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PERSPECTIVE PIECE

The challenges of facilitating a mindfulness programme in a psychiatric inpatient unit

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Facilitating mindfulness programmes within an inpatient mental health setting is discussed. The difficulty in effectively engaging patients at this acute stage in their illness is focussed upon. Other challenges discussed are identifying appropriate inclusion and exclusion criteria; identifying the optimal programme format for this setting; promoting mindfulness within the environment of the inpatient unit and the training requirements for programme facilitators. The article concludes that due attention should be given to these challenges in order to maintain the integrity of mindfulness as an effective intervention for mental health difficulties.

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Mindfulness meditation is now a popular psychological intervention in the mental health field. There is an increasing body of research suggesting that mindfulness can achieve significant improvements in mental health outcomes (Chiesa & Serretti, 2011; Fjorback *et al*. 2011). Programmes such as mindfulness-based stress reduction (MBSR) (Kabat-Zinn, 1991) and mindfulness-based cognitive therapy (MBCT) (Williams *et al*. 2007), which largely target those with Axis I disorders, have been shown to be effective in reducing rates of anxiety and depression. Mindfulness has also been applied to more complex mental health populations and, for example, forms one of the core components of dialectical behaviour therapy for people with borderline personality disorder (Linehan, 1993). Mindfulness groups have also targeted those presenting with psychotic disorders (Chadwick, 2014).

In examining the body of research on mindfulness, it can be seen that the majority of studies have been conducted in an outpatient setting. There are only a few studies that have investigated the efficacy of running mindfulness programmes in an inpatient setting (York, 2007; Jacobsen *et al*. 2011). These studies have reported improvements in participants' awareness, concentration and acceptance, and increases in participants' willingness to expose themselves to problem thoughts and feelings (York, 2007). Although these findings are favourable, the fact that there is a paucity of studies in this area makes it difficult to draw firm conclusions around the efficacy of inpatient mindfulness programmes. It is the opinion of the present author that there are a number of potential difficulties in running mindfulness groups in this particular setting. This is based both on the author's personal knowledge and practice of mindfulness, and the experience of facilitating mindfulness programmes with mental health patients in both inpatient and outpatient settings. The aim of the present paper is therefore to describe the difficulties that may arise in running mindfulness programmes in an inpatient unit and to discuss what are the important things to address when considering setting up such a programme.

One of the main difficulties of engaging inpatients in a mindfulness intervention is that patients are in an acute phase of their illness. It is likely therefore that the majority of patients in an inpatient unit are experiencing high levels of psychological distress and emotional arousal. This may be in response to significant escalations in symptoms associated with a mental health difficulty, the regression of activities of daily living, the decompensation of inner ego resources and/or the increase of levels of suicidality. Given this psychological context, engaging in an intervention like mindfulness that requires the individual to look inwards may prove to be a significant challenge. Patient's ability to engage in this type of psychological intervention at this point in their recovery may be significantly impacted upon.

One of the key questions that arose for the author when facilitating mindfulness programmes with inpatients was to what extent are patients really engaged in doing mindfulness during the practices? A qualitative study (Wyatt *et al*. 2014) identified that there are key psychological components that are experienced during mindfulness training. These include awareness, acceptance, struggling, gaining a sense of control and choice, relating differently to thoughts and feelings,

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and awareness of relationship with the self and relationships with others. What helps to achieve these components (especially when beginning on the journey to learning mindfulness) is the ability to focus one's attention on a particular object, and when the attention wanders away to repeatedly bring it back to the object. Based on the observations of the present author, it appeared that many inpatients did not appear to follow these instructions. It seemed that participants became immersed and entangled in repeated ruminations and thoughts, and were either unaware of the instruction or unable to bring their attention back.

Why inpatients did not appear to engage with these instructions of mindfulness training may be related to their ability to do so. High levels of psychological distress and emotional arousal may lead to poor levels of attention and concentration and therefore make it difficult to focus one's attention. Patients may also be on high levels of sedating medication that may also impact on their ability to focus their attention. It may also be that many of the participants in this group are simply too chronic in their mental health difficulty to be able to fully engage with mindfulness. A recent study (Bos *et al*. 2014) found that patients who had a long-standing diagnosis of bipolar depression disorder did not improve on quality of life or psychological symptoms following a mindfulness programme, whereas patients in other diagnostic categories did (e.g. depression, anxiety disorders, adjustments disorder). The authors concluded that the bipolar category represented a patient group who were more chronic (i.e. they had a longer length of illness duration and more chronic symptoms). The authors postulated that these factors were likely significant mediators of the effectiveness of mindfulness training.

Participants may also feel resistant towards directing their attention inwards because they fear being overwhelmed by it. It is the author's experience that for some patients mindfulness training may overwhelm already fragile defence, and distressing thoughts (e.g. suicidal ideation) may be intensified. One could argue that the premise of mindfulness is to turn towards such difficulty and to allow distressing thoughts and feelings to arise so that one can also come to an understanding that eventually they will pass. However, Williams (Williams *et al*. 2007) has pointed out that it is important to 'work on the edge' of distress. This means that individuals should not force themselves beyond what they feel able to cope with. This seems particularly relevant in this setting as a number of people in this population are at risk of decompensation. Once a regression or decompensation occurs it is often extremely difficult to contain and so it is likely that a clear policy excluding these types of patients would be helpful.

Another difficulty is that the environment of an inpatient unit is often not conducive to facilitating a mindfulness group. An inpatient unit is often busy and chaotic and there can be frequent interruptions from other staff. In this environment psychological distress is also often dealt with by distraction, avoidance and/or medication. This culture clashes with mindfulness that encourages individuals to 'sit with' what is difficult. In order to promote the culture of mindfulness in this setting it may be necessary to try to influence the entire atmosphere of the facility so that what patients experience in the group setting is also mirrored in their environment. This change in culture may be achieved through running groups for staff that encourages staff members to become familiar with and practice the skills of mindfulness for themselves.

What is the best format for a mindfulness inpatient group is also an important question to consider. Although MBSR and MBCT programmes have weekly sessions with daily homework practice imbedded in it, it is unlikely that many patients would be able or motivated to practice homework within an inpatient unit. Furthermore, inpatients are less likely to be able to engage with the length of mediation practice that MBSR/MBCT programmes engage in (i.e. 40-minute practices). A study conducted by Chadwick *et al*. (2009) with psychotic patients used a format of engaging participants in short meditations of ten minutes in length. Chadwick recommended that there should not be a long period of non-guided practice in order to inhibit patients becoming lost in a struggle with paranoid or delusional inner stimuli and this may also be relevant to an inpatient population. What is also significant is the type of meditation exercises that are utilised. Exercises that are more concrete as opposed to abstract are likely to be more easily taken up by this patient group. Exercises particularly using movement, sound and smell may ground the patient, and may be a more tangible way for them to focus their attention to the present moment as opposed to breathing meditations or following moment to moment awareness.

It is necessary in running a mindfulness group to also consider what are the competencies needed by the facilitators to be able to train others in the use of mindfulness methods. Certainly, it is likely that the teachings of mindfulness are imparted more by the example and modelling of the facilitators than any individual instruction. A recent study (Stauffer & Pehrsson, 2013) proposed that mindfulness trainers should have 16 areas of competency in mindfulness, ranging from the ability to integrate mindfulness methods and skills into everyday tasks; the practice of regular mindfulness particularly when training others; the ability to distinguish between psychological processes related to mindfulness and other mental processes relevant to clinical practice (e.g. compulsion, obsession, psychotic features, dissociation); and

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the motivation to seek continuing education opportunities on mindfulness. What the authors emphasised was that facilitators should have a current active practice of mindfulness rather than having a large number of years of practice, although they do suggest that at a minimum facilitators engage in personal practice for at least a year and a half before training others. These competencies are further reflected in the University of Massachusetts, Centre for Mindfulness training (Kabat-Zinn & Santorelli, 2014). They identify several essential training elements including having a regular personal practice; attending supervision; attending residential retreats; attending teacher development days; and having well-developed learner-centred teaching skills. This topic is an ongoing important debate and with the further advancement of specific training courses in mindfulness, it is likely that there will be more regulation around the qualifications to teach mindfulness in the future.

Overall, this paper highlights that running mindfulness groups in an inpatient setting may have many difficulties. These difficulties include problems with patients being able to follow the basic instruction of mindfulness training in order to properly engage with the practice of mindfulness. Other difficulties include the fragile defences of individual patients and the possibility of them becoming overwhelmed by turning their attention inwards. The chronicity of the patient in their mental health problem may also relate to poorer outcomes with this type of intervention. If considering the establishment of an inpatient mindfulness group it may be helpful to establish clear inclusion and exclusion criteria to rule out those who are likely to struggle to engage with the intervention. It would also be important to consider the format and type of mindfulness practice that is most appropriate in this population; the environment and atmosphere of the inpatient unit in supporting patients in their mindfulness practice and the ongoing training requirements of mindfulness group facilitators.

In conclusion, it is felt that it is important to highlight these difficulties given the growing popularity of mindfulness interventions. It is easy to become complacent about the efficacy of treatments, however, we must always question the generalisability of interventions across patient groups and settings. Although it is not the intention of this article to rule out mindfulness groups in inpatient units, it is the intention to flag the potential barriers and difficulties of doing so, and to encourage those who may be planning on running such groups to think about how these challenges may be overcome. In the long run, this will protect the reputation of mindfulness-based treatments and ensure that it is continued to be seen as an important intervention for mental health and psychological well-being.

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Conflicts of Interest

None.

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