A Thesis Submitted to the University of Birmingham for the degree of

Doctor of Clinical Psychology

Volume 1: Research Component

Literature Review: Healthcare Professionals' Attitudes Towards Working with Self-Harm and Suicidality

Empirical Paper: Can Group-Based Mindfulness Reduce Vulnerability to Suicidality in Young Adults? A Pilot Study

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OVERVIEW

This thesis is submitted to the University of Birmingham in partial fulfilment for the requirements of the degree of Doctor of Clinical Psychology

Volume One represents the research component of the thesis, and consists of three papers. The first paper is a literature review, exploring healthcare professionals' attitudes towards working with suicidality and those that self-harm. The paper reviews 22 studies, to understand the types of attitudes that are held. It then continues by considering mediating factors to these attitudes. This is followed by a discussion of methodological implications and the likely impact of these attitudes on healthcare professionals' behaviour. This paper has been prepared with submission to the British Journal of Psychiatry in mind.

The second paper reports an empirical study that considers the impact of mindfulness on reducing individuals' vulnerability to suicidality. Two mindfulness groups were run for young people (aged 17-20), all of whom had a history of suicidal ideation, suicide attempts or self-harm. The report discusses the rationale behind running the groups, the details of the treatment, and the mixed method approach to examining its efficacy. The effect of and range of reactions to participation in mindfulness, in addition to the limitations of this, are then explored for the eight people who completed the intervention. This paper has been prepared for submission to the journal of Behavioural and Cognitive Psychotherapy

The third paper is a Public Domain Briefing Paper, summarising the main findings of both the literature review and empirical study for dissemination to a wider audience.

Volume Two represents the clinical component, and comprises five Clinical Practice Reports (CPR) that relate to anonymised work completed on the assessed clinical placements over the three years of the course. CPR One is entitled 'Formulating the Case of Amy: A Lady with Learning Disabilities, Presenting with Depression following a Bereavement'. Amy's case was discussed from cognitive-behavioural and psychodynamic perspectives. CPR Two describes an evaluation of service-user involvement in recruitment within a Service for People with a Learning Disability. CPR Three is a single-case experimental design, which considers the case of an 82 year old lady, presenting with symptoms of anxiety, depression and underlying low-esteem using a cognitive formulation. CPR Four is a case study of an adolescent female, undertaking cognitive-behavioural therapy for hearing voices. Finally, CPR Five considers the case of a 52 year old lady, presenting with depression and excessive alcohol-use, understood through a cognitive-behavioural framework.

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Health Professionals' Attitudes Towards Working with Self-Harm and Suicidality

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ABSTRACT

International and national prevalence rates of suicidality and self-harm have prompted various governmental initiatives aimed at reducing individuals' risk of mortality. Within this, the role of health care professionals in identifying risk and providing treatment aimed at alleviating distress is recognised. For this to be successful, sensitive communication is required; this is vulnerable to moderation by attitudes held by both healthcare professionals and service-users. This systematic literature review considers recent studies, published in the last decade, that explore healthcare professionals' attitudes towards working with suicidal service-users, or those who self-harm. The role of factors that may mediate these attitudes are explored, including: demographic information; professional background and training; religion and morals; perceptions of the behaviour; and wider organisational issues. Methodological issues were also found to impact on the assessment of attitudes, and are discussed in light of the wider literature on attitudinal research. Recommendations for further training and supervision of health care professionals are made.

INTRODUCTION

International Situation

Approximately one million people die annually from suicide worldwide, which has been estimated as one death every 40 seconds, or 16 people per 100,000 (World Health Organisation (WHO), 2011). Data collected to represent the suicide rates across 104 countries shows that with the exception of two countries, prevalence of suicide rates is consistently higher in males than females (WHO, 2011).

The international prevalence of suicide prompted the WHO to commission 'Suicide Prevention' (SUPRE) in 1999. Its main objectives included reducing morbidity caused by suicidality, breaking the taboo surrounding suicidality, and facilitating an international, integrated approach to the challenges of prevention (WHO, 2011). SUPRE have since published a series of resources for the professional groups deemed as having potential roles in this prevention, including prison officers; media professionals; general physicians and primary healthcare workers. The over-arching theme of these documents resides in an understanding that suicide is a '…complex problem for which there is no single cause' and is resultant of an 'interaction of biological, genetic, psychological, social, cultural and environmental factors' (WHO, 2000). Alongside this was the clear message that in most cases, suicide is preventable (WHO, 2000).

United Kingdom

In comparison to the global rate, the most recent annual mortality rate from suicide in the United Kingdom (UK) was approximately 8.3 deaths per 100,000 (Kapur & Gask, 2009). This is reportedly the lowest rate recorded in the UK, and one of the lowest in Europe (National Mental Health Development Unit, 2011). However, the rate of suicide in young men has doubled over the past twenty years, and in males under the age of 35, remains the most common cause of death (Kapur & Gask, 2009).

In response to awareness for suicide prevention, the white paper 'The Health of the Nation' outlined a strategic approach of improving understanding about suicidality and developing local service and good practice (Department of Health (DoH), 1992). A combination of research and development with public information strategies was recognised as important in increasing understanding, reducing stigma and informing individuals of their rights and responsibilities (Jenkins, 1994).

The paper 'Saving Lives: Our Healthier Nation' highlighted the impact of mental health on suicidality, and the necessity of focusing on improving mental health to reduce suicidality (DoH, 1999). Recommendations were set out, and progress reports five years later suggested positive achievements. This was evidenced by the setting up of specialist mental health services, increases in staff, and wider provision of treatment. Additionally, service-user reports of their treatment were positive and the rate of completed suicide had decreased. (DoH, 2004).

The UK's first National Suicide Prevention Strategy was launched in September 2002. With this, a key goal highlighted the importance of '…reducing risk in key high-risk groups, namely people under mental health care, people who harm themselves, young men, prisoners and those working in certain occupations (DoH, 2002).'

Comorbidity and Suicidality

Strong correlations have been found between suicidality and mental health problems (Appleby, 2000; DoH, 1999). In a sample of 15,629 cases of suicide worldwide, 35% were diagnosed with mood disorders, 11% with schizophrenia and 65% with anxiety disorders (Kapur & Gask, 2009). Analysis of completed suicides (N=288) in North-West England between 2003 and 2005 revealed diagnosis of schizophrenia (20%), affective disorders (48%) and substance use (12%; Da Cruz et al., 2010). In addition, of those that attended hospital in the 12 months prior to their deaths (N=124), 77% presented with self-harm; a quarter of which had presented with self-harm on more than three occasions (Da Cruz et al., 2010). Beautrais, Mulder, Fergusson, Deavoll and Nightingale (1996) found that within a sample of 302 individuals who had made a suicide attempt, 90.1% had a diagnosable mental health difficulty, with 56.6% having two or more disorders. They found that these individuals were 89.7 times more at risk of suicidality than someone without psychiatric problems (Beautrais et al, 1996).

Attempted Suicide, Self-Harm and Suicidality

Accident and Emergency (A&E) departments report high prevalence of service-users attending hospital following a suicide attempt (Hawton, Fagg, Simkin, Bale & Bond, 1997). However, no official international statistics exist which reflect this prevalence, as it is estimated that only about 25% of people who attempt suicide need or seek medical assistance (WHO, 2000b). Despite difficulties understanding the correlation between people who attempt suicide and then later complete, a history of attempts is recognised as a strong risk factor for future suicide (Hawton, Zahl & Weatherall, 2003; WHO, 2000). An important role therefore exists in understanding individuals who do seek help, in order to ease their situation, facilitate recovery through appropriate treatment, and reduce future risk.

There is a lack of consensus as to whether self-harm (SH) and suicidality are distinctive domains or operate as part of a continuum (Mangnall & Yorkovich, 2008). It has been postulated that SH is not a suicidal behaviour, as the intent is not to end life. Instead, its suggested purpose is manifold, including affect-regulation or an attempt to regain control with the intention of avoiding suicide (Chapman, Gratz & Brown, 2006; Duffy, 2009). However, others suggest that SH exists on a continuum and can predict suicidal behaviour, not just ideation (Whitlock & Knox, 2007; Hawton, Zahl & Weatherall, 2003; Owens, Horrocks & House, 2002). Perhaps SH should not therefore be dismissed as non-suicidal.

The National Institute of Clinical Excellence (NICE) defines SH as 'self-poisoning or self-injury, irrespective of the apparent purpose of the act' (NICE, 2004). It is conceivable that SH could result in serious injury, or even death, whereupon the individual's behaviour may become understood as suicidal. In this situation, issues of intent would increase understanding. However, this is difficult to measure or understand in hindsight, and reliable differentiation between SH and attempted suicide becomes subject to clinical interpretation (Mangnall & Yorkovich, 2008), where avoidance of stigmatising service-users may impact decisions over diagnosis (Zargoushi, Asghari, Zeraati & Fotouhi, 2011).

The National Suicide Prevention strategy (2002) has understood service-users who SH as constituting a high-risk category of individuals who may require support in preventing suicide. In order to meet the criteria for 'high-risk', groups had to demonstrate a significantly increased risk of suicide, actual numbers of suicides had to be known and evidence highlighted on which to base and measure preventative measures (DoH, 2002).

Who is Responsible?

For healthcare professionals (HCPs) to have a role in reducing individuals' risk, and facilitating the amelioration of distress, service-users are required to seek help. This requires either active help-seeking, or for an individual to have found themselves in a situation where others are insisting on them receiving help (Anderson, 1995). Research into explanations for not seeking help includes individuals underestimating their need, or severity of their injuries, fear of being judged or because SH is a solitary activity that the individual prefers to keep to themselves (Curtis, 2010; Milner & De Leo, 2010; Fortune, Sinclair & Hawton, 2008).

The positive influence primary HCPs (e.g. GPs or nurses) can have on suicidal or self-harming individuals lies in their accessibility, being embedded within the community means they are often a primary source of care (WHO, 2011). Furthermore, they are well positioned to assist links between the community and the wider health care system (WHO, 2011).

Although the link between mental health and suicidality is widely held, the majority of people who committed suicide were not seen by mental health professionals prior to death (WHO, 2011). This implies missed opportunities for treatment, especially as data suggests that before their deaths, these individuals were often seen in physical health settings, including A&E (Kapur & Gask, 2009). It has been suggested that whilst the 'suicidal process' is developing, "mutual communication between suicidal young people and those around them is crucially important (WHO, 2000)", which further emphasises the potentially important role of HCPs.

Healthcare guidelines highlight the importance of effective communication between HCPs and service-users who present with suicidal behaviours or SH (WHO, 2011; WHO, 2000b; NICE, 2004). Within this, recommendations are made that staff should "understand the person's feelings; give non-verbal messages of acceptance and respect; express respect for the person's opinions and values; talk honestly and genuinely and to share concern, care and warmth (WHO, 2000b)". Furthermore, it is suggested that staff should not "interrupt too often; become shocked or emotional; convey that they are busy or be patronising (WHO, 2000b)".

It has been acknowledged that the "initial contact with the suicidal person is very important" but that it often occurs in a "busy…place where it may be difficult to have a private conversation (WHO 2000)". Inherent in this statement is the implication that environments can impact the quality of contact. HCPs' capacity to display warmth, demonstrate understanding and adopt a genuine stance to their clinical responsibilities are also likely to be affected by their attitudes towards the service-users' behaviour and situation.

Definitions of SH classify it as a 'secretive or hidden' behaviour (Long & Jenkins, 2010), which raises questions about the position of service-users who seek help. It is likely that some individuals are particularly vulnerable in facing this exposure. Careful communication between the HCP and service-user is paramount; where the service-user may be particularly sensitive to picking up on attitudes towards their behaviour. In relation to this, the Irish National Strategy for Suicide Prevention (2005) identified the importance of raising awareness and challenging attitudes to facilitate provision of appropriate treatment for high-risk groups.

Aim of the Current Review

The purpose of this systematic review is to conduct a literature search to explore the current evidence for HCPs' attitudes towards SH or suicidality. It will consider two research questions regarding presence of positive or negative attitudes and the factors that appear to mediate them.

Terminology and Definitions Used in this Review

The terms 'self-harm (SH)' and 'people who SH' are used throughout to refer to self-injurious behaviour which does not take intent into account (NICE, 2004), though excludes self-injury that is related to developmental disorders. 'Suicidality' is used to refer to suicidal behaviour or ideation, and people who present to services will be referred to as service-users rather than clients or patients. All healthcare staff are referred to as healthcare professionals (HCPs).

Definitions of attitudes have varied over time and in line with research outcomes (Albarracin, Zanna, Johnson & Kumkale, 2005). Discrepancies have arisen between understandings of what attitudes comprise, however they all have in common the notion of evaluation. For the purposes of this review, Eagly and Chaiken's widely cited definition will be used: "Attitude is a psychological tendency that is expressed by evaluating a particular entity with some degree of favour or disfavour" (1993).

SEARCH STRATEGY

Overview of the Search Strategy

Literature was searched for within the PsycInfo, Embase and Ovid MEDLINE databases (for search terms, see Table 1). The review aimed to explore recent literature, and therefore considered studies published within the last decade (January 2000 to March 2011). Peer-reviewed journal articles in English were included. Book chapters, reviews or unpublished dissertations were excluded. For further details of the search results, see Table 2.

Table 1: Terms Used for the Literature Search

Terms Used in the Literature Search.
- Parasuicid* or Attempted Suicid* or Suicid* or Self Mutilation or Self Injurious Behaviour or Self Harm or Self-Harm   - Health Professional or Mental Health Professional   - Attitudes or Belief or Perception
Truncated terms are denoted with an asterix (*) to allow inclusion of suffix variations.

Table 2: Results of Literature Search

	Search Type	Actions
1	(Parasuicid* or Attempted Suicid* or Suicid* or Self Mutilation or Self Injurious Behaviour or Self Harm or Self-Harm).mp. [mp=ti, ab, sh, hw, tn, ot, dm, mf, ps, rs, nm, an, ui, tc, id]	162359
2	(Health Professional or Mental Health Professional).mp. [mp=ti, ab, sh, hw, tn, ot, dm, mf, ps, rs, nm, an, ui, tc, id]	9368
3	(health personnel or mental health personnel).mp. [mp=ti, ab, sh, hw, tn, ot, dm, mf, ps, rs, nm, an, ui, tc, id]	180888
4	2 or 3	188800
5	(attitud* or belief*).mp. [mp=ti, ab, sh, hw, tn, ot, dm, mf, ps, rs, nm, an, ui, tc, id]	831682
6	1 and 4 and 5	2160
7	Remove duplicates from 6	1424
8	7 and 2000:2011.(sa_year)	757
9	8 and "Journal" [Publication Type]	506

Inclusion criteria were studies with a primary focus on HCPs' attitudes towards working with SH/suicide in adults or adolescents, thus measuring attitudes through questionnaires or interviews. Exclusion criteria disqualified studies that were not accessible in English; focused on impacts of completed suicide; focused on attitudes of non-professional groups (e.g. lay people, students); focused on physician assisted suicide or that focused on the measurements of attitudes relating to self-harm or suicide, without describing the attitudes themselves.

Titles and abstracts of 506 articles were reviewed for suitability, yielding 17 articles. Cross-referencing from these highlighted a further 5 studies; producing a total of 22 studies. A subsequent search through Web of Science produced 416 studies, which were either duplicates from the PsycINFO search, or did not meet the inclusion criteria for this re

Table 3: Overview of Studies Exploring Health Care Professionals' Attitudes towards Working with Suicidality or People who Self Harm

Author	Country	Profession	Methodology (N; Response Rate (RR %))		Results
INPATIENT SETTINGS					
McCarthy & Gijbels, 2010	Republic of Ireland	A&E Nurses	**Design:**	Questionnaire design; between subjects	A&E nurses had positive attitudes towards people who SH. Nurses with SH training had most positive attitudes. Nurses aged 41-50 had more positive attitudes than those aged 51-60. Attitudes were positively correlated with education. Positive trend of years of A&E experience with attitudes until 16 yrs A&E experience; but >16 yrs, attitudes became less positive again.
			Sampling:	Opportunity sampling strategy. N=68 (85%)	
			Analysis:	T-tests; ANOVAs.	
Gibb , Beautrais & Surgenor, 2010	New Zealand	Nursing Staff: General and Psychiatric	**Design:**	Questionnaire design.	HCPs had mixed attitudes towards people who SH. HCPs believed their contact was helpful to people who SH, were patient, understanding, and optimistic about patients' outcomes. HCPs did not feel confident working with people who SH, reported the work as difficult and their training in this area was inadequate. Findings were not significantly associated with profession, demographic information or degree of burnout.
			Sampling:	Opportunity cluster sampling strategy. N=195 (64.4%)	
			Analysis:	Factor analysis; multiple regression; chi-square.	
Suokas, Suominen & Lönnqvist, 2009	Finland	A&E staff.	**Design:**	Repeated measures between subject.. Cross-sectional questionnaire design.	Overall demonstrated mixed attitudes; distribution of results are reportedly skewed towards the 'empathic end'. Following setting up of a psychiatric consultation service; no significant difference in scores. Gender, age, profession, length of work experience and amount of exposure to people who SH did not have a statistically significant effect on staff attitudes.
			Sampling:	Population survey Pre: N=34 (80%) Post: N=34 (48%)	
			Analysis:	T-tests ; Spearman rank correlations ; ANOVAs.	
Wheatley & Austin-Payne, 2009	UK	Nurses – secure setting.	**Design:**	Questionnaire design; between subject.	HCPs who reported feeling more negative about people who SH reported more worry about working with this patient group. Correlation of lower ratings of controllability over SH with greater sympathy and pity scores. Correlation of attribution of SH to external causes with higher pity / willingness to help scores. Correlation of lower levels of irritation with increase in perceived adequate skills. Correlation of rating of stability of cause and optimism for follow-up. Correlation of higher perceive optimism for follow-up and higher helping behaviour scores. Correlation of negativity and worry; unqualified HCPs had higher levels of each than qualified.
			Sampling	Opportunity Sampling Strategy N=76 (12%)	
			Analysis	T-tests, ANOVAs; pearson's correlations.	

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Suokas, Suommen,	Norway	A&E staff, General	**Design:**	Questionnaire design; between subject	A&E staff view attempted people who had attempted suicide positively and sympathetically. Mean scores on Understanding Suicidal Patients

Lonnqvist, 2008		and Psychiatric staff	**Sampling:**	Opportunity sampling strategy. N=66 (General hospital staff: 34 (47.9%); Psychiatric hospital staff=32 (40%). Overall RR=44%)	scale demonstrated overall mixed attitudes. HCPs in general hospital expressed more negative attitudes than psychiatric hospital. No association between HCPs' psychological distress and negative attitudes towards suiciality. Nonsignificant trend for older HCPs rating higher levels of distress. Nonsignificant trend for HCPs with more work experience and exposure to suicidality reporting higher levels of distress. No significant differences based on gender or professional background.
			Analysis:	Chi-square ; ANOVAs.	
Anderson and Standen, 2007	UK	Nurses & Doctors in A&E, Paediatrics General & Psychiatry.	**Design:**	Questionnaire design; between subject.	Overall, results indicate that HCPs view suicidality as reflecting mental illness; often constituting a 'cry for help'; and reflecting agreement that people have the right to take their own lives-this is often impulsive or aggressive, and could affect anyone. Disagreement on 'morality and moral evil' scale which suggests HCPs were less accepting that lack of religion is an influencing factor on suicidality, or that it's a morally bad idea. No significant difference relating to speciality, gender, age or length of experience in the current post.
			Sampling:	Questionnaires sent to entire sampling frame. N=179 (A&E staff=102; Paediatric staff=41; Psychiatry=36. (77.8%).	
			Analysis:	ANOVAs ; scheffe test.	
Sun, Long & Boore, 2007	Taiwan	A&E Nurses	**Design:**	Questionnaire design, between subject.	Overall positive attitudes toward HCPs' professional roles in working with suicidality; towards the communication and attention of suicidality; the acceptability of suicide; beliefs about suicidality and towards morality and mental illness. Positive correlation between attitudes and level of training. Negative correlations between existence of religious beliefs and positive attitudes. Negative correlation between amount of exposure to suicidal patients and positive attitudes. No significant relationship between overall A&E work experience and attitudes towards suicidality.
			Sampling:	Opportunity sampling strategy. N=155 (77.5%).	
			Analysis:	T-tests ; ANOVAS.	
McCann, Clark, McConnachie & Harvey, 2007	Australia	A&E Nurses	**Design:**	Questionnaire design,. between subject	Overall sympathetic attitudes towards SH; HCPs' didn't discriminate when making triage / care decisions**.** However, 88.4% of respondents reported having heard 'why didn't he do it right this time and save us a lot of trouble' from colleague in response to people who SH. Older and more experienced nurses had more supportive attitudes than younger, less experienced nurses. Nurses with SH training had more positive attitudes than nurses without.
McCann, Clark, McConnachie & Harvey, 2006			**Sampling:**	Opportunity sampling strategy- pre SH training; N=43 (100% RR - 65.2% of nursing department)	
			Analysis:	T-tests.	

Sethi & Uppal, 2006	India	A&E doctors from different specialities.	**Design:**	Questionnaire design;	Negative attitudes understood through three factors: <u>Factor 1:</u> Feelings of uneasiness, anxiety, anger leading to avoidance. suicidality as 'a burden on the medical profession'. <u>Factor 2:</u> attitudes of rejection to suicidality. <u>Factor 3:</u> Need for clinicians to deal with their feelings. Also reflected hostile attitudes towards suicidal individuals as 'cowards who should be ignored'. Awareness of service-users' need for help, but associated with HCPs' feelings of inadequacy.. External factors (e.g. medico-legal processes) and internal factors (e.g. attributions of behaviour; HCPs' inner conflicts).
			Sampling:	Opportunity sampling strategy; N=50 (RR-unknown).	
			Analysis:	Factor analysis.	
Sun, Long, Boore, Tsao, 2006	Taiwan	Nurses,	**Design:**	Semi-structured interviews and Participant Observation:	Some HCPs have <u>judgemental attitudes,</u> including anger, hatred, attention seeking, not accepting responsibility for their lives and attributions of foolish behaviour. Also <u>empathic attitudes</u> (non-discriminatory practice; sympathetic, caring; essential to believe the SUs), or <u>perceived inadequacy</u>.
			Sampling:	Theoretical sampling strategy; N=30 (Nurses=15; Service-users=15.RR-Unknown)	Attributions of behaviour, staff religion and organisational pressure.
			Analysis:	Grounded Theory	
Friedman et al., 2006	UK	A&E nurses (N=53; 84%) & doctors	**Design:**	Questionnaire design;	Evidence of unhelpful attitudes amongst some HCPs. Longer time working in A&E without SH training was correlated with anger in HCPs; they were also less likely to see SH as associated with mental illness.
			Sampling:	Opportunistic sampling strategy. N=63 (RR-53.8%)	
			Analysis:	T-tests; Regression	
Mackay & Barrowclough, 2006	UK	A&E Nurses and Junior Doctors	**Design:**	Between-subjects questionnaire design.	Mixed attitudes were found. Consistent with Weiner's attributional model of helping – negative correlation between attributions of controllability and negative affect of staff towards people who SH. Negative correlation between ratings of stability of outcome and staff optimism for successful outcome. Male staff & junior doctors had more negative attitudes; Junior doctors saw less need for further training.
			Sampling:	Opportunity sampling strategy; N=89 (RR- 49%)	
			Analysis:	T-tests; ANOVAs; pearsons correlations.	

| Rossbery & Friis, 2003 | Norway | Psychiatric Nurses; | **Design:** | Questionnaire between subjects. | design; | A combination of positive and negative feelings were reported in working with people exhibiting internal aggression (suicidal |

		Health Care Assts; Physicians; Psychologist	**Sampling:**	Opportunity sampling strategy N=253 (RR-83.8%)	behaviour). Service-users' aggressive/suicidal behaviour explained a large proportion of the variance in negative feelings. Internal aggression (self harm/suicidality) was correlated with negative dimensions including Rejected; Bored; On Guard; Overwhelmed and Inadequate
			Analysis:	Correlational and regression analysis.	
McAllister, Creedy, Moyle & Farrugia, 2002	Australia	A&E nurses	**Design:**	Questionnaire-based between subjects design.	Mixed range of positive and negative attitude towards people who SH. HCPs in large hospitals indicated a lower perceived ability to assess and refer SH service-users, and had more negative attitudes towards people who SH than those in small settings. Correlations were found between years A&E experience and total score on the Attitudes Towards Deliberate Self Harm Questionnaire; and years of A&E experience and an empathic approach towards people who SH.
			Sampling:	Opportunity sample strategy;N=352 (RR=35%)	
			Analysis:	Factor analysis; chi square; ANOVAs; pearson's correlation.	
Anderson, Standen, Nazir & Noon, 2000	UK	Nurses, General and Psychiatric	**Design:**	Mixed methods Questionnaire & Semi-Structured interviews.	**Quantitative:** Overall agreement on dimensions of: 'suicide reflects mental illness'; 'people have a right to die'; 'SH and suicidality are impulsive acts'; 'everyone is potentially capable of suicide'. General disagreement that 'suicide is an aggressive act'; 'suicide is a morally bad act' and that 'lack of religion has a role in suicide'. No main effect of profession or age; main effect of length of experience and gender .
			Sampling:	Opportunity sampling strategy - N=33 (55.9%) theoretical sampling strategy (N=8 - RR-unknown).	**Qualitative Themes**: Suicidality does not always involve a diagnosis of mental illness; "Attention seeking" is derogatory; Some individuals should have the choice to engage in suicidal behaviour (where chronically physically unwell); Suicidality can be related to 'getting even' or response to past sexual abuse. Religion was highlighted as both a protective and dangerous mechanism.
			Analysis:	Kruskal-wallis; t-tests. Constant comparative method	

Community Settings

Thompson, Powis & Carradice, 2008	UK	Community Psychiatric Nurses	**Design:**	Semi-Structured Interviews.	Mixed attitudes were demonstrated. Psychiatric nurses reported: feeling anxious in their work; understanding facilitates empathy but can be difficult; struggles with responsibility; fear of being blamed; a variety of negative motional reactions to people who SH. Highlighted the role of attribution,
			Sampling:	Purposive sampling strategy. N=8 (RR-unknown)	
			Analysis	IPA	

Mixed Settings

Fox, 2011	UK	Counsellors	**Mixed:** Communit	**Design:**	Semi-structured interviews.	Counsellors reported anxiety regarding SH (severity/ vividness of description), and fear / concern for people who SH;

			y Mental Health and Inpatient.	**Sampling:**	Purposive sampling strategy; subsequent snowball sampling. N=6. (RR unknown)	Pressure/Responsibility to stop/change SH and emotional reactions to organisational issues (fear of being blamed; balancing expectations from the agency; managing risk). Counsellors reported similar feelings of fear around working with service-users who self-harm as found in other professional groups
				Analysis:	Thematic analysis.	
Zadravec; Grad & Socan, 2006	Sloveni a	GPs and Psychiatrists	**Mixed:** Primary Care and Inpatient	**Design:**	Questionnaire design; Between subjects	Five explanatory models were compared across professinoal groups: personality, sociological, medical, crisis and genetic. Significant group differences were found – GPs and psychiatrists preferred the medical, genetic and crisis models. The crisis model gained considerable support - generally accepted as correct. Explanations change in relation to acceptance of the medical model; personal experience of suicidality; through education & professional contact with suicidal people.
				Sampling:	Probability sampling strategy for all except SAtts (purposive sampling strategy) N=619 (GPs=144, (57.6%); Psych=81, (36.7%))	
				Analysis:	Factor analysis	
Anderson, Standen & Noon, 2003	UK	Nurses and doctors from A&E; Paeds & CAMHS	**Mixed**: Acute and Communit y Mental Health.	**Design:**	Semi-Structured Interviews.	Analysis revealed mixed findings, which demonstrated empathic understanding alongside a frustrated impatience with SUs, (ie 'shouldn't be doing that' vs 'who am I to say?') Main themes were: *Experiences of frustration in practice* and *strategies for relating to young people*. Beliefs that adolescents were too young to choose their behaviour/treatment), vs beliefs that behaviour as related to experiences. This was mediated by the context of treatment; challenges where medical staff can feel the futility/fragility of support on offer. Staff highlighted difficulties relating personally to adolescents' different coping strategies.
				Sampling:	Convenience voluntary sampling strategy; N=45 (RR unknown)	
				Analysis:	Grounded Theory	

Crawford, Geraghty, Street & Simonoff, 2003	UK	Psychiatric staff (Doctors and Nurses); Psychologists, Social Workers,	**Mixed**: Inpatient and Community Mental	**Design:** Questionnaire design; between subjects. **Sampling:** Opportunity sampling strategy; N=126 (RR unknown)	Attitudes were understood as relating to one of three factors: effectiveness, negativity and worry. There were generally low scores on scale of negativity, indicating less negative attitudes towards people who SH. However, a substantial number of participants reported worry for this service user group, both for the individuals

	Physiotherapists, Psychotherapists.	Health	**Analysis:**	Exploratory factor analysis; chi square; t-tests; ANOVAs; tukey tests; linear regression & correlation.	but also for themselves that they may be blamed for what happens. There was a trend towards non-psychiatric nurses who felt more effective feeling less worry towards this group of patients. In addition there was a significant association between feeling more effective and less negativity. 42% of the participants wanted further training in SH amongst adolescents.
Huband & Tantam, 2000	UK	Staff from general psychiatry. Breakdown unknown.	**Mixed:** Inpatient and Community Mental Health.	**Design:** Questionnaire survey. **Sampling:** Opportunity sampling strategy. N=213 (55.2%) **Analysis:** Factor Analysis (principal component); Cluster Analysis (K-means); chi square; ANOVAs	Mixed attitudes, but skewed towards empathic responses were demonstrated re a vignette about a female exhibiting repetitive self-harm. However, 65% reported developing a therapeutic relationship was likely to be hard. Attitudes of staff who had additional qualification in counselling or psychotherapy differed significantly from those who had not. No effect was found for specific training in handling self-injuring patients. No effect of gender, but a main effect of age where younger professionals were less tolerant. Effect of professional background. Cluster analysis: Perceived control was a dominant factor in determining attitudes. Less tolerant group saw service-users as having more control and harder to understand: characterised by more young staff without specialist training.

Primary: Refers to GP settings. **Inpatient:** Refers to Acute settings e.g. A&E or Emergency Departments and Chronic (longer-stay units)**;** including both general and **psychiatric care. Community Mental Health:** Refers to Community Mental Health Teams, or working with counsellors/psychologists that aren't involved in the acute setting).

SUMMARY OF FINDINGS

Twenty-two studies were systematically reviewed to understand HCPs' attitudes towards suicidal people or those who SH (see Table 3). Of these, 17 quantitatively analysed self-report data; four qualitatively analysed semi-structured interview data; one adopted a mixed-methods design. Two studies were amalgamated and discussed together, as the studies describe the same data from different perspectives (McCann et al, 2007; McCann et al, 2006). Of the 22 studies, four focused on working with adolescents (Anderson & Standen, 2007; Anderson et al, 2003; Anderson et al, 2000; Crawford et al, 2003), one focused on both adolescents and adults (Wheatley & Austin-Payne, 2009) and the remainder discussed adult service-users.

The reviewed studies were carried out in three main settings: inpatient, community and mixed. Inpatient settings included acute settings (e.g. A&E and chronic units) within both general and psychiatric care. Community settings were typically community mental health teams, or counsellors/psychologists. Mixed settings were a combination of these inpatient and community settings. The studies will be discussed in light of the two research questions posed by the review regarding presence of positive or negative attitudes; and the factors that appear to mediate HCPs' attitudes.

A summary of the 22 studies included in the review can be found in Table 3. In order to organise the information, the studies are listed according to the setting in which the research was carried out. Information regarding the country of origin, professional group(s), methodology and results are provided to highlight their findings.

Research Question 1: Do Healthcare Professionals hold Positive or Negative Attitudes about Individuals that Self-harm or Attempt Suicide?

A range of attitudes towards working with suicidality or people who SH were highlighted in the 22 reviewed studies (see Table 4). This was both facilitated and constrained by various methodological limitations, which have implications for the generalisability of the claims. Ten studies, which were predominantly carried out in A&E settings, demonstrated HCPs' empathy towards service-users (Anderson et al, 2003; Fox, 2011; Friedman et al, 2006; Gibb et al, 2010; McCann et al, 2007; McCann et al, 2006; Sun et al, 2006; Suokas et al, 2009; Suokas et al, 2008; Wheatley & Austin-Payne, 2009). The HCPs considered in these studies were most commonly from nursing backgrounds, although two included doctors (Anderson et al, 2003; Suokas et al 2008), another involved counsellors (Fox, 2011) and another reported on A&E staff in general (Suokas et al, 2009). It cannot be assumed that the eleven remaining studies demonstrated a lack of empathy, but that perhaps there was no opportunity for that particular attitude to be endorsed due to the type of assessment tool used. It is therefore difficult to generalise findings between studies to obtain an overall picture of HCP's attitudes.

Table 4: Types of Health Care Professionals' Attitudes Towards Working with Suicidality or People who Self-harm

Positive Attitudes	Negative Attitudes
• Feelings of empathy and sympathy	• Feelings of anxiety or worry about the service-user, and the consequences/being held responsible
• Belief that the HCPs' role was potentially beneficial to service-users	• Feelings of frustration, anger or attitudes of rejection towards service-users
• Understanding that SH or suicidality could affect anyone	• Understanding that SH or suicidality may be 'attention seeking' or manipulative
• Understanding the communication of SH or suicidality as important, or reflecting distress	• Feelings of low self-efficacy, helplessness or being overwhelmed
• Awareness that 'attention seeking' as a label is derogatory	• Belief that SH or suicidality are 'wrong', demonstrative of failure to take responsibility or impulsive decisions
• Awareness of people's rights to choose; Disagreement that it's a 'morally bad idea'	• Feeling training in the area is inadequate
• Agreement that SH or suicidality is reflective of mental illness; Disagreement that it's reflective of personality flaws	• Feeling unwilling to help SUs

Positive Attitudes

Of the 22 reviewed studies, six suggested overall positive attitudes towards suicidality or people who SH (Huband & Tantam, 2000; McCann et al, 2007; McCarthy & Gijbels, 2010; Rossberg & Friis, 2003; Sun et al, 2007; Wheatley & Austin-Payne, 2009). Huband & Tantam (2000) reported that psychiatric staff from inpatient and community settings indicated positive attitudes towards people who SH on a self-report questionnaire which referred to a vignette. HCPs indicated their position in relation to semantic differential pairs (e.g. 'I would (not)

continue to work with her if she began cutting again'). Psychometric details were not provided for this questionnaire, which was constructed based on the researchers' experience of comments frequently expressed by HCPs, rendering the quality of the measure unknown.

McCann et al (2007) reported positive attitudes from Australian A&E nurses (N=43) towards people who SH as indicated by overall mean scores on a self-report questionnaire. Within this sample, 88.4% of nurses reported having overheard a colleague saying 'why didn't he do it right this time, and save us a lot of trouble' in response to a service-user who had repeatedly self-harmed. Whilst the sample reported that their triage decisions were subsequently unaffected, this indicates the presence of negative attitudes within the working environment. This highlights the bias inherent in opportunity sampling techniques, where opinions sampled are not necessarily representative of the population. Cognisance of this is important in this review, as 15 of the 22 studies employed opportunistic sampling techniques, and a further four used theoretical or purposive sampling strategies. As no data is available regarding those that chose not to participate in the studies, conclusions cannot be drawn regarding the samples. Caution must therefore be taken in interpreting results as, whilst informative, they cannot be treated as generalisable.

Rossberg & Friis (2003) asked HCPs to highlight their feelings towards working with suicidal or aggressive service-users. More positive words were endorsed than negative on a feeling word checklist, although regression analysis suggested that the service-users' behaviour explained more variance in HCPs' negative feelings than positive. It is important to remain cognisant of the potential impact of providing closed options to portray respondents' feelings.

Whilst the seven options provided may have accurately demonstrated their positions, they may also have masked important details.

McCarthy & Gijbels (2010), Sun et al (2007) and Wheatley and Austin-Payne (2009) highlighted positive attitudes in their samples which involved nurses (N=68, N=155 and N=76 respectively) scoring above particular cut-offs on self-report questionnaires. However, on closer perusal of Sun et al's (2007) data, 92.9% of the sample agreed that 'suicidal behaviour can be irritating'. Whilst this may represent a realistic attitude, it cannot be said to be particularly positive, and perhaps demonstrates a difficulty in reporting mean findings which can shroud important details. In addition, a low response rate (12%; Wheatley & Austin-Payne, 2009) and the use of modified questionnaires which may tamper with psychometric quality (McCarthy & Gijbels, 2010; Sun et al, 2007; Wheatley and Austin-Payne, 2009), requires that interpretations are made with caution.

Mixed Attitudes

Of the 22 reviewed studies, 13 highlighted a mixed range of attitudes towards working with suicidality or people who SH (Anderson & Standen, 2007; Anderson et al, 2003; Anderson et al, 2000; Crawford et al; 2003; Fox, 2011; Friedman et al, 2006; Gibb et al, 2010; MacKay & Barrowclough, 2005; McCann et al, 2006; Sun et al, 2006; Suokas et al 2009; Suokas et al, 2008; Thomspon et al, 2008). Crawford et al (2003) highlighted a range of attitudes, where HCPs from different backgrounds rated low scores regarding negativity towards working with SH, but higher scores demonstrating anxieties of being 'blamed' for outcomes. Fear of the consequences of service-users' behaviour permeated several studies, highlighting the strength

of this concern (Crawford et al, 2003; Fox, 2011; Rossberg & Friis, 2003; Sethi & Uppal, 2006; Thompson et al, 2008 and Wheatley & Austin-Payne, 2009).

Anderson & Standen (2007) and Anderson et al (2000) both reported complex ranges of attitudes being elicited by nurses and doctors working with suicidality across a range of settings, through self-report measures comprising several subscales. Awareness of the clinical implications of attitudes being elicited in this way is important. Anderson & Standen (2007) and Anderson et al (2000) administered the Suicide Opinion Questionnaire to HCPs (N=179 and N=59 respectively), where results indicated agreement with the 'suicide reflects mental illness' subscale. This subscale is defined by items such as 'people who commit suicide are usually mentally ill' and 'most persons who attempt suicide are lonely and depressed'. Whilst this demonstrates an understanding of the link between suicidality and mental health, the clinical implications remain uncertain. Agreement might indicate positive attitudes towards suicidality as it highlights awareness of co-morbidity that service-users may require support with, it may also indicate a broader understanding of the service-users' distress. However, it could also indicate negative attitudes if the association reduced the likelihood of HCPs viewing their roles as helpful, or if HCPs became dismissive of the service-user's case. Evidently, an individual's response is dependent on their interpretation of the question; whilst these remain inaccessible to the researcher, conclusions regarding the clinical implications of their responses are difficult to draw.

Anderson et al (2000), Fox (2011), Sun et al (2006) and Thomspon et al (2008) employed qualitative approaches, which allowed for a rich understanding of attitudes and exploration of a range of responses. This was demonstrated where HCPs reported difficulties in

understanding SH but also that understanding enables empathy, and was therefore rated as important. However, the nature of qualitative research often involves small sample sizes (Fox, 2011: N=6, and Thompson et al, 2008: N=8), and may preclude generalisation of findings.

A range of attitudes were reported from A&E nurses and doctors (Friedman et al, 2006) and nurses from medical and psychiatric specialities (Gibb, et al 2010) towards people who SH, from concern and sympathy to frustration and feeling professionally inadequate. Attitudes were elicited through self-report questionnaires; one of which had been constructed using information from literature searches into the area, and input from focus-groups; psychometric properties are therefore unknown (Friedman et al, 2006).

Interestingly, two studies used a questionnaire that utilised a four-point Likert rating scale, which allows choices of (strongly) agreeing or (strongly) disagreeing with an item (McCarthy & Gijbels, 2010; Gibb et al, 2010). This has the benefit of eliminating the opportunity for non-committal responses; however the dichotomous rating scale may also have an effect of forcing individuals into a position when their true attitude may have been neutral. Three studies used questionnaires with five-point Likert scales (McCann et al, 2009; Suokas et al, 2009; Suokas et al, 2008). Their findings that mean responses accumulated towards the middle of the range are also difficult to interpret; this may represent laissez-faire attitudes, a lack of understanding, or an appreciation of individual contexts that render self-report questionnaires difficult to answer. As different patterns of scores on Likert rating scales produce the same overall results, 'uniform meanings' cannot be associated with the scores (Aiken, 2002). Furthermore, without options for open-ended questioning clarification is not possible. Finally, although Suokas et al (2009; 2008) used the same questionnaire in both

studies, different cut-offs relating to positive or negative understandings were utilised; in the absence of a reason for this, the validity of their interpretations could be questioned.

MacKay & Barrowclough (2005) highlighted A&E nurses' and doctors' attitudes towards people who SH, ranging from sympathy to irritation, as rated by an 11 item self-report questionnaire. Attitudes were highlighted through responses to items considering seven typologies (irritation, sympathy, pity, frustration, personal optimism, optimism for follow up and helping). Whilst these may accurately represent their attitudes, limiting HCPs' options might also constrain the opportunity to understand; open-ended options could solve this difficulty.

Negative Attitudes

Of the 22 studies reviewed, two reported predominantly negative attitudes (McAllister et al, 2002; Sethi & Uppal, 2006). Sethi and Uppal (2006) reported negative attitudes from a sample of doctors from different medical specialities in India towards suicidal service-users. These included attitudes of avoidance, rejection, hostility, anxiety and fear which were endorsed through a dichotomously rated (i.e. yes/no) self-report questionnaire. Some of these attitudes were associated with medico-legal issues, and an understanding of suicidal individuals as a 'burden on the medical profession'. The extent to which the doctors were provided with an opportunity to endorse positive attitudes is unclear from the information given. It is also important to recognise the wider context, as suicide remains illegal in India, which is likely to affect the self-report of attitudes more explicitly than in cultures where it is legal (e.g. UK, Australia). McAllister et al (2002) highlighted negative attitudes from A&E

nurses towards people who SH, as indicated by overall mean scores from a self-report questionnaire. This was demonstrated in a large sample (N=352), but also requires consideration in context. The response rate was 35.42%, and as data is not available for the sample of non-responders, may represent a skewed sample.

Summary

In summary, the 22 studies reviewed highlighted a predominantly positive and mixed range of attitudes towards working with suicidality or people who SH. Several methodological limitations have been highlighted which suggest the difficulties of carrying out and interpreting attitudinal research in clinical settings, including sampling (i.e. sample size and attaining a representative sample) and the use of self-report questionnaires (i.e. closed versus open options; psychometric validation; cut-off or dichotomous rating scales) which can lead to the misrepresentation of attitudes. However, the results are informative in recognising the inherent complexity of attitudes and the importance of understanding factors that might mediate these attitudes, including the HCPs' demographics, professional and personal backgrounds and the wider context or organisation.

Research Question 2: What Factors Impact or Mediate the Attitudes that Health Care Professionals Hold?

Twenty-two studies were reviewed to consider HCPs' attitudes towards working with suicidality or people who SH. Having understood that HCPs often experience a range of positive and negative attitudes, it is important to explore any mediating factors. The findings have been amalgamated into the main themes that emerged from the literature (see Table 5) and will be discussed in turn.

Table 5: Mediating Factors of Health Care Professionals' Attitudes Towards Working with Suicidality or People who Self-harm

Overall Themes	Subthemes
Demographic Information	Age
	Gender
Professional Background	Professional Background
	Professional Qualifications
	Length of Clinical Experience
	Exposure to Suicidality or People who SH
	Previous Mental Health Training
Personal Background	Personal Experience
	Religion/Morals
	Perceptions of the Behaviour
Organisational Issues	

Health Care Professionals' Demographic Information

Age

Of the 22 articles reviewed, eight investigated the impact of age as a mediating variable on attitudes. The overall findings from these studies are represented in Table 6.

Table 6: Health Care Professionals' Age and Attitudes Towards Working with Suicidality or People who Self-harm

The Effect of Age on Health Care Professionals' Attitudes
• Younger staff had less empathy and tolerance for people who SH
• Younger staff found people who SH more difficult to understand
• Older age was associated with greater understanding
• Nurses over 35 years old were more likely than younger nurses to have more sympathetic attitudes towards suicide attempters
• Nurses aged between 31 and 40 reported higher perceived ability to deal effectively with service-users than with those between 21 and 30
• Nurses aged between 41 and 50 years had more positive attitudes than those aged between 51 and 60
• A trend was found of older HCPs' reporting slightly higher ratings of distress

Of the reviewed articles, four reported no statistical effect of age (Anderson & Standen, 2007; Anderson et al 2000; Gibb et al, 2010; Suokas et al, 2009). Three studies found significant effects where overall, younger HCPs tended to demonstrate less empathy, tolerance, understanding and perceived efficacy than their older colleagues (Huband & Tantam, 2000; McCann et al, 2006; Mackay & Barrowclough, 2005). However, cautious interpretation is required as they are based on small sample sizes, for example Huband and Tantam (2000) reported less empathy and tolerance in psychiatric staff aged 18 to 25 years, however this age-group represented only 8% of the overall sample. A further association was highlighted, where positive attitudes in A&E nurses peaked aged 41-50 years, and then declined slightly aged 51-60 years (McCarthy & Gijbels, 2010). However, the 41-50 age-group constituted

only 15% of the overall sample of the study, and the 51-60 age-group was represented by only 3%. Caution is necessary as small sample sizes increase the possibility of Type II errors being made.

A deeper understanding of the reasons for age impacting HCPs' attitudes is difficult to glean, as the data is correlational rather than causational. Whilst an understanding can develop of age being associated with more positive or negative attitudes, it is not possible to investigate hypotheses of why or how this might develop. It is also problematic to amalgamate the results to produce an overall understanding, as the attitudes have been measured using different questionnaires, across differently grouped age ranges, and with health professionals from different backgrounds.

Gender

Of the 22 reviewed articles, eleven considered the impact of gender on HCPs' attitudes (see Table 7). Of these, seven did not demonstrate main effects of gender; within this, six studies highlighted a female:male ratio in their samples of approximately 4:1 (Anderson & Standen, 2007; Crawford et al, 2003; Gibb et al, 2010; McCarthy & Gijbels, 2010; Suokas et al, 2009; Suokas et al, 2008). The seventh article which highlighted no effect did not provide details of the breakdown of the gender ratio (Huband & Tantam, 2000). It would be important to understand whether the gender ratio in the samples were representative of the ratio within the HPC population. The over-representation of females may limit the generalisability of these findings, as lack of an effect may be due to small numbers of male HCPs providing their information regarding their attitudes, rather than equilibrium of findings.

Table 7: Health Care Professionals' Gender and Attitudes Towards Working with Suicidality or People who Self-harm

The Effect of Gender on Health Care Professionals' Attitudes
• Female HCPs were less likely to view suicidal behaviour as "not real", and a 'Cry for Help' than male HCPs
• Male HCPs expressed less sympathy and greater levels of irritation and frustration than female A&E staff
• Male staff expressed less personal optimism than females & less subsequent willingness to help
• Female staff showed slightly lower effectiveness, negativity and worry than male staff

Of the eleven articles that considered the impact of gender on HCPs' attitudes, three highlighted an effect. It was demonstrated that female nurses from mixed settings (N=23) were less likely to agree than males (N=10) that 'suicide threats are not real, they represent a cry for help' (p=0.05; Anderson et al, 2000). Male A&E nurses and doctors (N=29) expressed less sympathy (p=0.02); greater levels of irritation (p=0.04) and frustration (p=0.01) than females (N=60; Mackay & Barrowclough, 2005). In addition, male A&E nurses and doctors expressed less personal optimism (p=0.03) and less subsequent willingness to help (p=0.005) than females (Mackay & Barrowclough, 2005). Again, however, care must be taken in interpreting these results, as the sample sizes are small, thus increasing the risk of a Type II error.

Professional Background

Of the 22 reviewed studies, nine considered the impact of professional background on HCPs' attitudes towards working with suicidality or people who SH (see Table 8). Two found no significant effect between nurses and doctors (Anderson et al, 2000; Suokas et al, 2009). Obtaining an overall understanding of the significant effects is complicated by the disparity in measures that were used, and HCPs being differently compared across and within professional

groups, rendering comparison across studies problematic. However, in general, HCPs from mental health backgrounds possessed more positive attitudes than HCPs in general medical settings, including A&E (Gibb et al, 2010; Huband & Tantam, 2000; Suokas et al, 2008). Psychiatric nurses reported higher levels of perceived ability to help compared to other HCPs (p=0.04), including A&E staff who reported lower levels of training and confidence within the field than other medical or psychiatric HCPs (p=0.03; Gibb et al, 2010). Additionally, there appears to be differences between doctors and nurses, where doctors reported significantly more negative attitudes, including irritation, less personal optimism and less helping behaviour (Mackay & Barrowclough, 2005) and were more likely to associate suicidality with mental illness than nurses (p=0.006; Anderson & Standen, 2007).

Table 8: Health Care Professionals' Professional Background on Attitudes Towards Working with Suicidality or People who Self-harm

The Effect of Professional Background on Health Care Professionals' Attitudes
• Doctors associated suicide with mental illness more than nurses
• Doctors rated higher levels of irritation, less personal optimism, and less helping behaviour to people who SH than nurses
• Psychiatrists reported more worry than medical doctors or nurses
• Psychiatric nurses viewed suicidality in adolescents as a choice, resultant of their experiences, rather than a disrespect for life
• Psychiatric nurses reporting higher levels of 'perceived ability to help' than all other HCPs, and were more able to recognise their roles in improving / preserving life than HCPs from acute settings
• HCPs within inpatient settings rated people who SH as more demanding than those in outpatient settings
• HCPs in general hospitals were significantly more negative towards suicidality than in psychiatric hospitals
• Some HCPs felt that HCPs from psychiatric specialities were more able to use specific skills (e.g. listening, talking, being motivated to establish rapport) than acute doctors and nurses

Qualitative trends were observed where mental health nurses had more positive views of their role in working with SH and suicidality, in addition to more positive attitudes towards the service-users than nurses in acute settings (Anderson et al, 2003). Views were held that HCPs from psychiatric backgrounds were more able to use specific skills in assessing and working with suicidal individuals. This was linked to nurses from general medical backgrounds feeling both inadequately trained and concerned that talking about problems may 'make it worse' (Anderson et al, 2003). When asked 'what is the most difficult thing about working with people who SH ?', a significant difference of specialism was found, where 'communication' was endorsed by 27.8% of general medical staff, 10.6% of A&E staff, and 1.7% of psychiatric ($p=0.0001$; Gibb et al, 2010). This could support the notion of professional background impacting HCPs' attitudes towards their work. However, further investigation into influential variables such as training, support networks or resource availability within different specialties would help to understand the nature of this sway.

Professional Qualifications

Of the 22 reviewed studies, five considered the impact of professional qualifications on HCPs' attitudes towards suicidality or people who SH. In general, higher education was associated with greater perceived ability to cope with people who SH and medico-legal aspects of working in the field (McCarthy & Gijbels, 2010); with more positive attitudes overall (McCarthy & Gijbels, 2010; Sun et al, 2007) and significantly lower levels of negativity and worry (Wheatley & Austin-Payne, 2009). However, these studies appear to focus on the education of nurses, hence understandings cannot be gathered regarding other HCPs. In addition, although nurses with postgraduate diplomas were understood as having more positive attitudes than hospital trained nurses, there was no effect of nurses who had

obtained degrees (McCarthy & Gijbels, 2010). The reasons for this are uncertain; it could represent an anomaly of the research or sample, or perhaps the training involved in undertaking a degree differs from other types of qualification.

Huband and Tantam (2000) highlighted that HCPs with therapeutic qualifications were better able to understand that people who SH required tolerance and understanding; possibly related to their enhanced abilities of containing anxiety. However, as this has not been focused upon in other studies, or explored with HCPs from other backgrounds, it is uncertain whether this is related to therapeutic training, or an approach possessed by HCPs who are naturally sensitive or aware. It was acknowledged within the literature that the type of person who would choose to seek out further education due to interest in the field may have held more positive attitudes even without the training (Huband & Tantam, 2000). Whilst this may have some bearing, it is difficult to ascertain without further investigation.

Length of Clinical Experience

Nine of the 22 articles in this review considered the impact of length of clinical experience on HCPs' attitudes towards working with suicidality or people who SH (see Table 9).

Table 9: Length of Health Care Professionals' Clinical Experience and Attitudes Towards Working with Suicidality or People who Self-harm

The Effect of Length of Clinical Experience on Health Care Professionals' Attitudes
Positive Effect of Clinical Experience
• HCPs with more experience were more likely to agree that suicidal behaviour is normal behaviour
• Length of A&E experience was linked to increased anger regarding working with people who SH, and negatively correlated with empathy
• Experienced nurses endorsed more positive attitudes towards people who had attempted suicide
• HCPs with more experience tended to feel more inadequate and less likely to view the people who SH as mentally unwell. However, this did not exist for those that had received training in SH
• Length of experience was associated with increasingly positive beliefs until 16 yrs experience, when it began to decrease

Of these nine studies, four studies demonstrated non-significant findings. Here, length of experience was not significantly associated with effectiveness, worry or negativity (Crawford et al, 2003), perceived ability to help, optimism and patience, or confidence and training (Gibb et al, 2010). Additionally, no effect was found of clinical experience on willingness to care (Suokas et al, 2009). Conversely, significant effects were found where increased ratings of angry attitudes and lower levels of empathy were reported in nurses in association with longer A&E experience (Friedman et al, 2006; McAllister et al, 2002). However, when the analysis controlled for those that had training, the reports of anger were no longer significant (Friedman et al, 2006). McCann et al (2006) and McCarthy and Gijbels (2010) highlighted trends for A&E nurses' attitudes to become more positive over time. McCann et al (2006) understood this through disagreement with the items 'suicide attempters, as a group, are less religious' (p=0.04) and 'those that threaten suicide rarely do so' (p=0.01). Here, length of clinical experience explained 10% and 19% of the variance in responses respectively. McCarthy and Gijbels (2010) reported a trend where length of clinical A&E experience was

associated with increasingly positive attitudes until the nurses had reached 16 years experience, when they started to decline. Unfortunately, due to lack of opportunity for qualitative information being gathered, reasons for this remain unclear. In addition, this finding is based upon small sample sizes, and therefore must be understood with caution.

Overall, it appears that HCPs attitudes generally become more positive over time, with the exception of the findings demonstrated by Friedman et al (2006) and McAllister et al (2002). This might be understood via a third factor, (e.g. burnout) but without further exploration using larger samples, understanding of why some HCPs' attitudes improve and some do not cannot be fully appreciated.

Exposure to Suicidality or People who SH

Of the 22 studies reviewed, two highlighted a significant effect of amount of exposure to suicidality or people who SH on HCPs' attitudes (See Table Ten. Sun et al, 2007; Zadravec et al, 2006) and four did not (Crawford et al, 2003; Huband & Tantam, 2000; Suokas et al, 2009; Wheatley & Austin-Payne, 2009).

Table Ten: Clinical Exposure and Health Care Professionals' Attitudes Towards Working with Suicidality or People who Self-harm

The Effect of Clinical Exposure on Health Care Professionals' Attitudes
• Nurses who had worked with less than 10 people who had attempted suicide had more positive beliefs than nurses those that had worked with more than 10
• The least positive beliefs were held by those who had worked with between 21 and 30 people who had attempted suicide
• HCPs without contact with people who attempted suicide were more likely to endorse the medical model to understand behaviour, whereas those with contact rated the genetic model more highly
• GPs also rated the sociological model of understanding more highly following contact with suicidality than psychiatrists
• HCPs who took care of people who had attempted suicide at least weekly did not have differing attitudes to those that did so less often

Significant findings suggested positive attitudes in HCPs who had worked with over 10 suicidal service-users, but beyond that, attitudes started to decline (Sun et al, 2007). The reasons for which were not explored.

In Zadravec et al's study (2006), general practitioners (GPs) and psychiatrists were asked to rank models of suicidality in order of preference. The explanatory models are explained as concerning "the ways in which an illness episode is interpreted and understood… (Zadravec et al, 2006)" Five explanatory models were yielded from factor analysis of participants' responses to a self-report questionnaire. The results suggested an effect of exposure to suicidality where HCPs without contact were more likely to endorse the medical model ("A Changed Mental State Occurs in Suicide Attempters, Necessitating Psychiatric or Psychological Treatment of the Mental Disorder") and HCPs with exposure to suicidality rated the genetic explanatory model more highly ("Promotes the Genetic Basis and Proneness to Suicide") or sociological mode ("Contemporary Society is Responsible for Putting Extensive Pressure on its Members; This Should be Reduced and Concrete Help Provided to Suicide Attempters) (Zadravec et al, 2006). In both of these cases, further analysis would be needed to understand the reasons for the different endorsements, and the types of appraisals or situations that mediate the difference. Again, due to small sample sizes, differing measures, different professional groups and the studies being conducted in different countries, caution must be used in comparing the studies or generalising their findings regarding exposure mediating attitudes to different settings.

Previous Mental Health Training

Of the 22 studies reviewed, five explored the impact of previous training on HCPs' attitudes (See Table 11). Of these, two studies found significant effects of training on A&E nurses' attitudes (McCarthy & Gijbels, 2010; McCann et al, 2006). McCann et al (2006) found that nurses who had undertaken training were more likely to disagree with the item 'most people who try to kill themselves do not want to die' and 'people who attempted suicide were trying to get sympathy from others' where training was reported as explaining 10% and 11% of the variance in responses respectively. In this study, nurses who had undertaken training constituted 18.6% of the sample (N=8). McCarthy and Gijbels (2010) also reported a positive effect where training elicited increased empathy for people who SH, based on 22% of the sample (N=15) having undertaken training. However, as previously discussed, HCPs that decide to undertake voluntary in-service training may already possess different attitudes towards service-users than the sample of HCPs who would not (Huband & Tantam, 2000); this is important to bear in mind when considering the meaning of presence or absence of effect of training on attitudes.

Table 11: Health Care Professionals' Previous Mental Health Training and Attitudes Towards Working with Suicidality or People who Self-harm

The Effect of Previous Training on Health Care Professionals' Attitudes
• A&E nurses who attended SH training had more favourable attitudes towards people who attempted suicide than nurses who had not
• HCPs that had undertaken SH training had higher ratings of empathy for people who SH
• No effect of training on self-reports of confidence in assessments of people who SH; effectiveness in work role or with legal/hospital regulations
• A&E doctors and nurses working with people who SH who self-lacerate reported high levels of frustration; not correlated to past SH training
• lack of SH training may be an influential factor in the development of negative attitudes

Of the five studies that investigated the impact of training on HCP attitudes, one study where 19.7% of the sample of psychiatric staff from mixed settings had undertaken SH training did not find any effect (Huband & Tantam, 2000). Another study found that despite training A&E nurses and doctors reported negative attitudes towards people who SH (Friedman et al, 2006). Understanding why training may be more beneficial for some HCPs than others is difficult due to the small sample sizes and measures that restrict an exploratory understanding.

Health Care Professionals' Personal Background

Personal Experience

Of the 22 studies considered within this literature review, only three explicitly considered the impact of HCPs' personal experiences on their attitudes towards suicidal individuals or people who SH. McAllister et al (2002) found no statistical effect of personal experience on attitudes which was measured by asking whether A&E nurses had experienced people who SH in their personal lives, of which 36.1% of the sample had (N=127). Within Anderson et al's (2003) qualitative study, a relevant theme highlighted the difficulties nurses and doctors from a range of settings faced in separating their understanding of service-users from their own pasts or present situations. Where they were unable to separate their own adolescent experiences from the suicidal adolescent, they were more likely to understand the adolescent as 'unconventional and difficult to associate with.' Following difficulties separating their current experience from the service-user's circumstances, greater empathy was described (Anderson et al, 2003).

Sethi and Uppal (2006) discussed the role of doctors' personal experiences as a means to understand the negative attitudes elicited in their study. They suggested that doctors' empathic recoil may be related to their own "inner conflicts…including anxiety over [their] own suicide

proneness, together with guilt, shame and contempt (Sethi & Uppal, 2006)". Whilst this is an interesting proposition, further research would be required to understand its applicability or impact on HCPs' attitudes.

Religion/Morals

Overall, five studies considered the impact of HCPs' religious beliefs on attitudes towards working with suicidality or people who SH. Two highlighted significant results (see Table 12). In these studies, which were carried out in Taiwan and Slovenia, HCPs without religious beliefs were likely to have more favourable attitudes towards suicidal individuals or SH (Sun et al, 2007; Zadravec et al, 2006). In Sun et al's study in Taiwan, approximately half the sample of A&E nurses held religious beliefs which were associated with less positive attitudes towards suicidality. The predominant religion was Buddhist, which teaches suicide precludes reincarnation, meaning the "soul will permanently remain in hell to receive punishment (Sun et al, 2007)." Another Taiwanese qualitative study highlighted a similar awareness, which led to appraisals of suicidality as 'foolish' (Sun et al, 2006). In Zadravec et al's study (2006), religious GPs and psychiatrists were more likely to endorse the personality model of explanation for suicidal behaviour than their non-religious colleagues. This model ascribes suicidal behaviour to "personality traits … that were developed in the family of origin by improper upbringing. Spoiled, overly ambitious or weak people over-react to everyday problems and should change their personality" (Zadravec et al, 2006). Unfortunately, no further details regarding the HCPs' belief system were provided.

Table 12: Health Care Professionals' Religious or Moral Beliefs and Attitudes Towards Working with Suicidality or People who Self-harm

The Effect of Religious or Moral Beliefs on Health Care Professionals' Attitudes
• Nurses without religious beliefs held more positive attitudes
• Suicidal attempts as 'foolish' where HCPs' religious beliefs forbid suicide
• Religious HCPs were more likely to endorse the personality model of understanding suicidal behaviour than non-religious
• Differences in moral understanding of the value of life led to negative attitudes
• Suicidality contradicts the HCPs' main aim of preserving life, thus eliciting frustration

Anderson et al (2003) acknowledged the conflict between suicidality and HCPs' main aim of 'preserving life', which led to frustrated attitudes being reported by nurses and doctors (2003). Whilst this concerns vocational rather than religious beliefs, both appear to impact attitudes. A lack of separation between the HCPs' belief systems and the service-users' situation may lead to the development of negative attitudes for some HCPs. However, this also raises awareness of research being carried out in different countries, where individuals are likely to have been shaped by a diverse spread of personal, cultural and religious influences, which within a research context inevitably leads to a significant number of confounding variables. For these reasons, in addition to the small sample sizes, and variety of measurement techniques employed, it is very difficult to make meaningful comparisons across the data.

Perceptions of the Behaviour

Of the 22 reviewed studies, three demonstrated significant impacts of HCPs perceptions of behaviour on attitudes towards suicidality or people who SH (Mackay & Barrowclough, 2005; Sethi & Uppal, 2006; Wheatley & Austin-Payne, 2009), and five studies highlighted

important trends within the data (Anderson et al, 2003; Anderson et al, 2000; Friedman et al, 2006; Sun et al, 2006; Thompson et al, 2008; See Table 13)

Consistent with Weiner's model of helping behaviour (1980), positive attitudes including sympathy and pity, and higher helping behaviour were linked to attributions of SH as being externally caused over which the service-user was perceived as having low levels of control (Huband & Tantam, 2000; Mackay & Barrowclough, 2005; Wheatley & Austin-Payne, 2009). In addition, where the SH was understood as having an unstable cause or outcome, nurses and doctors from a range of settings rated negative attitudes and low levels of optimism of outcome (Anderson et al 2000; Mackay & Barrowclough, 2005; Wheatley & Austin-Payne, 2009), which in turn was associated with lower levels of helping behaviour (Mackay & Barrowclough, 2005; Wheatley & Austin-Payne, 2009). Higher perceived skill in work roles was associated with lower levels of HCPs' irritation (Wheatley & Austin-Payne, 2009). HCPs' negative attitudes were also associated to their attribution of service-users' behaviour as 'manipulative (Anderson et al 2000; Friedman et al, 2006; Sethi & Uppal, 2006; Sun et al, 2006; Thompson et al, 2008)'. It was suggested that understanding service-user's behaviour could be instrumental in disabling negative attitudes (Thompson et al, 2008).

Table 13: Perceptions of Behaviour and Health Care Professionals' Attitudes Towards Working with Suicidality or People who Self-harm

The Effect of Perceptions of Service-user's Behaviour on Health Care Professionals' Attitudes

Optimism
- Less personal optimism was associated with viewing frequent SH as unstable, or unresponsive to treatment
- Low optimism was associated with lower levels of helping behaviour

Frustration /Anger
- Higher frustration associated with attributions that SH was controllable
- Higher frustration associated with low perceived skill in dealing with SH
- Higher frustration associated with lower levels of helping behaviour
- Linked with perceiving service-users' behaviour as manipulative
- Associated with SH that's unresponsive to treatment

Sympathy/Pity
- Higher sympathy associated with higher perceived adequate skills
- Higher sympathy associated with viewing behaviour as being less controllable
- Higher pity associated with seeing trigger to SH as externally caused

Ratings of Helping Behaviour
- Higher levels of helping behaviour were associated with perception of behaviour as externally caused

Suicidality as Attention Seeking
- 'Attention seeking' was linked to service-users being 'irritating', 'selfish' or 'time wasters'
- Service-users were 'attention seeking' when suicidal for no 'good reason'

Different understandings of service-users' behaviour were highlighted between nurses' perceptions of physically unwell service-users and suicidal individuals, where the latter were understood as 'having done it to themselves' (Anderson et al, 2000). Nurses described concern about mixing suicidal individuals with other service-users on the ward, for fear of eliciting negative emotions in the terminally ill who had not 'chosen' their plight (Anderson et al, 2000). HCPs were more likely to endorse adolescents' 'right to choose' suicide if they were terminally unwell (Anderson et al, 2000). Nurses perceived suicide attempts as a 'potential waste of life', and evidence that individuals disrespected the dangerous consequences of behaviour that was often triggered by something 'trivial' (Anderson et al, 2003; Sun et al, 2006).

Although there was an association of 'attention seeking' as being linked to suicidal service-users, there was also an acknowledgement of the term as unhelpfully derogatory (Anderson et al, 2000; Friedman et al, 2006; Thompson et al, 2008). Within this, awareness existed of people who 'attention seek' as requiring care and understanding (Anderson et al, 2000; Thompson et al, 2008).

Organisational Issues

Eight of the 22 reviewed studies considered the impact of the HCPs' organisational system on their attitudes towards suicidality or SH (see Table 14). Three studies highlighted a theme of negative attitudes from nurses and doctors from mixed backgrounds in response to organisational limitations, including lack of time, limited resources, feeling unsupported, insufficient education or training and medico-legal processes associated with the service-users' behaviour (Anderson et al, 2003; Sethi & Uppal, 2006; Thompson et al, 2008). Furthermore, it was found that these limitations heightened A&E nurses' sense of responsibility (Thompson et al, 2008) However, HCPs' reported feeling unconfident and inadequately trained within the field, which was associated with feelings of helplessness (Friedman et al, 2006; McAllister et al, 2002; Sun et al, 2006). 'Perceived ability to help' was significantly associated with personal accomplishment (Gibb et al, 2010), and to increased likelihood of positive attitudes towards people who SH from A&E nurses (McAllister et al, 2002). 'Confidence and training' was negatively associated with emotional exhaustion for A&E nurses (Gibb et al, 2010). Furthermore, Anderson et al (2003) and McCarthy and Gijbels (2010) reported nurses' and doctors' experiences that the organisational system within A&E, paediatric, and children and adolescent mental health teams impeded their ability to work effectively with people who SH.

Table 14: Organisational Issues and Health Care Professionals' Attitudes Towards Working with Suicidality or People who Self-harm

The Effect of Organisational Issues on Health Care Professionals' Attitudes
• HCPs' frustration was associated with lack of time or resources to develop therapeutic relationships
• Nurses reported feeling 'used' by the hospital system
• Hospital system impeded their ability to work effectively with people who SH.
• Organisational pressures (e.g. lack of time, limited resources, feeling unsupported by other services) heightening feelings of responsibility
• Service-user safety at the expense of therapeutic relationship
• 'Perceived ability to help' was associated with personal accomplishment. 'Confidence and training' factor was associated with emotional exhaustion
• Sense of HCPs' 'powerlessness' with suicidality was linked to insufficient education and training
• HCPs' anxiety regarding the unpredictability of service-users' presentations over time, impacted by being 'held accountable' for decisions made
• Difficulties regarding ward environment not meeting multiple needs

Anderson et al (2003) highlighted HCPs awareness and associated frustrations with the busy ward environment, which was deemed inappropriate for the provision of a safe, confidential setting for vulnerable service-users. HCPs from psychiatric backgrounds were more likely to rate people who SH as having more control over their actions, and as being more demanding than HCPs' in outpatient settings (Huband & Tantam, 2000). Furthermore, A&E nurses working in smaller hospitals (N=20) demonstrated higher perceived ability in working with people who SH, and more empathy than those working in larger settings (N=40; McAllister et al, 2002). However, it remains important to interpret these findings with caution, due to aforementioned implications of small sample sizes, the use of a range of measures and the application of them within a mixed sample of professionals and settings making generalisations difficult.

Summary

It appears that several factors impact the beliefs of HCPs towards working with suicidality and SH, including age, gender, length of experience and training, perception of service-users' behaviour, HCPs' personal experiences and morals or religious beliefs, and organisational or systemic pressures. It is unlikely any one of these factors represents a sole influence. Rather, the factors are likely to impact each other and as such should be held together as a matrix of influence. However, without further in depth analysis, this is difficult to accurately draw together.

CONCLUSION

One aim of attitudinal research concerns the impact of attitudes on behaviour. Historically, it was readily accepted that attitudes directly impacted behaviour (Ajzen & Fishbein, 2005); however, as research techniques developed, incongruities in this understanding were found where attitudes and behaviour did not marry up. From this, attention was paid to the impact of psychometric properties, such as validity, and the role of bias in individuals' self-report (Ajzen & Fishbein, 2005). A long-standing concern relates to the construction of questionnaires where a singular evaluative focus can underestimate the complexity of attitudes, and may explain their lack of bearing on behaviour (Ajzen & Fishbein, 2005). Within this literature review 18 of the 22 studies were questionnaire-based designs. Several studies raised limitations inherent within this, including 'forcing [attributional] ratings' (Mackay & Barrowclough, 2006); prohibiting the expansion of answers to promote a causational understanding (Anderson et al, 2007); the impossibility of accessing the relationship between self-reports and actual practice (Anderson et al, 2000), and the results reflecting only the 'conscious feelings of the interviewee (Suokas et al, 2009)'. The data regarding HCPs' attitudes towards service-users may therefore differ on a day-to-day basis, under the pressures of competing demands and fluctuating levels of stress.

The theory of reasoned action (Ajzen & Fishbein, 1977, in Ajzen & Fishbein, 2005) focuses on how attitudes shape and impact behaviour. The theory posits that in addition to intention and motivation, behaviour is determined by subjective norms and attitudes, thus highlighting the importance of an individual's context. Whilst attitudes concern an evaluation of

behaviour, subjective norms reflect other peoples' beliefs about what should be done (Traffimow & Finlay, 2001). The relative weight given to attitudes or subjective norms is variable, therefore accounting for varied behavioural intentions which are changeable over time. The effect of subjective norms has been recognised within the field of research into socially sensitive subjects, where drive for 'social desirability' acts as a potential conforming influence over participants' self-reports (Van de Mortel, 2008). This may apply to the reviewed studies, as norms might expect HCPs to care for service-users in a non-discriminatory fashion, regardless of presenting difficulty. The majority of studies reviewed attempted to control for social desirability by ensuring anonymity, however this may not have fully eliminated the effects of such bias.

Ybarra and Traffimow (1998) explored the role of priming in the weighting of attitudes or subjective norms in behavioural intention. Where an individual's private self-concept had been primed, through requiring them to think solely of themselves before answering questions, attitudes were more influential in forming behavioural intentions. Where individuals were encouraged to think about their collective self-concept (i.e. them in relation to the wider society of family, friends, work etc), their behavioural intentions were more likely to be influenced by subjective norms (Ybarra & Traffimow, 1998). Within the context of this literature review, the wording of the questionnaires or interview questions, may have primed differing self-concepts. Responses may therefore reflect subjective norms rather than attitudes.

Difficulties in predicting behaviour from attitudes lie not only in the means of accessing the attitudes, but also within the individuals themselves. Moderating variables include self-monitoring and self-consciousness. Self-monitoring may suggest that those who are sensitive

to social expectations would be more likely to demonstrate a "socially appropriate performance" whereas those with a lesser ability may be more likely to reflect their true attitudes which were more predictive of behaviour (Ajzen & Fishbein, 2005). Whilst this may be the case, in the reviewed studies it is possible that the process of asking HCPs about their attitudes prompted self-monitoring or self-reflection which allowed an opportunity to challenge latent assumptions that may have been unknowingly held.

The overall findings recognise a range of attitudes in HCPs towards those that are suicidal or SH. Of significance, HCPs who were older, female, from mental health backgrounds, had higher levels of education and longer clinical experience tended to demonstrate more positive attitudes towards suicidal individuals and those who SH. Additionally, increased exposure to suicidality elicited more positive attitudes, to a point, whereupon attitudes declined. Personal experience and religious or moral backgrounds seem to be lesser studied factors, however both appeared to have an impact, where personal experience of suicidality or SH, and a non-religious background may have elicited more positive beliefs. Additionally, the role of attribution was highlighted, where perceived controllability and stability of behaviour had significant impacts on HCPs' attitudes. Finally, organisational issues were understood as having an impact on HCPs' feelings and attitudes. In combination, these factors appeared to effect HCPs' levels of confidence, self-efficacy and hopefulness in caring for those in significant distress. However, as previously mentioned, care must be taken in interpreting these results due to methodological limitations. A substantial number of studies also found non-significant effects; whilst the reasons for this were not always clear, it raises the possibility that the factors do not have consistent effects on attitudes.

CLINICAL IMPLICATIONS AND RECOMMENDATIONS

Whilst the prevalence of suicidality and self-harm remains high, maintaining an awareness of HCPs' attitudes towards working with vulnerable service-users is important. The potential for nurses' attitudes to impact service-users' care has been suggested as influencing further incidents of SH (Emerson, 2010; McCarthy & Gjbels, 2010; Rayner, Allen & Johnson, 2005; Wheatley & Austin-Payne, 2009). Without the opportunity to 'work through' negative attitudes towards service-users, decisions could be made that affect individuals' care decisions (McCann et al, 2007; Rossberg & Friis, 2003; Sethi & Uppal, 2006; Sun et al, 2006). This was reiterated by Fox (2011), who raised awareness regarding risks of communication between HCPs and service-users, some of which may be unconscious. Even when the motivation for communication is to convey concern, the potential for service-users to interpret the perception of their behaviour as negative or unhealthy risks eliciting shame, or reinforcing stigma (Fox, 2011); subsequently reducing the likelihood of help-seeking in future. Whilst an incidence of SH or suicidality may increase future risk, it is also an opportunity to end a suicidal process if appropriate help is received through the medium of effective communication (Bertolote, Fleischmann, De Leo & Wasserman, 2004).

Weiner's model of helping behaviour (1980) suggests that ratings of willingness to help others are lower when the need for help is deemed to be internally caused and controllable. Uncontrollable or externally caused difficulties are proposed to elicit more positive affect, and higher levels of helping behaviour. This model was borne out in two studies within this literature review (Mackay & Barrowclough, 2005; Wheatley & Austin-Payne, 2009) and led

to the suggestion of incorporating Weiner's understanding to work with HCPs' perceptions, to facilitate better service-user care (Mackay & Barrowclough, 2005).

Overall, a consensus emerged across the studies of attitudes towards suicidality and SH as being complex rather than either positive or negative, or being caused by definitive factors. This complexity needs to be taken into account in HCPs' training and in the development of contemporary suicide prevention policies. Of the 22 studies reviewed, 19 advocated the need for training and provision of support. This could form part of a mandatory continuing professional development requirement, to educate and inform HCPs regarding the prevalence, risk factors, treatment and communication of SH and suicidality. This could enhance awareness and understanding, reduce stigma and increase confidence and self-efficacy. Provision of locally developed guidelines for working with SH and suicidality, which are supported by management and developed through working groups of HCPs with a range of clinical experience, would foster ownership and facilitate awareness. Finally, reflective practice, through clinical or peer supervision, would allow HCPs to express their feelings, reactions and attitudes in a safe environment. The stressful nature of work within healthcare settings, and the competing demands of HCPs' roles, requires that reactions are normalised. This might aid the challenging of unhelpful attitudes, and support adaptive attitudes towards service-users, to maximise their experience and likelihood of engaging with treatment.

REFERENCES

Aiken, L.R. (2002) *Attitudes and Related Psychosocial Constructs: Theories, Assessment and Research*. London: Sage Publications

Ajzen, I. & Fishbein, M. (2005) The Influence of Attitudes on Behaviour. D. Albarracin, B.T. Johnson & M.P. Zanna (Eds), *The Handbook of Attitudes.* (pp173-222). New Jersey: Lawrence Erlbaum Associates

Albarracin, D., Zanna, M.P., Johnson, B.T. & Kumkale, G.T. (2005) Attitudes: Introduction and Scope. In D. Albarracin, B.T. Johnson & M.P. Zanna (Eds), *The Handbook of Attitudes.* (pp3-20). New Jersey: Lawrence Erlbaum Associates

Anderson, M. & Standen, P.J. (2007) Attitudes Towards Suicide Among Nurses and Doctors Working with Children and Young People who Self-Harm. *Journal of Psychiatric and Mental Health Nursing*, 14, 470-477

Anderson, M., Standen, P. & Noon, J. (2003) Nurses' and Doctors' Perceptions of Young People who Engage in Suicidal Behaviour: A Contemporary Grounded Theory Analysis. *International Journal of Nursing Studies*, 40, 587-597

Anderson, M., Standen, P., Nazir, S. & Noon, J.P. (2000) Nurses' and Doctors' Attitudes Towards Suicidal Behaviour in Young People. *International Journal of Nursing Studies*, 37, 1-11

Anderson, R.M. (1995) Revisiting the Behavioural Model and Access to Medical Care: Does it Matter? *Journal of Health and Social Behaviour*, 36, 1-10

Appleby, L. (2000) Safer Services: Conclusions from the Report of the National Confidential Inquiry. *Advances in Psychiatric Treatment*, 6, 5-15

Beautrais, A.L., Mulder, R.T., Fergusson, D.M., Deavoll, B.J. & Nightingale, S.K. (1996) Prevalence and Comorbidity of Mental Disorders in Persons Making Serious Suicide Attempts: A Case-Control Study. *The American Journal of Psychiatry,* 153 (8), 1009-1014

Bertolote, J., Fleischmann, A., De Leo, D., & Wasserman, D. (2004) Psychiatric Diagnoses and Suicide: Revisiting the Evidence. *Crisis,* 25(4), 147–155

Chapman, A.L., Gratz, K.L., Brown, M.Z. (2006) Solving the Puzzle of Deliberate Self-Harm: The Experimental Avoidance Model. *Behaviour Research and Therapy,* 44, 371-394

Crawford, T., Geraghty, W., Street, K. & Simonoff, E. (2003) Staff Knowledge and Attitudes Towards Deliberate Self-Harm in Adolescents. *Journal of Adolescence,* 26, 619-629

Curtis, C. (2010) Youth Perceptions of Suicide and Help-Seeking: They'd Think I was Weak or 'Mental'. *Journal of Youth Studies*, 13 (6), 699-715

Da Cruz, D., Pearson, A., Saini, P., Miles, C., While, D., Swinson, N., Williams, A., Shaw, J., Appleby, L. & Kapur, N. (2010) Emergency Department Contact Prior to Suicide in Mental Health Patients. *Emergency Medicine Journal*. DOI:10.1136/emj.2009.081869

Department of Health (2004) *The National Service Framework for Mental Health – Five Years On.* Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4099120 Accessed March 17th 2011

Department of Health (2002) *National Suicide Prevention Strategy for England*. http://www.nmhdu.org.uk/silo/files/national-suicide-prevention-strategy-for-england.pdf. Accessed March 17th 2011

Department of Health (1999) *Saving Lives: Our Healthier Nation*. Available at http://www.archive.official-documents.co.uk/document/cm43/4386/4386.htm. Accessed March 17th 2011

Duffy, D.F. (2009) Self-Injury. *Psychiatry*, 8 (7), 237-240

Eagly, A.H. & Chaiken, S.L. (1993) *The Psychology of Attitudes*. Fort Worth: Harcourt Brace Jovanovich

Emerson, A. (2010) A Brief Insight into how Nurses Perceive Patients who Self-Harm. *British Journal of Nursing,* 19 (13), 840-843

Fortune, S., Sinclair, J., Hawton, K. (2008) Help-Seeking Before and After Episodes of Self-Harm: A Descriptive Study in School Pupils in England. *BMC Public Health*, 8, 369-382

Fox, C. (2011) Working with Clients who Engage in Self-Harming Behaviour: Experiences of a Group of Counsellors. *British Journal of Guidance & Counselling*, 39 (1), 41-51

Friedman, T., Newton, C., Coggan, C., Hooley, S., Patel, R., Pickard, M. & Mitchell, A.J. (2006) Predictors of A&E Staff Attitudes to Self-Harm Patients who use Self-Laceration: Influence of Previous Training and Experience. *Journal of Psychosomatic Research,* 60, 273-277

Gibb, S.J., Beautrais, A.L. & Surgenor, L.J. (2010) Health-Care Staff Attitudes Towards Self-Harm Patients. *The Australian and New Zealand Journal of Psychiatry,* 44 (8), 713-720

Hawton, K., Zahl, D. & Weatherall, R. (2003) Suicide Following Deliberate Self-Harm: Long-Term Follow Up of Patients who Present to General Hospital. *The British Journal of Psychiatry*, 182, 537-542

Hawton, K., Fagg, J., Simkin, S., Bale, E & Bond, A. (1997) Trends in Deliberate Self Harm in Oxford 1985-1995: Implications for Clinical Services and the Prevention of Suicide. *British Journal of Psychiatry,* 171 (12), 556-560

Huband, N. & Tantam, D. (2000) Attitudes to Self-Injury within a Group of Mental Health Staff. *British Journal of Medical Psychology,* 73, 495-504

Irish National Strategy for Suicide Prevention; Department of Health and Children, (2005) *Health Service Executive, National Suicide Review Group 2005. Reach Out–Irish National Strategy for Action on Suicide Prevention 2005–2014.* http://www.nosp.ie/reach_out.pdf Accessed March 17th 2011

Jenkins, R. (1994) The Health of the Nation: Recent Government Policy and Legislation. *Psychiatric Bulletin*, 18, 324-327

Kapur, N. & Gask, L. (2009) Introduction to Suicide and Self-Harm. *Psychiatry* (8) 7, 233-236

Long, M. & Jenkins, M. (2010) Counsellors' Perspectives on Self-Harm and the Role of the Therapeutic Relationship for Working with Clients who Self-Harm. *Counselling and Psychotherapy Research,* 10 (3), 192-200

McAllister, M., Creedy, D., Moyle, W. & Farrugia, C. (2002) Nurses' Attitudes Towards Clients who Self-Harm. *Journal of Advanced Nursing*, 40 (5), 578-586

McCann, T., Clark, E., McConnachie, S., Harvey, I. (2006) Accident and Emergency Nurses' Attitudes Towards Patients who Self-Harm. *Accident and Emergency Nursing*, 14, 4-10

McCann, T.V., Clark, E., McConnachie, S. & Harvey, I. (2007) Deliberate Self-Harm: Emergency Department Nurses' Attitudes, Triage, and Care Intentions. *Journal of Clinical Nursing*, 16, 1704-1711

McCarthy, L. & Gijbels, H. (2010) An Examination of Emergency Department Nurses' Attitudes Towards Deliberate Self-Harm in an Irish Teaching Hospital. *International Emergency Nursing*, 18, 29-35

Mackay, N. & Barrowclough, C. (2005) Accident and Emergency Staff's Perceptions of Deliberate Self-Harm: Attributions, Emotions and Willingness to Help. *British Journal of Clinical Psychology*, 44, 255-267

Mangnall, J., & Yorkovich, E. (2008) A Literature Review of Deliberate Self-Harm. *Perspectives in Psychiatric Care*, 44 (3) 175-184

Milner, A. & De Leo, D. (2010) Who Seeks Treatment Where? Suicidal Behaviors and Health Care: Evidence from a Community Survey. *The Journal of Nervous and Mental Disease*, 198 (6), 412-419

National Institute of Clinical Excellence (2004) *Self-harm: The Short-Term Physical and Psychological Management and Secondary Prevention of Self-Harm in Primary and Secondary Care*. Available at

http://www.nice.org.uk/nicemedia/live/10946/29421/29421.pdf.   Accessed March 17th 2011

National Mental Health Development Unit (2011) *Suicide Prevention.* Available at http://www.suicideprevention.org.uk/ Accessed March 17th 2011

Owens, D., Horrocks, J. & House, A. (2002) Fatal and Non-Fatal Repetition of Self-Harm: A Systematic Review. *The British Journal of Psychiatry*, 181, 193-199

Rayner, G.C., Allen, S.L. & Johnson, M. (2005) Countertransference and Self-Injury: A Cognitive Behavioural Cycle. *Journal of Advanced Nursing*, 50 (1), 12–19

Rossberg, J.I. & Friis, S. (2003) Staff Members' Emotional Reactions to Aggressive and Suicidal Behavior of Inpatients. *Psychiatric Services*, 54 (10), 1388-1394

Sethi, S. & Uppal, S. (2006) Attitudes of Clinicians in Emergency Room Towards Suicide. *International Journal of Psychiatry in Clinical Practice*, 10 (3), 182-185

Sun, F., Long, A. & Boore, J. (2007) The Attitudes of Casualty Nurses in Taiwan to Patients who have Attempted Suicide. *Journal of Clinical Nursing*, 16, 255-263

Sun, F., Long, A., Boore, J. & Tsao, L. (2006) Patients and Nurses' Perceptions of Ward Environmental Factors and Support Systems in the Care of Suicidal Patients. *Learning Disability and Mental Health,* 15 (1), 83-92

Suokas, J., Suominen, K. & Lonnqvist, J. (2009) The Attitudes of Emergency Staff Toward Attempted Suicide Patients: A Comparative Study Before and After Establishment of a Psychiatric Consultation Service. *Crisis*, 30 (3), 161-165

Suokas, J., Suominen, K. & Lonnqvist, J. (2008) Psychological Distress and Attitudes of Emergency Personnel Towards Suicide Attempters. *Nordic Journal of Psychiatry,* 62 (2), 144-146

Thompson, A.R., Powis, J. & Carradice, A. (2008) Community Psychiatric Nurses' Experience of Working with People who Engage in Deliberate Self-Harm. *International Journal of Mental Health Nursing*, 17, 153-161

Traffimow, D. & Finlay, K.A. (2001) The Relationship Between Normatively Versus Attitudinally Controlled People and Normatively Versus Attitudinally Controlled Behaviours. *The Social Science Journal,* 38, 203-216

Van de Mortel, T. (2008) Faking It: Social Desirability Response Bias in Self-Report Research. *Australian Journal of Advanced Nursing,* 25 (4), 40-48

Weiner, B. (1980) A Cognitive (Attribution) Emotion Action Model of Motivated Behavior: An Analysis of Judgements of Help-Giving. *Journal of Personality and Social Psychology*, 39 (2), 186-200

Wheatley, M. & Austin-Payne, H. (2009) Nursing Staff Knowledge and Attitudes Towards Deliberate Self-Harm in Adults and Adolescents in an Inpatient Setting. *Behavioural and Cognitive Psychotherapy,* 37, 293-309

Whitlock, J. & Knox, K.L. (2007) The Relationship Between Self-Injurious Behaviour and Suicide in a Young Adult Population. *Archives of Paediatric & Adolescent Medicine*, 161 (7), 634-640

World Health Organization. (2011) *Suicide Prevention (SUPRE).* Available at http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/ Accessed March 17th 2011

World Health Organistion (2000) *Preventing Suicide: A Resource for Primary Health Care Workers*. Department of Mental Health: Geneva

World Health Organisation (2000b) *Preventing Suicide: A Resource for Media Professionals.* Department of Mental Health: Geneva

Ybarra, O. & Traffimow, D. (1998) How Priming the Private Self or Collective Self Affects the Relative Weights of Attitudes and Subjective Norms. *Personality and Social Psychology Bulletin,* 24, 362-370

Zargoushi, R., Asghari, F., Zeraati, H. & Fotouhi, A. (2011) Treating Patients Differently: Comparison of Medical Staff Behaviour and Attitudes towards Cases of Self-Immolation and Unintentional Burns. *Burns*, 37, 153-158

Zadravec, T., Grad, O. & Socan, G. (2006) Expert and Lay Explanations of Suicidal Behaviour: Comparison of the General Population's, Suicide Attempters', General Practitioners' and Psychiatrists' Views. *International Journal of Social Psychiatry*, 52 (6), 535-551

Can Group-Based Mindfulness Reduce Vulnerability to Suicidality in Young Adults?

A Pilot Study

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To be Prepared for Submission to **Behavioural and Cognitive Psychotherapy**

ABSTRACT

People with a history of depression and suicidality may display increased cognitive reactivity to emotional events, leaving them vulnerable to relapse (Van der Does, 2002; Williams, Van der Does, Barnhofer, Crane & Segal, 2008). This may also be the case for adolescents (Miller, Rathaus & Linehan, 2007). Mindfulness is suggested to reduce such vulnerability. In order to test this hypothesis, a mindfulness-based group intervention was run with two groups of young service-users (aged 17-20), of mixed diagnoses, all of whom had histories of self-harm or suicidal behaviour. A mixed-method approach involving self-report questionnaires and semi-structured interviews was utilised to understand change. Group-based analysis highlighted non-significant change. Individual change via the reliable change index (Jacobson & Truax, 1991) suggested some significant reduction in cognitive reactivity but non-significant increases in mindfulness skills. Interview data, analysed using Template Analysis (King, 2004) revealed a range of responses to the experience of mindfulness. Benefits were highlighted, some of which may be attributable to mindfulness, and others to more general processes of group membership. More detailed analysis of the results and the limitations thereof are discussed, and highlight the necessity for further research into the effects of mindfulness on reducing vulnerability to suicidality in adolescents.

INTRODUCTION

Differential Activation, Cognitive Reactivity and Suicidality

A potential framework for understanding a young person's vulnerability to recurrent depression, self-harm and suicidality is the Differential Activation Hypothess (DAH; Teasdale, 1988). This builds on Beck's cognitive model, and recognises the role of individual differences and cognitive schemas that may be activated by specific situations to induce depression (Lau, Segal & Williams, 2004). Alongside this, Teasdale (1988) suggested that particular patterns of negative thought processing developed within the early episodes of depression then serve to elongate the episode. Interaction of these thought patterns with other factors including environmental demands, social support and biological determinants further strengthen the formation of a 'depression-maintaining cognitive-affective vicious cycle' (Teasdale, 1988). It is therefore suggested that an individual's vulnerability to severe and relapsing depression is elicited by the thought patterns that are activated whilst depressed (Lau et al., 2004).

Cognitive reactivity (CR) describes the process whereby previously established negative thinking patterns remain intact during remission (Antypa, Van der Does & Penninx, 2010), and are then retriggered (Lau et al., 2004). Furthermore, sensitisation can occur where repeated reactivation through CR increases the probability of patterns being triggered by small, non-clinical changes in mood in the future (Lau et al, 2004). Studies also suggest that levels of CR are higher in individuals with a history of depression representing a risk factor for relapse (Segal, Gemar & Williams, 1999; Van der Does, 2002).

Suicidal ideation can arise during episodes of depression (Lau et al, 2004). Within the DAH framework, once these thought patterns have been established, the depressed mood and suicidal thoughts can become associated in such a way that future depression will reactivate suicidal ideas (Lau et al, 2004). Again, through sensitisation, becoming easier over time.

In recent studies, individuals who reported suicidal ideation when previously depressed were more likely to have higher scores on a particular hopelessness subscale on the Leiden Index of Depression Sensitivity-Revised (LEIDS-r); a measure of CR to low mood (Antypa et al., 2010; Williams et al., 2008). This was also found to be associated with feelings of guilt regarding the past, which suggested that upon reactivation of the patterns, individuals were likely to become 'trapped' between feeling guilty about the past and hopeless about their future, whereupon the option of suicide became a solution (Antypa et al., 2010). Overall, these findings support the link between suicidal ideation and a specific cognitive response pattern, which even following remission, may be reactivated by mild fluctuations in mood (Williams et al., 2008).

Research into CR raises awareness of the importance of assessing for 'latent cognitive response patterns' when considering an individual's stage of recovery or the effect of treatment for alleviating distress (Antypa et al., 2010; Williams et al, 2008). A distinction is highlighted between assessment of 'explicit measurements of risk factors' and 'reactivity patterns'. Reliance on the former type of assessment alone may lead to treatment decisions that could underestimate an individual's level of risk (Antypa et al., 2010).

Adolescents and Mental Health

Adolescence has been associated with mental health difficulties with prevalence rates of approximately 12% in the United Kingdom (UK) for individuals between 13 and 15 years old (Patel, Flisher, Hetrick & McGorry, 2007). The 'rising importance' of emotional difficulties in adolescence has been acknowledged due to the negative and potentially long-standing impact that mental health problems can have, particularly on educational and social engagement (Wille, Bettge & Ravens-Sieberer, 2008). Strong psychosocial risk factors for both male and female adolescents have been found to include chronic illness of one parent, low socioeconomic status, conflicts within the family, growing up in a single parent or step-parent family, low subjective ratings of mental health and parental mental health difficulties, a history of sexual or physical abuse, or presence of self-reported chronic illness (Wille et al., 2008). The risk of development of mental health difficulties was associated with an increase in age, leaving adolescents at higher risk than younger children (Wille et al., 2008). Additionally, risk factors were found to have an accumulative effect, where presence of mental health difficulties significantly increased in relation to the number of risk factors that an individual reported.

Protective factors were also found to have an accumulative buffering effect. These included self-efficacy; self-concept; family climate; parental support; social support and personal resources. However, prevalence data showed that adolescents (14-17) reported having fewer resources available to them than younger age groups (11-13) at a time when they were exposed to more risk factors, thus suggesting a vulnerable stage for developing mental health problems (Wille et al., 2008).

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Adolescents and Suicidal Ideation or Self-harm

Patton et al. (2009) analysed data from the 2004 Global Burden of Diseases study (World Health Organisation, 2008) to focus on different stages of adolescence. Overall, rates of suicide in males and females aged between 10–24 years constituted the second most common cause of death (6.3%), after road traffic accidents. Death from self-inflicted injuries was highlighted as the most common cause of death in females aged 15-19 (8.2%) and the third most common cause in males aged 15-19 (6.5%), after road traffic accidents (16.2%) and violence (9.3%; Patton et al., 2009).

In a UK sample of 4,532 people aged between 10 and 15, 6.7% (N=308) had tried to harm or kill themselves, with higher rates being found in girls than boys (7.5% vs 5.9%), and in 13-15 (7.5%) rather than 11-12 year olds (5.5%). This data was recruited from both self-report data and parents' reports of their children's behaviour (Meltzer, Harrington, Goodman & Jenkins, 2001). Risk factors for suicide included presence of mental health difficulties, where 25.5% of this sample had anxiety or depression. Logistic regression analysis revealed that adolescents with depressive disorders were 14 times more likely to have attempted to harm themselves than those without (Meltzer et al, 2001). Further prevalence data from the UK suggests that approximately 7-14% of adolescents self-harm and between 20-45% of adolescents have suicidal thoughts (Hawton & James, 2005). Risk factors have been postulated for the incidence of these, and include family breakdown or relationship instabilities; substance misuse; instability of employment; media influences; higher educational need; exposure to more stressful life events including being physically unwell; those with same-sex preferences

and people with mental health difficulties, particularly depression (Hawton & James, 2005; Meltzer et al, 2001; Miller, Rathaus & Linehan, 2007; Patel et al, 2007; Skegg, 2005). In addition, suicidal behaviours have been correlated with individual's difficulties in problem solving, affect regulation and with high levels of hopelessness (Sidley, 1998).

Research suggests that the more problematic behaviours an adolescent exhibits (e.g. violence; binge drinking; drug and tobacco use; high-risk sexual behaviour; disturbed eating behaviours) the greater the risk of suicidal behaviour, where exhibiting six behaviours elicited a 277 times greater risk of suicidal attempt (Miller et al, 2007). In addition, a large proportion of individuals who attempt suicide continue to make future attempts, which highlights the need for effective identification, assessment and treatment or support being offered to adolescents in need (Miller et al, 2007).

Mindfulness

Mindfulness is a meditative practice that encourages individuals' sustained attention to internal processes and external events, to create a moment-by-moment, non-judgemental awareness of experience (Brown & Ryan, 2003). Within mindfulness, distress is seen as a reaction to experience, dependent on peoples' interpretations, rather than being inherent in experience (Abba, Chadwick & Stevenson, 2008), and which can be exacerbated or maintained through avoidance (Kabat-Zinn, 1990).

Mindfulness-based (MB) approaches focus on 'decentering oneself' from these reactions (Kabat-Zinn, 1990)' and treat thoughts and feelings as transitory rather than 'aspects of the

self, or reflections of objective truth (Bishop et al., 2004; Fennell, 2004)'. They therefore aim to alleviate distress by offering an alternative way to relate to inner experience (Chadwick, Huges, Russell, Russell & Dagnan, 2009). Rather than making attempts to 'get rid' of or change distressing experiences, MB approaches encourage individuals to accept them (Lau & McMain, 2005). Through this, an individual is freed from the struggle of avoidance or confrontation, therefore alleviating anxiety and sense of futility which often becomes associated with this struggle.

The aim of MB approaches is therefore not to eliminate distress, but rather to change an individual's relationship with it, in order to prevent escalation of mild mood states to more severe disabling ones (Lau & McMain, 2005). This is achieved through mindfulness exercises which encourage individuals to 'turn towards' their distress, in order to explore and get to know it; thus enabling an individual to 'step back' and observe their thoughts and feelings as mental events rather than over-identifying with them (Bishop et al, 2004). Techniques involve practising meditative exercises to encourage a deeper awareness of the mind and body; developing an understanding of being on 'auto-pilot' also referred to as the 'doing mode', and how to access its counterpart the 'being mode'; fostering acceptance and a non-judgemental stance to the self, which can also help to promote self-compassion (Segal, Williams & Teasdale, 2002; Bishop et al, 2004).

Mindfulness and Psychopathology

There has been a growing interest in the applicability of mindfulness to physical and mental health conditions over the past twenty years. As a result there has been an increasing evidence

base, which highlights the efficacy of MB approaches in alleviating distress caused by chronic pain (Kabat-Zinn, 1990), anxiety (Evans et al, 2008; Hofman et al, 2010), depressive symptoms (Baer 2005; Kenny & Williams, 2007; Raes, Dewulf, Van Heeringen & Williams, 2009; Segal et al, 2002; Teasdale, Segal, Williams, Ridgeway, Soulsby & Lau, 2000) and eating disorders (Kristeller & Hallett, 1999). More recently, mindfulness approaches have also been considered for people with psychosis (Abba et al, 2008; Chadwick et al., 2009; Chadwick et al, 2005; Jacobsen, Morris, Johns & Hodkinson, 2011).

It has been suggested that particular cognitive thinking styles (e.g., avoidance or suppression, rumination and confrontation) are engaged with as a means to avoid distress (Siegel, Germer & Olendzki, 2010). However, they have paradoxically been associated with exacerbation of symptoms and subsequent increased distress in people experiencing psychosis (Abba et al, 2008; Morrison & Wells, 2003). This has been underpinned by empirical research from experimental and clinical psychology; Wegner's model (1987) highlights the 'ironic impact' of thought suppression in increasing thought frequency and thus increasing subjective distress (Purdon, 1999; Wegner, Schneider, Carter & White, 1987). This has not only been demonstrated to exacerbate individuals' experiences of psychotic disorders, but also of depression (Van der Does, 2005), post-traumatic stress disorder (Beck, Gudmundsdottir, Palyo, Miller, & Grant, 2006) and obsessive-compulsive disorders (Tolin, Abramowitz, Przeworski, & Foa, 2002; Rassin, Diepstraten, Merckelbach & Muris, 2001). MB approaches may be helpful in breaking these patterns; studies have demonstrated associations between increasing mindfulness skills and reductions in avoidance and rumination tendencies (Deyo, Wilson, Ong & Koopman, 2009; Hepburn et al, 2009; Kumar, Feldman & Hayes, 2008).

A combination of negative beliefs about the uncontrollability and danger of thoughts along with positive beliefs about the benefits of worry have also been associated with distress in people experiencing psychosis (Garety & Freeman, 1999; Morrison & Wells, 2003). This is congruent with reports of individuals experiencing 'tyrannical relationships with psychosis (Abba, et al., 2008; Birchwood, Meaden, Trower, Gilbert & Plaistow, 2000)' and suggests a potentially important role of developing more adaptive relationships with symptoms.

Mindfulness, Cognitive Reactivity and Suicidality

There is some evidence to suggest that the effects of CR may be mitigated by psychotherapy; cognitive-behavioural therapy in particular (Segal, Gemar & Williams, 1999). More recently it has been suggested that, amongst other effects, mindfulness may also have a role in moderating the effects of CR on depressive recurrence (Lau et al, 2004; Raes et al, 2009; Williams, Crane, Barnhofer, Van der Does & Segal, 2006). This in turn has implications for treatment options for people with depression and suicidal ideation.

Williams et al (2006) explored the notion of MB cognitive therapy (MBCT) on preventing the recurrence of suicidal behaviour, and demonstrated its efficacy through a case study example. It was suggested that using the aforementioned MB techniques, distress may be alleviated in individuals who may otherwise fall into habitual self-destructive or suicidal patterns (Williams et al., 2006).

Mindfulness techniques have also been incorporated into other therapies designed to target suicidal ideation and behaviour, for example, dialectical-behaviour therapy (DBT; Linehan,

Armstrong, Suarez, Allman & Heard, 1991). DBT was developed for the treatment of people with borderline personality disorder who engage in repeated self-harm, with results showing significant reductions in repetition of self-harming behaviour (Linehan et al., 1991; Verheul et al., 2003). However, DBT incorporates a variety of intensive techniques, making it difficult to conclude to what extent MB techniques contribute to reductions in suicidality and self-harm. Research into mindfulness and its effects on CR is in its infancy; further studies are required to test its efficacy in clinical populations.

The Current Study

The current study is intended to test the feasibility of a MB intervention for young people (17-20 years old) with a history of transdiagnostic distress and associated self-harm (SH) or suicidality. With an understanding of the DAH framework and the mechanism of CR (Lau et al, 2004; Teasdale, 1988), it is possible to see how these individuals are likely to be vulnerable to continued distress through the processes of reactivating patterns. Mindfulness has been highlighted as helpful not only in alleviating multiple forms of distress, but in reducing an individual's level of CR. If, as the research suggests, CR and suicidal thinking patterns become linked in individuals, to be able to reduce the level of CR may be crucial in reducing the likelihood of suicidal processes being reactivated. The study will therefore focus on whether mindfulness has a direct impact on cognitive reactivity.

Research Question

Does mindfulness, which involves being 'aware in the present moment', reduce vulnerability to suicidality (as measured by the LEIDS-r total score, and Hopelessness/Suicidal subscale (H/S)) in young people with a history of suicidal thinking and/or behaviour?

METHOD

Two mindfulness groups were held for between six and eight participants, as a proof of concept study into whether mindfulness can help reduce young individuals' vulnerability to suicidality.

Design

Due to the service's small caseload prohibiting a separate control group, a within-subject control design was adopted. Both qualitative and quantitative data were collected and analysed. Self-report questionnaires were administrated at four time points: baseline (time 1); six weeks later at the start of the group (time 2); at 12 weeks, at the end of the group (or at the point of disengagement; time 3) and at 18 weeks follow up (time 4). Change in scores between the first and second period allowed for an understanding of non-intervention related change, which acted as a control measure at the data analysis stage. Change in scores between the third and fourth time-point helped to establish the durability of treatment over a period of six weeks following the intervention.

All participants were asked to participate in an exit interview on completion or disengagement from the group. This aimed to explore individuals' impressions and experiences of mindfulness to inform an understanding of its utility and applicability to this age group.

Ethical and Research and Development approval were sought and obtained from the appropriate committees (Appendix A). Informed consent processes were adhered to, and

anonymity regarding dissemination of the results assured. All participants retained the right to disengage with any stage of the research without it affecting their group membership.

Participants

All individuals were on the caseload of a mental health service for young people (aged 16-35) with complex presentations, and met the inclusion criteria. These were to be known to the service, and to have good expressive and receptive language skills. The exclusion criterion was presence of a moderate or severe learning disability. Exclusion criteria did not consider specific details of individuals' diagnosis, including the length, severity or diagnostic category of distress, as the group aimed to alleviate transdiagnostic distress.

Purposive sampling techniques (Barker, Pistrang & Elliott, 2002) were utilised, where individuals' key-workers selected people from their caseload whom they thought might benefit from a MB approach. The key-workers then contacted the participants to provide initial information, and to seek consent for their participation (Appendix B). Further information regarding the process and attrition is provided in the Results section.

All individuals participated in a pre-group assessment interview, to ensure their appropriateness for a group-based intervention. For individuals who did not wish to join a group, alternative approaches were offered.

Measures

Beck Depression Inventory (BDI-II)

This is a 21-item measure, with strong inter-rater reliability (r=.90), which assesses the intensity of depression in individuals over 13 years old. It was used in this study to assess individuals' initial levels of depression. Total scores range from 0-63, scores between 0-13 indicate minimal depression; 14-19 indicate mild; 20-28 suggest moderate and scores above 29 reflect severe depression (See Appendix C; Beck, Steer & Brown, 1996).

Mindful Attention Awareness scale (MAAS)

The MAAS is a 15 item self-report measure, which measures mindfulness, or 'the presence or absence of attention to, and awareness of, what is occurring in the present moment' (See Appendix D; Brown & Ryan 2003). It has an internal consistency of α=.86 and strong test-retest reliability (r=.81) (Brown & Ryan, 2003). This has been used previously with a sample of adolescents (Bögels, Hoogstad, van Dun, de Schutter & Restifo, 2008).

Leiden Index of Depression Sensitivity-Revised (LEIDS-R)

This 34-item measure with six subscales assesses individuals' degree of CR to sad mood (Williams et al., 2008; Van der Does & Williams, 2003). The questionnaire is conditional, requiring people to respond with how they would react if they were experiencing low mood. The subscales are Hopelessness/Suicidality; Acceptance/Coping; Aggression; Control/Perfectionism; Harm Avoidance and Rumination. Internal consistencies range between α=.64 to α=.84 (See Appendix E)

Further psychometric properties of the LEIDS-r have not yet been published. Test-retest reliability correlations, using Pearson's r statistic, were therefore established by administering the questionnaire to 24 clinical psychology trainees twice, a week apart. The results demonstrate good test-retest reliability, with the exception of the Acceptance/Coping and Risk Aversion subscales which are rated as moderately reliable (see Table 1).

Table 1: Reliability of the Leiden Index of Depression Sensitivity-Revised

Scale (N=24)	Test-Retest Reliability (r)	Sig (2-tailed)
Total Score	.789	.000
Hopelessness/Suicidality Subscale	.886	.000
Acceptance/Coping Subscale	.621	.001
Aggression Subscale	.803	.000
Control/Perfectionism Subscale	.823	.000
Risk Aversion Subscale	.649	.001
Rumination Subscale	.848	.000

The Mindfulness Sessions

Each group ran for six sessions, and lasted for 90 minutes with a 15 minute break. The group outline was written using literature on mindfulness (Segal, Williams & Teasdale, 2002). To ensure fidelity to the tenets of mindfulness the outline was checked by a Clinical Psychologist experienced in facilitating MB interventions. The outline followed Chadwick et al.'s (2005) adaptations to MB approaches for people with psychosis, which aim to minimise the possibility of symptoms being exacerbated through their practice (see Table 2). They were deemed appropriate for use in this study as some of the participants had histories of attenuated psychotic symptoms. A pilot study was then conducted with psychology undergraduate students to refine the outline, in accordance with their feedback.

The content of the sessions depended upon the needs of the individuals as they arose and were therefore relatively flexible. However an outline of the intervention was necessary (see Appendix F).

Table 2: Chadwick et al.'s (2005) Adaptations to Mindfulness

Adaptations for Mindfulness for People with Psychosis
▪ Exercises involved only mindfulness of the breath, in two 10 minute sittings each session
▪ All practice began with mindfulness of the body; to help ground clients
▪ Mindfulness was taught as "choiceless attention" rather than concentration meditation which has been linked to onset of hallucinations
▪ Practice was guided: Instructions and gentle comments offered every few minutes, ensuring people weren't lost in their reactions to symptoms
▪ Homework was encouraged but not required
▪ Sessions were shortened to 90 minutes, with a 15 minute break
▪ Emphasis on therapeutic process, and structure, to ease levels of anxiety, paranoia and voices leading up to and during groups
▪ Group membership was up to six participants, to facilitate group process

CDs of guided mindfulness exercises were provided for each participant, along with weekly handouts of the materials covered in the previous session. This was to enable practising of techniques between sessions, should the individuals choose to.

RESULTS

Attrition

Over the course of the first group (N=7), two people disengaged. In addition, Participant 1 (Abie) missed three sessions in the middle of the group and Participant 4 (Dee) missed one session due to a family holiday. During the second group (N=8), five participants disengaged, as depicted in Fig 1. Reasons for disengagement were not related to disagreeing with or disliking the experience of mindfulness (for details, see Appendix G). Of the fifteen participants who completed the initial baseline measures, eight completed the group and Time 3 measures. Following this, Participant 7 (Gwen) was unable to complete the Time 4 measures due to leaving the area to attend university. Attrition rates were therefore 47% for group completion, and 53% at follow up.

Fig 1: Recruitment and Attrition Process.
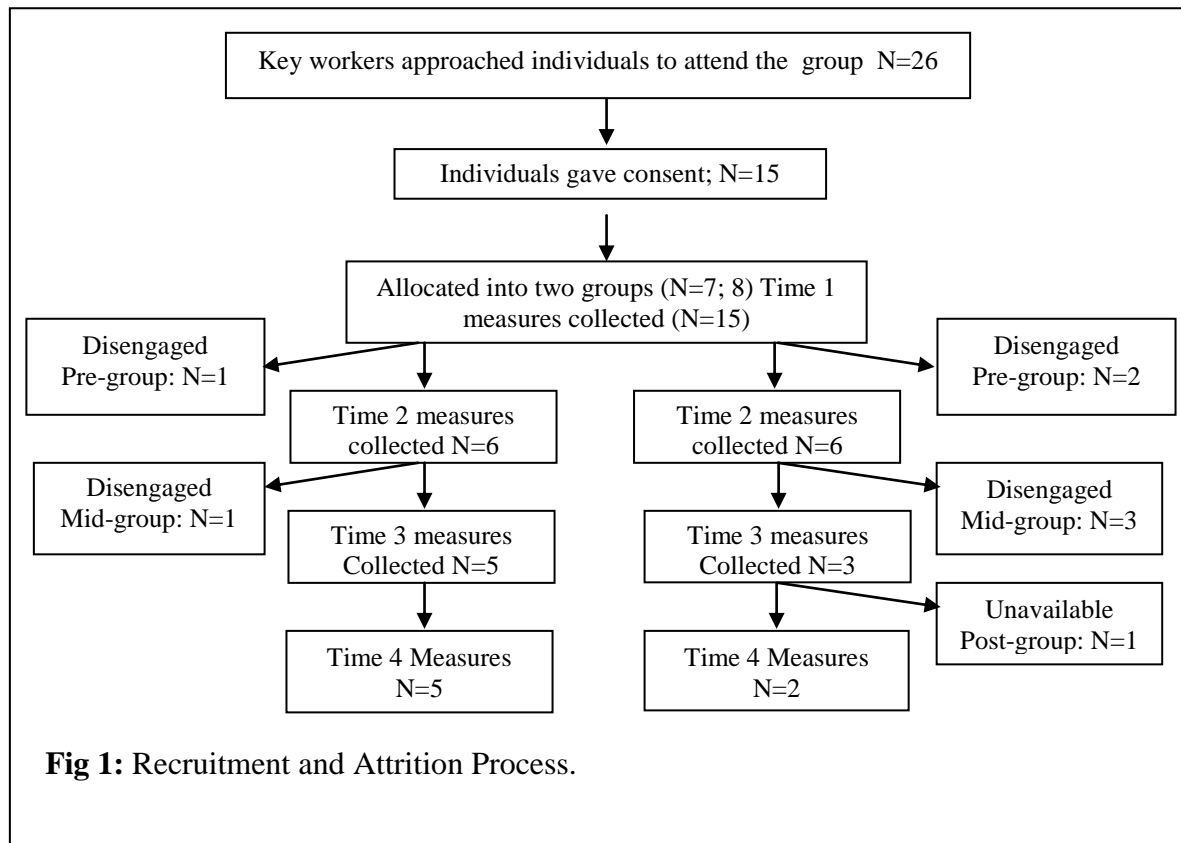
Demographics

Participants were 3 males and 5 females between the ages of 17 and 20 (Table 3). Five participants lived with their parents, and six were in full-time education at the time of the study. All participants had a history of SH, suicide attempts or ideation and had received varied support for this including psychotherapy (cognitive-behavioural therapy: N=3; systemic therapy: N=1; dialectical behavioural therapy:N=1) or medication (N=6). In addition to other difficulties, all participants had a history of experiencing depression (N=8), and six reported a history of anxiety-related difficulties.

Table 3: Participants' Demographic Information

Name*	Gender	Age	Main difficulties	Previous Support
Abie	F	18	Depression, with SH involving a previous suicide attempt	Individual CBT
Ben	M	17	Anxiety and depression, with SH	Antidepressants
Carl	M	20	APS: paranoia, anxiety with suicidal ideation	Individual CBT
Dee	F	17	History of OCD, anorexia nervosa, anxiety and depression with suicidal ideation and SH. APS: voice hearing	Previous DBT as an inpatient
Ellie	F	18	APS: hallucinations, depression with previous suicide attempt	Individual CBT
Finn	M	18	PTSD, anxiety and depression with SH and suicidal ideation	Antidepressants
Gwen	F	18	History of abuse. Anxiety and depression with SH and suicide attempts	Individual systemic therapy
Hana	F	18	Anxiety and depression with suicidal ideation	Antidepressants

*All names have been changed.
(**OCD:** Obsessive Compulsive Disorder; **APS:** Attenuated Psychotic Symptoms; **PTSD:** Post-Traumatic Stress Disorder)

Descriptives

Beck Depression Inventory (BDI-II)

The participants' levels of depression were all screened at the beginning of the group. The initial scores are represented in Table 4, and highlight a range of intensity.

Table 4: Screening Scores on the Beck Depression Inventory-II

Name*	BDI-II score	Interpretation
Abie	22	Moderate
Ben	43	Severe
Carl	28	Moderate
Dee	15	Mild
Ellie	40	Severe
Finn	23	Moderate
Gwen	32	Severe
Hana	29	Severe

* All names have been changed.

Group Assessment Measures

Measures were collected at four time points, the means and standard deviations (SD) of which can be seen in Table 5, where increases in scores suggest increased distress or CR on the LEIDS-r and increased mindfulness on the MAAS. The results suggest fluctuations over the baseline (time 1 – time 2) where increased levels of distress were reported on the LEIDS-r over the initial six weeks before the groups.

For the eight participants that completed the groups, the means (See Table 5) suggest overall improvement across the treatment condition for all measures. The decrease in self-reported distress appears to continue over the follow up period.

Table 5: Participants' Initial Scores on the Leiden Index of Depression Sensitivity-Revised and the Mindful Attention Awareness Scale

		LEIDS-r Total	LEIDS-r H/S	MAAS
Time 1	Mean	81.62	3.38	2.65
	SD	*10.97*	*0.78*	*0.73*
Time 2	Mean	86.50	3.25	2.64
	SD	*8.60*	*0.87*	*0.65*
Time 3	Mean	77.63	2.98	3.03
	SD	*10.32*	*1.06*	*0.53*
Time 4	Mean	75.71	2.68	3.10
	SD	*10.56*	*1.19*	*1.00*

Group-Based Analysis

As the majority of individuals who disengaged from the group did so before completion of the second set of measures, it was not possible to include their data in the group analysis. The analysis therefore only considers change for group completers.

Paired sample t-tests were conducted to explore statistical differences in change scores between the baseline (time 2 – time1), treatment (time 3 – time 2) and follow up (time 4 – time 3) conditions for each measure. Overall, non-significant results were found, although there was a trend towards significance on the difference between baseline and treatment scores on the LEIDS-r (t_7=2.09; p = 0.075). However, it is important to note the impact of the small sample size on reduced power, and the increased possibility of a Type II error being made. This risk would have been compounded by loss of statistical power had non-parametric tests been used.

Case Cohort Analysis

Exploring the Effect of Treatment

In order to investigate the impact of the group on participants' self-report measures, case by case analysis was adopted, using the reliable change index. Change in scores across the baseline time

period (time 2 – time 1) revealed an unstable pattern where some individuals were already significantly deteriorating before the intervention started. As the reliable change index requires a stable baseline (Wise, 2004), it was deemed necessary to include baseline change in the analysis of effect of treatment. For this reason, the amount of change made by an individual over the baseline (time 2-time 1; constituting the 'pre' score) was compared with the amount of change over the treatment period (time 3-time2; constituting the 'post' score), using the reliable change index.

Reliable Change Index

In considering individual therapeutic change, Jacobson and Truax (1991) suggested a means to conceptualise clinical improvement and obtain an understanding of statistically reliable change. Reliable change is a means of understanding whether an individual has changed more than would be considered through chance, by taking into consideration the standard error of the measure, derived from the standard-deviation and test-retest reliability scores. Change is therefore defined as difference in pre and post treatment scores that is larger than could be expected by chance, at a confidence level of 95%. This means that a reliable change index (RCI) of or above 1.96 would indicate statistically reliable improvement, and a score of or below -1.96 would suggest statistically reliable deterioration that cannot be attributed to measurement error.

Overall results for each measure and each participant are provided in Table 6 below, allowing for consideration of the research question, after which closer consideration is paid to each individual.

Table 6: Participants' Reliable Change Indexes

Participants	LEIDS-R total	H/S subscale	MAAS
Abie	-3.02**	-5.02**	-1.19
Ben	0.3	0	-1.13
Carl	2.87*	1.67	1.35
Dee	4.68**	2.51**	1.28
Ellie	3.17**	-1.67	-0.08
Finn	0	0.84	0.75
Gwen	3.02**	0.84	0.9
Hana	5.58**	5.85**	1.72

*$p < 0.01$ ** $p < 0.001$

The results highlight that six people met reliable change on the LEIDS-r total; three met reliable change on the H/S subscale and none met reliable change on the MAAS (Table 6). Perusal of the data depicts, for example, how Ellie made reliable improvement on the LEIDS-r, when considering her baseline change and treatment change (RCI=3.17, $p < 0.001$). However, her RCI indicates non-significant decline on both the H/S scale (RCI=-1.67, p=0.1) and the MAAS (RCI=-0.08, p=0.4).

Changes in Cognitive Reactivity

It can be seen in Table 6 that reliable improvement was made on the LEIDS-r for five people (Carl, Dee, Ellie, Gwen and Hana), which would suggest a reduction in cognitive reactivity over the course of the group. Ben and Finn made no or slight improvement. Abie's self-report on the LEIDS-r significantly worsened (RCI= -3.02, $p < 0.01$).

A higher CR score on the H/S subscale may be associated with a history of suicidality (Antypa et al., 2010; Williams et al., 2008) and may represent a risk factor for future reactivation of suicidality. As Table 6 depicts, two people met criteria for significant reliable improvement on

this subscale (Dee and Hana); three made non-significant improvements, one made no change (Ben); one made a non-significant decline (Ellie) and one significantly declined (Abie).

Overall, H/S subscale scores decline over time, which might represent preliminary evidence for the modifiability of CR through mindfulness, however these results were not significant (Table 7).

Table 7: Participants' Scores on the Hopelessness/Suicidality Subscale of the Leiden Index for Depression Sensitivity-Revised

	Hopelessness/Suicidality scores for Completers.			
	Time 1	Time 2	Time 3	Time 4
Mean	3.75	3.25	2.98	2.69
SD	0.78	0.87	1.06	1.18

Changes in Mindfulness

Participants' self-report of mindfulness, as measured by the MAAS did not significantly change over the course of the group (Table 6). Five participants' level of mindfulness increased over the treatment phase (Carl, Dee, Finn, Gwen, Hana), for two it decreased over time (Abie and Ben) and for one person only a slight reduction was found (Ellie). However, the overall means and SD for each assessment point suggest general increases in mindfulness over the participants' involvement in the study (see Table 8).

Table 8: Participants' Scores on the Mindful Awareness Attention Scale

	MAAS scores for Completers.			
	Time 1	Time 2	Time 3	Time 4
Mean	2.65	2.64	3.03	3.10
SD	0.73	0.65	0.53	1.00

Impact of Mindfulness on Cognitive Reactivity

Fig 2: Reliable Change Scores for the Hopelessness subscale (LEIDS-r) and the MAAS.
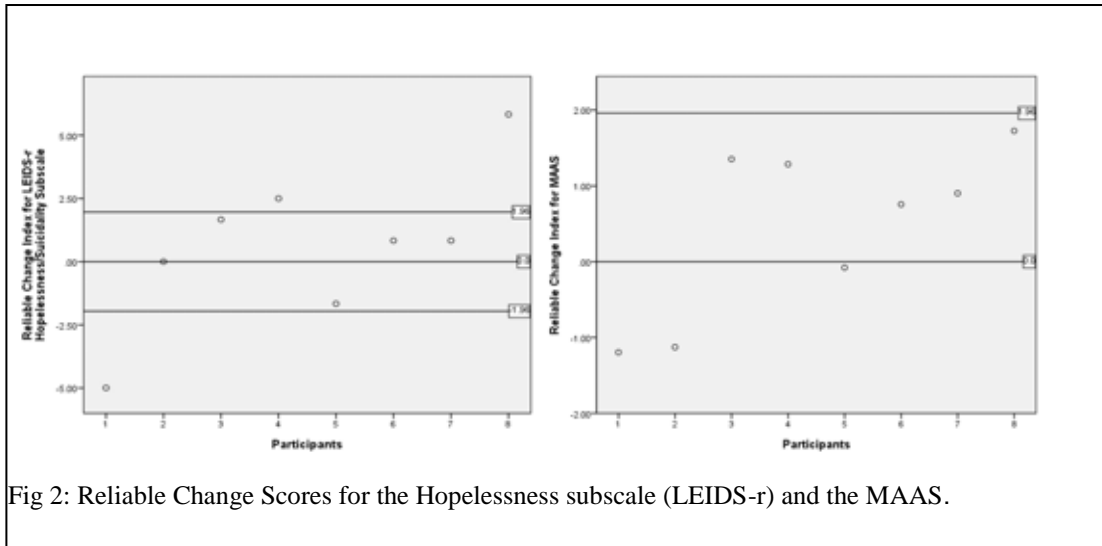
The primary aim of the study was to investigate whether the practice of mindfulness could reduce an individual's vulnerablity to suicidality, through the mechanism of cognitive reactivity. As can be seen through the visual portrayal of H/S scores (see Fig 2), significant improvement was not found in the majority of individuals over the course of the group. However, the MAAS scores also fail to show significant change in any individual, making conclusions as to the potential impact of mindfulness on CR difficult to draw in this study.

Due to the small sample size, it was not possible to conduct statistical analysis to explore correlations between change in hopelessness and in mindfulness. However, it is interesting to note trends between participants' scores on the LEIDS-r and MAAS. Participant One (Abie) demonstrated significant deterioration on both the LEIDS-r and MAAS, whereas Participant Eight (Hana) demonstrated the most improvement on both. The patterns of response for all other participants appears similar across both graphs, where slight improvement on the H/S was mirrored by similar improvement on the MAAS. This is with the exception of Participant

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2 (Ben), who demonstrated no change on the H/S and a significant decline in mindfulness. Pre-group assessment scores on the Beck-Depression Inventory (Beck et al, 1996) suggest no difference in severity of depression score that would offer an understanding of degree of change (i.e. the greater severity of depression indicating more or less change on either the LEIDS-r or MAAS). Further exploration with a larger sample size would enable exploration of these patterns, to understand whether a correlation may exist, or whether these patterns are just a characteristic of this dataset.

In order to understand individuals' experience of the group, and what may have impacted the self-reported change, it is important to consider the qualitative information they shared.

Template Analysis

Following the group, seven participants consented to being interviewed regarding their experience of mindfulness and of being part of a group. Their interviews followed a semi-structured interview schedule which was specifically devised with the aim of eliciting the individual's experience, understanding and evaluation of the group (Appendix H). The schedule was reviewed by a Clinical Psychologist with experience of qualitative interviewing and analysis techniques, and the subsequent interviews were carried out and recorded by an Assistant Psychologist from the service. The interviews were then transcribed verbatim, and data from two interviews were analysed using template analysis (King, 2004). Having identified higher order codes, and lower-order codes within them, this was used as a template to analyse subsequent interviews. The codes and overall template were subsequently revised until the data was saturated within the final template (Table 9), which was then reviewed by independent

psychologists, thereby providing triangulation of the analysis. The final template highlights three higher-order codes encompassed within the interviews, and the second-order codes that were encapsulated within. The following sections will describe the codes in turn, with supporting quotations from the interviews (For further details of the coding, see Appendix I).

Table 9: The Final Template: Highlighting the Codes within the Data

Template Analysis
Being and Talking in the Group
Settling In and Speaking Up
Sharing Helps Understanding and Normalising
Perspectives on Mindfulness
Accessibility and Progress in Understanding
Mindfulness is Applicable to Adolescents
Mixed Impressions of Exercises
Perspectives on Change
Mindfulness Increasing Awareness and Effecting Change
Adding to the Toolbox rather than a Cure
Futility / Difficulties Breaking the Mould
Awareness of Personal Agency
Responsibility / Choice
Practice

Being and Talking in a Group

This theme captures the individuals' first impressions and reactions to the group, in addition to their feelings about group processes of talking and the effect that this had of normalising their experiences and distress they feel.

Settling In and Speaking Up

Within this second-order code, most individuals mentioned being nervous at the start of the group, although two reported it had been better than had been expected:

Gwen: *"...I didn't think it would be like…it wasn't that bad. It was okay, whereas I dunno what I thought…but I dunno…I get all these mad ideas. I dunno…I just thought that I'd have like, all these questions pelted at me in front of everyone…but I wasn't, and you didn't have to talk if you didn't want to…"*

However, individuals seemed to require a 'settling in period' where their initial fears or feelings could subside, allowing them to become more a part of the group, as illustrated by Carl:

"...erm yeah I felt a bit erm uncomfortable like to begin with coz err I'm not used to like being part of group sessions and stuff but err once I got to know everybody erm they made me feel welcome and err comfortable and err yeah that's when that's when I decided err yeah I I I kinda err like this group therapy thing…"

As people settled in, they reported feeling more comfortable about speaking up in the group. However, different reactions to this were elicited, where some individuals felt pressured to speak, despite their own unwillingness, as other group members were very quiet:

Ellie "I would have preferred not to [talk] so erm I just thought there was a hell of a lot of talking and sharing and just people talk too much…it just got on my nerves…it's like here's my life story you are all going to listen."

Another individual felt a need to compete with talkative members, which was illustrated in other accounts of having an effect of intimidating some into remaining quiet, and irritating other group members. The effect of this is partially described in the following quote:

Dee "…It's just that I used to be ever so quiet and shy before and it's just I really want to prove that I was much better that I really did get involved in things that I could talk I could speak my own mind and looking back now I shouldn't have felt so nervous about it because I did contribute an awful lot."

In addition to reacting to the amount that people did or did not speak, some also reported having emotional reactions to the content. This seemed to impact their uncertainty about how much they could tolerate or whether they wanted to return to the group:

> Abie "...hearing about other people's stuff as well as mulling over my own...the only way I can explain it was when you got one layer of crap with other layers of crap coming in it's eventually gonna topple over..."

In order for the engagement of individuals within the group to be maximised, the impact of the group processes, as highlighted in this theme, requires attention. The understandable unease when joining a new group, can be mitigated by encouraging a supportive and respectful group dynamic, and allowing participants time to settle in. Whilst the mindfulness groups aimed to incorporate these elements, some participants still found the process difficult. A nurturing group environment will therefore require time, not least in allowing the less confident to be able to share their experiences.

Sharing Helps Understanding and Normalising

In spite of some negative reactions to the experiences of talking in the group, an understanding of it as a necessary, helpful process was also elicited. Recognition was given to the impact of hearing people talk about their circumstances of realising that they were not alone or 'abnormal' in the experiences they had faced:

> Ellie "I s'pose knowing I'm not like the only one with the problems that I go through. I mean it's obvious I'm not the only one but I'm not the only one who has strange thoughts and such."

Talking was highlighted as a necessary stage for individuals to allow themselves to become involved in the process, as explained by Finn:

"...I could draw parallels to like some of the concepts which were discussed I could draw parallels with myself and then that's when I just kinda knew that what they were kinda telling us was kinda true and then once I saw that I kinda believes the other things they were telling us. So it kinda let me almost gave me permission to try..."

In addition, for the members of the group that did not feel confident in their understanding, the process of talking also helped them to consolidate their learning, which is likely to help with the later application of skill. This is highlighted by Hana:

"I found talking quite useful to be honest coz I'm not very good at kindof independence and being able to kindof identify how and why you could do it in a certain place so it was good to like hear people tell you things so you're kindof like oh yeah I get that now."

The theme of 'Sharing Helps Understanding and Normalising' highlights a widely reported benefit of group-based psychotherapy (Ruddle, Mason & Wykes, 2011). Where participants felt able to share their experiences or distress it had an effect of creating a shared understanding, which in itself appeared to help ameliorate distress.

Perspectives on Mindfulness

This code encapsulates participants' perspectives of how accessible or understandable mindfulness was, in addition to what they had found most important or personally salient about mindfulness.

Accessibility and Progress in Understanding

When considering their understanding of mindfulness, a theme was found within this code of describing a learning curve over the course of the sessions. Initially, mindfulness was seen as an abstract concept that was quite difficult to follow, however this changed over time:

Hana "…I got a basic understanding of what was going on but it wasn't until the end that I started to be able to link things together a bit more err yeah…I think it's quite err it's kinda like common sense really but it's kinda like common sense that isn't very common. It's kinda like well that's kinda obvious but why haven't I been doing that before? "

After the group ended, some found their understanding and recall waning, as demonstrated by Ellie.

"…I didn't actually understand what mindfulness is what this term mindfulness means. They did ask us actually in the last session what do you think mindfulness is and I had a few I had a fair idea but it's just I've just forgotten."

Alongside ease of understanding there was a general consensus between participants of the difficulties in applying the skills that they had learned. Emotional reactions to these were described, as depicted by Gwen:

"…it was kinda annoying in the first two weeks when we got told about it coz it was hard to do so I was kinda getting annoyed with myself that I didn't start like thinking straight away like like that kinda thing…so that, that was hard coz I felt a bit stupid then coz I felt like we'd be told what to do and think and whatever and I dunno I weren't very good! Like I kept forgetting to do it."

This theme highlighted change in participants' understanding over time and their reactions, including self-judgement to not being able to do it quickly enough or to not having known about the techniques sooner. This is an important observation, as noticing self-judgement is encouraged within mindfulness, followed by stepping back and 'letting go', rather than holding it as accurate. However, these reactions can only be explored if participants are able to raise them in the group.

Mindfulness is Applicable to Adolescents

All the interviewees felt that mindfulness was appropriate and applicable across all age groups, particularly to adolescents or young adults to help coping with distress. Within this code resided the notion of 'catching people early' before they potentially become rigid in their thinking, as described by Gwen:

"…yeah coz when you're older… I dunno, if I was older and then some person came in and said right… that's you thinking in the being mode, the doing mode, and trying to like think about it this way – I might be more kinda like no, this is my way of thinking, I've used this all my life."

Other participants raised the importance of learning mindfulness early so that they could teach their own children, as highlighted by Abie:

"…yeah coz it's around this age […] where you start to become an adult and if you think a certain way as they say it will carry on into an adult and you'll have children and you'll force these onto your children…"

The potential role for mindfulness in supporting adolescents through difficult life stages was highlighted, in offering a different means to relate to distress but also preventing painful exacerbations of difficulties as Gwen recalled:

"I wish I knew it earlier actually I wish I ... when things were starting to go bad before like I dunno…shoving me on all meds and throwing me in places I didn't want to be in…I wish that kindof I was told that coz it has helped me to cope like a lot more than I thought it would now. So I just think like, if I'd went to a group like that when I was younger, before things went bad then maybe I would have coped with things a bit better then, to stop things getting so bad."

However, there was a strong notion that people would have to choose to participate in mindfulness and would not necessarily be attractive to all:

Finn "I think it's possibly more helpful for people my age because 16 to 18 gap is when a lot of things confusing things are going in your life so and mindfulness would help you cope with that more easily I think […] it's just it that some 16 year olds might not be keen to do…because it's effort I suppose […]so it's just making it more attractive to the 16-18 group."

An awareness also existed that this approach may not be so accessible to those who were more acutely unwell as highlighted by Dee:

Dee "…it also depends on what situation they're in […] you cant just expect them to come along and just be open they'll obviously just want to go thinking that why are you intruding into my personal life I'm feeling really bad right now its like I said about the bull you cant tame it until it's calmer."

Mixed Impressions of Exercises

This subtheme related to the exercises of mindful breathing and yoga. A range of reactions to these techniques were described. Some individuals recognised their importance in facilitating skill development and experiencing the 'being mode,' which Dee described:

"erm part of the being mode I think its done in the first session an exercise that I particularly like that actually opened my mind a bit..."

Other participants found the exercises tedious or mundane:

Abie "well initially I was okay with it it was really really good and it is really good concept it was like towards the end that it was like here we go again."

For Ellie, her experience of boredom seems to have led to disengagement from them:

"there was a yoga one erm [...] that went on too long [...] I couldn't really see what it had to do with breathing I know it's meant to put you in the being mode but erm it... it didn't work for me, I was just distracted by things in the room I was just not concentrating or not being bothered."

Individual's reactions to the exercises included clear descriptions of feeling self-conscious:

Finn "I thought that was a bit silly to start off with... it was just the err preconceptions that you have about it so the way you have [...] it was just if someone else was looking in on that room and they saw you do that they'd just think you're a... I I can see why you'd do it now, but at the time it felt... yeah self-conscious yeah..."

Some seemed able to notice their reactions, and observed them changing over time, whilst others found themselves holding onto their initial reactions, which Ellie and Hana illustrate:

Ellie "you can either sort of take that either way. You can think this is a complete waste of time or you can try and I dunno practice."

Hana "we did the breathing exercises when you kindof sit for quite a while and focus on the breath. We did that one a lot so that was kindof good and you kindof have different reactions to it each time it's weird…"

This theme highlighted a broad range of reactions to the mindfulness exercises, including awareness of self-consciousness, boredom, distraction and open-mindedness. These reactions are often reported within mindfulness, and are explored in discussions of experience following practice. This theme highlights the importance of ensuring this happens, to acknowledge reactions, understand them as normal, and be able to 'let go' in order that they do not become a barrier to practice.

Perspectives on Change

The final highest-order code represents individual's experience of change, any impact that they perceived mindfulness to have had, and the difficulties associated with change.

Mindfulness Increasing Awareness and Effecting Change

For some, mindfulness opened up an awareness of their previously unrecognised internal experience:

Carl "…thinking about the future and the past and all these things err that's that's kinda how erm like your mind works if you're in like deep thoughts or depression things like that sometimes you- your mind slips away from the present kinda thing."

Others noticed the reduced power of their thoughts, as Dee explained:

Dee "…the thoughts you have no matter how bad how serious how good how terrible at the end of the day they are just thoughts they cant do any harm to you unless you let them…they're thoughts just like good thoughts it's just that they have a more harsh impact than good thoughts is all."

The group seemed to have helped encourage ideas of acceptance and letting go for people:

Hana "I think in the past I I used to kindof fight it a bit more but erm after like mindfulness and you've just gotta kindof accept that that's how you're feeling and kinda just let it go which… I didn't think like you could stop it…coz it just happens anyway but like they was kindof explaining how to well not how to stop it but like how to push it aside a bit."

There was also recognition of heightened relaxation as a benefit of mindfulness practice; highlighted by Abie and Dee:

Abie "…The relaxation technique it kindof made me just a bit like I've had a sedative or something...made me think a bit more clearly."

Dee "…I think it's taught me to be a bit more relaxed in the situation and not just in that situation but also in lots and lots of other different social situations."

Mixed evaluations of mindfulness effecting change were noted; five members noticed some difference following using mindfulness, included being able to self-harm less (Gwen), 'take things to heart less' (Finn) and engaging in social situations more (Carl, Dee and Hana). However, it appears to have been less useful for some members, as illustrated by Ellie:

Ellie "I erm don't (cope) any differently now, I sort of go and hide in my bed and lock the door and just hide from everyone or erm just cut everyone off or erm…comfort eating."

This theme highlighted different areas where mindfulness had impacted experience, but it also revealed relatively little effect for some in the face of older coping strategies.

Adding to the Toolbox rather than a Cure

A strong subtheme emerged of mindfulness being helpful as an addition to previous methods of coping, rather than acting as a panacea, as illustrated by Dee:

> Dee *"I mean it hasn't like cured me completely… I don't think any one therapy session could or or any certain number of therapy sessions but it has sort of erm given me enough to be able to go onto the next step"*

Within this, there was an awareness of personal progress:

> Gwen *"I really feel like I've come quite- like I've learnt quite a lot coz like I went to the dentist and I don't harm myself so much or straight away now. I just feel generally better, not cured, not like cured and whatever, but a lot easier to cope now. But that's… that's really good."*

The impact of mindfulness appeared to be in line with expectations of change, as Finn explains:

> *"you obviously you cant expect it to be a magical cure that will solve everything for you, but it's just that it's nice to have something there just to support you a bit more."*

Overall, this theme highlights an appreciation of mindfulness as being a helpful addition to the skills the adolescents already possessed. There was an awareness that whilst it had been helpful, mindfulness had not been an explicit 'cure.' However, this understanding did not appear to carry disappointment, rather it was in line with their expectations of change.

Futility: Difficulties Breaking the Mould

In exploring perspectives on change, a subtheme arose regarding the difficulties that the individuals faced. This included Abie's awareness of the onus being on the individual to change rather than anyone else, making the decision to apply mindfulness difficult.

Abie "...knowing how the world works and how even if you do change your own approach the person that's fighting with you doesn't change their approach"

There was an acknowledgement of the difficulty in breaking established habits, particularly those involving relating to experience. This was heightened by the relative novelty of mindfulness as an alternative:

Finn "...obviously I haven't been doing mindfulness for that long...so I do attempt to bury and subdue and kinda detach from my emotions that's generally how I cope [...] it it's not really a way to process it but that's what I do... yeah, I'm aware of what I do...it's just hard to get out of old habits."

Several interviewees recognised that applying mindfulness was particularly effortful when feeling low or distressed:

Hana "...it's harder to use on a low day I think. It it's kindof easier to kindof put into place when you know you're gonna get panicky but low mood is a different story I think... I think because it's not a habit yet and it's a kindof a lot of effort and you can already kindof feel low it's kindof you know just a lot harder to try."

In addition to increased effort, further difficulties in applying mindfulness were highlighted, as described by Dee:

D*ee "when I...have a bad day I still find it hard to think about the mindfulness...as anybody probably would I think it's hard thinking about mindfulness when you're feeling so bad that it's almost like you block out any ... good or reasonable thoughts..."*

This theme recognises barriers to applying mindfulness, centred around difficulties associated with 'bad days' or feeling low. This is an important acknowledgement as, ideally, the mindfulness aims to support individuals at these times. As the interviewees mentioned, change takes time and 'old habits die hard'. In time and with individual practice, the process of applying mindfulness in these more difficult times might become easier. However, further support may also be required to support the assimilation and practice of the skills.

Personal Agency
Responsibility and Choice

Linked to the difficulties of applying mindfulness was the concept of personal responsibility. For some, there was a clear expression of responsibility for feeling better:

Carl "I'm the only person who can actually fight this kinda thing..."

Alongside this was awareness that participation or engagement with mindfulness was a choice that only that individual could make; and this could represent a barrier to progress:

Finn "the most challenging was kinda just making that change in your minds that it's not well that I-it-it would work if you give it a go.... So just that little obstacle I had to get over [...] it's not just breathing exercises there is some backbone to the theory...once you acknowledge that it kinda let me get more involved in the mindfulness."

Practice

Part of the individual choices that were highlighted extended beyond engagement with the sessions to decisions about undertaking personal practice to develop skills. Some understood that progress was dependent on practice:

Ellie: "I think [mindfulness] is alright as long as you practice it. Erm…because otherwise it's just not gonna work it's not like a quick fix."

Alongside this was awareness that the sessions could only go so far, as Finn recognised:

Finn "…the number of sessions just kindof gives you the method of doing mindfulness and then it's down to you after the session to kindof put yourself in the situations where you're able to practise the mindfulness."

However, difficulties associated with this involve having to practice without the support of the group, as raised by Hana:

"I felt as though whilst they [sessions] were going on I was handling things a bit better it's it's not quite as well now that they've finished I think it'll be a case of kinda practising."

Experiences of using mindfulness outside of the sessions were linked to the necessity of 'getting into the habit.' Some group members appeared keen to persevere:

Gwen "I just kept trying to do it. And the more…the more I kept trying to remind myself to do it, the easier it got. And now, it is a lot easier. So that was the hardest thing, just trying to do it, on your own without help kinda thing."

whereas other members remained uncertain:

Ellie "erm it's like…you have automatic reactions to things in your head and mindfulness is breaking the habit to create another habit. I dunno whether that's good or bad."

This theme highlighted participants' awareness of the need for practice in order for mindfulness to be useful, whilst recognising the role of personal responsibility and choice.

DISCUSSION

The study aimed to explore whether mindfulness had an effect of reducing young peoples' cognitive vulnerability to suicidality, as measured by the LEIDS-r and the H/S subscale. Overall, group-based analysis revealed non-significant change. Case cohort analysis revealed five individuals' scores on the LEIDS-r reduced significantly, however only two individual's level of CR were reduced on the H/S. No statistical increase was found for individuals in self-reported mindful attention and awareness as measured by the MAAS. Due to the small sample size, it is not possible to explore the possibility of an association between these variables. However, it is noteworthy that the three individuals who reported the largest decrease in CR on the H/S also reported the largest increase in mindful attention and awareness as measured by the MAAS.

In considering a possible link between CR and mindfulness, it is important to consider other mediating factors that might impact individuals' reduction in distress on the LEIDS-r. The qualitative data highlights a strong role for normalising and reassuring impacts of group membership, where talking facilitated joint problem solving, and enabled people to feel 'less alone' with their distress.

Interestingly, Abie, displayed the most significant decline in self-report across the LEIDS-r and MAAS. She also highlighted the frustration she felt within the group process, and the impact that listening to others was having on making her feel worse. It is important to acknowledge that she did not attend 50% of the sessions; drawing conclusions about the reasons for her heightened distress is therefore difficult. It might be the case that attending all

six sessions would have enabled an understanding that could have eased distress, or conceivably the group had an effect of exacerbating her distress.

The qualitative analysis highlighted how individuals' experience of mindfulness and involvement in the group was complex, with a range of reactions to the group processes of talking, listening, and practicing. An overall theme linking many of these reactions together was self-judgement, where participants were concerned or self-conscious about how they were coming across, or relieved to hear of other people's difficulties to learn that it "wasn't just me being stupid". One of the aims of mindfulness is to develop an awareness of internal processes, therefore noticing patterns of self-judgement. With this awareness and through practice, the aim is to learn to 'let go' of these mental events or thoughts, and to understand that they are not depictions of reality, thus alleviating distress. Voicing private thoughts and reactions are therefore of paramount importance, yet may remain difficult for the frustrated or self-conscious. Thus, facilitators of mindfulness interventions have an important role in ensuring suitable environments that are conducive to maximum engagement. This seems to echo Chadwick et al's (2005) reflections of the importance of developing alliance in order to maximise the potential therapeutic benefits.

In addition to self-judgement, another overarching theme that arose from the data was one of time. Time was required for individuals to 'settle' into the group, to develop understanding and put mindfulness into practice. This acknowledgement introduces questions regarding the necessity of a longer follow up period to establish change over time. However, alongside awareness of this was the existence of the theme of choice. Whilst some participants illustrated the desire to practice mindfulness, and incorporate it into their lives, two remained

unsure. All interviewees acknowledged change as difficult, and effortful; therefore to choose to change was not an easy decision. It might be that in this study, the group encouraged an awareness of alternative means of relating to experience that may become more useful over time, once they've assimilated their knowledge and tried it in everyday life, in their own way.

There was a strong understanding of mindfulness being harder to utilise when individuals were 'having a bad day'. One participant may have been very astute in recognising that with practise, his ability to use mindfulness in less distressing situations will develop to be able to use it in more distressing situations. However, it may also be important to consider offering informal or impromptu sessions when difficulties are encountered, to provide opportunities to share experiences, and understand how mindfulness might be useful or be applied. For mindfulness to have an impact on cognitive reactivity, it is likely to be necessary to apply it at times when distress is more significant.

Overall, the interviewees supported the notion of mindfulness groups being offered to teenagers or young adults. However, noticeably this represents the opinions of participants who completed the group. It was hoped that the opinions and experiences of the participants who chose to disengage could have been captured and understood but, with the exception of one participant, this was not possible. Although their reasons for disengaging with mindfulness were said to be unrelated to their reactions to mindfulness, they may have held different opinions about its applicability.

In addition to the small sample size and lack of explicit control group which precluded detailed statistical analysis, cognisance of other limitations is required. The methods of data

collection relied on self-report measures and self-disclosure through interviewing. The premise of the LEIDS-r assessing CR is contingent on mood induction, where an individual is asked to conjure up the feeling of low mood before answering the questions. Whilst the participants involved in this study may have been able to do this, it is worth considering the extent to which they chose to engage in this process in an unknown group situation. Whilst all participants were accustomed to completing self-report questionnaires, due to their involvement with healthcare services, this task was novel, and questions were raised about how to induce mood. The LEIDS-r does not appear to have been validated with a sample of adolescents before, further information about its applicability to this age group is therefore unknown, and represents a limitation of the study.

An important element of outcome assessment requires individuals' understanding of items to remain constant over time, in order that fluctuations in scores represent change in the dimension being measured. Whilst this represents an idealistic position, as scores can be confounded by measurement error or factors unrelated to the dimension, it is important to acknowledge in this study. With the exception of one participant, the individuals had not heard of mindfulness before and were therefore approaching the concepts and answering the MAAS from an unknowing angle. Once they had attended some of the sessions they reported how their understanding had changed and therefore given new meaning to the questions being asked. The extent to which the pre-group questionnaires can therefore be reliably compared with the post-group scores is difficult to ascertain. This was highlighted by one of the participants:

Gwen " the one questionnaire we got given at the start was like, and now I know it

was like a mindfulness thing but when I was filling it in it was things...it was like

questions that I didn't really understand so I was like so I was kinda like circling like

random things that I thought I felt, then when I filled it in in the end, I understood it a

lot more. So at first when I was given out questionnaires, I was thinking like what the

hell, I don't know what I'm doing kinda thing."

Furthermore, the MAAS understands mindfulness as a trait, and measures the tendency to be mindful in everyday life. It has been suggested that mindfulness could instead be understood as a state, which occurs when attention is intentionally directed towards sensations, thoughts or feelings (Baer, Walsh & Lykins, 2010; Bishop et al, 2004), therefore encouraging the use of an alternative measure. As both forms of mindfulness are important in informing an individual's experience, use of multiple assessments has been suggested (Baer et al, 2010), although burden to the participant is an important consideration. Future studies might consider the use of the recently amended tool, the Mindful Attention Awareness Scale-Adolescent, which has been validated on a younger population (14-18) and may therefore yield more accurate results (Brown, West, Loverich & Biegel, 2011).

Qualitative interviews were used to understand participants' experiences of mindfulness, the limitations of which are important to consider. In order to encourage individuals' feelings of containment and to maximise honesty, neither of the group facilitators conducted the interviews. However, the individuals' awareness that the facilitators would be analysing the data may have biased their descriptions. Whilst care was taken to create an environment for the participants in which they could speak openly, the efficacy of this is unknown. Additionally, the process of qualitative analysis has its limitations, as it cannot occur in an objective manner, freed from the analyser's own beliefs and experiences. These will inevitably guide the selection of data, codes and themes. Self-reflexivity is therefore

important, as indeed is triangulation, which occurred in this study with other psychologists. Had time allowed and the participants been amenable, the qualitative findings would have ideally been presented to the participants, to request feedback regarding the representation of their opinions.

Finally, the limitations of the statistical analyses require consideration. The reliable change index is designed to calculate change between pre and post measures. In this situation, due to an unstable baseline prior to the group, it was important to consider baseline change within the analysis. Baseline change was consequently compared to treatment change, rather that the absolute scores. It is possible that this amendment caused some threat to the validity of the statistic. The extent of this is unknown, but likely to be small due to continued consideration of variation in responses and test-retest reliability.

In order to draw conclusions about an association between CR and mindfulness, a consistent pattern of evidence from both the quantitative and qualitative analysis is required. As discussed, the group-based analysis drew non-significant results, which may be the result of a Type II error. The case-cohort analysis demonstrated some improvement, as measured by the LEIDS-r and MAAS, although the change reported by participants did not consistently meet the criteria for reliable change. The qualitative analysis highlighted a range of opinions regarding the process of group participation, individuals' experiences of mindfulness and the impact of ameliorating distress. This indicates some benefit, but should be repeated with further case cohorts in order to draw more fixed conclusions.

REFERENCES

Abba, N., Chadwick, P. & Stevenson, C. (2008) Responding Mindfully to Distressing Psychosis: A Grounded Theory Analysis. *Psychotherapy Research*, 18 (1), 77-87

Antypa, N., Van der Does, A.J.W. & Penninx, B.W.J.H. (2010) Cognitive Reactivity: Investigation of a Potentially Treatable Marker of Suicide Risk in Depression. *Journal of Affective Disorders, 122 (1-2), 46-52*

Baer, R.A., Walsh, E. & Lykins, E.L.B. (2009) Assessment of Mindfulness. In F.Didonna (Ed), *Clinical Handbook of Mindfulness.* New York: Springer

Baer, R. (2005) *Mindfulness-Based Treatment Approaches: Clinician's Guide to Evidence Base and Applications*. Academic Press: London

Barker, C., Pistrang, N. & Elliott, R. (2002) *Research Methods in Clinical Psychology: An Introduction to Students and Practitioners (2nd Ed).* Chichester: John Wiley & Sons Ltd

Beck, A.T., Steer R.A., Brown, G.K. (1996) *Manual for Beck Depression Inventory II (BDI-II).* San Antonio: Psychology Corporation

Beck, J.G., Gudmundsdottir, B., Palyo, S.A., Miller, L.M. & Grant, D.M. (2006) Rebound Effects Following Deliberate Thought Suppression: Does PTSD Make a Difference? Behaviour Therapy, 37, 170-180

Birchwood, M., Meaden, A., Trower, P., Gilbert, P. & Plaistow, J. (2000) The Power and Omnipotence of Voices: Subordination and Entrapment by Voices and Significant Others. *Psychological Medicine,* 30, 337-344

Bishop, S.R., Lau, M., Shapiro, S., Carlson, L., Anderson, N.D., Carmody, J., Segal, Z.V., Abbey, S., Speca, M., Velting, D. & Devins, G. (2004) Mindfulness: A Proposed Definition. *Clinical Psychology: Science and Practice*, 11, 230-241

Bögels, S., Hoogstad, B., van Dun, L., de Schutter, S., & Restifo, K. (2008) Mindfulness Training for Adolescents with Externalizing Disorders and Their Parents. *Behavioural and Cognitive Psychotherapy*, *36* (02), 193–209

Brown, K., West, A.M., Loverich, T.M., Biegel, G.M. (2011) Assessing Adolescent Mindfulness: Validation of an Adapted Mindful Attention and Awareness Scale in Adolescent Normative and Psychiatric Populations. *Psychological Assessment,* EPub Ahead of Print.

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 (4), 822-848

Chadwick, P., Hughes, S., Russell, D., Russell, I & Dagnan, D. (2009) Mindfulness Groups for Distressing Voices and Paranoia: A Replication and Randomised Feasibility Trial. *Behavioural and Cognitive Psychotherapy,* 37, 403-413

Chadwick, P., Newman Taylor, K. & Abba, N. (2005) Mindfulness Groups for People with Psychosis. *Behavioural and Cognitive Psychotherapy*, 33, 351-359

Deyo, M., Wilson, K.A., Ong, J. & Koopman, C. (2009) Mindfulness and Rumination: Does Mindfulness Training Lead to Reductions in the Ruminative Thinking Associated with Depression. *Explore,* 5 (5) 265-271

Evans, S., Ferrando, S., Findler, M., Stowell, C., Smart, C. & Haglin, D. (2008) Mindfulness-Based Cognitive Therapy for Generalised Anxiety Disorder. *Journal of Anxiety Disorders,* 22 (4), 716-721

Fennell, M.J.V. (2004) Depression, Low Self-Esteem and Mindfulness. *Behaviour Research and Therapy,* 42, 1053-1067

Garety, P.A. & Freeman, D. (1999) Cognitive Approaches to Delusions: A Critical Review of Theories and Evidence. *British Journal of Clinical Psychology,* 38, 113-154

Hawton, K. & James, A. (2005) ABC of Adolescence: Suicide and Deliberate Self Harm in Young People. *British Medical Journal,* 330, 891-894

Hepburn, S.R., Crane, C., Barnhofer, T., Duggan, D.S., Fennell, M.J.V. & Williams, J.M.G. (2009) Mindfulness-Based Cognitive Therapy May Reduce Thought Suppression in Previously Suicidal Participants: Findings from a Preliminary Study. *British Journal of Clinical Psychology,* 48, 209-215

Hofmann, S. G., Sawyer, A.T., Witt, A.A. & Oh, D. (2010) The Effect of Mindfulness-Based Therapy on Anxiety and Depression: A Meta-Analytic Review. *Journal of Consulting and Clinical Psychology*, 78 (2), 169-183

Jacobsen, P., Morris, E., Johns, L. & Hodkinson, K. (2011) Mindfulness Groups for Psychosis. *Behavioural and Cognitive Psychotherapy,* 39, 349-353

Jacobson, N.S. & Truax, P. (1991) Clinical Significance: A Statistical Approach to Defining Meaningful Change in Psychotherapy Research. *Journal of Consulting and Clinical Psychotherapy,* 59 (1), 12-19

Kabat-Zinn, J. (1990) *Full Catastrophe Living*. Bantam Dell: New York

Kenny, M.A. & Williams, J.M.G. (2007) Treatment Resistant Depressed Patients Show a Good Response to MBCT. *Behaviour Research and Therapy,* 45, 617-625

King, N. (2004) Template analysis, in G.Symon and C.Cassell (Eds.) *Qualitative Methods and Analysis in Organizational Research.* London: Sage

Kristeller, J. L., & Hallett, C. B. (1999) An Exploratory Study of a Meditation-Based Intervention for Binge Eating Disorder. *Journal of Health Psychology,* 4 (3), 357–63

Kumar, S., Feldman, G. & Hayes, A. (2008) Changes in Mindfulness and Emotion Regulation in an Exposure-Based Cognitive Therapy for Depression. *Cognitive Therapy Research,* 32, 734-744

Lau, M.A. & McMain, S.F. (2005) Integrating Mindfulness Meditation with Cognitive and Behavioural Therapies: The Challenge of Combining Acceptance and Change Based Strategies. *Canadian Journal of Psychiatry,* 50 (13), 863-869

Lau, M.A., Segal, Z.V. & Williams, J.M.G. (2004) Teasdale's Differential Activation Hypothesis: Implications for Mechanisms of Depressive Relapse and Suicidal Behaviour. *Behaviour Research and Therapy,* 42, 1001-1017

Linehan, M.M., Armstrong, H.E., Suarez, A., Allmon, D. & Heard, H.L. (1991) Cognitive-Behavioural Treatment of Chronically Parasuicidal Borderline Patients. *Archives of General Psychiatry,* 48, 1060-1064

Meltzer, H., Harrington, R., Goodman, R. & Jenkins, R. (2001) Children and Adolescents who try to Harm, Hurt or Kill Themselves. Crown Copyright: London

Miller, A.L., Rathaus, J.H., & Linehan, M.M. (2005) *Dialectical Behavior Therapy with Suicidal Adolescents*. New York: The Guilford Press

Morrison, A. P., & Wells, A. (2003) A Comparison of Metacognitions in Patients with Hallucinations, Delusions, Panic Disorder, and Non-Patient Controls. *Behaviour Research and Therapy*, 41, 251-256

Patel, V., Flisher, A.J., Hetrick, S.E. & McGorry, P.D. (2007) Mental Health of Young People: A Global Public-Health Challenge. *Lancet,* 369, 1302–1313

Patton, G.C., Coffey, C., Sawyer, S.M., Viner, R.M., Holler, D.M., Bose, K., Vos, T., Ferguson, J. & Mathers, C.D. (2009) Global Patterns of Mortality in Young People: A Systematic Analysis of Population Health Data. *The Lancet*, 374, 881-892

Purdon, C. (1999) Thought Suppression and Psychopathology. *Behaviour Research and Therapy,* 37, 1029-1054

Raes, F., Dewulf, D., Van Heeringen, C. & Williams, J.M.G. (2009) Mindfulness and Reduced Cognitive Reactivity to Sad Mood: Evidence from a Correlational Study and a Non-Randomised Waiting List Controlled Study. *Behaviour Research and Therapy,* 47, 623-627

Rassin, E., Diepstraten, P., Merckelbach, H. & Muris, P. (2001) Thought-Action Fusion and Thought Suppression in Obsessive-Compulsive Disorder. *Behaviour Research and Therapy,* 39, 757-764

Ruddle, A., Mason, O. & Wykes, T. (2011) A Review of Hearing Voices Groups: Evidence and Mechanisms of Change. *Clinical Psychology Review*, 31, 757-766

Segal, Z.V., Gemar, M. & Williams, S. (1999) Differential Cognitive Response to a Mood Challenge Following Successful Cognitive Therapy or Pharmacotherapy for Unipolar Depression. *Journal of Abnormal Psychology,* 108, 3-10

Segal, Z.V., Williams, J.M.G. & Teasdale, J.D. (2002) *Mindfulness-Based Cognitive Therapy for Depression: A New Approach to Preventing Relapse.* New York: The Guildford Press

Sidley, G.L. (1998) Parasuicide. In N. Tarrier, A. Wells & G. Haddock (Eds.), *Treating Complex Cases: The Cognitive Behavioural Therapy Approach.* Cornwall: John Wiley & Sons Ltd

Siegel, R.D., Germer, C.K. & Olendzki, A. (2010) Mindfulness: What is it? Where Did it Come From? In F.Didonna (Ed), *Clinical Handbook of Mindfulness.* New York: Springer

Skegg, K. (2005) Self-Harm. *Lancet*, 366, 1471-1483

Teasdale, J.D. (1988) Cognitive Vulnerability to Persistent Depression. *Cognition and Emotion,* 2, 247-274

Teasdale, J.D., Segal, Z.V., Williams, J.M.G., Ridgeway, V.A., Soulsby, J.M. & Lau, M.A. (2000) Prevention of Relapse/Recurrence in Major Depression by Mindfulness-Based Cognitive Therapy. *Journal of Consulting and Clinical Psychology* 68 (4) 615-623

Tolin, D.F., Abramowitz, J.S., Przeworski, A. & Foa, E.B. (2002) Thought Suppression in Obsessive-Compulsive Disorder. *Behaviour Research & Therapy,* 40, 1255-1274

Van der Does, W. (2005) Thought Suppression and Cognitive Vulnerability to Depression. *British Journal of Clinical Psychology*, 44 (1), 1-14

Van der Does, W. (2002) Cognitive Reactivity to Sad Mood: Structure and Validity of a New Measure. *Behaviour Research and Therapy,* 401, 105-120

Van der Does, A.J.W. & Williams, J.M.G. (2003) Leiden Index of Depression Sensitivity – Revised (LEIDS-R). Leiden University. http://www.dousa.nl/publications_depression.htm#LEIDS Accessed 5th April, 2011

Verheul, R., Van den Bosch, L. M. C., Koeter, M. W. J., de Ridder, M. A. J., Stijnen, T., & Brink, W. (2003) A 12-Month Randomized Clinical Trial of Dialectical Behaviour Therapy for Women with Borderline Personality Disorder in The Netherlands. *British Journal of Psychiatry*, 182, 135–140

Wegner, D. M., Schneider, D. J., Carter, S. R., & White, T. L. (1987) Paradoxical Effects of Thought Suppression. *Journal of Personality and Social Psychology*, 53, 5-13

Wille, N., Bettge, S. & Ravens-Sieberer, U. (2008) Risk and Protective Factors for Children's and Adolescent's Mental Health: Results of the BELLA Study. *European Child and Adolescent Psychiatry,* s1 (17), 133-147

Williams, J.M.G., Van der Does, A.J.W., Barnhofer, T., Crane, C. & Segal, Z.V. (2008) Cognitive Reactivity, Suicidal Ideation and Future Fluency: Preliminary Investigation of a Differential Activation Theory of Hopelessness/Suicidality. *Cognitive Therapy Research,* 32, 83-104

Williams, J.M.G., Crane, C., Barnhofer, T., Van der Does, A.J.W., & Segal, Z.V. (2006) Recurrence of Suicidal Ideation across Depressive Episodes. *Journal of Affective Disorders,* 91, 189-194

Wise, E.A. (2004) Methods for Analysing Psychotherapy Outcomes: A Review of Clinical Significance, Reliable Change, and Recommendations for Future Directions. *Journal of Personality Assessment*, 82 (1), 50-59

World Health Organisation (2008) *The Global Burden of Disease: 2004 Update.* Geneva: World Health Organization

PUBLIC DOMAIN BRIEFING PAPER:

Literature Review and Empirical Paper

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PUBLIC DOMAIN BRIEFING PAPER

Literature Review: Healthcare Professionals' Attitudes Towards Working with Self-Harm and Suicidality

Worldwide rates of attempted and completed suicide remain high. This has prompted international policies aimed at increasing awareness and understanding of suicidality, reducing stigma and encouraging the development of prevention strategies. Self-harm and suicidality are not always linked, as people who self-harm are often motivated by different reasons. However, research suggests that some people who self-harm are at much higher risk of attempting suicide in the future. It is therefore important, when thinking of preventing risk, to consider people who self-harm as at risk of suicidality.

Not all people who attempt suicide or self-harm either need or seek medical assistance. Those who do seek help are often vulnerable and sensitive to how they are received; here, the role of the healthcare professional (HCP) and the manner in which they communicate is vital (World Health Organisation, 2000). It is suggested that sensitive communication between HCPs and service-users (SU) is key in ensuring the SUs' treatment needs are met, increasing the likelihood of engaging with healthcare in the future. However, this communication can be complicated by the HCPs' attitudes towards the SUs' behaviour.

This literature review considered 22 studies, published in the last decade, which explore HCPs' attitudes towards working with suicidal SUs, and those that self-harm. Six of the 22 studies highlighted largely positive attitudes, including empathy, believing HCPs' roles are important to service-users, and understanding the communication of the service-users' behaviour as important or reflecting distress. Thirteen studies highlighted a mixed range of attitudes, for example reporting low reports of negativity towards the SUs, but high levels of HCPs' anxiety about being blamed for the consequences of the SUs behaviour. Two studies highlighted predominantly negative attitudes, which were characterised by avoidance, rejection, hostility and fear of the SUs.

The literature review then considered factors that impact these attitudes. Of the significant findings, HCPs who were older; female; from mental health backgrounds; had higher levels of education; and longer clinical experience tended to demonstrate more positive attitudes towards suicidal individuals and those who self-harm. Personal experience and religious or moral backgrounds were lesser studied, however both appeared to have an impact, where personal experience of suicidality or self-harm, and a non-religious background elicited more positive beliefs. Where HCPs perceived the SU had control over their behaviour their attitudes were more negative. Finally, organisational issues were also found to have an impact. In combination, these factors had an effect on HCPs' levels of confidence, self-efficacy and hopefulness in their roles. However, care must be taken in interpreting the results as they were based on small sample sizes, and were difficult to compare due to different assessment methods. Importantly, a large number of studies found non-significant effects. Whilst the reasons for this were not always clear, it highlights that these factors do not have consistent effects on attitudes. It is likely that no single factor had a particularly strong influence, but that they were inter-linked, impacting attitudes together.

To clarify the links between factors that influence HCPs' attitudes, further research is needed with well defined methods and large sample sizes. However, the review demonstrated the importance of training for HCPs, this being advocated by 19 of the 22 studies. Further training would increase HCPs' knowledge and understanding and increase their confidence in their roles. Furthermore, provision of supervision groups could explore HCPs' reactions to self-harm and suicide allowing analysis and understanding, and thereby minimising the opportunity of impacting SUs' care.

Empirical Paper: Can Group-Based Mindfulness Reduce Vulnerability to Suicidality in Young Adults? A Pilot Study

The Differential Activation Hypothesis (Teasdale, 1988) provides an explanation as to why people who suffer from depression may experience frequent recurrences. It explains how, when an individual is depressed, certain patterns of thought become linked. When s/he starts to feel more positive, this network of thought is deactivated. However, when they feel low again, the pattern is reactivated, making them feel depressed once more. This serves to lengthen their experience of depression. Over time, the pattern becomes more easily triggered, so even small decreases in mood can leave them increasingly vulnerable to depression. This process of activation is called cognitive reactivity (CR). If, during an episode of depression, an individual felt suicidal, this would become linked into the pattern of thoughts. Therefore, even following a recovery from depression, the individual remains at risk of feeling suicidal again, if their mood lowers and the pattern is reactivated.

Approximately 12% of adolescents in the United Kingdom suffer from mental health difficulties (Patel et al, 2007). This can have a significant impact on their social and educational development. Furthermore, statistics suggest that at 6.3%, suicide is the second most common cause of death in individuals aged 10-24 (Patton et al, 2009). Effective treatment strategies are therefore important in helping to alleviate their distress.

Mindfulness-based approaches (MBA) have recently been shown to help people who struggle with different types of mental health problems. Mindfulness is about paying attention to the world, the present moment and the contents of our minds in a particular way. It recognises that too much time spent thinking about the past or the future can cause people to become unhappy, and unable to see what exists for them in the present. MBA encourage individuals to understand that distress is a reaction to experience, but not part of the experience, and as such can be changed, rather than becoming part of the experience itself. Once these reactions are recognised, people are helped to 'let go' of them. Studies have begun to show that MBA may help reduce levels of CR, thereby lowering an individual's level of risk of recurring depression or suicidality.

To investigate whether mindfulness can help to reduce CR, and therefore vulnerability to suicidality, two mindfulness groups were run for young people aged 17-20. These individuals had a range of emotional difficulties, and all had histories of self-harm or suicidal behaviour. The effect of the groups was measured through self-report questionnaires and through

interviews with the individuals about their experiences. There were two questionnaires, one that indicates levels of individuals' CR, and the other that looks at mindfulness skills. Participants completed these before and after the group, and again at a follow up appointment after the group. The groups ran for six weeks and had up to eight people per group.

Although 15 people initially agreed to participate, only eight people completed the process. This meant that statistical analysis of changes to their self-report questionnaires were difficult. When statistical analyses are carried out on small numbers of people, the chance of a change being misidentified as insignificant is increased. Overall group analysis suggested no statistically significant change for the 8 participants; indicating no significant reduction of cognitive reactivity or increase in mindfulness skills. Individual progress was considered using the reliable change index (Jacobson & Truax, 1991), which suggested that of the 8 participants, 5 showed significant reduction on their reported CR and one showed an increase. On the mindfulness scale, none showed statistically significant change, but five showed increased levels, one showed no change and two showed decreased levels of mindfulness. Due to the small sample, it wasn't possible to statistically investigate an association between these results, but it was interesting to note a pattern in the data, where the participants who demonstrated the most reduction in CR also showed the most improvement in mindfulness skills.

The qualitative data was analysed using template analysis (King, 2004), and highlighted three main themes relating to participants' experience of mindfulness and the pros and cons of having participated in the group. The first theme was entitled 'Being and Talking in the Group' and included sub-themes of 'Settling in and Speaking up' and 'Sharing Helps

Understanding and Normalising'. The second theme was called 'Perspectives on Mindfulness' and incorporated sub-themes of 'Accessibility and Progress in Understanding', 'Mindfulness is Applicable to Adolescents' and 'Mixed Impressions of the Exercises.' The third theme was 'Perspectives on Change' which included 'Mindfulness Increasing Awareness', 'Adding to the Toolbox Rather Than a Cure', 'Futility / Difficulties Breaking the Mould' and 'Awareness of Personal Agency; Responsibility, Choice and Practice'.

Overall, this data suggested that participants had taken some benefit from participating in the group, some of which was related to mindfulness, including developing an awareness and understanding of different ways of relating to their experience. Other elements were: relating to belonging to a group; recognising that they were not alone or 'abnormal'. The difficulties that were highlighted in applying mindfulness, included the necessity for effort and practice, and the fact that this was a personal choice and responsibility that was not for everyone.

Overall, the results suggested some evidence of benefit to young people of mindfulness in reducing their distress. However, further research is required with larger numbers of people in order to understand whether mindfulness can help reduce vulnerability to cognitive reactivity.

REFERENCES

Jacobson, N.S. & Truax, P. (1991) Clinical Significance: A Statistical Approach to Defining Meaningful Change in Psychotherapy Research. *Journal of Consulting and Clinical Psychotherapy,* 59 (1), 12-19

King, N. (2004) Template analysis, in G.Symon and C.Cassell (Eds.) *Qualitative Methods and Analysis in Organizational Research.* London: Sage

Patel, V., Flisher, A.J., Hetrick, S.E. & McGorry, P.D. (2007) Mental Health of Young People: A Global Public-Health Challenge. *Lancet* 2007; 369: 1302–13

Patton, G.C., Coffey, C., Sawyer, S.M., Viner, R.M., Holler, D.M., Bose, K., Vos, T., Ferguson, J. & Mathers, C.D. (2009) Global Patterns of Mortality in Young People: A Systematic Analysis of Population Health Data. *The Lancet*, 374, 881-892

Teasdale, J.D. (1988) Cognitive Vulnerability to Persistent Depression. *Cognition and Emotion,* 2, 247-274

World Health Organisation (2000b) *Preventing Suicide: A Resource for Media Professionals.* Department of Mental Health, World Health Organisation: Geneva

Volume 1: Research Component

APPENDICES

UNIVERSITY^{OF} BIRMINGHAM

Participant Information Sheet

We are planning to **run a group** which aims to help people who feel stressed, anxious or depressed – and who have had some thoughts about suicide or harming themselves in the past.

It uses **mindfulness**, which is a new approach to working with people and has been shown to help reduce distress. We hope to have between six and eight people in the group.

You have been invited to take part because we are aware that, as you are being seen by XXX, it is possible that it may be **something you could benefit from**. We are interested in seeing **whether it is helpful, or not.**

If you decide to take part – we will ask you to fill in some **questionnaires about how you are feeling**, and **talk with you** about some of your past experiences, and what you think about mindfulness. We will then run the group – which **will run for 6 weeks**, with one session a week.

We would like to ask you to complete the questionnaires before and after the group, to see whether it has been helpful. We would then like to ask you to complete them 6 weeks later to see if it's still helpful.

You do not have to take part in the group if you do not want to. You can also leave the study at any time if you choose to. Your **care will not be affected**.

If you decide to leave the study before it is finished, we would like to ask you a few questions about your reasons. This is not because you're not allowed to leave but because we'd like to understand how to change the group in the future. We may record this conversation to help us to remember what you say. However, if you don't want it to be recorded, you do not have to.

We **will not be able to offer money for participation**, but we would be happy to **provide transport** to and from the group.

The **results of the study will hopefully be published in a scientific journal**. Your name will be removed from the questionnaire information so you will not be identified. If quotes are published from the interviews, names will also be changed. However, if you're unhappy with this – your information can be left out. You will be able to decide to remove your information until February 2011.

If you have any questions, please call Lisa Barber-Lomax, or XXX on XXX.

We would be happy to chat on the phone, or to arrange an appointment. You can also pass on your question to your key worker who will find out the information from us.

Thank you for your time.

Appendix B: Participant Consent Form

Consent Form: <u>Mindfulness Groups</u>

<div align="right">Please Tick</div>

1. I have understood the information sheet dated February 2010 about Mindfulness Groups. I have had the opportunity to think about the information and ask questions. I have also had these questions answered.

☐

2. I know that my participation is voluntary and that I can withdraw at any time, without giving any reason, without my own care or legal rights being affected.

☐

3. I understand that I will be asked to participate in two interviews, which may be audio-recorded. I can decide not to have these recorded if I like. I can also decide not to have the interviews if I choose

☐

4. I understand that I will be asked to complete questionnaires on four occasions over a six month period. This may take around 45 minutes.

☐

5. I understand that the information collected in this study will be looked at by Lisa Barber-Lomax and her supervisors at the University of Birmingham. This will be to check that the data is analysed fairly.

☐

6. Parts of the data may also be made available to members of the XXX team, but only if there are concerns about my safety or wellbeing.

☐

7. I understand that parts of my interview may be written up in a report, but that my name will be removed so I will not be identifiable by my comments.

☐

8. I understand that I can ask any quotes to be taken out of the report, up until February 2011.

☐

9. I agree to take part in the above study.

☐

....
Name of participant   Date   Signature

....
Name of researcher   Date   Signature

Mindful Attention Awareness Scale (MAAS)

Please indicate the degree to which you agree with each of the following items using the scale below. Simply circle your response to each item.

1	2	3	4	5	6
almost always	very frequently	somewhat frequently	somewhat infrequently	very infrequently	almost never

1. I could be experiencing some emotion and not be conscious of it until some time later. 1 2 3 4 5 6

2. I break or spill things because of carelessness, not paying attention, or thinking of something else. 1 2 3 4 5 6

3. I find it difficult to stay focused on what's happening in the present. 1 2 3 4 5 6

4. I tend to walk quickly to get where I'm going without paying attention to what I experience along the way. 1 2 3 4 5 6

5. I tend not to notice feelings of physical tension or discomfort until they really grab my attention. 1 2 3 4 5 6

6. I forget a person's name almost as soon as I've been told it for the first time. 1 2 3 4 5 6

7. It seems I am "running on automatic" without much awareness of what I'm doing. 1 2 3 4 5 6

8. I rush through activities without being really attentive to them. 1 2 3 4 5 6

9. I get so focused on the goal I want to achieve that I lose touch with what I am doing right now to get there. 1 2 3 4 5 6

10. I do jobs or tasks automatically, without being aware of what I'm doing. 1 2 3 4 5 6

11. I find myself listening to someone with one ear, doing something else at the same time. 1 2 3 4 5 6

12. I drive places on "automatic pilot" and then wonder why I went there. 1 2 3 4 5 6

13. I find myself preoccupied with the future or the past. 1 2 3 4 5 6

14. I find myself doing things without paying attention. 1 2 3 4 5 6

15. I snack without being aware that I'm eating. 1 2 3 4 5 6

Appendix F: Mindfulness Session Outline

Mindfulness Group
Plan for Facilitators: Outline Plan only – Group to be Governed by Group/Individual Need.
Timings are approximate, apart from length of break.

Week 1

Questionnaires and Cake: 60 mins

Welcome and introductions

	Icebreaker	**15 mins**
	Ground Rules	**15 mins**
	Outline plan for today	**5 mins**

Session 1   **Automatic Pilot** – (Driving / Walking / Loss of Attention).
- How often are we present, and aware of what's going on in the current moment?

Being vs Doing mode
- Doing mode: When the mind sees that things as being different from how we would like them to be. Occurs when we see how we wish things were, or how we think things ought to be.

Exercise 1
- **Discuss** in small groups: How does it make us feel when we wish things were different to how they are right now?

10 mins

Feedback

10 mins

	Break	**15 mins**

Session 2   **Recap** on discussion about doing mode (helpful/unhelpful).
- Awareness that sometimes it drives us to achieve, can motivate us. It can be helpful – especially when we can then chill out and enjoy it.
- But it can be unhelpful…
  - What happens if we get there, and want to be somewhere else? Where does it stop?
  - What happens if we can't figure out how to get there, or actually can't get there?
- Can activate some form of negative thinking, can make us feel upset/angry/disappointed.

Mindfulness can help bring our attention back to the present; awareness of what is going on right now (Being mode)

Exercise 2   **Raisin Exercise**   **10 mins**
- **Feedback/Discussion**
- Highlight how it can raise awareness of sensory input that we are often unaware of.
- Suggestion: Make some food in the week – eat half mindfully, and half as usual (whilst watching tv/reading) – notice the difference.

10 mins

Total: 90

Mindfulness Group

Plan for Facilitators: Outline Plan only – Group to be Governed by Group/Individual Need. Timings are also approximate, apart from length of break.

Week 2

Welcome and Introductions

Session 1	**Recap, Handout and Feedback/Thoughts on last week.**	**10 mins**
	• The Doing mode.	
	• How this can be triggered when there's a discrepancy between what we perceive that we have, and what we want to have.	
	Small Group Discussion	**5 mins**
Exercise 1	• Someone you know well walks past you on the opposite side of the street – you wave to say hell. They don't wave back, or acknowledge you. You're sure they saw you. What do you think/feel?	
	Feedback	**10 mins**
	• Acknowledgement of effect of thoughts on feelings – how these seem to happen automatically/on autopilot.	
	• What's it like to be overwhelmed by feelings?	
	• In this case, how helpful is it to be in the 'doing mode?'	
Exercise 2	**Breathing Exercise**	**5 mins**
	Feedback	**10 mins**
	Break	**15 mins**
Session 2	**Recap**	
	• When we're caught up in worries, and what we'd like, we often stop being aware of what's happening right now	
	- There's a lot of life that we miss out on.	
	- Mindfulness techniques can help us to re-develop awareness	
	• What is Mindfulness?	
	- Paying attention in a particular way, on purpose, in the present moment. Non-judgementally.	
	- Alternative approach to coping with stress and worry.	
	- Not reliving mistakes or events from the past.	
	- Not anxiously thinking about the future.	
	- Not struggling with symptoms, experiences, thoughts and feelings.	**10 mins**
Session 3		
	Practise – Mindfulness Exercise.	**5 mins**
	Feedback	**5 mins**
		15 mins
	• **Bring in feedback from exercise - talk about range of reactions.**	
	- Mind wandering / Boredom / Judgements / Worry – Normalise.	
	- Developing an awareness of where your mind might naturally take you.	

Total: 90 minutes

Mindfulness Group

Plan for Facilitators: Outline Plan only – Group to be Governed by Group/Individual Need. Timings are also approximate, apart from length of break.

Week 3

Welcome - Recap / Handouts		**15 mins**
Exercise 1	**Breathing Exercise.**	**5 mins**
	Feedback	**10 mins**

- Comments on where their thoughts took them. Developing awareness of minds.
- When practising – some times may be easier than others.
- Puppy metaphor: Mind is like a puppy. Constantly bringing toys/thoughts. Train to stand in corner. Hard but rewarding.
- Important not to judge yourself.
- When the mind wanders -just bring awareness back to the breath.

Whole Group Discussion

Exercise 2   **10 mins**

- Lying in bed at night – trying to sleep. Thoughts racing through your mind. Mind is too active to sleep.
  - Has this happened to you? Can you think of the thoughts going around your head?
  - What effect does it happen? (tossing / turning)
  - What is the result? (next day, less energy. Less able to cope. More easily overwhelmed)
  - What are you likely to be thinking / feeling?

	Break	**15 mins**
Session 2	**Recap - Linking Both Exercises**	**15 mins**

- Describe option of noticing thoughts, rather than believing / acting on them.
- Consider impact that this can have on how we feel and behave.
- This can be achieved through mindfulness

Whole Group Discussion   **10 mins**

- What is Mindfulness?
  - Check out Understanding
  - Recap on Practise.
  - Has anyone tried it? How do you feel about not having tried it?

Session 3	**Practise – Mindfulness Exercise.**	**5 mins**
	Feedback	**5 mins**

Total: 90 minutes

Mindfulness Group

Week 4

Welcome - Recap / Handouts / Feedback		**15 mins**
Exercise 1	**Mindfulness Exercise.**	**10 mins**
	Feedback	**5 mins**

- Comments / Questions / Difficulties / Points to Share.

- How our minds are busy in the 'doing mode' – avoiding or confronting what's happening in the present moment.
- Related to certain thoughts or feelings.
- Mindfulness is about allowing ourselves to 'be' in the present moment.
- There are no 'wrong' thoughts or 'wrong feelings' – it's all part of being normal

Whole Group Discussion   **10 mins**

Exercise 2
- What do you think of that?
- Do you agree/disagree?

Idea: That to *act* on the thoughts or feelings may be wrong, or unhelpful, or hurtful to others.
- But they're not wrong if they just cross our minds.
- It's about learning to watch the thoughts come and go – without acting on them.
- Train metaphor.

                                                              10 mins
Break   **15 mins**

Session 2   **Recap**
- *Idea:* If we can be aware of what is happening in our minds, we can act more wisely, and more kindly to ourselves, as we don't have to be caught up in the struggle of fighting or interpreting them.
- Allow the thoughts and feelings to pass.
- Do not judge them, or yourself.

Whole Group Discussion   **5 mins**
- What do you think of this?
- Does it make sense?
- What difference do you think it could make to your life?   **10 mins**

Session 3   **Practise – Mindfulness Exercise.**   **5 mins**
                   Feedback   **5 mins**

                                              Total: 90 minutes

Mindfulness Group

Week 5

Welcome - Recap / Handouts / Feedback		**15 mins**
Exercise 1	**Mindfulness Exercise.**	**5 mins**
	Feedback	**5 mins**
	• Comments / Questions / Difficulties / Points to Share.	

Exercise 2   **Whole Group Discussion**   **10 mins**
- Handling an Unresolvable Emotional Situation.
- Argument – Someone walks away without hearing your point of view.
- How does this affect you?
  - Where do you notice it?
  - Feelings/Sensations in your body?

Exercise 3   Three Minute Breathing Space

5 mins

<div align="center">

Break   **15 mins**
</div>

Session 2
- What happens when we don't want to be in the present moment, when we'd rather be anywhere else?

Exercise 4   **Whole group discussion**   **15 mins**
- Last time you <u>had</u> to go to an event that you really didn't want to? Family party? College - boring lecture? Dr's appointment? Being around people you didn't want to be around?
  - What was this like? So what did you do?
  - Did it change the fact that you still had to go?
  - So how did you feel once your were there?

Doings things/having feelings or thoughts we don't want is part of life. Avoiding them doesn't make them go away – generally just makes us feel worse about them.

Exercise 5   **Whole Group Discussion**   **10 mins**
- What happens when we accept these things?
- What happens to the way we were feeling?
- Do our emotions stay the same?
- Observe – Changes in emotions, like the tide.

Idea: The problem is not situations or symptoms per se, but how one responds to them… Sensations are uncontrollable.

Exercise 6   **Practise – Mindfulness Exercise.**   **5 mins**
          Feedback   **5 mins**

Total: 90 minutes

Mindfulness Group

Week 6

Welcome - Recap / Handouts / Feedback		**10 mins**
Exercise 1	**Mindfulness Exercise.**	**10 mins**
	Feedback	**5 mins**

- Comments / Questions / Difficulties / Points to Share.

Exercise 2   **Whole Group Discussion**   **20 mins**

Last session: Helpful to recap?

- What have people remembered from our discussions?

Being mode vs doing mode.

- When is doing mode helpful / unhelpful?
- When is being mode helpful / unhelpful

Developing an awareness of ourselves

- sometimes this can feel overwhelming.
- may notice things you weren't aware of before.
- Important to remember that mindfulness is a non-judgemental practise.
- Acknowledging experience - not judging or acting on it.

Three Minute Breathing Space

Exercise 3   **5 mins**

<center>**Break**   **15 mins**</center>

Session 2   **Whole group discussion**   **20 mins**

- Discussion about how the group has been.

Exercise 4
- Helpful / Unhelpful?
- Does anyone need clarification?

Recap

- Aim is not to get thoughts or feelings out of our heads – as we're then entering into a struggle with them.
- Purpose of coping is <u>not</u> to decrease symptoms' frequency, but to carry out valued activities whether or not symptoms occur
  - Pink elephant / polygraph metaphor
  - Aim is to allow thoughts or feelings into our experience, without having to act on them

Recap

- How to manage practise, ways it can be incorporated into everyday life

Exercise 5   **5 mins**

Practise – Mindfulness Exercise.

Questionnaires   **Cake Break**

<div align="right">**Total: 90 minutes (+60)**</div>

Appendix G: Reasons for Disengagement

Table 1: Information Regarding Individuals' Decisions to Disengage from the Group.

Reasons for Disengaging from the Group (N=7)

Group One.
Following Collection of Baseline Measure
- Made transition to psychosis; referred to another service. Invited to attend anyway, no response received.

Following Session 4
- Disengaged due to family difficulties. Contact made to re-establish or discuss engagement, no response received.

Group Two
Following Collection of Baseline Measure
- Secured employment; unable to attend.

Following Session 1
- Became acutely unwell and admitted to an inpatient unit. Contact made to re-establish engagement, declined.
- Was unhappy about the presence of another group member. Requested to be placed on the waiting list for another group.

Following Session 2
- Secured employment; unable to attend.

Following Session 3
- Became actuely unwell and admitted to an inpatient unit.

Appendix H: Semi-Structured Interview Schedule

Setting the scene:

The aim of the interviews is to obtain as much information about the person's experience of the group/mindfulness as possible. It would therefore be helpful if you could outline what's going to happen so the person knows that the format is for them to do most of the talking, and you to do most of the listening. Please let them know that anything they have to say is important for us to hear, so not to worry about how things come out, and just to talk.

It is important to spend time making sure they feel comfortable in the situation, and that they're not too anxious. Please reassure them regarding the process, and let them know how appreciated their involvement is. Please let them know how much time you have available for them, so they know how much they can talk (approx 45-60 mins)

If they talk in a way that goes off on a tangent, if it's still related to the group, please allow this. The prompts below are a guide to try and ensure most aspects of the experience are asked about, to help people's responses.

Semi Structured Interview: Post Mindfulness Group

- So to begin with, it would be helpful to know what happened when you decided to join the mindfulness group please?

<*prompt 1*: what was going on for you at the time?>

- Do you remember how you felt after the first session?

<if they cant remember how it was after the first session, how they generally felt at the beginning of the group is fine>
<*AIM:* to elicit first reactions to the group and to mindfulness – please prompt for as much info as possible, re the group, the members, the facilitators, the content>
<*prompt 1*: did this change over time?>
<*prompt 2*: and if so, how did it change?>

- How did you find the groups generally?

< please *prompt* for as much info as possible, re the group setting (location, length of sessions, number of sessions), the members, the facilitators, the content>
<*prompt 1*: what sorts of things did you do together?>

- Before the group, we talked a little about times when you felt upset – can you remember this?

<*prompt 1:* remind participant what they said / clarify what they remember>

- …has this happened to you recently? … How did you manage what happened?

- Is this different to how you used to cope with distress?

<*prompt 1:* If yes: What has changed? Why do you think this has changed?>
<*prompt 2*: If no: Would you like this to change? >
<*prompt 3*: If no: What stopped you from using other strategies (including mindfulness) ?>

- Do you think the group has met your expectations?

<*prompt 1a*: if yes – can you say what your expectations were, and how/why they were met?
<*prompt 1b:* if no, what were your expectations? What would you have liked to have happened?>
<*prompt 2*: What was the most challenging?>
<*prompt 3*: What was the most helpful?>

- What do you think of mindfulness?

<*AIM*: to find out what kind of information was conveyed… what they learnt, what they thought of it. What they thought of the theory of it, and also the practical exercises we did>
<*prompt 1*: What do you understand mindfulness to be?>
<*prompt 2:* Do you think you'll use it again?>
<*prompt 3*: If yes, which bits do you think you'll use, or how will you use it?>

- Is there anything about the group that you think should be done differently?

<*prompt 1*: Or anything that you think should remain the same?>

- What advice or guidance would you give a friend who was thinking about joining a group like the one you've just had?

- Do you think it's helpful for people of your age?

<*prompt 1*: if yes - why do you think it's helpful? Which parts of it would be useful?>
<*prompt 2*: if no - why do you think it's unhelpful? Which part?>

- Is there any thing that I should have asked, that I haven't?

<is there anything you'd like to ask, or add?>

Thank you for your time.

TEMPLATE ANALYSIS: Data Within the Codes

Being and Talking in the Group
Settling In and Speaking Up
(Ellie) I felt kind uncomfortable and I felt like I didn't particularly want to go back because of all the talking…"

(Gwen) "I felt better, I didn't feel as nervous… coz we did like erm we kinda just had a normal talk first before like going on straight into the group or anything…and it felt a bit better that we'd erm, that I went, and it weren't that bad."

(Gwen) "erm I was nervous about going there all on my own, and turning up all on my own, but I got picked up so that made me turn up, else I probably wouldn't of"

(Gwen) "well when I had the group I stopped feeling nervous beforehand. Whereas the first couple of sessions I really didn't wanna go much. But after that I was okay, and erm, I was not confused after the first session. Coz the first one I was left a bit like 'what the hell?!' but then, like the rest of the weeks we did were done in order and explained well and stuff."

(Dee) erm… I'm not sure if enlightened is the word, maybe a little enlightened and certainly more open minded more happy but then again that's pretty natural for me… even after sessions with [CAMHS] I felt much better …but after a few hours it would start to wear off and I think it was the same after the first mindfulness group …"

(Ina) because like there was like loads of people at first and then like less people started going or when it got smaller like people like more people that didn't talk proper loud like could talk and then like it was easier.'

(Ellie) "I felt kind of uncomfortable and I felt like I didn't particularly want to go back because of all the talking it seemed to be like erm there were some people in the group who just wouldn't speak and to avoid like…because the people who were running it would talk and would like ask us things and there's people who wouldn't speak so I felt sort of obliged to speak and fill in for them and really I didn't want to say anything at all."

(Dee) I also erm felt quite pressured to keep on talking saying something coz even though I knew I was contributing quite a bit there was one or two that kept on contributing as well and I think I felt a bit in competition with them to be honest…

(Abie) "because of the progress I've made not meaning to sound arrogant erm a lot of the other people in the group were a lot further down than me and not meaning to sound hurtful to them but it kinda brought me down a little form how much progress I had made coz it reminded me of when I was at that stage."

(Ina) people were going off subject and talking about odd things that weren't like relevant and then it wasn't like helpful and it took up most of the time… and like everyone could tell it was happening but you cant really say anything…'

(Carl) yeah I mean som- some erm some I like found quite err sad kinda thing

(Dee) yeah, although there were times when I just thought 'oh god I wanna go home' coz there were days when I was pretty tired and I felt bored but I tried to keep my mind open even if it was a bit hard sometimes.'

(Dee) it was a bit like nerve-wracking…and err there were quite a few other people and even though I was smiling and saying 'hi' I was still very nervous and thinking I don't know any of you what will you think of me because I mean I haven't got any makeup on I look a right state but that's self-judgement again I know.

Sharing Helps Understanding and Normalising
(Abie) "just like seeing people like that were or are in the same boat as you kinda thing erm so there was a little bit more understanding that say it was to talk to friends. They can understand to a degree but unless they've been through it they really can't."

(Carl) "…I get to meet people who are like minded … who have the same kind of problems and erm

and like get to know them and erm it's good to have a chat with them err and to be part of a group…"
(Carl) "some of them I could kinda relate to as well … erm… it made feel like I'm not the only one."
(Dee) "I think the main thing that helped as well was actually listening to other people knowing that they'd had similar experiences even though they hadn't had the illness that I've had that in a way we all think and feel the same and I felt much much better thinking well I'm not alone in this."
(Gwen) "it was helpful…it was… although it's not nice for them to feel like that, it was like…a lot of them felt how I did and had the same feelings as I did, so that made me feel a lot better, and not so shy to say things myself. And like it people came out with something really like different to other people like no one laughed or anything so…so it was alright coz you felt you were was able to talk. No one really cared what you came out with."
(Dee) "erm being able to reassure them because you know what they've been through coz you've sort of been through it yourself I think it also helps you as well as reassuring yourself that you're erm not alone in this it can also erm prompt you with how they've got through it just sort of prompt you to get through it as well just use some tips that they've used and just sort of pass them on and I think with the group as well that gives you even more tips as well it's like there's a lot of support around."
(Dee) "just relating to people erm knowing that I'm not the only one that who finds it hard to concentrate who has these bad thoughts who erm judges myself"
(Finn) "I think with the group members I could start to see other people who were going through the same thing as me so …erm … that kinda gave me the opportunity to know people who'd been through similar experiences as me and err just so see how they were reacting in the group err they just didn't make me feel quite as weird as I did before I came to the group."
(Gwen) "being in a group where people were feeling the same and like I dunno if I was on my own I dunno…say if someone came to do mindfulness with me when I was on my own I don't think it would have helped me so much."
(Hana) "…it was also coz erm I met other people there who were also nervous and stuff so it kinda made it a bit easier it kinda made you realise that you're not the only one and people always say that but you know you don't quite believe them but erm yeah it was I dunno like nice kinda thing."
(Hana) "you kinda sit there and think that's exactly how I am sometimes you know so it's nice to know that you know it's quite normal and what normal people do not being in the moment for living…"
(Abie) I think it was kindof necessary to do it coz in order to –for the mindfulness to kindof size fits all kinda thing you need some details about people in the group erm which is like beyond gender and age and such it's more in depth that just the basic details that originally came in."
(Gwen) "it was because, like, when you talk you're having a conversation, and someone brings something up if they don't focus on it you think I dunno you're left thinking about it on your own and stuff. Whereas when they carried on talking about it using like mindfulness like how you'd approach it using mindfulness that was really helpful than being like…give…being told a scenario that really wasn't relevant to any of us."
(Gwen) "talking about it helps me not like do things like hurt myself as much kindof thing. So … that been a big help really. Instead of getting into a big mess…"
(Hana) "it got easier to go after I'd done it once or twice erm I dunno I had kindof up and down days so it's kindof like some days I could talk in the group and some days I'd be okay kindof getting there but then there were others when it was just not so great but it was alright."

Perspectives on Mindfulness

Accessibility and Progress in Understanding

(Ellie) "it seemed okay it seemed to be like the same things discussed every time…life experiences and erm basically training yourself not to think negative thoughts or erm or judge yourself etcetera"
(Dee) it did help just understanding how your mind works in certain areas and erm since actually that first erm sessions I've actually managed to notice when I'm on auto pilot it's quite helpful actually.
(Hana) "I was kindof on quite a high after it was kindof like I'd managed to do it…so that was like amazing"
(Abie) the actual mindfulness course is set in a err erm in a one scenario err all suggestions kinda fit all kinda thing…"
(Carl) like with the mindfulness group err they they tell you about erm like kindof how your mind works and…if erm if you like keep thinking too much and err you'll infect err affect your kinda mental health sortof thing…"
(Carl) erm yeah its helping you to be more aware of like erm how your brain works in general like sometimes you can do things but without realising what's happening and like you know err it's like say for instance if you hold something in your hand like a pen and you're looking everywhere for the pen

and you realise eventually that it's in your hand and [laughs] and then that's kind that falls into that category.

(Dee) autopilot…it's basically when erm your mind is thinking of other things and you erm blank err blank out from what you're doing and erm that links into something called the doing mode it's where your mind is constantly thinking and running around in circles and sometimes that can be okay particularly if it's something important you're thinking about and the situation that you're in is pretty relaxed sometimes…but it's not good always particularly if it's the situation you're in you need to concentrate and erm sometimes the doing mode can lead us to self-judgements as well and it can just get us into that spiral of self-judgement feeling awful self-harm etc just going in that circle. Which is why we sometimes need to be in the being mode where you can be more aware of what's happening and erm you have more of an open mind and you can think more clearly without having too many self-judgements and you can recognise more easily when you're getting into that vicious circle."

 (Finn) yeah I can draw parallels with myself and erm I can see how the concept was thought of and how by doing certain things so by changing the way you interpret things that can have a direct effect on your mood."

 (Gwen) "I thought it was a bit crazy at first, like having all these different modes and and stuff but now it's like now I think it's actually quite good and it makes a lot of sense I dunno like just accepting your thoughts instead of challenging them. and being kinda nicer to yourself than thinking you're all bad and stuff…I didn't even realise sometimes how I was kinda thinking and being a bit like – no wonder I was feeling so bad really…."

(Gwen) "Mindfulness is about being in the present and not…instead of focusing on the pact or the future or… and it's about being kind to yourself as well, and accepting all these thoughts that you might have instead of dwelling on them and making them like 10 times worse, just to accept them and realise that they're just thoughts and … and stuff."

(Hana) "I don't think it was I mean I got a basic understanding of what was going on but it wasn't until the end that I started to be able to link things together a bit more err yeah….I think it's quite err it's kinda like common sense really but it's kinda like common sense that isn't very common. It's kinda like well that's kinda obvious but why haven't I been doing that before? I did find kindof the title confusing but you know it made sense anyway in the end… I think it's more like being aware of your feelings and kindof accepting them and then it's trying to step back and give yourself the time to kindof deal with how you're feeling it's kindof like take some time out and not go straight into a panic…"

Mindfulness is Applicable to Adolescents

 (Abie) "Yeah I would suggest that between the ages of 16 and 20 maybe that the mindfulness groups would be targeted at…I'd say we all think we know it all at this age and to like be shown these other ways you can always choose to not take it on board but at least the option is out there and the concept is out there to think about"

(Ina) if they're willing to do it but if you're not willing to do it then there's no point… [people would be less motivated to do it because] they don't wanna be doing stuff like you- wanna like I dunno go out and get drunk and stuff.

(Carl) erm yeah, I mean there's a lot of teenagers who have erm a lot of personal problems err erm there's a lot of em who dislike themselves erm but you know err no- nobody's perfect really erm you know err every- everybody goes through problems through life it's just learning how to control it and how to conquer it really."

(Carl) anything could happen erm I mean I'd say anybody could get kindof a mental illness if if like any personal problems get out of hand and out of their control and it starts affect their mind err yeah, I'd say for any age group.'

(Dee) "I think it's helpful for people of all ages particularly even grownups I think… because throughout our lives we all go through difficult situations it doesn't matter what age you are they continue."

(Dee) "and I think it's good that it's particularly if erm you have these sessions when you're young because you can actually remember them when you're old and maybe you can teach your kids…"

(Dee) [do you think it's accessible for young people?] "I think so I think it also depends on what situation they're in if they're feeling really really bad or if they're going through a really bad time you cant just expect them to come along and just be open they'll obviously just want to go thinking that why are you intruding into my personal life I'm feeling really bad right now its like I said about the bull you cant tame it until it's calmer"

(Dee) "I think you definitely need to be at a stage in your recovery of whatever illness you have with whatever problems you have to actually you know engage in these sorts of sessions and to be more

open and to be relaxed enough to actually takin in enough and to say how you feel."

(Ellie) "I thought before I went I thought that it was going to be really patronising because of our age and stuff erm because we are young people as they like to say erm I thought they were going to be like really really patronising and annoying and overly chirpy and just trying to I dunno like just get on everyone's nerves basically… they weren't, they were fine, they were just like normal."

(Ellie) "I don't think it works for everyone…I think it's down to the type of person you are. It's just different people it's not a certain type of person erm just erm different people… I think you just have to really sort of want to do it…but that would be suited to different people – it would be absurd to try and categorise them"

(Finn) "I think it's possibly more helpful for people my age because 16 to 18 gap is when a lot of things confusing things are going in your life so and mindfulness would help you cope with that more easily I think so I think it's vey helpful for our age group it's just it that some 16 year olds might not be keen to do…because it's effort I suppose and it's time that could be spent watching tv or listening to music so it's just making it more attractive to the 16-18 group."

(Finn) "I think recognising your thoughts because people my age group tend to just err and I think people of all age groups tend to get trapped almost in their minds so that they get so used to doing something one way that they'll just keep on – that almost becomes the default and then even if it does make them upset they'll just keep on doing it coz it's all they know what to do and mindfulness is just like a key and it just like just shows you a different way and makes you cope more easily."

(Gwen) "I wish I knew it earlier actually I wish I … when things are starting to go bad before like I dunno…shoving me on all meds and throwing me in places I didn't want to be in…I wish that kindof I was told that coz it had helped me to cope like a lot more than I thought it would now. So I just think like, if I'd went to a group like that when I was younger, before things went bad then maybe I would have copied with things a bit better then, to stop things getting so bad."

(Gwen) "it's been just as helpful now, it's just if I'd known earlier, I think I just would have coped with things a bit better…and so it stopped getting so bad."

(Gwen) "I just think people our age they might- a lot of the time people don't wanna do things or think really bad a bit more when you're this age and a bit less grown up kinda thing… so I just think it would be helpful at my age, coz it has helped me."

(Gwen) "I think yeah, at this age, or even a bit younger 13 or 14. it's just a change of ways of thinking whereas I think maybe if I was a bit older I'd be a bit like no I need to think about the future and the past because I dunno problems with…money. Whereas at this age if you start…I think if you start thinking like that at this age, then when you're older you might be able to accept that way of thinking a bit more. Coz I'm sure it's helpful for older people as well. But I just think at this age, maybe a little bit younger, it would definitely help."

(Gwen) "yeah coz when you're older… I dunno, if I was older and then some person came in and said right I… that's you thinking in the being mode, the doing mode, and trying to like think about it this way – I might be more kinda like no, this is my way of thinking, I've used this all my life."

(Gwen) "if it was taught when you're this age and younger, that's when things always seem so much worse, like little things than I think if you were older – so it's like erm if you argue with a friend at this age, you'd worry about it more at this age than if you were older and had a little argument kinda thing, so if you had mindfulness at this age then you'd be able to cope with that better."

(Gwen) "coz I think anyone could benefit from it especially at this age, coz it's when everything seems like 100 times worse."

(Hana) "I think it depends on what situation there is. Erm I think It's been helpful erm I don't know whether other people who were coping okay would need it but I think for people who are struggling a bit it would be helpful as long as they're mature enough o kindof try things and not just go…

Mixed Impressions of Exercises

(Finn) "my initial reaction I suppose was this is kinda stupid really and I was very getting quite self-conscious about it"

(Abie) "getting the guys involved unlike talking coz otherwise it just wouldn't have worked"

(Abie) "one good thing about the group though was that relaxation period thing."

(Abie) "well initially I was okay with it it was really really good and it is really good concept it was like towards the end that it was like here we go again."

(Carl) "I left a bit weird at first but it err helps you to feel more relaxed. It was weird having to close my eyes in front of the group."

(Dee) "another thing that I found pretty hard was when we were doing that erm exercise you know where we're sitting back in the chair with our eyes closed and we were listening to that guy on the tape

I couldn't really concentrate that much coz I was giggling coz erm his voice was very deep and sexual"

(Dee) "I thought the concentrating on the breathing was pretty good although I was a bit frustrated coz I found that hard and but I think that anyone that comes into mindfulness groups they will erm struggle with a few of the exercises."

(Ellie) "Oh erm there was a breathing one where this man just talks on endlessly and you have to try and breathe and not think about stuff…that went on too long"

(Ellie) "there was a yoga one erm and I think that was like breathing and sort of stretching and that went on too long as well and erm I couldn't really see what it had to do with breathing I know it's meant to put you in the being mode but erm it… it didn't work for me, I was just distracted by things in the room I was just not concentrating or not being bothered."

(Finn) "the concepts I'd heard before were based around the breathing activities…and it was only after like the 3rd or 4th one when we went into more depth I understood the difference between breathing exercises and mindfulness so…"

(Gwen) "it was weird at first, but then it got better. Like it weren't so weird then and the first time I was nervous coz like I don't wanna close my eyes in front of everyone but we turned our chairs away which was good."

(Hana) "we did the breathing exercises when you kindof sit for quite a while and focus on the breath. We did that one a lot so that was kindof good and you kindof have different reactions to it each time it's weird so…"

(Hana) "weird! you kinda think it's a bit strange but it kinda depends on what kindof day you were having so some days you could concentrate and other days you couldn't but it's nice to know that other people felt a bit kindof weird doing it."

(Hana) "it got easier to do coz you kinda knew what you were expecting and you could…you didn't feel quite so self-conscious I don't think"

(Hana) "I think the whole concept was helpful but it's just like little things that you can do like we did one on self-compassion thing and it was like on of the things was you could write down like some of the achievements you've made… I'm doing that one… having little things that you can do it kindof you know a bit more instantaneous is okay!"

(Hana) "I always used to write down all the negative stuff that happened beforehand…so it's kindof a different thing writing down the positive things that you've done but it does kinda change the effect it has on you a bit so that was definitely helpful I think just kinda like the little things you can do like that."

(Finn) "the first session I was really doubtful that it was going to work because it seemed… because I'd heard all of the words before from many professionals and err the first session just felt like kinda one of those breathing exercises and I…I'm not a big supporter of the whole breathing exercises so I was kind of doubtful that it was going to work."

(Dee) "I thought the concentrating on the breathing was pretty good although I was a bit frustrated coz I found that hard and but I think that anyone that comes into mindfulness groups they will erm struggle with a few of the exercises."

(Abie) "a bit too much…it made me super aware and I'm not keen on being super aware. I'm okay with being just aware but being super-aware is just too much to deal with at one time"

(Carl) "I think we had I think we had like a raisin…or something and you had to put it in your mouth…and we had to taste it and erm like taste the texture and stuff and that kinda thing. Erm I'd say it's like just erm I can- I can' actually remember erm erm it's just like making you think about what you're tasting and why/and how it feels and that kinda thing."

(Dee) "erm part of the being mode I think its done in the first session an exercise that I particularly like that actually opened my mind a bit was where you know how erm you're constantly in the doing mode or sometimes in the doing mode and we just rush by and we don't really take notice things that are sometimes important things and so… and so this exercise it just to help us err to sort of take more notice of things to take in a bit more details of what's going on and it's where we had a raisin…I was actually quite pleasantly surprised how quite a simple task could have quite a big effect obviously it didn't with everybody… "

(Dee) "it helps you to be able to be more relaxed inside here knowing that you don't have to rush everything."

(Ellie) "you can either sort of take that either way. You can think this is a complete waste of time or you can try and I dunno practice."

(Finn) "I thought that was a bit silly to start off with… and err so kindof just forgot about that task after in the well in the next session coz everyone just thought it was silly … erm well it was just the err

preconceptions that you have about it so they way you have … they way you put the fruit pastille to your lips and you smelt it and you sniffed it and it was just if someone else was looking in on that room and they saw you do that they'd just think you're a… I I can see why you'd do it now, but at the time it felt… yeah self-conscious yeah…"

(Gwen) "I left the first group feeling a bit confused, coz the last thing we did was…eat a fruit pastille. And we had to like focus on a fruit pastille. Which was a bit strange…but Lisa did explain why we did it. It was just a bit bizarre… but then I get why she did it now, but at the time I just…took two minutes to eat a pastille."

Perspectives on Change
Mindfulness Increasing Awareness and Effecting Change

(Abie) "I think it wasn't like any eureka kinda moment but it calmed me down enough to actually initialise alternative thinking."

(Abie) 'if you're still on the grand tour of a shitty day with the relaxation technique it kindof made me just a bit like I've had a sedative or something...made me think a bit more clearly.'

(Abie) Relax before doing – rather than 'going this this this this oh crap meltdown' slow down thoughts.

(Abie)The relaxation technique it kindof made me just a bit like I've had a sedative or something...made me think a bit more clearly.

(Ina) when like your mood goes down and like how you can stop whe- if you could stop it and like think and but I've forgot now but like you could stop it in the downwards thing

(Carl) just like the way I think really coz just just in general being kinda aware of the present and err to be kinda stop thinking about the past and start thinking more about the future in like a positive way kinda thing.

(Carl) thinking about the future and the past and all these things err that's that's kinda how erm like your mind works if you're in like deep thoughts or depression things like that sometimes you- your mind slips away from the present kinda thing."

(Dee) I think it's taught me to be a bit more relaxed in the situation and not just in that situation but also in lots and lots of other different social situations

(Dee) "I can certainly recognise when I'm on autopilot and when I'm getting into that sort of spiral or into that funnel as we talked about of like the bad thoughts leading onto depression and self-harm etcetera and I can actually get myself out of that and I can force myself not to do anything drastic"

(Dee) particularly something my dad taught me as well he said erm if you're feeling bad just think okay what am I feeling bad about? Okay. Just observe it but don't think it's bad it's good it's wrong it's right just think okay and then just sort of just acknowledge it and then move on just acknowledge that you're feeling bad and move on

(Dee) and one of the main things that's helped me erm that the thoughts you have no matter how bad how serious how good how terrible at the end of the day they are just thoughts they cant do any harm to you unless you let them…they're thoughts just like good thoughts it's just that they have a more harsh impact than good thoughts is all."

(Dee) "…I just say okay I'm feeling such and such and I just observe it and just let it go and that's actually really helped as well and I think by doing those things it's actually helped me to sort of make better decisions"

(Ellie) "I erm don't do it [cope] any differently to now, I sort of go and hide in my bed and lock the door and just hide from everyone or erm just cut everyone off or erm…comfort eating."

(Ellie) "Occasionally I'll try to take like a minute and think about trying to focus on breathing and noticing things and trying to get myself in the being mode…but not for too long. Just on the odd occasion that I actually think about it"

(Ellie) "will I be using it again? I can try… when there's a lot of things going on the last thing on your mind is mindfulness."

(Ellie) "I'll probably just notice the doing and being modes. And erm sort of noticing when I'm in either more or … maybe just practising being in one of them'"

(Finn) "Well I…in the little things so for example I was at my dad's work and he said and err I've just stated a job at my dad's work and he said 'oh you're not very time efficient err sortof cost effective are you… normally I would have got err taken that to heart and taken it rather personally then instead instead I just kinda took a step back and thought oh okay well no one in this factory is cost effective."

(Finn) "so instead of taking it to heart I kinda just acknowledged how I was feeling and kindof took a step back from it so and I don't get all upset through it."

(Finn) "…when I'm doing it I don't think okay I'm doing mindfulness now… it's kindof just slipped in

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unconsciously. And then when I look back at certain times when I look back at say the past week I can pick out times when I have used mindfulness and not really realised that I've used it so…"

(Finn) "I wont really use the whole concentrating on the breath coz it's quite hard to practically do that…but I I I but I will start to recognise my thoughts a lot more and think about why I'm thinking certain things and try and stop certain thought patterns."

(Gwen) "it has been a lot better actually… it's not that I've completely stopped hurting myself and everything's fine but I dunno if something bad happens or like I keep thinking about something that happened that wasn't good or something I try and now think like that's happened that's it kind of shut it off. I dunno and kinda like instead of getting so worked up to just kindof stop and focus on where I am kindof thing."

(Gwen) "if I feel really sad then usually I'm like just … I dunno go hurt myself straight away. but now, I do kinda think to myself ahead like don't think like this or do this, or handle it in a normal way. It doesn't always work but it sometimes does."

(Gwen) "yeah definitely it's helped. Even with little things. Like when I cant sleep I used to like get really annoyed and be more wide awake but now I can lie on my bed and not get annoyed and stuff. It's just really good coz I get to sleep faster then."

(Gwen) "[I'm] accepting a lot of the thoughts that come into my head instead of getting annoyed. That was helpful… that's what I use quite a lot kindof thing."

(Gwen) "I'm like going to uni now on Friday. I'm trying to not like think about it but kinda instead if just thinking all the bad things and that just like saying well that could happen but it might not. So focusing on like now, instead of wasting all my time thinking about everything else and how it's going to go so bad and stuff."

(Gwen) "whereas in mindfulness instead of distracting yourself just accept it and stuff"

(Gwen) "with mindfulness, I've managed to do things that I never used to like, I went to the dentist and like sat in the chair instead of like not going, and just getting outside of the door and standing there being like okay go in now. So it has helped me do things like that… So it's good now, coz I feel like I can do some things that I definitely wouldn't have done at all."

(Gwen) "I was quite shocked coz I was initially going coz like to use that when things are really bad, but now I use… think like that sometimes automatically now, which I don't realise…and things are just easier and nicer on a day to day basis and I'm enjoying things a lot more than I used to…and that's really helped and that makes me feel happier as well."

(Hana) "it was before the last session one of my friends texted me and I agreed to go out which I didn't usually do so it was like really a major thing there and then there was a little like going out a bit more after to like even if it's just down to Asda or something it was kinda like you know…they're small [changes] to other people but yeah."

(Hana) "I think in the past I I used to kindof fight it a bit more but erm after like mindfulness and you've just gotta kindof accept that that's how you're feeling and kinda just let it go which… I didn't think like you could stop it…coz it just happens anyway but like they was kindof explaining how to well not how to stop it but like how to push it aside a bit

Adding to the Toolbox rather than a Cure

(Abie) "yeah like the basic meditation and relaxation definitely kinda worked to a degree hand in hand with the alternative thinking so it was like making it a bit more solid."

(Dee) "I've sort of accepted that it's still a bit hard sometimes"

(Dee) "I mean it hasn't like cured me completely… I don't think any one therapy session could or or any certain number of therapy sessions but it has sort of erm given me enough to be able to go onto the next step…it's like you've got to fill this beaker full of water and it's like erm talking to my parents that fills up a few drips and then erm learning from my illness that's helped fill it up … and erm doing this mindfulness group has just helped me to fill it up it's just like erm giving me more to fill up the beaker."

(Dee) "it's just something so I've got something that I can think about relate to think back to even if I miss some of it because I'm bored or worried about something I can at least think okay I I can actually remember that I can relate to it and I think also being given these handouts is good"

(Finn) "you obviously you cant expect it to be a magical cure that will solve everything for you, but it's just that it's nice to have something there just to support you a bit more so yeah."

(Finn) "well it's just there it's there to support me in situations."

(Finn) "it's kinda just like an extra crutch for me to lean on almost."

(Gwen) "it hasn't made it all go away but kinda like made me like think a bit more clearly when I feel really bad and stuff so"

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(Gwen) "I really feel like I've come quite- like I've learnt quite a lot coz like I went to the dentist and I don't harm myself so much or straight away now. I just feel generally better, not cured, not like cured and whatever, but a lot easier to cope now. But that's… that's really good."

(Hana) "so it was a bit more manageable I didn't manage to get where I wanted to go but it's still kindof if I keeping managing to calm it down it could be possible which is cool so yeah."

Futility / Difficulties Breaking the Mould

(Abie) "knowing how the world works and how even if you do change your own approach the person that's fighting with you doesn't change their approach and all of this is knowledge of the world."

(Dee) I err find it quite hard getting from the doing mode to being in the being mode even though I do manage it eventually…but what I usually do is I just sort of take a step back and I observe things...

(Dee) "although there are times when I find it incredibly difficult to make better decisions when I'm feeling really bad when I…have a bad day I still find it hard to think about the mindfulness…as anybody probably would I think it's hard thinking about mindfulness when you're feeling so bad that it's almost like you block out any … good or reasonable thoughts…"

(Dee) "it's just like if you're erm trying to tame a bull you cant if it's really angry just wait until it calms down and try and do it."

(Ellie) "I think erm maybe it could help erm it just sort of takes a long time to you know I think erm coz we were talking about some of the choices you have when you get sad or when you get angry and it… it will take a long time to erm notice yourself getting into these moods and stop and think 'at mindfulness they said we have these choices'…"

(Ellie) "So I just think it takes a long time to help…to help yourself rather than sort of six sessions…I think six sessions is fine, but it doesn't take you six sessions to erm notice the mindfulness techniques and blah blah blah."

(Finn) "well erm, I still do this coz obviously I haven't been doing mindfulness for that long…so I do attempt to bury and subdue and kinda detach from my emotions that's generally how I cope and then also I so I need to when things happen I always just blame myself for them even for the littlest things I just blame myself as almost a way for me to process it it's not really a way to process it but that's what I do… yeah, I'm aware of what I do…it's just hard to get out of old habits."

(Finn) "it depends on the severity of the situation… if it's just a minor thing then I find it easier to do and I know that if I err practice then I'll be able to apply it to the more sever cases but at the moment it's just with the minor."

(Gwen) "I think the mindfulness has definitely helped. The group. Coz at first it was a bit like hard like what we were told to do like to like think like this and think like that and I still go to think back to like what I used to think like ages ago but as well as thinking about that I think about like I dunno the … the mindfulness way. Yeah, I don't know how to explain it!

(Gwen) "If I feel really horrible then, like really bad, then it's hard coz I dunno, all you think about really is all the bad things and that. But I have used the CD when we got given a few times when I feel really bad and actually that has helped me."

(Gwen) "it was like learning a new thing completely like I dunno it felt like it was kinda trying to teach my brain to think completely differently and forget about my old ways of coping kindof thing. So it was really weird at first."

(Hana) "it's harder to use on a low day I think. It it's kindof easier to kindof put into place when you know you're gonna get panicky but low mood is a different story I think… I think because it's not a habit yet and it's a kindof a lot of effort and you can already kindof feel low it's kindof you know just a lot harder to try."

(Hana) "it it's the whole concept of letting things go that was quite hard to do really…it's like that's your fallback isn't it. You've got to try and stop that and it's hard. It's kindof changing it's kindof tiring. Very tiring… it's kindof coz you have to like consciously think about everything like how you're thinking are you doing the exercises and you feel a bit overwhelmed but I think when it gradually becomes kindof like more subconsciously…it'll be a lot easier it's just getting to that point I think."

(Ina) I don't know erm it's it's a good way to like separate what's going on but it it's going to confuse some people it would confuse people at first but if it was explained like properly then like it would be good

Awareness of Personal Agency
Responsibility / Choice

(Abie) "I thought it was really good and the kindof examples they gave us of kindof driving was really

good kinda thing erm I'm aware that I purposely do the doing mode quite a lot but I still am like to do the being mode but when classes are boring the doing mode is more applicable."

(Ina) "like I had to keep going coz I aint gonna like sort anything out if like I don't"

(Ina) "I dunno coz like after like I'd finished going to some of them like when I finished it I was like happy coz I was like doing something like and it was good…"

(Carl) "I'm the only person who can actually fight this kinda thing … erm I've like really pushed myself and I've kinda got to where I want to be not as good as err I'm not as like as perfect as I want err want it to be kinda thing but at least I'm able to function normally and err and err you know be normal really…yeah, you have to conquer your own fears"

(Ellie) "I think you just have to really sort of want to do it. Erm I think it's … you can get to know it, and get to understand what it is and then it's whether you want to erm do it and whether you think it's a load of rubbish"

(Finn) "Yeah it [my perception] did start to shift as the number of sessions that I'd attended increased so as I say about the 3rd or 4th lesson I was starting to kindof my beliefs had started to shift and I started to put more effort I suppose into the whole mindfulness thing to get some results out of it…when I understood it wasn't just a bunch of breathing exercises"

(Finn) "well when I understood it wasn't just a bunch of breathing exercises…as soon as I realised it wasn't just that then I actually just thought I'd rather do along with it coz I've got nothing to lose."

(Finn) "the most challenging was kinda just making that change in your minds that it's not well that I-it-it would work if you give it a go…. So just that little obstacle I had to get over so…yeah just the erm just the idea that erm…it's not just breathing exercise there is some backbone to the theory…so once you acknowledge that it kinda let me get more involved in the mindfulness."

Practice

(Ellie) "I think [mindfulness] is alright as long as you practice it. Erm…because otherwise it's just not gonna work it's not like a quick fix."

(Gwen) "people then came back and said how annoyed they were and stuff so I felt a bit better then I felt my god at least I'm not the only one being stupid and then erm we got told that things don't just change overnight which sometimes I hope for [laugh]"

(Gwen) "it helped a lot to have like people's different points of view points and I think that if it was on my own I wouldn't have done it so much coz I probably would have just thought …like when I kept forgetting to think that way and like – just and I was getting annoyed that I couldn't do it I think that if I was on my own then I – id just feel like I just couldn't do it and just give up straight away whereas when I went and then everyone was like yeah I cant do it like all the time I felt like okay I'll like carry on with it kinda thing but if I was on my own I'd just keep forgetting it and be like yeah it's not working."

(Ellie) "erm it's like…you have automatic reactions to things in your head and mindfulness is breaking the habit to create another habit. I dunno whether that's good or bad."

(Finn) "I mean six sessions isn't really enough to become well practised… so you cant really expect to use mindfulness in the most serious cases… well you cant really you cant… it's not the number of sessions the number of sessions just kindof gives you the method of doing mindfulness and then it's down to you after the session to kindof put yourself in the situations where you're able to practise the mindfulness."

(Gwen) "I just kept trying to do it. And the more…the more I kept trying to remind myself to do it, the easier it got. And now, it is a lot easier. So that was the hardest thing, just trying to do it, on your own without help kinda thing."

(Hana) "I felt as thought whilst they [sessions] were going on I was handling things a bit better it's it's not quite as well now that they've finished I think it'll be a case of kinda practising."

(Hana) "yeah it's kindof I think- I think it's kindof hard when you're on your own doing it it's hard to ground yourself I think… I think sometimes…yeah I think erm im not sure if it's … practice in other real life situations that's difficult… and it does make sense it does kindof but it's getting in to the habit of using it which is hard."

(Hana) "yeah it kindof you have to yeah you just have to persevere"

(Hana) "it takes a lot of effort but your kindof it it is going to practice getting into the habit of it… time consuming but I think it will be worth it if I can stick to it definitely."