether the sessions delivered in this way would be practical and of benefit to the participants. Therefore the evaluation of their experiences and the outcomes, by which it could be discerned (whether there had been any beneficial results), were the focus for the evaluation.

### **3.13 Thematic approach**

Three particular studies influenced how the text should be analysed. These were a study by Allen et al (2009) which was undertaken with adults who had completed a similar course in mindfulness-based cognitive therapy, a short mindfulness experimental course given to psychology trainees (Moore 2008) and a study of questionnaires used to evaluate mindfulness with a view to quantifying their relative effectiveness (Baer et al 2006). Because two of these studies delivered a course in mindfulness and the third evaluated a questionnaire to evaluate mindfulness, their conclusions were useful in thinking about this research. Baer et al's (2006) study was conducted with a series of self-report questionnaires and identified four facets that develop with mindfulness practice. These are acting with awareness, non-judgmentally, non-reactively and ability to describe feelings. Allen et al's (2009) study comprised a series of participant interviews with people who had previously undertaken a course in mindfulness-based cognitive therapy.

Bryman and Burgess (1994) point out that discussions of qualitative research methods sometimes fail to explain how decisions have been made. Reflecting on how the analysis should be undertaken, there were a number of things that were relevant. Dawson (2009) provides a list of options that researchers engaged in this type of study may consider:

- Comparative analysis
- Content analysis

- Discourse Analysis
- Thematic Analysis

Harper (2012:85) offers a guide to map the kind of qualitative analysis that best fits with the particular research. Thematic analysis seemed to fit the question: '*Do you want to summarise unstructured data in thematic categories?*' Had the focus been on representing these data numerically or using percentages then content analysis may have been more appropriate. Also interpretative phenomenological analysis would not have been appropriate as the participants were not selected because they could '*offer a valuable perspective on the topic*' (Larkin and Thompson 2012:103).

Although different accounts were given by different people, it was considered to be more a question of combining these rather than contrasting them. Thus comparative analysis did not seem appropriate. Content analysis, looking at how often certain factors occur, also did not seem the most useful. There were likely to be other things that might emerge and maybe some important points that only appeared once. However it would be important not to dismiss this approach altogether as, if there were to be a number of similar views, it would be important to consider these. As this was not discourse analysis the actual patterns of speech were less important than the overall views. Thus thematic analysis seemed the most appropriate. However this method is primarily associated with inductive approaches and while it was an aim to see what the transcriptions revealed, there was an intention to look for indications of the benefits of mindfulness, thus presenting a deductive element.

Guest et al (2012:11) claim that thematic analysis is most useful in capturing the complexities of meaning within a textual data set. Aronson (1994) suggests that thematic analysis is one way of analysis of participants' '*talk*'. Boyatzis (1998) characterises thematic analysis as a tool. Saldaña (2013) identifies coding as one way of analysing data – but not necessarily THE way. He points out that it is important to find the right tool for the job. Joffe (2012) makes an important distinction in terms of domination of a theme. This relates to whether it is drawn from the researcher's theoretical idea (termed deductive - based on the ideas the

researcher holds) or from the raw data (termed inductive – or ideas which come to mind from reading the material). One goes to the data with certain preconceived categories derived from theories yet one also remains open to new concepts that emerge. It is important to approach each data set with knowledge of previous findings in the area under study *'to avoid re-inventing the wheel'* (Joffe 2012:210). Boyatzis (1998) contrasts theory driven codes with inductive codes albeit with some overlap. Thus there is often an element of theory influencing the researcher. However, in addition one wants to take seriously the findings that do not match with previous frames and have the potential to revolutionise knowledge of the topic. Harding (2013) cautions against overlooking important themes emerging from the data. Thus a dual deductive–inductive and latent-manifest set of themes are used together in high quality qualitative work. That is, some views are expressed directly (manifest) while other themes emerge more latently from the data. Thematic analysis is among the most systematic and transparent forms of such work however, as Salaña (2013) emphasises, one tends to view the research through coding filters – that is the interpretations and perceptions of the researcher. It was therefore important to be aware of this.

### **3.14 Thematic analysis**

Thus, in analysing the contents of the focus group transcriptions a thematic approach was taken. The first step was in searching the text for codes that seemed to come together. As Gibbs (2009:41) phrases it –*'what it (the data) is about'*, considering the text and trying to link similar themes. Gibbs' (2009) suggestions about photocopying, cutting up and placing different themes in different *'wallets'* lent itself to this analysis.

These interviews were then transcribed verbatim and analysed using thematic analysis. Four *'overarching'* themes emerged in Allen et al's data. These were control, acceptance, relationships and struggle. Moore (2008: 334) used self-report questionnaire and thematic analysis methods. The main themes that he identified he named as *'Accessible and manageable'*, *'A good introduction'*, *'A scheduled space'*, *'new insights'* and *'Recognition of being unmindful'*. It seemed useful to consider whether any of these themes had any relevance to the experience of the group. Many of the acknowledged benefits of mindfulness can

be linked to various interventions which have an established research basis. Segal et al (2002), Kabat-Zinn (1990, 1994) and Shapiro and Carlson (2010) are some of those who have established this evidence base. It would be interesting to see if any of the same themes appeared.

Thus there was a certain aspect of Harding's (2013) '*a priori codes*' which are created to reflect categories that are already of interest before the research has begun. The primary focus was about the experiences of mindfulness and how these experiences had impacted on the young people. A number of questions (required by the Ethics Committee) and designed to help the discussion were to be put to the group. Some questions were directly related to experiences of mindfulness. These were intended to try and ascertain whether the sessions had been helpful to them, what the young people's views of the sessions had been and whether or not they were likely to continue with their individual mindfulness practice. Thus these points were directly relevant to the research question. Also relevant were the three studies mentioned earlier: Allen et al (2009), Moore (2008) and Baer et al (2006) as they centred on development of qualities which increased with mindfulness practice. Some of the themes might be relevant to the young people in the group and these were all points to consider.

### **3.15 Codes and themes**

Aronson (1994) makes the point that thematic analysis focuses on identifiable themes and patterns. King and Horrocks (2010) comment that there is surprisingly little in the literature defining a theme. Also there are a number of similar words which at times seem to almost overlap in the literature: codes - themes – concepts. Braun and Clarke (2006) state that themes themselves are composed of codes. Saldaña (2013:3) defines codes as a word or short phrase that symbolically captures the essence of a portion of language. King and Horrocks (2010:266) suggest the following definition of a theme:

*'Themes are recurrent and distinctive features of participants' accounts, characterising particular perceptions and/or experiences which the researcher sees as relevant to the research question'.*

Joffe (2012:209) notes that '*because thematic analysis refers to themes the notion of themes must be examined more closely*'. She refers to specific patterns found in the data. This can contain a '*manifest content*' – that is something directly observable. As examples of this she takes themes from her research. '*Stigma*' is one theme which appears as '*manifest content*' while '*maintaining a social distance*' places this in a more latent context. Gibbs (2009) states that coding is how you define what the data is about – simply a way of organising your thinking about the text, forming a focus for thinking about the text and its interpretation. Blaxter et al (2010) say that themes are the key issues or concepts identified as being of relevance.

### **3.16 Identifying themes**

As far as possible the aim should be to be as open as possible to matters arising from the data. Harding (2013) advises to make notes of whatever is interesting. This is somewhat similar to the ideas of White and Epston (1990) Narrative Therapists, who advise to see what '*resonates*' with the individual (from the dialogue) as a basis for taking ideas forward. Gibbs (2009:52) advises to

*'pay close attention to what the respondent is actually saying and to construct codes that reflect their experience of the world, not yours'*.

As mentioned earlier Harding (2013) outlines '*a priori*' codes and empirical codes which are derived from reading the data. Although possible themes relating to the known benefits of mindfulness (as outlined in Chapter 1) were a focus, it was also important not to disregard any other points that might arise from the text. Joffe (2012:216) states that a good thematic analysis includes the bulk of the data and not simply the sections that support the argument that one wishes to present.

Starting with the transcription of the focus group, consideration was given about what to code. Charmaz (2015:69) suggests some basic questions:

1. What is going on?
2. What are these people doing?
3. What is this person saying?

4. What do these actions and statements take for granted?
5. How do structure and context serve to support, maintain, impede or change?

Harding (2013) advocates summarising portions of the text as one method which may make it easier to identify what is said as longer dialogues can be challenging, also it can help the researcher to become more familiar with the text. Joffe (2012) discusses whether themes identified in the data are of a manifest content or are more latent in nature. Boeije (2010:76-77) notes that qualitative analysis consists of

*'cutting data up in order to put it together again in a manner in that seems relevant and useful'.*

Thus one looks first for main themes and then to see whether these are comprised of smaller sub-categories or codes and perhaps the codes come together to form new main headings.

### **3.17 Ways to progress coding to themes**

Braun and Clarke (2006) advise that thematic analysis should be seen as a foundation method and provide an account of a way this can be done. Gibbs (2009) also provides a useful account of the coding process, as does Harding (2013). A number of authors advocate initial coding in quantitative analysis, progressing to identifying themes. Throughout the process reviews and re-appraisals are fundamental to the method (Braun and Clarke 2006, Gibbs 2009, Harding 2013, Spicer 2007, Aronson 1994, Saldaña 2013 and Boyatzis 1998). Charmaz (2001) describes coding as the '*critical link*' between data collection and explanation of meaning.

In the coding process King and Horrocks (2010:272) identify '*stage one: descriptive coding*'. The aim is to identify parts of the data that are likely to be helpful in addressing the research question. Before this the researcher will have read and re-read the transcript to have become very familiar with it. This can be done in different ways – for example highlighting the text. However too many markings on the text may become confusing and thus some other method might



serve better. Gibbs (2009) advocates producing many photocopies of coded transcriptions so that it is possible to cut up the sheets and store the extracts with the same code in separate wallets, also tagging each extract so as to identify which document it came from and using line numbers points to where in the document the extract came from. A similar technique is possible with a computer by cutting and pasting – if one has access to computer software programmes to do this.

A number of authors describe a number of steps or phases in this process.

Harding (2013) suggests four steps in analysis:

- Firstly identifying bullet categories based on reading the transcriptions
- The second stage is writing codes against these transcripts
- Then reviewing and revising the list of codes – deciding which code goes into which category and
- Finally looking for themes and findings in each category.

Braun and Clarke (2006) outline six phases of thematic analysis:

- The initial familiarisation with the data
- Generating initial codes
- Searching for themes
- Reviewing these themes
- Defining and naming themes - the final checking through
- Producing the final report.

Harding (2013) emphasises that it is important to accurately describe what happened. Aronson (1994) focuses initially on identifiable themes and patterns – patterns which can be listed. Her next step is to identify all data relating to these patterns. This is followed by combining and cataloguing related patterns into sub

themes. Then she suggests building a valid argument for choosing the themes (with reference to reading the relevant literature) to formulate theme statements and develop a story line. When literature is interwoven into the findings the story so constructed then stands with merit.

King and Horrocks (2010:275) recommend that only when coding seems '*good enough*' can '*stage two: interpretive coding*' proceed. They recommend leaving theoretical concepts aside at this stage of analysis but to be guided by the research question. The next stage is '*stage three: defining overarching themes*'. These themes should be at a higher level of abstraction than the interpretive themes and they suggest that two to five themes are the norm but this is not prescriptive. Joffe (2012) observes that specific criteria need to be stipulated concerning what can and what cannot be coded within such themes. Without such a stipulation the overall analytical process would be highly subjective. She identifies explicit and implicit themes often with some overlap between them.

These were the issues in considering the methodology of the project. How the content of the focus group was analysed and also the analysis of the parent interviews is discussed more thoroughly in Chapters 7 and 8. A thematic approach was used drawing on the view of the participants although there was a certain aspect of identifying themes that have been previously known to be associated with the benefits of mindfulness. The discussions were partly structured by a number of questions although largely open to individual comment.

### **3.18 The quantitative outcome measures used**

The four outcome measures used in the more quantitative aspect of this research include the Strengths and Difficulties Questionnaire (SDQs Goodman et al 1998), CGAS (Gould et al 1983), the health of the nation outcome scales for children and adolescents (HoNOSCA) (Gowers et al 1998) and the FMI (Walach et al 2006). The first three measures are commonly used in child mental health to establish whether any positive changes have occurred in the mental health of the young person. The FMI is specifically designed to measure mindfulness. These questionnaires are discussed individually below.

### 3.19 Strengths and Difficulties Questionnaire (SDQ)

The SDQ is a brief validated screening tool commonly used in child mental health settings and it is also widely used for research (Goodman and Goodman 2009). It aims to identify any strengths or difficulties a young person may be having and thus it is useful to assess how a young person is coping emotionally. The questionnaire is designed for self-completion – either by adolescents or by a parent in the case of a younger child. Usually it would be the parent if the child is below the age of 11.

Usually questionnaires are filled in when a patient first accesses a service and subsequently after a period of treatment or more routinely after a six-month period. In the case of this research the aim was to assess whether, during the period over the eight sessions, there had been any improvement in the young person's emotional well-being.

The SDQ is also used in educational settings, particularly in settings where pupils may be under emotional stress, to record any progress (*'progress'* would be apparent by lower scores on retest). It was developed by Robert Goodman in 1997 and covers five main domains which may impact on a young person's life. These are overall stress, emotional distress, behavioural difficulties, hyperactivity, peer relationships, helpful behaviour and impact on life. The lower the scores the better the young person is coping and thus it can prove a useful measure to assess young people and also whether there have been any improvements during a *'before'* and *'after'* period.

The SDQ questionnaire can be rated by the young person, the parent and a teacher although all three are not always asked to complete these. Goodman et al (1998) developed the self-report version for young people aged 11-16. Eleven to sixteen year olds would complete their own but often it is better to ask their parent to complete one as well as there may be differences in opinion which could be highlighted by the separate forms. For example a young person scoring highly in an area where the parent had not recognised there was any problem or conversely the parents seem more concerned where the young person's score does not

reflect this. Both cases would need further clarification which may emerge with further enquiry. Jones (2003:114) states that

*'securing parental support is likely to be a very important factor in terms of supporting them'.*

This was a relevant point. This research aimed to gain the views of the parents not only during the interviews but they were also asked to complete SDQs in respect of their children before and after the sessions. It would be useful to get their views. This would add to the information already collected further clarifying whether there had been any improvements in the emotional health of the young people, a point which the research aimed to discover.

Two of the domains on the strengths and difficulties questionnaire were relevant to the research question - that is whether the sessions had helped stress levels decline. The two domains selected were '*overall stress*' and '*emotional distress*' (lower scores indicate improvement). These were areas where improvement in emotional health may be indicated.

The SDQ is in the form of 25 main questions. There are five areas each of which contains five items. These areas cover emotional symptoms, conduct problems, hyperactivity or inattention matters, peer relationship problems and pro-social behaviour. People are asked to rate by ticking one of three boxes arranged in a Likert form: not true, somewhat true or certainly true. For example one of the questions asks if the young person is considerate of other people's feelings. (See appendix 3 for the form.)

After the main 25 questions there is an additional space for writing any other comments. In this research very few additional comments were written on the questionnaires but where they are this is referred to. Such comments can provide a qualitative indication of the difficulties. Finally there are five further questions on the back, firstly asking whether they considered their difficulties, if any:

- To be '*minor*', '*definite*' or '*severe*' (the young people who had any difficulties would presumably know if they thought they were '*minor*' or '*severe*'. Any falling in the mid-range were likely to be defined as '*definite*').

- The next question was about the length of time that any difficulties had been present.
- A question about levels of distress – again tick boxes in a Likert scale. The remaining two questions follow the same style.
- The first of these asks about the impact of the difficulties on four areas of the young person’s life: home, friendships, learning and leisure.
- The final question asks if the difficulties place a burden on the family as a whole.

The results are collated using an on-line computer formulation and results are indicated in the five areas mentioned above. Thus ‘before’ and ‘after’ scores can be useful in determining whether an intervention had been helpful. Overall improvement is clearly a sign of progress although improvement in one area may be significant - particularly if that is an area where the young person has particular difficulties. Hyperactivity and peer relationships could be two such areas where improvements are more significant where this area had previously been problematic to the young person. It needs to be said that young people differ in the way they present. One young person may have no problems with hyperactivity, for example. Thus you would not expect to see any changes as their scores are already within the average range.

Mathai et al (2004) studied the use of SDQs compared with the diagnosis of clinicians without this measure in a child mental health service. They deemed it a useful tool aiding diagnosis but also as some measure of assessing progress in terms of mental health or emotional difficulties.

The SDQs thus cover a range of different domains each with a scale range which varies through low, average and high. Also it should be noted that where some scores appear to only show a slight improvement it should be considered that this slight improvement may have moved a young person from a ‘*slightly high*’ to a ‘*close to average*’ range. If this is the case, it would appear to be a more significant improvement. The score ranges are worked out nationally and can be calculated by the Youth in Mind service which has an online service to assess results.

### 3.20 The Children's Global Assessment Scale (CGAS)

This scale was adapted for children from the adult Global Assessment Scale (Endicott et al 1976) and was compiled by Shaffer et al (1983) for use with children. It has been found to be a useful measure in identifying the overall severity of disturbance that a young person may experience. Thus it was hoped by using this measure any positive influences of the sessions would reflect in lower scores of disturbance – i.e. in the case of CGAS this would be indicated by higher scores. Shaffer et al (1983) recommend it to both clinicians and researchers as a complement to syndrome-specific scales. Blake et al (2007) reports that it is one of the most commonly used mental health measures of functioning. It is relatively simple to use and generally a reliable measure. Dyrborg et al (2000:206) have described the CGAS as a '*sufficiently reliable tool in clinical practice*'. Lundh et al (2010) do point out that to be reliable the clinician should have training and be familiar with the measure. In this case the previous experience of the researcher in the use of the CGAS in clinical setting over a lengthy period of time was thought to be adequate to achieve this. Young people are given a numerical score: 100 is the best one could ever be and 1 the worst, although most young people will fall somewhere in between. The scores are arranged in groups: 100-91, 90-81, 80-71 etc.; each group is given a heading: doing very well, doing well, doing alright etc.; and each section has examples of what may be experienced in that category – for example '*secure in family*'. (See Appendix 3 for questionnaire). There is some on-line training available to score the sheets. One difficulty in scoring particularly at the initial stage was a limited knowledge of the young people. The clinician is asked to give the young person a numerical score based on the descriptions which best fit how they are managing. '*Doing Very Well*' is the top category with a score range from 100 (the best) to 91. Others below this score have some difficulties increasing as the scores get lower. The lowest possible score would be '*Extremely Impaired*' with a score range from 1-10. Most fall between these ranges. For example a score between 71 and 80 falls into the '*doing all right*' category. The description reads:

*Doing All Right – 'minor impairment'*

*No more than slight impairment in functioning at home, at school, and with peers. Some disturbances of behaviour or emotional distress may be present in response to life stresses (e.g. parental separations, deaths, birth of a sibling) but these are brief and interference with functioning is transient, such children are only minimally disturbing to others and are not considered deviant by those who know them.*

A score between 81 and 90 would place people in the category which has the following description:

*Doing Well*

*Good functioning in all areas. Secure in family, school, and with peers. There may be transient difficulties and “everyday” worries that occasionally get out of hand (e.g. mild anxiety associated with an important exam, occasionally “blow-ups” with siblings’ parents or peers.*

The next category down is termed ‘Some Problems’ and included the following description:

*Some Problems – ‘in one area only’*

*Some difficulty in a single area, but generally functioning pretty well, (e.g. sporadic or isolated antisocial acts such as occasionally playing hooky, petty theft, consistent minor difficulties with school work, mood changes of brief duration, fears and anxieties which do not lead to gross avoidance behaviour, self-doubts). Has some meaningful interpersonal relationships. Most people who do not know the child well would not consider him/her deviant but those who do know him/her well might express concern.*

It can be difficult to rate a young person especially those scoring on the edges of the categories. For example it is hard to differentiate between a score of 70 and 71 and there is no exact way to define it. No doubt it is subjective to some extent but it is a widely used scoring tool which helps to assess how well a young person is functioning. With additional information – which is usually available through other

sources – it becomes easier to score and therefore less subjective. In CAMHS there would be a referral which would be likely to contain quite a lot of information. Indeed it was policy to reject those referrals that didn't give adequate information and return them to the sender. Also usually the young person would be present with their parent to provide extra information. The interview itself would comprise the initial assessment and the score done at the end. This research did not facilitate this extra information as the young people themselves would be the only source of information and thus filling in the forms without this would not guarantee accurate results. However it seemed useful to include the CGAS as an extra measure. The young people themselves would be invited to say how well they thought they were doing although this was not the only view to consider as previous clinical experience of using the measure would assist to allocate scores. However it must be underlined that the CGAS measure is designed to evaluate how well a young person is doing from a population that includes individuals who would not represent the mainstay of the population. Those for example in the extremely impaired range would be likely to require 24-hour care. Holland (2011) estimates that 2% of children have a learning difficulty. Although he does not quantify the different proportions of severity, he identifies different levels of learning difficulty from mild, moderate, severe and profound. The population for which the research was planned, where they had any level of learning difficulty this was likely to be at the high end of this continuum.

### **3.21 The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)**

The other outcome measure that seemed particularly useful in interpreting emotional functioning was the HoNOSCA. The HoNOSCA was developed by a research team from the University of Manchester and the Royal College of Psychiatrists as an outcome measure to evaluate how well young people were functioning (Gowers et al 1998) and it is a measure widely used in child mental health services. These scales were developed from the Health of the Nation Outcome Scales designed for adults to evaluate adult functioning in different areas of their life. Regard was given to young people and the areas of their lives which were likely to lead to stressful situations. Field trials were conducted to assess the



feasibility and acceptability of the tool in routine outcome measurement. Clinicians using this measure would have had training on its use of as was the case in this research. Often the training would be given in a group format in an attempt to ensure some consistency of scores within disciplines. Gowers et al (1998) concluded that HoNOSCA demonstrated satisfactory reliability and validity characteristics. Also it was sensitive to change which correlated to the clinicians' independent rating. It has also been found to be a reasonably acceptable outcome measure for clinicians from a wide range of disciplines. Thus it is widely used in child mental health services.

There are 13 categories in section A, and a further 2 in section B. However Section B relates mainly to parents' knowledge and information about mental health and about services. It is not always included and was not used in this research. The young people would be seen individually and not with parents for this research. Clinicians are asked to give a score on the individual points. These are outlined below:

1. Disruptive, anti-social or aggressive behaviour
2. Over-activity, attention and concentration
3. Non-accidental self-injury
4. Alcohol, substance/solvent abuse
5. Scholastic or language skills
6. Physical illness or disability problems
7. Hallucinations and delusions
8. Non-organic somatic symptoms
9. Emotional and related symptoms
10. Peer relationships
11. Self-care and independence
12. Family life and relationships

13. Poor school attendance.

#### Section B

14. Lack of knowledge – nature of difficulties
15. Lack of information – services/management.

During the appointment where an assessment is being made of the young person's functioning, the clinician asks questions about different aspects of the young person's life and scores them from one to four - for example, if there had been any instances of disruptive, anti-social or aggressive behaviour over the last two weeks: if there had been no problems, a score of 0 would be given; had there been a minor problem which required no action this would be scored as a 1; a 2 would constitute a problem that made more impact; 3 would be a more severe problem; and 4 would be a very severe problem. There may have been difficulties in some areas but not others. It may be that the young person had difficulties with scholastic skills, peer relationships or school attendance or none of these. Scores are added up and a number given. Clearly the lower the number the better the young person is managing. (See Appendix 3 for the HoNOSCA Score Sheet).

With training and familiarity clinician's skills develop in the completion of the questionnaire. It is a useful tool to identify the areas in which problems exist as well as to be able to reassess any improvements which have been made. It also gives an idea of more overall functioning. As it is divided into different sections of a young person's life it perhaps gives a more detailed picture than the CGAS does. The initial questionnaires were completed following a brief individual meeting with the researcher, before the start of the sessions, and a further one was completed at the end.

### **3.22 Freiburg Mindfulness Inventory (FMI)**

The choice to include the FMI (short version) (Walach et al 2006) was made on the basis that it was a good effective measure to evaluate whether the participants had developed mindfulness skills and had been specifically designed for that purpose. This is a fully validated self-report questionnaire which is longer established than other measures (Mace 2008). The short version contains 14

questions and was chosen as it seemed less daunting for the young people to complete rather than the 30-point full version.

Participants are asked to choose from four categories whether they rarely, occasionally, fairly often or almost always do the following. For example: '*I accept unpleasant experiences*'. (Please see Appendix 3 for the questionnaire and the full list of questions which were asked.) The hypothesis was that with more knowledge and practice of mindfulness the scores would increase.

### **3.23 Summary**

This chapter has considered the research framework and the various aspects of this taking into account the Buddhist roots. Both quantitative and qualitative aspects are involved. The link to the research aims has been addressed. Some consideration has been given to 'reality' before moving on to more philosophical aspects.

Consideration was given to the design of a suitable programme with an emphasis on '*child friendly*' sessions taking into account previous similar work that has been undertaken. Of equal importance was the evaluation of the impact of the sessions. The research involved young people and their experiences needing an interpretive and constructivist viewpoint. As much of the research presented in the theme of dialogue (focus group and parent interviews), a thematic analysis was pursued as a way of analysing the transcripts, identifying various themes. The other aspect to the study was a single case evaluation method in which questionnaires, linked to emotional functioning (the SDQs, CGAS, HoNOSCA discussed above) were completed '*before*' and '*after*' the sessions: thus presenting a quantitative positivist paradigm. The three aspects to the study (outlined in this chapter) provide some measure of triangulation. The actual analysis of the single case evaluation, the focus group and the parent interviews will be more thoroughly covered in Chapters 6, 7 and 8. Combining the different aspects helped to provide a fuller picture. Additionally there was also the perspective of the future development of a therapeutic strategy based on knowledge gained during this research.

This chapter has dealt with the more theoretical aspects of the research. The following two chapters trace the course of the more practical issues which the research followed.

## **4. Setting the research in a methodical and contextual framework**

### **4.1 Overview**

As it was within CAMHS where the project was designed and envisaged that it would be delivered to a clinical population, this chapter looks at some of the background to CAMHS with the various shortfalls in the face of increasing demands. The continuing need to develop cost effective services is identified. The development of the idea for the research within the CAMHS framework, which existed at a time when certain protocols were being followed, is discussed in relation to the '*fit*' with the research design. The workings of the '*choice*' and '*partnership*' approach are explained with emphasis on what might be the best '*fit*' for the research. An outline of the official process involved is discussed along with issues relevant to research with children. Certain issues – such as the position of '*the control group*' - are discussed and also consideration is given to the mindfulness context and the recruitment of the group along with any ethical implications which may present. The question of ethics is reviewed linking with Buddhism as well as more general views of ethics, before moving on to ethical issues more clearly linked to research. Values shared by health professionals are identified. Consideration is given to the position of mindfulness in the research in the light of ethical issues. The stages in obtaining ethical approval are outlined and an outline of the research protocol is provided. The continuing process and the eventual outcome continue in Chapter 5.

### **4.2 CAMHS issues**

Firstly attention is given to CAMHS and some of the issues which set in context how the idea for the research developed. Also the structure of CAMHS is important here as this point greatly influenced the original development of the ideas.

### 4.3 Background to CAMHS

The NHS CAMHS Benchmarking Report (December 2013:5) points to '*service access restrictions in some areas*'. They identified that there were a variety of service models and a range of relative funding arrangements. They report that information from the independent sector is '*relatively sparse*' (p4). The report also claimed that:

*'There is a high level of variation observed in relative activity which reflects a number of issues including demand and available funded capacity' (p23).*

The third report of the House of Commons Health Committee (2014-15:23) reported hearing from many voluntary sector providers.

*'They described extremely fragile funding arrangements and increasing uncertainty about their future sustainability.'*

Even so they described such services as '*absolutely integral*'. Thus in some areas where there happens to be a voluntary service, mental health service users might fare better than in other areas. Williams and Kerfoot (2005) clearly identify the importance of relationships within the child mental health service. Relationships can be at a strategic level involving other agencies but also the relationships between clinicians and clients are important as through these the benefits to the public are delivered. Equally they stress the importance of the context of the whole enterprise. They explain that this context frames knowledge, skills and attitudes but more significantly can either promote or hold back development and shape the expectations and demands of the public; thus the need to develop effective services which meet the needs of the population.

As outlined in Chapter 2, CAMHS have continued to develop from the early child guidance clinics in 1927 (Hall 1965). The 1946 Health Services Act incorporated the child guidance clinics which were to continue until the 1990s slowly becoming CAMHS services. As outlined above, not all services are alike and while some services are excellent, with some very skilled people working within them, others face more challenges. Stallard et al in 2007 carried out a national survey about the

usage of Cognitive Behaviour Therapy (CBT) within CAMHS. Questionnaires were sent out to specialist CAMHS professionals, to which approximately 10% replied. These workers were canvassed about the usage of CBT treatment: 40% reported that they rarely used this therapy. This illustrates the point that services nationally are not uniform and some may achieve better results in some therapies which may not be as available in other areas.

There are differences in the way services are commissioned and less funding availability has impacted on service delivery. The role of charities has been mentioned above and it is important to recognise their contribution which frequently takes some of the pressure off CAMHS. On 13 October 2015 a children's charity, Safe with Sam, highlighted that CAMHS had insufficient funding to cope with the demand for the service. They introduced a petition to their website inviting people to sign in favour of appointing counsellors in schools to '*take the pressure*' off CAMHS. Often in inner-city areas extra funding is provided by various means to offset the high levels of deprivation. For example Fairbridge is a charity operating as part of the Prince's Trust. It is quite effective in helping young people cope better with difficulties in their lives.

McCabe et al (2013:21) suggest that that providing '*evidence based early intervention*' provides the '*greatest opportunity for cost savings*' in terms of children's future mental health. Charities are often very localised and commissioned to provide a service to a specific area. Such services supplement child mental health services in areas where they are provided and are often very valuable to the young people.

The National Assembly for Wales (2001:19) reported that '*access to good CAMHS services depends more on geography than on need*'. The report also suggests that the distribution of services owes more to historical patterns and local advocacy of service development than it does to assessed need. They claim that the:

*'potential of the voluntary sector is insufficiently understood' and its 'contribution has not been systematically developed' (p17).*

Biggins (2014:97) outlines how '*CAMHS has begun to colonise its sister agencies*' giving examples of how social care agencies have taken a role in providing mental health services such as behaviour support teams.

As has been mentioned previously, services to young people have not historically followed the basic framework which now exists in the tier system. The 1995 Health Advisory Service (HAS) report '*Together We Stand*' introduced the tier system. CAMHS is not alone in providing services for vulnerable young people and a number of initiatives have continued to develop. For example the Government's Quality Protects innovation in 1998 which was launched to improve the life chances of looked-after children. The Sure Start local programmes which helped younger children and their families started in 1999. The Welsh Assembly (2001) acknowledged that despite new initiatives neither the education nor social service departments could play their full part in the delivery of child mental health services. This pattern seems to have been repeated in many areas throughout the UK not only in Wales. In 2003 the Every Child Matters document was published giving attention to five outcomes: being healthy, staying safe, enjoying and achieving, making a positive contribution and achieving economic well-being. The 2004 Children Act gave statutory force to these objectives (Youngminds.org 2015).

One of the difficulties within modern society is that while progress has been made in treating mental health conditions, so have the stress levels within the general public risen considerably (Twenge 2000, Seaward 2012, Bor et al 2014). The Nuffield Foundation published a report in 2012 which claimed that young people in the 2000s were twice as likely to have experienced anxiety or depression and that the rate had doubled in the last 30 years. Thus there would seem to be a shortfall in some respects. There is a net but there is also space to fall through the net. This highlights the need to provide effective strategies to counteract this and thus the intention of this research to try to develop an effective programme.

Kurtz (2005:417) states that there is not only one way of providing a comprehensive service but examining the local 'service map in the light of the assessed local needs' identifies the strengths and can highlight unmet needs and point towards service development. In 2007 the Government commissioned an



independent review of CAMHS (CAMHS review 2008). The report advocated closer working arrangements with the roles of various agencies needing to be clarified. In 2012 the Government produced their response to this survey noting that the review had highlighted that the quality and accessibility of provision needed to be more consistent across the country (CAMHS service model 2012). The NHS CAMHS Benchmarking Report (2013) identifies the growing demands made on the service, acknowledging that average waiting times have increased since their report in 2011. This has also meant that other services – for example paediatric services which have absorbed some of the work but are insufficiently resourced to provide this addition to their service - have also suffered. Thus more demands are made on the services with a knock-on effect to other services. This underlines the need to develop more effective services.

#### **4.4 Supply and demand**

There is frequently a tension between the needs of the local community and the resources available to meet these. The 2013 NHS Benchmarking report (CAMHS) concluded that most of the service providers surveyed did manage to see patients within the accepted 18 weeks. However two organisations had a waiting period of 40 weeks. Initiatives developed to better the service provision and the concept of child mental health as *'Everyone's business'* was promoted.

Increasingly demands were made to justify practice. Parahoo (2006) cites the emergence of the evidence-based practice movement since the 1990s as being influenced by a number of factors. These include the increasing cost of health care, the variation in practice, a relative lack of research, changing management structures and sometimes unnecessary interventions. Moule and Goodman (2014:10) identify that evidence-based practice promotes quality and cost-effective outcomes of health care.

Byford and Knapp (2005:143) discuss the growing awareness of the need to improve *'not only the effectiveness but also the cost effectiveness'* of health care, social care and other services. Clearly this is important as services need investment and they need to provide value for money. The more cost effective the more people can be helped and likewise the more effective the interventions the

more people would benefit. Another dimension to providing an effective service is developing the tier one services as if difficulties are identified earlier, strategies can be put in place to address the issues before they develop into something more serious. Burton et al (2014) discuss some of the programmes which are available – for example parenting programmes. Overall there is a need to identify what works best and thus research is an important part of the process. To date many initiatives continue although some have succumbed to austerity. There is a continuing need to develop services that will work to fill such gaps.

#### **4.5 The idea for the research**

Bearing in mind the challenges faced, the shortfalls in provision, the demands to justify practice and the push to develop evidence-based cost-effective treatments, consideration was given to undertaking research with a view to developing a mindfulness intervention for young people. McLeod (1994) suggests five potential reasons for doing research:

- gaining a wider perspective,
- accountability,
- developing new ideas,
- application in new areas and
- personal and professional development.

These reasons were all relevant in respect of the proposed research. Thus there was the need to provide an effective service to young people within a climate that struggled to meet demands and also to justify that the method was viable. Were the research to prove a reliable and useful intervention the implications for future service development appeared very positive.

The NHS organisation where this research idea was formulated was a CAMHS facility, part of a larger Mental Health NHS Foundation Trust. It included a number of in- and outpatient services and covered a number of urbanisations which were geographically fairly close. The service had provision for older adults, learning disability, adults, children and young people. Within the child and adolescent

facility there appeared to be a number of young people who were either tied up with issues which had happened in the past or were suffering anxiety about what might happen in the future. The concept of mindfulness with its focus on the here and now seemed to be something that might be useful to such young people. Also it was anticipated that the prospect of delivering the intervention in a group format would fit well with some of the issues mentioned above, thus addressing a more efficient service delivery and potentially progressing clinical practice.

The idea for the research developed within a tier three in a NHS CAMHS team where the researcher was employed. The CAMHS team served young people in the local geographical area up to the age of 18. The researcher was a qualified senior mental health practitioner with many years of experience working with children and young people. In child mental health, issues arise which place considerable demands on the service. Depression, self-harm and other issues disrupt young people's lives and problems may extend into adulthood. O'Connell et al (2009:1) claim that:

*'Several decades of research have shown that the promise and potential lifetime benefits of preventing mental, emotional and behavioural disorders are greatest by focusing on young people'.*

Williams (1995:1) in his foreword to *'Together we Stand'*, a publication which transformed the local delivery of child mental health services, states that mental health in children *'foreshadows'* future generations, thus underlining the fact that if young people can be helped earlier this would save a lot of suffering, not to mention the drain on future health services. Boyd (2008:630) states that:

*'Many adult mental health problems can be prevented, coped with or at least reduced in their scope and severity through focused interaction with children'.*

Harrington and Clark (1998) discuss the point that there has been increasing interest in the possibility that early intervention might prevent mental disorders later in life. They conclude that there are some programmes which could protect from later depression. Bruce (2015) discusses the National Children's Bureau

(NCB) published framework for schools which promotes social and emotional well-being, recognising the early onset of mental health problems affecting young people.

Williams and Penman (2014) promote the positive effects of mindfulness on day-to-day anxiety, stress, depression and irritability. Baer et al (2006) also state that anxiety, depression and irritability all decrease with regular sessions of meditation. Thus mindfulness seemed an appropriate and useful intervention to introduce. Delivery in a group format would provide the advantage of reaching a number of individuals at any one time rather than the usual one-to-one sessions. Also there would be the potential for clinicians to become familiar with mindfulness and thus some others may go on to deliver sessions to young people. There are mindfulness courses for potential trainers but the main thing is for people to be able to fully engage with mindfulness themselves so as to effectively conduct sessions for the young people. If mindfulness delivered in this way proved to be viable and helpful it held the potential to also be cost effective.

#### **4.6 The CAMHS structure when the research was planned**

The Health Advisory Service (HAS 1995) lays out a tiered structure which remains the structure to date in child mental health. The idea was that all should be concerned with child mental health.

- Tier one services would be the services available to everyone through their GP, schools or other public services.
- Tier two would be the more specialised services – school counsellors and others with a more specialised knowledge of child mental health.
- Tier three services would be derived from specialist teams for the most complex and enduring mental health conditions.
- Tier four would be mainly inpatient facilities.

At the time the research was planned the Trust was using the 'CAPA' model. The 'choice' and 'partnership' approach (CAPA) (York and Kingsbury 2009). This is a service transformation model which the Trust utilised. The theories are that the

client will be placed at the centre as the practice will be collaborative. Demand and capacity are also considered as is '*skill layering*' which results in the delivery of the most efficient and effective intervention. The idea of '*skill layering*' was so that a clinician would be identified at the '*choice*' appointment who would be '*well suited to working with the service user*' at the '*partnership*' stage. They would be selected by skill rather than job role although the two tend to go together (*Mental Health Foundation 2009:44*).

It was not the purpose of this research to evaluate the effectiveness of the model but to outline the system which was in place at the time the research was designed. York and Kingsbury (2009) advocate '*full booking*' – i.e. when a patient is seen for a '*choice*' interview they are immediately booked in for a '*partnership*' interview. This was not possible in that particular CAMHS at that time for a number of reasons. Firstly the service was stretched and there was a long waiting list. Secondly the most appropriate clinician may not have the capacity to take on more cases. Knowledge of the full range of skill levels within the whole team was not optimal to all of the team members and therefore the '*choice*' clinician may not know who would be best suited to take on a case. People had already been waiting a while and unless the waiting list could be cleared it seemed unfair to allocate some clients before others if there were to be a '*skills match*'; starting from a level playing field there would have been the potential to fully implement the CAPA model.

At the time the practice was to screen all referrals (see Figure 1 below). If accepted, contact would be made with the family who would then be invited to opt in. Any young person referred viewed to be inappropriate to the service would be declined and the referrer would be informed.

Once accepted by the service people would be contacted by letter and asked to opt in. In the case of younger children referred it would be the parents who would be contacted; 16 and 17 year olds would be sent their own individual letters. This being done there would be a period of about 4 weeks while they waited for their initial or '*choice*' appointment.

The CAPA model advocates that people accepted into the tier three services have a 'choice' interview which is effectively an initial assessment. The young person and their parents are asked about what they would want from the service and a decision is reached about whether CAMHS can help or whether another service would be more appropriate. The model advocates building a therapeutic approach and developing a joint understanding of the problems until a 'choice point' can be reached – i.e. whether the service is for them or not. The model itself maintains that the appointment can be as long or as short as necessary with even further appointments being offered to reach a 'choice point' but in reality clinicians would normally have 45 minutes to reach this point.

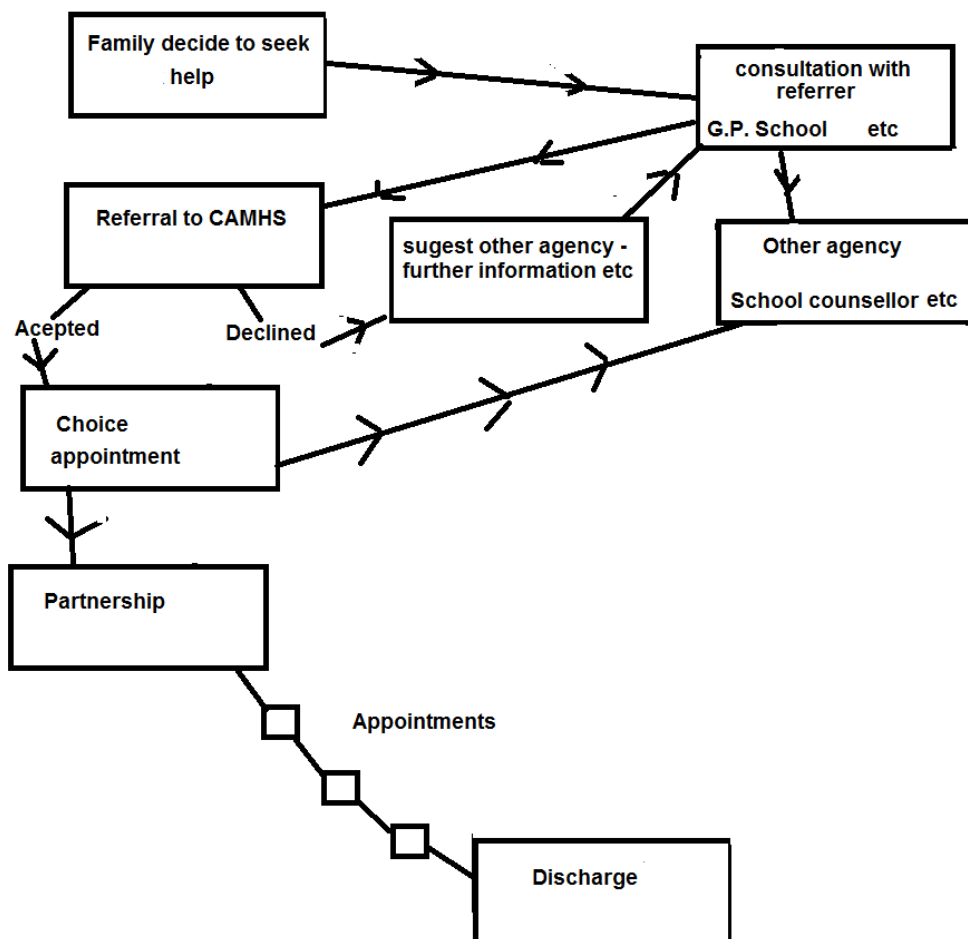


Figure 1 The referral process

At this appointment people are routinely screened and assessed for risk and according to their need are given clinical priority. Any needing urgent treatment would be seen as necessary and followed up. Those regarded as routine would be likely to wait for a period until a '*partnership*' (further assessment and follow on treatment) appointment could be offered. This could be a period of between 8-12 weeks due primarily to the staffing situation in the team. '*Choice*' appointments are effectively initial appointments and '*partnerships*' mark the start of full assessments.

#### **4.7 The planning stage for the research**

Consideration was given to the potential target group for the research:

- They should be patients known to the child mental health system.
- However the group should be comprised of individuals who were not in urgent need of psychiatric treatment and would otherwise be waiting many weeks for their treatment to continue.
- Mindfulness appeared to be an appropriate intervention to deliver to such a group.
- Additionally it would fit within the normal 8-12 week waiting period.
- It could be delivered by professionals within the health service in a manner not dissimilar to their everyday duties except that this being research it required special safeguards and protocols to be followed.

What is interesting is that the intervention could have been delivered without any further restrictions as part of the '*normal*' work of the clinic. The difference was that the clinicians had not used such a programme previously in a group format and by doing this as research they hoped to be able to justify the effectiveness of the method; the hope being that it would be found to be an effective treatment, verified by the design of the research. The move to conduct the project as research made it an entirely different prospect.

## 4.8 The first approach

The first approach was to gain the support of a university who could facilitate this research. Mindfulness seemed to be a topic which was outside the area of expertise of many universities. Even ones who professed to be centres for mindfulness were quite specific in their own research projects and did not feel that the proposed research protocol fitted with what they were doing. However the application was accepted by Manchester Metropolitan University who were most helpful in their approach.

It was necessary to talk to team managers to discuss the idea and show them a research proposal. This was favourably supported and a presentation was delivered to colleagues shortly afterwards in order to give them a flavour of what mindfulness was and to outline how it could potentially be useful in child mental health. Also it was considered that it would help to involve them in the identification of potential participants.

Fuller and Petch (1995) emphasise the distinction between the identity of the researcher as opposed to the practitioner working with colleagues in a different capacity which can present challenges, such as degrees of suspicion or anxiety. Thus one of the first steps was to inform the team in order to facilitate working relationships and mutual co-operation. A number of team members were very interested and offered their support and assistance. One team member in particular asked to be included in running the group.

As outlined in Chapter 1, mindfulness interventions have an established evidence base although this is more prominent in the case of adults than with children (Kabat-Zinn, 1994, Segal et al, 2002, Linehan, 1993, Hayes et al 2005). Delivering a mindfulness intervention between '*choice*' and '*partnership*' would effectively fill this gap for the participants as well as testing out whether this could be an effective intervention for young people. Also the advantage from the research perspective would be that no other intervention would be taking place at that time and thus any improvements in mental health could be more directly attributed to the mindfulness intervention. Also a '*control*' group seemed completely ethical as people would otherwise be awaiting a service anyway.



Williams and Kerfoot (2005) highlight the challenges of planning, commissioning and delivering effective CAMHS services. All these points contributed to the wait between 'choice' and 'partnership' and in reality there was frequently a gap of some weeks between the 'choice' appointment and the first 'partnership' appointment. This period, as mentioned previously, would often be between 10 and 12 weeks although much depended on staff availability and the season. For example there was frequently an excess of referrals from schools shortly before the long summer holiday.

York and Kingsbury (2009) maintain that it does not matter how big the clinician's caseload is but common sense appears to suggest that if one is already fully committed to a number of young people one cannot take on many more before others are closed. Core 'partnership' work is described as eclectic work using a range of skills. The model describes this core work as on average lasting 7–8 appointments. The 'partnership' appointment involves more assessment and proceeds to the core work or to specialist treatment. Considering the CAPA model the eight sessions planned for the mindfulness intervention in this research would be the equivalent of the average number of appointments suggested by the model. Therefore, based on CAPA calculations, one would presume that many of the young people, having had such a series of appointments, would not perhaps need any other input.

#### **4.9 Research with children**

Hendrick (2010) identifies the two main agendas in doing any research with children. These are the need to protect them from harm and the need to respect their independent rights. Working within CAMHS the age range is from 0 to 18 although realistically extremely few children are seen before around four years of age and even then numbers are very small. However there are large developmental differences between, for example an eight year old child and a seventeen year old young person. Graupner (2006) discusses EU legislation designed to combat sexual exploitation but failing to distinguish between five year olds and seventeen year olds. This was an important point in planning the research as the age of the potential participants needed to be considered.

#### **4.10 Consideration of age appropriate research methods**

An important part of the research was in delivering the sessions (see section 6.13 below) and it was important that these were age appropriate. Consideration was given about the age group of the potential participants. Suitable mindfulness activities are available for younger children (see Willard 2010, Kaiser Greenland 2010) but these may not be suitable for older children. Bays (2011) describes a number of ways to become more mindful of oneself that can be more appealing to children – for example the ‘*silly walking*’ section gives children a more playful way of noticing what their body’s reaction is. Saltzman and Goldin (2008:149) have ‘*seaweed practice*’ listed as one of the exercises which ‘*honours the children’s natural need for movement*’ as they pretend to be seaweed swaying in the current, and also at the same time notice how their bodies feel. Clearly working with children needs to be appropriate to their age and understanding. There were fewer younger children presenting to the service and young people of secondary school age presented more frequently to CAMHS. Thus aiming for a secondary school age group gave more potential to the recruitment process as well as the point that this was the age group that was more likely to benefit. Hofmeister (2012) emphasises that today’s adolescents live in a culture characterised by worldwide communication and a culture of pop. They are no longer shielded from outside influences. Could this be one possible reason why child mental health problems are now more prevalent? Gray (2010:452) suggests that people have much less control over achievement of ‘*extrinsic goals*’ and yet we are exposed to a ‘*culture of materialism*’ from an early age. If this is the case mindfulness, with its focus on ‘*intrinsic goals*’, might prove to be very helpful. He also suggests that a decline in play is another factor. Younger children may not be so influenced by the outside world as they are more likely to be protected from these influences. This was a further point to consider in the decision to recruit the older group who were more likely to be under stress. Thus the decision was made to recruit young people of secondary school age.

#### **4.11 Understanding the process**

Young people would need to understand what was happening in the research which would be a pre-requisite for any ethical research. Consent forms designed

for young people are often more pictorial, more colourful and basically more child friendly. Any literature containing information about the research should follow these principles. Tools to assist children express themselves may be used during the process of research. For example Fuller and Petch (1995) discuss a method which involves circling names of people who are important to them on a paper e.g. mother, father, sister uncle etc. They also use speech bubbles in which the children write their '*thoughts*'. King and Horrocks (2010) also make the point that any literature should be appealing and placed at the child's level. Mindfulness with children also needs to be '*child friendly*' compatible with the age group it is presented to.

#### **4.12 Consent**

The issue of consent is more complicated: 16 to 18 year olds are expected to be competent to give their own consent, however this can be overruled (Bond, 2010). If, for example, they were to refuse life-saving treatment their decision may be overruled by the court. Young people under the age of 16 are able to give their own consent if they are thought to be '*Gillick competent*' (see footnote 2 in Section 2.9 above).

Clearly it is very important for people to understand just what they are signing before they give consent to treatment. The British Medical Association (2013) gives a number of case examples where people have not been fully informed of the risks of particular procedures. For example a woman successfully won her case in court when it was established that she had not been told of the 1-2% risk of potential nerve damage in the particular surgical procedure. The operation went ahead with resulting nerve damage. Thus the duty to inform people about any risk is important, especially young people who may need more clarification. However the point is also made that people need to know the purpose and the full implications of any research in which they are involved - what it means for them.

*'It may simply be that their records are used and their health monitored'*  
(BMA 2013:72).

McLeod (1994) advocates giving careful consideration to ethical issues at all stages. He identifies the main principles as acting to enhance client well-being,

avoiding doing harm, respecting clients' rights to self-determination and treating everyone fairly. Beauchamp and Childress (2009) reflect the same concepts as beneficence, non-maleficence, autonomy and fidelity. These are important principles which guided the development of the research project by ensuring that the young people fully understood the process and wished to take part.

#### **4.13 The best time to do the research**

Within the '*choice*' and '*partnership*' approach (CAPA), consideration was given to what would be the best time to undertake the intervention. It appeared that following the '*choice*' appointment but before the '*partnership*' would fit well with the CAPA model as well as '*filling the gap*' in treatment. However consideration was also given to whether it might be more appropriate to deliver the intervention after patients had reached the '*partnership*' stage. This was discussed with team members and their views were canvassed. Some felt that the intervention would be better placed post '*partnership*'. This was carefully considered. Potentially this could cause difficulties in deciding at what point the case should be transferred; a mindfulness intervention could be regarded as a specialist treatment which would fit with the model. However if another worker had already been involved with the client how would you distinguish which intervention was successful? Thus it would seem logical that those potential participants who had already received some '*therapy*' from another clinician should not be participants in this particular study. This indicated that to plan the intervention between '*choice*' and '*partnership*' might be a better option.

Assessment and therapy go hand in hand in mental health (Goodman and Scott 2002). To understand the client one has to be receptive to them and a therapeutic relationship needs to develop. Bond (2010) clearly emphasises the need to develop a trusting relationship which promotes the client's autonomy. Doing the intervention post '*partnership*' would mean that the original clinicians (who would have done the full assessment) would have built up some relationship with their client. The intervention would be a break in this therapy for eight weeks during the life of the group. This had the potential to be disruptive but on the other hand a change in the therapeutic intervention may be helpful. There are times when clinicians feel their strategies are going nowhere. Clients might well agree. Bond

(2010) advocates discussing such issues with clients as and when they arise and guiding them towards a change in clinician. Additionally it would be difficult to imagine what a control group would look like. Those not accepted for the mindfulness intervention would need to continue appointments or have a similar service provided. This would need to be monitored and would involve extra costs as well as worker time and resources.

#### **4.14 Considering a 'control group'**

Baer (2003) has reviewed a number of mindfulness interventions and among the criticisms she states lack of a control group. She also points out that a '*treatment as usual*' (TAU) group - which potentially could mean a number of different things in different circumstances - medical or pharmaceutical or other unspecified mental health interventions - is a wide term. Such TAU groups would be unlikely to allow for comparison. Hence a client who had already been assessed as needing, for example, medication could not ethically be denied this while undergoing a mindfulness intervention and thus it would be difficult to establish whether the medication had been effective or whether it had been the intervention.

Consideration was given to this point but it seemed that the potential group would not be young people likely to require medication as they would be '*routine*' and '*non-urgent*' clients. A client who was in a position to need medication at this stage of treatment could not be regarded as routine and therefore not eligible for group membership. Those who later developed problems and needed to be assessed for medication could be excluded from the study.

Doing the intervention post '*choice*' would overcome this difficulty and would also avoid the problem of quantifying the effects of the mindfulness intervention. Those who were not selected for the group could be a control group i.e. they would be waiting for a '*partnership*' appointment and not currently having any intervention. A potential difficulty might be that the '*choice*' clinician may not have enough information to decide whether the client would be suitable for a mindfulness group but this could be screened during the introduction process.

In either case these patients would be either coming into the service or in the service anyway. In both cases there would be benefits to the team. Any successes

would cut down the additional time they remained in the service and thus have an overall impact on the team workload. After much consideration, post 'choice' seemed to be the best time for the intervention. This would allow for potentially reducing the workload of the team, would allow for a control group and would be relatively separate from any other therapeutic input taking place at that time.

#### **4.15 The mindfulness context**

In the first instance the idea was to introduce a mindfulness intervention which was likely to be effective in helping young people known to the CAMHS service. However in order to fully establish that this could be an effective intervention it was necessary to undertake this as a research project.

There are few contra indications for mindfulness interventions. MBCT does not appear to be effective for those with only two previous episodes of depression (Segal et al 2002) and Kabat-Zinn (1990) has commented that it probably will not work with those who do not think it will work and do not like the method. In the latter case it is presumed that those really not willing to try the method would not opt in.

The front cover of Kaiser Greenland's book 'The Mindful Child' (2010) bears the legend '*How to help your kid manage stress and become happier, kinder, and more compassionate*'. This was the hope; that the young participants would benefit from the mindfulness intervention. They would be recruited from young people coming into the service suffering mainly from anxiety and/or depression of a non-urgent nature. These people would otherwise be on a waiting list until staff had the capacity to take on new cases. It seemed feasible that at least some of the young people would benefit from the group intervention, although it could not be classed as therapy as it was research, therefore no undertakings were given about its success. However others have evidenced health benefits (Segal et al 2002, Kabat-Zinn 1994, Linehan 1993, Hayes et al 2005) from similar interventions and therefore benefits were not entirely unlikely. The intervention might also promote the service as any improvement in mental health would not only help the participant but would also lessen the workload of future clinicians. It also seemed fair to collect before and after scores of people who would not be taking part in the

actual group but would in effect be a '*control group*'. All it would involve for them would be an extra questionnaire. Other than this they would receive treatment as usual (TAU in this case would mean waiting until a '*partnership*' appointment was available). Such a questionnaire would specifically attempt to evaluate how mindful they were. It would be interesting to look at whether there was any correlation between their levels of mindfulness and those of the actual group participants.

#### **4.16 Reviewing Ethics**

Consideration of ethical issues is always a factor, however this is especially so within the NHS as actions are likely to impact on other human beings who generally have more vulnerability. However it is worth pointing out that there are other parallels and wider considerations.

#### **4.17 Buddhist foundation - ethical overlaps**

As continually stated, mindfulness itself has its origin within Buddhist culture. Kabat-Zinn (2011) has recognised connections between medical ethics foundations in the West and Buddhist moral thought: such Buddhist concepts as non-harming and placing the participants' good before one's own. However it would seem also that the same virtues also have representation within other major religions – Buddhism, Christianity, Islam or Judaism. Such concepts as do not lie, do not kill and show compassion. These also reflect the medical ethics of '*do no harm*'.

Within Buddhism part of the ethic is a belief in such things as Karma (the belief that one ultimately pays for one's deeds). Indeed we see representations of this in other places. Take for example the story of *The Water Babies* (written by Charles Kingsley in 1863) and the two characters – Mrs Do-as-you-would-be-done-by and her sterner sister Mrs Be-done-by-as-you-did. Buddhist belief also embraces the principle of rebirth – that one comes back into another life again and again until enlightenment. These views irrespective of their validity do not sit well within the majority mainstream Western culture. However it appears to be a useful ethical concept to consider acting as Mrs Do-as-you-would-be-done-by.

Gunaratana (2002) discusses the differences between Buddhism and the theologies in the West. Buddhism shapes cultures. Countries as diverse as China, Japan, Tibet and many others in that region follow this religion. McCown (2013:91) defines ethics and morals (ethos/mores) as *'the salutary customs and manners of a people'*. What was hoped would be gained was a little of the essence of mindfulness – some of its culture. Enough to help the young people find their own calm within themselves so they could better cope with whatever challenges they faced. Mindfulness is something which has to be experienced and not something that can be *'taught'*. However by explaining the process over a number of sessions (see Section 6.13 below) and having mindfulness practices within these sessions it was hoped that the young people would be able to experience mindfulness for themselves. Germer et al (2005) in fact say that mindfulness cannot adequately be described as it is mostly experienced. It was therefore not known how much these young people would take on board the concepts, apply the practice themselves and thus benefit from the shared experience.

#### **4.18 Wider ethical considerations**

Ethics surely relate to what is ethical but there is a complicated interwoven pattern behind this involving several layers of processing. Parahoo (2006) states that there are ethical questions to be posed at every stage of research. Moule and Goodman (2014) identify that morality refers to norms about right and wrong. However it is not always so clear-cut and in some new situations this is of little use. Another issue is whose rights and wrongs are we judging?

Gergen (2013:9) makes the point that although many knew that the dropping of the atom bomb on Hiroshima was morally wrong, there were others *'in high places'* who argued that it would cost less lives than continuing the combat. The benefits should outweigh the risks. Lederer and Grodin (1994) discuss how in the 1700s children were deliberately infected with smallpox in the pursuit of a smallpox vaccine without much concern for ethical considerations at that time. Thus in different time periods and in different cultures we *'find what is ethical in one culture is an abomination in another'* (Gergen, 2013:10).



In Western society there are varying ways in which research is regulated such as ethical codes, European regulations, various statutes and the law of consent. This research took place solely in the UK. By virtue of the fact that it was intended to concern National Health Service patients and employees it thus was governed by the National Health Service research governance and went through the research ethics committees (RECs).

King and Horrocks (2010) point out that our own moral outlook is shaped by our different experiences and the social and cultural influences which surround us. What is considered ethical and moral by an individual will vary from culture to culture within different time periods and political frameworks. As illustrations of this consider the '*dress code*' in Iran in 1968 and that of the present day and of '*women's rights*' in the UK in 1900 and today. Clearly what is considered '*moral*' can change. Progress has been made in the field of equality in the UK but there are now additional challenges. Life has become more complicated and less predictable. Vulnerable young people suffering emotional challenges are likely to have experienced less than optimal influences and thus are more in need of developing a coping strategy. This would seem to endorse the justification for developing a mindfulness intervention with the potential to assist in this respect.

Beauchamp and Childress (2009) speak of '*thinking ethically*'. While one would presume that professionals in the Health Services would always want to adhere to high moral standards, there is no doubt that atrocities have been committed by doctors at certain points in history. The Nazi regime was one such period. Over the years professional codes and guidelines have arisen to guard against any malpractice as well as promoting high ethical standards. These include those of the British Medical Association, the Department of Health and the Royal College of Psychiatrists to name but a few. These codes are very influential and although without legal force they do shape the key principles which govern research. Hendrick (2010:173) has summarised these below:

1. The research must be scientifically sound

There was good reason to do this research based on the evidence base which appeared scientifically sound.

## 2. The benefits must outweigh the risks

There seemed to be relatively little risk. Possibly some would not benefit while some may become upset being unaccustomed to the exercise but professional CAMHS workers would be present to help them.

## 3. No coercion must be brought to bear on participants

No coercion would be brought to participants. In fact it would be counterproductive. Kabat-Zinn (1990) makes the point that for those who do not believe it will work - it probably won't.

## 4. Ideally those involved should be competent

Ideally this would have been the case but given that the target population of participants were a vulnerable group there was potential for some misunderstanding. They may find mindfulness difficult. However the professionals were experienced clinicians.

## 5. Participants should be fully informed

This would be done firstly to ensure that participants wanted to be included (see above) and also because it was an ethical stipulation.

Such codes and ethical approval in general have resulted from previous '*mistakes*' and are designed to protect vulnerable individuals. These considerations were as relevant to this research as to any but as this research involved children particular consideration was needed as young people are naturally more vulnerable.

### **4.19 Do no harm**

This principle is basic to those in the health professions and thus the concept of '*do no harm*' was paramount in this research. Further it aimed not only to '*do no harm*' but to attempt to increase the young people's resilience. McCown (2013) cites the Hippocratic Oath – with its date back to around the fourth century BC - as being in use in many countries. These principles are very much in use in the field of medicine influencing the ethos of the different professionals who work there and the essence of care that is given to the patients using the service. This is

especially relevant where research is concerned and where additional safeguards are important to ensure standards are maintained. These aspects very much influenced how this research progressed. The British Medical Association (BMA 2013) states that doctors throughout history have had special Hippocratic obligations. Other health professionals are also expected to possess such qualities as integrity, compassion and altruism. Additionally there is an ethos of continuous improvement, excellence and effective multidisciplinary working (BMA 2013). This ethos promotes a culture which favours research. Such professionals invariably already have their individual codes of conduct. Doctors have their own code of conduct overseen by the General Medical Council. Other professionals have similar codes. Nurses are expected to adhere to four principles: respect for autonomy, justice, beneficence and non-maleficence (Hendrick 2010, Moule and Goodman 2014). Social Workers, governed by the Health Care Practitioner Council in England, have six points on the list. These include promoting and respecting rights whilst seeking to ensure their behaviour does not harm themselves or others, promoting the independence of clients, establishing trust and confidence, promoting the interests of clients, promoting public trust and being responsible for the quality and conduct of their work whilst maintaining and improving their skills. Research puts another layer on these principles involving protocols to be laid out and approved by various bodies such as the NHS Ethics Committee and Universities. This is especially so in the case of children and vulnerable people in general. However the ideas about clients' autonomy, safety and basic rights are not new ideas. Biestek (1967) established the seven principles of case work:

1. Individualisation
2. Purposeful expression of feelings
3. Controlled emotional involvement
4. Acceptance
5. Non-judgmental attitude
6. Client self determination

## 7. Confidentiality

These values are important for anyone working in the helping professions but are of particular relevance when research is being undertaken. Mark Cooper, in his foreword to Bond (2010:ix), states that '*All professions are grounded in ethics*'. The principles are much the same. There are protocols for employees to follow and no distinction is made about their profession or rank within the service (except perhaps doctors who have far more autonomy and are more likely to engender co-operation than those of lesser rank). All these points become even more relevant when any research is being undertaken. There are any number of protocols to be followed, depending on the particular type of research in question, in the interests of promoting ethical standards without infringing the rights of the individuals concerned.

### 4.20 Justifying the research

From this researcher's perspective all life should be sacred and not only the principle of '*do no harm*' should be followed but also one should try and promote better standards. The main aim was not only to satisfy research ethical practice issues but to aim towards the development of an ethically therapeutic practice. It was with these points in mind that the idea of this research was pursued.

Potentially it offered better outcomes; it was planned to be delivered at a time when no other interventions were taking place – thus it would not only '*fill a gap*' for those participants but could be done in a way that would give more scientific credibility. If it were to be successful it could be repeated to benefit others.

'*Political correctness*' has become a mainstay for health as well as many other professions working within the field of human society, but mindfulness promotes tolerance and also fosters compassion (Gilbert and Choden 2013). Promoting such qualities goes beyond saying the right thing in the correct terminology. There is also a need to establish values that are shared - such things as fairness, confidentiality and respect for autonomy. While again this should be common practice within CAMHS – as mentioned above - the concept of mindfulness itself promotes compassion.

Bond (2010) emphasises the need to recognise and develop the client's autonomy. It could be argued that these themselves are a set of ethical standards and further it would seem that to satisfactorily obtain ethical approval one has to show adherence to these ethical views.

#### **4.21 The influence of research protocols**

Cullen (2011) advises the importance of not imposing just a single set of ethics in most mainstream settings because of potential conflicts. This is perhaps more relevant to practice as it is to research as to proceed with formal research a protocol has to be followed. All of the above points should be part of the mindfulness intervention and thus taken into account in research. Within this however there is room for a difference of opinion between what is ethical and what is not. McLeod (1994:166) claims that:

*'all research necessitates making value judgements which may be in conflict with' those of others.*

This illustrates the point that will be seen later, where a personal view of what would be fair and ethical did not fit with the view of the committee.

#### **4.22 The paradox of definitions**

Ruedy and Schweitzer (2010:81), state that *'individuals high in mindfulness report that they are more likely to act ethically'* and that many unethical decisions result from a lack of awareness. McCown (2013) in his pursuit of an ethic for mindfulness postulates that what is most needed is a definition of mindfulness and standardisation of teacher development to meet the needs of this expanding field. We already have broad definitions of what mindfulness is and perhaps the best known of these is Kabat-Zinn's (1994:4) is the most quoted:

*'Mindfulness means paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally'*

McCown further considers a definition of mindfulness from the perspectives of four different discourses:

- the scientific

- Western social psychological
- an Eastern definition
- a definition from neuroscience.

These four areas have been explored in depth. Notwithstanding the contribution this makes to the understanding of mindfulness for both researchers and clinicians, there is something of a paradox in this view. Mindfulness is essentially an experiential phenomenological approach and thus each of us is unique and therefore likely to experience mindfulness in a different way, even though there may be parallels. Hamer (2006:5) explains that we are all ordinary and what *'makes us ordinary is the fact that each one of us is different'*. Searching for an accurate definition of mindfulness in this way might be perceived as like pulling a rose to pieces to nail down its beauty.

#### **4.23 Pulling the plan together**

Firstly the go ahead was required from the Trust although it quickly became self-evident that an application would have to be submitted to the national NHS ethics committee for approval before the Trust's own approval would be granted. The Trust's application was comparatively straightforward involving only four pages however the process was clearly interwoven with that of the NHS ethics application. Any research done with NHS patients or on NHS property requires approval from the National Research Ethics Service (NRES). Additionally the University had their own ethical procedures and required forms to be completed. Thus three separate application forms needed to be completed although approval by the NHS ethics committee heralded final approval by the other two.

#### **4.24 Outline plan of the research protocol**

The plan was to deliver eight sessions explaining mindfulness including some practice in every session. An outline of these sessions is given in Chapter 6 but full session plans and materials used can be found in Appendix 1. Homework tasks would be given to continue this. Each session should last an hour. There were a number of reasons for this. Firstly the MBCT (Segal et al 2002) and MBSR (Kabat-Zinn 1994) adult programmes ran over a similar length of time. The period

between the 'choice' and 'partnership' appointments (*the gap*) was estimated to be between 8–12 weeks and thus this intervention would fit nicely into this time period. York and Kingsbury (2009) also estimate that the average duration of CAMHS 'core' work lasts on average from 7–8 appointments. Thus eight sessions seemed a reasonable length of time for the group to run. A gap of two weeks following the sessions was allowed to give the young people time to digest what they had learned before following up with a focus group. The focus group would form an integral part of the research in evaluating the experiences of the participants and also considering any future service delivery. Lastly interviews would be held with the parents of the young people. Their views would assist with the research aims in gaining a better understanding of how they might support their young people. In this way it was hoped to canvas the views of both the young people and their parents about the effectiveness of the intervention.

- eight group sessions would form the main focus of the mindfulness intervention
- followed by the focus group in which the young people would participate
- finally individual parent interviews.

This could provide some evidence (or not) of the effectiveness of the sessions in helping the young people to cope better with their difficulties. Additionally a number of questionnaires were planned to be used at time 1 and time 2 (that is before and after the mindfulness sessions) to see if there had been any changes during this period. These outcome measures (described in Chapter 3) should give a quantitative measure of the effectiveness of the intervention if this in fact proved to be the case. They are as follows:

- The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA Gowers et al 1998)
- The Children's Global Assessment Scale (CGAS Gould & Brasic 1983)
- The SDQs (Goodman 1997)
- The FMI questionnaire – short version (Walach et al 2006).

## 4.25 Participant selection

The proposal was to

- Select young people at the point of the 'choice' interview
- Inform clinicians undertaking these about what the mindfulness course would involve
- Provide clinicians with information sheets to give out (see Appendix 2)
- Ask clinicians to enquire as to the young person's possible interest in such a group.

Decisions had been made that the age range should be for young people of secondary school age as it was felt they would be in a better position to understand the concepts and additionally it would put some limit on the age range within the group. Also the number of potential participants in the group should be a maximum of 10 young people. This would work well with two clinicians delivering the intervention and also with the room size. The first 10 young people to express an interest would form the group with the next 10 being in the control group.

McCrorie (2006:5) states that, '*A typical view of a 'small group' is around eight to 12 learners facilitated by a teacher*', this number would allow individuals to participate in discussions. If the group were to be too small participants might feel inhibited and have difficulty in sharing their views. Likewise a very large group might have a similar effect and additionally would not offer the opportunity for everyone to have their say should they so wish. Other factors such as ability to manage the group effectively and staff availability were additional important considerations. Consideration was also given to the fact that this was not individual therapy and clearly participants would benefit from sharing their experiences of mindfulness (Mace 2008). The size of the rooms available was another factor in the group size. Although clearly there would have been other venues but the protocol for securing the use of these premises plus the additional expense was prohibitive. As the research project was independently funded by the researcher on a very small budget this deterred against further exploration. A room was available within the clinic which could accommodate this number.



The time period between '*choice*' and '*partnership*' seemed not to conflict with what the patients would normally experience. In the event of anyone becoming so unwell that they required treatment sooner, there was a procedure in place. In any event those potential participants who had expressed an interest in the group were themselves in the '*routine*' range of patients – i.e. not predicted to need urgent treatment. There was of course the slight possibility that a '*partnership*' appointment might be arranged before the mindfulness course had been completed. In this case there were options depending on the stage at which the appointments fell. If it were towards the end of the mindfulness course a decision might be made for the participant to continue. If it were at the beginning, any effects of mindfulness were likely to be inconclusive at this early stage. Of course participants were free to withdraw at any time they wished from the course and likewise we should allow any participants having earlier '*partnership*' appointments to continue if they so wished. The difference would only be in whether their results were included or not. Confidentiality would be basically the same as for other patients in the NHS. Records would be kept secure with only clinicians having access to any confidential information. Further it was not envisaged that any very personal information would be discussed in the group as the focus would always be on the here and now. We would advise members to have regard for the respect of others as we would respect their rights. Both the young person and their parent(s) would be required to sign an informed consent form (see Appendix 2). We also planned to hold an introductory session where the purpose of the group and mindfulness in general could be explained.

## **5. The research continues**

### **5.1 Overview**

Previously Chapter 4 set the research in the context in which it was originally designed. This chapter continues to provide more detail of the process and of the development of the research project from its original concept. Modifications resulted from the views of the NHS Ethics Committee and thus ethical issues are revisited. Further, as the structure of the CAMHS service in which the research was to take place changed substantially during the period with a departmental re-organisation, further considerations were necessary. It is important here to emphasise that the time period was all important. What would have been possible in the '*old world*' organisation quickly became problematic in the '*new world*'.

The plan as originally envisaged needed some modification but it did become possible to go ahead with what later became a pilot group. Further decisions had to be made on the conclusion of the pilot group and the reasoning behind it is clarified. Finally a new direction was taken and the research was planned in a new organisation with a different group of vulnerable young people.

### **5.2 How hard can it be?**

This section considers some of the difficulties faced by those who embark on the process of research before moving on to set in context the organisational changes which led to a rethink of the previously formulated research proposal. (For a full account of the research proposal please see Chapter 3.)

### **5.3 The NHS process and the novice researcher**

The NRES form (see Chapter 4 which describes the beginning of this process) itself proved to be most complicated and lengthy. At first in the early stages although access to University supervision was in place the task appeared daunting. The form itself requests that proposals are written in plain English that a layman can understand. However the first question asks researchers to outline their proposal. The guidance on this suggests using an acronym "IPOC". The letters in this stand for 1) Intervention, 2) Population, 3) Outcome and 4)

Comparator. The intervention was clear and it was also clear who the target population would be. The hoped for outcomes and the measures to be used also posed no difficulties but the word Comparator was unfamiliar to the researcher. Chambers dictionary (2005) did not yield an answer. A Google search gave an engineering explanation '*In electronics, a comparator is a device that compares two voltages*' (Wikipedia)<sup>3</sup> which made little sense in terms of social research and psychological interventions. The word has some similarity with comparison and subsequently this became clearer, but at the time this seemed to be a different mode of speech – a different way of explaining things – even a different language and with 32 pages to go a very daunting prospect.

The National Health Service's National Research Ethics Service (NHS NRES) form is an online application for a research project which requires some familiarisation before one can be confident in navigating it without the fear of wiping out already input information. In the beginning there seemed to be too many unknowns. Bulmer & Ocloo (2009) regard the ethical view of research in health and medical fields as '*particularly rigorous*'.

Some of the terms used were confusing: who was the chief investigator's representative? Should it be someone in the Trust? Would this be someone in the University or even oneself? Colleagues who had been through this process before had more idea of what was expected and were helpful in sharing their knowledge to complete certain aspects. Other sections were met with mental question marks. Tarling (2006:169) states that '*medical research is viewed as potentially intrusive and harmful*' and the purpose of the NHS Research Committee is to ensure that participants are protected. Indeed there were questions on the form about the use of radioactive materials. The application form covers many aspects of research. Bulmer & Ocloo (2009:130) however, raise an interesting question:

*'Do bio-scientists, for example, properly understand the way in which sociologists conduct research?'*

---

<sup>3</sup> Although Wikipedia is not a usual source of information for PhD students this was discussed with supervisors and in its context it was decided to leave the reference in.

A help line was available but in the early stage there seemed to be too many questions to ask of anyone answering the help line (later with help and supervision from my University Supervisor it became clearer). Many questions required a particular way of answering. For example there is a fair amount of repetition. One may hesitate to know what to put when it is recognised that this has already been stated. Do they want something else? What has been missed? For researchers familiar with the document or for those who had had sight of similar forms completed by others the task is made easier but it remains difficult for the research novice. Applications may be declined simply because the researcher had not understood what was required. For example the question about how long the data would be stored. Those with no previous research experience may as well be guessing the answer to this question. Some may assume that it is not a good idea to hang on to data and would be tempted to tick the shortest time period. Markopoulous et al (2008) identify a potential conflict between the desire to keep data for possible future use and the desire to destroy sensitive and personal data. Consideration needs to be given not only to how long the process will take but other issues such as leaving time to triangulate and revisit results. This could not be done if data has been destroyed. Also many agencies have a policy about how long data is to be stored and familiarity with such policies is therefore an advantage. Wood (2005:244) advises that data should be destroyed once it has served its purpose that is '*once you are confident that you will no longer be asked to produce these*' (for example for verification purposes).

The form asks the researcher to give a start date for the project. This seems a fair enough question but how does one know how long the ethical process will take? The University ethics form also asked the same question. Elsewhere on the form it had clearly been stated that the whole process was subject to favourable NHS ethical approval.

Although lengthy, the form did cover the necessary points and in completing the form the issues of the research being scientifically sound and ethical are addressed. That the project had more benefits than risks was clear from completing the form and also that it was without coercion and delivered to those who were fully informed and gave their consent appropriately. In this particular

case the research was aimed at secondary school age young people i.e. from 11 years upwards but as the service goes up to 18 there were likely to be some in the group who could give their own consent.

Without the support of the University the process would have been even more daunting and later the employees of the Trust research department were also very helpful. Therefore by working through the forms eventually all the information was input.

#### **5.4 The climate within the Trust**

In order to explain this research, it is necessary to explain the context in which the idea developed and the changes that occurred throughout the process. The outline plan for the research has already been discussed in Chapter 4 but in view of the changes it is necessary to explain the framework on which the new ethical considerations evolved.

The difficulty here was not so much the ethical journey but the time period in which the research was undertaken. At the time the research was designed there was no indication (at least as far as the general workforce were concerned) that the whole structure of CAMHS within the Trust was about to change. Further into the process it became clear that change was inevitable. It became something of a race against time to see if the research could go ahead as planned. The main reasoning for this impetus was the fact that the research design itself would have to be fundamentally rethought if not completed within the parameters already outlined. Notwithstanding the thought of redoing another 31-page NHS ethics form plus the SSI (site specific information which asks details of the research to be undertaken in the 'site' that it is proposed to take place), there were other considerations. The research as planned stood to be a beneficial intervention for a number of young people and there was already a provisional list of those who had expressed an interest and who were therefore potential participants. To abandon such a worthwhile project seemed unthinkable. Another factor was that to redesign the research would require a hands-on knowledge of the workings of CAMHS. As this was to be a new structure and, although known in theory, how it would actually work out remained in question.

Between the time that the design was proposed to the NHS Ethics Committee and the final agreement to go ahead there was a reorganisation. The previous waiting period for patients was not at all optimal and the Trust made moves to improve on this. The new design included a change of venue located in a different town. The team itself would be amalgamated with that of a different area in the region. All new referrals would be dealt with at a single point of access, situated in another location and dealt with fairly quickly. The aim was to substantially reduce the wait and establish new and more efficient timelines. Longer-term cases would ultimately be passed on to three longer-term teams. The usual '*choice*' interview was to be followed by one or two follow-up sessions focusing on specific short-term interventions. There would ultimately be '*partnership*' appointments but it was envisaged that this would be reserved for the more complex and intractable cases – not in fact the group that had been the primary focus when the idea was first conceived.

Just before the move to new premises caseloads were building up with the anticipated departure of staff to the new team. Assurances were given that with the move and amalgamation within the new team caseloads would be redistributed. With the move however, as is often the case, what is planned to happen does not all work out that way and rather than being helped to share the load each clinician was given an extra 12–15 cases. It was in this climate that the final ethical approval arrived from the NHS, quickly followed by approval from the Trust. The University had already given conditional approval. Managerial approval and support had already been promised but the management in the new climate imposed a new set of directives. Firstly there was not the scope to undertake the work given the need to assimilate the new caseloads. When the matter to take the project forward was pressed, further conditions were laid down. Bell (1993) gives a clear checklist of how to negotiate a research project but advises that research inevitably takes longer than anticipated. However it had not been anticipated that although approval had already been given to the research going ahead (and signatures obtained to this effect) that this would now be denied. It appeared this was a new set up and new rules applied. Cameron and Green (2015:97) quote the following statement in respect of change:

*'new people are in power with new views and new ways of allocating scarce resources'.*

The new conditions included 10 extra points. Those which appeared most salient and likely to cause delays are outlined below:

- The researcher would have to arrange extra supervision (additional to regular on-going managerial, clinical and University supervision).
- The participants would need to have a new risk assessment. It should be written in their care plan that they were to take part in the group (clients in the system would already have care plans but there would need to be an additional meeting with each of them to re-do the care plan to include this stipulation).
- Stipulations were made about staff and contingency plans for any emergency cover – (management had already refused to let a colleague take part but psychology students and junior doctors were willing to help).
- Points were raised about the safety of the building (despite the fact that no such issues were raised about the on-going regular appointments which continued to be held there).
- The issue of the '*control group*' was particularly problematic.

These stipulations arose after managers had been given copies of all relevant documents including research proposals and copies of all the necessary permissions obtained. These concerns were fully addressed but agreement for the go ahead was protracted. Fuller and Petch (1995:48) state that '*the presence of departmental routines for research access should not always be seen as an additional hurdle*' but more of a sounding board and moral support. However it would seem that no matter how ethical one's personal standards are, and no matter how closely national and departmental standards are followed, conditions can change dramatically if a new power structure is applied.

## 5.5 The structure of the initial project

This chapter forms a continuation of the progress of the research. Methods and measures used are briefly referred to here but these have been fully outlined in the previous chapters (Chapter 3 which focuses on methodology and Chapter 4 which clarifies the beginning of the process). Eight sessions of the mindfulness-based intervention would be delivered to the young people. The participants would be asked to complete questionnaires before and after the eight sessions to identify how well they were functioning. These would provide some feedback on the way the young people appeared to be functioning. The FMI questionnaire (Walach 2006) would be used to attempt to quantify how mindful they were. Additionally a focus group with the young people would be held two weeks after the end of the sessions aimed to gather their views. Later the views of their parents would also be sought. This was to obtain a degree of validity which would not be available through one method alone. The questionnaires were also an attempt to introduce some quantitative data to a project that was essentially more qualitative. Parahoo (2006:48) describes '*hard*' scientific knowledge as being '*the highest form of evidence*' and this was perhaps an attempt to be more scientific.

What was also considered was that a further 10 people could be in the '*control group*'. At the time the research was planned, they would in any case be waiting for treatment. Giving consideration to how it should be decided which patients should be in the actual group and who should be the '*controls*', it was felt that the first 10 to opt into the mindfulness group should be the group participants. The next 10 who would otherwise have been suitable would be in the '*control group*'. This seemed fair. The first 10 would have been waiting longer and the '*controls*' would only be asked to fill in an additional questionnaire.

Should any untoward problems of a psychiatric nature arise during the course of the group, the issue could be referred back to the team and dealt with accordingly. The work of the CAMHS team was supported by three psychiatrists, a psychologist and a number of other experienced clinicians. The researchers would also be experienced clinicians working in the field of child mental health and would be competent to deal with any day-to-day matters arising within the process of the group.



## 5.6 Questionnaires used as outcome measures

The outcome measures planned to be used with the group (and therefore provide a quantitative measure of its effectiveness) were standard forms used in child mental health. These were the HoNOSCA (Gowers et al 1998) and CGAS (Gould and Brasic 1983). These are both routinely used in CAMHS and any improvements in mental (or emotional) health can be identified by an improvement in scores. The same is true for the SDQs (Goodman 1997). These questionnaires are discussed more fully in Chapter 3. Parents and patients would be asked to complete these before and after the sessions. The outcomes of the three questionnaires would indicate any changes thus providing a single case method of evaluation. The only additional measure would be the FMI questionnaire – short version (Walach et al 2006). This was chosen because it is a validated measure of mindfulness and as such would indicate how '*mindful*' the participants were at the beginning and end of the intervention. It was felt that the '*control*' group members need only fill in one questionnaire as having no experience of the group it was unlikely that their '*mindfulness*' would have changed any.

## 5.7 Modifications

McLeod (1994) cautions that those undertaking research should expect to negotiate entry and access and the whole thing is likely to be subject to change and modification. The NHS ethics committee had received the application and sent out a date for the researcher to give a presentation to the committee. There were a number of points which they questioned and clarified minor changes to be made. The main difficulty seemed to be about the '*control group*'. The '*chairman*' of the committee expressed the view that it was not fair to conduct the research in this way. Participants should be '*randomised*' into either the control or mindfulness groups and told that this was to happen. Hoge et al (2013) identify that prior studies of mindfulness have been limited by an active comparison group. It was hoped that by randomising the participants this would provide more scientific rigor to the research and thus promote the knowledge base. Nevertheless it still felt unethical to tell people there was a group and then tell half of them that they had not been selected. However in medical science there are hard decisions to make. Not everyone who needs one can get a kidney transplant. There simply are not

enough kidneys to go around and also some may not be suitable. Schneiderman (2008) suggests that another aspect of the rationalisation is to control costs. It seemed somehow not dishonest to invite participants to fill in a questionnaire for research purposes as a '*control group*', but inviting them to take part and then making them aware that they had not been selected for the group seemed not quite right. However the view of the Ethics Committee dictates whether approval is granted.

This was the main objection of the Ethics Committee. Other clarifications were sought such as an explanation of a '*non-urgent*' case and other minor matters that had not been completely clear. The consent form was required to be amended and the information form was felt to be lacking in sufficient information about the study. These points were addressed. The initial reasoning behind the '*lack of information*' was that it had seemed somewhat overwhelming for people to read so much detail especially when there would be opportunities to ask anything that participants were unsure about.

However the Ethics Committee is always right in that they have been authorised to make the decisions and dissent from their view involves reapplication. Remenyi et al (2010:99) state that there is '*no theoretical maximum number of times an application may be submitted*'. However if one cannot satisfy criteria which were previously stipulated there would seem to be little hope of moving beyond this point. Also as Remenyi et al (2010:99) state NHS Ethics Committees may declare a re-application as '*vexatious and thus refuse to consider it again*'. It should be made very explicit what would happen so that potential participants can give their informed consent. Separate consent forms were required for the young person and the parent. In the event three separate consent forms were produced: one for the parent, one for the older group of young people (16 and 17 year olds) and an assent form for younger people. Particular attention was paid to the information and consent forms for the children and young people including graphics and colours. As is advocated by King and Horrocks (2010) the literature should be aesthetically appealing to children (see Appendix 2 for consent forms). A further result of these necessary modifications was that the project was delayed and could not go ahead until these points had been addressed.

## 5.8 Ethics revisited

Ethical issues have already been discussed but due to the changes within the organisation it became necessary to consider these issues again. King and Horrocks (2010) advocate that respect for the person is of great importance in research, paying particular attention to the voluntary nature of their co-operation and thus their right to withdraw should they so wish. Also they stress the necessity of informed consent which reflects respect for the person.

Sanders and Liptrot (1993) advocate the '*fours Cs*' of ethical research as competence, consent, confidentiality and conduct. They explain competence as working within your own limits. Consent is interpreted as informed consent. Confidentiality includes preserving identity, treating all data as confidential and keeping this safely. Conduct ensures honesty, putting the welfare and safety of the participants as a priority and respecting ethical values.

Thus the main ethical issues in social research are considered to be morality, ethical principles according to research governance, professional codes, informed consent, confidentiality and physical safety. These points are addressed more fully below.

## 5.9 Informed consent

The principle of informed consent means that participants should understand exactly what is involved in the research (Thompson and Chambers 2012). This may be explained in a variety of ways but consent forms offer tangible proof that consent has been obtained. Ali and Kelly (2004) discuss written informed consent verified by a signed consent form. With young people different rules apply depending on their age. Ultimately the consent of the parent would be needed although most 16 and 17 year olds would be capable of giving their own consent. Thus having separate consent forms highlighted this. Routinely within CAMHS these young people would be sent their own copies of correspondence as well as their parent while younger ones would not receive individual letters. Nevertheless it would be important for any young person, even below the age of 16, to give their full consent (even if not legally necessary) and their right to withdraw from the study if they so wish should also be maintained. As the participants were recruited

from a vulnerable population it was important not to let them be '*taken for granted*' (Thompson and Chambers 2012:27). Another point is that if they were not really interested in attending the group – even if their parents would want them to – it would be unlikely that they would gain anything from the group. As previously stated mindfulness is experiential and requires engagement with the process. Those who do not really want to engage are not likely to benefit.

### **5.10 Confidentiality**

In the CAMHS service confidentiality is an established principle which is maintained throughout treatment except in cases where it becomes known that someone is being hurt (in which case safeguarding procedures are followed). Routinely this is explained to clients. There is no reason why research protocols should be any different. However the focus of the group was on developing mindfulness practice rather than sharing personal information. Only basic information such as name, age and contact details were required. Hard copies of patient-identifiable information such as consent forms and contact details were kept in a locked filing cabinet. Any information on computers was password-protected and in line with Trust policy. Any information on home computers was coded and therefore not personally identifiable. All identifiable information was removed from the results and findings disseminated from the project. Quotations were only cited using pseudonyms and never with identifiable information. Only the research team had access to the information which could link participants to codes. After the conclusion of the group process all person-identifiable information would be destroyed and any information used anonymised. There would be no impact on further service delivery.

### **5.11 Anonymity**

In counselling research participants may say things which are later quoted in publications. Such quotes should be anonymised to protect the identity of clients. Pseudonyms are often a useful way of doing this. However in this particular research it was not anticipated that very personal details would emerge. The Data Protection Act 1998 (implemented in the UK in March 2000) stipulates that misuse of personal details has legal implications. Personal information needs to be kept

secure as well as any cross-referencing information – for instance with pseudonyms that could identify people. For the purposes of contact and later feedback to participants this information would need to be available.

### **5.12 Codes of conduct, patients' rights and protocols**

Professionals working in the health service have their own codes of conduct which may vary but essentially follow the basic principle of '*Do no harm*'. Within the Trust there are also protocols to be followed. Some of them seemingly having very little to do with morality, such as using a particular red zipped bag to carry files away from the office or other such seemingly illogical rules (although no doubt there is a logical reason if not generally known). Other protocols are easier to understand – using black ink when writing in files and using the 24 hour clock can be seen to make the notes as legible as possible and avoid any confusion with time therefore maximising patient care. There were individual and professional standards, health ethics and a Trust ethos all of which fall within the law. This is the standard that is set for routine work but as will be seen research, particularly when it is with young people, requires extra safeguards. The BMA (2013) comments that medical law has developed significantly since the 1980s and it continues to be fast moving making it challenging to keep abreast of developments. The Human Rights Act (fully into force in the UK by 2000) has contributed significantly to the rights of individuals. One point about modern Western society is the amount of legislation that has developed. Some can be attributed to litigation or fear of litigation but overall the aim seems to be to protect individuals and standardise services and as has been noted this is especially so with vulnerable young people.

As an example of how an '*incident*' can become part of law which then introduces protocols into the work place, the following example is given. Rule '43' (Ministry of Justice 2011) was introduced following a serious case review. A GP had marked a referral '*urgent*' but the screening clinician considered it not to be urgent and thus it was not handled as '*urgent*'. It appears that, shortly after, the individual patient had died in previously unforeseen circumstances. The presiding coroner had reprimanded the clinician for disregarding the doctor's '*urgent*' referral saying that the GP had a better knowledge than any clinician. From this rule the Trust developed a protocol of responding to every referral marked '*urgent*' within 24

hours unless the screening clinician had had a conversation with the referring doctor and an agreement was reached that the patient did not need to be seen within the 24 hour period. In actual fact subsequent practice showed that often GPs mark a referral as urgent when they merely mean '*as soon as possible*'. This illustrates that new circumstances can bring a new level of bureaucracy into being illustrating the BMA's (2013) comment about the development of medical law. Often CAMHS waiting lists have been lengthy. There is pressure for people to be seen although some cases may not be psychiatric emergencies. Not all GPs are familiar with CAMHS criteria. However most mental health clinicians have had direct experience of the needs of the client versus the needs and capacity of the agency. Williams and Kerfoot (2005) stress the importance of developing a '*better harmony*' between the needs of the young people and their families and the '*realities of practice*'. Herein lies a power balance. The same point was reached when the Ethics Committee required the research to be modified and the same was the case with the new managers who wanted their own interpretation. There is an element of fearing litigation in the development of protocols, but also some learning from previous mistakes leading to the development of an ethos within organisations. Serious events that occur tend to produce a response within organisations. The essence of caring for people does involve a certain aspect of measures to '*cover your back*' and therefore protect yourself and your organisation but all within the concept of ethical care. After all, it is better to be proactive than to later regret it. Thus the point is made that within a large organisation such as the NHS certain protocols and ways of doing things have to be followed. Research however leads to another dimension where all the t's have to be crossed and the i's dotted.

### **5.13 Preparing to redesign**

It was a considerable time later when the new management were satisfied that the go ahead could be given. Thus potential participants who had previously been identified in the '*old world regime*' would not necessarily be interested in the '*new world*'. Some found other resources, some no longer needed mental health services and some were just no longer interested. Also it would be hard to decide how to organise a '*control group*'. It would not now be ethical to keep people

waiting. Previously people had waited for appointments as the capacity to see them sooner had not been an option but with the new structure the aim was to eliminate the wait.

### **5.14 Making the best of the situation**

In the midst of the new organisation things were very uncertain. Within a very short time the waiting time for young people would change. As already outlined there would no longer be a gap between '*choice*' and '*partnership*'. The idea of a control group seemed an impossibility as did the point about randomisation, and yet there were a number of young people who had been seen for '*choice*' and who had expressed an interest in mindfulness. These young people were at present waiting for further appointments. During this period NHS ethical approval was granted but the problem was how to do this research in the way that had been outlined in the application. Without a control group a new application would be required and the Committee had been quite specific about its inclusion to make the research both ethical and scientific. Therefore it was unlikely that the research would be approved without this and a complete redesign would be needed. However, the people who had been waiting and were on the point of being allocated to workers might be amenable to being included in a '*control group*'. These patients would have been waiting up until this point but would have already have had a '*choice*' appointment where initial forms would have been completed as a part of the normal process. These would include HoNOSCA and CGAS and the SDQs. Those people who had shown an interest in mindfulness but preferred not to join a group could be invited to join the '*control group*'. For example, very socially anxious young people may prefer an individual format rather than a group. Consents could be obtained and they could then be seen by a clinician for on-going treatment without further delay. However it would be important to identify these participants and ask them to complete the necessary questionnaires before the start of their on-going treatment. As it had been some weeks since the '*choice*' appointment new forms would routinely be done by the new clinician to assess whether there had been any changes. If they were willing to join the '*control group*' all that would be necessary would be to fill in one extra form – the FMI. Although it could not be a completely randomised selection, those who had been interested in mindfulness

but were apprehensive about taking part in a group would be good candidates for such a programme and this seemed to be a fair way of approaching the problem.

Logistical problems remained. There had been a change of location for clinicians but not for patients. The previous building was being de-commissioned and the new location was not yet available for patients. In order to see how many potential participants might be available, phone calls were made. An introductory meeting was planned and, with the assistance of a psychology student, letters were sent out inviting people to this meeting. It was decided to use the 'old' building on the basis that it was convenient for clients (and was the location of the 'old' clinic ) and also it contained a room that had enough space for about 20 people. The meeting was intended to be a briefing session for those who might be interested; however a disappointingly small number of people attended (four young people and two parents). One mother had telephoned to say they would be late and this was unavoidable. It became clear that this was a bad time for her. We considered making the meeting a little later but management were concerned as only the researcher and the psychology assistant would be present with the group if it were to be held later. This raised issues of security which management were not able to address. Therefore they stipulated a time for the group to finish by. Changing the day would not suit other people who attended.

This session introduced mindfulness and explained the process of the research and a brief session of mindfulness was delivered so that people would have a better understanding of what it actually was. Information leaflets (see Appendix 2) were given out and people were invited to ask questions. It had been decided that four participants was the minimum number that would be viable to run a group. The Changing Minds website states that three can be regarded as a group although four is a further '*improvement*'. This was bearing in mind that during the course of the group there may well be people who dropped out and some participants may not be able to attend some sessions. Thus it seemed clear that it was going to be difficult. One young person was unlikely to come because of the time the group would be held and changing the day to the viable day for her would exclude another young person. We did advise people that we would not be able to start the group straight away but would let them know. At the end of the session



one young person said she was not interested - it was clear that '*it was not for her*'. In discussion afterwards it seemed from the four young people who had attended, one clearly had dropped out, and one was unable to come on the day planned. Thus it seemed we were '*back to the drawing board*'. The following week at the same time another young woman arrived having mixed up the date of the meeting. It was explained to them what would be involved but they were advised that the group would not be starting until we had sufficient numbers. This was the point where we asked colleagues for support in identifying people who may be interested.

At the time the Psychology Department had been planning to run a Cognitive Behaviour Therapy (CBT) group for young people suffering from anxiety but they too were having difficulties getting sufficient numbers. We collaborated and pooled resources. The decision had been made to postpone the CBT group but those who had been interested in joining would be invited to take part in the mindfulness group if they so wished. Further information about mindfulness was given at the first meeting where consents were obtained from those who wished to take part. In this way sufficient numbers were put together to get a small group off the ground. Colleagues were extremely helpful in putting young people forward as potential participants for the group.

### **5.15 Pulling together a group**

In line with ethical approval ten letters were sent out to potential participants to invite them to an introductory session. This session was held in our original building as we were confident about the facilities in this venue. Four young people attended, two with parents. There were none of the people who had come to the original briefing. We established that they did understand that the CBT group would not be going ahead until January, but for those who might be interested there was an opportunity to take part in a mindfulness group. A practical demonstration of mindfulness was given along with a full explanation of the research project and what would be involved. It was clear that one young person was extremely nervous and possibly she would not return. Handouts were given out and a FMI questionnaire was completed. One young woman in particular had difficulty in understanding the questions. Thus the questions were explained one

by one as this seemed likely to benefit them all. Ground rules were set. The suggestion we should be courteous and respectful to each other was agreed as was confidentiality. We discussed the outline and content of the course. A practical mindfulness practice was undertaken and the young people were asked to carry this on at home. The two young people with parents signed the consent forms and returned them. The very nervous 17 year old did not sign – she said she was not sure and she was assured that this was fine. The following session was to be held in our new premises and thus maps were given out so that people could find their way. (Please note that the first names used are all pseudonyms with the exception of my own name.)

### **5.16 The pilot group**

Between sessions, on talking to a colleague it became clear that she knew '*Marcia*' (the very nervous 17 year old). My colleague expressed that '*Marcia*' had in fact done tremendously well to attend at all considering that she had been unable to attend school for two years due to social anxiety. I decided to give her a call to tell her how well she had done to attend as I had not realised just how difficult this must have been for her. I felt that it should be acknowledged that she had made a big effort to attend. She said she would be attending the next session. I rang the young woman who had arrived on the wrong day to discover that she had declined mindfulness in favour of Spanish lessons held at the same time and day. Perhaps her Spanish grades were causing her stress and she decided to try and resolve this by doing extra lessons.

For the next two or three sessions it was not clear whether this was the full complement we could expect. The two young people who attended seemed to be benefiting. They both had serious problems with social anxiety and yet they had managed to cope in a small group situation. This in itself was a positive outcome. Given that it had already been difficult to recruit sufficient numbers of young people it was by no means certain that postponing the group with the objective of getting larger numbers would be any more successful. Plus there were other young people who had agreed to act as a '*control group*'. These young people had been approached and while they did show an interest in mindfulness they did not wish to take part in a group. This appeared to be the only way a '*control group*'

could be envisaged in the new structure and to by-pass this opportunity meant that a complete redesign would have been necessary for the research to continue. Thus there were a number of valid reasons to continue with the sessions at that time – small as the group was. Baldwin (2005:1) points out that '*As part of a mostly psychologically based service, it is also much harder to research*'. Sometimes it is not clear how things will evolve.

### **5.17 The 'control group'**

There had been a further six young people potentially interested although they had not attended the information session. Four people were still interested. Consents were obtained but in the event only two of these were used as '*control group*' members. These were the participants who had all the relevant questionnaires (HoNOSCA, CGAS and SDQs) completed on file. At that time they were starting their '*partnership*' appointments where routinely the above three forms would again be completed (as they were some months previously). Additionally they were asked to complete a FMI questionnaire.

### **5.18 Conclusions and new pathways**

It was an interesting first step although disappointing with the small number of participants. It did however seem that the young people appeared to be benefiting which helped to make the decision to let the group run its course. The mindfulness group continued throughout the eight sessions with Marcia and Bethan attending most sessions. It proved to be a valuable experience in formulating session plans and acting as a pilot study. This pointed the way to undertaking the project again with more participants. The process of the group and the outcomes are discussed in Chapter 6.

### **5.19 New decisions**

After this pilot group had run its course there were some decisions to be made. There had been some encouraging results but the group had been very small and there was a need to undertake the sessions again with a larger group. One important decision was whether to try and recruit participants within NHS CAMHS. There were very legitimate considerations:

- The new referrals were now going to the new '*single point of access*' team located in a different building.
- By this time any '*new*' patients known to the current team would all have started receiving some kind of therapy which would cloud any results of a mindfulness group.
- Also the idea of a '*control group*', insisted upon by the NHS ethics committee, would be out of the question. (The Trust had been very clear that there would be no further waiting period and any other group of patients would thus be having some other sort of treatment.)
- Clearly new ethical approvals would have to be sought, not only from the NHS ethics committee but also from the University and the Trust.
- Agreement would need to be reached about the research protocol with the new set of local managers. At this time they were struggling to cope with the new organisational structure with each team having their own agendas.

The new structure limited the possibilities not only in terms of recruitment but of procedures which could be followed. There was no longer '*the gap*' and people were being seen quickly for one or two sessions. This would not fit with an eight-week course of mindfulness. Although it might become clearer to map a way forward when the new system settled it did not seem that a way would be found without radical rethinking. Maitland and Thomson (2014) claim that people are more productive if they have more autonomy over their work. How the project could evolve seemed very uncertain during this time period. Bond (2010) writes about agency policy, professional codes and bureaucracy. Not only does one have individual moral standing to achieve, but also this has to fit with agency policy and the requirements of bureaucratic organisations. Within an organisation as complex as the NHS, there is a high level of bureaucracy. As Gilbert and Choden (2013:19) express, '*the drive for increased efficiencies is now recognised to be turning the British National Health Service'....' into an uncompassionate service*'.

As part of CAMHS work we often had contact with the local Inclusion Centre as many of our clients attended there. A favourable conversation with the head teacher of this Centre opened a new possibility as interest was shown in taking the project forward for the pupils attending the Centre. The Centre was small and had a lot of autonomy. The fact that they welcomed the idea of a mindfulness intervention was encouraging. Much of what has been said in previous chapters about mental health being '*Every One's Business*' highlighting the pressures on all services gave validity to conducting the research with these vulnerable young people in their educational setting. It is not always necessary that young people should attend CAMHS as Kurtz (2005) has said there is not only one way of providing a service. Also it had always been envisaged that the potential group would be '*routine*' and '*non-urgent*' in respect of their mental health. Young people attending the Centre would be in a similar category.

A decision was made to take the research out of the NHS completely and enlist the co-operation of the Head and staff of this Centre. This also opened up new possibilities as teaching staff were also interested in the research.

## **5.20 A sideways step**

The Centre provided a tuition service for the local authority. The building was shared with a pupil referral unit although the services were separate. Pupils were of secondary school age and were referred from their mainstream school. The criterion for referral was that they were not achieving nor succeeding in their mainstream school. Part of the admission criteria was that they were receiving help from CAMHS. The Centre sought to provide a positive and inclusive community where young people were enabled to achieve high standards of progress and succeed in a supported safe environment where this would be possible. The unit was small (about 20 pupils on roll) and the staff ratio was good. The pupils remained on the roll of their mainstream school but attended the Centre for their education. A few of the pupils received home tuition from the service as they were not able to attend the Centre – for example those young people who were suffering from agoraphobia. Often progress would be made with home tuition and the young people would be encouraged to attend the Centre. Often this would start on a part time basis. Thus the environment was a very nurturing one where

staff sought to look to the emotional needs of the young people. In addition to formal lessons they often undertook various projects. For example the art room was full of various creations and the corridor displayed photos of trips they had been on and various activities they were involved in. Additionally from time to time there would be displays celebrating various festivals such as Easter, Diwali, Eid and Hanukkah.

Having said this, it should be mentioned that this was an area where 95.25% of children were white British (Local Authority Statistics 2015). Demographically the area was neither especially disadvantaged nor affluent compared with the rest of the country. For example child poverty figures were 26.3 for the area compared with 25.1 for England. Clearly there were parts of the Borough which were more affluent than others. The Centre itself was situated in an urban area close to the town centre consisting mainly of residential terraced houses. However, the young people themselves came from different parts of the town, many of them being transported to the location, thus representing more than one geographical area. There did not appear to be any clear class difference between the young people and they all had in common the fact that they struggled in their mainstream school.

Thus the students were vulnerable and likely to be of a similar vulnerability to young people known to CAMHS. In fact, of the eight pupils who joined the group 5 had been or were open to CAMHS and two had ASD. The Centre had previously shown an interest in mindfulness and it seemed likely that we could collaborate.

Clearly this new partner organisation would involve new sets of ethical approval to be obtained but it seemed more viable than the NHS process. There were a number of reasons for this:

- firstly because the parameters seemed fairly clear,
- the Head wanted involvement with the mindfulness project and
- a number of teachers were also interested
- the young people were students at the Centre and would be attending daily for their education. A weekly session on mindfulness seemed to fit in

- it would no longer be in the auspices of the NHS and although new ethical approvals would be necessary it seemed it would involve only the co-operation of the Centre and University approval.

A presentation facilitated by the Head was given to the teachers and this was favourably received. Research at the Centre would need new approvals but it seemed a more favourable environment in which to take the research forward.

### **5.21 Approvals and modifications**

The Head was already on board with the idea and there was little difficulty in gaining consent from the educational establishment which involved only an outline of the protocol and a request to carry out the research. New ethical approval applications were forwarded to the University and, facilitated by the fact that NHS ethical approval for a very similar project had already been obtained, did not take too long to gain new University ethical approval. Two staff members expressed an interest to join the group and it was agreed that they would take part.

In the original NHS ethical approval forms there had been questions about safeguarding the participants – for example if they were to become distressed. In the original plan there had been a team of people who could have been called upon – although the likelihood of this being needed was remote. In this case the teachers would already know the young people well and would be present to facilitate any necessary assistance. The project itself was not wildly different from the original except that the control group was no longer a component as this was not available. This gave weight to the use of the single case evaluation method (Kazi and Wilson 1996) which has been more thoroughly discussed in Chapter 3. The group would run for a number of sessions with the same questionnaires being utilised. The results would then be evaluated. The teacher's presence presented a further modification. The original questionnaires used routinely in CAMHS for young people were fine for the young people but were not suitable for adults. Thus consideration was given to appropriate questionnaires for the adults. The FMI (Walach et al 2006) was still appropriate but another measure that quantified stress levels was necessary. The PSS (Cohen et al 1983) seemed appropriate. This is a measure which is widely used and appears on the website for the online

mindfulness course introduced by Dr Mark Williams. Not only did this seem suitable for the adults but it also seemed useful for the young people. Thus this questionnaire was introduced to be completed by both adults and young people.

## **5.22 The new recruitment process**

As outlined above in the first instance a meeting was arranged with members of the teaching staff to explain to them what mindfulness was about and to outline the process. This also put them in a position to be able to talk to the young people to and monitor their interest. It was explained that the group would consist of eight sessions followed by a focus group and a subsequent interview with parents. This had also been the original outline plan. Also there would be questionnaires to complete at the beginning and end of the sessions. New consent forms were produced – largely based on the originals but suited to pupils attending an inclusion centre. Staff followed up this meeting by giving out information sheets (see Appendix 2). A number of pupils were interested and a meeting was arranged to discuss mindfulness and what was involved in attending the group. In all, 11 young people and teachers attended this meeting. Eight of the eleven young people who had attended the introductory session put their names forward to join the group. The project would go ahead. The pilot group had helped to map out the progress of the sessions and would be valuable now to adapt to this group of young people.

Chapter 4 considered the beginning of the research process and how this developed and this chapter has continued, considering some of the difficulties encountered with the ethical process within a climate of organisational change. Modifications became necessary and a revisiting of ethics. Finally a pilot group, proving very useful in helping to focus ideas for future groups, went ahead. Subsequently new decisions were made when an opportunity presented itself. New ethical approvals were obtained and a new group was established. Chapter 6 describes the participants and follows the process.



## 6. The research pilot, the new group and the outcomes

### 6.1 Overview

The aim of the research was to establish whether mindfulness delivered in a group format to a group of vulnerable young people would assist them to manage better the challenges they faced. As discussed in Chapter 5 difficulties of an organisational nature delayed the main project, however a small group of participants did take part in what became a pilot study. This chapter considers firstly this pilot group, the progress and the results and the learning that was then taken forward. The chapter goes on to give some background to the recruitment process of the new group before proceeding to describe the individual profiles of the young people who went on to attend the mindfulness sessions. The chapter then moves on to consider outcome measures for the new group of participants. As has been noted, after completion of the sessions, the mindfulness-based intervention was to be evaluated in a number of different ways (see Chapter 3). This chapter considers the quantitative outcome measures: the SDQs (Goodman et al 1998), the CGAS (Gould et al 1983), the HoNOSCA (Gowers et al 1998) and the FMI (Walach et al 2006) thus providing a single case review method (Kazi and Wilson 1996). Both the pilot and the main group results are discussed. Before looking at the results of the outcome measures for the '*new group*', consideration is given to the content of the actual sessions. The results of the SDQs are discussed with a reflection on links to mindfulness benefits and other factors. CGAS and HoNOSCA, the PSS (Cohen et al 1983) and the FMI (Walach et al 2006) are all discussed in relation to the impact of the mindfulness intervention. Some reflection is given to the questionnaires and what they are intended to measure.

### 6.2 The pilot group

As the research progressed organisational changes necessitated a different focus. A number of young people had been interested in taking part and it became possible to put together what became the '*pilot group*'.

The pilot group was composed of two young people. Segal et al (2002:92) promote the idea of discussion and feedback as '*the main vehicle for teaching*'. It was always anticipated that it would be difficult due to the high level of social anxiety that the participants suffered and getting them to discuss their individual experiences of mindfulness would be challenging. The Merriam Webster dictionary (2016) defines a '*group*' as two or more people but higher numbers would have been preferable. Nevertheless as discussed in Chapter 5 it was not clear whether more participants would join in and additionally the mother of one of the young people (Bethan) joined in. Although she was not regarded as a participant, Bethan had not wished her mother to leave and her presence facilitated conversation with Bethan. (The Changing Minds website states that three can be regarded as a group.) '*Marcia*' was the other participant (only pseudonyms are used) and was aged 17. '*Bethan*' was aged 14. All of the sessions were attended by Marcia and Bethan (and Bethan's mother) apart from one session which Bethan missed due to illness. Neither Marcia nor Bethan attended on the date set for the '*focus group*' session. The date had been specified before Christmas with a date early in the New Year but people were busy with their own activities. In the event the relevant questionnaires were sent out to the participants together with a request for them to write down their views about the group on a separate piece of paper. Given the difficulties they both had with social anxiety this seemed a more productive method of getting their views. Gony et al (2010) discuss various strategies for retaining participants in a study. One such idea was to send out handwritten greetings cards. Retrospectively a Christmas card together with the questionnaires and the request for their views would have been better.

### **6.3 Participant and adult views about the effect of the sessions**

A meeting was arranged with Bethan's parents to complete the parent interview. Marcia's situation was a little different: her mother was in full time employment and I had never met her. Marcia had usually arrived for the sessions with her boyfriend. Marcia was 17 and her mother seemed less involved in her life. Thus it seemed appropriate to ask him about any changes he had noticed in Marcia. He was actually an adult (having just turned 18) and had done much to support her.

Bethan's parents felt unable to say whether or not they thought mindfulness had helped her. They remained concerned about her and it was clear that she needed further review from CAMHS. Thus it seemed that the role of researcher was somewhat overshadowed - one of the issues with practitioner research. Fox et al (2007) identify some of the potential role conflicts that this may incur, however in this case Bethan was not my direct client and I was able to relay the parents' concerns to her mental health practitioner. Fuller and Petch (1995) list the closeness of the practitioner to the '*regular*' work as one of the disadvantages of practitioner research.

As mentioned above, the focus group had not taken place but questionnaires had been sent out to the young people together with a request for them to write down their comments about their experience of the group. Bethan's paper was blank. Her parents said that she told them '*I don't know what to write*'. I later discovered that while she had attempted the FMI questionnaire she had only completed the first two questions. She had had a fairly high score to begin with (36) but answering only two of the fourteen questions made it impossible to establish whether she had made any progress in mindfulness (results for the FMI are given in Table 2 below).

A meeting was arranged with Marcia's boyfriend as he was probably in a better position to comment on any difference in Marcia as he was frequently in her presence. I had received her written comments which read '*I am sorry Anna but my mind is just too busy to be able to be mindful*'.

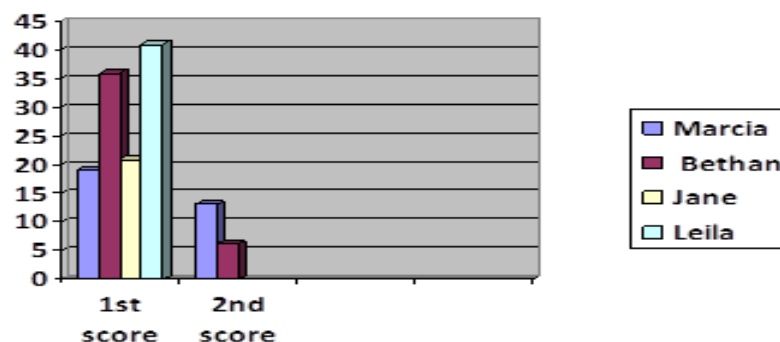
Although her boyfriend said he hadn't seen any change there were some positives. He had been surprised to see her following the sessions through all the way as often she had given up on things. He explained that it was difficult for Marcia to go places and how he tried to keep her settled. He described how recently they had been at a friend's house - she had appeared '*frozen*' but had stuck it out and not just left. These were improvements in her ability to manage her social anxiety and it was hard to be sure of causality although it remained a possibility that some of the mindfulness practice had helped her to be more tolerant. Marcia's mindfulness questionnaire score had been a low of 19 at the

start of the sessions but at the end she had an even lower score of 13. Part of this could be due to her being unsure of the concepts in the beginning and thus filling in the form without adequately understanding it was likely to produce an unreliable result. Additionally she missed out 2 of the 14 questions.

## 6.4 The control group

As discussed in Chapter 5 the '*control group*' consisted of young people who had been waiting for individual appointments but had not wanted to join in group sessions. The two young people selected for the control group were '*Leila*' who was 14 and '*Jane*' who was 16.(pseudonyms are used). They had previously completed paperwork on file from the time of their '*choice*' appointment (CGAS, HoNOSCA and SDQs). They were asked to complete the FMI and as a matter of on-going treatment they also repeated the CGAS, HoNOSCA and SDQs which they had agreed would be utilised for this research.

**Table 2 FMI scores**

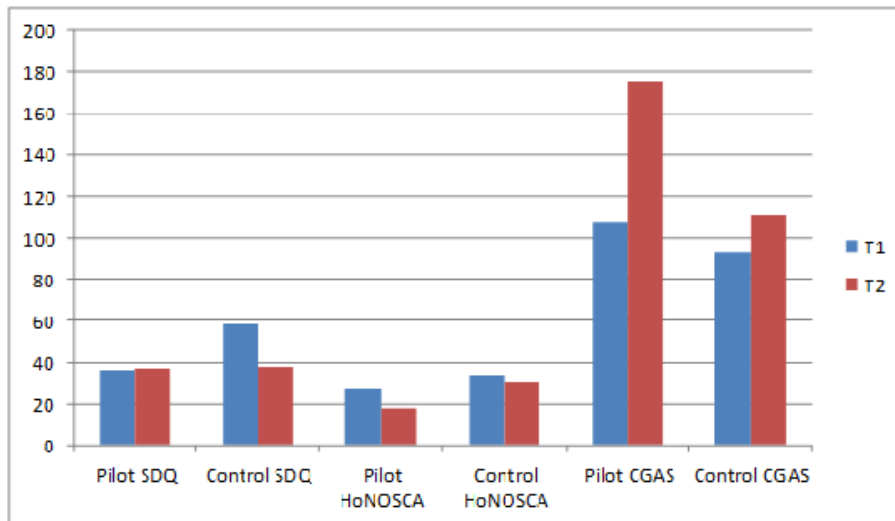


In the above table the '*control group*' only completed the FMI on one occasion and the pilot group's second scores were incomplete. Marcia left out two questions and Bethan only completed two of the questions. Leila's scores are interesting as discussed below with her other results.

## 6.5 Outcome measures for the pilot and 'control' groups

Firstly because of the size of the group and especially as some of the outcome measures were not completed, any analysis became very difficult, thus any results can only be very tentative. A single case review method (Kazi and Wilson 1996) was used and the collective results are given below in Table 3 before considering the individual questionnaire scores.

**Table 3 Collective outcome scores**



The total SDQ scores before and after the sessions (T1 and T2) appear first in Table 3 above. There was little change in the scores of the pilot group although the control group score did reduce. This was thought to be mainly due to the improvement of one of the participants (Leila - see below). The HoNOSCA scores showed improvement for both pilot and control groups which was again reflected in the CGAS scores (please note that in the case of CGAS higher scores indicate improvement).

The SDQ scores are given below: firstly the pilot group (Table 4) and then the control group (Table 5). As discussed in Chapter 3 the SDQs cover a range of domains divided between the 25 questions. Total scores are given on the 'overall stress' measure and the scores are then given in the various sections. This can be useful in considering whether there has been any improvement in a particular domain – for example peer relationships. The questionnaires are largely scored on line and an individual print-out gives a score line by line with an indication of whether the score is low, high or average and where that score lies within the general population. Each domain has a different scale range and for the purpose of this research average ranges have been indicated by the side of each domain. Two boxes are positioned after the young person's name, the first of which is the score before the mindfulness sessions (T1) and the second box is the score after

the sessions took place (T2). Lower scores indicate less stress except in the case of *'helpful behaviour'*, representing the pro-social domain. Higher scores here are seen as improvements.

### 6.6 SDQ Outcomes of the 'pilot group'

These are given below in Table 4. Results for Marcia and Bethan as well as their parents are represented.

Marcia seemed not to have benefited during the sessions based on her SDQ results. Her reported overall stress had increased as had three other domains. Her *'helpful behaviour'* decreased but peer relationships remained the same and there was a slight reduction in her emotional stress levels. Her mother's scores cannot be compared as only one set was present. However her mother's scores were overall lower than Marcia's suggesting perhaps a more optimistic view.

**Table 4 SDQ outcomes for the pilot group**

Overall Stress	Marcia	17	22	Parent Score	15		average range 0-14
	Bethan	19	15		9	11	
Emotional Distress	Marcia	10	9		6		average range 0-4
	Bethan	7	7		6	5	
Behavioural Difficulties	Marcia	0	3		1		average range 0-3
	Bethan	1	1		0	2	
Hyperactivity	Marcia	6	7		5		average range 0-5
	Bethan	4	3		1	2	
Peer Relationships	Marcia	1	3		3		average range 0-2
	Bethan	7	4		2	2	
Helpful Behaviour	Marcia	9	8		8		average range 7-10
	Bethan	9	7		10	9	
Impact on Life	Marcia	5	6		3		average range 0
	Bethan	3	1		3	5	
		T1	T2		T1	T2	

Bethan's self-report score on overall stress had dropped (from 19 to 15). Her parents however scored an increase although their scores were lower than Bethan's. Her emotional distress levels remained the same while her parents registered a slight drop. They also noted an increase in behavioural difficulties. Bethan rated her hyperactivity levels as slightly decreased while her parents' scores had increased. The fact that her reported '*helpful behaviour*' had dropped was also confirmed by her parents. The impact of her problems on her life had, in Bethan's view, decreased while her parents registered an increase. The differences in Bethan's and her parents' scores are interesting and, as Burton (2014:5) suggests, this could provide '*a window of opportunity*' for further discussion and clarification. It would seem that Bethan had a range of emotional difficulties. Her mother described her as '*difficult to read*' (as written in the comments of the initial SDQ) and sometimes '*going from crying to laughing*'. I discovered this for myself when I asked her to draw her '*favourite place*' and she burst into tears. However as Thompson and Chambers (2012:28) state, it is important to recognise that we are all vulnerable and they refer to the '*core principles*' of normalisation already employed by mental health practitioners.

## **6.7 SDQ Outcomes of the 'control group'**

The results of the '*control group*' SDQs appear below (Table 5). The CGAS and HoNOSCA results for both groups appear later in this chapter. While it might be anticipated that a period without treatment would tend to make a person worse this is not always the case. Bowden (2011:10) writes about the body having '*an almost wondrous ability to heal itself*' a fact that is '*absent in conventional Western medicine*'. Leila had improved during the period she had been waiting for further appointments. Leila's SDQs show a reduction in stress levels in all areas. This was except in the category of '*helpful behaviour*' which increased (as one would expect from better functioning). Her mother's scores in the main also reflect the same trajectory. One interesting point is that while Leila felt that the impact of her problems had diminished (down from five to zero), her mother had thought the impact had increased.

**Table 5 SDQ outcomes for the control group**

Overall Stress	Leila	30	11	Parent Score	23	20	average range 0-14
	Jane	28	27		25	22	
Emotional Distress	Leila	10	5		9	8	average range 0-4
	Jane	10	9		8	8	
Behavioural Difficulties	Leila	6	1		4	3	average range 0-3
	Jane	4	5		3	1	
Hyperactivity	Leila	9	4		6	5	average range 0-5
	Jane	7	7		6	5	
Peer Relationships	Leila	5	1		4	4	average range 0-2
	Jane	7	6		8	8	
Helpful Behaviour	Leila	7	8		6	7	average range 7-10
	Jane	5	7		9	6	
Impact on Life	Leila	5	0		1	5	average range 0
	Jane	8	8		5	10	
		T1	T2		T1	T2	

Jane however had not shown such progress although her scores had shown a little reduction in her overall stress and emotional stress levels, both of which were extremely high. Behavioural difficulties had slightly increased. Her hyperactivity levels remained the same. Peer relationships had slightly improved as had her *'helpful behaviour'* but the impact of her difficulties on her life had remained the same - at a high level. Her mother considered that the impact of her difficulties on her life had increased and were at an even higher level.

From these SDQ results there would seem little difference between the control group and those young people who had attended the mindfulness sessions. There were improvements in both groups but Marcia's final scores had increased although Bethan's score had somewhat improved. Both young people in the



'control group' had shown some improvement (Leila more so than Jane). However with such small numbers it would be difficult to draw conclusions.

## 6.8 HoNOSCA and CGAS

The HoNOSCA is a score that is graded to measure different areas of potential difficulty in a young person's life. The scores are then added together to give an overall result (see Chapter 3 for further details). The different scores for young people in the pilot and control groups for the HoNOSCA are shown in Figures 2 and 3 below.

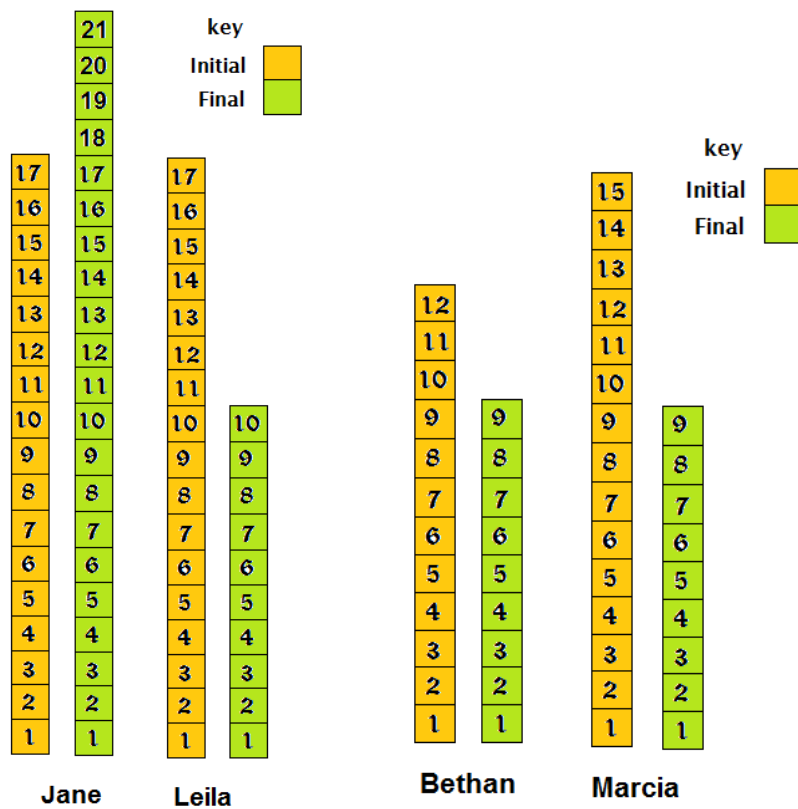


Figure 2 'Control group'

Figure 3 'Pilot group'

Please note that with the HoNOSCA (above) lower scores indicate progress but with the CGAS higher scores indicate progress.

**Table 6 CGAS results**

**Pilot group**

Name	Initial	Final	changes
Marcia	45	55	>10
Bethan	62	65	>3

**Control group**

Name	Initial	Final	changes
Jane	43	50	>7
Leila	50	61	>11

**6.9 The outcomes of the control group**

As shown in Figure 2 Jane had increased her HoNOSCA score signifying that at the time of second questionnaire she was doing worse than she was when the first scores were taken and although her CGAS score is up a little (showing some improvement) it is still within the same band of *'obvious problems'*. Overall this would be expected for someone in the *'control group'* not receiving treatment for the period under review. Jane's SDQ scores had shown the same pattern. Dahl and Lundgren (2006:293) describe a case study where a person who suffers from a physical condition gives up more and more of her normal activities. *'It sounds like your pain is squeezing the life out of you?'* This pattern is often followed by people who are low in mood or depressed. They avoid going places, doing things even hiding away and not attending school but these activities are just the ones which bring some respite to the bad feelings which otherwise tend to go round and round in people's heads. Without any distraction this ultimately makes them feel worse. Segal et al (2002) explain clearly how such rumination cumulates which is often a factor in depression. It seems that these factors may well have been present in Jane's life.

Leila on the other hand had improved on all the score tables. This was an unexpected result but the history showed that there had been bereavement in her family around the time that she was seen for a 'choice' appointment. Time itself can be a great healer in helping people to adjust to loss. Dogra et al (2002:138) describe a 'normal' mourning stage where the young person

*'may express despair, anger, guilt, sadness, hopelessness, self-blame and worthlessness', with possible changes in behaviour and sleep'.*

It would seem that Leila may have been referred to CAMHS when she was in such a distressed state. At her 'choice' interview the clinician would have listened and reassured her about 'normal' grief reactions – told her that it wasn't her fault and that it would take time. This may well have helped her set things in a better context and started her on the road to recovery. Also her mindfulness score had been quite high (41) establishing that she was already quite mindful - which may have helped her recovery, while Jane's mindfulness score had been relatively low (21). See Table 2 above.

## **6.10 The outcomes for the pilot group**

There had been a slight reduction in Marcia's emotional distress score on her SDQ although other scores were not as encouraging. However it seems that while Marcia felt she was not doing well clinicians who scored her independently on the CGAS and HoNOSCA felt that she had improved. Her HoNOSCA score showed an improvement of 6 points and her CGAS score had also progressed pulling her out of the 'obvious problems' range into the 'some noticeable problems' area. Marcia's statement 'my mind is just too busy to do mindfulness' resonates with Gilbert and Choden's (2013) three problems of practice: *attention hopping, rumination and brooding, and emotional avoidance*. These can be overcome by non-judgement but in order to do this you need to be able to be compassionate to yourself. This is not easy for people who have had a lot of difficulties in their life.

*'For all kinds of reasons our present-moment experience can be so painful and conflicted that we don't want to be there' (Gilbert and Choden 2013:144)*

Bethan's score on the SDQs showed some slight improvement although this was not always reflected by her parents' scores, however her HoNOSCA score (and again this was independently scored), improved from 12 to 9 points and CGAS improved slightly from 62 to 65 although still within the same category of '*some problems*'. It may be that Bethan also faced similar challenges to Marcia. It was hard to tell and, as her mother had observed, she '*was hard to read*'. It is a matter for consideration whether people are at a stage where they can be receptive to mindfulness. It was assumed that '*routine*' clients would fall into this category but this would need to be reviewed – especially in view of potential future service delivery. It may be that some clients with more serious problems would require a different approach.

It had been my belief that the young people in the pilot group did seem to be benefiting and that had helped to make the decision to let the group run its course. The pilot was a useful exercise and proved to be a valuable experience especially in formulating session plans and considering which strategies seemed most effective. Although the results were unclear my own observations were that the young people appeared to be doing quite well. The fact that this was echoed by other CAMHS clinicians who gave the final scores, despite the young people's individual more negative view, was very encouraging. Also it had been very useful to conduct the sessions with young people as this provided a focus on the activities and materials used. This pointed the way to undertaking the project again with more participants.

### **6.11 The new mindfulness group**

Chapter 5 describes the process which led to the establishment of a new group of participants. The NHS re-organisation had made it necessary to re-think the project and a local Inclusion Centre had been interested in mindfulness. The first step in the Inclusion Centre was to hold an introductory session to explain what would be involved in the project for those who wished to take part. At this stage it was unclear who the participants would be although some of them had shown an interest. The session was attended by eleven young people and some teachers. Subsequently eight young people and two teachers, (Mary and Christine) put themselves forward for the group. Three young people dropped out (one after the

first session) and thus there were five young people who completed the sessions. Altogether most of the sessions were attended except for an occasional absence due to illness. Individual profiles are given below although all names have been changed to protect identity.

## **6.12 Individual Profiles**

Individual descriptions of the young people who took part in the sessions are given here using pseudonyms. The following information about the young people was gained from discussions with the teachers as well as personal contact. Katie was a delightful young woman with a bubbly personality. She lived with her Mum and Dad and younger brother and sister. Katie was 13 years old at the time of the intervention and she had attended the Centre for about a year. She had previously attended a mainstream school but her parents had been concerned because of some 'odd' behaviour. Thus she was referred to CAMHS where she was assessed and found to have a very patchy intelligence quotient and attention deficit hyperactivity disorder. However her verbal skills masked her other difficulties. Her mainstream school had failed to recognise that Katie had any difficulties and reported that she was working in the middle range and had no behaviour problems. Katie was most unhappy at school but things only came to a head when she completely refused to attend school. Agreement was reached for her to attend the Centre, initially for a temporary period to give time for reviewing her school placement. However her progress and happiness improved so much that it was agreed that she could remain at the Centre.

Jack was 14 at the time of the project. He had been diagnosed with autism, although at the higher achieving end of the spectrum. Jack was an intelligent and thoughtful boy although he didn't always get social cues. He had an older brother (who had no apparent difficulties and attended a mainstream school). They lived with their Mum and Dad. Jack had experienced difficulties on joining high school. He had coped with it somehow for a while but problems became more complicated. Meetings were held and Jack was placed in a special unit within the school designed to meet the needs of autistic pupils. However this did not work for Jack. After some quite lengthy negotiations he started attending the Centre which

proved to be a much better placement for him. He continued to make good progress.

Jessica was 14. She was the youngest of three siblings in a family with a single parent Mum. She had an adult brother and sister and her sister had a child of her own. Her sister had recently had operative treatment (at the time of the sessions) which although not at all life threatening had required her Mum to undertake extra responsibilities while she recovered. Jessica had emotional problems and needed support – for example she was unable to travel by public transport. Nevertheless her Mum had taken on board Jessica's difficulties and had gone to some length to help her. Jessica had obsessive compulsive disorder and had had periods of trichotillomania (compulsive hair pulling). When it came to starting high school Jessica just could not manage this and she started to attend the Centre. She had been a pupil at the Centre for the last two and a half years. Her Mum felt that Jessica did not talk to her much about any concerns she might have. Jessica kept herself busy with her two horses which seemed to have made a positive improvement in her life.

By contrast it would seem that Emily and her Mum did talk about issues with each other. Emily was 15 at the time the sessions were held and she appeared quite a mature young woman. She lived with her Mum and Dad and older sister. Her older sister faced pressures at high school and had undergone a considerable amount of stress. Emily was an intelligent young woman who had not wanted to have the same experience. Also at the time of starting high school she had other issues to cope with. She had epilepsy and also became ill with glandular fever leaving her with ME. Her placement at high school had hardly managed to get started when she was referred to CAMHS. Shortly after this she was referred to the Centre. She was functioning much better and achieving at school when I met her and she had been discharged from CAMHS.

Matthew was 13 years old when the sessions were held. He lived with his Mum who also had some difficulties of her own. Matthew had attended the Centre since January 2014. He suffered from a form of dyslexia that seriously hampered his academic progress. He was an intelligent boy and appeared confident and able to

speak up for himself but there was a marked difference between his verbal performance and what went down on paper. This previously caused him much frustration as his learning difficulties were never diagnosed in high school. He was also bullied. He frequently lost his temper and got himself into a lot of trouble. At the Centre he made progress and his temper had no longer been an issue.

William was autistic and at the age of 12 was the youngest pupil attending the Centre. I know little about his family but understand that he came from a fairly large family. He had a number of siblings and social services were trying to help the family. William expressed a concern that he did not get time to himself. He attended the first four sessions but then said that he did not wish to continue. His reasons are given later in this chapter.

Megan was 16 at the time of the project. She lived with her grandparents and it seems that she had done so for most of her life. It would seem that her mother had her own difficulties and had another family living elsewhere. Her grandparents were doing well with her care but Megan had had a number of traumas to face in her life. She suffered from diabetes which had only been diagnosed comparatively recently. Megan attended the first four sessions but she had an exam on the day of the fifth session and did not attend. By the time of the next session she had finished all her exams and was therefore able to leave school. Although she was invited to join us she did not return to school.

Paula was 15 at the time the sessions were held. She was a girl who had problems with an eating disorder and attended CAMHS for that reason. She attended the first session but then told staff that she no longer wished to attend.

Thus all the participants had some level of difficulty although these were different from one another but with some overlap. Their average age was 14 and although the age range was between 12 and 16 they were likely to have attended many lessons together because of the small numbers attending the school (there were about 20 pupils on role but not all of them attended the Centre). Therefore in some respects they were already a group when the sessions started.

### **6.13 The plan for delivering the sessions**

As discussed in Chapter 1 other work of a similar nature has been done before. Semple et al (2006) held a series of mindfulness-based sessions over twelve sessions containing many of the same elements that this research contained. Salzman and Goldin (2008) undertook a programme of mindfulness-based stress reduction for children which ran over an eight week period. Semple and Lee's (2008) programme was designed to treat anxiety in children using mindfulness. This also ran over a twelve-week period; much of the content was about experiencing things - hearing, touching, and differentiating thoughts and feelings. Thus this programme was designed to include many of these elements and giving consideration to varying the sessions but always with the element of mindfulness practice being an essential part of the sessions.

This was to be a series of sessions delivered over an eight-week period and then evaluated in three separate ways: a focus group, the parents' views and the questionnaires (outcome measures) which reflected the single case method of evaluation (Kazi and Wilson 1996). Gunaratana (2009) states that the benefits of mindfulness are more like '*side effects*' and that the calm that one may seek from it is illusive. Although it seemed that no hard and causal '*evidence*' could be certain it was felt that any trends indicating improvement might be encouraging. The aim was to see if mindfulness might potentially impact although of course there were likely to be many other things in the lives of these young people which could also have impact. Indeed some positive changes were noted as will be seen later in this chapter.

### **6.14 The content of the sessions**

The session plans can be found in Appendix 1, together with the supplementary materials which were used in the sessions. Below is an outline of the sessions as they were delivered. All the sessions contained actual mindfulness practices and some home practice (during which they were encouraged to continue mindfulness). Sessions started with a '*feedback slot*' on the previous home practice and the previous week's session.



### **6.15 Introductory Session**

This is described in detail in Chapter 5. The plan was to outline the research and give some explanation of mindfulness. A snow globe was useful in illustrating just how busy our minds normally are, hence: let the snow settle to view things more '*clearly*'.

### **6.16 Session 1**

Much of the session was about '*getting to know you*', ground rules and basically what mindfulness was about. We looked at how the brain works – how it has developed through evolution and of our tendency to remember the '*bad*' things rather than the good. These points were illustrated by different stories – '*the 10 shops*', '*the mule in the well*'. We concluded by looking at pictures of different images to help with the idea of letting thoughts go – falling leaves, running water, clouds drifting etc.

### **6.17 Session 2**

This session discussed the body's stress reaction with a video clip to support this. The young people were then asked to breathe slowly and deeply, then quickly and shallowly to illustrate how this made them feel different. They were asked to identify three good things that had happened during the day focusing on finding the positives. A CD with a guided 15 minute body scan was played and a home practice handout with instructions for mindfulness practice was given out.

### **6.18 Session 3**

We talked about the '*good things*' with encouragement to continue this. This led to talking about emotions – what they are – why they are useful –and how they can be unhelpful. Thoughts are not necessarily true. The story of the magic tree and a picture of the Gruffalo's child helped with this. We then looked at some illusions - pictures that could be seen in different ways.

### **6.19 Session 4**

The session looked at not pre-judging using the story of Sai and the horse to illustrate this. Attention was paid to noticing thoughts and feelings and their effects. Also to the senses – smell, touch and taste. Activities used were '*Know your Orange*', '*Eating a raisin mindfully*' and '*What's in the box?*'

### **6.20 Session 5**

This session continued the theme of noticing thoughts and feelings and their effects. A video clip illustrating selective attention was played followed by a listening exercise (which in this particular case was very difficult due to noise coming from two adjoining classrooms) The importance of belief was pointed out with a hand-out on this topic.

### **6.21 Session 6**

This session focussed on individual experiences of mindfulness with discussions about activities that could be done mindfully. We discussed the point that what you focus on gets bigger - emphasising focusing on what you want – not what you don't. Trying to resist thoughts by blocking them is difficult. This was illustrated by trying to fend off paper planes or letting them settle to see which was easier.

### **6.22 Session 7**

In this session different mindfulness practices were tried – using a recorded CD and with music. We considered '*the two darts of pain*', that is the actual pain and the added emotion, '*I was careless*' etc. The story of the man who was shot by a poison arrow assisted in this. We looked at wise mind/logical mind/emotional mind and the need for a balance, ending with a discussion about next week's activity as it was to be the last session.

### **6.24 Session 8**

This session was a mindfulness practice session outside in the park (as decided by the young people) followed by a discussion of the experience. Mindfulness practices were tried using different types of music and with a discussion after each. A hand out of the '*Prayer of serenity*' was given out. As will be seen the activities are varied and were designed to be appropriate to the young people. Some activities required less time than others while some of the discussion was longer than at other times.

The sessions seemed well received although some sessions seemed to have more appeal than others. For example, the session where we went out to a local park to do the mindfulness session there was very popular with all of the

participants. Fortunately we were blessed with a warm sunny day which added to the enthusiasm. Another popular session was listening to a CD of the sound of the sea with waves crashing on the shore. Less popular was the '*eating a raisin mindfully*' session. The young people found the '*illusions*' (see Appendix 1) pictures interesting but it was apparent that some were more skilful than others in identifying the different aspects. The sessions were generally well attended with the exception of short periods of illness. The most difficult sessions were those where we were next door to two other classrooms and the noise levels were far from optimal.

## **6.25 Questionnaires**

The questionnaires used were the same for both the pilot group and the mindfulness group with the exception of the Perceived Stress Scale (Cohen et al 1983). As two of the teaching staff would be joining in the sessions with the new group it was necessary to consider how their views of the mindfulness sessions would be taken into consideration. SDQs, CGAS and HoNOSCA questionnaires were designed for young people and thus were not suitable for adults. However The FMI had been designed with adults (Baer 2011) and therefore was relevant to both teachers and pupils. Thus a search for a suitable alternative was undertaken. The PSS was identified as it seemed to have merit and seemed to be relevant to the young people. A further discussion of the questionnaires used can be found in Chapter 9.

## **6.26 The Perceived Stress Scale (PSS)**

The PSS (Cohen et al 1983) is a global measure of individual perceived stress and as such it seemed an excellent tool to assess whether stress levels had changed during the course of the sessions. The PSS is a measure of the degree to which situations in one's life are appraised as '*stressful*.' The questionnaire contains ten items (see Appendix 3 for the form). For each question participants are asked to circle which seems most relevant in a Likert style: never, almost never, sometimes, fairly often or very often. Each of these is given a value (from 0-4) and scores are added at the end. For example one question is: '*In the last month how often have you felt nervous and "stressed"?*' This seemed a reasonable measure

for the adults but also for the young people (whose ages ranged from 12-16). There were ten questions with answers to be circled. Levenstein et al (1993) describe how the effect of stress on the population has led to difficulties and thus there has been a drive to develop a tool to measure this as previously there had been no consensus. Cohen et al (1983) developed this tool to measure this 'stress' which according to the Mind Garden website (Cohen 1994) is now the most 'widely used' psychological instrument for measuring the perception of stress. Lee (2012:121) describes the PSS as an 'easy to use questionnaire with established acceptable psychometric properties'. This is a measure which appears at the beginning of an online course in mindfulness (be mindful online) inviting people to do the test to measure their stress levels. Dr Mark Williams, co-author of 'Mindfulness: a practical guide to finding peace in a frantic world' and well known in the field of mindfulness, introduces the course. A number of studies have been undertaken to establish the validity of this measure (Reis et al 2010, Andreou et al 2011) and Cohen et al (1983) report that the PSS has adequate internal test retest reliability. Therefore the decision was made to ask the young people to complete this questionnaire as well. The results are charted below in Table 12. The two teachers (who were given pseudonyms – Christine and Mary) were also asked to complete this questionnaire and their results are included with those of the young people.

## 6.27 The results of the outcome questionnaires

**Table 7 Collective results**

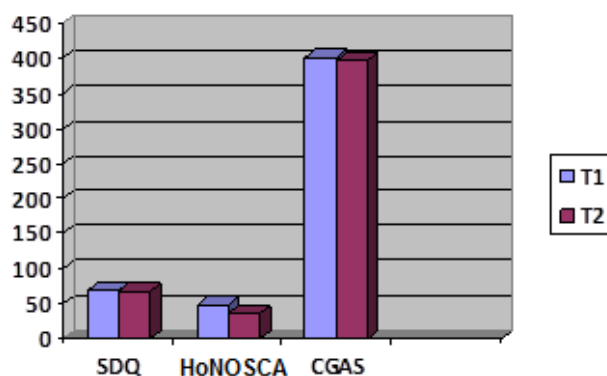
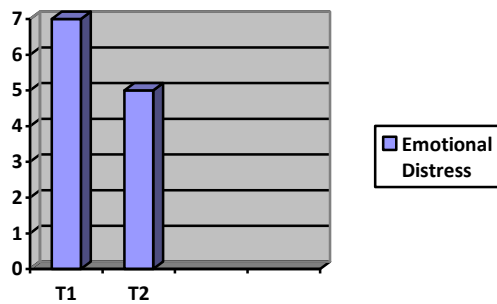


Table 7 above shows a slight reduction in overall SDQ and HoNOSCA scores with only a slight increase in CGAS for the whole group. However a further question on

the SDQs lent itself to a separate evaluation of the group as a whole. The question relevant to the research was whether the sessions had helped stress levels decline. Thus the '*emotional distress*' domain was relevant. As Table 8 below illustrates this was also a positive result.

**Table 8 Emotional distress scores**



Parts of the questionnaire were not suitable to analysis in this way – for example young people having no problem with peer relationships would be unlikely to show any change in this domain although it would be interesting to look at the results of those who had problems in this area. It also seemed fair to focus on those areas that would be likely to show some change if the sessions had made impact. The other outcome measure that lent itself to this method of interpretation was the HoNOSCA. This score provides an overall indication of how a young person is functioning (the lower the score the better the functioning). This was a measure that lent itself to a group '*before and after*' measurement which indicated that there had been a beneficial effect within the group as a whole as is seen in Table 8 above. Individual results are considered below.

## 6.28 Results from the SDQs

### 6.29 Overall stress

Table 9 below shows the results of the SDQs. Emily's overall stress levels had halved in the time period between the two reports and Jack's had also decreased which would seem to indicate that the sessions had been of benefit. However both Jessica and Kate had increased their scores. It would seem from Katie's own report (see later in this chapter) she found this period in her life quite difficult –

hence the reported increase in her overall stress levels. Emily's parents report indicates that they had seen no difference in her 'overall stress'. Also Jessica's parent felt that her overall stress had remained the same. Jack's parents' overall stress scores mirrored Jack's own report, although his parents had scored him one point higher than he had done. There was only one parent report available (completed at the end of the sessions). Katie did say that she had returned her first questionnaire but it could not be located. Although Katie's parents' scores were incomplete it was possible to make some observations. The overall stress scales rated her one point higher than Katie's score.

**Table 9 SDQ results from mindfulness group**

Overall Stress	Emily	20	10	Parent Score	18	18	average range 0-14
	Jessica	10	17		16	16	
	Jack	17	15		18	16	
	Katie	22	24			25	
Emotional Distress	Emily	7	3		9	7	average range 0-4
	Jessica	6	7		6	7	
	Jack	6	6		8	8	
	Katie	9	8			5	
Behavioural Difficulties	Emily	3	3		1	2	average range 0-3
	Jessica	1	3		3	3	
	Jack	1	1		0	0	
	Katie	3	5			5	
Hyperactivity	Emily	5	1		3	4	average range 0-5
	Jessica	1	5		6	5	
	Jack	2	2		3	2	
	Katie	7	8			10	
Peer Relationships	Emily	6	4		4	4	average range 0-2
	Jessica	2	2		1	1	
	Jack	8	6		7	6	
	Katie	3	3			5	
Helpful Behaviour	Emily	7	7		8	9	average range 7-10
	Jessica	9	8		8	9	
	Jack	8	5		6	5	
	Katie	4	4			2	
Impact on Life	Emily	0	0		6	2	average range 0
	Jessica	0	2		0	2	
	Jack	1	2		7	7	
	Katie	6	5			9	
		T1	T2		T1	T2	

### 6.31 Emotional distress

Emily's emotional distress levels had fallen and Katie's emotional distress scale had slightly decreased which was interesting, indicating that perhaps mindfulness had been helpful to her. Jack's emotional distress levels remained the same.

Jessica's scores however reported an increase in '*emotional stress*'. Emily's parents had noticed a fall in her levels of '*emotional distress*'. Again this was a move in a positive direction confirming what Emily herself had noted although to a lesser extent. This is perhaps not unusual as parents often tend to be more worried about their children than the children. Although it was not known what they thought at the beginning of the sessions, Katie's parents gave a much lower score on the '*emotional distress*' scale than Katie had. Perhaps this indicates that they were not fully aware of her level of distress. Jack's parents ranked the emotional distress scores slightly higher than Jack himself had done. Jessica's parent felt that her emotional stress had increased. The scores, in Jessica's own emotional distress category, followed the same trajectory.

### **6.32 Behavioural difficulties**

The scores for behavioural difficulties remained the same for Emily and for Jack. Both were in the '*average*' band but behaviour was never an issue. Jessica's score for '*behavioural difficulties*' were also in the average band but had risen. Katie's score had increased, now placing her in the '*slightly raised*' category. In the '*behavioural difficulties*' category again there were no changes with Jack although his parents scored him with slightly less behavioural problems than did Jack - albeit both well within the average range. Jessica's parents reported no difference in her scores for '*behavioural difficulties*'. Emily's parents placed her '*behavioural difficulties*' score as one point higher than previously but still in the average range. One wonders whether this may be due to increased confidence or some other more positive attribute. Katie's parents' score concurred with that of Katie's.

### **6.33 Hyperactivity**

Emily's '*hyperactivity*' levels had reduced. This would seem to be consistent with one benefit of mindfulness – helping people to become calmer (Mace 2008). This improvement would almost certainly have impacted positively on her concentration. Jack felt that his '*hyperactivity*' level had remained the same. Jessica noted an increase in '*hyperactivity*' (including attention and concentration) – although still within the average range. Katie's scores for '*hyperactivity*' had risen slightly but perhaps this could be explained by the fact that although it had been suspected previously a diagnosis of attention deficit hyperactivity disorder (ADHD)

had not been made until then. ADHD can be a very serious problem for some young people as it affects their ability to learn. Freed and Parsons (1997:158) stress that in the classroom environment the emphasis is on '*quiet and order*' with the young people '*like little sponges*' waiting to soak up the knowledge. For a young person with ADHD this is certainly more difficult although in a '*hands on*' situation they may do better. Another aspect of ADHD while '*undiagnosed*' is often viewed as '*naughty*' rather than having ADHD. Reid and Maag (1997:15) term the diagnosis as '*a label of forgiveness*'. Perhaps Katie's slightly higher score meant that having the diagnosis confirmed she could acknowledge the behaviour. Jessica's parents felt that her '*hyperactivity*' levels had slightly decreased as did Jack's parents - by a point - within the average range but perhaps indicating a higher level of calm. Also Emily's parents felt that her '*hyperactivity*' levels were a point higher - again in the average range. Katie's parents rated her '*hyperactivity*' score higher than Katie. The '*ADHD Across the Lifespan*' website reports that raising an adolescent with ADHD is challenging to parents and more conflict between teenagers and parents is likely. It would seem that this may be true in Katie's case.

### **6.34 Peer relationships**

Emily noted an improvement in her score for relationships with her peers. Although this may appear to be '*slight*', effectively this improvement had taken her out of the '*high*' bracket and placed her in the '*slightly raised*' category. Hick and Bien (2008) have noted the benefits of mindfulness in establishing better relationships. This is a move in a positive direction. Interestingly there had been an improvement in Jack's peer relationships. Jack scored himself two points closer to the average and considering that Jack was autistic this is really an achievement for him. Again it reflects the concussions of Hick and Bien (2008) that mindfulness can help improve relationships. Jessica's '*peer relationships*' remained the same as did Katie's - at a '*slightly raised*' level. Jack's parent's scores also reflected an improvement with peer relationships. Emily's parents felt that her peer relationships were the same. Jessica's own peer relationships scores concur with her parents and are in the average range. Katie's parents placed her in a '*high*'



range for peer relationships – higher than Katie’s more positive opinion, indicating that they thought she had more difficulties with friendships.

### **6.35 Helpful behaviour**

Emily’s *‘helpful behaviour’* score had remained the same in the average range – again Emily never had any issues in this respect. There was a slight difference (one point) in Jessica’s *‘helpful behaviour’* score. In terms of being *‘helpful’* Jack felt that his helpfulness had decreased by three points. His scores were now in the *‘low’* range. Perhaps this is not so unusual for a teenage boy although it may not place him in the *‘average’* range. Katie’s *‘helpful behaviour’* remained the same in the low range. Emily’s parents felt that her *‘helpful behaviour’* had increased. Jessica’s parents found her to be more helpful although Jessica’s scores reflected that she thought she was less helpful. Jack’s parents agreed with Jack about a decrease in helpfulness. Katie’s parents felt she was even less helpful placing her lower than she herself had done, in the *‘very low’* range.

### **6.36 Impact on life**

Emily continued to feel that any impact difficulties had on her life were within average range. Katie felt that her difficulties were now making less impact on her life although still in the *‘high’* range. However Jack felt that there had been an increase in the impact of the problems on his life now placing him in the *‘high’* category. Jessica felt that her difficulties now had more impact on her life. This may have indicated difficulties at that particular time were more challenging (for example the exam period). However it is unclear just how many other influences had a bearing on what Jessica was facing at that time period. It is also fair to say that without the benefit of the mindfulness intervention she may have fared even worse. Both Jessica and her parents’ reports agree that her difficulties now appear to have more impact on her life than before. Katie’s parents also placed her on a much higher score for the impact that her difficulties were having on her life. However Emily’s parents felt that the impact of her difficulties on her life had fallen by four points placing it now in the *‘slightly raised’* category. This would appear to signify that they were far less worried about her as it would seem that they felt more confident about her ability to manage any difficulties. Jack’s parents’ scores on the impact of the problems remained the same but were substantially higher

than those Jack had attributed to himself. This might just mean Jack had not acknowledged the full extent of the impact of the difficulties on his life. After all people on the autistic spectrum have their own way of viewing the world which is not necessarily the same as those who are not on the spectrum. Tony Attwood (2007:61) describes how people on the autistic spectrum *'have difficulty with Theory of Mind tasks that is conceptualising the thoughts feelings knowledge and beliefs of others.'* Jack was unlikely to pick up on any anxiety his parents may have had about him. Particularly where parents are concerned it is not uncommon for them to be more anxious for their child than the child himself. Burns (2015) in a BBC news item stated that children's mental health is parents' greatest concern.

### 6.38 Incomplete questionnaires

**Table 10 SDQ scores for incomplete questionnaires**

Overall Stress	Megan	13		Parent Score	9		average range 0-14
	Matthew		16				
	William				30		
Emotional Distress	Megan	5			5		average range 0-4
	Matthew		3				
	William				10		
Behavioural Difficulties	Megan	3			0		average range 0-3
	Matthew		2				
	William				6		
Hyperactivity	Megan	3			3		average range 0-5
	Matthew		8				
	William				7		
Peer Relationships	Megan	2			1		average range 0-2
	Matthew		3				
	William				7		
Helpful Behaviour	Megan	10			9		average range 7-10
	Matthew		9				
	William				5		
Impact on Life	Megan	1			0		average range 0
	Matthew		2				
	William				9		
		T1	T2		T1	T2	

The above reports for the young people are incomplete. The first self report and the parent report for Megan were completed, but she left school before the end of the course and did not wish to continue. Matthew and William had joined the school comparatively recently and had not been attending when the initial SDQs were completed by school. These were done routinely at the beginning of each school year. This point had not been realised until a number of sessions had been held. Therefore it no longer seemed useful to complete questionnaires as it would have been too close to the final questionnaire. A questionnaire was sent to William's parent and returned but, as William decided not to complete, no final questionnaires were requested. Matthew's initial parents' questionnaire had not been returned and therefore a final report was not requested. Thus in Matthew's case he only completed a self report at the end of the sessions. The following table combines the results.

Little can be said about Megan's report as there was nothing to compare it with. However her scores did appear to be mainly within the average range.

However although William dropped out after the third session the report which he gave to his teacher is included as it provides some insight into his perceptions. William had approached his teacher as he no longer wished to continue with the mindfulness sessions. His teacher made the following report:

*William has decided to leave mindfulness. He gave the following reasons*

- *Getting boring now*
- *Don't like it much*
- *The way everything's done you can't concentrate in sessions and when trying to do the practice*
- *Don't feel like I've learned anything*
- *Not what I thought it would be more meditating wise*

*He spoke very maturely about this and was clear about his reasons. A few months ago William may not have dealt with this so well and I'm pleased he didn't get stressed or aggressive about the matter but calmly spoke to me about wanting to stop. This is massive progress and he was pleased when I praised him. Maybe the mindfulness has affected him and his behaviour without him realising it.*

William had stated during the sessions that he was unable to do mindfulness at home. It seemed he lived in a busy household and he couldn't get the space to practice.

### **6.39 Reflections on the outcomes of the 'new group'**

The number of participants who completed the sessions was five but only three people completed all the questionnaires. Katie's results can also be considered as her 'before' and 'after' self-report questionnaires had been completed although only one of her parent reports was available. The following positive changes can be identified. There was a decrease in overall stress levels in Emily and Jack also confirmed by Jack's parent. There was a decrease in emotional distress levels in Emily and Katie also confirmed by Emily's parent. Burnett (2009) discusses promoting a relaxed calm aspect in his classes and Huppert and Johnson (2010) identify a calm and centring effect of mindfulness which would seem to be a parallel to the decreased levels of emotional distress.

A number of authors have linked mindfulness to qualities of happiness and contentment (Ivanowski & Malhi 2007, Shapiro et al 2008, Shapiro et al 1998, Siegel 2010). A decrease in 'hyperactivity' in Emily's self-report was noted and the same decrease was also noted by both Jessica's and Jack's parents although not by the young people themselves. Baer et al (2006) note a decrease of irritability as one of the effects of mindfulness practice and these results suggest that there may be a link here. Emily and Jack improved in peer relationships, also confirmed by Jack's parent. Again Hick and Bien (2008) have noted better relationships resulting from mindfulness practice. Both Emily and Katie now felt that their difficulties impacted less on their lives. From this it would seem that Emily has made the most progress followed by Jack but also Katie and Jessica

had made some progress. Although not everyone showed changes in the same direction, there did seem to be sufficient positive change to attribute the contribution of mindfulness to the results.

Little can be said about the incomplete scores especially where there was nothing to compare. However it was clear that William's scores were very high (necessitating an extra two boxes on the original table!) – at least from his parents perspective. Such young people are likely to be attending CAMHS but sometimes they are not. Even so this illustrates the point that there are similar difficulties overlapping both populations suggesting similar interventions in service delivery. Hackett et al (2011) stated that there were more young people who needed mental health services but were not receiving them. Sometimes those who need the service are just not identified as such or alternatively may become known to the juvenile justice system. This perhaps reflects the scale of the difficulties faced by some of these young people and thus the position of this research to see if it would be helpful in managing stress levels and therefore preventing deterioration into more persistent problems.

Emily's scores were interesting. She showed a clear reduction in her '*overall stress*' and '*emotional stress*' scores and also for '*hyperactivity*' and '*peer relationships*'. This is in many respects in line with the identified benefits of mindfulness, for example Low et al's (2008) findings that meditation reduces the key indicators of stress and Hick and Bien (2008) point that meditators enjoy better relationships. Her parents regarded her overall distress as the same but had noticed a reduction in her emotional distress. They found her behaviour more helpful. It was surprising that she placed such a low score on the impact difficulties had had on her life. She had noticed no change. Her parents, although marking this with a higher score than Emily had clearly noticed a reduction.

Jack's overall stress had reduced and was also mirrored by his parents report in all of the seven categories although parents tended to rate Jack somewhat higher than he did himself. Improvement in the peer relationship scale were interesting for Jack given that this was an area where he had long since had serious difficulties by nature of the fact that he was on the autistic spectrum. Frith (1992:136-155)

has a chapter on '*the loneliness of the Autistic Child*' which highlights their difficulties and social impairment in this respect. Viewed in this way Jack had indeed made great progress.

Although Katie's scores were incomplete it was interesting to note that her parents' scores in the overall stress category were higher than Katie's and in the impact on her life area. They also found her more hyperactive and having more difficulty with friendships. It is also perhaps interesting that around this time she received a formal diagnosis of ADHD. Could it be that they were more aware of this and therefore more observant of the symptoms? As Hamer (2006:31) maintains '*What you focus on gets bigger*'. They also found her to be less helpful than Katie had rated herself. These discrepancies may suggest difficulties between parents and young people. It would seem possible that they found her a difficult young person to raise. This may be further illuminated in the parent interviews.

Jessica's scores do show an increase in overall stress and emotional stress and in the impact the difficulties are having on her life. Her parents agreed with the first and last categories but felt that her emotional stress had remained the same. Jessica also reported an increase in '*behavioural difficulties*' and '*hyperactivity*'. Her parents' report shows a decrease in '*hyperactivity*' and no change in the '*behavioural difficulties*' category. Her parents now find her more helpful while Jessica considered herself to be less helpful. So it would seem that the parents have registered small positive changes while Jessica herself had apparently not noticed this. A further point for consideration is the fact that their lives now seem much busier (see parent interview with Jessica's mother). Might this be that there had been little time for reflection?

Megan reported higher overall stress levels than her parents. As stated above (Burns 2015) it is more usual for parents to be more concerned about mental health matters than their offspring but with maturity young people may become more aware of the pressures on parents (Megan was the oldest in the group) and may be able to conceal the depth of their feelings. Often there is a concern not to unduly worry a parent. However scores for '*emotional distress*' and '*hyperactivity*' correspond exactly. There were only slight differences in the other categories

although it seemed that Megan thought that she had more behavioural problems than her parents did. Sometimes it is useful to compare the reports of the parent with that of the young person. In some cases this may mean that one or other has over- or under-estimated the difficulties or it could mean a lack of rapport between them. Dogra et al (2002:53) highlight the '*diversty*' of individual family members having different '*agendas*' but

*'providing prospectives that are unobtainable elsewhere'*.

Further information is needed to be clear about such matters. There appeared to be some positive results as well as some that were more difficult to understand. Given that this study was designed to have input from the young people and their parents these are perhaps questions that should be viewed in a broader light. Indeed the interviews with parents did assist in this process (see Chapter 8).

#### **6.40 The Children's Global Assessment Scale (CGAS)**

These scales aim to evaluate how well a young person is doing compared with the rest of the population (see Chapter 3 for further detail about this measure). The individual scores appear in Table 11 below. As will be seen, the scores of Emily and Jessica remained the same. Jessica's score was just into the 'Doing Well' category and Emily only one point lower in the 'Doing all right' category. Matthew's score went down one point placing him in the 'Doing all right' category. The extent of his dyslexia had only become clear to the researcher by the end of the sessions illustrating the fact that he was not actually doing as well as he appeared and therefore influencing his score. Jack felt that he was doing better and thus his score had moved him up a category and he did now seem to be 'Doing Well'. Katie's score dropped to place her in the 'Some Problems' category largely because of her view that many things in her life were now worse than they were previously and she was having a lot of arguments with her parents.

**Table 11 CGAS scores**

Name	Initial	Final	changes
Katie	80	70	-10
Matthew	81	80	-1
Jack	80	86	+6
Jessica	81	81	same
Emily	80	80	same

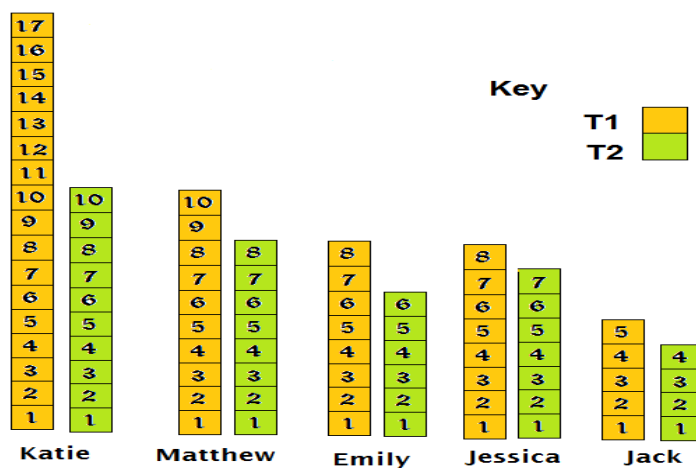
Please note that higher scores indicate improvement.

As the above table shows, most of the young people showed no substantial change in their scores at the end of the sessions. However it would seem that this was more to do with them already being in the '*Doing All Right*' – '*Doing Well*' category'. On the cusps of the area it is difficult to decide which group fits best. None of these scores indicated serious concerns or major differences between scores. Katie's was the biggest discrepancy echoed by her own feelings about how her life was going at that point – as she termed it '*worse*'. Matthew's score had also fallen – but only by one point and although it placed him in a different category it did not necessarily indicate that there was much difference. The decision to use this measure was mainly based upon its regular use in CAMHS and as an extra measure to evaluate the results of the questionnaires. However the results did not indicate any substantial progress during the period of the mindfulness sessions with only one young person moving up the scale. Perhaps used as a measure to confirm that these young people were functioning fairly well it was useful, however as a measure to evaluate how effective mindfulness as an intervention might be, this measure did not seem to accomplish the task.



## 6.41 The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)

As noted in Chapter 3, the HoNOSCA being divided into different aspects of a young person's life perhaps gives a more detailed picture of overall functioning than CGAS. The results appear below in Figure 4.



**Figure 4 HoNOSCA results**

(N.B. the lower the score the more positive the result.)

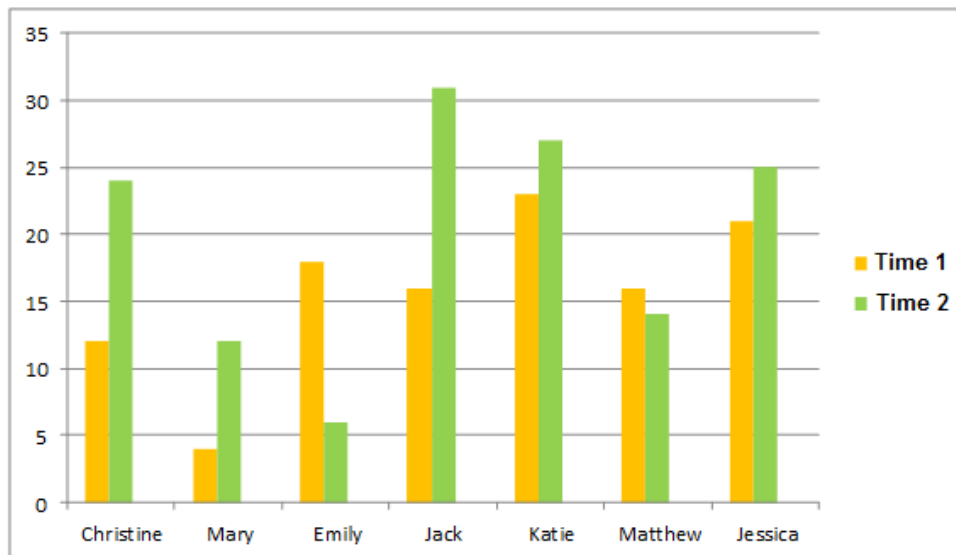
These results are encouraging as they clearly show a reduction in difficulties overall in all of the young people. Many authors have identified the benefits of mindfulness (Davis and Hayes 2011, Gunaratana 2009, Olendzki 2013 Kabat-Zinn 1990, 1994, 2009, 2013, Williams et al 2007, Williams & Penman 2014, Shapiro and Carlson 2010) and it seemed that something of its essence had made an impact on these young people. Despite Katie's protestations that things were 'worse', she appears to have made the most progress by this measure. However both Matthew and Emily had reduced their scores as had Jack and Jessica. Individual results showed that Emily had reduced her score in the area of '*emotional and related symptoms*', as had Jessica. Reductions in this area clearly correspond with the '*side effects*' (Gunaratana 2009) of mindfulness which reduce stress.

Matthew had also improved in this area and also one point in the area of '*non-organic somatic symptoms*' (stress is often felt in parts of the body as expressed in

our culture with such expressions as '*I felt sick to my stomach*' Stora 2007, Lawrence and Lawrence 2014. Therefore improvements in this area often correspond to a reduction in stress). Jack had improved in the area of peer relationships which was also indicated in his SDQ score. As stated previously mindfulness has been identified as helpful in improving relationships and Charles (2014) and Carson et al (2006) have developed mindfulness interventions for improving relationships. Katie had made progress in six of the thirteen areas. Mainly these were by one point for each section and included '*Disruptive or aggressive behaviour*', '*scholastic or language skills*', '*Emotional and related symptoms*', '*Peer relationships*' and '*Self-care and independence*'. In the area of '*Over activity attention and concentration*' she scored two points lower. It would seem that as all five of the young people had made improvements on their original scores after the mindfulness sessions, something of the content of the sessions had made an impression. This is particularly relevant to the area of '*emotional and related symptoms*'. Gunaratana (2002:13) speaks of mindfulness allowing '*peace with him or herself*'. This would certainly be related to emotional symptoms. Kaisier Greenland (2010) cites mindfulness breathing techniques which help to calm young people. Where young people are able to manage their emotions better there is likely to be a reduction in the score for this area. It was also interesting to note that in Biegel's (2009) '*The Stress Reduction Handbook for Teens*' among the activities described many of the same activities delivered in the sessions are listed – such as mindful eating, thoughts and feelings and physical effects of stress. Methods can work although perhaps there are some whom it is difficult to reach.

#### **6.42 The Perceived Stress Scale scores**

**Table 12 PSS scores**



Please note the higher the score the higher the stress ratings, thus the top of the table represents high stress while the bottom end indicates low stress. The scores of the various individuals clearly vary with the amount of ‘*stress*’ they feel themselves under and clearly these may vary from time to time. The initial scores are highlighted in orange, the final scores in green.

The scores of the PSS did not reveal any substantial improvements in stress levels and indeed most had increased their stress levels with only Emily and Matthew showing any reduction in stress levels over the period. However it would seem that the questionnaire merely represents a snapshot of what is going on for that person at any one period of time. For example the teacher Mary initially had the lowest stress level (with a score of 4). This had gone up a further 8 points at the end of the sessions. One might imagine that the stress of exams and end of term deadlines had a part to play in this but also there were to be some changes in the Centre – both in terms of organisation and of staff. This latter point may well have impacted on some of the students. Both Katie and Jack found it very difficult to get used to new people and thus the idea of new teachers was quite ‘*scary*’ for them. The facts about possible re-organisation were not clear although there had been talk about the possibilities – which might make the idea more stressful. The Head and two very well respected teachers, with whom the young people got on

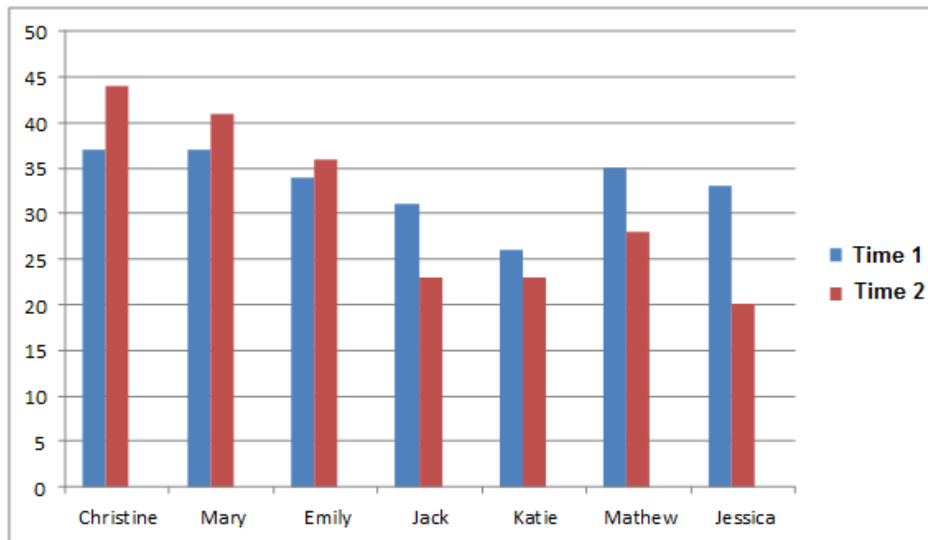
very well, were retiring at the end of term. There were a number of uncertain factors which may well have contributed to these higher scores despite any benefits that may have been gained from the mindfulness sessions. The other teacher, Christine, was also subjected to the same stresses and had had additional family problems due to the illness of a parent. Her stress score she now realised had increased by 12 points. At the time of completing the questionnaire she had recognised that her scores would be high and had said to me that she *'hoped I didn't think that she had not benefited from mindfulness'* – it was just that there was so much going on for her at the moment. The young people had perhaps also been affected by end of term events as well as the anticipated changes. Jack, Katie and Jessica had all increased their perceived stress scores. For Jack, being on the autistic spectrum any changes would be a huge stress. Rumours of what might be happening in the Centre could lead to unnecessary worry. This is also true for Katie. Having a background where she had come from a school where she was just not managing and was now feeling fairly secure in her placement she would not want things to change. It would seem that some of this had also affected Jessica. Somewhat surprisingly however Matthew had managed to decrease his score by 2 points and Emily's had come down by 7 points. Overall it would seem that Emily has gained more benefit from the mindfulness intervention, but it is less clear in Matthew's case. Difficulties with his dyslexia may have complicated the scores (as he may have had difficulties in understanding the self-report questions). Interestingly Moore's (2008:334) study which delivered an experimental course of brief mindfulness exercises to trainee clinical psychologists using the PSS (Cohen 1983) also found that

*'no significant differences were found in pre-course and post- course measures of perceived stress on the PSS.'*

### **6.43 Freiburg Mindfulness Inventory (FMI)**

This measure has been described more thoroughly in Chapter 3. Table 13 below gives scores taken at the beginning and at the end of the sessions. The first results appear in blue and the second in red. Higher scores suggest a better knowledge and experience with mindfulness.

**Table 13 FMI scores**



The results were indeed surprising. It seemed that, with the exception of Emily, the young people had decreased their mindfulness skills rather than gained anything, while the adults increased their mindfulness skills.

Both of the teachers (Christine and Mary) in addition to Emily had increased their scores although no one else had. One possible explanation for this is that the questions were strange to the participants who were new to mindfulness. It was unlikely that they would have encountered these concepts before and therefore might have had difficulty in answering the questions. For example consider the following question which appears on the list.

*7. I feel connected to my experiences in the here and now.*

Would this not be a difficult concept for a young person who had no knowledge of mindfulness? A measure of how mindfulness had increased would have been useful and this was a validated questionnaire. It had not been anticipated that the terminology would have proved difficult and retrospectively it is difficult to know how best to ask questions about mindfulness when people are completely new to the experience. Perhaps this also has relevance to the expectations of the young

people (as discussed in Chapter 7) where they seemed to be expecting something which didn't quite come into fruition. Could they also have missed the point with this measure? In fact de Bruin et al (2011) have questioned whether people who are intellectually disadvantaged can understand mindfulness questionnaires. This point was relevant as within the group there was some level of learning difficulty.

The participants in de Bruin et al's (2011) study were 717 school children with an age range of 11-17 years. They chose only the highest two levels of education. They also identified a number of points that are of relevance: '*some participants show only partial improvement or no improvement*' (de Bruin et al 2011: 242). Another unexpected outcome from their study was the fact that those not familiar with meditation scored higher than those who had some familiarity. They suggest that awareness of mindfulness may affect the way they fill in the questionnaire. If this is the case it may also have been valid in this study. After the sessions the participants should have had more awareness which might well make a difference to the way the questionnaire was filled. A further point identified in the study was the low scores on the issue of acceptance. They concluded that teenage years are a period of black and white thinking and things like acceptance do not usually feature strongly. They are at an age when '*fast black and white judgements are made but this does not necessarily imply an attitude of accepting without judgement*' (de Bruin et al 2011:20). This may go some way to explain how only one young person's mindfulness score showed any improvement.<sup>4</sup>

Participants are asked to circle a response on a Likert scale (Likert 1932) ranging from rarely to almost always. The only logical explanation would seem to be that they were unaware of what the question actually meant. Some of the young people had asked for clarification about the questions and while explanations were given, the thought only occurred later that without any concept of mindfulness it would indeed be difficult to answer the questions. Additionally some of the young people had some level of learning difficulty – more accurately specific learning difficulties in particular areas. Emily however did not have any such difficulties.

---

<sup>4</sup> In September 2014 the Government changed the law about the way special educational needs were dealt with. This was not known to the author in July 2014.

Matthew, on the other hand, despite being a bright boy suffered from some type of dyslexia for which he was still being assessed. The scale of his difficulty was not known to the researcher at the point when the first questionnaires were completed.

Had the young people not made any progress in mindfulness one would have expected the same scores as before. Had they made progress, higher scores would be expected. For scores to decrease for the majority of the group might indicate that they had not understood the question in the first place and one could argue that numbers might have been circled randomly. When the second questionnaire was completed it would have been anticipated that at least something about mindfulness would have been learned. Thus they should have been more able to answer the questions and therefore their responses would be more realistic. Baer et al (2006) have observed that the authors of the FMI questionnaire were concerned that its meaning may not be clear to non-practising meditators. This seems to have been the case here but particularly because there were additional factors – such as specific learning difficulties – it was difficult to evaluate the reason for this especially as the same sorts of difficulty did not appear to have arisen with other questionnaires. However it is likely that they would have been more familiar with other questionnaires particularly those young people who had been known to CAMHS where the forms were in regular use. However the aim of the research was designed to help such vulnerable groups who might well have similar difficulties. It is difficult to know how their knowledge of mindfulness could best be evaluated.

#### **6.44 Summary**

This chapter has considered the outcomes of the questionnaires some of which are very encouraging. Emily in particular appears to have benefited but there have also been others who appeared to have gained from the sessions. However, this was not the only means of evaluation as the following chapters illustrate. Consideration of the whole research project also needs to include these important aspects.

## **7. The focus group and emerging themes**

### **7.1 Overview**

This chapter considers the focus group and the themes that emerged. Firstly it is pointed out that although there appear to have been some positive results this does not mean that the mindfulness intervention was directly linked to this – nor that it was insignificant. Although as Weare (2013) states it can be effective in promoting a wide range of outcomes. Mindfulness is an individual thing and it is not easy to gauge the benefits that any one person will gain. Reflection is given to the participants who all faced some difficulties and in this aspect of the research two teachers also took part. The section on the focus group considers focus groups in general before considering this particular group. Particular questions were put to the participants although general conversation and independent comments were encouraged. The transcription and how this was undertaken is considered. Moving on to look at themes led to the identification of seven main areas for discussion. These are discussed next under their respective sub-headings in the section on the young people's views. Next the views of the teachers are represented. It had not been possible to include them in the focus group due to their other commitments on that day and thus a meeting with them took place separately. Their views interestingly do cover some of the same points as those of the young people; however they offer an additional perspective. Aspects of delivering a course in mindfulness are considered. There were challenges and also benefits and some potential for the future considered in the analysis. In addition to the focus group there are two other aspects of the research. The outcome measures (the results of the questionnaires), discussed in Chapter 6 and the parent interviews which are discussed in the next chapter (Chapters 8).

### **7.2 Correlation and causation**

Firstly this was a quantitative study which does not attempt to claim that mindfulness is responsible for any of the improvements which may have occurred in the participants who took part. However it is not to say that it had no effect. It is



not possible to state the cause of any changes as there are a number of variables and some would not be known to the researcher. This was a small group of young people and it was not controlled for such things as ADHD or other conditions. Therefore the research does not claim causality although there may have been some positive impact. An important point about mindfulness practice is that you are not trying to get anywhere or do anything - *'it is not an effort of striving to achieve some special state'* Kabat-Zinn (2009:75). Shapiro and Carlson (2010:11) includes the quality of *'non-striving: non-goal-orientated, remaining unattached to outcome or achievement'* as necessary qualities of mindfulness. The essence is one of merely being. The effects accumulate over time (Mace 2008:41) and *'emerge as the result of sustained practice'*. Thus what you get back is relevant to how much you put in. It was not known just how much practice had been undertaken although the young people claimed to have practised – and there is no doubt that this was true – but to what extent and what depth was not known. In mindfulness practice only the individual is aware of what is happening and there is little point in trying to measure things like duration as this may mean nothing – or something. Each person is individual.

Fuller and Petch (1995) discuss how facts put together by association may at first glance seem to imply that one is the cause of the other whereas this cannot be stated with any certainty from the evidence. For example take the statement, where there is a higher concentration of religious places of worship there is a higher number of law breakers. This does not mean that religious people are law breakers. It is more likely that in a place where there are more churches there are likely to be more people and thus more laws are broken. Harding (2013) states that it is not possible to produce the same sorts of 'laws' of causality as in the natural sciences; for example the way water takes form is directly affected by temperature. Whether it is a solid, a liquid or a vapour is caused by different temperatures. Indeed quantitative research is more likely to fit with causation than more qualitative methods. Langdrige and Hagger-Johnson (2009:134) describe how a causal link is formed by 'a constant occurrence of one event preceding another'. However in the case of human beings we do not always know what other things in peoples' lives may have impacted. Timimi (2002) tells of an encounter

with a tearful boy. The consultant thought that he might be clinically depressed but Timimi learned that the boy's father had recently left and the boy was missing him. Sometimes one can assume too much – either in a positive or a negative way. Segal et al (2002:311) quote an interesting tale from Mullah Nasruddin the 'wise fool' of the Middle East. His neighbour sees him sprinkling breadcrumbs round his house. Curious he asks him why he is doing that. 'To keep the tigers away' he replied. 'But there aren't any tigers in this part of the world'. 'I know. Effective isn't it?' replied Nasruddin. In this case tigers there were (challenges which the young people faced) whether the breadcrumbs (mindfulness sessions) were effective needs to be considered by the reader. All in all the conclusions should be viewed objectively. There appear to be some positive results following the mindfulness sessions and although no causal link has been established there is some indication that mindfulness might have been helpful.

### **7.3 The young participants**

The profiles of the young participants have been given in Chapter 6, however it is worth reiterating that they all faced some level of difficulty in their lives and thus there were many similarities between this group and a similar group of young people attending CAMHS. Indeed many had or were attending CAMHS. Five young people completed the sessions attending the majority of the sessions except for the occasional absence due to illness. Also two teachers took part in the research. The age range of the young people was from 12 to 16 (with an average age of 14) but in many respects they were already an established group having attended many lessons together. The participants all showed an interest in mindfulness and generally the sessions appeared to be well received. An outline of the content of the sessions has already been given in Chapter 6 but plans for each of the sessions together with any additional materials or hand-outs used during the sessions can be found in Appendix 1.

### **7.4 The focus group**

Focus groups can be combined with other methods producing different data within a multi-modal approach (Tonkiss 2007). This was the aim of this research. Harding (2013) notes that the interaction between group members, rather than solely

between the interviewer and the respondent, is an important aspect of a focus group. These young people were already an established group socially in so far as they all attended a small inclusion unit. In this instance some description of the group's composition is necessary to put into context the process of the research. Overall it should be noted that each of them had some level of difficulty in social situations. The fact that they were attending a special inclusion centre underlined this point. Although otherwise quite competent they faced a number of difficulties. Some had some level of learning difficulties (including specific learning difficulties), developmental and emotional difficulties, some had physical conditions, some had autism. This was a very small sample and was not selected to include or exclude any particular conditions. In fact the group elected themselves through their interest in mindfulness. Tonkiss (2007) highlights the usefulness of focus groups for generating qualitative data on the basis of group discussion. The conversation engendered in this focus group, although valuable, was not what might have been had the young people not faced these difficulties. However the point of undertaking this research with such a group was to establish whether it would be useful to them and help them with whatever difficulty they faced. In the first place the research had been planned to be delivered within a CAMHS setting in order to help vulnerable young people. Essentially these young people were facing similar vulnerabilities. The programme had been designed to discover whether it would help young people who were struggling emotionally in some way and thus any improvements they showed in respect of their emotional well-being were seen as positive.

The organisation of the focus group, although largely open to individual comment, centred on a number of questions which were designed to start the discussion. First of all it was important to know if the sessions had been helpful to the participants. This was asked firstly in a very open way and then with more probing to find out what their experience had been. It was also of interest to know what had been challenging as well as what they had found helpful. Asking about whether they had any previous knowledge of mindfulness was a point of interest as they may already have had experiences of mindfulness. Two questions were designed to try and gauge how much they were likely to continue with

mindfulness. Such questions as: ‘*Would you practice regularly?*’ and ‘*Would you recommend it to a friend?*’ They were also asked whether they would be interested in joining a group for mindfulness. This was partly for the above reason but also as it had been mooted that the Centre may be able to continue with mindfulness sessions given that sufficient pupils were interested. The last question was something that had recently been in the news and was on the government’s agenda – ‘*What do you think about the government’s idea to introduce mindfulness in schools?*’ This might also provide further insight into how far they had taken on board the concepts.

## 7.5 Transcription

Transcription was the first stage of the process. This was done verbatim in a literal manner and without any additional resources. The material was transcribed by the researcher – taking much longer than had been anticipated, but providing the advantage to become very familiar with the text. Many authors advocate reading and re-reading the text again to become familiar with it (Braun and Clarke 2006, Gibbs 2009, Harding 2013, King and Horrocks 2010). Mackenzie and Knipe (2006) make the point that thematic analysis is more cyclic than linear. Thompson and Harper (2012), state that all qualitative methods share an interest in a detailed reading of the material.

The idea was to firstly use the focus group transcription and identify the themes that had come up to see if this would reveal any kind of ‘*template*’ (King 1998). This being the basis of the ‘*voice*’ of the young people as it were, the individual interviews with parents would then be scrutinised to see if some of the same codes could be applied. Although the analysis was to be conducted in the spirit of ‘*an open mind*’ there was a curiosity to see whether some of the known benefits of mindfulness (Williams and Penman 2014) would occur in the dialogue of the focus group.

The nature of the recording necessitated a number of repeats and rewinding to understand what was being said as the recorder used was primarily designed to identify one voice. Tonkiss (2007) offers some useful advice about recording a focus group – most of it technical information. Ideally the research would benefit

from such points - for example recording in a room with soft furnishings rather than lots of hard surfaces to prevent echoing and thus improve the quality of sound. However the best equipment is not always available and choosing the best location for the recording is not always possible. Some of the sessions had to be delivered in a room that was quite unsuitable in this respect. King and Horrocks (2010) make a very useful point – if a participant says something that is not clear, the researcher is advised to repeat it. The focus group in this instance was comprised of a number of people with very different voices. Some with very low volumes and others with fast speech and relatively strong regional accents necessitating numerous rewinds to transcribe what was being said. Thus by the time the transcription was complete familiarity with the material had greatly increased and awareness of what had been said made it somewhat easier to begin to think about analysis.

The text was considered as it was spoken – the words and the meaning which seemed to accompany them. There did not appear to be any great inconsistencies i.e. such as someone saying they were really interested when their tone of voice suggested that they were not remotely interested. It was not apparent that there were any particularly ambiguous areas needing further clarification. One partial exception was when a participant answered yes in a somewhat hesitant way. This was transcribed as 'y e s' to reflect this. As far as possible the intention was to seek out the individual views of the participants with regard to mindfulness and they were encouraged to speak freely.

## **7.6 Emerging themes**

Reading and re-reading, as mentioned above, had produced some familiarity with the data. The next step was marking of sections of the transcription into similar concepts and codes but this proved somewhat confusing. Gibbs's (2009) suggestions of multiple photocopying and cutting up in order to divide concepts into different wallets proved to be the most helpful. This method produced about 20 different '*wallets*' which seemed rather an unwieldy number of topics. Further consideration identified that some items could come under the same heading. A number of these categories could however be combined – for example the group discussed mindfulness in other areas of education such as mainstream or college.

These could be combined into views of mindfulness in education. Some group members considered that mindfulness helped them get to sleep while another felt that it made her *'too tired'* if she practised it during the day. These were facets of the same theme. In this way the themes were condensed into seven main themes. These were Expectations, Practising, Challenges, Benefits, Mindfulness in Education, Environment, and Future Groups. These are discussed below under their respective headings.

Some of the dialogue did not appear to contain any additional issues but some of it confirmed a previous statement. For example when a participant said *'yeah'* in confirmation of another participant's statement, such occurrences gave an extra validity to the original statement.

A number of points need to be clarified in respect of the questions put to the group. One was about their views of the government policy of introducing mindfulness in schools. This was a topical issue at the time and asking this would not only facilitate discussion but would seek their views about the topic. Questions relating to interest in mindfulness were an indication of any sustained interest which they might continue with in the future. Recommending mindfulness to a friend was also considered to be in this category. The question about whether they had heard of mindfulness before was asked primarily out of curiosity. Had there been any significant previous knowledge or experience of mindfulness this may well have influenced the outcomes of the group. As it was there was little previous knowledge of mindfulness, as discussed below and thus it did not seem to have any great influence. This later point is discussed first.

## **7.7 The young people's views**

Only Matthew said he had heard of mindfulness before. The following were the conversations on this topic.

*Matthew: My Mum had done the mindfulness course in college and my Mum had told me about that. I was telling my Auntie about it once we got told that we could do the course and she told me she has done it as well in her job.*

*Anna: Right and have they found it useful at all?*

*Matthew: Em my Auntie said it was alright she never found it that useful but I think my Mum did. My Mum's very tolerant like.*

Clearly Matthew had some awareness And Jack's comment

*Jack: I know about like the em meditation sort of bit*

Other than this there was no further discussion about any previous knowledge of mindfulness. None of the others had heard about mindfulness previously.

The rest of the themes and the observations of the young people are now discussed below under the various sub headings. The question about whether they had found the sessions useful proved to be an interesting one as it was not at all straightforward.

## **7.8 Expectations**

Asking the young people whether they had found the sessions useful proved to be complicated. Clearly the young people had developed some awareness of mindfulness and some of this they had found useful (as is shown by some of their comments below). However they seemed to have different expectations of what mindfulness would do— somewhat unrealistically – which becomes apparent from their views, seeming to highlight the limitations of their knowledge. One young person explained that the sessions had not been '*up to my expectations*'. Another young person said that they agreed with this view. It appeared that they assumed that mindfulness would '*transform*' them. For example Matthew made the following comment:

*Matthew: Yeah Say I was in the middle of a massive argument and I just had a pause button –*

*(Jessica laughs)*

*Matthew: I know it sounds stupid but say that I did. - I'd find it useful for that 15 minutes but as soon as I pressed that play I'd just go straight back to the argument that's why I find it not useful.*

Matthew's comments are interesting. An online article on the 'argument buster' web site (March 2016) advocates hitting the 'pause button' advising that it takes 20 minutes for adrenalin and other stress related hormones to subside. Despite the fact that it had been explained that emotions do not change right away this point had been missed or more likely it had not been explained properly. As Kabat-Zinn states (2009:37) '*Mindfulness doesn't just come about by itself*'. It does require some commitment and practice. However it would seem that Matthew had at least found the 15 minutes useful. Following some discussion it was acknowledged by the group that it might help you to calm down a little. Jessica reported:

*Jessica: Like it worked when you were actually doing it but then when you went and did it, it didn't feel any different – like when you stopped.*

And Jack:

*Jack: Em I felt it benefited for like about an hour after but then... my mind went*

And Emily:

*Emily: Em. Like that it didn't really seem like I expected it to be*

*Anna: Ah uh*

*Emily: I could do it. But it wouldn't really ---- change anything*

Roemer and Orsillo (2003:173) explain that people are '*not encouraged to expect their distress to reduce*'. The '*Dharma Wisdom*' website (Moffitt March 2016: week 19) describes '*the tyranny of expectations*'. Halliwell (2015:38) advises leaving expectations *at the door* and states '*If you practise with the expectation of results ... you've already moved out of the moment*'. Puddicombe (2011:147) also advises against '*trying to force anything*'. These points seemed not to have been realised by the young people but after all it is a difficult concept to grasp.

Jack's comment on the other hand is very encouraging although he seemed to pick up on the negative side. These were all positive statements although not recognised by the young people. Emily too seemed to expect to notice change. It



seemed that they expected instant results. Williams and Penman (2014) advise participants undertaking a mindfulness course that they do need to do the practice to get the benefit. Kabat-Zinn (1994) also emphasises this. It would seem that this point was not emphasised enough to the young people and it did seem that they had not practised enough. However, it is perhaps not so surprising for these young people who, as Pavord (2014:120) phrases it, are negotiating the '*most difficult of developmental stages*'. Slee and Shute (2003:52) speak of '*storm*' and '*stress*' and '*lack of emotional steadiness*'. Rustin (2011:14) explains how

*'the pressures of a mobile, image-conscious and marketised society combine to create strong tensions and anxieties for young adolescents'*.

One can hardly blame these adolescents for assuming that mindfulness would steer them through these difficult times and not be a little disappointed when it did not make everything better.

This links to Moore's (2008) '*new insights*' and '*recognition of being unmindful*'. The young people's expectations of how they might suddenly be able to manage their emotions does not fit in with what is realistic. Mindfulness has health benefits and helps with emotional regulation (McKay et al 2007) but it requires practice over time. This point appears not to have come over. Changes may be very subtle and occur only gradually. Kabat-Zinn (2009:94) states that '*patience and consistency in the meditation practice over a period of weeks if not months and years*' is required. These themes were '*a skill to practise and develop*' for '*future personal benefits*'.

## **7.9 Practising Mindfulness**

Many of the adult courses ask their participants to undertake 45 minutes of mindfulness practice during each session. This had seemed a long time for the young people and also the lesson time itself was only an hour. To maintain that length of practice and get feedback alone would have been a tight fit. Burnett (2009) discusses '*contact time*' and its relevance to delivering a mindfulness course. Deciding on a fifteen minute period of mindfulness practice with a request for them to continue with home practice seemed reasonable. The home practice

appeared to vary and there was no way of clearly establishing how much had been done. Matthew's statement:

*Matthew: No I did practise it I tried everything you told us to at least once like with the toothbrush and things like that but I just didn't really find it that useful like*

It seemed to imply that the practice had been minimalistic but there was no way to clearly establish this. Perhaps the point had not been made clear that mindfulness was not something that was instantaneous it did require practice. An alternative perspective might be that this is too much to ask of adolescents to commit themselves to. Perhaps with the support of their parents this may be easier. Kabat-Zinn (1994) states that many people don't get the idea right away. They immediately look for progress and if they don't notice any they may become disheartened. However considering that these young people were teenagers they had other things on their mind apart from doing the '*home practice*'. As one of the teachers remarked '*it takes discipline to do the practice*'. She herself had found the commitment difficult.

Also of relevance is Burnett's (2009) comment about providing 'scaffolding' to foster the project. Were mindfulness to be part of the curriculum there may have been more regularisation to the practice but again mindfulness is a very individual thing and you cannot legislate for progress. As Gunaratana (2002:154) states '*It proceeds at its own pace*'. All in all the young people had not done at all badly in attempting to commit to regular practice. Williams and Penman (2014:62) state that mindfulness '*is not even about trying to relax – although that is a by-product*'. Matthew had clearly missed this point – or rather it had not been emphasised enough - as was made clear from his comment when we were discussing the challenges:

*Matthew: I didn't find anything challenging. I don't think there is anything challenging about it really it's just sitting and relaxing isn't it?*

Matthew's statement seemed a little simplistic especially in the light of the comments of some of the others (later in the chapter) and the views of Williams

and Penman (2014:62) quoted above. Shapiro and Carlson (2009) talk of a '*non-striving*' and a '*non-goal-oriented*' attitude to mindfulness. Perhaps the concept had indeed been difficult for Matthew. As discussed in Chapter 1 the process of cultivating mindfulness to realise the 3<sup>rd</sup> Noble Truth (Teasdale and Chaskalson 2013) - that suffering can be overcome - would seem to take a certain attitude of mind to reach the point where this can be realised. Possibly Segal et al (2002) touched on this point when they discovered that their MBCT did not work as well for those who had had less than two previous episodes of depression. Perhaps it takes a certain level of life experience or perhaps the '*faith*' to try it anyway. This would not seem to be easy for teenagers.

It seemed difficult to assess how useful it might be to evaluate any future commitment to mindfulness practice, whatever their response might be to the question. Mindfulness does offer other benefits (as outlined in Chapter 1) but as Allen et al (2009) quote Segal et al (2002:135) '*let people know that the lack of homework will likely affect how much they get out of the programme*'. Williams and Penman (2014) also make this point. Perhaps this was not made clear to the participants therefore affecting their expectations. However the questions about interest in a future group and recommendations to a friend (addressed below) may give some indication of willingness to continue practice. Interest in a future group appears to be an indication of willingness to continue. Likewise recommending mindfulness to a friend is an indication that they themselves have found it useful – and therefore may wish to continue. This would also be important to know as it would facilitate development of future programmes which may be undertaken with other vulnerable young people either in similar settings or within CAMHS.

## **7.10 Challenges**

A number of young people expressed their difficulty in keeping their mind on the task.

*Jessica: I think trying to keep your mind*

*Emily: yeah*

*Jessica: like where it is*

*Emily: like in that zone sort of thing –*

*Jessica: stop it going off*

*Katie: Hard to focus especially when there was a lot of noise*

The comments of the young people are all common findings when people seek to practice mindfulness (McKay et al 2007, Segal et al 2002, Mace 2008). Killingsworth and Gilbert (2010:932) undertook a study sampling 2,250 adults. One question they posed using a web-based iphone technique was '*are you thinking about anything other than what you are doing?*' They concluded that mind wandering occurred in 46.9% of their population. Thus it is a very common theme - the '*monkey mind*' as Gunaratana (2009) has termed it jumps all over the place. Once you settle down to do mindfulness practice it is common for your mind to fly off in different directions. This is especially difficult when there are lots of other things going on. The principle is just to notice – if your mind wanders just bring it gently back, acknowledging it but not getting tied up with it is the essence. In fact O'Morain (2014:10) has termed this mind wandering as '*a golden moment*'. When you can notice that your mind has wandered it provides an opportunity to bring it back and thus give you more practice in mindfulness. Thoughts and emotions will pass. Even if you feel angry you just notice that emotion and let it pass just as any other. This ties in with the Buddhist concept of impermanence and how things come and go (Gunaratana 2009).

Jack, when pressed, acknowledged that his challenge had been '*finding time*' to do the practice. Although it would seem that his challenge had really been one of discipline. Kempson (2012) lists one of the barriers to developing mindfulness as having '*other priorities*'. From other conversations (outside of this focus group) and later with his mother, it was clear that he spent a lot of time on computer games and just '*not getting round to it*' was an issue. Kempson (2012) lists '*forgetfulness*' as one of the barriers to mindfulness practice. This is in itself not unusual. Grandin (2012) discusses a finding from a study which claims that the majority of youths with ASD (Autistic Spectrum Disorder) spent most of their free time using non-social media. Thus this fits with his diagnosis of being on the Autistic spectrum –

as well as being a teenager! Burnett (2009) discusses the issue of holding attention and contextualising mindfulness in a helpful way for adolescents.

### 7.11 Benefits

The young people had not seemed to notice any differences since attending the mindfulness sessions. The exception was Katie who stated that she had sometimes noticed a difference but when asked how things were different now, she reported '*no differences*'. However there clearly were some benefits as has been mentioned above – for example Jack's '*I felt it benefited for about an hour*' and Jessica's '*it worked when you did it*'. Additionally a number of the young people specifically said that mindfulness helped them sleep.

*Emily: it was helpful to get me to drift off to sleep*

*Jessica: yeah. Like it would take me awhile to get to sleep*

*Anna: Right but now you can?*

*Jessica: I'd lay there thinking but if I did something – some of that like it would clear your mind and help it switch off*

*Katie: Mindfulness makes me sleepy and relaxed sometimes helps to get to sleep at night.*

This observation was very similar to one quoted by Allen et al (2009:425) in a similar study concerning the experience of adult participants following a mindfulness cognitive therapy course expresses how mindfulness helped her sleep. Additionally it was one of the findings in the studies of Burnett (2009) and also in Kempson's (2012). This had also been an observation that one of the teachers (Christine) had made in a previous session – that mindfulness helped her to get off to sleep. Jessica however added:

*Jessica: It didn't help me through the day like when I'd done it because after I'd done it I was really tired*

*Anna: Right*

*Jessica: It's like I couldn't get on with anything else then.*

It also seemed that some of the qualities in the studies of Allen et al (2009), Moore (2008) and Baer et al (2006) were present in this group. There had been a previous session (one of the eight sessions in the study) where the young people had gone outside to do a mindfulness session in a small park. Afterwards they had all commented on the benefit of this session. They were now reminded of the session and of their comments at that time:

*Anna: Well I noticed something – last time – and I don't know whether any of you will sort of pick up on this – but – and I think it was Matthew that said this and I think it was Jessica that sort of confirmed it was true for her – that you noticed in the background the sound of the digger and you just sort of said oh well that's a digger and it didn't really bother you and you noticed that it was different. Is that right?*

*Jessica: Yeah*

*Anna: Well I think that's the beginning of it because sounds that may have been irritating*

*Matthew: No I'm not saying I didn't find it useful in that sense*

Matthew did acknowledge, when pressed, that there had been something that he had found useful during the project. The comments of the young people indicated they now had less of a reaction to things that previously had been more difficult. This also ties in with Moore's (2008) 'new insights' theme in his study. 'Struggle' also seemed to feature with the group as they described how they struggled to manage their thoughts and struggled to devote time to doing the mindfulness practice in a regular way. This seemed to resonate with Allen et al's (2009) 'acceptance' and Baer et al's (2006) non-reactively. Jessica subsequently confirmed that sounds that she had previously found that 'did her head in' were less bothersome now.

*Anna: Does it still 'do your head in' or is it just annoying now?*

*Jessica: It's just annoying*

It also seemed that the young people were more forthcoming and more relaxed with my presence. However although we agreed this was the case it could well have been due to increased familiarity.

## **7.12 Education and Mindfulness**

The question asked about the government's idea to introduce mindfulness in schools did produce some interesting discussion although it did not seem to enhance the research question any further.

None of the young people felt that mindfulness would work in mainstream schools. The following dialogue illustrates this.

*Anna: okay so what do you think about the government idea to introduce mindfulness in all schools and make it a formal lesson?*

*Emily: No*

*Matthew: no*

*Jessica: It wouldn't work in public (state) schools*

*Anna: Why not?*

*Jessica: disruptions*

*Anna: Too many distractions?*

*Jessica: Yeah*

*Emily: yeah*

Matthew thought that mindfulness had originated with adults and was therefore more likely to be of benefit to adults. Jessica commented:

*Jessica: You're going to get more adults interested than kids*

This led into a discussion about college students accessing mindfulness. In relation to college students Matthew felt that:

*Matthew: you know what I mean? So if they are already wanting to relax for whatever reason – because they are not finding the time to relax*

He felt that college students would already be overburdened with work and that this would be difficult. However Emily added another observation:

*Emily: If someone really wanted to do it then they'd make time*

In fact mindfulness is being used increasingly more in schools (Rechtschaffen 2014, Olson, 2014 and the Mindfulness in Schools Project which has been underway since 2007). It would seem that these young people's views of mainstream high school had been somewhat clouded by their own experience. None of them had been happy in their various high schools. Jessica used the words '*disruptions*' to quantify her experience of mainstream high school. Matthew had been bullied and Katie had felt so bad about school that she had refused to attend. Nevertheless the fact that they were not part of the mainstream culture must have held an element of '*exclusion*' for them even though they were now settled. It would be easy to understand how they might develop a more negative '*script*' about mainstream schools (Nashat & Rendall 2011).

### **7.13 Environment**

This was an aspect that came up during the conversation which requires further consideration. Jessica had raised the point with her comment:

*Jessica: It works better in different types of environment it depends what's in the background and where you are.*

Jack had previously commented about it sometimes being harder than others.

*Jack: Em Sometimes it was relaxing and sometimes it like em – it was more trickier*

Jessica also added:

*Jessica: Like it was easier at the park than when you are sat in here.*

Katie also said that it was helpful when they were in the park. There was general agreement that this had been the best place to do mindfulness practice. Burnett



(2009:13) discusses the relevance of '*a different place to practice*'. It does clearly make a difference and trying to focus on being mindful is difficult when there is a lot of external noise. Not only that but there is a therapeutic quality about contact with nature (Marcus and Barnes 1999, Townsend and Weerasuriya 2010, Maller et al 2006, Hartig et al 2010) which fits in well with the concepts of mindfulness. For example accepting what is there, not striving to change things. In a previous session when we had done a mindfulness practice (in a fairly quiet environment) one of the teachers had remarked that she had heard birds singing and normally she would not have noticed that. In another session for mindfulness practice the group had listened to a CD playing the sound of waves breaking on the sea shore. All had felt that this had been a good session and had enjoyed listening to the sounds. This reflects the findings of Huppert and Johnson (2010) who identified that their participants had enjoyed the programme. Also it would seem that capitalising on nature when possible would be helpful in developing mindfulness practice.

### **7.14 Future Groups**

Some of the young people (Matthew and Jessica) were clear that they would not wish to participate were there to be such groups held. However Emily, Jack and Katie said that they would be interested in such a group. Matthew and Jessica were also clear that they would not recommend mindfulness to a friend. Emily and Katie said they would and Jack did not comment. It would seem his reluctance to give his view was more likely to do with his difficulties with relationships but as we see later he had actually shared many things about mindfulness with his mother.

Finally there was the idea, as one of the teachers voiced it, of '*planting seeds*'. These young people now had the ability to practise mindfulness; perhaps with a little more maturity they might realise more of the potential and begin to give it more of their attention.

However a number of points came through which seemed to establish that mindfulness had shown some benefits. Jack's finding that his '*one hour*' which lasted after his mindfulness practice is actually very good. The question of improved relationships, although not raised in this group, came to light later when

his parent stated that she was very pleased that he had joined a tennis club because socialising was difficult for him. This echoes one of Allen et al's (2009) '*overarching*' themes which emerged from their study – that of relationships and some improvement in relationships was also identified by Kempson (2012) in his study.

Summing up the main points there seemed to be some evidence that at least some of the young people had found some benefit in helping them to be calmer and found it especially useful when clearing their mind when trying to get to sleep. Weare (2013) also identified that programmes were well received by students. There also seemed to be a thread of increased tolerance. Environment was clearly important and this linked in with focusing and '*keeping your mind from going off*'.

### **7.15 Teacher Interviews**

Although it had been intended that the teachers would be part of the focus group, this had not been possible due to their other commitments that day. Thus a separate meeting was held with Mary and Christine (the teachers) to discuss their experiences and obtain their comments about the project. There had been an intention to consider the same format as in some form of template (King 1998) but the discussion, although including some of the same points, was of a different nature. There was a difference between what the teachers thought about the students in the group and about what they themselves had experienced although this was not always easily identifiable as being one perspective or the other.

### **7.16 Personal evaluation**

The first point of discussion was whether the group had been helpful to them and both felt that the group had been. Christine explained that '*understanding the practicalities of how to do it*' had been particularly helpful. She had read about mindfulness but it had not been clear to her. Some of the images used and activities had also been helpful. Both mentioned that they liked the snow globe. Kaiser Greenland (2010) uses this to help children calm their thoughts. Here the snow globe was used to illustrate how, when thoughts are swirling around in your head, it is hard to think clearly. When the '*snow*' settles you can see things more

clearly, also just by watching the 'snow' settle gives an analogy of settling – a calming effect.

The teachers had limited previous knowledge of mindfulness. Christine had known 'a little bit' and Mary had done some relaxation and some meditation but hadn't done mindfulness in that form previously. In this case it appeared they knew little about mindfulness before the commencement of the sessions.

### 7.17 Challenges

Both teachers explained that they had found it difficult to separate themselves in the roles of participants and teachers. In particular they found it hard not to think about how the students were perceiving it and managing it. Being there as participants rather than teachers felt like, as Mary expressed it: '*crossing that line all the time*' making it difficult to be in that '*mindfulness moment*'.

Some of the mindfulness practices had been more difficult than others. '*It didn't work for me*'. Clearly there was not just one way of doing things - and other ways had been suggested in response to what students were saying. However on an individual level some things worked better than others although they acknowledged this was a group situation. Both had found the earlier sessions more helpful to them but had struggled later with slightly different methods; Segal et al (2002) caution against looking for a '*best method*' or the '*right technique*'. Mace (2008:59) discusses getting participants to

*'compare the effects of different procedures in order to make future choices about which procedures are likely to be most helpful to them'*.

They also mentioned the difficulties they experienced in the different environments. One room in particular had been very difficult because of the noise coming from the next door classes. This made the point that the environment in which the mindfulness is undertaken is significant. However although one would wish to choose a quiet situation where one was not likely to be interrupted, Segal et al (2002:133) describe how in the development of the MBCT course held at Cambridge they were in a situation where cleaning staff were working just outside the meeting room. In later discussion they found that some participants were able

to *'weave the cleaners' noise into the fabric of the awareness of sounds in general'*. However others experienced the noise as a distraction making the practice difficult.

### **7.18 Continuing practice**

Although she did not regard it as a *'top priority'* Christine said that when she now found things really stressful she had practised some mindfulness and it *'had helped'*. In one of the previous sessions she had said that she did her mindfulness practice before she took her blood pressure as she had found that mindfulness reduced her blood pressure. Low et al (2008) discuss how meditation can reduce the effects of hypertension.

Christine was very clear that she intended to continue with mindfulness practice

*'Now I think the fact that I, amidst everything, I am doing it. I do think definitely I will'. Mary added 'Yes I think I need to be more disciplined; I am hoping that the summer will allow for that'.*

Mary described it as *'planting a seed'*. She said that this wasn't necessarily going to *'germinate'* right now but would come later. She added that it was really hard to find the time to practise especially when things were very busy. However she felt that now was the right time of year (towards the end of the summer term) to start thinking about putting some of these things into practice.

Gunaratana (2009:70) lists five hindrances which can get in the way of meditation. Such things as *'sensual desire', 'ill will' 'restlessness and worry' 'sloth and torpor'* and *'doubt'*. When we particularly want something we cannot get it out of our heads, for example we want to be warmer or cooler. When there is something that we abhor our mind gets stuck on it – for example that irritating noise that we can hear. We feel restless and can't get our worries out of our head. Sometimes we are just too tired or lazy to bother with meditation and sometimes we just doubt that it has any purpose. Also the points made earlier about enhanced expectations will no doubt also come into play. Considering that any or all of these hindrances may kick in perhaps we should wonder why it does sometimes work. Williams and Penman (2014) have a rather different slant to the issue of motivation. They point

out that when the mood is low you have to do something before the motivation comes. You have to '*drag yourself*' to any social gathering before you can begin to feel more at ease with it. Motivation follows action – not the other way round. Thus cultivation of the meditation habit can overcome this difficulty for people who are feeling low.

### **7.19 Mindful eating**

Mindful eating was something that we had discussed in the sessions. Christine acknowledged that she had been '*doing a lot more of mindful eating*'. Mary added that she had recognised – at the end of a meal that '*I've not been very mindful but it's there it's the planting of the seed isn't it?*' Mary had in fact recognised something that Moore (2008) identified in his study – that of recognition of not being mindful. Bays (2011:105) advocates '*one bite at a time*' as a mindfulness practice. All too easily we fall into the habit of '*layering*' bites of food. That is having the next fork ready before the food has gone down. She advocates putting the fork down between bites. Many of us do not notice what we are eating – until it is gone – as Mary discovered.

### **7.20 Student challenges**

The teachers felt that mindfulness was not, as Christine put it, '*an incredibly easily accessible concept*' for this group of young people. They did not seem to fully grasp what it was about and what the point was. This echoes what others have said about mindfulness (Kabat-Zinn 1994) and also seems to emphasise the point that perhaps a certain level of maturity is needed to grasp the point. Perhaps because of this they were not really prepared to try as they could not see the benefits for themselves. Mary pointed out that doing the mindfulness practice is quite a challenge. If you cannot see the benefit it makes it more difficult and it involves discipline. She added:

*'There is a bit of a discipline there which they don't have or want to have, or know they want although they need to have you know - it is very complicated isn't it?'*

There are various issues affecting young people's development and as discussed in Chapter 2 there can be multiple reasons for this. Some young people develop more quickly than others and all this impacts on how they manage the changes. For example a young person who is physically taller than average is

*'often expected to act more mature, be more responsible and have higher academic performance' than his or her class mates (Bogin 1999:328).*

Birth order (Blair 2011) can also affect how children develop. In short there are many variables which may impact and such things as learning difficulty and emotional distress can make a big impact on how young people react to things. Teasdale and Chaskalson (2013) have discussed how mindfulness can develop a view of seeing life as an unfolding process rather than identifying with experiences as if they were personal. One wonders how difficult or easy it might be for these young people to develop such an accepting view of the world. The teachers felt that it was *'too conceptual for them at this age'* and easier as adults to step back and look at their lives. They felt that Matthew *'was starting to get it'* but whether he would continue is another matter. Matthew had appeared to take to the idea but his views in the focus group had been contrary to this. They also felt that *'Emily was beginning to take it on board'*. Indeed Emily's results (see Chapter 6) seemed to indicate that she had in fact taken the concepts on board and had gained some benefit. They felt that Jack found it very difficult – most likely because - *'he is on the spectrum and everything is very black and white'*. Jack had also been something of a surprise as although both the teachers and myself had assumed that he had not seen much benefit, the interview with his mother (see Chapter 8) gave a different aspect. Christine commented that *'I think Katie just couldn't'* and Mary added, *and 'William as well didn't understand'*. These were valid observations. Both Katie and William had their difficulties academically and William had decided to drop out. It was of interest that while Matthew in the focus group had said that he would not be interested in further mindfulness sessions, the girls (that is Emily and Katie) had said that they were, which had been somewhat surprising. However perhaps it needs to be pointed out that due to Katie's very late arrival in the focus group (she had had a medical appointment) she had expressed

her views somewhat separately. Had she been in the company of her friend Jessica she may have been much influenced by Jessica's views (Fishbein and Ajzen 1975).

Mary made the point that

*'but again it's about planting the seed isn't it. These might be skills that they don't realise will benefit them later but they'll think back and think yeah you know that's what that meant in mindfulness when we were looking at it. That's what – you know – that's how I can benefit and it might come later'.*

Penman (Williams and Penman 2014: viii) gives an acknowledgement to a teacher who introduced mindfulness to a group of stroppy teenagers (including him).

## **7.21 Future group**

A discussion took place about the possibility of running a future group. They felt that it needed to be a small group and there would need to be *'more ownership'* on the part of the students. They should decide how much mindfulness practice they did within the group. They would be guided by the students and if it were to be something they wanted they would look at that. Another point was how much practical *'hands on'* mindfulness to do and how much theory. A balance would be needed.

Discussions took place about which students may be interested. Katie had said she would be but (as discussed above) she had arrived late and had not been part of the main group when this was discussed and it was not clear whether she would adhere to this. Jack had been interested which had been interesting as this was not something that would have been anticipated. Jack had been the student who had asked about leaving the group earlier before he had been given a CD to take home to practise. It was now also clear that his Mum was fully supporting him in mindfulness practice (see Chapter 8), illustrating the point that opinions may be wrong.

They felt that the group would be helpful to all of them, however some preferred guided mindfulness whereas others preferred silence or listening to the sound of waves. This would be something for consideration in any future group. One teacher made the point that mindfulness *'It's a very very personal and individual act mindfulness and you are trying to do it collectively within a group'*.

Nevertheless mindfulness is often undertaken in a group format.

The point was made that the timing of the group had not been the most helpful because of term time commitments school holidays and a number of bank holidays. The first session had been timed to start after the school programme was a little less hectic and Monday was chosen as the best day as this was when the students had a *'study period'*. The first session was followed by a bank holiday the following Monday which so early on in the course was unfortunate. Continuity is important and it would have been far better to have a break after a few sessions by which time the participants would have been more familiar with mindfulness and thus the chances of them taking up their own individual practice out of school would have been greater. However it seemed that to schedule it otherwise would be unavoidable as the group was run on school premises during term time and Monday was the best day for them. The loss of continuity did not help some students who seemed to be *'losing the thread'*. As Mary put it:

*I don't know how you would do that because other than coming in in your half term – you couldn't could you but I don't think that helped some of them. I think they were losing the thread a bit with it.*

Rustin (2011:8) explains how ordinary events like coming back from half term can *'stir children up to a surprising degree'*. No doubt the breaks did make an impact. Had the students regularly practised mindfulness at home this may have been compensated for but it seemed more likely that the whole idea had gone out of their heads completely. There were too many gaps - two bank holidays and one half term over the course of the eight sessions.

Christine expressed her view about the student's apparent lack of interest:



*'I just feel in a way they weren't – none of them really seemed to be really fired up with enthusiasm for it'.*

One young person whom we had thought was really interested had clearly said in the focus group that he was not. It was not what he expected. This had been a surprise but the teachers recognised that he can *'flatter to deceive'* and thus it is not always evident which students are interested.

## **7.22 Other points**

Outcomes for the group were perhaps not as positive as they might have been although some benefit had come out of it. However expectations had been high and then as Mary said:

*'I think it's just that your expectations are high aren't they and then you realise that can they at this age access it? Jessica is still year nine isn't she you know but it's like she's in year seven'.*

However it is also relevant to add that some of the claims for mindfulness in the popular media can easily lead to increased expectations - *'improves well-being' 'physical and mental health' etc.* While these are essentially true statements the point is not always made that practice and the right approach are also components of mindfulness.

Jessica had her own issues. She was in year nine but her development and maturity made her more like a year seven pupil. These were some of the challenges facing the group and when one considers Kabat-Zinn's (2009) statement about what mindfulness is it is easy to see why this is a difficult concept for this age group to take in, not to mention specific learning difficulties which some of the group experienced.

*'Mindfulness is a lifetime's journey along a path that ultimately leads nowhere only to who you are'.* (Kabat-Zinn 2009:15)

This is indeed a difficult concept for young people to grasp. Any benefits as Williams and Penman (2014) describe are more like *'side effects'* and occur incrementally.

Some of the young people had found other ways of dealing with their stresses. Jessica for example had her horses which for her proved to be a huge resilience factor (Pearce 1993). This also underlies the fact that it is not easy to establish causation when so many other things are going on in the lives of the young people, some of which may only be known to themselves.

Mary commented:

*'So it's almost a bit disappointing what they got out of it isn't it really but I don't think they put in that much to be honest'.*

*'But I'm not sure some of them knew how to either'.*

It has to be recognised that effort does need to be put in and perhaps this was not clearly explained. The teachers felt that as a piece of research the participation was useful. Christine clarified:

*'But I think that as a piece of research though is useful because I feel as if mindfulness is being seen as the answer to everything. I thought the reality of it and delivering it to this age group was really very difficult'.*

In some respects her point was correct. Mindfulness is widely advocated to be a useful tool to help people. While this is essentially correct, mindfulness is perhaps not so easy to deliver not only to this age group but also to those who face their own individual challenges. The young people themselves, when asked, had been very clear that they thought that delivering mindfulness in mainstream schools would not work.

One of the teachers made the point that it was difficult for a mental health practitioner to come into a school to deliver a mindfulness programme. Christine expressed her view that:

*'there is a massive amount of classroom management that teachers are – have developed skills over a long period of time and I think it would be difficult I think for somebody to come in, you know you have a different set of skills'.*

This is a very valid point. The researcher did not have the years of teaching experience that Christine and Mary had accumulated, on the other hand years of working with young people in a mental health or similar environment in a professional capacity was an off-set to this. Nevertheless teachers are more *'used to selling and delivering and engaging'* in the school environment. Here the mindfulness in schools project may influence the future delivery of mindfulness interventions. Added to this there needs to be consideration given to the type of students, the composition of the group as well as the environment. A further point is that teachers within a school, especially a small school, have a good deal of interaction with other teachers. They get to know the pupils and the workings of the school very well. This information is not readily available to an outsider especially one who merely attends once a week for a particular lesson. Various mindfulness-based interventions have requirements for teaching the programme. Baer (2006) lists the qualifications required for teachers of MBSR required by the University of Massachusetts where MBSR began. They require a master's degree in a mental health field, daily meditation practice and attendance at 2 silent teacher-led meditation retreats of 5-10 days duration. The Zen tradition requires 3 years Hatha Yoga (or similar) in a group setting plus 2 years' experience in teaching MBSR or yoga and completion of a 5-7 day retreat plus professional training in MBSR which basically is about translation of the concepts. In 2016 the UK Mindfulness trainers' network recommended a number of points that their trainers should adhere to. Mindfulnet.org (2010) lists ten points, however there is considerable overlap and some of these can be included in the same category. For example having a professional qualification in mental health, training and knowledge of that client group covers 3 points on the list. Completion of and familiarity with the mindfulness teacher training course would appear to be one and the same thing. In the case of MBCT (which was the nearest to this research programme) training in counselling or psychotherapy with a knowledge of CBT (Cognitive Behaviour Therapy) is required. The researcher held these qualifications and also maintained individual on-going mindfulness practice which is also a necessary qualification for teaching mindfulness. The only point which was not fully covered was on-going contact with other colleagues working in the same field as mindfulness was not commonplace within CAMHS at that time.

The purpose of the research had been to see whether it would be helpful to a group of vulnerable young people delivered in this way. All in all, while there were challenges, there also seemed to be benefits. Christine had noticed positive benefits on an individual level and while Mary didn't quite seem to have got round to a positive commitment to mindfulness she had found some of it helpful and intended to use it in the future. The idea of planting seeds is also a good analogy. Even though the ideas may not quite have taken off with some of the young people they may well do so at some time in the future. This was perhaps the case with Daniel Penman, co-author of '*Mindfulness: a practical guide to finding peace in a frantic world*' (Williams and Penman 2014). Looking at similarities between the experiences of the young people and the teachers it seems that the teachers had been more realistic with their expectations. However there had also been difficulty with maintaining the motivation to keep the practice up – at least as far as Mary was concerned. Christine however seems to have done well with the practice and used it to good advantage (including reducing her blood pressure). There were some common threads and some of the same headings were used but there was not enough similarity to form any sort of template with which to consider the analysis. Another aspect of the study which was discussed in Chapter 6 (the outcome measures - results of the questionnaires) had proved to be largely positive but there remained a further aspect - the parent interviews. These are discussed in the next chapter (Chapter 8).

## **8. The parents' stories and their perspectives of the research**

### **8.1 Overview**

This chapter considers the position of the parents and is primarily based on the interviews that were held with the parents of the young people who participated in the eight sessions of mindfulness. Their views are as important as those of the young people as they provided additional information about whether they had seen any benefits of the mindfulness sessions. Additionally the information gathered illuminates the role of parents in such research and provides ideas of how the research design might be improved. Firstly, however, although Chapter 2 considered many aspects of parenting and child rearing, this chapter revisits some aspects of child rearing and child mental health to put some perspective to the interviews with the parents of the young participants. The chapter then moves on to consider individually the five separate parent interviews and issues arising from them which link with the young people and the sessions. The chapter then briefly considers the aims of the research before considering a more thematic analysis of the transcripts. The theme of parents' previous knowledge of mindfulness seems to have interesting implications. There also seemed to be a link with how much the young person engaged with their parent about mindfulness. Further issues raised in the interviews are also discussed. All in all comments from parents appeared to be quite positive. However it also seemed that there was a connection between family knowledge and participation with mindfulness and the relative benefits of mindfulness in the young person. Thus, highlighting the need to consider the parents position in future research.

### **8.2 Young people in today's economic and political climate**

Adolescence is a period of rapid psychological and physical change and thus it was hoped that mindfulness would assist the young participants to cope better with the challenges they faced. Additionally in modern Western society there are further challenges. As has already been stated in Chapter 4, today's adolescents live in a globalised pop culture (Hofmeister 2012) . Burton (2014) states that there

are cultural differences and expectations around development. In the Western world adolescence is now considered to be '*a relatively long process*' (Burton 2014:41). There are social, economic and political factors contributing to this with young people tending to live at home for longer and attend compulsory education for a longer period. Dogra et al (2002:85) point out that there is a '*rapid physical and intellectual growth*' in early adolescence with an increase in self-confidence coming later. Burton (2014) states that the only other period where there is such rapid growth is in the womb. Emotional maturity may lag behind physical maturity and this may be especially so if there is some level of learning difficulty. Education is significant and the management of children in school has a big impact on their lives (Rutter et al 1979, Cooper, 2002).

Thus there is a longer period where there may be confusion about the role of young people. Timimi (2005:16) considers how the status of childhood has changed in contemporary Western society. He explains that children are seen from two sides of the same coin – they are both vulnerable and deserving of children's rights at the same time as being seen as '*the risk*' with a fear that there has been a breakdown in adult authority. Dogra et al (2002:84) have also stated that media representations of adolescents can also distort realities. Wahl (2003) identifies media depictions as influencing perceptions, but suggesting that there are other socialising agents with family, friends and teachers potentially contributing to children's attitudes.

Parents' relationship with their children is an important factor. Chapter 2 has already discussed many aspects of the parenting role but it is referred to here to emphasise the large overlap between parents and their children especially now that children remain dependant on their parents for a longer period.

Budd (2001:5) has discussed the '*child-adult fit*' (by which she means the quality of their relationship) as depending on:

- The connection between a child's developmental needs and the parents care giving skills

- The connection between the parent's competence to care for his or her own needs and for the child's needs.

These were important considerations; however the interviews were undertaken with parents with only a limited knowledge of the full circumstances of their situations. Apart from what was discussed in the interviews and some limited knowledge from the young people, no prior knowledge of family composition, socio-economic status, environmental and historical contexts was available. As such the analysis presents only a snapshot of the parents' experience. Some parents gave information which helped to put things more in context but the aim was not to review their parenting or to examine their relationships (although aspects of this did become evident) but to gain their views about whether mindfulness had been useful to their son or daughter.

### **8.3 Nature, nurture and attachment dynamics**

There has long since been a nature/nurture debate concerning child rearing and there is no doubt that both play a part. Parents are often influenced by their own experiences of being parented when they were young. '*Ghosts from the Nursery*' as Karr-Morse and Wiley (1997) have termed this. Howe (2003:375) rightly states that an

*'attachment perspective sees a much more dynamic relationship between carers, their parenting capacity and children's development'.*

He continues to explain that a time dimension is key to understanding this as it is impossible to understand behaviour or states of mind (whether of the parent or young person) without understanding their relationship history. The parents' own socio-economic history can be one aspect that may influence how they parent their own children.

However Hackett (2003) makes the point that it is important not to '*pigeonhole*' parents into one category or expect that their responses at all times and all circumstances will be indicative of a particular parenting style. There is always room to change. Hackett (2002:164) states that '*despite our ideas about how best to parent children we often fail to live up to our own expectations.*' Howe (2003)

also suggests that parenting experiences may be substantially influenced, if not determined by children. For example where a child has a particularly strong will and the parent is more lenient or in cases where the child has special needs which require certain routines of care. (Please see Chapter 2 for a further discussion of these issues).

## **8.4 The constituents of good mental health**

Firstly a mentally healthy young person is considered to be able to show the following qualities as defined by the Mental Health Foundation (1999):

- Healthy development in all areas
- Satisfying personal relationships
- Use and enjoy solitude
- Ability to empathise
- Play and learn
- Develop a sense of right and wrong
- Face problems as they occur and learn from them with others

It was hoped that the mindfulness sessions would help in the cultivation of good mental health for its participants. However Dogra et al (2002:18) identify that mental health is a culturally-bound concept and '*these definitions are clearly set out from a Western perspective*' Child mental health lies on a '*continuum between mental wellbeing and mental disorder or illness*' (Dogra et al 2002:18). Thus there are different aspects to being mentally healthy. These young people were already at something of a disadvantage and thus the parents' views of any benefits of the sessions was important. Parents are significant people in child development and indeed within CAMHS it is important that young people have the support of their parents. Clinicians gain a better understanding of the young person's difficulties from the parent as well as from the young person. Burton (2014:5) has termed this '*a window of opportunity for intervention*'. Not only do parents provide a past and present history of the difficulties but it is often apparent from the interactions what



may be contributing to the problem or what may be helpful in aiding recovery. For example if a parent always speaks for the child it may be useful to point this out. Older children are routinely asked whether they would like to be seen alone and sometimes it is important to make the point that the young person's voice needs to be heard. Burton (2014) states that young people presenting with difficulties are always thought of systemically and contextually. The parents can facilitate or impede the recovery of the young person. Vetere (2007:vii), in her foreword to Dallos (2007), states that

*'Family and intimate relationships can either foster or erode the sense of security of its members which can be influential in the development of distress or resilience'*.

## **8.5 Risk and resilience and other interactions**

Pearce (1993), as discussed in Chapter 2, outlined the risk/resilience defining three areas within which risk or resilience could present. These were environmental situations, family and areas within the individual young person. Although relationships between parent and child are of primary importance other aspects of life come into this and, as stated above, young adolescents face many challenges particularly in this era. Van Bakel and Riksen-Walraven (2002) considered three domains in a study of 129 Dutch families. These were:

- Parental characteristics
- The content of stress and support and
- Child characteristics

Where all three domains were intact – that is they were fairly nurturing and presented no overwhelming challenges - the results were almost always positive. Where one area was weak – that is nurturing was not what it might have been or there were a high number of challenging situations - the other two domains appeared to buffer it. Thus if the child's needs were very challenging but the parents own support needs were adequately met the outcome also was mainly positive. However where two or more of these domains appeared weak, this was a strong predictor of poor outcomes for such children.

## 8.6 Including parents in mindfulness

As mentioned in Chapter 1, a number of authors advocate including parents in their programmes (Saltzman and Goldin, 2008, Mace, 2008, Singh et al, 2010, Dumas, 2005, MacDonald, 2010, Bögels, 2008 and Phelps, 2010). Parents were included in this project, in so much as the interviews formed an important part of this research. Originally it had been envisaged that parents would play more of a part. Before the pilot group an introductory session had been held with parents and young people, but after the research had to be modified in this case an introductory session had not been held with the parents. (This is further discussed below). However there had been correspondence via the young people who had attended the briefing session and wanted to take part in the sessions. These young people then took home some information about mindfulness, the sessions and the project as well as consent forms for themselves and their parents. Additionally there were SDQs which parents were asked to complete before and after the sessions.

## 8.7 The parent interviews

One of the objectives of the research had been to evaluate a better understanding of how parents might support and interact with a mindfulness intervention. Below is an analysis of the individual interviews held with the parents of the young people who took part in the mindfulness sessions. Also the completed SDQs (see Chapter 6) also reflected their views. As discussed in Chapter 3 the decision to hold individual interviews was to put the young people's situation in some sort of context. As Burton (2014) has identified a systemic and contextual understanding is important in considering young people. As their families were likely to be as individual as the young people the decision was made to see them separately. This would also allow parents to have an in-depth discussion in a confidential way, within their own home environments. Tod (2007:354) has described the flexibility of this method of data collection as '*one of the greatest advantages*'. Lazar (2001) points out that the researcher is able to change the course of discussion if so warranted and this indeed did arise in one interview. (See Katie's parent interview below.) However he also states that the quality of information is related to the interviewers' experience (Lazar 2001:70). Although as stated in Chapter 3 the

researcher was familiar with interviewing parents about the health of their son or daughter this did in fact raise a different issue as identified by Moore and Field (1996) the risk of losing the research role. All in all it seemed to be the most practical way of approach as getting all the parents together would have been a strange situation for them and may well have proved to be inhibiting. Had all the sessions been conducted to include both parents and young people this would have been very different.

The interviews were planned to be of about equal length although some parents had more to say and some had less. The process was semi-structured in so far as there were a number of specific questions which were put to the parents. (See Appendix 3 for this list). These were very similar to the questions that had been put to the young people in the focus group discussion.

### **8.8 Katie's parents' interview: exclusion and misunderstanding**

Both Katie's parents were present for some of this interview but her Dad left to collect the younger child from school. It was thus her Mum who engaged in the discussion (all of the quotes are hers). The question was raised about previous knowledge of mindfulness. The answer was a definite 'No' with a further addition

*'I still don't know anything now, because she hasn't said anything about it'.*

This highlighted the point that not all young people will relay the information correctly or in sufficient detail. There is also a balance between allowing young people autonomy and not being sure whether the task will be carried out, being both vulnerable and deserving – somewhere between child and adulthood, as Timimi (2005) has commented (above). Also this comment was despite my outline explanation of the sessions. However it did seem that Katie had delivered at least some of the information as they confirmed that they had received the initial information.

*I read that yeah but she's got a poem she came home with that laminated thing she got that on there (indicating the mantelpiece) but it's never moved from there'.*

The 'laminated thing' that Katie's Mum referred to had been a handout in one of the sessions. The 'poem' had been an inspirational statement that read '*the voice in your head that says you can't do this is a liar*'. It had been intended to give out for all the young people to keep for themselves – wherever they wished to keep it. It would seem that the mantelpiece is often a place of pride where things are displayed in the family. It did not seem relevant to ask where she felt it ought to have been moved to. Katie's Mum added '*that's what she's like anyway doesn't talk about things*'.

It is possible that Katie is displaying something of an anxious-avoidant attachment pattern (Ainsworth et al 1978) although it is also possible that she is displaying her independence as a teenager and is just choosing not to share. An anxious-avoidant pattern of attachment would tend to inhibit discussions with parents although there is no firm evidence that this is the case. Howe (2011:13) points out that

*'the strength of a child's attachment behaviour in a given circumstance does not indicate the strength of the attachment bond'*.

Also information about the parents' background and their experiences as children was not known. How things in the parents' lives may have impacted on their relationship with Katie also was not known. It did seem however that there had been a limited amount of interest shown in what mindfulness involved as was witnessed by the necessity to explain this at the beginning of the interview. Katie's not talking about it may have been because she picked up that there was little interest.

The next point was whether any differences had been noticed in Katie's behaviour. The reply was '*Just the same – or if not worse. Temper wise its going worse*'. Katie's Mum felt that Katie may not have been paying close attention.

*Katie's Mum: 'It's whether she's been listening though in the classes isn't it. It is actually whether she has took it in herself. Do you know what I mean because she is not even – apparently she gets told off all the time for her concentration so –'*

Given Katie's recent diagnosis of ADHD this was not unremarkable. Lack of concentration and distractibility are common features of ADHD. Her Mum laughed and added that she had '*two like that*' (Katie's brother also has similar problems).

It was curious that Katie's Mum appeared to blame Katie for what was not her fault – her lack of concentration. Selikowitz (2012) advocates discussing the child's limitations with them to put them in a better position to cope with issues. I also wondered whether her Mum understood the range of Katie's difficulties and whether anyone had tried to explain these to her. Another possibility is that she may just have made her mind up that it was all down to Katie and thereby it wasn't her fault. This may be one way of dealing with the emotional situation. Pavord et al (2014) discuss the impact of social responses towards people who have some disability. The effort to make a child normal gives a very clear message that there is something about them that no-one likes - often leading to them not liking themselves. Wilson (2003:114) highlights mismatch in the child's experience between actual needs and needs as perceived by their carers. This gap can lead either to over care or neglect,

*Katie's Mum continued: 'But I've not heard anything she never spoke about it nothing apart from – and all she asked me to do was to fill that form in you sent home. That's it I filled that in and she took it back.'*

A further explanation was given about the use of the forms. Acknowledgement was made of the fact that in this case there would be few differences in family life except that if Katie was losing her temper more often that would increase the stress on the family. Other than that things will probably be the same. Katie's Mum agreed that they would be,

*'The same Yes. Cos to be honest, I didn't even know how long she was doing this for. I didn't know anything about it apart from reading that thing and that's the only thing I knew about it. And I said to her every week have you done that thing? 'Yeah we've done it'. That's all I get and I try to ask her she just doesn't go into conversation about it. I said what did you learn then? 'Don't know' that's all I get 'Don't know'*

It seemed clear that they were finding Katie difficult to manage with a number of things which were challenging; her *'temper'* being one of these. Omar (2004) advises parents when dealing with young people's difficult behaviour, to choose one aspect of the behaviour to focus on. Too many aspects of behaviour that all seem unacceptable to parents cannot all be changed at once and will often result in the young person feeling they are being *'got at'*. There was a possibility that this could be what was happening here and contributing to Katie not wanting to engage in conversation – for fear of being *'got at'*. It seemed that the relationship between them was not very good at present and Katie's Mum seemed to feel that it was Katie who should be different. Siegel and Hartzell (2004:186) describe *'ruptured connections'* between parents and children, where relationships *'become filled with tension'*. They comment that rupture without repair leads to a deepening sense of disconnection between parents and children.

It was perhaps inevitable that the question about whether this would be a useful intervention for other young people could not be answered.

*'I don't know because I don't know what. I don't know. I can't answer that can I really?'*

There was therefore less likelihood of further comments.

*'About?' 'About the group' 'I don't know because I don't know anything it. I'm sorry.'*

It seemed clear that Katie's Mum felt excluded which highlighted the point that parents had not had a direct opportunity to be included. This was not the case with all parents but it does reflect the importance of including parents more thoroughly.

*Katie's Mum elaborated: 'It's not - she doesn't say - She won't tell you anything she is not like that type of person you know come and tell you what's - she not - once she leaves there that's it - schools gone do you know what I mean?'*

It seemed necessary (and this was when directing the conversation seemed appropriate - Lazar 2001 above) to establish that Katie was not the only young

person not to share things with their parent as others had also not known what mindfulness was. Katie's Mum remarked

*'I remember reading the thing at the beginning and signing the form to say she was alright to do it. And that was it and then last week at the end like I said'.*

It also seemed right to acknowledge that Katie did have problems with her concentration but that this was not her fault. She was likely to have taken some of it in and the techniques stood to help her although she would need practice. Katie's Mum went on to further explain about Katie:

*'I think it is when somebody – she's easily wound up that's the problem. She doesn't think she will just go from nought to a hundred instead of like building – like she just goes straight to the – one extreme to the other'.*

This was a recognition of Katie's functioning but without any reference to anything that might overcome this. Again it seemed necessary to put a more positive slant on this – after all these were just the circumstances which might benefit from mindfulness although it may take time, and this was pointed out to the parent. Katie had said that mindfulness helped her get off to sleep. Katie's Mum disputed this saying that, *'She's not been sleeping'*. Katie's claim was repeated *'she says it helps her get off to sleep'* but her Mum countered this:

*'She is still not sleeping because I've been into her 3 times last night because like Jane's (her sister) going to school during the day and they share a room and I've still not had any luck with that housing'.*

It seemed quite evident that Katie's Mum was quite exasperated by it all. There had long since been a problem in respect of accommodation. The family lived in council accommodation in a three-bedroomed house. However because of the needs of the three children they really needed a larger house to provide each child with their own space. This brought in another dimension – that of environmental influences. The family were not in a position where they could choose their own house and were dependent on the local council to allocate them a suitable

property. This situation would surely have put extra stress on all the family members and would not have been helpful in their interrelationships with each other. As Howe (2011:121) explains attachment insecurity *'is just one element albeit a significant one if found in association with other vulnerability and risk factors adds to the probability'* of poor outcomes. Such things as poverty and accumulation of life's stressors all contribute to this. Katie's Mum elaborated on the problem:

*'She's keeping her up - she's waking her up because I can hear her saying 'Katie will you shut up'. She sings to herself and talks to herself in her bedroom. So I've took everything off her now – the phone – and now – well she talks to herself all the time anyway – she used to – she has always done that. My son does it as well.'*

Other interventions may have been tried but clearly this was a long-standing issue for them. Sensing that the mood was becoming rather negative a more humorous aspect was introduced with the statement:

*Anna: 'I hope she doesn't think that's being mindful because you are supposed to be quiet when you are being mindful'.*

This established a lighter mood resulting in some laughter but brought a new point for Katie's Mum to raise,

*'She does that – she's always done that before. She can't even read to herself – you know when she is reading a book?' 'She won't actually read to herself she has to read it out loud because she can't – she says it helps her better if she reads out loud so I don't know'.*

This illustrates something of the level of difficulty that Katie faced. It seemed that her developmental milestones in reading were somewhat behind what they should have been for her age. Raymond (2014) discusses some reading difficulties and points out that some who can read aloud may not necessarily comprehend this on a different level. A *'kid's health'* website (2015 reading Milestones) puts the developmental age for this stage of reading as 7-8 years. For Katie this seemed about right given the difficulties she faced but also it was clear that her parents



had not recognised the level of difficulty that she did face. It should also not be forgotten that the parents themselves faced difficulty in managing her needs – not having fully grasped what the issues were. Also it has to be pointed out that Katie did not have difficulties in all areas – which tended to cloud the extent of other difficulties. Additionally they not only had one but two children challenged with special needs and another child who although having no such problems did have her own needs which might sometimes conflict with those of her siblings. Katie would seem quite low on resilience just now but as Rutter (1985) points out exposure to risk (at manageable levels) develops resistance. *'What doesn't kill you makes you stronger'* – attributed to Nietzsche. Also the *'fit'* between the child's and parents' needs, as described by Budd (2001), maybe something that is currently somewhat out of sync.

I did wonder whether it might have been better to involve Katie's parent from the start but I also wondered about her understanding – Katie's reading for example. Had it ever been explained properly that she had such difficulties? But again her level of difficulty had not been discovered in mainstream school. This seemed a complex issue.

Effectively this was the end of the conversation about mindfulness and about Katie's part in the group. Retrospectively it may have been better to involve parents from the very beginning ensuring that they know about mindfulness and the likely benefits for their youngsters so that they can foster the young person's progress and avoid the *'because I don't know anything'* scenario.

The results of the data from the questionnaires (given in Chapter 6) do indicate that Katie has the worst outcome of the participants. It would also seem that the tone of the interview with Katie's Mum was stressful. It seemed that her Mum did feel excluded from Katie and also she was misunderstanding some of the issues. One wonders whether this level of family stress has negatively impacted on any potential effects of the mindfulness intervention.

### **8.9 Matthew's parent interview: supported beginnings**

It had been clear from what Matthew had previously said that his mother had some previous experience of mindfulness. She was asked about this experience. She

had done an eight-week course arranged through the local hospital. She stated *'It was good'*. She had found the information sent out about Matthew's course useful.

She was asked about any differences she had noticed in Matthew and she replied that she had discussed it with Matthew along the way and

*'Initially he was enjoying it and he did feel it was helping him. So he has not talked about it as much I suppose it was when it first started but yeah he feels it has helped him staying calmer and focused'. 'That is what he was saying in the beginning you know. He liked it.'*

This was a very positive start to the interview. Matthew's Mum was already familiar with mindfulness and had a positive attitude towards it. Singh et al (2010) have established that compliance in the parents improves compliance in the children. Also of note was the point that his Mum had discussed what he was doing with Matthew. This is not always an easy task as Robin and Foster (2003:66) have expressed it an adolescent is the *'most difficult family member with whom to establish rapport'* but Matthew's Mum appeared to have been able to do this.

Matthew was present at the time and had presented a less than positive face. His Mum picked up on this and now addressed him and asked:

*'Have you changed your mind since and not said it to me?' Matthew's reply was 'I don't know we have not really spoke about it recently have we?'*

As Burton (2014:66) has stated *'identity formation can be an increasingly complex task'* and it was good to see that there appeared to be room for Matthew to hold his own views. They agreed that they hadn't talked about mindfulness recently. Nevertheless this indicates that Matthew's response to the sessions had been positive – at least at first. This also indicated that Matthew and his Mum had quite a good relationship. Not only had they discussed things but she also picked up on his less than positive face and responded accordingly. This may well indicate a secure attachment pattern (Ainsworth et al 1978).

Matthew's Mum was very positive about her experience of mindfulness:

*'Yeah definitely'. 'I think it makes us both more to think about what's going on in the here and now. And sort of focus and moving on and not getting as worked up about things. Not letting things work us up as much. I didn't know whether I was coming from Matthew's point of view because he was moving school or whether it was wholly down to the mindfulness'.*

Matthew had moved school a few months before the start of the sessions and the change had been a positive one for him. He had been bullied previously. In a large mainstream school as Pavord (2014:122) states *'it is easy for the bullies to remain "under" the radar'*. It was difficult to know how much the sessions or the positive school change had affected him but as his Mum stated:

*'There has been a massive improvement in his behaviour and the way he processes things'.*

Matthew's Mum was clearly in favour of mindfulness and reflected some of the benefits (see Williams and Penman 2014). She felt that it would be a useful intervention for young people. She added

*'It's just good to introduce it at a young age that's the thing really because it wasn't something I was familiar with and I'm in my forties and I think it's quite empowering'.*

When questioned about continuing with the practice she reported:

*'I don't do it all the time but it's there. I use the tools subconsciously – so I suppose I am doing it. I don't physically attend any courses but I suppose you just introduce it into everyday life don't you really the techniques?'*

It seemed that some of the momentum might have been lost. It may be that the pressures of life had come between the practices or as Chopra and Tanzi (2015) have commented some people may use mindfulness as a sort of band-aid – not practising when things seem better. The reasons were not clear but nevertheless the ability to draw on mindfulness remained.

However given his Mum's positive experience of mindfulness it seems a shame that Matthew seemed to lose some of his enthusiasm and it seemed something of a missed opportunity after such a supported beginning.

This raised a relevant point: Matthew's Mum was clearly on board with the idea of mindfulness and might have been a big influence in guiding Matthew had she been more included in the programme. This was a point needing serious consideration for the future. Would closer contact with his parent have improved on this result or was it enough that the seed had been planted?

One additional aspect to the '*story*' which was not included in the recorded interview as it seemed outside the realm of mindfulness, Matthew's Mum had mentioned that he was to go for tests for his dyslexia. They were not sure exactly what form the problem took and thus tests were necessary. This would have also limited them from sharing the problem as Selikowitz (2012) advises. Additionally she was unsure of the system and the statementing process in general. A brief discussion took place about the issues that might be involved. It later occurred to me that Matthew was 13 and his difficulties had not been identified. This was similar to what had been the case with Katie.

Matthew had himself said in the focus group:

*My Mum's very tolerant like.*

Was it the case that the issues of Matthew's specific learning disability had not been pursued? Having seen how his Mum appeared to be aware of Matthew's needs this did not seem to fit. However within CAMHS we had often observed that it seemed to be the '*pushy parents*' that were the most successful in getting better outcomes for their children. While this should not be the case it added another dimension to delivering mindfulness to vulnerable groups. If their basic educational needs were not being addressed there would seem to be a limit to how successful it might be. As Maslow (1943) has said some needs need to be met before others.

### **8.10 Jessica's parent interview: seeking inclusion**

Jessica's Mum had not heard of mindfulness before. She acknowledged that she hadn't '*got a clue*' and laughed explaining that,

*'I know it's counselling and things like that. I should imagine a similar type of therapy'.*

Clearly Jessica had not shared her experience of the sessions with her Mum, however her Mum had expressed an interest to be included by hazarding a guess as to what her daughter might be doing. Her Mum clarified,

*'She doesn't come home and say oh I've – we've been in group therapy today and I've done this that - it was just when she said that you would be coming along to see me. I was like 'What's this all about?' 'Well I've been having therapy an' But she never explained anything'.*

This did not capture what the sessions had been about and also Jessica herself had described the sessions as 'therapy'. Thus an explanation was given about the project. Jessica's Mum further enquired about what they had actually been doing (a further indication of her wish to be included). After the explanation Jessica's Mum expressed: *'I might try practising it myself'*. She laughed and added *'I could do with doing'*. As she seemed interested and in order to provide an example a brief mindfulness session was given. At the end of the session Jessica's Mum remarked *'I'd stay there for ever'*.

Further examples were given about what had been done in the sessions. Jessica's Mum explained

*'But she didn't come home and – you know – I think she thinks I'm too nosey'. 'I ask too many questions but I'd like to know and I feel like she doesn't include me in anything'.*

This might have been an issue relating to teenage years but Jessica's Mum stated

*'I don't know because the other two used to - I was involved you know what I mean?' She went on to explain that 'It's like this wall – don't be nosey and don't ask me questions' 'It's like I'm trying to bash this wall down all the time with her'.*

Clearly she very much wanted to communicate with her daughter but it seemed Jessica herself found this difficult - *'trying to bash this wall down'* although this

didn't seem to have been the case with her 'other two' It seemed her mother might have felt excluded (Rustin 2011) and perhaps felt that Jessica had a closer relationship with her teachers from which she was left out. Adolescence is a difficult time for young people but particularly so when the young person has difficulties (Dogra et al 2002). A suggestion was made that she might directly ask Jessica about the mindfulness sessions. Her Mum thought this may indicate whether she had been taking any notice but quickly added,

*'I think she must be doing it a lot because we have gone from this pulling her hair out when she doesn't get – I can't say her own way - when she is stressed about things she will take off on her own and I used to find bald patches of hair – you know where her hair is missing – and she'd pull her hair out from the root. Now that seems to have stopped since she got the horses'.*

Whether it was 'the horses' or mindfulness that had helped – or in fact both – is not clear. One of the difficulties of planning an intervention such as mindfulness is that other influences cannot always be controlled for. As Bryman (2008:1) states, 'social research does not exist in a "bubble" '.

This was one illustration of just how difficult things had been for Jessica. She had suffered from trichotillomania but it seemed this was improving. Also she had acquired two horses during the past year. Jessica had a talent with horses and this 'should not be underestimated' (Burton 2014:10). These were her main interest and kept her pretty busy – as well as content. Her mother had gone to some lengths to provide her daughter with positive outlets although they were not a particularly affluent family. The following is an example of how busy their day could be.

*'So I'll pick her up from school and she is straight down to the farm. And I only pick her up then about 8 o'clock – half past 8 so she's here – in the shower – bed so she's no time to go back to what she was doing'.*

It seemed that they were very busy 'doing' for much of the time, whereas mindfulness clearly stresses the essence of being. Books (2015:14) states that

*'mindfulness meditation focuses on being rather than doing'*. In fact in total in the dialogue above Jessica's Mum used the word *'doing'* six times in contrast with *'being'* which appears only once. With such a busy life would it perhaps be so much more difficult to settle to mindfulness? It appeared to put a different perspective on Jessica's comment (in the focus group) about mindfulness making her too tired.

Jessica's Mum acknowledged that she was keeping Jessica busy as a diversion from some of her difficulties. Jessica also had OCD as the example below shows. Still her mother regretted that Jessica did not take her Mum into her confidence more rather than just asking for things she needed.

*'I'm keeping her busy but I still – you know – I said to her I've got you the horse and you've got this hobby and but it would be nice if you know 5 minutes of your time to tell me what you've been doing and what you know. Not its 'Mum can I have this and Mum I need that'.*

She clearly wished that this would be the case and this is a further example of her wishing to be included in her daughter's life. Although the teenage years may be part of this her Mum clearly expressed that *'But that's me working with her isn't it?'*, thereby giving ownership to her part in the relationship. McCarthy and McCarthy (2002:159) state that *'when you own a task'* then the product of that ownership *'is tightly bound to you'*. Hackett (2003:159) lists *'parenting behaviours as mediators'* as one of the elements that *'help'* cushion the risk factors. This Mum clearly had done her best to help *'cushion'* against the odds. However she realised that not communicating was not a unique problem and expressed,

*'They don't tell you what they've been doing' but added from her own experience, 'I couldn't wait to get home and tell my Mum what I'd been doing – but that's me'*

The question was asked about any differences in Jessica that she had noticed since the mindfulness sessions had started.

*Jessica's Mum replied, 'It's so hard now because – like I said – we don't get to experience – because she's got the horse constantly. We don't*

*get the time with her. She is sort of moved out of the – she used to clean and clean. That’s all she ever did. If she was in here – she – really bad OCD - she would be cleaning constantly – fixing pillows - she wouldn’t let anybody sit down - we have gone from that extreme to just picking her up from school – running in – practically picking her wellies up and straight out. So having the horse has dealt with it but she has got the cleanest tack room on the farm. Because she still likes her order. Everything has got to stay in order but I think she has cut herself off from the house type of thing and just keeps her own room tidy. So it’s like she doesn’t look in the living room or the kitchen any more, and I thought ‘have they been working with her on this?’ because she is not doing it any more like she used to do it and I thought maybe its she’s got the horses now she got something else in her life and it has totally distracted her’.*

Clearly there had been positive improvements with Jessica although it was not clear whether mindfulness or a combination of other things had been responsible for this. Although she was busy Jessica had been encouraged to try mindfulness when she was carrying out other tasks – such as riding her horse or cleaning the tack room. There had clearly been a change in routines but it was hard to say what had been most helpful. It is indeed hard to quantify what has been most helpful where different influences are involved. In child mental health two publications Fonagy et al (2002) and Carr (2000) are well known for listing which therapies are most effective for children and young people. Both approach this from a diagnostic perspective – for example anxiety disorders or developmental disorders - and link these to the most appropriate therapy for that condition. Neither of these mention mindfulness nor in fact ‘*equine therapy*’ although it could well be that later editions may include these. Mindfulness appears to be much less specific and there are many different ‘*disorders*’ that stand to benefit. It would seem that notwithstanding any benefits that the ‘*equine therapy*’ may have provided, mindfulness may also have contributed to some improvement.



Jessica's Mum had noticed a definite improvement '*I have noticed a definite improvement I can say that*'. Also she felt that the mindfulness intervention would be a helpful thing for other young people.

A further discussion took place about the schools Jessica had attended. Her previous high school had been a local Catholic school known for its high rate of success but with a lot of pressure placed on pupils. The social and political emphasis was on meeting targets. Parsons (1999:13) refers to UK education policy from the 1990s as '*moving from optimistic and enabling to restrictive and controlling*'. Schools are predominantly assessed by government (and the public at large) by the academic achievements of their pupils. For young people with specific issues this can be very difficult. Jessica had difficulty with large groups. As her Mum explained

*'Yeah she's no good in group form really to be honest she's – she won't get on a bus - no bus routes – she won't - everything is done by car. Any family functions she just avoids them altogether she won't go. She will not go to a wedding – anything – she won't go'*.

Again this is an illustration of Jessica's particular difficulties but it also highlights just how much her Mum has understood how this affects her (see also her following comment).

It had been noted that Jessica seemed more talkative in class and whether this was due to familiarity or something else it was an encouraging sign. This was raised with her Mum who remarked

*'I think it's when she is in her comfort zone. When you take her out of her comfort zone she's absolutely useless. She goes to bits. You can see her panicking, she will go red and you know panic attacks will come on'*.

All in all Jessica appeared to be doing very well despite her difficulties. She had now been attending the Centre some 2½ years but her Mum could not envisage her returning to mainstream school. However her future education was clearly still a worry as she expressed,

*'So we've only like two years left really haven't we. I don't know. I don't know which way she is going to go'.*

Her Mum was clearly worried about her daughter and how she would cope with things in the future and indeed this is a worry for many parents whose young people have difficulties. Solomon (2011) outlines the risks of excluding pupils and the advantages of reintegration. Nashat and Rendall (2011) draw attention to the fact that official school exclusion policies do not exist in some other European countries. While there are clear indications of the disadvantages of exclusion there is another side to the coin in the case of young people who are not able to manage their mainstream high school but who find a niche in the '*inclusion centre*'. Nashat and Rendall (2011) give an analogy of replacing a light bulb (as if young people can be moved from their educational placement as easily as changing a light bulb) – which does not fit with humans who have a narrative within social constructionism. Once settled in an institution, movement out of this is a big challenge. Not all pupils at the Centre are sure of a continuing place there and meetings with their original schools are often held to determine whether they are ready to resume their mainstream education. In many cases this is a very positive move but in some others it proves to be an extra pressure for the young person. With older pupils (which appeared to be the case for Jessica) they usually remained at the Centre until they reached the age of 16. Jessica's Mum thought that she should definitely go on to college,

*'Oh definitely yes. I have spoken to her. I would like her to go to university because she is bright. But like they said we will cross these hurdles as we - she is very bright'.*

She added

*'I think that would be her only set back if they say right we are going to put you back to mainstream. I don't know where we would go then'.*

I also wondered whether her Mum was over-emphasising Jessica's potential future. Although it is always good to be optimistic Jessica would seem to have a

lot of barriers in her way. Perhaps her Mum realised this when she said: *'But like they said we will cross these hurdles as we'* –

Parents are encouraged to take part in such meetings at the Centre and have their say but as the mainstream school provides the funding for the pupils at the Centre there is always pressure to have them back in mainstream. Jessica's Mum, as she said

*'had years of it now with her. As I say it's been like 3 years from her being 11 we've been going to CAMHS'.*

And she did not wish to go back to square one. Some young people just can't manage high school; as Jessica's Mum said,

*'You can either hack it or you don't isn't it? She just couldn't deal with it. And I think it is all to do with confidence'.*

Society has changed and the employment situation and the political climate necessitates young people staying in education for a longer period than they would have done in the past (Burton 2014). For some young people who are less competent, either academically or socially, further education can be difficult. There is not always a suitable educational placement which might compensate for their needs.

Jessica had attended a local Catholic primary school and had *'been okay'* but the school was very small and as her Mum put it,

*'and they sort of – they mollycoddled them and then they were threw out into the big ocean type thing. They didn't know what was happening. They'd gone from giving the teacher cuddles in the morning and sitting on their knee to – So I blame the primary school'.*

She had had fond memories of the primary school. She loved the school:

*'I mean I used to always go in and help out but I can see that coming out into the senior school from there is a big big difference. A lot! I mean*

*most of her friends they're all –you know – great. She stays in touch with one girl from the primary school'.*

Rustin (2011:7) terms the movement from primary to secondary school as 'a *moment of intense anxiety for most children*'. It seems that the primary school had formed something of a 'secure base' for Jessica (Paiva 2011) but this did not extend into high school. The discussion continued noting that it was regrettable that secondary school could not be more nurturing. Jessica's Mum felt that was,

*'because that's all it is. Isn't it? If they were that little bit more - I don't mean lenient with them – if they didn't shout and – you know – we wouldn't have this problem as parents. I'd love to be able to get a group up to go into schools to state that – you know – a little bit of patience with the children could – you know – have – we wouldn't be at this stage now'.*

This underlines some of the big issues within education – the focus on academic results, large classes and cost effective measures often with little scope for those young people who have some difficulties. Although Jessica was well settled at the Centre which was now meeting her academic and social needs these issues had clearly affected this family and the future was still not clear. Jessica still attended CAMHS; although much improved she was still not discharged. Clearly there are young people who face great difficulties and following the normal school career does not fit with all young people. Mindfulness may help insofar as it provides a respite giving more ability to be able to face difficult situations and deal with them as they are without adding to the emotional difficulty, but it would also seem that there is a bigger picture.

### **8.11 Jack's Parent Interview: family engagement**

Jack's Mum did know about mindfulness as she and Jack had previously attended a mindfulness meditation session. (Jack had not previously mentioned this). She added

*'But it was done by a Buddhist and I found it quite – it was too religious – you know what I mean because Jack and me are both Christians and*

*I felt - so that was interfered in my mind – I couldn't - it felt too much but really I know mindfulness isn't actually anything to do with religion. It's totally separate really'*

Although mindfulness is not connected to any specific religion it is a known fact that Buddhists practise it more. Reger-Nash et al (2015:207) clearly state that 'practising mindfulness' does not mean that you 'have to become Buddhist'. However mindfulness clearly does spring from Buddhist roots (Kabat-Zinn 2011), although as Gunaratana (2009:2) points out it is something you have to 'see if this path works for you, to see for yourself' not something that would be forced upon you. Nevertheless in this situation it had been off putting for Jack's Mum as she explained

*'That's it but yeah yeah he was a Buddhist so it was more you know there was – there was – I don't know what you call it burning and stuff and there was a Buddhist thing and I felt it was too much for me to cope with but Jack did find it quite relaxing but – em I think it was quite a long session as well so it was probably too long'.*

It was not clear how long the session had been

*'I think it could have been up to two hours - It might not have been quite – I can't remember exactly - it seemed long'*

Wittman (2009) has identified that time seems to pass more slowly when one is anxious or bored. However it seemed that Jack had got more out of it than his mother had.

*'There was a lot of – as you probably know – Jack needs – he needs kind of to be told what to do. It's how his mind works you know with him having the Autism. It's –you know he needs to process words just to sit in silence is just not Jack'.*

She had recognised that Jack needed direction and thus guided mindfulness was more suited to his particular needs. He needed to be directed rather than just being free to listen to the waves. Thus an on-going commentary is more suitable

for him. Jack's Mum had been pleased to receive the information about mindfulness and the course. As she expressed it,

*'Yes Yes I was actually really made up when you were on about doing it because I do think that something like this will really help Jack' she laughed and added 'And me as well'.*

This was very encouraging to hear – the fact that she was 'made up' and not only that but she recognised the need for her to play a part 'and me as well'.

When asked about any differences she had noticed she replied

*'Not not loads – I mean and it's hard to say whether the differences are through the mindfulness or through something else but he does seem to be getting on with people better at school and he has just started going to a tennis club and whether that's to do with – you know – whether that's a change through this or through other things I don't know because he has been generally happier lately'.*

As mentioned earlier in Chapter 7, correlation does not imply causation nevertheless this appears to be a clear benefit to Jack. His Mum also clearly recognised that she also had a role in this as is identified by her statement,

*'But what I need to do is to encourage him to do it more at home as well to continue it because obviously he was just doing it at school and it needs to be really an everyday thing'.*

It seemed that she had made a clear connection between the sessions and Jack's improvement in relationships. Also it was enlightening to hear a parent reflect what is absolutely correct – mindfulness does need practice (Magill 2003). Jack, during the sessions had frequently said that he hadn't had time to practise. His Mum confirmed that *'It's very difficult to get them to motivate themselves to do that each day'*. Even so in Jack's case being too busy usually meant he had been playing video games. When asked whether mindfulness had been helpful to her she replied,

*'Yeah – again I need to do it more often'. She added 'But sending that CD because I didn't have anything – I think I'm a bit like that as well I need something'.*

When Jack had been struggling a bit to do the practice a copy of a mindfulness CD had been given to him to help with this. His mother had also found it useful to have something to focus on. Interestingly Jack had given the impression that he had not done any of the '*homework*'. Talking to his mother had put a new perspective on things and also provided insight as to the likelihood that Jack could continue with mindfulness. Given her support it seemed quite possible.

This was an interesting point which established that it is not always clear how much students have taken the ideas on board. It would also seem to suggest that improved communication with parents might enhance this.

Some young people had said that they preferred silence during meditation and that voices distracted them. However others had said that they needed a voice to guide them. Jack's mother had obviously some experience of this herself as illustrated by her comment:

*'I think it's a case of if your mind is very busy, you need something else to take your mind off that business but something else to focus on to take you away because I have OCD and I think my mind is very - going 10 to the dozen and that – and I find it hard just to be quiet. So - but I know that – because I've done kind of meditations in the past you know I've been to different people so I've done different meditations and of all of them that's the best I find you know'.*

The above comment appears to show that she has some insight as to how it might work and had clearly found this approach helpful '*that's the best*'

Asked about any differences within the family Jack's Mum explained that she only had one other son and,

*'He's very much not into anything like that. He's very much the other way. Don't touch anything like that it's too weird'.*

And she laughed and added,

*'It's just really me and Jack. We did think as - because I think Karl, my husband would probably do it but I think as well he's a bit like my older son. I think me and Jack are alike and those two are alike and it's kind of – so it would probably be me and Jack more than anybody doing it'.*

Jack's Mum has considered other members of the family although she has concluded that mindfulness is not something that they are likely to be interested in. This family approach was not something that the other families had considered although Emily's family shared this perspective (see later in this Chapter). Jack's Mum had obviously tried a number of things to help Jack. She mentioned imagery which they had tried:

*'when Jack was having quite severe difficulties and we both found that helpful'.*

She saw a parallel in this as it was,

*'talking through something rather than just being nothing - you have something again to focus on haven't you?'*

There was a further surprise when she stated

*'and Jack's been good because he has explained the mindfulness to me – which is I know that he has took it in'. 'Because that's another thing with Jack he doesn't always take stuff in but I know he has. Because I was asking him about you know when you focusing on a spot on the wall?'*

She went on to describe how Jack had explained the technique to her and they had practised together proving that he had indeed listened – which had not been apparent in class at the time. With some young people it is difficult to gauge whether they have really taken things in. Whether this was something about Jack's autism or just about adolescence was not clear. It is the nature of human beings to be affected by multiple influences and it is not easy to discern which is which.



With Jack:

*'You probably wouldn't with Jack because he doesn't give anything away.'*

His Mum was thoughtful and had a positive view of mindfulness being potentially helpful to Jack,

*'He's very very quiet and he just – he does take things in and probably because mindfulness is a quiet area – you know it's not – there's nothing else really going on, he would probably take that in more because the concentration would be better. It probably would improve his concentration as well wouldn't it?'*

Jack had asked one of the teachers if he could be mindful when playing tennis. Saltzman and Goldin (2008:150) pose a valid question in relation to this *'if you are thinking about winning and losing is your head in the game?'*, which would be the case, as playing the game rather than being worried about winning or losing would be an advantage. Jack's Mum picked this up and identified that *'that's your anxiety coming in isn't it?'*

She definitely thought that this would be a useful intervention for other young people. She was keen to know whether the Centre would be carrying on including mindfulness. This was uncertain but staff had said they would run something should there be enough interest. There were other changes scheduled at the Centre with some staff leaving and some possibility of relocation – none of which was certain at this point in time. Jack's Mum remarked that in the event of changes,

*'That's also going to add a lot of stress to Jack'. She felt that mindfulness would probably be quite good in this instance.*

Jack would need structure to do the mindfulness. His Mum explained,

*'I think it would be a case of – there is no way if I just leave Jack at home to do it he won't do it. It would have to be me as well so I need to sort myself out as well so that we can both do it together and maybe I*

*will talk to him about that and organise it so that we pick a time you know'.*

Again this illustrates her 'ownership' of the task – she needs to sort herself out in preparation to help Jack. Jack had had some doubts around the fifth session; he felt he was not getting enough actual mindfulness practice as not all of the session was devoted to practice but included other background information. Jack had been wondering about whether it was worthwhile continuing. His Mum felt

*'That would kind of ring true with Jack because obviously if he is not - it wouldn't be of any benefit to Jack then really you know if it was going all the way round everything else as well because it's a lot to take in'.*

This is a consideration. There would need to be a balance between any necessary theory and time for practice with any future programmes. Mindfulness from the beginning to end of a session would be right for Jack as all the explanations would have been given in previous sessions and as his Mum pointed out '10 minutes isn't long is it?' but would this help other young people?

With Jack it seemed that he would need to be directed - for example at four o'clock to quarter past four is mindfulness time. Jack's Mum asked whether it was beneficial to do mindfulness before bedtime. Mindfulness is more about being awake (Kabat-Zinn 1990) but some young people had said that it helped them get off to sleep. If you want to do mindfulness to be fully awake it's not a good idea. Jack's Mum also said that she found mindfulness sends her sleepy, which is a common experience. She said.

*'But I think that's because I'm not a person that usually relaxes so when something does work it does make me feel sleepy'.*

Also it seemed Jack could get quite anxious going to bed.

*'He will start to worry about you know - have you locked the doors and he'll start to get – you know – start to think about things that have happened in the day just when he is going to bed'.*

Thus this seemed to be a good time for Jack to practise mindfulness. Individuals are all different and some may find doing mindfulness first thing in the morning is best for them. So it's really what fits in with the individual. Bedtime seemed to fit best for Jack – perhaps rather than a bedtime story (which younger children find comforting).

Jack's Mum had come across other ideas and mentioned a book that a psychologist had once recommended for Jack. We agreed that whatever helps is useful but mindfulness is even more about developing a clearer calmer mind but both are needed because if you are not relaxed it becomes difficult.

We discussed the trip to the park which all the young people had found useful. Interestingly Jack had not told his Mum about this experience which led her to remark *'Oh right he doesn't tell me anything I get to know nothing.* However this was an entirely different tone to the comments of Katie's and Jessica's parents when they had complained of not being told anything by their child. She laughed as she said this – which makes the point that even when there is a close relationship between young people and their parent they do not share everything. It seemed that this sort of experience was something that they might share together. Even if the weather didn't permit creating an image or going back to a memory of a comfortable place might be equally useful.

### **8.12 Emily's parent interview: promoting engagement**

Emily's Mum had heard about mindfulness before in connection with her work. She was a retired nurse specialist and had had a psychiatrist patient and they spoke a lot about mindfulness.

*'Basically because –just talking about her job and stuff. I'd suffered from post-traumatic stress previously after an assault at work. That's how come I know about mindfulness.'*

She had found the information useful. When asked about any differences she had noticed in Emily since she had been attending the group, she replied

*'She talks about it. She says she finds it difficult but I think that's because it's a group session. So when she's been coming home we've*

*been talking about it and we've been chatting and saying how useful it is to use it to sort of make – calm yourself down – be positive about things. Em but she does find it difficult and I think it's their age as well isn't it.'*

She continued

*'They are young but she does seem calmer. She says she doesn't but she does seem a lot calmer and at least she's talking about the tools that she has learned really and the understanding of relaxation.'*

It was good to know that Emily had talked about the sessions to her mother and her mother had also known about mindfulness which could facilitate the conversation. Kaiser Greenland (2010) relates how she uses mindfulness meditations with her children. Additionally as Bohhi (2013) has outlined, mindfulness is not commonplace in the West so where it is it can help develop the culture. Emily's mother had also added some observations – that Emily had some difficulty with groups and that she had noticed that Emily seemed calmer. Mace 2008 lists this latter point as one of the benefits of mindfulness. Her mother had not said whether being in a group seemed any easier for her but it is interesting to note that Emily's score on the peer relationships SDQ sub-scale had improved.

Emily had been absent on the day that we had gone to the park where the young people had found this useful. We discussed the session and Emily's Mum thought she would do something like that with Emily – establishing that she was willing to take on such ideas.

Asked about her own experiences of mindfulness Emily's Mum said,

*'I've tried it before. I do it when - I have triggers to the assault so I'll do it when the – sort of - when I anticipate – I can anticipate a trigger so instead of avoiding it I use it to sort of cope and not get all anxious and have the flashbacks and stuff. So that's when I'll use it and I'll also talk to Emily about it and my other daughter when they are up in the air and stressed to bring them back down.'*

The above comment clearly shows that Emily's Mum uses mindfulness herself and shares this experience with her daughters. Further discussion revealed Emily's Mum's perception:

*'Em I think that because of what's happened to me through my career and stuff. It's something that I have developed and I just do it as you go along- it sort of becomes a habit - the girls have picked up a little bit on it because – an example – if someone is angry or road rage and stuff – their Dad sort of calls them for having road rage and stuff where the girls will be sort of mindful that you don't know what's happened in that person's day and you don't know what they are feeling and that's what you've got to think about and der der der they look at things differently. They are very - they are both very tolerant of people because they think deeper than the surface really and it's just something that we do - but he does it a little bit but he is more of a man's man.*

This further illustrates how the Mum promotes a sort of culture of mindfulness in the family. She acknowledges that their Dad isn't usually of that frame of mind but he is also included *'he does it a little bit'*.

The question about any differences in family life produced the following response,

*'Yes. Even though Emily's a lot better since she has been to the Centre on the whole and she has done a lot of sort of one-to-one counselling at CAMHS and stuff but before she was always a very calm child it was the high school that made her anxious and all the rest of it and her physical health. Emily's got psychological problems that she deals with but she's also got physical problems which it was the physical ones and going to the high school that triggered the psychological ones'.*

Emily had found the transition to high school very difficult. Her Mum reported

*'What she was scared of – and one of the CAMHS workers got it out of her – was the way they treated Martha (her sister). She didn't want treating the same and she was very frightened and she could see the pattern was developing really and she didn't feel safe there so'.*

From personal observation it seemed that her psychological problems seemed to have abated. Her Mum confirmed that she was now discharged from CAMHS. However it seemed that there had been a catalogue of events that had led up to her difficulties:

*'She started off having counselling at the hospital because she was diagnosed with epilepsy and we were not allowed to use the word. And then she got glandular fever - chronic fatigue and her health just deteriorated quite quickly so they kept seeing her and then the high school started putting pressure on her because she was off school but they were still expecting her to be a high achiever – which – she wasn't in school – she wasn't well so it just got a little bit out of hand. – that's why she was under a psychiatrist as well'.*

We agreed that considering these events she had done brilliantly and her Mum added:

*'Yeah we tell her she's very resourceful and she is a tough cookie you know she's coped really well with it she has'.*

Apparently there was more to the story. There had been a car accident returning from the new high school where she had gone for a visit and to get her uniform – she had bumped her head which had led to her *'starting having fits'*. On the day she had already been quite anxious:

*it was like being at a football crowd – you know everyone was on top of each other type of thing. So that's how it all started that was her first experience of high school'.*

Harris and Sargent (2011) discuss how traumas can come to be associated with other events – and for Emily multiple things were happening at the same time. McDannald (2008:2) describes how the anxiety response *'might come to be elicited by innocuous events through associations with traumatic events'*. Thus placed in this context, Emily's issues with high school do not seem difficult to understand.

Emily's Mum did think that mindfulness would be a useful intervention for other young people. She said

*'I do. I think youngsters – and it's something I feel really strongly about – teenagers these days have far too much pressure put on them. For their exam results you know – peer pressure you know – we had peer pressure when I was at school but it was nothing like it is now – you know - and the teachers they're under pressure for grades and they bounce it back to the kids and there is just too much pressure on them. And I know there is a lot of children that's got eating disorders in the school you know – control and all the rest of it. I do I just think it should be part of the curriculum. I do because there's so many messed up kids isn't there?*

Emily's Mum's views were quite critical of the educational system but in view of Emily's story and also the fact that her older daughter had been affected by the pressure at school, this is understandable. Her reference to children in the school with eating disorders was also reflected by CAMHS referrals (and in fact 'Paula' who dropped out after the first session had been one of these young people). She added:

*'It's a shame and I think there's messed up kids for other reasons but education is causing a lot of it'.*

We agreed that stress levels in young people today were higher than those of the 1950s (Twenge 2000, Bor et al 2014) and acknowledged that for many youngsters who attended the Centre within a few weeks this provided a certain measure of respite from the pressures of high school and they managed better. Emily's Mum continued,

*'Yeah it's awful. The school find me quite difficult because I'm vocal you know and I tell them that I do think they have got a lot to do with it. Okay there are physical problems but you're putting too much pressure on the kids and Emily has seen Martha who is older, crumble and go to pieces and she doesn't want that you know. Both the girls have been told the*

*same you just try your best. I don't expect you to make yourself ill, stay up nights studying, not go out and socialise because you have got this that and the other to do you just try your best whatever that is but then you have got school saying A's are only good enough and there're not.'*

Having learned something of the context that fitted with her daughters it was perhaps not surprising that she had developed this attitude. It also seemed clear that both girls were intelligent ('A's are only good enough') and this was likely to have influenced the school to put more pressure on for them both to attend and achieve. It becomes clearer how it 'just got a little bit out of hand'.

Emily's Mum did think that mindfulness should be a school subject:

*'So I do think it should be standard like sex education. They put sex education in to stop teen age pregnancies but they are actually causing mental health issues in the majority of the kids'.*

We discussed the point that some young people were saying mindfulness was useful while others found it not so helpful. It really was a matter of practice. Emily's Mum had a view on the age factor of the young people

*'Yeah and I think as well they are at that age - therapists where – they're more susceptible to it because they do see and stuff don't they but they are at that age where – and society – where mental health is a big taboo but if you look after your mental health you are going to flourish further on and I just think it should be instilled into people - it's an important issue'.*

Emily's Mum appeared to have experienced more than the average contact with CAMHS and thus had strong views about mental health and attitudes towards it and she did seem to think that mindfulness would help. All in all Emily's Mum felt that,

*'I think it has been positive for Emily because she has been more open about her feelings. Because she – she's very she keeps a lot in – you have to drag it out of her she is very private so you know we have*



*spoken more about it because I've got a little insight we've discussed it and I do think it's a good thing especially for them in the Centre. It's just a shame that they don't put it into ordinary schools isn't it?*

We agreed that the young people have got to want to do mindfulness. Emily's Mum felt that there should be - *'they need to be more supportive for children – for teens'*.

Funding is frequently an issue although pressure to achieve remains but she said,

*'Yes they just wait for them to crumble in adult life' and laughed at this before adding, 'and then they find out 'oh yeha it was when you were at school'.*

Emily's Mum had very much promoted mindfulness within her family and had engaged her daughters in this. They had not had very positive experiences in mainstream schools and this seems to have influenced her view. However other parents had also had some issues with the educational system as it stands. It would seem that gaps do exist perhaps particularly where problems may not be obvious at first glance.

### **8.13 Rounding up**

The aims of the research which link with the above '*stories*' concern developing a better understanding of what might be done to help parents support their young people in mindfulness. The parents' views of the mindfulness experience on the young people are therefore important. These are discussed below with some consideration given to further therapeutic programmes.

The transcript was analysed in the same way as the focus group (see Chapter 7) using the thematic analysis method described by Gibbs (2009). Dividing the transcripts up into different sections produced six main themes. These are discussed below under the relevant subheadings. The individual challenges faced by the young people, although not specifically discussed here, do come to light in the conversations. Overall this did show that between them the young people faced a number of difficulties which were also reflected by their families concerns

about them. Some of the headings are similar to those identified in the focus group and these will be discussed first.

### **8.14 Experiences of mindfulness**

All of the parents had received information about the sessions and three of them (the parents of Emily, Jack and Matthew) had heard of mindfulness previously. Clearly the parents of the other two young people had required more of an explanation of mindfulness which the others had not. Katie's Mum had not known about mindfulness but had not asked further questions. However it is interesting that Jessica's Mum had not known about mindfulness either - although she had hazarded a guess. She had been curious and asked for further information and after a very short hands-on experience she had remarked '*I'd stay there for ever*'. Clearly she had found the experience positive. Jack's Mum had described being '*made up*' when she heard about the sessions. Matthew's Mum talked about mindfulness being '*empowering*' for her and Emily's Mum remarked '*I use it to sort of cope and not get all anxious*'. These latter comments were all positive comments and in the case of the three families, who were familiar with mindfulness, gave some indication of the likelihood of them pursuing the practice.

### **8.15 Continuing practice**

Clearly two of the parents were not in a position to undertake this. Jack's Mum appeared to be the most proactive in this respect '*But what I need to do is to encourage him to do it more at home as well to continue it*'. Emily's Mum seems to have promoted this in her family '*it becomes a habit the girls have picked up on*', and Matthew's Mum stated '*Yeah definitely*'. '*I think it makes us both think more think about what's going on in the here and now*'.

### **8.16 Benefits**

All of the parents (except Katie's) had noticed some positive changes in their young people. Emily's Mum stated, '*she does seem a lot calmer and at least she's talking about the tools that she has learned*'. Jack's Mum commented, '*he does seem to be getting on with people better*'. Matthew's Mum added, '*he did feel it was helping him*' and Jessica's Mum said '*I have noticed a definite improvement*'. It was only Katie's Mum who reported that things were '*Just the same - or if not*

worse'. She appeared to be having the most difficulty in engaging with her daughter. There would seem to be a number of factors which need to be considered and it cannot be stated that these positive results were due to mindfulness. However it would seem that mindfulness may at least have made some contribution.

### **8.17 Talking to parents**

One theme seemed to be how much the young person had '*talked*' to their parent about the group. Emily, Jack and Matthew's parents all reported this had been the case while it was absent in the cases of Jessica and Katie. This may have linked with the parents' knowledge of mindfulness as these were the same three families who had known about mindfulness previously. Looking at the SDQ results it is interesting to note that Emily and Jack scored best in this respect (see Chapter 6). Unfortunately Matthew's score was incomplete and thus no comparisons could be made – however his final score did not seem too bad as compared with the final scores of the rest of the group.

This point alone would seem to be a good reason for more inclusion of parents from the beginning. This lack of talking about the programme need not have been due solely to the young people. Had the parents had more information they might have been in a better position to help and encourage. Jessica's Mum for example seemed to want to help her daughter as much as possible. It seemed somewhat irrelevant whether the young person had engaged with their parent to explain mindfulness as this ought to have been a task more suited to the researcher. Originally it was hoped to include parents in the introductory session but the move to an educational establishment made this difficult to organise. The introductory session became a session enabling the young people to decide whether they wanted to join the group and following this it no longer seemed appropriate to bring the young people back with their parents for a further introductory session. The need to complete the project before the long summer holiday was also a factor in the decision to go ahead without a further introductory session with parents. Parents of pupils attending secondary school are not normally part of the school community but do attend events from time to time. Further consideration needs to be given to how best to include parents in any future groups. However,

despite the thought that had gone into preparing a written account of just what was involved (as well as previous drafts being corrected as stipulated by the NHS ethics committee), the information sheets seemed to be a little redundant in view of the impact the 'live' session with the young people.

### **8.18 Mindfulness in schools**

Four out of the five parents felt it would be useful to deliver mindfulness programmes to young people. Only Katie's Mum felt that '*I can't answer that*' – again had she had further information this may have helped her answer this question. Under the '*other comments*' theme Matthew's Mum emphasised that she felt it was good to introduce mindfulness at a young age. Emily's Mum wanted to emphasise the positive effect she felt mindfulness had had on Emily and Jack's Mum had been keen to know about future groups.

### **8.19 School issues**

The remaining theme was about schools and education in general, how pressure is put on young people and how some young people cannot handle this very well. There was also concern from Jack's Mum about changes which would be likely to affect the Centre. Although the details were unknown this was likely to affect Jack and potentially other pupils. There are issues in the educational system which can be difficult for vulnerable young people and while mindfulness may be helpful to some there will always be other things that need to be addressed – for example whether specific educational needs are being properly addressed. For some parents these are really important issues.

### **8.20 Different families' different stories**

There are very different '*stories*' given by the parents above. It was interesting to see the different perspectives of the individual parents and indeed there was a wide variation. One aspect is clearly the family's position in this but also the young person's individual approach. The views of Riksen–Walraven (2002) about the three domains – the parents, the child and the impact of stress versus support are illuminated in these stories. There are other factors occurring in the lives of young people some of which may not be known to the researcher. Bishop (2002) also states that it was not possible to rule out social desirability effects in his study and

suggested that future studies should take account of this. Within the group there were in fact a number of influences in the lives of the young people but it is difficult to know how one would evaluate or exclude these.

In evaluating the effectiveness of mindfulness, while it is difficult to exclude other variables, it is perhaps of note that those families who were familiar with mindfulness and who engaged with their young person to talk about it appear to be the ones who benefited most from the sessions. However it was not clear whether talking to the young people had been the most salient factor or talking to the young people about mindfulness per se. Whatever the answer it would seem that including parents at the earliest stage would promote the most positive outcomes.

## **9. Cultivating a milieu for mindfulness**

### **9.1 Overview**

This chapter considers the research and its overall findings. Firstly mindfulness is briefly referred to, revisiting its setting within a therapeutic framework and outlining something of the context of the research. The research question is then considered in relation to the design. The research findings are then discussed under relevant headings. The issue of the family inter-dependency with mindfulness is identified including some reference to wider society. This is followed by a consideration of mindfulness in schools as this is an important aspect. The chapter goes on to reflect on some of the popular views about mindfulness and how this might influence young people. There follows a discussion on the necessity of practice and some of the difficulties in maintaining this with young people. The importance of discussion to promote mindfulness with consideration of how this might be enhanced is addressed. The issue of evaluating mindfulness with questionnaires is considered highlighting the difficulty in measuring this. Consideration is given to further studies before the issue of including parents is discussed, identifying that this is a key area for reflection. The chapter concludes, identifying that mindfulness is a broader issue than merely the participants and requires a wider perspective.

### **9.2 Approaching conclusion: reviewing the steps**

This research has considered mindfulness with particular emphasis on its relationship with vulnerable young people. Chapter 1 saw how mindfulness, from its ancient Buddhist traditions, has in recent years become more prevalent in the West (Black 2014). It is particularly for its therapeutic qualities that mindfulness has become popular (Segal et al 2002, Kabat-Zinn 1994, Hayes et al 2005, Linehan 1993 and Shapiro and Carlson 2010). However, mindfulness is not an easy concept and thus Chapter 1 discussed something of the essence to provide some measure of explanation. As highlighted previously, although we need not adopt the religious aspect, mindfulness does involve a different way of thinking. Nataraja (2008) explains that mindfulness is essentially a right-brained activity and

although the left and right functions of the brain are much disputed nevertheless mindfulness is not our usual way of thinking. As has been identified mindfulness requires cultivating but it is not something that can be forced (Puddicombe 2011). However it is in relation to its therapeutic qualities that the research aimed to consider how mindfulness might be used with vulnerable young people. This chapter will consider the findings after briefly recapping on the aims and the process of the study.

There is an evidence base for mindfulness in neurology and psychology but this is less well established with young people (Burke, 2010, Kaiser-Greenland 2010 and Coholic 2010). Thus there is a need to consider how mindfulness, with its claimed (as well as evidenced), might fit with vulnerable young people. The aims of the study were to investigate this, explore the young people's engagement, their forms of support and the impact mindfulness would have on them.

The research was conducted during a time of change and re-organisation presenting challenges to the research. The culture within the organisation became far more bureaucratic. Mullins (2007:48) has listed one of the disadvantages of bureaucracies as '*initiative may be stifled*' and within the new conditions the research that had been planned did not fit. McRoy et al (2012) discuss the advantages of doing research in a research-priority culture. In practitioner research challenges do arise sometimes requiring new directions. McLeod (1994) advises to expect renegotiation but for this research it was more like a '*back to the drawing board*' approach which had to be taken involving modification and new plans being outlined and instituted. Chapters 4 and 5 described how this process evolved before the final intervention which was delivered to the group of vulnerable young people in an Inclusion Centre. However the young people represented a similar population to the initial proposed CAMHS population hence the aims for the research remained the same overall.

### **9.3 Reviewing the research question and objectives**

The research sought to design and deliver a mindfulness programme suitable for work with vulnerable young people. This was achieved by a combination of reviewing the literature and personal experience of work with young people in

CAMHS, considering what had been helpful with young people of this age and ability. The CAMHS structure considerably contributed to how and when the programme should be delivered. The Ethics Committee's views necessitated some changes. The pilot group needed some modification due to organisational changes. Finally further changes needed to be made and the main group took place with a similar client group but in an educational setting.

The second objective had always been a primary purpose as without evaluating the experiences of young participants nothing would be learned. There is a continuing need to provide evidence-based practice. A single-case evaluation was employed using outcome measures before and after the sessions. A focus group (discussed in Chapter 7) was also held, the dialogue transcribed and a thematic analysis was conducted.

Additionally the research sought to gain a better understanding of how parents might support and interact with their children in this respect. Parental support, as discussed in Chapter 2, is a major factor in child mental health and thus it was important to understand how this might be influenced. Individual semi-structured interviews were held with the parents (discussed in Chapter 8) to gain their views and it became clear that parental involvement impacted on the young people's experience of mindfulness.

The research was designed to be of mixed methods both qualitative and quantitative. It was approached from a relativist social constructionism stance (Harper 2012) considering the world of people's experiences (Schwandt 1994) - not only the views of the young participants but also those of their parents. The other aspect to the research was the single-case evaluation method.

Questionnaires were used before and after the sessions to '*evaluate client progress*' (Kazi and Wilson 1996:700). This approach to the research required a pragmatic stance. As a method of evaluation this method has merit as changes can be noted in the before and after period. However this was not a case where behavioural occurrences were being counted and it was a much more subjective viewpoint that was measured. Therefore the nature of the questionnaires used requires particular consideration. The three aspects to the study offered a certain



measure of triangulation a technique advocated by Denzin (1978) for '*validating data*' and as proving '*methodological rigor*' (King and Horrocks 2010).

Two further objectives were identified. It was always envisioned that the intervention would have a therapeutic purpose and therefore gaining a better understanding of how a mindfulness intervention might be used was important. There is increasing demand placed on services and therefore it seems appropriate that such an intervention should be available to young people having a range of vulnerabilities. This would include those at Tier 1 and 2 and as such would extend to special educational settings. This research contributed to this aim.

The final aim was to consider the impact mindfulness may have in terms of potential future service delivery. There are a number of issues which deserve further thought. A significant point is the position of the parents and this research highlighted their importance. Consideration should also be given to the length of the sessions and the emphasis placed upon home practice. The findings are discussed below.

#### **9.4 Family inter-dependence in developing mindfulness skills**

The findings of this research indicate that the position of the parents can promote mindfulness in the young people. Looking at the parents' stories and their situations there was a clear link between the parents' knowledge of mindfulness and their discussions with the young person in promoting mindfulness.

Winnicott (1956:303) made the statement that '*there is no such thing as an infant*'. By this he meant that an infant cannot survive alone and thus there is interconnectedness between a young child and the family. Semple et al (2006:143) describe young people as being '*more embedded in their supportive environment systems*'. Clearly this need reduces as the child grows but it remains to some extent. The issue is wide and the development of a personality is a complicated matter. Dallas (2007) discusses '*making meaning*' in families describing how attachment, systems theory and narratives work together to create family systems. As outlined in Chapter 2 all experiences count in some way towards the development of individual youngsters as they mature as well as the interdependence of families. This viewpoint was very much evident in the

research. The family support system for young people as identified in this research, can promote better mindfulness outcomes in the young people. Knowledge and interest in mindfulness together with a preparedness to engage in discussion were key findings.

Parents are important in creating the right milieu to encourage mindfulness. This also connects to culture and how easily the concept of mindfulness sits within the family but also the interest the parent takes in this with the young person. Omer (2004) has identified '*parental presence*' as an important aspect of parenting. Clearly there are variations in the amount of engagement any parent has with their child and as Howe (2003) describes the relationship is a '*dynamic one*' requiring interaction on the part of the parent and the young person.

Teasdale and Chaskalson (2013) refer to mindfulness as something that should be '*tested*' and '*checked out*' by people. Where this can be done in a family setting there is both encouragement and healthy questioning which is more likely to place a value on the method. However there is also a wider aspect - the question of culture, the attitudes of the family and the wider community in which the individual has his or her identity. Mindfulness meditation may be one thing to people living in a mainly Buddhist culture, another to people living in the West. Bodhi (2013) has pointed out that most people in the West do not have the cultural background in which mindfulness is an integrated part. This research showed that the young people in families unaware of mindfulness did not do as well as those from families who placed value on mindfulness. Mindfulness is about being; people need to allow that time.

*What is this life if full of care*

*We have no time to stand and stare      (Davies 1911:15)*

Thus there has to be a '*preparedness*' to accept mindfulness. This research identified that where this was there the young people benefited.

As mentioned in Chapter 1 there has been increasing interest in mindfulness over recent years which may have paved the way for further interest. Gray (2010) and also Twenge (2010) have established that there has been an increase in '*extrinsic*'

goals in recent years. Intrinsic goals are more about self-development and are altruistic – much in line with mindfulness goals - whereas extrinsic goals tend to be more about material possessions or status. There is no doubt that value is placed on such things as '*multi-tasking*'. Hasson (2013:6) refers to our '*rushing around*' '*trying to be somewhere else*' while Taylor (2012) speaks of our constant need for '*distraction*' from our '*thought chatter*' needing to have the TV on, or otherwise be engaged in the internet, the phone or a game console often more than one activity at a time. Living in such a culture is it any wonder that as Gunaratana (2002) claims 90% of the time we are tuned out from what is really going on. This would have been a familiar state of mind influencing the young people in this research. Cultivating a space for mindfulness is therefore no easy task and for this to take hold in a family they would firstly have to be familiar with mindfulness and assign it some value and indeed this research reflected this point. However, some have speculated that society is beginning to become more intrinsic in its aims perhaps by the process of homeostasis (Shoham 2006) - the theory that things balance themselves out. Etzioni (2007:83) maintains that societies tend '*to lose their balance*' moving to correct '*conflicting core values*' – a paradigm shift as it were. Thus if society has moved so far in the direction of pursuing material goals then at some stage it must re-balance and tilt back in the opposite direction embracing more intrinsic goals. If this is in fact the case it would fit with the interest in mindfulness. There would seem to be more examples of people advocating qualities reflected in mindfulness – hence the year by year increase in publications of this type and various individual authors such as Christina Crook (2015) who advocate qualities such as '*presence*' and '*peace*'. This would be good news for future mindfulness research as society may find it an easier concept which would reflect on individuals taking part.

Nevertheless society takes time to adapt (consider the process of evolution) and for young people it is not only the family who are important, the school environment is also a major part of young people's lives. Rutter et al (1979) estimate '*fifteen thousand hours*' as the average amount of time pupils spend in school. This is a substantial amount of time and the school environment makes

considerable impact on young people. Schools which were sympathetic to the concepts of mindfulness could promote this in the young people.

Returning to the parental environment, parallels can also be drawn with the issue of homework. Dodge (2014) claims that parents can create an environment that is conducive to children getting their homework done and also that children who spend more time on homework on average do better academically. Kristof (2015) in an article in the New York Times discusses the Asian advantage that Asian-American young people have. This is thought to be a combination of setting the right environment to do homework and parents having higher expectations of their young people. Okayaki and Bingham (2010) also reflect that similar results are found where parents can see themselves as equal partners with teachers. Thus it is largely a matter of attitude and readiness but also there would seem to be further factors. Nowadays schools are large and collaboration between parents and teachers is no easy task. Griffin and Tyrrell (2004:122) cite the '*law of 150*' as the optimum number for a community. Larger establishments made interaction more difficult and considering the difference in mind-set that teaching of mindfulness may involve further consideration is needed. However in this research the Centre was small and potentially had an advantage over most schools which are far larger than 150. A presentation on mindfulness was given to all staff and many of them were interested. This presents future opportunities as is reflected by the commitments of the teachers to run a future group should this be something the students wanted.

## **9.5 Bringing mindfulness into schools**

The role of schools is a point requiring further consideration in relation to teaching mindfulness in main stream schools. Recently the Government has promoted the idea of mindfulness in schools. The Mindful Nation UK was set up with the following remit: to review the evidence on mindfulness, develop policy recommendations and provide a forum for discussion within parliament. In October 2015 the Mindfulness All-party Parliamentary Group produced a report recommending that mindfulness be taught in schools. One of the points contributing to this decision was the evidence (Diamond and Lee 2011 and Sanger

and Dorjee 2015) that mindfulness had been shown to enhance executive control in children and young people.

The issue of teaching mindfulness in schools was a question put to the participants in this research. Interestingly the views of the young people were mainly negative although their parents' views were mainly positive. This research identified that many of the parents were already familiar with mindfulness and another was in favour of a more '*nurturing*' approach thus they could identify the potential benefits that such a mindfulness approach may bring. As identified by this research, the young people struggled more with the concepts of mindfulness and it was not easy for them to take a wider perspective on this. Also they all had had a poor experience in mainstream school – typically seeing it as a place of '*disruption*' - which may have impacted on their attitudes and views. Additionally (as discussed in the next paragraph and also in Chapter 2) they were teenagers at a period in their lives characterised by rapid changes affecting their sense of identity and views on life.

A number of points identified in this research may well be useful for consideration for schools planning to deliver such programmes.

- These would particularly include involving parents given that parents can help create a home environment conducive to mindfulness.
- Consideration of the contextual significance of mindfulness in a society where it is largely unfamiliar.
- The age of the young people as different activities are more suited to different ages.
- The structure and timing of the sessions would be points to consider. Younger pupils may require shorter sessions. Also planning sessions to avoid too many breaks.
- Providing an availability to have a brief '*check in*' session early in the day would also seem advantageous in facilitating the '*normalisation*' of mindfulness practice.

## 9.6 Unrealistic expectations?

Another finding of this research identified that unrealistic expectations can sometimes arise which was the case for the young people. Bertin (2013) states that the concept behind the MBSR programme can be unintentionally misleading. People might assume that in eight weeks all your stress problems can be fixed. This may well have influenced the belief some of the young people had when they started on the programme. In reality MBSR does not actually change anything but over time with continued practice people can learn to cope differently with stress.

Thus to notice any changes one would have to maintain the practice. However for young people who are going through '*such rapid growth*' (Burton 2014) there are other things which may be more important. Balaguru (2013) discusses some of the challenges facing adolescents and, with hormones surging and emotions changing rapidly, attending to mindfulness would require some steadying context. This research has identified that parents can provide this and where this was present better results were reflected in the young people.

Bertin (2013) states that it is not a '*quick-fix*' like a dose of antibiotics. This is a difficult point to grasp and thus as Kabat-Zinn (1994) suggests it is necessary to have some '*vision*' about why you are practising. In the West there is a strong cultural belief in medical means to overcome distress – taking a pill for example. This view extends to other aspects of life where the '*quick fix*' solution has more appeal. Harrison and Huntington (2000:46) discuss the '*struggle between short and long term*' and state that '*the former will win unless a value intervenes*'; thus to persevere when things become difficult people need a value, a purpose or goal, Kabat-Zinn's '*vision*'. This seemed to be difficult for the young people in this research.

However in view of the fact that these young people were teenagers in Western society this view would seem understandable. Gilbert and Chodden (2013) have identified three major emotional '*drive*' systems operating in people. To remain healthy there has to be a balance between the three systems. The nurturing system is often the one that is in deficit and this is the system that can benefit from mindfulness. The aspects of '*loving kindness*' and compassion can nurture people;

this is particularly when one can be kind to oneself. However Western society as a whole tends to value the materialistic drive system more than any other; pursuing material goods and positions of status. Teasdale and Chaskalson (2013) describe this '*unquenchable thirst*' struggling for possessions, the '*tanha*' or second noble truth which brings about '*dukkha*' together with a failure to develop compassion. Also the other main emotional drive comes into play – the fight or flight system. With the drive for '*tanha*' comes the fear of not achieving. The young people in this research all had some vulnerability and at their age when self-consciousness becomes strong the '*fear*' of not achieving would be present. When the benefits of mindfulness did not materialise quickly this contributed to their disappointment.

The research finding has enabled a deeper reflection on how to work with teenagers. At this age young people are particularly emotionally vulnerable with their own issues of '*angst*' and their '*black and white*' thinking patterns as described by de Bruin et al (2011), when they are trying to establish who they are and where their allegiances lie. Taylor (2012) points out that adolescence is a time of strong ego development with a focus on identity and much self-consciousness. Although young people may make a stand to establish that they are '*different*' - perhaps in following a teenage mode of dress or hairstyle that makes a statement of difference yet they want to belong (Humphreys and Ruddle 2012). However teenagers are unlikely to stray too far from the basic values that surround them and although the '*nurturing*' system is frequently given a low priority in society their family environment is important. Thus we return to the inter-relationship with their parents who do provide the nurturing and something of the identity. This research has shown that where mindfulness was also part of the family value the young people fared better.

Also this research highlights the point that the benefits of mindfulness have been popularised to the extent where they may raise false expectations. Pickhart (2012) in an article in *Psychology Today* discusses how adolescence encourages the notion of entitlement. Reflection on the current values in Western society echoes this trait which seems to promote expecting to gain possessions, status or other achievements as some sort of right and without much effort. Lehman (2016) in an article on the same subject entitles it '*I want it now*'. With such attitudes being

common makes it more understandable why young people might expect to get instant results. Swart et al (2015:53) describe how '*mindfulness is surrounded by much hype in Western psychology*'. This may additionally be why the programme wasn't up to the '*expectations*' of some of the young people. Young (2015), in an article in *The Telegraph*, describes how she had struggled with meditation having been told that five minutes meditation a day would alleviate stress. Again it seems that she had missed the long-term nature of commitment. It is not just teenagers who may struggle with this. Thus there is additionally a popular view that mindfulness can achieve perhaps extrinsic goals. However if schools were to reflect a more embracing view of mindfulness this may well influence future attitudes and generally more understanding of mindfulness in society.

Young (2015), goes on to interview three people prominent in the field of mindfulness and discusses the issues with them. Puddicombe, (2011) comments that people often lose their enthusiasm when '*nothing*' happens. He suggests cultivating the habit without trying to force anything. Chaskalson (2011) suggests two reasons that meditation may be difficult: one is that people try too hard to empty their mind and also they feel too busy. Oliver, (2015) explains that mindfulness is one way to develop the skill to pause our lives but the practice is not for everyone.

Moreover Gilbert and Chodden (2013) illustrate that there are those who cannot access mindfulness. Those who have had painful memories may not be able to face their own memory and thus the last thing they would want to do would be to accept what comes. As they state,

*'People who feel overwhelmed by distress in themselves and others tend to turn away from it' (Gilbert and Chodden 2013:109).*

As Maslow (1943) described, some things need to come before others in a hierarchy of emotional needs. The findings of this research identified that many of these young people were struggling with their own issues and sometimes these can cloud any benefits that may otherwise be possible.



## 9.7 Mindfulness meditation practice

The research highlighted the difficulties of quantifying mindfulness practice when it could not be established just how much they had engaged in exercising. Bishop (2002:72) states that '*time spent practising meditation correlates with reductions in mood disturbance*'. Again Huppert and Johnson (2010) identified that those who practised more reported increased benefit. Because it was not known just how diligently the young people had practised mindfulness this could not be quantified. Biegel et al (2009) undertook an MBSR intervention with a clinical sample of adolescents. Their report found that more time spent in sitting meditation predicted improved clinical-rated functioning and declines in self-reported depressive and anxiety symptoms. Semple and Lee (2008:73) compare practice in mindfulness by the analogy '*we cannot learn to swim without getting in the water*'.

Family values, support and culture may promote or inhibit practice. If the young person belongs to a peer group where it is not '*cool*' to meditate the chances of mindfulness being fostered are poor. The results for this research confirm the idea of family support enhancing outcomes and thus the suggestion of more inclusion of parents to support home practice and strengthen treatment efficiency.

Given that practice is so important, maintaining it needs some consideration. Klein (2010) suggests reasons why practice may be difficult. Some reasons relate to people's attitudes to meditation for example - that it is a '*self-centred*' thing to do, or because it seems too religious. Jack's Mum (see Chapter 8) was clearly '*put off*' when she attended a Buddhist-led meditation. Klein suggests four reasons that might make practice difficult: '*discomfort*', '*no time*', '*mind won't get quiet*' and '*boring*'.

Meditation was clearly difficult for the young people in this research as they expressed in citing the challenges. Marcia also clearly expressed this in her experience of mindfulness '*my mind is just too busy to be able to be mindful*'. Minds are like this but we do not usually notice until we begin to meditate. Klein (2010) states that minds do not get quietened by willing it or making the effort to quieten and disentangle ourselves from the constant '*thought chatter*'. Klein (2010) acknowledges that meditation is actually quite boring. This was one reason that

William gave for dropping out, '*Getting boring now*'. Mindfulness remains a difficult concept for teenagers to understand. Some do, but inevitably there will be those who do not. More familiarity – perhaps longer guided practice sessions - may have been helpful, continuing support in the family and even perhaps a short mindfulness '*check in*' session on a regular basis at school. Lally et al (2010) estimate that it takes 66 days before a repeated action becomes a habit. Perhaps such repetition could be a solution to the difficulty with practice. Such a process would contribute to the normalisation process (May and Finch 2009). Although as they state: '*the production and reproduction of a material practice requires continuous investment by agents*' (p:540). Schools would be well placed to implement this. Given these difficulties in settling to mindfulness perhaps it is no surprise that practice is not all it could be.

## **9.8 Promoting discussion**

The focus group highlighted some positive changes (see Chapter 6). For young people who are struggling with challenges, positive results are encouraging. However this research identified that the discussion within the group appeared to be less than optimal. One of the advantages of a focus group is that it allows people to interact with others exploring and clarifying experiences (Goodman and Evans 2010). Young people stand to learn from discussing their individual experiences of mindfulness. Segal et al (2002:92) advocate that '*feedback should be the main vehicle for teaching*'. Kabat-Zinn (1994) advocates similar ideas. In this group the exchange of conversation was not ideal but was substantially better compared with the pilot group. The young people in the pilot group suffered with social anxiety and had understandably found it difficult to talk. As Baker and Warren (2015) suggest, promoting conversation is about creating the right climate and skills. Perhaps more could have been done to facilitate this - for example including aspects to promote self-esteem such as the work of Kelly and Sains (2014) although this would have impacted on the number of sessions.

## **9.9 Evaluating mindfulness with questionnaires**

Having reflected on the findings it remains difficult to evaluate mindfulness. Even brain scans (Davidson 2004, Lazar et al 2005) would not necessarily tell us how a

person was functioning. Baer (2011) cites the commitment to evidence-based practice in psychology as strongly linked to a scientific foundation. The use of validated questionnaires measuring mindfulness was part of that commitment. In employing a single-case evaluation method, the research attempted to use questionnaires to establish whether there had been any changes during the research period. It seems appropriate to reflect on whether the questionnaires were appropriate for this group.

Grossman and Van Dam (2013:234) discuss '*integrating strikingly unfamiliar concepts into Western paradigms of psychology*' and how this can cause '*pit falls*' in questionnaires attempting to measure mindfulness. There seems to be no easy answer to evaluating mindfulness in this way.

Although not designed to measure mindfulness, two of the questionnaires used - the HoNOSCA (Gowers et al 1998) and SDQs (Goodman et al 1998) - did seem to be useful in this respect. Both had scores in different areas - two of which correspond with qualities attributed to mindfulness. These questionnaires seemed to have advantages over the CGAS (Gould et al 1998) which provides a more general overall idea of functioning.

However they remain basically self-report questionnaires and thus present certain risks. Being honest, that is circling answers which relate to themselves and not just randomly or choosing those which may please the researcher is one point. Understanding the questions in the spirit that they were meant is another aspect which may prove difficult for the young people (Matthew's individual attempt, before being assisted by the teacher, had to be torn up).

The FMI (Walach et al 2006) (see Chapter 6), seems to have been a difficult form for the young people to complete, although not for the adults. Perhaps it is more relevant to adults as Baer (2011) states that its original design was for use with adults on retreats. Malinowski (2008:158) suggests that '*direct declarative access to this experiential quality may not be possible*' and that there is no solid basis for measuring mindfulness. The same item of a questionnaire may have very different meanings to somebody who actively practises mindfulness.

Further consideration should be given to the length of the questionnaire and the wording. Not only might the concepts be difficult but some young people may not understand the words. Other measures seemed too long – for example the Kentucky Inventory of Mindfulness Skills (KIMS) (Baer et al 2004) has 39 items as has the Five Factor Mindfulness questionnaire (FFMQ) (Baer et al 2008). No doubt these questionnaires may have been more comprehensive. Retrospectively the Mindful Attention Awareness Scale for Adolescents (MAAS-A) (de Bruin et al 2011) may have been a better option. However, (as discussed in Chapter 6) de Bruin et al identified a number of relevant points including the level of intellectual functioning – the fact that some participants showed no improvement - those not familiar with mindfulness appeared to score higher than those who were more familiar with it. These are all points which require further consideration. Whether the outcomes were influenced by intellectual functioning, teenage years or awareness of mindfulness there is clearly a more complicated relationship to choosing a form to measure mindfulness.

It remains difficult to evaluate the PSS (Cohen et al 1983) results which were contrary to what might have been expected but it seems likely that other factors – the forecast changes and accompanying rumours (as discussed in Chapter 6) influenced the outcomes. It may be a useful measure but further consideration needs to be given.

These were all validated questionnaires. Three of them, the HoNOSCA, SDQs and CGAS, were specifically designed for young people and are regularly used in clinical practice. Although not specifically for mindfulness the HoNOSCA and SDQs were considered appropriate. The other two questionnaires, one of which was designed to measure mindfulness, seemed more appropriate for adults. Thus this research identified the difficulty of measuring mindfulness. However it is of interest that Huppert and Johnson's (2010) study did not identify any significant increase in mindfulness following the mindfulness sessions.

### **9.10 Considerations for further study**

Having reflected on the findings, the following points are relevant. Given a further opportunity to run such a group it would seem prudent to include parents from the

start. Burnett (2009) has also considered including parents 'in the loop'. They should be part of the introductory session – something which was originally planned but which for reasons of practicality did not take place with the main group of participants. Also it would seem in order to provide more validity the size of the group should be larger. Kempson (2012) has considered boys and girls separately and this is a consideration although larger numbers would certainly be necessary. A larger group may have promoted much more discussion within the sessions. However, as Kasinski et al (2003:169) point out '*in the large group they (the participants) could sit silently nestled in*' and not necessarily take any active part. As discussion is an important vehicle in teaching mindfulness (Segal et al 2002, Kabat-Zinn 1994) the issues of promoting discussion could have been more carefully considered. Certain difficulties are posed with young people facing such challenges. Possibly increasing the number of sessions allowing discussion to become more familiar would have been helpful.

This research was undertaken within a 'vaguely Christian' area and it may well be that other religious groups and ethnicities may perceive mindfulness differently. However Burnett (2009) does make the point that some may be '*put off*' by the religious background. This was initially the experience of Jack's mother. However, while it is important to clarify that mindfulness does not need to be religious, many of the values it promotes are those shared by other major religions (for example compassion). Given the importance of practice in mindfulness it would be important to enhance this practice, perhaps by the provision of a personal guided CD for each participant and indeed this was provided in Huppert and Johnson's (2010) study although this would impact on the cost.

A further consideration was how the sessions should be structured. MBSR and MBCT are manualised and follow a set procedure. This research did not follow a manual although many of the elements were included with an attempt to be more age appropriate for the young people. The research had varied activities to accommodate different personalities and thus covered more than one approach. Some young people expressed a clear preference for the meditation to be guided while others found '*the voice*' '*irritating*'. Beginners are unlikely to know which method suits them best and at first would require the meditation to be guided.

Later there would be time to try other ways and choose the best ways for themselves. It would seem appropriate to consider a balance between being guided or just silence – or listening to natural sounds – such as waves. Kaiser Greenland (2010) suggests a range of different activities for young people.

Length of the sessions is an aspect for consideration. Semple et al (2006) advocates shorter meditation periods perhaps in 3-5 minute blocks. Semple and Lee (2008:76) also advocate shorter periods for young people – for example the ‘3 minute breathing space’ as well as introducing games and stories, also advocated by Hooker and Fodor (2008). Dowling(2010) explains that the child’s age should indicate the length of the meditation session - one minute of meditation for each year of age. The group’s average age was 13.8 years but in view of some level of learning difficulty, mindfulness practices were around 10- 15 minutes long. Mace (2008) suggests a 15-minute period although Kabat-Zinn’s (1994) adult sessions take up 45 minutes of mindfulness practice in MBSR. Semple and Lee (2008) although varying their sessions had about 90 minutes in which to conduct their lesson. In the case of this research the session was fitted in to a school length lesson of 55 minutes duration. Unfortunately it also fell just after break and the students often arrived a little late and with their minds very much on other things. These are points for consideration. Much as it is hoped to maximise optimal conditions there will frequently be issues within the organisation that need to be accommodated.

A further finding was that continuity had influence on the outcomes. This was especially during the early sessions when participants were beginning to grasp what was involved. This became apparent when it appeared that the young people had ‘*forgotten*’ the earlier sessions when returning from half term. The choice of Monday for the sessions was perhaps unfortunate in view of the number of Bank Holidays during the summer months. This resonates with the findings of Semple et al (2006) who identified that repetition enhances the practice. Armitage et al (2012) also identify the importance of continuity. Possibly increasing the number of sessions might have been helpful. However there was also a need to accommodate both the students and the Centre. Such points often override other

considerations when research is planned. Ideally the sessions should follow on from each other providing continuity to the learning experience.

These are important considerations as is the structure of the sessions although there may be restrictions on timing, length of sessions and duration of the course. The age and ability of the participants is a key factor impacting on content. Various activities and approaches would seem to fit best with young people unfamiliar with mindfulness as was the case with this research. Semple et al (2006) claim that variety increases children's interest. They introduce several different exercises within each session. Willard (2010) also advocates variation in practice. Composition and size of the group, although needing careful consideration, would seem to be less important than promoting discussion and facilitating feedback to obtain the best outcomes.

### **9.11 Including parents**

The findings of this research clearly highlight the importance of parents. Parents' views give a wider perspective of the young person's functioning (Dogra 2002). The inclusion of parents is a significant factor whether they are active participants or not. As discussed in Chapter 1, Saltzman and Goldin (2008), Singh et al (2010), Semple et al (2006:158), Mace (2008), Dumas, (2005), MacDonald (2010), Bögels (2008) and Phelps (2010) all discuss including parents in their programmes. Clearly the situation may vary from one family to another. An interested parent may greatly facilitate this in their child. Discussing things and explaining them could be a very helpful part of the process. Doing mindfulness practice with a young person can be a great benefit. But even if the parent only brings their child to sessions this in itself provides emotional support.

This raised the question: could a better knowledge of mindfulness have increased the interest and promoted more discussion with the young people? This might in turn lead to more benefits from mindfulness. Although this remained a largely theoretical question it seems prudent to follow this line of approach. Singh et al (2010) report on their small study in which children participated in a 12-week mindfulness meditation intervention following the mindfulness intervention of their

parents. They reported increased compliance following the parent mindfulness intervention.

Including parents in the introductory session would seem a positive move. The NHS National Institute for Health Research, Briefing note 5 (2016), recommends involving people as early as possible. As this research has identified parents are important people in delivering a mindfulness programme and thus should be included as early as possible. Originally an introductory session was envisaged and this took place to include parents in the case of the pilot group. However, as discussed in Chapter 8, in the Centre the introductory session did not include parents due to time constraints and the necessity to schedule the programme before the long summer break. A further idea would be inclusion in the sessions although for some parents there may be logistical problems. At least individual contact with parents at the beginning could facilitate explanations and promote better understanding of mindfulness. Some parents may not wish to take part and some young people may not wish to engage. There is a clear inter-relationship but something of a shared interest in mindfulness is required to progress this.

## **9.12 Final thoughts, contribution to knowledge and points for further research**

The point of this research was to see whether mindfulness would be effective for vulnerable young people in a group setting such as this or within CAMHS. Also the research sought to gain a better understanding of how mindfulness might be employed as a therapeutic strategy. Overall the conclusions involve a complex picture of interdependency. Not only do the young people have a part but their parents, the environment and society all feature.

The findings and subsequent recommendations will be of particular interest to clinicians working with young people as well as some who are involved in special educational provision. It may also be of interest to service providers who are seeking to expand their range of therapeutic interventions. Chapters 4 and 5 have highlighted the shortfalls within CAMHS and the need to meet the demand. Given that funding is insufficient, points to considering different ways of working. To start



to fill the gaps, services in tiers one and two may be in a position to include mindfulness interventions in their work.

There is interconnectedness with research and the environment in which it takes place. This point greatly influenced the progress of this project, leading to a change of venue but with what essentially was the same client group. McRoy et al (2012) highlight the advantages of undertaking research in a 'research-priority culture'. Even within a climate where research is valued, pressures can arise which detract from this leading to a focus on other priorities. Bond (2010) discusses the interrelationship of agency policies, professional codes and bureaucracy while Baker and Warren (2015) discuss promoting conversation about creating the right climate. It would seem that the need for support when undertaking research is of great importance. This can extend to all levels: colleagues, managers, supervisors and ethics all of whom may have their own agendas, particularly in a large organisation. It is important to anticipate the agendas of those who might be involved and as far as possible to work with this.

The findings of this research highlight that it is not just the participants involved, the importance of families in promoting mindfulness as well as the influence of wider society all play a part. This research may have benefited from more meaningful involvement of parents. Maintaining mindfulness practice is not easy but discussion appears to be an important part of learning to be mindful.

Enhancing this facilitates the benefits. The age of the participants is significant but would not being teenagers tend to detract from serious regular meditation when it had not previously been part of their culture? Popular views on mindfulness are not always the most helpful and it would not seem surprising that there were unrealistic expectations. However often we do not have the right infrastructure to promote the best results. There remains the difficult issue of how to measure how mindful people are.

Overall the method would appear to be not too difficult to deliver and in schools there would be some support for the feasibility of taking this forward (Huppert and Johnson (2010) Kempson (2012) Burnett (2009) and Weare (2013)). This research was a small-scale sample with mixed results. It lacked randomisation or a control

group and was limited by self-report. Burke (2010), Bishop (2002) and Weare (2013) also mention the lack of randomised controlled trials in this type of research highlighting the necessity of further empirical research.

Considering the Mindfulness in Schools literature, a further point emerges: the voluntary nature of engaging. Huppert and Johnson (2010) identified a clear relationship between the amount of mindfulness practice and benefits obtained. It would seem to follow that those who are not really interested are unlikely to give much commitment to practise. As discussed in Chapter 5, the young people should want to be included – not just because their parents and/or teacher said so. Although this would seem to be an obvious point it would be difficult to evaluate as the whole research process is about consent.

Although not everyone stands to benefit from mindfulness, on the other hand some therapeutic interventions can take a good deal of time to produce positive results. Also there is the question of cost effectiveness which is borne out by this research. However as discussed in Chapter 7, training in mindfulness and personal practice is required by the session leader. This mindfulness intervention was delivered over an 8-week period. No harm was done and the young people seemed to enjoy the sessions. All in all it seemed to have been a helpful measure and if as Mary (the teacher) suggested these '*seeds would germinate*' in due course it seemed certainly worth the effort.

## References

- 42<sup>nd</sup> Street and Salford Primary Care Trust, (2001) *Under Pressure: Young People and Mental Health: Needs and Service Provision in Salford*.
- Ainsworth, M.D., Blehar, M.C., Waters, E. & Wall, S. (1978) *Patterns of Attachment* (New Jersey: Erlbaum)
- Ali, S. and Kelly, M. (2004) 'Ethics and Social Research' In Seale (Ed) (2004) *Researching Society and Culture* (London: Sage)
- Allen, M., Bromley, A., Kuyken, W. & Sonnenberg, S.J. (2009) 'Participants Experiences of Mindfulness-Based Cognitive Therapy' "It Changed Me in Just about Every Way Possible" *British Association for Behavioural & Cognitive Psychotherapies* 10<sup>th</sup> June 2009 37, 413-430
- American Psychiatric Association (2000) *Diagnostic and Statistical Manual of Mental Health Disorders (DSM-IV)*, 4<sup>th</sup> ed. (Washington D.C.: American Psychiatric Associates)
- Andersen T. (1987) 'The reflecting team: Dialogue and meta-dialogue in clinical work.' *Family Process*, 26:415-428.
- Andreou, E., Alexopoulos, E.C., Lionis, C., Varvogli, L., Gnardellis, C., Chrousos, G.P. & Darviri, C. (2011) 'Perceived Stress Scale Reliability and Validity Study in Greece', *International Journal of Environmental Research & Public Health* 2011, 8 (8), 3287-3298
- Argument Buster Web Site How to Stop an Argument (March 2016)  
[www.argumentbuster.com how-to-stop-an-argument-escalating-out-of-control/](http://www.argumentbuster.com/how-to-stop-an-argument-escalating-out-of-control/)
- Armitage, A., Evershed, J. & Hayes, D. (2012) *Teaching and Training in Lifelong Learning* (Maidenhead: Open University Press)
- Arora, S. K., Shah, D., Chaturvedi, S., & Gupta, P. (2015). Defining and Measuring Vulnerability in Young People. *Indian Journal of Community Medicine JUL-Sept, 40(3)*, 193–197.
- Aronson, J. 'A pragmatic View of Thematic Analysis' *The Qualitative Report* Volume 2 Number 1 spring 1994
- Attride-Stirling, J. (2001) 'Thematic Networks: An analytical tool for qualitative research' *Qualitative Research* Vol. (3) pp. 385-405
- Attwood, T. (2007) *The Complete Guide to Asperger's Syndrome* (London: Jessica Kingsley)

- Auerbach, C.F. & Silverstein, B.S. (2003) *Qualitative Data: An Introduction to Coding and Analysis*, (New York: New York University Press)
- Baer, R.A. (2003) 'Mindfulness training as a clinical intervention: A conceptual and empirical review', *Clinical Psychology: Science and Practice*, 10, 125-143.
- Baer, R.A. (2011) 'Measuring Mindfulness' *Contemporary Buddhism: An Interdisciplinary Journal*, 12:01, 241-261
- Baer, R.A. (ed) (2006) *Mindfulness Treatment Approaches: Clinician's Guide to Evidence Base and Applications*, (Burlington MA: Academic Press)
- Baer, R.A., Smith, G.T. & Allen, K.B. (2004) 'Assessment of mindfulness by self-report: The Kentucky Inventory of Mindfulness Skills', *Assessment*, 11, 191-206.
- Baer, R.A., Smith, G.T. Hopkins, J., Krietemeyer, J. and Toney, L. (2006) 'Using Self-Report Assessment Methods to Explore Facets of Mindfulness' *Assessment 2006*: 13:27
- Baer, R.A., Smith, G.T. Hopkins, J., Lykins, E., Button, D. Krietemeyer, J. , Sauer, S., Walsh, E., Duggan, D. & Williams, J.M. (2008) 'Construct Validity of the Five Facet Mindfulness Questionnaire in meditating and non-meditating samples', *Assessment* , 15, 329-342
- Baker, T. & Warren, A. (2015) *Conversations at Work: Promoting a Culture of Conversation in the Changing Workplace*, (Basingstoke: Palgrave Macmillan)
- Balaguru, V. (2013) *Mental Health and Growing Up: Factsheets for Parents, Teachers and Young People* (London: Royal College of Psychiatrists)
- Baldwin, L.(2005) A Clinicians guide to Audit and Research or 'Why do you do what you do?' [www.chimat.org.uk/resource/view.aspx?RID=](http://www.chimat.org.uk/resource/view.aspx?RID=)
- Barash, D. P. (2014) *Buddhist Biology: Ancient Eastern Wisdom Meets Modern Western Science* (Oxford: University Press)
- Barcham, C. (2008) 'From ASW to AMHP' *Community Care* 28<sup>th</sup> October 2008
- Barker, P. (1971) *Basic Child Psychiatry* (London: Staples Press)
- Bateson, G. (1979) *Mind and Nature: A Necessary Unity* (New York: Bantam Books)
- Baumrind, D. (1967). 'Child care practices anteceding three patterns of preschool behavior'. *Genetic Psychology Monographs*, 75(1), 43-88.

- Baumrind, D.(1991) 'The influence of parenting style on adolescent competence and substance use', *Journal of Early Adolescence*, 11(1), 56-95
- Bays, J. C, (2010) *The Mindfulness Diet: Using mindful techniques to heal your relationship with food* (Lewes: Leaping Hare Press)
- Bays, J. C, (2011) *How to Train a Wild Elephant: & other adventures in Mindfulness* (Boston: Shambhala)
- BBC News item (2005) *Small classes 'do no better'*  
<http://www.bbc.co.uk/news/education>
- Beauchamp, T.L. & Childress, J.F. (2009) *Principles of Biomedical Ethics*, 6<sup>th</sup> Edition (Oxford: University Press)
- Belfer, M.L. (2014) *Global Child Mental Health*  
<http://www.psychiatrictimes.com>
- Bell, J. (1993) *Doing your Research Project: a guide for first time researchers in Education and Social Sciences* (Maidenhead: McGraw-Hill Education)
- Belsky, J. & Fearon, R.M.P. (2008) 'Precursors of attachment security' In Cassidy, J. And Shaver, P. (Eds) *Handbook of Attachment: Theory Research and Clinical Applications* (New York: Guilford Press)
- Be Mindful on line *Test Your Stress* viewed 14.02.14  
[www.bemindfulonline.com/test-your-stress/](http://www.bemindfulonline.com/test-your-stress/)
- Benedictus, L.(2014) 'Sick cities: why urban living can be bad for your mental health' *The Guardian* 25.02.14
- Bentall, R. & Sanders, P. (2009) 'Introduction to the Straight Talking series', In Timimi, S. (2009) *A Straight Talking Introduction to Children's Mental Health Problems* (Ross-on-Wye: PCCS Books)
- Bernard, H. R. (2011) *Research Methods in Anthropology: Qualitative and Quantitative approaches* (Walnut Creek, C.A.: Alta Mira Press)
- Bertin, M. (2013) 'Mindfulness Means Nothing: Lose the Word Find a Habit' *Psychology Today* 24.06.2013
- Biegel, G.M.(2009) *The stress reduction workbook for Teens: Mindfulness skills to help you deal with stress* (New Harbinger: Oakland)
- Biegel, G.M., Brown, K.W., Shapiro, S.L. & Schubert, C.M. (2009) 'Mindfulness-Based Stress Reduction for the Treatment of Adolescent Psychiatric Outpatients: A Randomized Clinical Trial' *Journal of Consulting and*

*Clinical Psychology* American Psychological Association 2009, Vol. 77, No. 5, 855– 866

Biestek, F. P. (1957) *The Casework Relationship* (London: Unwin)

Biggins, T. (2014) (Abingdon: Routledge) '*Home-Based Treatment*' In McDougall, T. & Cotgrove, A. (Eds) (2014) *Specialist Mental Health Care for Children and Adolescents: Hospital, intensive community & home based services*

Bishop, S.R.(2002) 'What do we really know about mindfulness Based Stress Reduction?' *Psychosomatic Medicine* 64:71-84 (2002)

Black, D.S. (2014) 'Mindfulness-Based Interventions: An Antidote to Suffering in the Context of Substance Use, Misuse, and Addiction', *Substance Use and Misuse*, 49:487-491, 2014

Blair, L. (2011) *Birth Order: what your position in the family really tells you about your character* (London: Little Brown Book Group)

Blake, K., Cangelosi, S., Johnson-Brooks, S. & Belcher, H.M.E. (2007) 'Reliability of the GAF and CGAS with children exposed to trauma', *Child Abuse and Neglect*, 31 (8) August 2007, pp. 909-915

Blaxter, L., Hughes, C. & Tight, M. (2010) *How to Research* (Maidenhead: Open University Press)

Bluglass, R. (1983) *A Guide to the Mental Health Act 1983* (Edinburgh: Churchill Livingstone)

Bodhi, B. (2013) 'What does Mindfulness really mean? A canonical perspective' In Williams, J.M. and Kabat-Zinn, J. (Eds) (2013) *Mindfulness: Diverse Perspectives on its Meaning, Origins and Applications* (Abingdon: Routledge)

Boeije, H. (2010) *Analysis in Qualitative Research* (London: Sage)

Bögels, S. (2008) 'Mindfulness training for Adolescents with externalising disorders and their parents' *Behavioural and Cognitive Psychotherapy*, volume 36(2), pp 193-209

Bogin, B. (1999) *Patterns of Human Growth* (Cambridge: University Press)

Bond, T. (2010) *Standards & Ethics for Counselling in Action* (London: Sage)

Books, E. (2015) *Key Takeaways, Analysis & Review of Jon Kabat-Zinn's Wherever You Go There You Are* (London: St. Paul Press)

- Boone, M.S. (ed) (2014) *Mindfulness Acceptance in Social Work: Evidence – Based Interventions & Emerging Applications* (Oakland: New Harbinger)
- Bor, W., Dean, A.J., Najman, J. & Hayatbakhsh, R. (2014) 'Are child and adolescent mental health problems increasing in the 21st century? A systematic review' *Australia & New Zealand Journal of Psychiatry* July 2014 vol. 48 no. 7 606-616
- Bowden, J. (2011) *The Most Effective Natural Cures on Earth: The Surprising Un biased Truth about What Treatments Work & Why* (Beverly Massachusetts: Fair Winds Press)
- Bowen, S., Witkiewitz, K., Dillworth, T.M., Chawla, N., Simpson, T.L., Ostafin, B.D., Larimer, M.E., Blume, A.W., Parks, G.A. & Marlatt, G.A. (2006) 'Mindfulness Meditation and Substance Use in an Incarcerated Population', *Psychology of Addictive Behaviors*, 20 pp. 343-7
- Bowis, J. (2005) 'Foreword' In Williams, R. and Kerfoot, M. (Eds) (2005) *Child and Adolescent Mental Health Services, strategy, planning, delivering and evaluating* (Oxford: University Press)
- Bowlby, J. & Ainsworth, M.D.S. (1965) *Child Care and the Growth of Love* (London: Penguin)
- Bowlby, J. (1997) *Attachment and loss: Vol. 1: Attachment* (London: Hogarth Press)
- Boyatzis, R.E. (1998) *Transforming Qualitative information: Thematic analysis & code development* (Thousand Oaks, C.A.: Sage)
- Boyd, M.A. (2008) *Psychiatric Nursing: Contemporary Practice* (Philadelphia: Wolters Kluwer Health)
- Bradley, S.(2013) 'Don't call me crazy' (Programme about Mental Health) <http://www.bbc.co.uk/programmes/p01b86w5>
- Braun, V. & Clark, V. (2006) 'Using Thematic Analysis in Psychology' *Qualitative Research in Psychology* 3 (2) pp.77-101
- Brefczynski-Lewis, J.A., Lutz, A., Schaefer, H.S. Levinson, D.B. & Davidson, R.J. (2007), 'Neural correlates of attentional expertise in long term meditation practitioners', *Proceedings of the National Academy of Sciences* (US), 194 (27), pp.11483-8
- Breton, J.J., Bergeron, L., Valla, J.P., Berthiaume, C., Gaudet, N., Lambert, J., St-Georges, M., Houde, L. & Lépine, S. (1999) 'Quebec Child Mental Health

Survey: Prevalence of DSM-III-R Mental Health Disorders' *Journal of Child Psychology and Psychiatry* Volume 40, Issue 03. March 1999, pp. 375-384

British Medical Association (2013) *Everyday Medical Ethics and Law* (Chichester: Wiley –Blackwell)

Brown, K. (2015) *Vulnerability & Young People: Care & Social Control in policy & Practice* (Bristol: Policy Press)

Brown, K.W. & Ryan, R.M. (2003) 'The benefits of being present: Mindfulness and its role in psychological well-being' *Journal of Personality and Social Psychology*, 84, 822-848

Brown, M. (1976) *Introduction to Social Administration in Britain* (London: Hutchinson)

Bruce, L. (2015) 'National Children's Bureau Social and Emotional Well-being Framework', *Young Minds* 13<sup>th</sup> March 2015

Bryman, A. & Burgess, R.G. (1994) 'Developments in qualitative data analysis: an introduction' In Bryman, A. & Burgess, R.G. (1994)'(Eds) *Analysing Qualitative Data*, (London: Routledge)

Bryman, A. (2008) *Social Research Methods* (Oxford: University Press)

Buchheld, N., Grossman, P. and Walach, H. (2001) 'Measuring Mindfulness in Insight Meditation (Vipassana) and Meditation-based Psychotherapy: the development of the Freiburg Mindfulness Inventory (FMI)' *Journal of Meditation and Meditation Research*, 1, 11-34

Budd, K. S. (2001) 'Assessing Parenting Competence in Child Protection Cases: A Clinical practice Model', *Clinical Child and Family Psychology Review*, 4: 1, 1-18

Bulmer, M. & Ocloo, J. (2009) 'Looking Forward: The Researchers Perspective' In Strain, J., Barnett, R. & Jarvis, P. (Eds) (2009) *Universities, Ethics & Professions: Debate & Scrutiny* (New York: Routledge)

Burke, C. A. (2010) 'Mindfulness-Based Approaches with Children and Adolescents: A Preliminary Review of Current Research in an Emergent Field' *Journal of Child and Family Studies*, vol. 19, no. 2 pp 133-144 April 2010

Burnett, R. and Director, C., 2009. Mindfulness in schools: *Learning lessons from the adults-secular and Buddhist [online] available from: <http://mindfulnessinschools.org> [Accessed 4.3.2012].*

Burns, J. (2015) *Improve children's mental health, head teachers urge* BBC News Item <http://www.bbc.co.uk/news/education>



- Burton, M., Pavord, E. & Williams, B (2014) *An Introduction to Child Mental Health* (London: Sage)
- Burton, M. (2014) 'Children and Young People's Mental Health' In Burton, M., Pavord, E. & Williams, B (2014) *An Introduction to Child Mental Health* (London: Sage)
- Burton, M. (2014) 'Infant, Child and Adolescent Development' In Burton, M., Pavord, E. & Williams, B (2014) *An Introduction to Child Mental Health* (London: Sage)
- Byford, S. & Knapp, M. (2005) 'What is best value? The health economic evidence' In Williams, R. & Kerfoot, M. (Eds) (2005) *Child and Adolescent Mental Health Services, strategy, planning, delivering and evaluating* (Oxford: University Press)
- Cadman, D., Boyle, M., Offord, D., Szatmari, P. Rae-Grant, N.I., Crawford, J. & Boyles, J. (1986) 'Chronic illness and disability in Ontario children: Findings of the Ontario Child Health Study', *Canada Medical Association Journal* 135, 761-767
- Calder, M. (2003) 'The Assessment framework: A Critique & Reformulation' In Calder, M. & Hackett, S. (Eds) (2003) *Assessment in Child Care: using and developing frameworks for practice* (Lyme Regis: Russell House Publishing)
- Cameron, E. & Green, M. (2015) *Making sense of Change Management* (London: Kogan Page)
- Cameron, J. & Sturge-Moore (1990) *Ordinary Everyday Families: A Human Rights. Issue. Action for Families and their Young Children with Special Needs, Disabilities and Learning Difficulties* (London: MENCAP)
- Carmody, J. (2009) 'Evolving Conceptions of Mindfulness in Clinical Settings' *Journal of Cognitive Psychotherapy: An International Quarterly* Vol. No 23, No 3 2009
- Carr, A. (Ed) (2000) *What Works with Children and Adolescents?: A Critical Review of Psychological Interventions with Children, Adolescents and their Families.* (London: Routledge)
- Carson, J.W., Carson, K.M., Gil, K.M. & Baucom, D.H. (2006) '*Mindfulness Based Relationship Enhancement (MBRE) in Couples*' In Baer, R.A. (ed) (2006) *Mindfulness Treatment Approaches: Clinician's Guide to Evidence Base and Applications*, (Burlington MA: Academic Press)
- Carter, B. & McGoldrick, M. (Eds) (1998) *The Changing Family Life Cycle: A Framework for Family Therapy* (Boston: Allyn & Bacon)

- Charles, F.A. (2014) *Mindfulness Meditation Made Simple: Your Guide to Finding True Inner Peace* (Raleigh: Paradigm Press)
- Chambers (2005) *The Chambers Dictionary* (Edinburgh: Harrap)
- Changing Minds Web Site *Groups* viewed 14.02.14  
[www.changingminds.org/explanations/groups/groups.htm](http://www.changingminds.org/explanations/groups/groups.htm)
- Charmaz, K. (2001) 'Grounded Theory' In Emerson, R.M. (Ed) (2001) *Contemporary field research: Perspectives and formations* (Prospect Heights II: Waveland Press)
- Charmaz, K. (2015) 'Grounded Theory' In Smith, J.A. (Ed) (2015) *Qualitative Psychology: A Practical Guide to Research Methods* (London: Sage)
- Chaskalson, M. (2011) *The Mindful Workplace: Developing Resilient Individuals & Resonant Organisations with MBSR* (Chichester: Wiley – Blackwell)
- Child Poverty Action Group *Number of children in poverty has 'flat lined'*  
[www.cpag.org.uk](http://www.cpag.org.uk) (March 2016)
- Cohen, S. (1994) *Perceived Stress Scale*  
[www.mindgarden.com/products/pss.htm](http://www.mindgarden.com/products/pss.htm)
- Children and Young Persons Act 1933 (London: H.M.S.O.)
- Chomsky, N. (2006) *Language and Mind* (Cambridge: University Press)
- Chopra, D. and Tanzi, R.E. (2015) *Super Genes: the hidden key to total well-being* (London : Penguin)
- Ciarrochi, J., Kashdan, T.B. & Harris, R. (2013) 'The Foundations of Flourishing' In Kashdan, T.B. & Ciarrochi, J. Eds (2013) *Mindfulness, Acceptance and Positive Psychology* (Oakland: New Harbinger)
- Cohen, S., & Janicki-Deverts, D. (2012) 'Who's stressed? Distribution of psychological stress in the United States in probability samples from 1983, 2006 & 2009' *Journal of Applied Psychology* 2012 42 6 1320-1334
- Cohen, S., Kamark, T. & Mermelstein, R. (1983) 'A Global Measure of Perceived Stress' *Journal of Health and Social Behaviour* (1983) Vol. 24 (December): 385-396
- Coholic, D. (2010) *Art Activities for Children and Young People in Need: Helping Children to Develop Mindfulness, Spiritual Awareness and Self-esteem* (London: Jessica Kingsley)

- Cole, T., Daniels, H. & Visser, J. (2005) 'The mental health agenda from an educational perspective', In Williams, R. and Kerfoot, M. (Eds) (2005) *Child and Adolescent Mental Health Services, strategy, planning , delivering and evaluating* (Oxford: University Press)
- Cooper, M. 'Foreword' In Bond, T. (2010) *Standards & Ethics for Counselling in Action* (London: Sage)
- Cooper, P. (Ed) (2002) *Understanding and Supporting Children with Emotional and Behavioural Difficulties* (London: Jessica Kingsley)
- Costello, E.J., Angold, A., Burns, B.J., Stangl, D.K., Tweed, D.L., Erkanli, A. & Worthman, C.M. (1996) 'The Great Smoky Mountains Study of Youth: Goals, design, methods & the prevalence of DSM-III-R disorders' *Archives of General Psychiatry* 53, 1129-1136
- Creswell, J.W. (2014) *Research Design Qualitative, Quantitative and Mixed Methods Approaches* (Thousand Oaks: Sage)
- Crook, C. (2015) *The Joy of Missing Out: Finding Balance in a Wired World* (Gabriol Island: New Society Publications)
- Cullen, M. (2011) 'Mindfulness-based interventions: An emerging phenomenon' *Mindfulness* 2 186-193
- Cunningham, S. & Tomlinson, J. (2006) 'Children, Social Policy & the State: The Dichotomy of Care and Control' In Lavalette, M & Pratt, A. (Eds) (2006) *Social Policy: Theories Concepts and Issues* (London: Sage)
- Cutler, H.C. (1999) *The Art of Happiness: A handbook for living* (Croydon: Hodder & Stoughton)
- Dahl, J. & Lundgren, T. 'Acceptance and commitment Therapy (ACT) in the treatment of chronic pain' (2006, In Baer, R.A. (ed) *Mindfulness Treatment Approaches: Clinician's Guide to Evidence Base and Applications*, (Burlington MA: Academic Press)
- Dallos, R. (2007) *Attachment Narrative Therapy: Integrating Narrative, Systemic and Attachment Therapies* (Maidenhead: Open University Press)
- Davidson, R., Kabat-Zinn, J., & Schumacher, J. (2003) 'Alterations in Brain and Immune Function produced by Mindfulness Meditation' *Psychosomatic Medicine*, 65, 564-70
- Davidson, R.J. (2004) 'EEG Asymmetry and Mindfulness Meditation: Response', *Psychosomatic Medicine: January/February 2004-Volume 66 – Issue 1-* pp. 147-148

- Davies, W.H. (1911) *Songs of Joy and Others* (London: A.C. Fifield)
- Davis, D.M. & Hayes J.A. (2011) 'What are the benefits of mindfulness?: A practice review of psychotherapy-related research' *Psychotherapy* Vol. 48(2) June 2011, 198-208
- Davis, J.H. & Thompson, E. (2015) '*Developing Attention and Decreasing Affective Bias Towards a Cross-Cultural Cognitive Science of Mindfulness*' In Brown, K.W., Creswell, J.D. & Ryan, R. M. (Eds) *Handbook of Mindfulness : Theory Research and Practice* (New York : Guilford Press)
- Dawson, N.K. (2009) *Introduction to Research Methods*, (Oxford: How to Books Limited)
- De Bruin, E.I., Zijlstra, B.J.H., van de Weijer-Bergsma E. and Bögels, S.M. (2011) *The Mindful Attention Awareness Scale for Adolescents (MAAS-A) Psychometric properties in a Dutch sample*, *Mindfulness*, 2, 201-211.
- Denzin, N.K. (1978) *The Research Act: A Theoretical Introduction to Sociological Methods* (Englewood Cliffs, N.J.: Prentice Hall)
- Department for Education and Skills (2003a) *Every Child Matters* <https://www.education.gov.uk/consultations>
- Department for Education, (1997) *Code of Practice on the Identification and Assessment of Special Educational Needs*, (London: H.M.S.O.)
- Department of Health (1991) *Working Together*, (London: H.M.S.O.)
- Department of Health (1996) 'Mental Illness Can Children and Young People have Mental Health Problems?' *The Health of the Nation*, (London: H.M.S.O.)
- Department of Health (2000), *Framework of the Assessment of Children in Need and their Families*, (London: The Stationary Office)
- [dharma wisdom.org/](http://dharma wisdom.org/) (March 2016)
- Diamond, A. & Lee, K. (2011) 'Interventions shown to aid executive function development in children 4 to 12 years old', *Science* 2011: 333(6045):959-964
- Dinsdale, P. (2001) 'Child psychiatrist shortage undermines services' *The Guardian* 16<sup>th</sup> Jan. 2001
- Dobkin, P.L. (Ed) (2015) *Mindful Medical Practice: Clinical Narratives & Therapeutic Insights* (New York: Springer)
- Dodge, J. (2014) 'Should Parents Help With Homework?' *Scholastic Scope*; Dec. 2014, Vol. 63 Issue 4, p20

- Dogra, N., Parkin, A., Gale, F. & Frake, C. (2002) *A Multidisciplinary Handbook of Child and Adolescent Mental Health for Front-line Professionals* (London: Jessica Kingsley)
- Dogra, N., Das Gupta, M. & Leighton, S. (2009) 'The aetiology of child mental health problems' In Dogra, N. & Leighton, S. (2009) (Eds) *Nursing in Child and Adolescent Mental Health* (Maidenhead: Open University Press)
- Donaldson, M. (1987) *Children's Minds* (London: Harper Collins)
- Doward, J. (2014) 'Children 'kept from parents' at centre for failed asylum seekers' *The Observer* (26<sup>th</sup> April 2014)
- Doward, J., & Helm, T. '*Child Poverty rise across Britain halts progress made since 1990's*' *The Observer* 20.06.15
- Dowling, M. (2010) *Young Children's Personal, Social and Emotional Development* (London: Sage)
- Dumas, J. E. (2005) 'Mindfulness-Based Parent Training: Strategies to Lesson the Grip of Automaticity in Families with Disruptive Children' *Journal of Clinical Child and Adolescent Psychology*, volume 34, no. 4. Pp 779-791
- Dunn, B., Hartigan, J. and Mikulas, W. (1999) 'Concentration and Mindfulness Meditations: Unique forms of consciousness?' *Applied Psychophysiology and Biofeedback*, 24, 147-65
- Dunne, J. (2013) 'Toward an understanding of non-dual mindfulness' In Williams, J.M. and Kabat-Zinn, J. (Eds) (2013) *Mindfulness: Diverse Perspectives on its Meaning, Origins and Applications* (Abingdon: Routledge)
- Dyrborg, J., Warborg Larsen, F., Nielsen, S., Byman, J., Buhl Nielsen, B & Gautrè-Delay, F. (2000) 'The Children's Global Assessment Scale (CGAS) and Global Assessment of Psychosocial Disability (GAPD) in Clinical practice-substance and reliability as judged by intraclass correlations' *European Child and Adolescent Psychiatry* October 2000, Vol. 9, Issue 3, pp. 195-201
- Eastoak, S. (Ed) (1994) *Dharma Family Treasures sharing Buddhism with children* (Berkeley: North Atlantic Books)
- Education Act 1944 (London: H.M.S.O.)
- Education Act 1981 (London: H.M.S.O.)
- Elliott, R. (2012) 'Qualitative Methods for Studying Psychotherapy Change Processes' In Harper, D. & Thompson, A.R.(Eds) (2012) *Qualitative*

*Research Methods In Mental Health and Psychotherapy: A Guide for Students and Practitioners* (Chichester: Wiley-Blackwell)

Endicott, J., Spitzer, R. L., Fleiss, J. L., & Cohen, J. (1976) 'The Global Assessment Scale', *Archives of General Psychiatry*, 33, 766 -771.

Etzioni, A. (2007) *The Common Good* (Cambridge: Policy Press)

Feldman, C. and Kuyken, W. (2013) 'Compassion in the landscape of suffering' In Williams, J.M. and Kabat-Zinn, J. (Eds) (2013) *Mindfulness: Diverse Perspectives on its Meaning, Origins and Applications* (Abingdon: Routledge)

Fairbridge Charity viewed 10.04.15 [www.princes-trust.org.uk](http://www.princes-trust.org.uk)

Fennell, M. and Segal, Z. (2013) 'Mindfulness-based cognitive therapy: culture clash or creative fusion?' In Williams, J.M. and Kabat-Zinn, J. (Eds) (2013) *Mindfulness: Diverse Perspectives on its Meaning, Origins and Applications* (Abingdon: Routledge)

Fields, R.D. 'Meditations on the Brain' (2006) *Scientific American Mind* 17 No. 1 Feb/ March 2006 pp 42-43

Fishbein, M. & Ajzen, I. (1975) *Belief, Attitude, Intention and Behaviour, An Introduction to Theory and Research* (Reading, Massachusetts: Addison-Wesley)

Fonagy, P., Target, M., Cottrell, D. Phillips, J. & Kurtz, Z. (2002) *What Works for Whom?: A Critical Review of Treatments for Children and Adolescents* (New York: Guilford Press)

Fontana, D. (1996) *Your Growing Child: from birth to adolescence* (London: Diamond Books)

Forman, E.M., Herbert, J.D., Moitra, E., Yeomans, P.D. and Geller P.A. (2007) 'A Randomised Controlled Effectiveness Trial of Acceptance and Commitment Therapy and Cognitive Therapy for Anxiety and Depression', *Behavior Modification* November 2007 31: pp.772-799

Fox, M., Martin, P. & Green, G. (2007) *Doing Practitioner research* (London: Sage)

Fredrickson, B.L. & Joiner, T. (2002), 'Positive emotions trigger upward spirals toward emotional well-being' *Psychological Science*, 13, pp. 172-5

- Fredrickson, B.L. & Levenson, R.W. (1998), 'Positive emotions speed recovery from the cardiovascular sequelae of negative emotions', *Cognition and Emotion*, 12, pp. 191-220
- Freed, J. & Parsons, L. (1997) *Right-Brained Children in a Left Brained World: Unlocking the potential of your ADD child* (New York: Simon and Schuster)
- Frith, U. (1990) *Autism: Explaining the Enigma* (Oxford: Blackwell)
- Fuller, R. & Petch, A. (1995) *Practitioner Research: The reflexive social worker* (Buckingham: Open University Press)
- Garland, E.L. & Fredrickson, B.L. (2013) 'Mindfulness Broadens Awareness and Builds Meaning at the Attention-Emotion Interface' In Kashdan, T.B. & Ciarrochi, J. (Eds) (2013) *Mindfulness, Acceptance and Positive Psychology* (Oakland: New Harbinger)
- Gelles, D. (2015) *Mindful Work: How Meditation is changing business from the inside out* (London: Profile Books)
- Gergen, K.J. (2013) 'Foreword' In McCown, D. (2013) *The Ethical Space of Mindfulness in Clinical Practice: An Exploratory Essay* (London: Jessica Kingsley)
- Germer, C.K., Siegel, R.D. and Fulton, P.R. (Eds.) (2005) *Mindfulness and Psychotherapy* (New York: Guilford Press)
- Gesch, C.B., Hammond, S.M., Hampson, S.E., Eves, A. & Crowder, M.J. (2002) 'Influence of supplementary vitamins, minerals and essential fatty acids on the antisocial behaviour of young adult prisoners. Randomised, placebo-controlled trial'. *British Journal of Psychiatry* 2002 July 181:22-8.
- Gibbs, G.R. (2009) *Analyzing Qualitative Data* (London: Sage)
- Gilbert, P. (2013) *The Compassionate Mind* (Constable and Robinson: London)
- Gilbert, P. & Choden (2013) *Mindful Compassion: Using the Power of Mindfulness and Compassion to Transform Our Lives* (Robinson: London)
- Goleman, D. (1996) *Emotional Intelligence: Why it can matter more than IQ* (London: Bloomsbury).
- Goodman, A. & Goodman, H. (2009) 'Strengths and difficulties Questionnaire as a Dimensional Measure of Child Mental Health' *Journal of the American Academy of Child and Adolescent Psychiatry*, 48 (4) pp. 400-3

- Goodman, C. & Evans, C. (2010) 'Focus Groups' In Gerrish, K. & Lacey, A. (Eds) (2010) *the Research Process in Nursing* (Oxford: Wiley Blackwell)
- Goodman, R. & Scott, S. (2002) *Child Psychiatry* (Oxford: Blackwell)
- Goodman, R. (1997) 'The Strengths and Difficulties Questionnaires: a research note' *Journal of Child Psychology* 1997, 38(5) pp. 581-6
- Goodman, T.A. & Kaiser Greenland, S. (2009) 'Mindfulness with Children: Working with Difficult Emotions' In Didonna, F. (Ed) (2009) *Clinical Handbook of Mindfulness* (New York: Springer)
- Goncy, E.A., Roley, M.E. & van Dalmen, M.H.M. (2010) 'Strategies for Retaining Participants in Longitudinal Research with Economically Disadvantaged & Ethnically Diverse Samples' In Streiner, D.L. & Sidani, S. (Eds) (2010) *When Research Goes Off the Rails: Why it Happens & What You Can Do About It* (The Guilford Press: New York)
- Government legislation (2008) CAMHS Review  
[www.webarchive.nationalarchives.gov.uk/.../publications.../camhs-review.pdf](http://www.webarchive.nationalarchives.gov.uk/.../publications.../camhs-review.pdf)
- Government legislation *Children and Young Person's Act 2008* viewed 21.07.14 [www.legislation.gov.uk/ukpga/2008/23/contents](http://www.legislation.gov.uk/ukpga/2008/23/contents)
- Government legislation *Criminal Courts Sentencing Act* viewed 28.07.14 [www.legislation.gov.uk/ukpga/2000/6/contents](http://www.legislation.gov.uk/ukpga/2000/6/contents)
- Government legislation (1998) *Data Protection Act* <https://www.gov.uk/data-protection/>
- Government legislation *Education Act 1970* viewed 28.07.14 [www.legislation.gov.uk/ukpga/1970/52/enacted](http://www.legislation.gov.uk/ukpga/1970/52/enacted)
- Government legislation *House of Commons Committee & Local Government Committee Audit & Inspection of local authority 4<sup>th</sup> report of Session 2010-12* [www.publications.parliament.uk/pa/cm201415/cmselect/.../821/821.pdf](http://www.publications.parliament.uk/pa/cm201415/cmselect/.../821/821.pdf)
- Government legislation (1998) *Human Rights Act* [www.legislation.gov.uk/ukpga/1998/42/contents](http://www.legislation.gov.uk/ukpga/1998/42/contents)
- Government legislation *Mental Health Act 2007* viewed (21.07.14) [www.legislation.gov.uk/ukpga/2007/12/pdfs/ukpga](http://www.legislation.gov.uk/ukpga/2007/12/pdfs/ukpga)
- Government legislation *Quality Protects 1998* [www.webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/.../DH\\_4010508](http://www.webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/.../DH_4010508)



Government legislation *Report of the House of Commons Health Committee 2014 (CAMHS)* [www.publications.parliament.uk](http://www.publications.parliament.uk) . Health (CAMHS 3<sup>rd</sup>)

Government legislation *Revised Code (Gillick Competent)* viewed 03.09.14  
[www.legislation.gov.uk/ukpga/1999/22](http://www.legislation.gov.uk/ukpga/1999/22)

Government legislation *Special Educational Needs 2001*  
[www.education.gov.uk/publications/standard/](http://www.education.gov.uk/publications/standard/)

Government legislation *Sure Start 1999*  
[www.publications.parliament.uk/pa/cm200910/cmselect/.../130i.pdf](http://www.publications.parliament.uk/pa/cm200910/cmselect/.../130i.pdf)

Government legislation *The 2004 Children Act*  
[www.legislation.gov.uk/id/ukpga/2004/31](http://www.legislation.gov.uk/id/ukpga/2004/31)

Gowers, S.G., Harrington, R.C., Whitton, A., Beevor, A.S., Lelliott, P., Jezzard, R., & Wing, J.K. (1998) HoNOSCA Health of the Nation Outcome Scales Child and Adolescent Mental Health (Liverpool University )

Grandin, T. (2012) 'Tablet Computers: What They're Good for, What They're Not' *Autism Asperger's Digest* March/April 2012

Graham, P. (2000) 'Treatment interventions and findings from research: bridging the chasm in child psychiatry', *British Journal of Psychiatry* 176, 414-9

Grant, J.A. & Rainville, P. (2009), 'Pain sensitivity and analgesic effects of mindful states in Zen meditators: A cross-sectional study', *Psychosomatic Medicine*, 71(1), pp. 106-14

Graupner, H. (2006) 'The 17 year old child an absurdity of the late 20<sup>th</sup> Century', *Journal of Psychology and Human Sexuality*, 11 (2-3), 7-24

Gray, P. (2010) 'The decline of play and rise in Children's Mental Disorders'  
<https://www.psychologytoday.com/.../the-decline-play-and-rise-in-childr...> June 26 2010

Griffin, J.& Tyrrell, I. (2004) *Human Givens* (Chalvington, Sussex: HG Publishing)

Grossman, K.E., Grossman, K. & Walters, E. (Eds) (2005) *Attachment from Infancy to Adulthood: The Major Longitudinal Studies* (New York: Guilford Press)

Grossman, P. & Van Dam, N.T. (2013) 'Mindfulness by any other name... Trials and Tribulations of Sati in Western Psychology and Science' In Williams, J.M. and Kabat-Zinn, J. (Eds) (2013) *Mindfulness: Diverse Perspectives on its Meaning, Origins and Applications* (Abingdon: Routledge)

- Guba, E.G. & Lincoln, Y.S.(1994) *Handbook of Qualitative Research* (Thousand Oaks: Sage)
- Guest, G., MacQueen, K.M. & Namey, E.L. (2012) *Applied Thematic Analysis* (London: Sage)
- Gunaratana, B. H. (2002) *Mindfulness in Plain English* (Boston : Wisdom Publications)
- Gunaratana, B. H. (2009) *Beyond Mindfulness: in Plain English* (Boston: Wisdom Publications)
- Hackett, L., Aslam, N. & Theodosiou, L. (2011) 'Understanding the mental health needs of older adolescents with behavioural disorders' *Procedia Social and Behavioural Sciences* 30 (2011) 1205-1208
- Hackett, S. (2003) 'A framework for Assessing Parenting Capacity' In Calder, M.C. & Hackett, S. (2003) *Assessment in child Care: Using and developing frameworks for practice* (Lyme Regis: Russell House Publishing)
- Hall M. P. (1965) *The Social Services of Modern England* (London: Routledge and Kegan Paul)
- Halliwell, E. (2015)*Mindfulness: How to Live Well by Paying Attention* (London: Hay House Basics)
- Hamer, M. (2006) *The Barefoot Helper: Mindfulness and creativity in social work and the helping professions* (Lyme Regis: Russell House publishing)
- Hanh, T.N. (1988) *the Sun in my Heart* (London: Rider)
- Hanh, T.N. (1991)*The Miracle of Mindfulness* (London: Rider )
- Hanh, T.N. (2012) *The Pocket Thich Nhat Hanh* (Boston: Shambhala)
- Hanushek, E.A. (1998) 'The Evidence on Class size', *Occasional paper* Number 98 – 1 (W. Allen Wallis Institute of Political Economy: University of Rochester)
- Hanushek, E.A. & Woessman, L. (2015) OECD (2015), *Universal Basic Skills: What Countries Stand to Gain*, OECD Publishing.  
[http://dx.doi.org/ 10.1787/9789264234833-en](http://dx.doi.org/10.1787/9789264234833-en)
- Harding, J. (2013) *Qualitative Data Analysis from Start to Finish* (London: Sage)
- Harker, L. (2002) 'Children in turmoil' *Community Care* March 28<sup>th</sup> 2002

- Harper, D. (2012) 'Choosing a Qualitative Research Method' In Harper, D. & Thompson, A.R. (Eds) (2012) *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners* (Chichester: Wiley-Blackwell)
- Harrington, R. & Clark, A. (1998) 'Prevention and early intervention for depression in adolescence and early adult life', *European Archives of Psychiatry and Clinical Neuroscience* 1998;248 (1):32-45
- Harris, T.B. & Sargent, J. (2011) 'Trauma and Associated disorders' In Cheng, K. & Myers, K.M. (2011) *Child & Adolescent Psychiatry: The Essentials* (Philadelphia: Lippincott Williams & Wilkins)
- Harrison, L.E. & Huntington, S.P. (Eds) 2000) *Culture Matters: How Values Shape Human Progress* (New York: Basic Books)
- Hartig, T., van den Berg, A.E., Hagerhall, C.M., Tomalak, M., Bauer, N., Hansmann, R., Ojala, A., Syngollitou, E., Carrus, G., van Herzele, A., Bell, M.T., Podesta, C. & Waaseth, G. (2010) 'Health Benefits of Nature experiences: Psychological, Social & Cultural Processes' In Nilsson, K., Sangster, M., Gallis, C., Hartig, T., de Vries, S., Seeland, K. & Sckipperijn, J. (2010) *Forests Trees & Human Health* (New York: Springer)
- Hasson, G.(2013) *Mindfulness: be mindful live in the moment* (Chichester: John Wiley & Sons)
- Hatch, S.L., Frissa, S., Verdecchia, M., Stewart, R., Fear, N.T., Reichenberg, A., Morgan, C., Kankulu, B., Clark, J., Gazard, B., Medcalf, R. & Hotopf, M. (2011) 'Identifying socio-demographic and socioeconomic determinants of health inequalities in a diverse London community: the South East London Community Health (SELCoH) study' *BMC Public Health* 11, 861-861
- Hayes, S.C. (Eds) (2008) *Acceptance & Mindfulness Treatments for Children & Adolescents: A Practitioners Guide* (Oakland: New Harbinger Publications Inc.)
- Hayes, S.C., Luoma, J. B., Bond, F.W., Masuda, A. and Lillis, J. (2006) 'Acceptance and Commitment Therapy: Model, processes and outcomes' *Behaviour Research Therapy* Volume 44 Issue 1 January 2006 pgs 1-25
- Hayes, S.C., Strosahl, K. & Houts, A. (Eds) (2005) *A Paradoxical Guide to Acceptance and Commitment Therapy* (New York: Springer)
- Health Advisory Service (1995) *Child and Adolescent Mental Health Services: Together we Stand - the commissioning Role and management of child and adolescent mental health services*, (London: H.M.S.O.)

- Health Service Act 1946 (London: H.M.S.O.)
- Hebb, D.O. (1949) *The Organization of Behaviour: A Neuropsychological Theory* (New York: Wiley)
- Heckman, J.J. & Krueger, A. (Eds) (2003) *Inequality in America: What role for human capital policy?* (Cambridge MA: MIT Press)
- Hendrick, J. (2010) *Law and Ethics in Children's Nursing* (Chichester: Wiley-Blackwell)
- Hick, S.F. & Bien, T. (Eds) (2008) *Mindfulness and the therapeutic relationship* (New York: Guilford Press)
- Hill, P. (2005) 'Mental Health Promotion, prevention and early intervention in Childhood and Adolescence', In Williams, R. and Kerfoot, M. (Eds) (2005) *Child and Adolescent Mental Health Services, strategy, planning, delivering and evaluating* (Oxford: University Press)
- Hofmeister, L. (2012) '14 to 18 Year Olds as "Children" by Law? Reflections on Developments in National & European Law' In Graupner, H. & Bullough, V.L. (Eds) (2012) *Adolescence, Sexuality and the Criminal Law: Multidisciplinary Perspectives* (Abingdon: Routledge)
- Hoge, E.A., Bui, E., Marques, L., Metcalf, C.A., Morris, I.K., Robinaugh, D.J., Worthington, J.J., Pollack, M.H. & Simon, N.M. (2013) 'Randomised Controlled Trial of Mindfulness Meditation for Generalised Anxiety Disorder: Effects on Anxiety and Stress Reactivity' *Journal of Clinical Psychology* 2013 Aug;74(8) 786-792
- Hooker, K. & Fodor, I. (2008) 'Teaching Mindfulness to Children' *Gestalt Review*, 12 (1): 75-91, 2008
- Howe, D. (1995) *Attachment Theory for Social Work Practice* (Basingstoke: Macmillan Press)
- Howe, D. (2011) *Attachment across the Lifecourse: A Brief Introduction* (London: Palgrave Macmillan)
- Howe, D. (2003) 'Assessment Using an Attachment Perspective' In Calder, M.C. & Hackett, S. (2003) *Assessment in Child Care: Using and developing frameworks for practice* (Lyme Regis: Russell House Publishing)
- Humphrey, N., Lendrum, A. & Wigelsworth, M.(2010) *Social and emotional aspects of learning (SEAL) programme in secondary schools: national evaluation Research Report DFE-RR049*  
<https://www.gov.uk/government/uploads/system/uploads/> .

- Humphreys, T. & Ruddle, H (2012) *Understanding Teenagers: Sometimes Wild Always Wise* (Dublin: Gill & Macmillan)
- Huppert, F.A. & Johnson, D.M. (2010) 'A co-ed trial of mindfulness training in schools; the importance of practice for an impact on well-being' *Journal of Positive Psychology* July 2010 vol. 5 Issue4, 364-274
- Ivanowski, B. & Malhi, G.S. (2007) 'The psychological and neurophysiological concomitants of mindfulness forms of meditation' *Acta Neuropsychiatrica*, 19. Pp. 76-91
- Iwaniec, D. (2004) *The Emotionally Abused and Neglected Child: Identification, Assessment and Intervention* (Chichester: Wiley)
- Jha, A.P., Krompinger, J. & Baime, M.J. (2007), 'Mindfulness training modifies subsystems of attention', *Cognitive Affective and Behavioral Neuroscience*, 7 pp.109-19
- Joffe, H. (2012) 'Thematic Analysis' In Harper, D. & Thompson, A.R. (Eds) (2012) *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners* (Chichester: Wiley-Blackwell)
- Jones, D.P.H. (2003) *Communicating with Vulnerable Children: A guide for practitioners* (London: Royal College of Psychiatrists)
- Joughin, C. & Morley, D. (2007) *Conduct Disorder in Older Children & Young People: Research Messages for Practice problems* (Dartington: Research in Practice)
- Kabat-Zinn, J. (2013) 'Some Reflections on the Origins of MBSR skilful means and the trouble with maps' In Williams, J.M. and Kabat-Zinn, J. (Eds) (2013) *Mindfulness: Diverse Perspectives on its Meaning, Origins and Applications* (Abingdon: Routledge)
- Kabat-Zinn, J (1990) *Full Catastrophe Living* (New York: Delta)
- Kabat-Zinn, J (1994) *Wherever You Go, There You Are: Mindfulness Meditation for Everyday Life* (London: Piatkus Books)
- Kabat-Zinn, J (2009) *Letting everything become your teacher: 100 Lessons in Mindfulness* (New York: Bantam Dell)
- Kabat-Zinn, J. (2011) 'Some reflections on the origin of MBSR: skilful means and the trouble with maps' *Contemporary Buddhism* 12 (1) 281-306
- Kabat-Zinn, J., Lipworth, L., Burncy, R. & Sellers, W. (1986) 'Four year follow-up of a meditation-based program for the self-regulation of chronic

pain: Treatment outcomes and compliance'. *The Clinical Journal of Pain*, 2 (3), p.159

Kagan, J.(1999) 'The Role of Parents in Children's Psychological Development' *Paediatrics* Vol.104 No. 1 July 1999

Kaiser Greenland, S. (2010) *The Mindful Child* (New York: Free Press)

Karr-Morse, R. & Wiley, M.(1997) *Ghosts from the Nursery: Tracing the Roots of Violence* (New York: Atlantic Monthly Press)

Kashdan, T.B. & Ciarrochi, J. Eds (2013) *Mindfulness, Acceptance and Positive Psychology* (Oakland: New Harbinger)

Kasinski, K., Pooley, J. Worthington, A. & Ward A. (Eds) (2003) *Therapeutic Communities for children and young people* (London: Jessica Kingsley)

Kazi, M.A.F. & Wilson, J. (1996) 'Applying Single-Case Evaluation in Social Work' *British Journal of Social Work* (1996) 26,699-717

Kelle, U. (200) 'Computer-assisted analysis coding and indexing' In Bauer, M.W. & Gaskell, G. (Eds) *Qualitative researching with texts, images & sound* (London: Sage)

Kelly, A. & Sains, B. (2014) *Talkabout for Teenagers: Developing Social & Emotional Communication Skills* (London: Speechmark Publishing)

Kempson, R.J., 2012. *Mindfulness in schools. A mixed methods investigation of how secondary school pupils perceive the impact of studying mindfulness in school and the barriers to its successful implementation* (Doctoral dissertation, Cardiff University).

Kids Health Web Site (2015) *Reading Milestones* [www.kidshealth.org/](http://www.kidshealth.org/) Parents › School & Family Life

Killingsworth, M.A. & Gilbert, D.T. (2010) 'A Wandering Mind is an Unhappy Mind' *Science* Vol. 330 November 2010 pp. 932

King, N. & Horrocks, C. (2010) *Interviews in Qualitative Research*, (London: Sage)

King, N. (1998) 'Template Analysis' In Symon G. & Cassell, C. (Eds) (1998) *Qualitative Methods and Analysis in Organizational Research* (London: Sage)

Klein, E. (2010) *7 Reasons Meditation Doesn't Work and how to fix them* (Encinitas C.A.: Wisdom Heart Press)

- Klinger-Lesser, L. (1994) 'Karma, Dharma and Diapers' In Eastoak, S. (Ed) (1994) *Dharma Family Treasures sharing Buddhism with children* (Berkeley: North Atlantic Books)
- Koemer, K. & Linehan, M.M. (2000) 'Research on dialectical behaviour therapy for patients with borderline personality disorder' *Psychiatric Clinic of North America* 23, 151-167
- Krashen, S.D. (1981) *Second Language Acquisition and Second Language Learning* (Oxford: Pergamon Press)
- Kristof, N. (2015) 'The Asian Advantage' *New York Times* 10<sup>th</sup> October 2015
- Kuhn, T.S. (2012) *The Structure of Scientific Revolution* (Chicago: University)
- Kurtz, Z (2005) 'Assessing need, mapping services and setting priorities', In Williams, R. and Kerfoot, M. (Eds) (2005) *Child and Adolescent Mental Health Services, strategy, planning, delivering and evaluating* (Oxford: University Press)
- Laing, R.D. (1971) *The Politics of the Family and Other Essays* (London: Tavistock)
- Lally, P., van Jaarsveld, C.H.M., Potts, H.W.W & Wardle, F. (2010) 'How are habits formed: Modelling habit formation in the real world', *European Journal of Social Psychology*, Vol. 40, Issue 6, pp. 998-1009
- Lametti, D. (2009) 'How mirror neurons let us interact with others' *Scientific American* June (2009)
- Langdridge, D. & Hagger-Johnson, G. (2009) *Introduction to Research Methods & Data Analysis in Psychology* (Harlow: Pearson Education)
- Larkin, M. & Thompson, A.P. (2012) 'Interpretative Phenomenological Analysis in Mental Health and Psychotherapy Research In Harper, D. & Thompson, A.R. (Eds) (2012) *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners* (Chichester: Wiley-Blackwell)
- Lask, B., Taylor, S. & Nunn, K.P. (2003) *Practical Child Psychiatry: The Clinician's Guide* (London: BMJ)
- Lau, M.A. and Yu, A.R. (2009) 'New developments in Research on Mindfulness-Based treatments: Introduction to the Special issue' *Journal of Cognitive Psychotherapy: An International Quarterly* Volume 23, Number 2009 Springer Publishing

Lau, M.A., Bishop, S.R., Segal, Z.V., Buis, T., Anderson, N.D., Carlson, L., Shapiro, S., Carmody, J. (2006) 'The Toronto Mindfulness Scale: Development and validation' *Journal of Clinical Psychology*, Vol. 62(12), 1445–1467 2006 Wiley Periodicals,

Lawrence, A. & Lawrence, L.R. (2014) *Stress related disorders: Illness an Intelligent Act of the body* (Allco Publishing: Tarzana)

Lazar, J. (2001) *User-centered Web Development* (Massachusetts: Jones & Bartlett Publishers)

Lazar, S., Kerr, C., Wasserman, R. (2005) 'Meditation experience is associated with increased cortical thickness', *Neuroreport*, 16, 1893-7

[learning.camhs.org.uk/](http://learning.camhs.org.uk/) (National CAMHS Support Service: Everyone's Business)

Lederer, S. & Grodin, L. (Eds) *Children as Research Subjects* (New York: Oxford University Press)

Lee, E-H. (2012) 'Review of the Psychometric Evidence of the Perceived Stress Scale' *Asian Nursing Research* Vol. 6 Issue 4 pp 121-127

Lee, M.Y., Ng, S., Leung, P.P.Y. and Chan, C.L.W. (2009) *Integrative Body-Mind-Spirit Social Work: An Empirically Based Approach to Assessment and Treatment* (Oxford: University Press)

Lehman. J.(2016) 'I Want it Now' How to Challenge a False Sense of Entitlement in Kids [www.empoweringparents.com](http://www.empoweringparents.com)

Levenstein, S., Prantera, C., Varvo, V., Scribano, M.L., Berto, E., Luzi, C. and Andreoli, A. (1993) 'Development of the Perceived Stress Questionnaire: A New Tool For Psychosomatic Research', *Journal of Psychosomatic Research* Vol.37, No. 1, pp. 19-32 1993

Likert, R. (1932) 'A Technique for the Measurement of Attitudes', *Archives of Psychology*, 140, 1–55.

Lindsey, C. (2000) 'Why focus on the mental health needs of looked after children?' In Richardson, J. & Joughin, C. (2000) *The Mental Health Needs of Looked After Children* (London: Royal college of Psychiatrists Gaskell)

Linehan, M. (1993) *Cognitive Behavioural Treatment of Borderline Personality Disorder* (New York: Guildford Press)

Local Government *Demographics and wider determinants of health* viewed 05.09.16 [https://www.sthelens.gov.uk/.../jsna-2015-section-1-demographics-and-wider-determinants of health](https://www.sthelens.gov.uk/.../jsna-2015-section-1-demographics-and-wider-determinants-of-health)



- Low, C.A., Straton, A.L. & Bower, J.E. (2008), 'Effects of acceptance-oriented versus evaluative emotional processing on heart rate recovery and habituation', *Emotion*, 8, pp. 419-24
- Lundh, A., Kowalski, J., Sundberg, C.J., Gumpert, C. & Landèn, M. (2010) 'Children's Global Assessment Scale (CGAS) in a naturalistic clinical setting: Inter-rater reliability and comparison with expert ratings' *Psychiatry Research* Vol. 177 (1-2), 2010 May 15, pp. 206-10
- MacCoby, E.E. & Martin, J.A. (1983) 'Socialization in the context of the family: Parent-child interaction'. In P.H. Mussen & E.M. Hetherington (Eds.) *Handbook of Child Psychology Vol.4. Socialization, personality and social development* (4<sup>th</sup> ed) New York: Wiley.
- MacDonald, E.E. (2010) 'Mindful parenting and care involvement of fathers of children with intellectual disabilities' *Journal of Child and Family Studies*, volume 19 (2), pp.236-240
- Mace, C. (2008) *Mindfulness and Mental Health: Therapy, Theory and Science* (London: Routledge)
- Mackenzie, N. & Knipe, S. (2006) 'Research Dilemmas, Paradigms, Methods & Methodology', *Issues In Educational Research* Vol. 16 2006
- Maex, E. (2013) 'The Buddhist roots of Mindfulness training: A practitioners view' In Williams, J.M.G. & Kabat-Zinn Eds. (2013) *Mindfulness: Diverse Perspectives on its Meaning, Origins and Applications* (London: Routledge)
- Magill, M. (2003) *Why is the Buddha Smiling?: finding calm and insight on the mindful path* (Alresford: Godsfield Press)
- Main, M. & Solomon, J. (1986) 'Discovery of an insecure disorganized/ disoriented attachment pattern: Procedures, findings and implications for the classification of behavior' In Braxelton, T. & Yogman, M. (Eds) *Affective Development in Infancy* (Norwood, N.J.: Ablex)
- Main, M (1991) 'Metacognitive knowledge, Metacognitive monitoring and singular (coherent) vs. Multiple (incoherent) model of attachment' In Murray, C. Stevenson-Hide, J. & Marris, P. (Eds) *Attachment across the life cycle* pp. 127-59
- Maitland, A. & Thomson, P (2014) *Future Work: Changing organisational culture for the New World* (Basingstoke: Palgrave MacMillan)

Malinowski, P.(2008) Mindfulness as psychological dimension: Concepts and applications *The Irish Journal of Psychology* 2008 Vol. 29 No. 1-2 pp. 155-166

Maller, C., Townsend, M., Pryor, A., Brown, P. & St Leger, L. (2006) 'Healthy nature healthy people: "contact with nature" as an upstream health promotion intervention for populations' *Health Promotion International* (March 2006) 21 (1): 45-54

Mallin, C.A. (2013) *Corporate Governance* (Oxford: University Press)

Marcus, C.C. & Barnes, M. (1999) *Healing Gardens: Therapeutic Benefits & Design Recommendations* (Hoboken N.J.: John Wiley & Sons)

Markopoulous, P., Read, J.C., MacFarlane, S. & Höysniemi, J. (2008) *Evaluating Children's Interactive Production: Principles & Practices for Interaction Designers* (Burlington: Elsevier)

Maslow, A.H. (1943) 'A Theory of Human Motivation' *Psychological Review*, 50, 370-396.

Mathai, J., Anderson, P. & Bourne, A. (2004) 'Comparing psychiatric diagnosis generated by the Strengths and Difficulties Questionnaire with diagnosis made by clinicians' *Australian and New Zealand Journal of Psychiatry*, 38, 639-643

Matthews, B. & Ross, L. (2010) *Research Methods: A Practical Guide for the Social Sciences* (Harlow: Pearson Education Limited)

Maughan, B. (2005) 'Young people with troublesome behaviour' In Williams, R. & Kerfoot, M. (Eds) (2005) *Child and Adolescent Mental Health Services, strategy, planning, delivering and evaluating* (Oxford: University Press)

May, C. & Finch, T.(2009) 'Implementing, Embedding and Integrating Practices: An Outline of Normalization Process Theory', *Sociology* 2009; 43; 535

McCabe, M.A., Wertlieb, D. & Saywitz, K. (2013) 'Promoting Children's Mental Health: The Importance of Collaboration & Public Understanding' In McDonald Culp, A (2013) *Issues in Child Clinical Psychology Child and Family Advocacy: Bridges the Gaps Between Research, Practice & Policy* (New York: Springer)

McCann, J.B., James, A., Wilson, S. & Dunn. G. (1986) 'Prevalence of psychiatric disorders in young people in the Care System', *British Medical Journal*, 313, 1529-1530

- McCarthy, J. & McCarthy, M. (2002) *Software for your Head* (Boston: Pearson Education)
- McCown, D. (2013) *The Ethical Space of Mindfulness in Clinical Practice: An Exploratory Essay* (London: Jessica Kingsley)
- McCracken, L.M. (Ed) (2011) *Mindfulness & Acceptance in Behavioral Medicine: Current Theory & Practice* (Oakland: New Harbinger)
- McCracken, L.M. & Yang, S.Y. (2008), 'A contextual cognitive-behavioral analysis of rehabilitation workers' health and well-being: Influences of acceptance, mindfulness and values-based action', *Rehabilitation Psychology*, 53, pp. 479-85
- McCrorie. P. (2006) *Teaching and Leading Small Groups: Understanding Medical Education* (Edinburgh: ASME)
- McDannald, M.A. (2008) *The Behavioral & Neural Mechanisms Underlying Conditioned Suppression: a model of human anxiety* (Baltimore: John Hopkins University)
- McKay, M., Wood, J.C. & Brantley, J. (2007) *The Dialectical Behavior Therapy Skills Workbook: Practical DBT Exercises for learning mindfulness, Interpersonal Effectiveness, Emotion Regulation and Distress Tolerance*, (Oakland: New Harbinger)
- McLeod, J. (1994) *Doing Counselling Research* (London: Sage)
- McRoy, R.G., Flanzer, J.P. & Zlotnik, J.L. (2012) *Building Research Culture and Infrastructure* (Oxford: University Press)
- Mental Health Act 1959 (London: H.M.S.O.)
- Mental Health Foundation (1999) *Bright Futures: promoting children and young people's mental health* (London: Mental Health Foundation)
- Mental Health Foundation (2009) *Evaluation of the Choice and Partnership Approach in Child and Adolescent Mental Health Services in England, December 2009* (London: Mental Health Foundation)
- Mertens, D.M. (2007) 'Transformative Paradigms: Mixed Methods & Social Justice', *Journal of Mixed Methods Research* Vol.1 No. 3 212-225 July 2007
- Merriam Webster Dictionary viewed 10.03.2016 [www.merriam-webster.com/dictionary/group](http://www.merriam-webster.com/dictionary/group)
- Miller, A. (1991) "For your own good" the roots of violence in child rearing (London: Virago Press)

Miller, J.J., Fletcher, K. & Kabat-Zinn, J. (1995) 'Three year follow up and clinical implications of a mindfulness meditation-based stress reduction intervention in the treatment of anxiety disorders', *General Hospital Psychiatry*, 17, 192-200

Mind (2014) Dialectical Behaviour Therapy (DBT)  
[www.mind.org.uk/information...and.../dialectical-behaviour-therapy-dbt/](http://www.mind.org.uk/information...and.../dialectical-behaviour-therapy-dbt/)

Mindfulness in Schools Project (2009) *Not for profit organisation*  
<https://mindfulnessinschools.org/about/about-us/>

Mindfulness in Schools project (2015) (Use of SDQs)  
<https://mindfulnessinschools.org/>

Mindfulnet.org/page/4htm. Teacher training (DEC 2015)

Ministry of Justice June 2013 *Summary of Reports & Responses under Rule 43 of the Coroners Rules* <https://www.gov.uk/government/uploads/>

Moffitt, T.E. (1993) 'Adolescence limited and life-course persistent antisocial behaviour: A developmental taxonomy', *Psychological Review*, 100, 674-701

Moffitt, P. (2016) The Tyranny of expectations [www.dharmawisdom.org/](http://www.dharmawisdom.org/)  
(March 2016)

Moore, J.M. & Field, P.A. (1996) *Nursing Research: The Application of Qualitative Approaches* (London: Chapman Hall)

Moore, P. (2008) 'Introducing Mindfulness to Clinical Psychologists in Training; An Experimental Course of Brief Exercises' *Journal of Clinical Psychology in Medical Settings* (2008) 15: 331-337

Morone, N.E., Greco, C.M. & Weiner, D.K. (2008), 'Mindfulness meditation for the treatment of chronic low back pain in older adults: A randomised controlled pilot study', *Pain*, 134(3), pp. 310-19

Moule, P. & Goodman, M. (2014) *Nursing Research: An Introduction* (Thousand Oaks, CA: Sage)

Mullins, L.J. (2007) *Management and Organisational Behaviour* (Harlow: Pearson Education)

Muth, J.J. (2005) *Zen Shorts* (New York: Scholastic Inc)

My ADHD Web Site ADHD across the Lifespan'  
[www.myadhd.com/adhdacrosslifespan.htm](http://www.myadhd.com/adhdacrosslifespan.htm)

Nashat, S. & Rendall, S. (2011) '*The social construction of school exclusion*' In Harris, R., Nashat, S. & Rendall, S. (Eds) (2011) *Engaging with Complexity: Child & Adolescent Mental Health and Education* (London: Karnac Books)

Nataraja, S. (2008) *The Blissful Brain: Neuroscience and proof of the power of meditation* (London: Octopus Books)

National Children's Bureau *Guidance for Schools* viewed 10.05.14  
[www.ncb.org.uk/...of...schools/what-works-guidance-for-schools](http://www.ncb.org.uk/...of...schools/what-works-guidance-for-schools)

National Collaborating Centre for Mental Health (Great Britain) (2013) *Antisocial Behaviour and Conduct Disorders in Children and Young People: The NICE guidelines on recognition, intervention and management.* (London: The British Psychological Society & Royal College of Psychiatrists)

National Institute for Health Research *Involving members of the public in health research (briefing note five)* Jan 2016  
[www.invo.org.uk/posttypesresource/before-you-start](http://www.invo.org.uk/posttypesresource/before-you-start) (2016)

Neale, M. (2011) *McMindfulness and Frozen Yoga*  
[www.milesneale.com/pdf/McMindfulness.pdf](http://www.milesneale.com/pdf/McMindfulness.pdf) (accessed in Oct 2016)

Nghiem, D. (2015) *Mindfulness as Medicine: a story of healing body and spirit* (Berkeley: Parallax Press)

NHS Wales *Child and Adolescent Health – Everybody's business* 2001  
[www.wales.nhs.uk/publications/men-health-e.pdf](http://www.wales.nhs.uk/publications/men-health-e.pdf) CAMHS 2001

NICE (2009) National Institute for Health and Clinical Excellence, *Depression: the treatment and management of depression in adults.* 2009. (Clinical guideline 90.)

NICE (2009) National Institute for Health and Clinical Excellence, *Borderline Personality Disorder* (Clinical guideline 78.)

Niglas, K. (2001) 'Paradigms & Methodology in Educational Research', Paper presented at the *European Conference on Educational Research*, Lille, 5-8 September 2001

NSPCC *Preventing abuse > Child abuse and neglect* March 2016  
[www.nspcc.org.uk](http://www.nspcc.org.uk)

Nuffield Foundation News item *The Increased levels of anxiety and depression in young people* 14 March 2012 [www.nuffieldfoundation.org/](http://www.nuffieldfoundation.org/)

O'Connell, M.E., Boat, T. & Warner, K.E. (Eds) (2009) *Preventing mental, Emotional and Behavioral Disorders Among Young People: Progress & Possibilities* (Washington: National Academic Press)

Offord, D.R., Boyle, M., Szatmari, P., Rae-Grant, N.I., Links, P.S., Cadman, D.T., Byles, J.A., Crawford, J., Blum, H.M., Byrne, C., Thomas, H. & Woodward, C.A. (1987) 'Ontario Child Health Study: II. Six month prevalence of disorder and rates of service utilization' *Archives of General Psychiatry*, 44, 832-836

O'Hara, M.(2014) *Austerity Bites: A Journey to the Sharp End of Cuts in the UK* (Bristol: Policy Press)

Okagaki, L. & Bingham, G.E. (2010) 'Diversity in Families: Parental Socialization & Children's Development & Learning' In Christenson, S.L. & Reschly, A.L. (2010) *Handbook of School-Family Partnerships* (New York: Routledge)

Olendzki, A. 'The construction of mindfulness' In Williams, J.M. and Kabat-Zinn, J. (Eds) (2013) *Mindfulness: Diverse Perspectives on its Meaning, Origins and Applications* (Abingdon: Routledge)

Oliver, J., Hill, J. & Morris, E. (2015) *Activate Your Life: Using acceptance & mindfulness to build a life that is rich fulfilling and fun* (London: Robinson)

Olsen, M.R. (Ed) (1984) *Social Work and Mental Health: A guide for the approved Social Worker* (London: Tavistock Publications)

Olson, K. (2014) *The Invisible Classroom: Relationships, Neuroscience & Mindfulness in School* (New York: W.W. Norton & Company)

Omer, H. (2004) *Nonviolent Resistance: A New Approach to Violent and Self-Destructive Children* (Cambridge: University Press)

O'Morain P. (2014) *Mindfulness on the Go: Peace in your Pocket* (London: Hodder & Stroughton)

Ortner, C.N.M., Kilner, S.J. & Zelazo, P.D. (2007) 'Mindfulness meditation and reduced emotional interference on a cognitive task', *Motion and Emotion*, 31, pp. 271-83

Paiva, N. D. (2011) '*The School as a Secure Base*' In Harris, R., Nashat, S. & Rendall, S. (Eds) (2011) *Engaging with Complexity: Child & Adolescent Mental Health and Education* (London: Karnac Books)

Parahoo, K. (2006) *Nursing Research: Principles, Process and Issues* (New York: Palgrave MacMillan)

Parsons, C. (1999) *Education, Exclusion and Citizenship* (London: Routledge)

- Patterson, G.R. (1975) *Families: Applications of Social Learning to Family Life* (Champaign IL: Research Press)
- Patterson, G.R. (1982) *Coercive Family Process*, (Eugene, OR: Castalia)
- Pavord, E. (2014) 'Mental Health Promotion Strategies with Children, Young People and Families' In Burton, M., Pavord, E. & Williams, B. (2014) *An Introduction to Child Mental Health* (London: Sage)
- Pavord, E., Williams, B. & Burton, M. (2014) 'Values, Attitudes, Beliefs and Inequalities when Working with Children, Young People and their Families' In Burton, M., Pavord, E. & Williams, B. (2014) *An Introduction to Child Mental Health* (London: Sage)
- Pearce, J. (1993) 'Child Health Surveillance for Psychiatric Disorder: Practical Guidelines' *Archives of Disease in Childhood* 69: 394-398
- Penketh, L. 'Racism and Social Policy' In Lavalette, M. & Pratt, A. *Social Policy: Theories Concepts and Issues* (London: Sage)
- Phelps, M.R. (2010) 'Mindfulness' (pp. 173-183) In Becker-Weidman, A. & Shell, D. (Eds) (2010) *Attachment parenting: Developing Connections and healing children* (Lanham M.D: Jason Aronson)
- Phillips, C. (2002) 'From Voluntary to Statutory Status: reflecting on the experience of three partnerships established under the crime & disorder Act 1998' In Hughes, G., McLaughlin, E. & Muncie, J. (Eds) *Crime Prevention & Community Safety* (London: Sage)
- Pickhardt, C.E. (2012) 'Adolescence and Entitlement: Because Adolescence Encourages Entitlement Mutuality Must be Taught' *Psychology Today* March 26<sup>th</sup> 2012
- Powers B.A. & Knapp, T.R. (2011) *Dictionary of Nursing Theory & Research* (New York: Springer)
- Prior, V. & Glaser, D. (2006) *Understanding Attachment and Attachment Disorders* (London: Jessica Kingsley)
- Puddicombe, A. (2011) *Get Some Headspace: 10 minutes can make all the difference* (London: Hodden & Stoughton)
- Raymond, E.B. (2014) *Learners with mild Disabilities: A characteristic approach* (Harlow: Pearson Education)

- Rechtschaffen, D. (2014) *The Way of Mindful Education in Cultivating Well-being in Teachers & Students* (New York: W.W.Norton & Company)
- Rees CA. (2005) 'Thinking about children's attachments' *Archives of disability in Childhood* 2005 90 1058-1065
- Reger-Nash, B., Smith, M. & Juckett, G. (2015) *Foundations of Wellness* (Champaign Il: Human Kinetics)
- Reid, R. & Maag, J.W. (1997) 'Attention deficit hyperactivity disorder: Over here and over there', *Education and Child Psychology* 14 (1), 10-20
- Reis, R.S., Hino, A.A.F. & Añez, C.R.R. (2010) 'Perceived Stress Scale Reliability and Validity Study in Brazil', *Journal of Health and Psychology* January 20210 vol.15 no. 1 pp 107-114
- Remenyi, D., Swan, N. & Van Den Assem,B. (2010) *Ethics Protcols & Research Ethics Committees: Successfully Obtaining approval for your Academic Research* (Reading: Academic Publishing International)
- Richards, H. (1990) 'What do they do at the Child Guidance?' News letter *Association for Child Psychology* Volume 12. No.3
- Richardson, J. & Joughin, C. (2000) *The Mental Health Needs of Looked After Children* (London: Royal college of Psychiatrists Gaskell)
- Richardson, J. & Liabø, K. (2007) *Conduct Disorder and Offending Behaviour in Young People: Findings from Research* (London: Jessica Kingsley & Royal College of Psychiatrists Research and Training Unit)
- Rizvi, S.L. & Nock, M.K. (2008) 'Single-Case Experimental Designs for the Evaluation of Treatments for Self-Injurious and Suicidal Behaviors', *Suicide and Life-Threatening Behavior* 38(5) October 2008 pp. 498-510
- Robin, A.L. & Foster, S.L. (2003) *Negotiating Parent-adolescent Conflict: A Behavioral Family Systems Approach* (New York: The Guilford Press)
- Robinson, G.E. (1990) 'Synthesis of research on the effects of class size'. *Educational leadership*, 47 (No.7), pp.80-90.
- Robinson, P.W., Davidson, L.J. & Drebot, M.E.I. (2004) 'Parent abuse on the rise: An Historical Review' *American Association of Behavioral Social Science Online Journal*
- Roemer, L. & Orsillo, S.M. (2003) 'Mindfulness: A Promising Intervention Strategy in Need of Further Study' *Clinical Psychology Science and Practice* V10 no 2 Summer 2003 American Psychological Association



Roemer, L., Salters-Pedneault, K. and Orsillo, S.M. (2006) 'Incorporating Mindfulness and Acceptance Based Strategies in the treatment of Generalised Anxiety Disorder' In Baer, R.A. (Ed) (2006) *Mindfulness Treatment Approaches: Clinician's Guide to Evidence Base and Applications*. (Burlington MA: Academic Press)

Royal College of Psychiatrists *Benchmarking Report 2013*  
[www.rcpsych.ac.uk/.../CAMHS%20Report%20Dec%202013%20v1\(1\).p](http://www.rcpsych.ac.uk/.../CAMHS%20Report%20Dec%202013%20v1(1).p)

Royal College of Psychiatrists March 2016 An evaluation of the use of the children Act [www.rcpsych.ac.uk/.../CAMHA-CAPS%20report%20for%20NIMHE.pdf](http://www.rcpsych.ac.uk/.../CAMHA-CAPS%20report%20for%20NIMHE.pdf)

Rubin, A. & Babbie, E. (2008) *Research Methods for Social Work* (Belmont CA: Thompson Higher Education)

Ruedy, N.E. & Schweitzer, M.E. (2010) 'In the Moment: The Effect of Mindfulness on Ethical Decision Making', *Journal of Business Ethics* September July Vol. 95 Supplement 1, pp. 73-87

Russo, M.F. & Beidel, D.C. (1994) 'Co-morbidity of childhood anxiety & externalising disorders: Prevalence, associated characteristics and validation issues' *Clinical Psychology Review* 1994; 14: 199-221

Rustin, M. (2011) 'Passion in the classroom: Understanding some vicissitudes in teacher –pupil relationships and the unavoidable anxieties of learning' In Harris, R., Rendall, S. & Nashat, S. (2011) *Engaging with complexity: Child and Adolescent Mental Health and Education* (London: Karnac)

Rutter, M. (1972) *Maternal Deprivation Revisited* (Harmondsworth: Penguin)

Rutter, M. (1985) 'Resilience in the Face of Adversity: Protective Factors and Resistance to Psychiatric Disorders', *British Journal of Psychiatry*, 147: 589-611

Rutter, M., Graham, P. & Yule, W. (1970a) *A neuropsychiatric study in childhood* (London: Heinemann Medical)

Rutter, M., Maughan, B., Mortimore, P. and Ouston, J. (1979) *Fifteen Thousand Hours: Secondary Schools and their effects on Children* (Wells: Open Books)

Rutter, M., Cox, A., Tupling, C., Berger, M. & Yule, W. (1975) 'Attainment and Adjustment in two geographical area: I – the prevalence of psychiatric disorder' *Journal of Child Psychology and Psychiatry* 126, 493-509

Safe with Sam Mental Health Charity School Counsellors made a legal requirement for all schools in England (viewed 13.10.15)  
<https://www.change.org/p/sam-morris...charity...a.../13757596>

Saldaña, J. (2013) *The Coding Manual for Qualitative Researcher* (London: Sage)

Sale, J.E.M., Lohfeld, L.H. & Brazil, K. (2002) 'Revisiting the Quantitative-Qualitative Debate: Implications for Mixed –Methods Research', *Quality & Quantity* 36: 43-53, 2002

Saltzman, A. & Goldin, P. (2008) '*Mindfulness-Based Stress Reduction for School-Age Children*', In Greco, L.A. & Hayes, S.C. (Eds) (2008) *Acceptance and Mindfulness Treatments for Children and Adolescents: A Practitioner's Guide* (Oakland CA: New Harbinger)

Salzberg, S. (2013) 'Mindfulness and Loving Kindness' In Williams, J.M. and Kabat-Zinn, J. (Eds) (2013) *Mindfulness: Diverse Perspectives on its Meaning, Origins and Applications* (Abingdon: Routledge)

Sanders, P. & Liptrot, D.(1993) *Research Methods and Data Collection for Counsellors* (Manchester: PCCS Books)

Sanger, K.L. & Dorjee, D. (2015) 'Mindfulness Training for adolescents: A neurodevelopmental perspective on investigating modifications in attention and emotion regulation using event-related brain potentials' *Cognitive Affective & Behavioral Neuroscience* 2015; 1-16

Schneiderman, L. (2008) *Embracing our Mortality: Hard choices in an age of Medical Miracles* (Oxford: University Press)

Schwandt, T.A.(1994) 'Constructivist Interpretivist Approaches to Human Inquiry' In Denzin N.K. & Lincoln, Y.S. (Eds) (1994) *Handbook of Qualitative Research* (Thousand Oaks: Sage)

Seale, C. (2007) *Reaching Society and Culture* (London: Sage)

Seaward, B.L. (2012) *Managing Stress: Principles and Strategies for Health and Well-being* (Ontario: Jones and Bartlett Learning)

Segal, Z. V., Williams, J.M.G. and Teasdale, J.D. (2002) *Mindfulness Based Cognitive Therapy for Depression: A New Approach to Preventing Relapse* (New York: The Guilford Press)

Selikowitz, M. (2012) *Dyslexia & Other Learning Difficulties* (Oxford: University press)

Semple, R.J. (2010) 'A Randomized Trial of Mindfulness-based Cognitive Therapy for children: Promoting Mindful attention to enhance social-emotional resiliency in children' *Journal of Child and Family Studies*, vol. 19, no. 2 pp. 218-229 April

Semple, R.J., & Lee, J. (2008) 'Treating Anxiety with Mindfulness: Mindfulness-Based Cognitive Therapy for Children' In Greco, L.A. & Hayes, S.C. (Eds) (2008) *Acceptance & Mindfulness Treatments for Children & Adolescents: A Practitioners Guide* (Oakland: New Harbinger)

Semple, R.J., Lee, J. and Miller, L.F. (2006) 'Mindfulness-Based Cognitive Therapy for Children' In Baer, R.A. (ed) *Mindfulness Treatment Approaches: Clinician's Guide to Evidence Base and Applications*. (Burlington MA: Academic Press)

Shaffer, D., Gould, M.S., Brasic, J, Ambrosini, P., Fisher, P. Bird, H. and Aluwahlia, S. (1983) 'A children's global assessment scale (CGAS)'. *Archives of General Psychiatry*, 40, 1228-1231

Shapiro, S.L. & Carlson, L.E. (2010) *The Art and Science of Mindfulness: Integrating Mindfulness Into Psychology and the Helping Professions* (Washington: American Psychological Association).

Shapiro, S.L., Oman, D., Thoresen, C.E., Plante, T.G. & Flinders, T. (2008) 'Cultivating mindfulness: effects on well-being', *Journal of Clinical Psychology* 54(7),pp. 840-62

Shapiro, S.L., Schwartz, G.E. & Bonner, G. (1998) 'Effects of Mindfulness-based stress reduction on medical and premedical students' *Journal of Behavioral Medicine*, 21, pp. 581-99

Shapiro, E. & Shapiro, D. (2011) 'Why we find it hard to Meditate'  
[www.mindful.org/why-we-find-it-hard-to-meditate/](http://www.mindful.org/why-we-find-it-hard-to-meditate/)

Sharry, J. (1999) *Bringing up Responsible Children* (New York: Ventas)

Shoham, S.G. (2006) *Society & the Absurd: A Sociology of Conflictual Encounters* (Brighton: Sussex Academic Press)

Siegel, D.J. & Hartzell, M. (2004) *Parenting from the Inside Out: How a deeper self-understanding can help you raise children who thrive* (New York: Penguin)

Siegel, D.J. (2007) *The Mindful Brain: Reflection and Attunement in the Cultivation of Well-being* (New York: W.W. Norton and Company)

Siegel, D.J. (2010) *Mindsight: the New Science of Transformation* (New York: Random House)

- Siegel, D.J. (2010) *The Mindful Therapist: A Clinician's Guide to Mindsight and Neural Integration* (New York: W.W. Norton and Company)
- Siegel, D.J. (1999) *The Developing Mind: How Relationships and the Brain Interact to Shape Who We Are* (New York: The Guildford Press)
- Simons, L. & Lathlean, J. (2010) 'Mixed Methods' In Gerrish, K. & Lacey, A. (Eds) (2010) *The Research Process in Nursing* (Oxford: Wiley Blackwell)
- Silverman, D. (2007) *A very short, fairly interesting and reasonably cheap book about Qualitative Research* (London: Sage)
- Singh, N.N., Singh, A.N., Lancioni, G.E., Singh, J., Winton, A.S.W. and Adkins, A.D. (2010) 'Mindfulness Training for Parents and Their Children with ADHD Increases the Children's Compliance' *Journal of Child and Family Studies* , 2010 19: pp. 157-166
- Slee, P. & Shute, R. (2003) *Child Development: Thinking about Theories* (London: Arnold)
- Sobh, R. & Perry, C. (2006) 'Research design and data analysis in the realism research' *European Journal of Marketing* Vol. 40 No. 11/12, 2006 pp. 1194-1209
- Solomon, M. (2011) 'Interacting reintegration: The role of child & adolescent mental health professionals in supporting the inclusion of excluded pupils' In Harris, R., Nashat, S. & Rendall, S. (Eds) (2011) *Engaging with Complexity: Child & Adolescent Mental Health and Education* (London: Karnac Books)
- Specia, M., Carlson, L.E., Goodey, E. & Angen, M. (2000) 'A randomised, wait-list controlled trial: the effect of a mindfulness meditation-based stress reduction program on mood and symptoms of stress in cancer outpatients', *Psychosomatic Medicine*, 62, pp. 613-22
- Spicer, N. (2007) 'Combining Qualitative & Quantitative Methods', In Seale, C. (2007) *Researching Society and Culture* (London: Sage)
- Spock, B. (1969) *Baby and Child Care* (London: New English Library)
- Stahi, B. & Goldstein, E. (2010) *A Mindfulness-Based Stress Reduction Workbook* (Oakland: New Harbinger)
- Stallard, P. (2007) 'The Availability of Cognitive Behaviour Therapy Within Specialist Child and Adolescent Mental Health Services (CAMHS): A National Survey' *Behavioural and Cognitive Psychotherapy* Vol. 35 Issue 04/ July 2007 pp. 501-506

- Stanley, S. (2015) 'Mindfulness as a translation of Sati' In Shonin, E., Van Gordon, W. & Singh, N.N. (2015) *Buddhist Foundations of Mindfulness* (New York: Springer),
- Steger, M.F., Sheline, K., Merriman, L. & Kashdan, T.B. (2013) 'Using the Science of Meaning to Invigorate Values-Congruent, Purpose-Driven Action' In Kashdan, T.B. & Ciarrochi, J. (Eds) (2013) *Mindfulness, Acceptance and Positive Psychology* (Oakland: New Harbinger)
- Stora, J.B. (2007) *When the Body Displaces the Mind: Stress, Trauma & Somatic Disease* (London: Karnac Books)
- Sunderland, M. (2006) *The Science of Parenting: practical guidance on sleep, crying, play and building emotional wellbeing for life* (London: Dorling Kindersley)
- Swart, J., Bass, C.K. & Apsche, J.A. (2015) *Treating Adolescents with Family Based Mindfulness* (New York: Springer)
- Tanaka, K. 'Jodo Shin Teachings for Young People' (1994) In Easkoak, S. (Ed.) *Dharma Family Treasures Sharing Buddhism with Children* (Berkeley: North Atlantic Books)
- Tang, Y.Y., Ma, Y., Wang, J., Fan, Y., Feng, S., Lu, Q., Yu, Q., Sui, D., Rothbart, M.K., Fan, M. & Posner, M.I. (2007), 'Short term meditation training improves attention and self-regulation', *Proceedings of the National Academy of Sciences (US)*, 104 (43), pp. 171-6
- Tarling, R.J. (2006) *Managing Social Research: A Practical Guide* (London: Routledge)
- Taylor, P. & Medina, M. N. D. (2013) 'Educational Research Paradigms: From Positivism to Multiparadigmatic', *The Journal of Meaning Centred Education* Vol. 1 Article 2 2013
- Taylor, S. (2010) *The Fall* (Alresford: O Books)
- Taylor, S. (2012) *Back to Sanity: Healing the madness of our minds* (London: Hay House)
- Teasdale, J.D. and Chaskalson, M. (2013) 'How does mindfulness transform suffering?' In Williams, J.M. and Kabat-Zinn, J. (Eds) (2013) *Mindfulness: Diverse Perspectives on its Meaning, Origins and Applications* (Abingdon: Routledge)
- The Children Act 1989 (London: H.M.S.O.)

- Teplin, L.A., Abram, K.M., McClelland, G.M., Dulcan, M.K. & Mericle, A.A. (2002) Psychiatric Disorders in Youth in Juvenile Detention, *Archives of General Psychiatry*. 2002;59 (No12): p1133-1143
- The Crime and Disorder Act 1998', In Hughes, G., McLaughlin, E. and Muncie, J. (Eds) (2002) *Crime Prevention and Community Safety, New Directions*, (London: Sage)
- The Department for Education (2015) *Mental health and behaviour in schools Departmental advice for school staff* <https://www.gov.uk>
- The Mindful Nation (2015) [themindfulnessinitiative.org.uk/.../Mindfulness-APPG-Report\\_Mindful-N](http://themindfulnessinitiative.org.uk/.../Mindfulness-APPG-Report_Mindful-N)
- The Organisation for Economic Co-operation and Development (OECD) (2015) Universal Basic Skills [www.oecd.org](http://www.oecd.org) ›
- Thera, P. (1974) *The Buddha's Ancient Path* (Kandy: Buddhist Publications)
- Thomas, H.J. & Hardwick, P.J. (1989) 'An audit of a small child psychiatry clinic', *Association of Child Psychology and Psychiatry Newsletter* 11, 19-14
- Thompson, A.R. and Chambers, E. (2012) 'Ethical Issues in Qualitative Mental Health Research' In Harper, D. & Thompson, A.R. (Eds) (2012) *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners* (Chichester: Wiley-Blackwell)
- Thompson, A.R. & Harper, D. (2012) 'Introduction' In Harper, D. & Thompson, A.R. (Eds) (2012) *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners* (Chichester: Wiley-Blackwell)
- Thyer, B.A. (1993) 'Social Work Theory and Practice Research: The approach of Logical Positivism', *Social Work and Social Services Review*, 4 (1) 1993 pp 5-26
- Timimi, S. (2002) *Pathological Child Psychiatry & the Medicalization of Childhood* (Hove: Brunner- Routledge)
- Timimi, S. (2005) *Naughty Boys: anti-social behaviour, ADHD and the role of culture* (Basingstoke: Palgrave Macmillan)
- Timimi, S. (2009) *A Straight Talking Introduction to Children's Mental Health Problems* (Ross-on-Wye: PCCS Books)
- Tod, A. (2010) 'Interviewing' In Gerrish, K. & Lacey, A. (Eds) (2010) *The Research Process in Nursing* (Oxford: Wiley Blackwell)

Tomm, K.(1989) 'Externalizing the Problem and Internalizing Personal Agency' *Journal of Strategic and Systemic Therapies* Vol. 8# Spring 1989

Tonkiss, F. (2007) 'Using Focus Groups' In Seale, C. (2007) *Researching Society and Culture* (London: Sage)

Topping, A. (2010) 'The Quantitative–Qualitative Continuum' In Gerrish, K. & Lacey, A. (Eds) (2010) *The Research Process in Nursing* (Oxford: Wiley Blackwell)

Townsend, M. & Weerasuriya, R. (2010) *Beyond Blue to Green: The benefits of contact with nature for mental health and well-being* (Melbourne, Australia: Beyond Blue Ltd)

Trudgil, P. (1974) *Sociolinguistics: An Introduction* (Harmondsworth: Penguin Books)

Tugade, M.M. & Fredrickson, B.L. (2004), 'Resilient individuals use positive emotions to bounce back from negative emotional experiences', *Journal of Personality and Social Psychology*, 86, pp. 320-33

Twenge, J.M. (2000) 'Age of Anxiety? Birth cohort changes in anxiety and neuroticism, 1852-1993', *Journal of Personality and Social Psychology*, 79, pp. 1007- 21

Twenge, J.M. (2010) 'Birth cohort increases in psychopathology among young Americans, 1938-2007: A cross-temporal meta-analysis of the MMPI' *Clinical psychology Review* 30, 145-154

UK Mindfulness Trainers' Network, *Extract from the Good Practice Guidance for Teaching Mindfulness-Based Courses*, 2010 [www.mindfulnet.org/UK\\_Mindfulness\\_Trainers%20guidelines\\_2010](http://www.mindfulnet.org/UK_Mindfulness_Trainers%20guidelines_2010).

UK Network for Mindfulness-Based teacher Training Organisations setting standards for Mindfulness-Based teaching (2016) [www.mindfulnesssteachersuk.org.uk/](http://www.mindfulnesssteachersuk.org.uk/)

UNICEF (2007) An interview of child well-being in rich countries <https://www.unicef.org/media/files/ChildPovertyReport>.

Van Bakel, H. & Riksen-Walraven, M. (2002) 'Parenting and Development of One-Year-Olds: Links with parental Contextual and Child Characteristics', *Child Development*, 73: 1, 256-73

Van den Boom, D. (1994) 'The influence of temperament and mothering on attachment and exploration: an experimental manipulation of sensitive

- responsiveness among lower class mothers with irritable infants' *Child Development* 65, 1457-1477
- Velez, C.N., Johnson, J. & Cohen, P. (1989) 'A Longitudinal analysis of selected risk factors of childhood psychopathology', *Journal of the American Academy of Child and Adolescent Psychiatry*, 28, 369-373
- Verhulst, F.C. & Van der Ende, J. (2004) *Assessment Scales in Child and Adolescent Psychiatry* (Abingdon: Informa U.K.)
- Vetere, A. (2007) 'Foreword' In Dallos, R. (2007) *Attachment Narrative Therapy: Integrating Narrative, Systemic and Attachment Therapies* (Maidenhead: Open University Press)
- Wade, D.T. and Halligan, P.W. (2004) 'Do biomedical models of illness make for good healthcare systems?' *BMJ* 2004 Dec.11 329(7479):1398-1401
- Wahl, O.F. (2003) *Media Madness: Public Images of Mental Health* (New Brunswick N.J.: Rutgers University Press)
- Walach, H., Buchheld, N., Buttenmüller, V., Kleinknecht, N. and Schmidt, S. (2006) 'Measuring mindfulness—the Freiburg mindfulness inventory (FMI)'. *Personality and Individual Differences* 40: 1543 –55.
- Walker, J. and Donaldson, C. (2011) *Intervening to improve outcomes for vulnerable young people: a review of the evidence*. Research Report DFE-RR078
- Walker, S. (2003) *Social Work and Child Mental Health* (Lyme Regis: Russell House Publishing)
- Wardhaugh, R. (1986) *An Introduction to Sociolinguistics* (Oxford: Blackwell)
- Watt, T. (2012) *Mindfulness: A practical guide* (London: Icon Books)
- Weare, K. (2013) 'Developing mindfulness with children and young people: a review of the evidence and policy content' *Journal of Children's Services* Vol. 8 issue. 3, pp. 141-153
- Webster-Stratton, C. & Moston, D. (1992) *The Incredible Years: A trouble shooting guide for parents of children aged 3-8* (Toronto: Umbrella Press)
- Webster- Stratton Parenting Programme Viewed 12.01.15*  
[www.incredibleyears.com/](http://www.incredibleyears.com/)
- Welford, M. (2012) *The Compassionate Mind Approach to Building Self-confidence using Compassion Focused Therapy* (London: Constable and Robinson)



- Wenk, G.L. (2013) 'Why Is Mindfulness so Hard to Achieve?: Blame your brain and evolution' *Psychology Today* May 14, 2013
- White, M. & Epston, D. (1990) *Narrative Means to Therapeutic Ends* (New York: Norton)
- White, M. (1995) *Re-Authoring Lives: Interviews and Essays*. (Adelaide: Dulwich Centre Publications).
- Willard, C. (2010) *Child's Mind: Mindfulness Practices to Help Our Children Be More Focused, Calm, and Relaxed* (Berkeley California: Parallax Press)
- Williams, J.M. and Kabat-Zinn, J. (2013) *Mindfulness: Diverse Perspectives on its Meaning, Origins and Multiple Applications at the Intersection of Science and Dharma* (Abingdon: Routledge)
- Williams, M. and Penman, D. (2014) *Mindfulness: a practical guide to finding peace in a frantic world* (London: Piatkus)
- Williams, R. (1995) 'Foreword' In Health Advisory Service (1995) *Child and Adolescent Mental Health Services: Together we Stand – the commissioning role and management of child and adolescent mental health services* (London: H.M.S.O.)
- Williams, R. & Kerfoot, M. (Eds) (2005) *Child and Adolescent Mental Health Services, strategy, planning, delivering and evaluating* (Oxford: University Press)
- Williams, R. & Kerfoot, M. (2005) 'Setting the scene: perspectives on the history of and policy for child and adolescent mental health services in the UK' In Williams, R. & Kerfoot, M. (Eds) (2005) *Child and Adolescent Mental Health Services: Strategy, planning, delivery and evaluation* (Oxford: University Press)
- Williams, M., Teasdale, J., Segal, Z. & Kabat-Zinn, J. (2007) *The Mindful Way Through Depression: Freeing Yourself from Chronic Unhappiness* (New York: Guilford)
- Winnicott, D.W. (1956) 'Primary Maternal Preoccupation' In Winnicott, D.W. *Collected Papers: Through Paediatrics to Psycho-analysis*. (New York: Basic Books)
- Wilson, A. (2003) 'Real Jobs', 'Learning Difficulties' and 'Supported Employment' *Disability and Society*, 18 (2) 99-1150
- Wilson, P. (2011) 'Foreword to Understanding Children and Young People's Mental Health', In Claveirole, A. & Gaughan, M. (Eds) (2011) *Understanding Children and Young People's Mental Health* (Chichester: John Wiley & Sons)

Wisner, B. L., Jones, B. & Gwin, D. (2010). School-based Meditation Practices for Adolescents: A Resource for Strengthening Self-Regulation, Emotional Coping, and Self-Esteem *Children and Schools*, 32(3), 150- 159.

Wittmann, M. (2009) 'The inner experience of time', *Philosophical Transactions of the Royal Society B Biological Sciences* 31 May 2009 Volume 364 Issue 1525 pp. 1955-1967

Wong, I.C.K., Murray, M.L., Camilleri-Novak, D. & Stephens, P. 'Increased prescribing trends of paediatric psychotropic medications' *Archives of Disease in Children* 2004; 89:1131-1132

Wong, S.E. (2010) 'Single-Case Evaluation Design for Practitioners' *Journal of Social Service Research*, Vol. 36 Issue 3, 2010 pp. 248-259

Wood, C. (2005) 'Data Protection Issues in Educational Research' In Sheehy, K., Nind, M., Rix, J. & Simmons, K. (Eds) (2005) *Ethics and Research in Inclusive Education: Values into Practice* (Abingdon: Routledge Falmer)

World Health Organisation (1992) *The ICD-10 Classification of Mental Health and Behavioural Disorders Clinical Descriptions and Diagnostic Guidelines* (Geneva: WHO)

World Health Organisation (2012) *Risks to Mental Health: An overview of vulnerability and risk factors*  
[www.who.int/mental\\_health/.../risks\\_to\\_mental\\_health\\_EN\\_27\\_08\\_12.p](http://www.who.int/mental_health/.../risks_to_mental_health_EN_27_08_12.p)

York, A. & Kingsbury, S. (2009) *The Choice and Partnership Approach: A guide to CAPA* (Bournemouth: Caric Press)

Young, K. (2015), 'Ask the Experts: Does meditation work for everyone?' *The Telegraph* 3.06.15

Young Minds *Government Response to CAMHS policy* viewed 21.07.14  
[www.youngminds.org.uk/training...in.../camhs\\_policy\\_in\\_england](http://www.youngminds.org.uk/training...in.../camhs_policy_in_england)

Young Minds *Major failings in CAMHS tiers* (2014) [www.youngminds.org.uk/.../2137\\_major\\_failings\\_in\\_camhs\\_tier\\_four\\_s...](http://www.youngminds.org.uk/.../2137_major_failings_in_camhs_tier_four_s...) 11 Jul 2014

Youth in Mind Web Site *SDQ scores* [www.youthinmind.com](http://www.youthinmind.com)

Zelago, P.A. & Lyons, K.E. (2012) Child Development Perspectives the potential benefits of Mindfulness training in Early Childhood: A Developmental Social Cognitive Neuroscience Perspective, *Child Development Perspectives* Volume 6 Number 2 2012 pages 154- 160

Zimmerman, J.L. & Beaudoin, M. (2002) 'Cats Under the Stars: A Narrative Story', *Child and Adolescent Mental Health* Volume 7, No. 1, (2002), pp. 31 – 40

# APPENDICES

# Appendix 1

## Introductory Session Plan

Welcome

Clarify that the meeting is to explain Mindfulness and what the group will be about.

Introductions

Mindfulness is helpful in lots of different ways – work has been mainly with adults. Helps people become calmer and make better decisions. It doesn't actually solve problems but it may help you to tackle them differently.

Mindfulness means being aware of the present. Not being in the future or the past but focused on the here and not making judgements

The group

- Research to see whether mindfulness helps.
- Because it is research certain ways to do it
- Informed consent from those taking part.
- Attending 8 groups where we will discuss and practice mindfulness
- Filling in some questionnaires at the beginning and end of the sessions.
- After this a focus group where you tell us what you thought of the group
- An interview with your parents to get their views

We ask you to attend the eight sessions – for about an hour each -we will try to make it fun and not boring.

Any Questions?

Explain mindfulness by demonstrating with Snow Globe.

Mindfulness practice for a few minutes.

It may sound easy but it takes practice -have to be kind to yourself.

How was that?

Any Questions?

## Snow globe



This is a useful tool to illustrate how the mind can be busy with a lot of thoughts to such an extent that nothing is clear any more. Allow the thoughts to settle – as in mindfulness practice and things will become clearer.

## Session 1

Thank you all for coming

We have had an introduction session to mindfulness and met again to fill in some questionnaires. Those of you who have not completed these yet I will speak to individually.

Basically this is an 8 week course in Mindfulness. Mindfulness has helped people with all sorts of different problems – physical illness, anxiety, depression and many more. Also you need not to be suffering from anything in particular for mindfulness to be a benefit to you. Mindfulness has its roots in Buddhist culture but that does not mean that anyone needs to become a Buddhist. There seems to be a lot of sense in some of the things they say and as they have been studying it for hundreds of years it is worth a look. We ask you to stick with the course for the 8 weeks and then decide whether it has been useful to you.

Getting to know you

Ground rules

### What mindfulness is about

Mindfulness is an altered state of consciousness where you can just be

Mindfulness practice 10 minutes plus feedback

Mindfulness has its roots in Buddhist culture but you don't need to be a Buddhist. I think a lot of what they believe makes a lot of sense. You need to see for yourself whether it is useful. Mention the emotional systems and their importance.

Story about the 10 shops to illustrate the tendency to negative thinking

The Mule in the well story

Images to illustrate different ways of letting thoughts go by – they choose

### Home practice

Try mindfulness for yourself at home

Make a note of things that make you feel good

## The 10 shops story

Near Christmas Mary went shopping to buy presents. In the first shop she went into they were very helpful and she found just what she wanted.



The next shop was a toy shop and they were equally helpful.



In the third shop Mary was impressed by how much trouble the assistant took to help her find exactly what she wanted.



The next place she visited was equally helpful and she found a delightful gift for her brother.





She then went into a cake shop. She bought some mince pies and sat down in the café part and had a lovely cup of coffee.



She went on to another shop and was met by helpful people who directed her to the part of the shop where she bought a gift for her sister.



Then she went into yet another shop. Here the people were friendly and smiled at everyone.



The eighth shop was no different and she found everything that she wanted.



She went on. She had two more gifts to buy; one for herself and one for her mother. In the next shop she was delighted to find some beautiful shoes which fitted her perfectly.



She now just had her mother's gift to buy. In the last shop she found them to be very rude, not at all helpful and they just couldn't be bothered to help her. She came out with nothing.



Which is the experience that Mary is most likely to remember?

## Ideas to help you let go of your thoughts

### Leaves

The idea about leaves is that your thoughts can attach to them and drift away in the breeze.



[



They can blow away

**Or drift in a stream**



**Falling from the tree**



**or from a single branch**



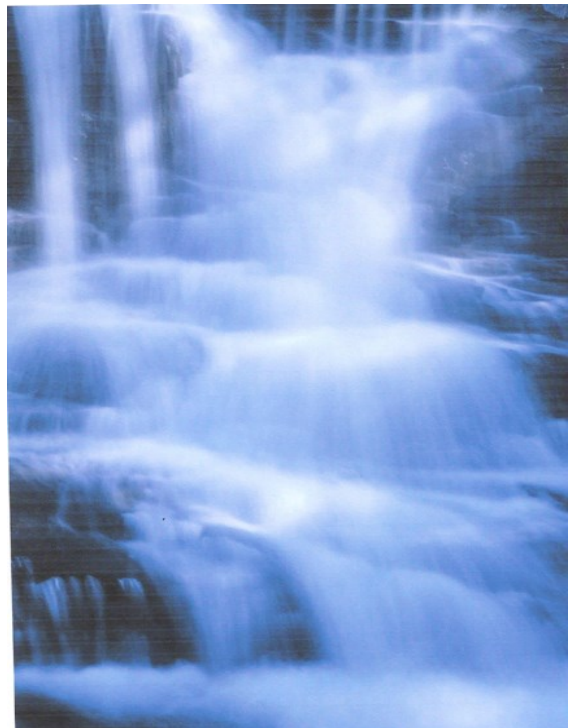


**Leaves drifting in a stream**

**or just the stream flowing past**



**The idea of a waterfall washing away any thoughts is useful to some people**



**Clouds drifting in the sky are a similar concept.**



**clouds can  
be all  
shapes**



**They can combine with other images**

**Or just drift across the sky**

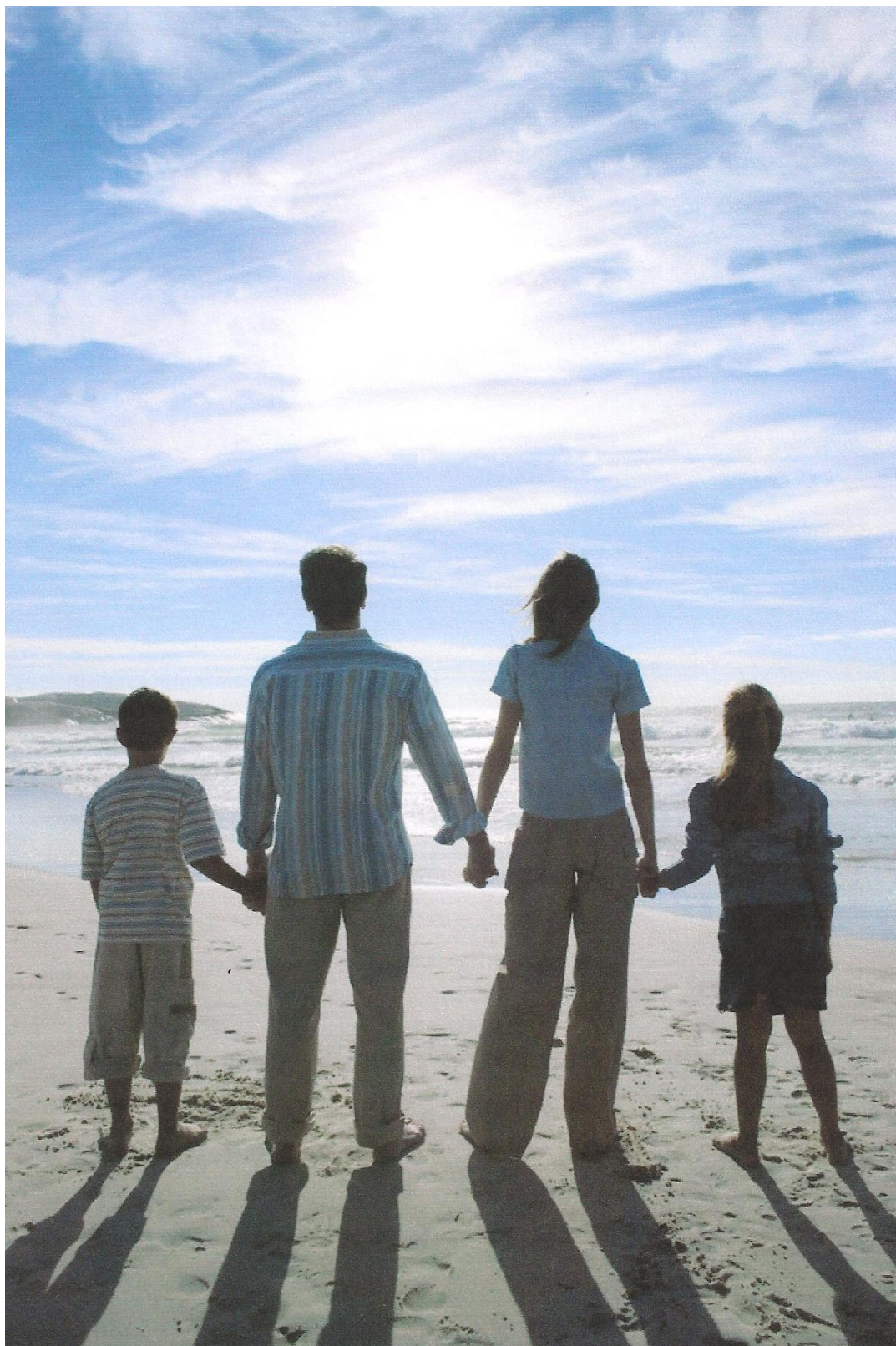


**Sand is another idea. Thoughts can be imprinted and then washed away.**



**Footsteps in the sand – washed away by the tide**

**This picture combines many ideas – it can help people chose what is best for them**





**Another idea is that you are traveling along, leaving intrusive thoughts behind.**



**You could imagine your thoughts written on a billboard**



**Then let them pass by**

**A different idea is a room with two doors. Thoughts come in one door and go out through the other without bothering you.**



**And there are also candles which can provide a good focus point.**

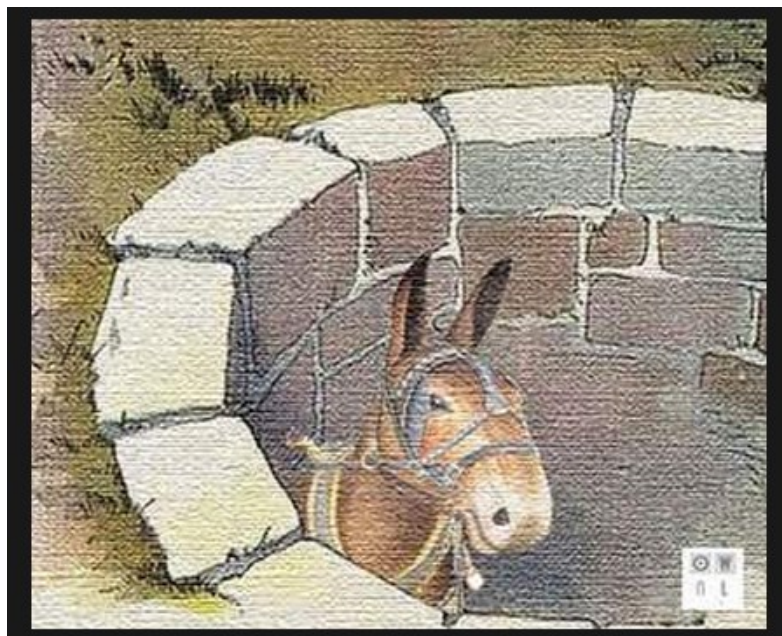


## The Old Mule in the Well

A parable is told of a farmer who owned an old mule. The mule fell into the farmer's well. The farmer heard the mule 'braying' — or whatever mules do when they fall into wells. After carefully assessing the situation, the farmer sympathized with the mule, but decided that neither the mule nor the well was worth the trouble of saving. Instead, he called his neighbours together and told them what had happened; and enlisted them to help haul dirt to bury the old mule in the well and put him out of his misery.

Initially, the old mule was hysterical! But as the farmer and his neighbours continued shovelling and the dirt hit his back, a thought struck him. It suddenly dawned on him that every time a shovel load of dirt landed on his back, he should shake it off and step up! This he did, blow after blow. "Shake it off and step up ... shake it off and step up ... shake it off and step up!" He repeated to encourage himself. No matter how painful the blows, or how distressing the situation seemed the old mule fought "panic" and just kept right on shaking it off and stepping up!

It wasn't long before the old mule, battered and exhausted, stepped triumphantly over the wall of that well! What seemed like it would bury him, actually blessed him; all because of the manner in which he handled his adversity. If we face our problems, respond to them positively, and refuse to give in to panic, bitterness, or self-pity, the adversities that come along to bury us usually have within them the potential to benefit and bless us.



## **Session 2**

**How did you get on with your mindfulness practice? Any issues?**

**I want to hear about the things you discovered to cheer you up?**

**Read out Surfing the Urge**

**Identify 3 good things that have happened during the day. It's a good idea to write them down before you go to bed at night – at least you can go to bed happy.**

**So yes you missed the train but for example it was a really good cup of coffee that you drank while waiting for the next train, or you met someone you hadn't seen for ages, or you didn't have to stand in the rain, the waiting room was nice and warm. No, you didn't get offered the job, but at least they took the trouble to phone and give you feedback, which was helpful. Thankfully you had an umbrella and avoided getting soaked in that downpour on your way home this evening.**

**Mindfulness practise 10 minutes plus feedback**

### **The body stress reaction**

**Last time we said that there were 3 major drive systems that humans have. One is the fight or flight system which we are going to look at today, another is the Drive system that motivates us to go and get things and another is the soothing system. As we said before we need a balance.**

**Show video clip -Any comments?**

### **How mindfulness can help**

**Did you notice that thinking about the audience in their underwear changed his stress reaction? Our thoughts, feelings and behaviour are all interconnected**

**Stress reactions and breathing exercise**

**15 minute body scan – check CD**

**Home Practise**

**Hand out – Instructions for mindfulness practice**

**Mindful breathing and mindful walking**

## Fight or Flight? Video Clip

[Stress Recess Home](#) > [Level\\_One](#)

### Fight or Flight

**What does "fight or flight" mean?**

The term "fight or flight" describes a mechanism in the body that enables humans and animals to mobilize a lot of energy rapidly in order to cope with threats to survival.

To see it in action, click the picture below. Warning! Not for the faint of heart.



---

Video Clip found at

[http://cmhc.utexas.edu/stressrecess/Level\\_One/fof.html](http://cmhc.utexas.edu/stressrecess/Level_One/fof.html)

## **Instructions for mindful breathing hand-out**

### Sample instructions for mindful breathing

**Mace 2008**

- 1. Settle into a comfortable balanced, sitting position on a chair or floor in a quiet room.**
- 2. Keep the spine erect. Allow the eyes to close.**
- 3. Bring your awareness to the sensations of contact wherever your body is being supported. Gently explore how this really feels.**
- 4. Become aware of your body's movements during breathing at the chest and at the abdomen.**
- 5. As the breath passes in and out of the body, bring your awareness to the changing sensations at the abdominal wall. Maintain this awareness throughout each breath and from one breath to the next.**
- 6. Allow the breath simply to breath, without trying to change or control it, just noticing the sensations that go with every movement.**
- 7. As soon as you notice your mind wandering, bring your awareness gently back to the movement of the abdomen. Do this over and over and over again. Every time, it is fine. It helps the awareness to grow.**
- 8. Be patient with yourself.**
- 9. After 15 minutes or so, bring the awareness gently back to your whole body sitting in the room.**
- 10. Open the eyes. Be ready for whatever is next.**

## Session 3

How did you get on with your mindfulness practice?

Any issues? There is not right or wrong way – some days are easier than others. There is no right or wrong way to practice mindfulness. Just do whatever works for you.

What about the Good things book Happy book? Read yours

Mindfulness practise 10 minutes plus feedback

### Emotions

What are they? Why are they useful?

Sometimes we get emotions that we don't want and sometimes they get too much. Emotions have 3 aspects to them :- 1.The situation 2. How we perceive it 3.Our bodies reaction to it

### Managing them

As the reaction of our bodies is largely automatic there is not much we can do to influence how our bodies react. So let's jump to number 2 - the middle aspect - perception.

If for example we believe that we are stupid or cannot do something – these are unhelpful thoughts which pull us down. They are not necessarily true but they pull us down. Thoughts are not necessarily true – even the ones that say they are.

How we perceive or think of things can make a big difference. Robber or victim- What would you feel?

Story of the magic tree The Gruffalo's child imagines a monster when it is the shadow a mouse casts in the moonlight.

Mindfulness encourages us to view our emotions just as they are from a neutral prospective and with openness and curiosity. Not mixing them up with memories or imagining add-ons.

### Illusions

### Home Practise

Mindfulness practice

Brushing your teeth mindfully with the other hand



# Illusions

What do



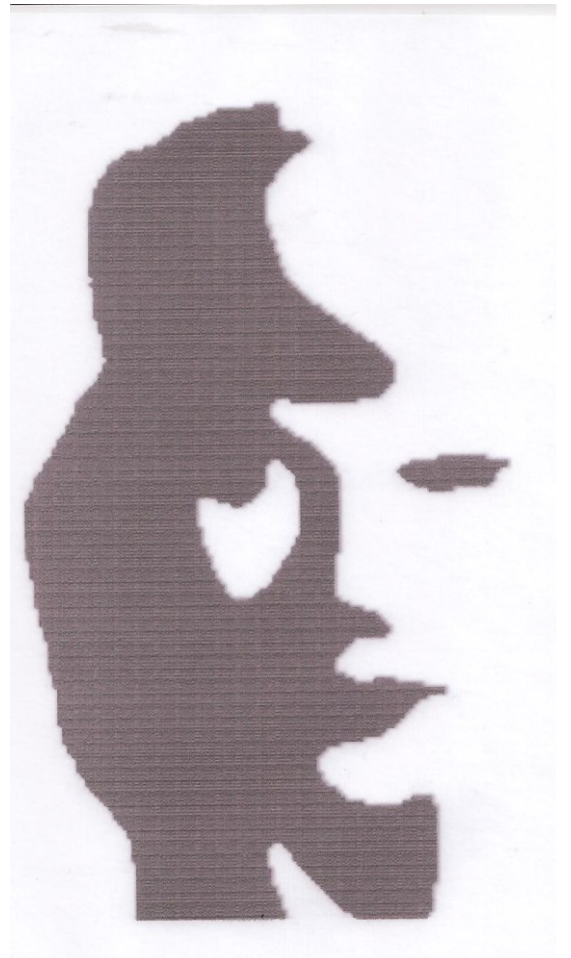
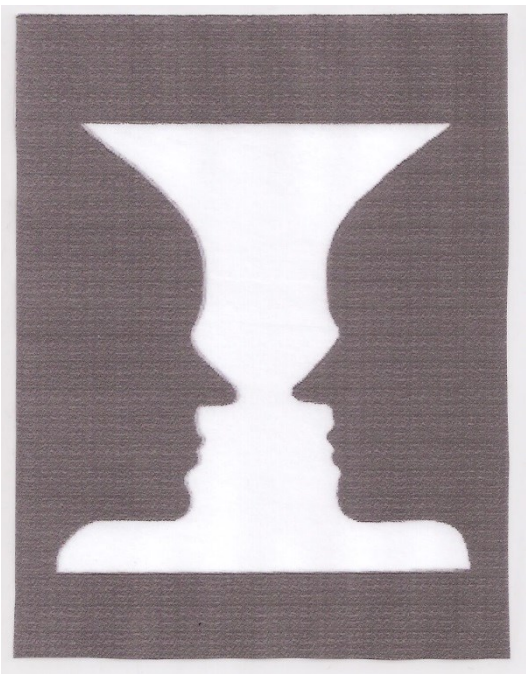
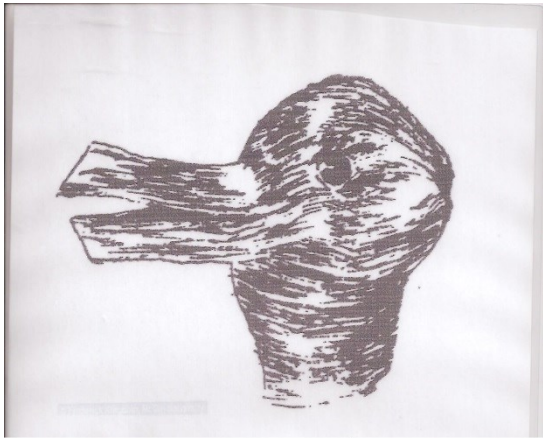
you see?

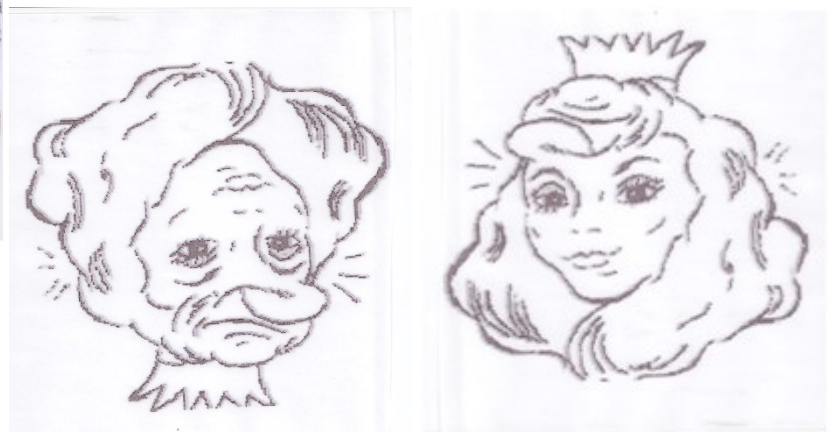
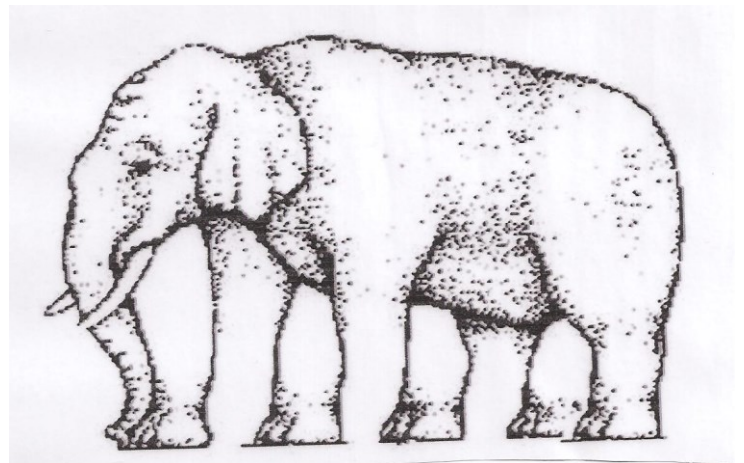
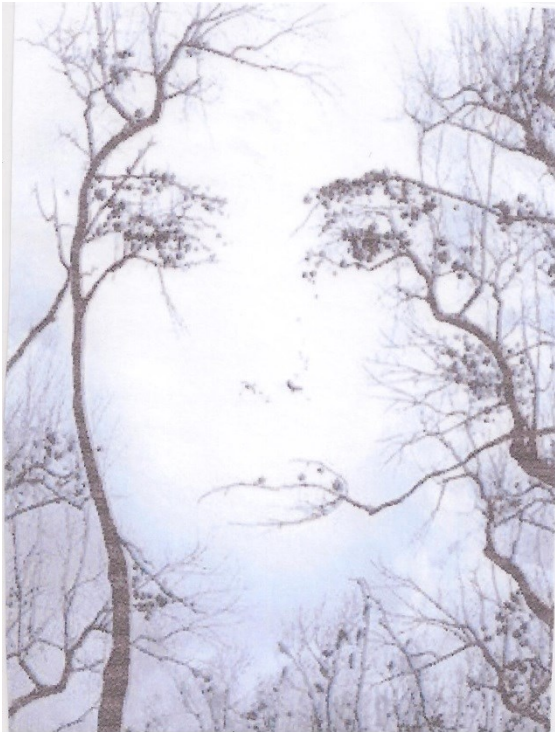
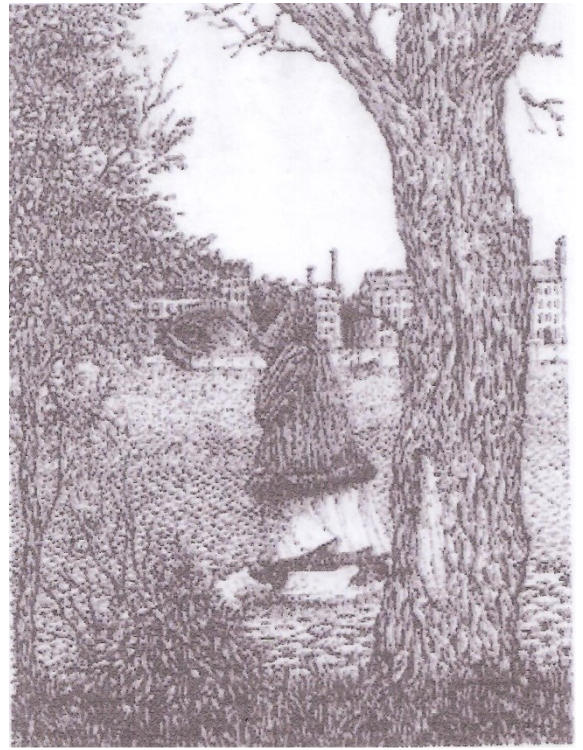
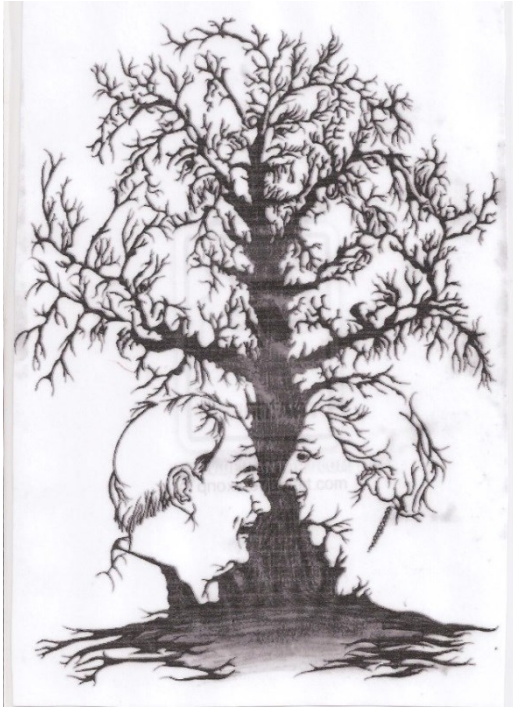
Old lady?

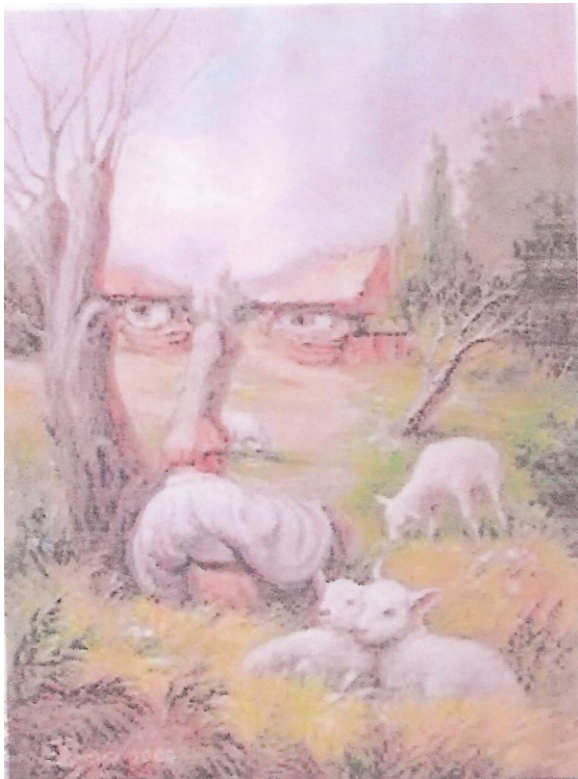


Young lady?





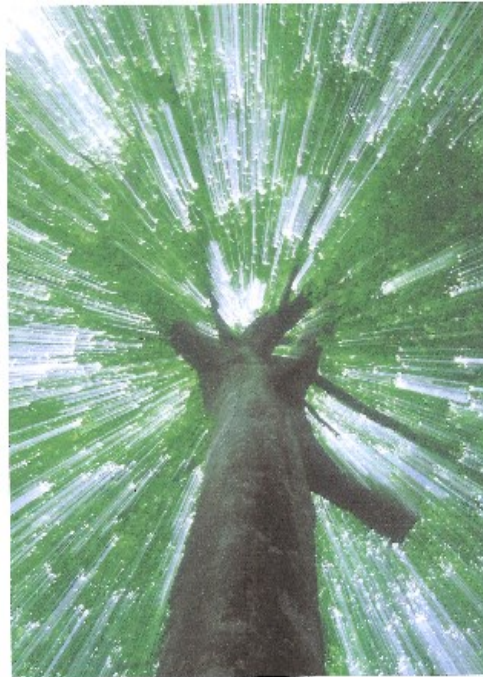




## The story of the boy under the magic tree

### The Boy under the Magic Tree

Once upon a time a boy was out playing in the woods. He had been out for a long time. The day was warm and he felt tired. He saw a tree that had soft leaves beneath it. He sat down for a moment to rest. What he did not know was that the tree was magic. "This is great" he thought, "but if only I had a soft comfy pillow to put under my head". No sooner had he thought this when suddenly a pillow appeared. "Wow fantastic" he thought. "All I am missing is a blanket to cover me." No sooner had he thought this than a soft fleecy blanket appeared round his legs. He was very comfortable and he went off to sleep. Some time later he woke up. Now he was feeling quite hungry. "If only I had some nice food to eat" he thought. No sooner had he had this thought than a small cottage appeared before him. He went inside and looked around. There was no one else there but in was a table laid out with all sorts of food. In fact all his favourites were there. He ate as much as he wanted and felt very pleased with himself. However after awhile he began to get a bit bored. He was no longer tired nor hungry. There seemed nothing to do. "I wish I had brought my game with me" he thought. No thought than all sorts of new and interesting games – including the ones he liked best. He played happily with these for quite some time. Quite a long time later he had another thought "Hang on this is odd. Could this tree be haunted?" There was a strange sound. "What if it is a monster?" he thought. Another louder sound came. "What if it gobbles me up?" he thought. And the monster DID.



## **Session 4**

**Review previous session and home practice (show picture from the Gruffalo's Child)**

**How did you get on with brushing your teeth with the other hand?**

**Not pre-judging –being your own best friend**

**Sai and the horse**

**Mindfulness practice plus feedback**

**Noticing your thoughts and feelings and their effect on you**

**Know your Orange**

**3 minute breathing space**

**Eating a raisin mindfully**

**What's in the box?**

**How did it feel not knowing? How did it feel when you found out?**

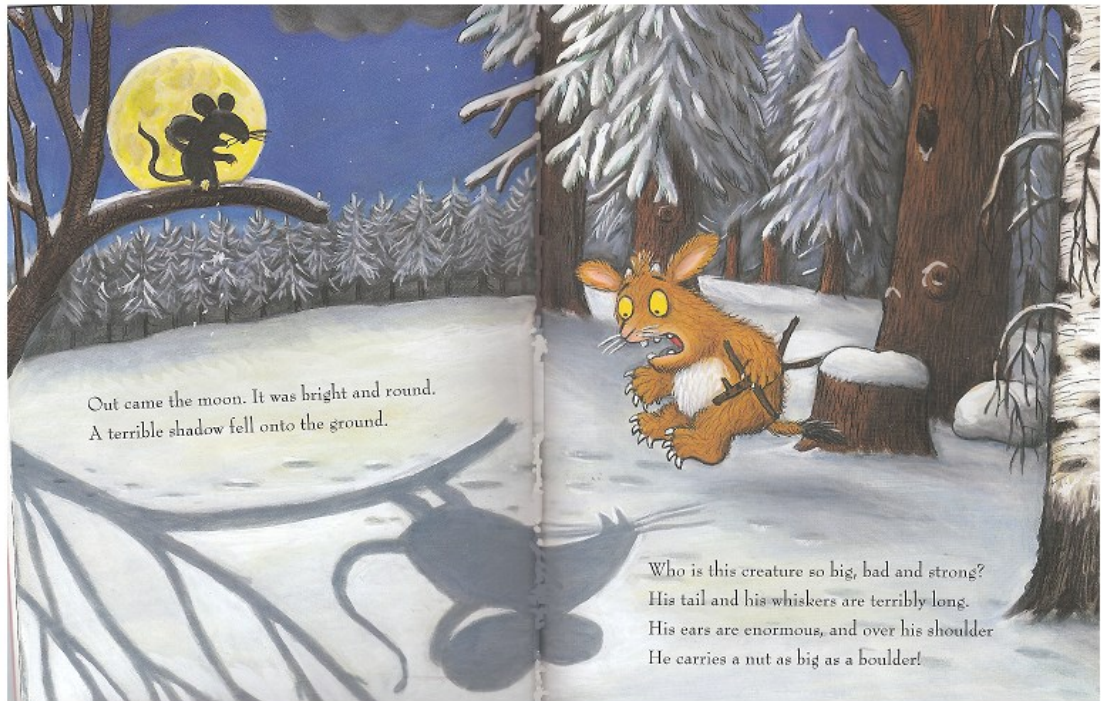
**Other ideas to help with mindfulness practice – hour glass – clouds-waves**

### **Home Practice**

**Eating a snack mindfully**

**Try different ways of letting your thoughts go by**

## The Gruffalo's Child faces his monster



## Sai and the horse

In ancient China lived an old farmer named Sai. He awoke one morning and looked in his stable, only to find that his horse had disappeared. He looked everywhere, but couldn't find it. His neighbours came by that afternoon to express their sadness at his apparent misfortune and bad luck. Sai took it in his stride. "Bad luck, good luck who ever knows?" He asked them. A few days later his horse returned, this time with a mare. His neighbours congratulated him. "Sai," they exclaimed, "congratulations on your luck! You have two horses now. "Bad luck, good luck who ever knows" he responded. A few weeks later, he awoke to the sound of his son crying outside. He went out to find his son crying and holding his broken leg- he had just been thrown by the mare. His son lay in bed for weeks and the neighbours again came by and clicked their tongues. "What bad luck!" they exclaimed. "Bad luck, good luck who ever knows?" said Sai. The next day the army came through town to take every young man to war, and the neighbours exclaimed again about the luck that Sai's son wasn't drafted for the war. So what do you think Sai said? "Bad luck, good luck who ever knows?"





## **Know Your Orange activity**

Have a collection of oranges – in a bowl or a basket. Ask the group to select an orange for themselves – which they do individually.

Ask them to look at it – notice the colours – the markings – how it feels – the textures – the weight – how it smells. Anything about it that you notice - get to know your orange. Then collect the oranges back into the container. Later get the young people to come and select their orange from the others.

(Willard 2011 inspired by a story by Jack Kornfield)

## **Eating a raisin Mindfully**

**The idea behind this exercise is to pretend that you have never seen a raisin before. Look at it carefully with fresh eyes, examine it, smell it feel it, listen to it, put it in your mouth see how it feels do not eat it yet. Feel it with your tongue, bite into it slowly savour the flavour now swallow. The usual way is to eat without any thought usually not noticing the taste. Very often people say that was the best raisin because perhaps for the first time they are actually noticing how raisins taste. This can be done with other small items of food and even whole meals but eating something small and doing it mindfully makes the point.**

## **What's in the box?**



This is another activity which the young people can engage in. They each have a turn to handle the box and guess what might be in there. It can help to develop attention and also lends itself to a discussion about how it felt not knowing what was in the box – how it felt when they found out – which all contribute to recognition of feelings and accepting them as they are.



## **Waves**

**This is a useful way of viewing thoughts– they come and go like the waves. Emotions rise and fall and thoughts and situations pass away – move on. Things are impermanent.**



## **Hour Glass**

**An hour glass – or an egg timer is a useful focusing point. One can imagine thoughts drifting away as the sand runs through. Clearly an egg timer provides perhaps too short a time to focus and an hour glass maybe too long for some young people.**



**Something in between is better.**

## Watching different cloud formations



## They come and go



## **Session 5**

**Review previous session and home practice**

**How did you get on with eating a snack mindfully?**

**Which way is easiest to practice mindfulness? - Ask individually**

**Did any of you who hadn't done it before try brushing your teeth with the other hand?**

**How was that?**

**Discuss the orange identification from last week. Did you believe that you would be able to find your own orange in a pile of others?**

**Mindfulness practice plus feedback**

**Becoming more aware of now -Noticing your thoughts and feelings and their effect on you**

**Imagine that your friend walks by and doesn't acknowledge you. How do you feel? Your friend has ignored you? Consider other explanations.**

**If we depend on others acknowledging us and giving us a smile to feel happy we potentially subject ourselves to reflecting the mood of everyone we pass in the street. Think about this– and if you see someone without a smile give them one of yours. Just try it as an experiment.**

**Video clip basketball selective attention test**

**Listening exercise**

**During the next 3 minutes I am going to ask you to just listen. Write down the sounds that you hear. Ask who has something written down. (Hands up) –different number of things**

**Did any of the sounds you heard bring up any associations – does it remind you of anything – do you have any feelings about the noise.**

**What you believe is important. If you think you can't do something then you probably won't be able to do it. Give out pictures with the text "that voice in your head that says you can't do this is a liar".**

**Home Practice**

**Mindfulness practice**

**Note any examples of things you notice and bring them back to class**

## Selective Attention Test

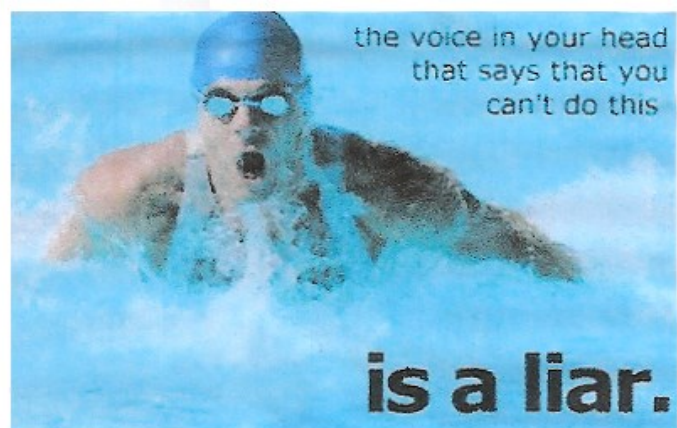
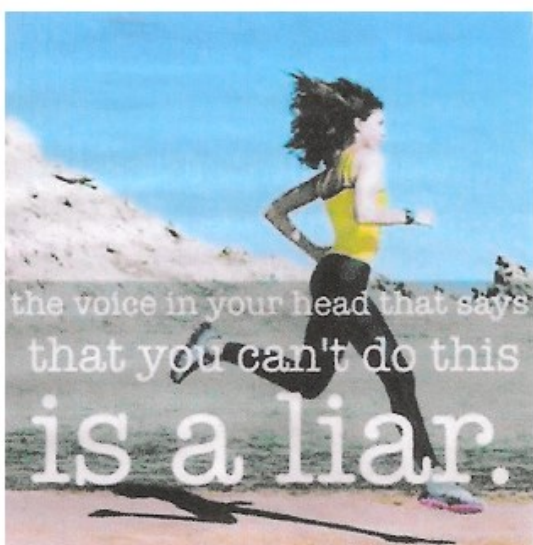
This was produced by Simons, D.J. and Chabis, C. in 1999 as a research project.

It is available at [www.youtube.com/watch?v=vJG6982M](http://www.youtube.com/watch?v=vJG6982M)

Selective Attention



## The voice in your head



## Session 6

Review previous session and home practice

Did any of you try eating a snack mindfully? – I didn't ask you last time.

Tell me about your experience of mindfulness – what is the best time for you? - inside or outside etc. Is anything particularly helpful/ unhelpful - The point about asking this is so that we can pool our ideas and help each other.

I would like to explain why the meditations have been relatively short – it really depends on you carrying it on I can only explain things – you have to experience it

Discussion about doing activities mindfully- walking the dog- riding a horse- sweeping up

Mindfulness practice plus feedback

What you focus on gets bigger - Resistance is futile – don't think of an orange with large purple spots easier just to notice rather than trying not to

Paper planes – paper supply – try and fend them off – let them settle which is easier?

Focus on what you want – not what you don't want e.g. winning the game or being scared of losing – just playing works well! Doing an exam – scared of failing – just look at what's in front of you. If you find your thoughts going to negative ones –just ease them back- just take one little step in a positive right direction. The journey of 1,000 miles starts with a single step. Any examples of something you want to do/achieve- which seems too big a task?

Be confident in yourself – be your own best friend, don't beat yourself up. Not pre-judging – letting yourself off the hook – it's not your fault it's the way the brain has evolved

Discussion about ways of doing mindfulness e.g. directed or silent music or other

### Home Practice

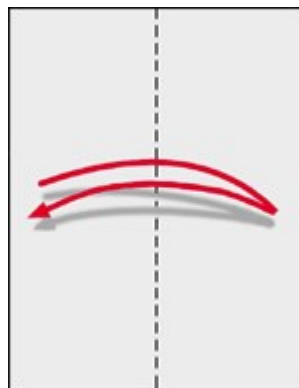
Mindfulness practice

Take a nature walk & notice what is really there – make a note of them and bring them back to class.

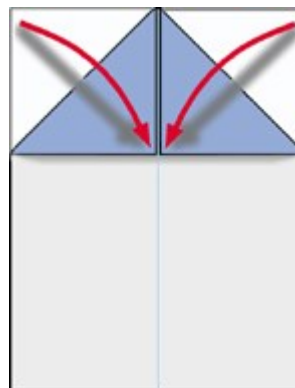
## How to make a paper dart

# Basic Dart

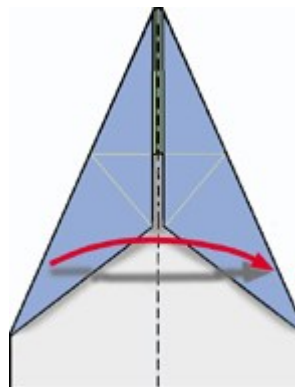
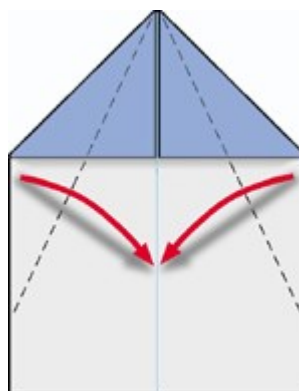
## Folding Instructions



Step 1



Step 2



Step 4

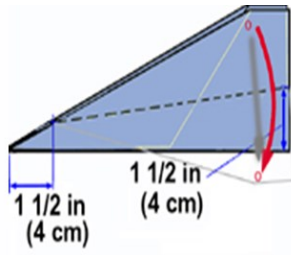
**Step 1.**  
Use a sheet of 8 1/2-by-11 inch paper. Fold the paper in half lengthwise and run thumbnail along the fold to crease it sharply. Now, unfold the paper.

**Step 2**  
Fold down the top corners as indicated by the arrows.

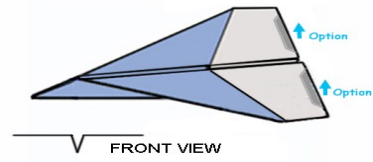
**Step 3**  
Fold the two edges toward the center line, as indicated.

**Step 4.**  
Make a valley fold in half. Turn the

Step 3



Step 5



Step 6

plane 90 degrees as shown in figure of Step 5.

## Session 7

Review previous session and home practice

Ask about nature walk

If you find your thoughts going to the negatives - (I'll never do it- I'm no good- it's impossible- I can't afford it – or any other excuses you might give yourself) – just take one little step in the right direction. Stick with the now and what is in your immediate location. Remember your thoughts aren't necessarily true – even the ones that say they are!

Mindfulness practice with CD

Mindfulness with music

The two darts of pain

e.g. of a young lady with a medical condition. She coped with this very well but couldn't come to terms with the fact that she had it – spending a good deal of her time just hating having it – accepting what is there – doesn't mean ignoring it – do what you can but don't focus on it

Story of the man who was shot by a poison arrow

Wise mind/ logical mind/ emotional mind.

Becoming more aware of now -Noticing your thoughts and feelings and their effect on you so that they don't trap you when you are not looking. Remember how when they were talking about alcohol next door - some of you were picking up on the feelings – this can happen. Just notice what is going on in your body and that way you will be more in charge.

Talk about the project and names

What would be useful for next time?

Home Practice

Mindfulness practice – try different things – activity mindfulness- walking- sitting

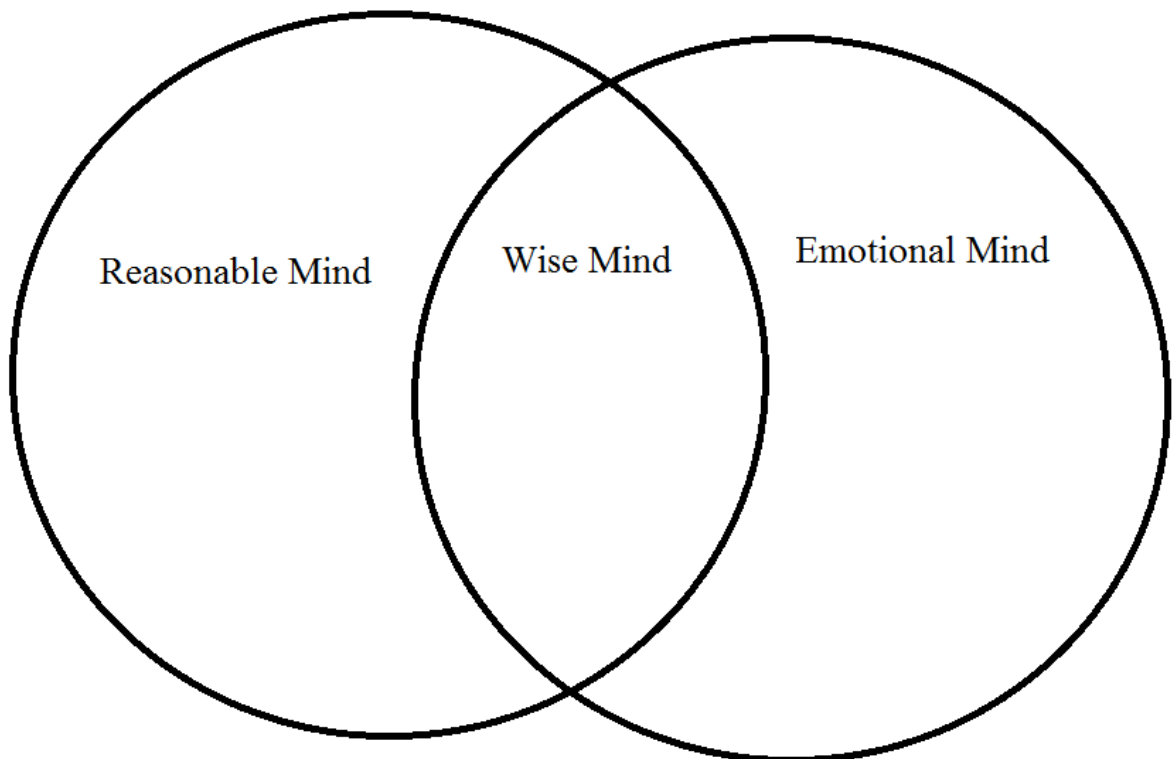


## The Man who was shot by a poisoned arrow

One of the most famous stories attributed to the Buddha is the parable about the man who was shot by a poisoned arrow. While travelling through a forest a man is shot with a poisoned arrow. A crowd gathers wanting to help. Before he allows a surgeon to remove the arrow and administer healing medicines, however the man insists on asking: “Who shot me. Was it a friend or foe? Was the person tall or short, dark or light skinned? To what caste did the person belong? Was I shot in anger or by accident?” Before he can complete his questions the man dies. Commenting on the story, the Buddha pointed out that the man is asking the wrong questions. The right question is much more direct and to the point. “Is there an antidote to this poison?”

## The balance between reasonable, wise and emotional

Reasonable Mind/Wise Mind/Emotional Mind



We need to get the balance right

## Session 8

Review previous session and home practice- what did you try? Which was helpful?

Mindfulness practice to be outside in the park

Prepare to go on mindfulness walk. Ok I want you all to get into a mindful state of awareness. You just notice what is happening around you. Be aware of everything especially the traffic! We are going to walk mindfully to the small park without any talking or communication between you. Just be yourself in the here and now. We will stay there for 10 minutes and then return here. I will give you a signal when it is time to come back.

How was that? Discussion.

Last time we talked about listening to music to do our mindfulness practice. Emily suggested guitar music – so we will try that first. The rest of you thought that the sound of waves would be good so we will do that next.

Discussion after each piece.

Ask yourself the question – can you fix it? - Yes – then fix it no point in worrying about - No – then no point in worrying about it.

Prayer of serenity - explain this to them –give copy of this to them

These eight sessions have just been to give you a taster of mindfulness. I hope you will continue to practice. Even the 3 minute breathing space – which you all thought was too short – can be useful sometimes. Say you feel you are '*losing it*' and need to compose yourself quite quickly.

I would just like to remind you about names.

We will meet next week just to do the questionnaires and the following week to have the focus group so that you can say what you thought of the sessions. Can I also ask you to take a questionnaire home to your parents? I would like to compare the ones I asked them to do earlier to see if there is any difference.

### Home Practice

Please try to continue with mindfulness practice.

## The Serenity Prayer

# The Serenity Prayer

**God grant me the serenity  
to accept the things I cannot change;  
courage to change the things I can;  
and wisdom to know the difference.**

## The Park



## Appendix 2

### Basic Information Sheet

#### Mindfulness

Most of us rush around fitting in all sorts of things in our day that we never have a moment to breath - so it seems. We are constantly in our heads thinking about all those things which we need to do or all those things which we have not done and we now think about with regret.

Mindfulness gives us the space - a moment of calm to reflect and just be ourselves. It allows us a breathing space to think outside the box.



**How often have you been in your head and not really noticing what is going on around you? How often have you driven to your destination and realised you did not know how you arrived there? How often have you gone through what was said and analysed it and re-analysed it becoming more and more angry as you did so? How often have you rehearsed what you would say, thought about the possible circumstances – how you would handle it? All these are natural reactions to what happens in our everyday life. They are examples of not being mindful. Furthermore you can get stuck in the future – or the past to the extent that you miss out on what is happening in everyday life.**

**Mindfulness offers a different access to another state of mind which allows escape from the worries about the past and the future. They do not go away it is just that it puts us in a better frame of mind to be able to deal with them. It allows the space to escape from our conditioning and space to consider what is reasonable and workable rather than what is expected or what our emotions dictate. It helps us realise how much our thoughts impact on our lives and creates a potential to change how we view things. Mindfulness creates a new dimension outside the box that allows us more clarity.**

**All you have to do is breath and remain in your present moment. It sounds simple but it also takes practice. First you need to find a space to sit. Sit proudly –upright but relaxed and comfortable - like a king or queen. Take a deep breath and then just notice how you are breathing. Notice which bits of your body are touching the chair. Notice where your feet are on the floor. Just be aware. If your mind turns to other things simply bring it back gently to your breathing, merely noticing that your mind has wandered. That is what minds do. Do not beat yourself up for it – just accept it and count it as practise – practice of bringing your mind back into focus. If this happens 100 times it will give you 100 times to practise. Each time gently bring**

**your mind back to where you are and focus on the breath, the feel of the chair and anything else that is happening to you right now.**

**That was an example of a simple mindfulness practise but you can be mindful anywhere. Just try being mindful when you are doing routine tasks- brushing your teeth- brushing your hair or walking down the road. Mindfulness helps to get you focused helps to ground you and take your head out of the clouds. There is firm evidence that it does help to overcome stress and other traumas which we all face. Just focus on your breath and whatever it is you are doing and just be.**

**The concept of mindfulness has its roots in Buddhist tradition although Western culture has caught on to its effectiveness. There is a developing scientific basis for mindfulness with brain scans establishing that mindfulness practice brings about changes in the brain with positive effect. The Mind/Body link is stronger than we might have previously imagined.**

**This has just been a brief introduction to Mindfulness and really it is not something that lends itself to description as it really should be experienced. However it does help us to quieten our minds and puts us in a better place to make good decisions.**

## Information Sheet - Young Person

# Mindfulness

We are running a research project in mindfulness and we are asking young people to take part. Mindfulness has been found to be helpful for a number of things and people have said it helps them be calmer. The group would not be trying to solve particular problems although the group may help you to do this yourself.

We invite you to read this leaflet to see if you would be interested.

The purpose of the group is to learn about and practice mindfulness. This is a state of mind where you can just be. More often than not we are too tied up in the past or the future so caught up with worries that we may not notice what is going on. Have you ever read a whole page of a book and realised that you don't know what you had just read? Mindfulness helps us focus on the present and let go of some of the worries about the past or the future. (For more information see attached leaflet).

We will hold an introductory session for those taking part in the group this will include a brief taster session for everyone so that you will have more of an idea what it is about. The group for the young people will run for 8 weeks, each session lasting one hour. Two weeks after the last session we ask you to attend a focus group so that we can ask you what you thought of the groups and whether it was helpful. This would help us to improve any future groups.

## What we ask you to do

Firstly contact us if you are willing to take part.

For those in the mindfulness group

We would ask you to

- come to the introductory session and bring your parent
- Fill in the questionnaires at the start and at the end of the sessions

- Fill in the strengths and difficulties questionnaire before the start of the group
- Come to a final “focus” group where we can ask you what you thought of the groups.

## What we ask your parent to do

- support you to attend the groups and with any home practice
  - attend a final interview where we ask them what they thought about the groups and whether it was helpful
- At the introductory session we will ask you and your parent to sign a form to say that you have understood what is involved and that you agree to take part. Whether or not you choose to take part will make no difference to your educational placement and you are free to leave at any time if you so wish.

If you are interested please let a member of staff know.

Please note that the code of confidentiality will apply and no personal information which could identify you will be

used. Thank You for reading  
this leaflet





## Information Sheet - Parent



**Dear Potential participant**

**We are undertaking some research into Mindfulness and running a group for young people for this purpose. This group is neither to explore particular difficulties nor to work out solutions, although by attending the group some may find it helps towards these aims. We invite you to read this leaflet to see if you would be interested.**

**The purpose of this group is to cultivate Mindfulness. This is a state of mind where you can just be. More often than not we are too tied up in the past or the future, absorbed in worries about the past or anxieties about the future. Mindfulness helps us focus on the present and therefore let go of some of these concerns (for more information see attached leaflet).**

**We will be holding an introductory session for those who are to take part in the group. This will include a brief taster session for everyone so that you will have more of an idea what it is about.**

**The group for the young people will run for 8 weeks. They will meet each week for an hour. Two weeks after the last session we ask the young people to attend a focus group. This will be so that we can ask them about their experience of the groups and whether or not it has helped them. This would help us to improve the groups for the future.**

**What do we ask you to do.**

**Firstly contact us if you are willing to take part.**

**For those that are to be included in the group, we would ask for**

- both the parent and young person to come to the introductory session

- We ask parents to support their child to:-

Attend the groups and

With any home practice

- Fill in the questionnaires before the start and at the end.

- Fill in the strengths and difficulties questionnaire before the start of the group.

- Come to a final interview where we can ask you what you thought of your child's attendance at the groups and whether it was helpful.

At the introductory session we will ask you and your child to sign a consent form to say that you have understood what is involved and you agree to take part. Whether or not you chose to take part will make no difference to your child's educational placement.

If you are interested please let a member of staff know.

Please note that the code of confidentiality will apply and no personal identifiable information will be used in the study.

*Thank you for reading this*

*leaflet*

**Young person's consent form**

# Mindfulness

**I agree to take part in the mindfulness project which has been explained to me.**

**I understand that this is a research project;**

**Any published results will not contain any personal information which could identify me.**

**I understand that the mindfulness group will run over 8 sessions.**

**This will be followed by a focus group where people would come together to discuss experiences of the group.**

**My parents will then be interviewed to give their views.**

**Confidentiality will be assured throughout and no personal identifiable information will be used.**

**I understand that whether or not I take part in this study will make no difference to my educational placement.**

**I understand that I may withdraw from the group at any time if I wish.**

**Signed.....Date.....**

**Signature of the young person.**

**Print Name.....**



**Parent's consent form**



- I agree to my son/daughter taking part in the mindfulness group the nature of which has been explained to me.
- I understand that the project will be for research.
- Any published results will not contain any personally identifiable information.
- I understand that the mindfulness group will run over 8 sessions.
- This will be followed by a focus group to discuss experiences of the group.
- I will then be interviewed to give my views on the group process that my son/daughter has been a part of.
- Throughout the process confidentiality will be assured and no personal identifiable information will be used.
- I understand that should I wish, or not wish to take part in this study, this will make no difference to my child's educational provision.
- I understand that I may withdraw from the group at any time if I or my child so wish.

Signed.....

Mother/Father of (name).....

Date.....

**Young person's assent form**

# Mindfulness



Young person to tick their answer



Has somebody else explained this project to you?

Do you understand what this project is about?

Have you asked all the questions you want?

Did you understand the answers to your questions?

Do you understand it's OK to stop taking part at any time?

Are you happy to take part?

YES NO

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

If any answers are "no" or you don't want to take part, don't sign your name!

If you do want to take part, you can write your name below

Your name .....

Signature of Adult.....

Name.....

Date.....



# Appendix 3

## SDQ parent

**Strengths and Difficulties Questionnaire** P 4-16

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months.

Child's Name ..... Male/Female

Date of Birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children (treats, toys, pencils etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often has temper tantrums or hot tempers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, tends to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally obedient, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries, often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets on better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sees tasks through to the end, good attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature .....

Date .....

Mother/Father/Other (please specify:)

Thank you very much for your help

# SDQ young person

## Strengths and Difficulties Questionnaire

S 11-17

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of how things have been for you over the last six months.

Your Name .....

Male/Female

Date of Birth.....

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am restless, I cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get a lot of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually share with others (food, games, pens etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get very angry and often lose my temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am usually on my own. I generally play alone or keep to myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually do as I am told	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I worry a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have one good friend or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I fight a lot. I can make other people do what I want	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other people my age generally like me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am easily distracted, I find it difficult to concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am nervous in new situations. I easily lose confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am often accused of lying or cheating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other children or young people pick on me or bully me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often volunteer to help others (parents, teachers, children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think before I do things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I take things that are not mine from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get on better with adults than with people my own age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have many fears, I am easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I finish the work I'm doing. My attention is good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side



Overall, do you think that you have difficulties in one or more of the following areas:  
emotions, concentration, behaviour or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following questions about these difficulties:

• How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties upset or distress you?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties interfere with your everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties make it harder for those around you (family, friends, teachers, etc.)?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your Signature .....

Today's Date .....

Thank you very much for your help

© Robert Goodman, 2005

# The Children's Global Assessment Scale

<b>Children's Global Assessment Scale (CGAS)</b> <small>David Shaffer, M.D., Madelyn S. Gould, Ph.D. Hector Bird, M.D., Prudence Fisher, B.A. Adaptation of the Adult Global Assessment Scale (Robert L. Spitzer, M.D., Nathan Gibbon, M.S.W., Jean Endicott, Ph.D.)</small>	
<b>PLEASE RECORD A CGAS SCORE EVEN IF THIS IS BASED ON YOUR MEMORY OF THE YOUNG PERSON'S FUNCTIONING AT THE TIME OF REFERRAL. THE DATE OF RATING IS REQUIRED ONLY IF THIS WAS RECORDED CLOSE TO THE TIME OF THE 'INDEX' REFERRAL.</b>	
43a	<b>DATE OF CGAS RATING:</b> ...../...../..... <b>OR</b> <b>FROM MEMORY</b> (PLEASE INDICATE AS APPROPRIATE) (IF RECORDED CLOSE TO TIME OF 'INDEX' REFERRAL)
100-91	<b>DOING VERY WELL</b> Superior functioning in all areas (at home, at school and with peers), involved in a range of activities and has many interests (e.g. has hobbies or participates in extracurricular activities or belongs to an organised group such as Scouts, etc.). Likeable, confident, everyday worries never get out of hand. Doing well in school. No symptoms.
90 - 81	<b>DOING WELL</b> Good functioning in all areas. Secure in family, school, and with peers. There may be transient difficulties and "everyday" worries that occasionally get out of hand (e.g. mild anxiety associated with an important exam, occasionally "blow-ups" with siblings, parents or peers).
80 - 71	<b>DOING ALL RIGHT - minor impairment</b> No more than slight impairment in functioning at home, at school or with peers. Some disturbance of behaviour or emotional distress may be present in response to life stresses (e.g. parental separations, deaths, birth of a sibling) but these are brief and interference with functioning is transient; such children are only minimally disturbing to others and are not considered deviant by those who know them.
70 - 61	<b>SOME PROBLEMS - in one area only</b> Some difficulty in a single area, but generally functioning pretty well, (e.g. sporadic or isolated antisocial acts such as occasionally playing hooky, petty theft; consistent minor difficulties with school work, mood changes of brief duration, fears and anxieties which do not lead to gross avoidance behaviour; self-doubts). Has some meaningful interpersonal relationships. Most people who do not know the child well would not consider him/her deviant but those who do know him/her well might express concern.
60 - 51	<b>SOME NOTICEABLE PROBLEMS - in more than one area</b> Variable functioning with sporadic difficulties or symptoms in several but not all social areas. Disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings.
50 - 41	<b>OBVIOUS PROBLEMS - moderate impairment in most areas or severe in one area</b> Moderate degree of interference in functioning in most social areas or severe impairment functioning in one area, such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, frequent episodes of aggressive or other antisocial behaviour with some preservation of meaningful social relationships.
40 - 31	<b>SERIOUS PROBLEMS - major impairment in several areas and unable to function in one area</b> Major impairment in functioning in several areas and unable to function in one of these areas, i.e. disturbed at home, at school, with peers or in the society at large, e.g. persistent aggression without clear instigation; markedly withdrawn and isolated behaviour due to either mood or through disturbance, suicidal attempts with clear lethal intent. Such children are likely to require special schooling and/or hospitalisation or withdrawal from school (but this is not a sufficient criterion for inclusion in this category).
30 - 21	<b>SEVERE PROBLEMS - unable to function in almost all situations</b> Unable to function in almost all areas, e.g. stays at home, in ward or in bed all day without taking part in social activities OR severe impairment in reality testing OR serious impairment in communication (e.g. sometimes incoherent or inappropriate).
20 - 11	<b>VERY SEVERELY IMPAIRED - considerable supervision is required for safety</b> Needs considerable supervision to prevent hurting others or self, e.g. frequently violent, repeated suicide attempts OR to maintain personal hygiene! OR gross impairment in all forms of communication, e.g. severe abnormalities in verbal and gestural communication, marked social aloofness, stupor, etc.
10 - 1	<b>EXTREMELY IMPAIRED - constant supervision is required for safety</b> Needs constant supervision (24-hour care) due to severely aggressive or self-destructive behaviour or gross impairment in reality testing, communication, cognition, affect or personal hygiene.
	Specified time period: 1 month
43b	<b>CGAS SCORE =</b>

# The Health of the Nation Outcome Scores for Children and Adolescents

## HoNOSCA Score Sheet

Scale 0 - 4

Rate 9 if not known

### Section A

1. Disruptive, antisocial or aggressive behaviour
2. Overactivity attention and concentration
3. Non accidental self injury
4. Alcohol, substance/solvent misuse
5. Scholastic or language skills
6. Physical illness or disability problems
7. Hallucinations and delusions
8. Non-organic somatic symptoms
9. Emotional and related symptoms
10. Peer relationships
11. Self care and independence
12. Family life and relationships
13. Poor school attendance

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

**SECTION A TOTAL SCORE**

### Section B

14. Lack of knowledge - nature of difficulties
15. Lack of information - services/management

<input type="text"/>
<input type="text"/>
<input type="text"/>

**SECTION A + B TOTAL SCORE**

# The Perceived Stress Scale

## Perceived Stress Scale

The questions in this scale ask you about your feelings and thoughts **during the last month**. In each case, you will be asked to indicate by circling *how often* you felt or thought a certain way.

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Gender (Circle): M F Other \_\_\_\_\_

0 = Never    1 = Almost Never    2 = Sometimes    3 = Fairly Often    4 = Very Often

- |  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. In the last month, how often have you been upset because of something that happened unexpectedly? .....                 | 0 | 1 | 2 | 3 | 4 |
| 2. In the last month, how often have you felt that you were unable to control the important things in your life? .....     | 0 | 1 | 2 | 3 | 4 |
| 3. In the last month, how often have you felt nervous and "stressed"? .....  | 0 | 1 | 2 | 3 | 4 |
| 4. In the last month, how often have you felt confident about your ability to handle your personal problems? .....         | 0 | 1 | 2 | 3 | 4 |
| 5. In the last month, how often have you felt that things were going your way? .....                                       | 0 | 1 | 2 | 3 | 4 |
| 6. In the last month, how often have you found that you could not cope with all the things that you had to do? .....       | 0 | 1 | 2 | 3 | 4 |
| 7. In the last month, how often have you been able to control irritations in your life? .....                              | 0 | 1 | 2 | 3 | 4 |
| 8. In the last month, how often have you felt that you were on top of things? ..   | 0 | 1 | 2 | 3 | 4 |
| 9. In the last month, how often have you been angered because of things that were outside of your control? .....           | 0 | 1 | 2 | 3 | 4 |
| 10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them? ..... | 0 | 1 | 2 | 3 | 4 |

Please feel free to use the *Perceived Stress Scale* for your research.

**Mind Garden, Inc.**

info@mindgarden.com

www.mindgarden.com

### References

The PSS Scale is reprinted with permission of the American Sociological Association, from Cohen, S., Kamarck, T., and Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior*, 24, 386-396.  
 Cohen, S. and Williamson, G. Perceived Stress in a Probability Sample of the United States. Spacapan, S. and Oskamp, S. (Eds.) *The Social Psychology of Health*. Newbury Park, CA: Sage, 1988.

# The Freiburg Mindfulness Inventory (FMI)

## Mindfulness Self Assessment

There are various mindfulness evaluation tools. This one is essentially\* the 14 scale (short version) Freiburg Mindfulness Inventory (FMI) © by Walach, Buchheld, Grossman & Schmidt.

It takes less than 5 minutes to complete and as such provides a useful quick tool to evaluate one's own mindfulness experience.

*Using the last 7 days as the time-frame to consider each item, answer every statement as best you can, answering as honestly and spontaneously as possible. Remember there are neither 'right' nor 'wrong' answers, nor 'good' or 'bad' responses: it is your own personal experience that is important.*

	Rarely	Occasionally	Fairly Often	Almost Always
1. I am open to the experience of the present moment.	1	2	3	4
2. I sense my body, whether eating, cooking, cleaning or talking.	1	2	3	4
3. When I notice an absence of mind, I gently return to the experience of the here and now.	1	2	3	4
4. I am able to appreciate myself.	1	2	3	4
5. I pay attention to what's behind my actions.	1	2	3	4
6. I see my mistakes and difficulties without judging them.	1	2	3	4
7. I feel connected to my experience in the here-and-now.	1	2	3	4
8. I accept unpleasant experiences.	1	2	3	4
9. I am friendly to myself when things go wrong.	1	2	3	4
10. I watch my feelings without getting lost in them.	1	2	3	4
11. In difficult situations, I can pause without immediately reacting.	1	2	3	4
12. I experience moments of inner peace and ease, even when things get hectic and stressful.	1	2	3	4
13. I am patient with myself and with others.	1	2	3	4
14. I am able to smile when I notice how I sometimes make life difficult.	1	2	3	4
<b>Summary Score**</b>				

Source: Walach, H., Buchheld, N., Buttenmüller, V., Kleinknecht, N., and Schmidt, S. (2006). *Measuring mindfulness—the Freiburg Mindfulness Inventory (FMI)*, *Personality and Individual Differences*, 40:1543–1555

## **Interview Schedule - Parents**

**Briefly the interview was about the parent's thoughts of the mindfulness group, whether they had noticed any differences in their son/daughter and anything else they wished to discuss**

- 1. Firstly did you know anything about mindfulness before you heard about the group?**
  
- 2. Did the information you received explain what mindfulness was?**
  
- 3. Have you noticed any differences since the group has been running in your son/daughter?**
  
- 4. Have you noticed any differences in yourself?**
  
- 5. Has this made any difference to your family life?**
  
- 6. Do you think that this would be a useful intervention to help young people in the future?**
  
- 7. Have you any other comments or observations you want to make?**

## **Outline Schedule for Focus Group**

- 1. Did you find it helpful?**
- 2. Did you know anything about mindfulness before you heard about the group?**
- 3. What did you think when you first heard about the group?**
- 4. What was the most helpful?**
- 5. What was most challenging?**
- 6. Has it made any difference to the way you approach things?**
- 7. How are things different now?**
- 8. If there were to be a mindfulness group at school would you attend?**
- 9. Do you think you will continue your mindfulness practice?**
- 10. Would you recommend it to a friend?**

**Also the question was asked:**

**What do you think about the Governments idea to introduce mindfulness in all schools and make it a formal lesson?**

**Certificate of attendance at the sessions**

# Certificate

**This is to confirm that .....  
has attended an eight week programme  
of**

**Mindfulness Practice**

Signed.....

Date.....