



Cogan, Nicola and Burge, Rupert and Wall, Ann-Marie and Barry, Louise and Tanner, Gary and Ross, Michael (2017) The mindful path to compassion in an adult mental health group. Clinical Psychology Forum (291). pp. 8-14. ISSN 1747-5732 ,

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The Mindful Path to Compassion in an Adult Mental Health Group

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Abstract

A naturalistic study was undertaken within a NHS setting to explore the effectiveness and satisfaction with a Mindfulness-Based Cognitive Therapy and Mindful Self-Compassion group programme in an adult mental health population. Outcome measures and qualitative feedback suggested beneficial effects and high levels of satisfaction.

Introduction

Modern Psychotherapy has been described as arriving in ‘waves’; in essence these waves of therapy arose through the adoption of a therapy and the scientific theory from which it derived (Öst, 2008). There has been recent interest in the sizeable list of novel therapies that come under the banner of ‘third wave’ therapies such as: Mindfulness-Based Cognitive Therapy (MBCT; Segal, Williams, & Teasdale, 2002), Compassion-Focused Therapy (CFT; Gilbert, 2009), Mindful Path to Compassion (MPC; Germer, 2009), Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1991), Dialectical Behaviour Therapy (DBT; Linehan, 1993), Integrative Behavioural Couple Therapy (IBCT; Jacobson & Christensen, 1996), Mindfulness-Based Stress Reduction (MBSR; Kabat-Zinn, 1990), Cognitive Behavioural Analysis System of Psychotherapy (CBASP; McCullough, 2000), and Functional Analytical Psychotherapy (FAP; Kohlenberg & Tsai, 1991). Taking into account the diversity between these therapies, they do still share some common conceptual denominators such as a focus on compassion, acceptance, mindfulness, distress tolerance and relationships (Hayes, 2004; Neff, 2013; Öst, 2008).

Of all the research, to date, that has explored the efficacy of the application of ‘third wave’ therapeutic interventions, it is MBCT that has been most widely researched and has shown the most promising results across a range of psychological issues and even within group settings (Chiesa & Serretti, 2011; Evans et al., 2008; Gilbert, 2009; Kuyken et al., 2008; Ree & Craigie, 2012; Segal, Williams, & Teasdale, 2002). Whilst Segal et al. (2002) focused primarily on the utilisation of mindfulness skills as the therapeutic mediator in recurrent depression, Gilbert (2009) turned his attention to compassion as a possible mediator of this positive effect.

Compassion orientated programmes have been found to work well within a group setting (Judge, Cleghorn, McEwan, & Gilbert, 2012). Judge et al.’s (2012) participants showed significant reductions in all of their outcome measures for depression, anxiety, self-criticism, and shame, with the exception of self-correction. Judge et al., (2012) found that even with a limited introduction to compassion, a wide array of participants responded well to the programme; including clients in the severe category of depression. These findings emphasise the strength of compassion-orientated programmes even within a heterogeneous group with no previous experience with compassion based therapeutic interventions. Moreover, it is advised that those that are to undertake such programmes should be introduced and have some experience in mindfulness practices (Neff & Germer, 2013). There is evidence that the application of mindfulness skills in conjunction with compassion focused therapeutic interventions may provide the essential mechanisms of therapeutic change with diverse populations (Kuyken et al., 2010). Whilst, to date, there are no direct investigations of mindfulness and self-compassion in a mixed group setting, meta-analysis (MacBeth & Gumley, 2012) has reported similar effect sizes between groups (Chiesa & Serretti, 2011; Green & Bieling, 2012; Judge, Cleghorn, McEwan, & Gilbert, 2012; Ree & Craigie, 2012).

Aims

The present study aimed to investigate the therapeutic effects of mindfulness in conjunction with a compassion oriented programme within an adult mental health group. However, the existing evidence base is significantly lacking in details of the application of such novel interventions within a mixed

clinical population setting. This is a key aspect that the present pilot study aims to address through examining the efficacy of a MPC group based intervention within a naturalistic, heterogeneous clinical group setting with an adult population. It also aims to explore participants' satisfaction with the group programme.

Outcome - Previous heterogeneous MBCT group based investigations observed significant decreases in their outcome measures of depression and anxiety (Green & Bieling, 2012; Ree & Craigie, 2012); in addition to this, a pilot trial of mindful self-compassion also found a significant improvement in anxiety, depression, and stress levels (Neff & Germer, 2013). Consequently, the current study proposed that there would be a significant decrease in anxiety, depression, and clinical outcome scores from pre-MBCT to post-MBCT, again from post-MBCT to post-MPC, and, lastly, across the combination of the two group programmes.

MBCT has been shown to increase levels of mindfulness (Ree & Craigie, 2012) and also levels of self-compassion (Kuyken et al., 2010). Neff and Germer's (2013) pilot study into the mechanisms behind mindful self-compassion observed an improvement in compassion, both toward self and others, and mindfulness from pre- and post-intervention. Increases in self-compassion have been suggested to be associated with the higher utilization of functional coping strategies (Allen & Leary, 2010). From the above findings it was proposed that there would be a significant increase in mindfulness, compassion, and coping from pre-MBCT to post-MBCT, again from post-MBCT to post-MPC, and, lastly, across the combination of the two group programmes.

The measurement of patient satisfaction within MBCT and other 'third wave' therapies is fairly limited, especially within the group setting. Within a heterogeneous MBCT group, credibility, expectancy, and satisfaction levels have been found to be high (Ree & Craigie, 2012). However, due to the limited research that has been undertaken on MPC, clinical patient satisfaction has not yet been recorded. The only data available examining satisfaction for mindful self-compassion has been through the "programme evaluation" question (Neff & Germer, 2013), however this was not an extensive investigation as the evaluation only consisted of one item. Consequently, an investigation into the

participants' views was undertaken in the current study to document the perceived effectiveness and satisfaction of the entire group programme. Where quotations have been presented, pseudonyms have been used to protect participants' anonymity.

Methods

Ethical approval was attained from the NHS Health Research Authority REC (through the Integrated Research Application System) and NHS Research and Development.

Design

The study used a naturalistic, within participant design as it was comparing participants' repeated measures against themselves across a timeframe of Pre-MBCT to Pre-MPC to Post-MPC group outcomes. These dependant variable measures were examined across one independent variable; the participant group. Participants' satisfaction was examined once at the end of the entire group programme (Larsen et al., 1979).

Participants

Potential participants were identified through their engagement in a rolling programme provided by a Psychological Therapies Team (PTT) in adult mental health services within the NHS. Of 28 potential participants to have entered in to the group programme, 22 participants provided consent to take part in the study with 20 completing all measures. Participants had a wide array of primary presenting problems including but not limited to depression, personality difficulties, compulsive checking, complex trauma and anxiety (see table 1).

Table 1: Descriptive statistics for participant’s demographics and primary diagnosis.

Demographics	Age			Gender	
	Range	M	SD	Female	Male
	23 – 62	39.68	11.28	13	9

Primary Diagnosis					
	<i>n</i>		<i>n</i>		<i>n</i>
Depression	5	Emotionally unstable personality disorder	4	OCD	2
PTSD	2	Complex trauma	2	Mixed anxiety	2
Chronic pain	1	Social anxiety	1	Complex grief	1

Note: M = mean, SD = standard deviation, n = number.

Measures

The measures used were the Clinical Outcomes in Routine Evaluation - Outcome Measures (*CORE-OM*; Core System Group, 1998), Hospital Anxiety and Depression Scale (*HADS*; (Zigmond & Snaith, 1983)), Coping Scale for Adults (*CSA*; (Frydenberg & Lewis, 1997), Mindful Attention Awareness Scale (*MAAS*; (Brown & Ryan, 2003)), and the Fears of Compassion Scales (*FCS*; (Gilbert, McEwan, Matos, & Rivis, 2011)). In addition to these outcome scales, satisfaction with the programme was measured using the Client Satisfaction Questionnaire (*CSQ-8*; (Larsen et al., 1979)) at the end of the programme.

Procedure

Participants were given three batteries of measures to complete across three separate time points in the study: Pre-MBCT, Post-MBCT, and Post-MPC. The measures tracked changes in distress, anxiety, depression, coping, mindfulness and compassion.

Group Protocol

MBCT (Segal et al., 2002) - The programme consisted of two hour sessions held over eight consecutive weeks. Sessions included: the teaching and discussion of cognitive and behavioural techniques and skills, mindfulness practice (e.g. meditation), participants reflecting on their experiences of the mindfulness practice, and, lastly, weekly homework exercises (e.g. 40 minutes mindfulness practice

per day). The programme was co-facilitated by two Clinical Psychologists and a Therapeutic Counselor.

MPC (Neff & Germer, 2013) - The programme consisted of two hour sessions held over six consecutive weeks. Sessions included an introduction to mindful awareness of self-compassion, developing a compassionate inner voice, building skills to deal with distress, and learning how to deal with difficult interpersonal relationships. The group setting allows for interpersonal exercises amongst the participants to aid in sharing and expressing a common humanity and compassion. Formal skills such as loving-kindness meditation were also taught. Lastly, weekly homework was assigned that consisted of session specific tasks (e.g. writing a compassionate letter to oneself), in addition, to regular 40 minutes of self-compassion practice. The programme was co-facilitated by two Clinical Psychologists and a Therapeutic Counsellor.

Results

Statistical analysis showed that in the outcome measures there was a significant decrease in all the outcome scores across MBCT, MPC, and the combination of the two. These results can be found in Table 2.

Table 2: Descriptive statistics and results from repeated measures ANOVA for outcome measures across the three points of measurement: Pre-MBCT, Post-MBCT, and Post-MPC. Descriptive statistics for CSQ-8 included. Post-Hoc analysis also included.

Scale	Pre-MBCT			Post-MBCT			Post-MPC			ANOVA			Post-Hoc
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	<i>df</i>	<i>F-value</i>	η_p^2	
CORE-OM Global Score	22	59.45	7.07	20	53.45	5.68	20	44.70	6.31	1.11, 21.02 †	84.11***	.81	A>B***, B>C***, A>C***
HADS Anxiety	22	16.85	2.06	22	15.00	2.96	20	13.20	2.55	1.42, 26.92 †	23.74***	.55	A>B***, B>C*, A>C***
Depression	22	15.80	2.31	22	14.30	2.60	20	10.50	2.35	1.23, 23.31 †	61.56***	.76	A>B***, B>C***, A>C***
CSQ-8							18	28.83	2.36				

Note. CORE-OM = Clinical Outcomes in Routine Evaluation Outcome Measure (Global Score = Total – Risk); HADS = Hospital Anxiety and Depression Scale; CSQ-8 = Client Satisfaction Questionnaire. *n* = number; *M* = mean; *SD* = standard deviation. *df* = degrees of freedom (between, within). **p*<.017, ***p*<.0033, ****p*<.00033. η_p^2 = Partial Eta Squared. Post-Hoc = Bonferroni (A = Pre-MBCT, B = Post-MBCT, C = Post-MPC). † = Corrected by Greenhouse Geisser.

Moreover, one participant entered the subclinical range after MBCT and seven entered the subclinical range after MPC. In terms of the process measures, there were significant improvements in fear of compassion from others, from self, and for others, non-productive coping, and mindfulness across all

of the conditions. Secondly, there were significant increases in optimism, and dealing with the problem across MPC and the entire programme but not for MBCT alone. There was a significant improvement in sharing but only across the entire programme and not by MBCT or MPC individually. The results for the measures can be found in Table 3.

Table 3: Descriptive statistics and results from Friedman test for all process measures across the three point of measurement: Pre-MBCT, Post-MBCT, and Post-MPC. Post-Hoc analysis significant differences are also represented.

Scale	Pre-MBCT			Post-MBCT			Post- MPC			Freidman Test		Post-Hoc Wilcoxon Signed-Rank Test
	<i>n</i>	<i>Md</i>	<i>IQR</i>	<i>n</i>	<i>Md</i>	<i>IQR</i>	<i>n</i>	<i>Md</i>	<i>IQR</i>	<i>df</i>	χ^2	
FCS												
For others	22	2.80	2.43 – 2.98	20	2.55	2.23 – 2.80	20	2.35	2.00 – 2.60	2	38.52***	A>B***, B>C***, A>C***
From others	22	3.07	2.71 – 3.28	20	3.00	2.63 – 3.61	20	2.61	2.31 – 2.74	2	36.55***	A>B***, B>C***, A>C***
For Self	22	2.90	2.60 – 3.13	20	2.77	2.48 – 3.05	20	2.60	2.28 – 2.66	2	40.00***	A>B***, B>C***, A>C***
CSA												
Non-Productive	22	4.00	3.00 – 4.75	22	3.00	2.00 – 4.00	20	2.00	2.00 – 2.00	2	33.52***	A>B***, B>C**, A>C***
Optimism	22	2.00	1.25 – 2.00	22	2.00	1.25 – 2.00	20	2.00	2.00 – 3.00	2	16.22**	C>B*, C>A*
Dealing With Problem	22	2.00	2.00 – 2.00	22	2.00	2.00 – 2.75	20	3.00	2.00 – 3.00	2	25.40***	C>B***, C>A**
Sharing	22	1.00	1.00 – 2.00	22	2.00	1.00 – 2.00	20	2.00	1.00 – 2.75	2	11.69**	C>A**
MASS												
Mindfulness	22	2.00	1.86 – 2.25	22	2.15	1.91 – 2.44	20	2.52	2.06 – 2.73	2	36.08***	A>B*, B>C***, A>C***

Note. FCS = Fear of Compassion Scales; CSA = Coping Scale for Adults (General Short form); MASS = Mindful Attention Awareness Scale. *n* = number; *Md* = median; *IQR* = interquartile range. *df* = degrees of freedom, χ^2 = Chi-square. **p*<.017, ***p*<.0033, ****p*<.00033. Post-Hoc = A - Pre-MBCT, B - Post-MBCT, C - Post-MPC

Finally, there was a high level of satisfaction for the therapy and, in addition to this; participants reported increases in mindfulness and self-compassion, whilst exploring their views on the benefits of mindfulness and self-compassion as a whole. A generally positive reception to the group protocols was also identified through participants' own reflections of having taken part in the group programme. Participants reported high levels of satisfaction with the group programme in quantitative measures. This was observed in high scores in terms of satisfaction for questions relating to the relevance of the programme to the service user, the quality of the service, and whether they would recommend the service. In addition, participants described qualitatively how the programme had increased their self-compassion and skills in mindfulness practices:

“Attending the group has helped me realize I need to be kinder towards myself.... it’s not easy but I’m getting better at it” (Claire).

“Coming to the classes has helped me understand that when I get down there are ways I can help myself to feel a bit better and to take care of myself” (John).

“I’m not the only one like this...I found it really helpful to see that other people have bad days and good days like me” (Louise).

Discussion

Preliminary results from this pilot study concur with previous clinical studies in MBCT and a non-clinical pilot study for MPC (Kuyken et al., 2008; Neff & Germer, 2013). Findings suggest that both MBCT and MPC may be effective at reducing symptoms of distress, anxiety, and depression within this mixed diagnoses group. Due to the design of the study it is difficult to say whether the extra duration of the therapy rather than the content of MPC may have contributed towards the improved outcomes following MBCT. The increases in participants’ scores on mindfulness and self-compassion cannot be directly compared to previous studies. This is due to dissimilarity of the scales used with other studies. Levels of ‘coping’, a skill described as the ability to deal with life stressors in a productive manner, is a robust indicator of an individual’s subjective wellbeing (Allen & Leary, 2010). The present study observed decreases in ‘non-productive coping’, such as *“Consciously ‘block out’ the problem”* and *“Find a way to let of steam: for example, cry, scream, drink, take drugs”* strategies across all conditions; these findings align with previous results suggesting that self-compassion and mindfulness may reduce the use of these maladaptive coping strategies (Allen & Leary, 2010). Due to the nature of the design, the actual effect of MPC alone cannot be stated. The effects observed from Post-MBCT to Post-MPC may be left over residual effects from the MBCT or other variables that were not controlled for. However, such findings do show MPC as a promising new therapy and future research into this area may further illuminate its clinical efficacy.

Recommendations

A randomised controlled trial that evenly splits a larger sample of participants into either a MBCT group or a MBCT plus MPC group would provide the most feasible comparison between these two groups and would allow the direct observation of key differences that the additional MPC group

therapy provides. Indeed, a feasibility study that assessed the safety, acceptability, potential benefits and associated change processes of using group CFT with people recovering from psychosis found promising results suggesting that changes in compassion may promote emotional recovery (Braehler et al, 2013). Follow up measures are also required to ascertain the programme's strength after the therapy has finished. Due to the nature of the programme it is not limited in use for alleviating current distress. The programme has the potential to be implemented in a wide array of settings, such as schools, universities, and the work place, to help in dealing with life stressors and prevent the onset of psychological distress before it becomes a clinically presenting problem. Lastly, the current study found that participants were satisfied with the group programme that they participated in; their comments on the programme were invaluable for future work. It is recommended that more naturalistic studies that incorporate both quantitative and qualitative outcomes be conducted to gain a broader understanding of how participants' feel about such therapeutic approaches.

Conclusion

In this preliminary pilot investigation, outcome measures following both MBCT and MPC have suggest there is efficacy in the entire group programme in reducing patients' symptoms such as anxiety, depression, and clinical distress within a naturalistic setting. These findings further add to the growing literature on the multiple applications of MBCT and, in addition to this, support the little research investigating MBCT as a viable treatment option within a diverse adult mental health group. The present study was the first to trial MPC within a clinical population and these preliminary results show promising outcomes suggesting its efficacy in this naturalistic heterogeneous adult population. Whilst both therapies are in need of being extensively further examined, especially given the present study's conditions, these findings are encouraging. Future work will need to examine their uses and to uncover the underlying mechanisms such as self-compassion, mindfulness, and coping to understand what is driving this therapeutic effect. It is recommended that as well as further naturalistic studies, there is a need for larger scale randomized controlled trials of such group programmes.

Studies which incorporate measures that explore patient satisfaction to gauge how service users feel about the group programme offered and to aid in the further development and improvement of the care provided by the NHS mental health services are needed. It is envisaged that the results from this pilot study may aid in the future design of both clinical and non-clinical group programmes that incorporate mindfulness and compassion orientated therapies.

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