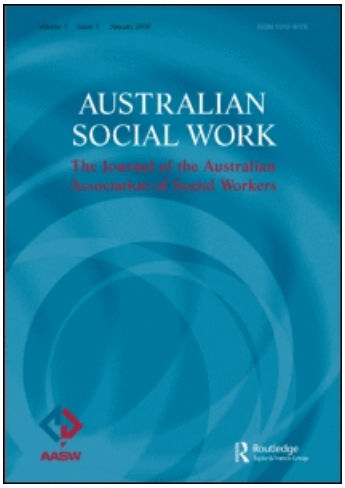

Australian Social Work
Publication details, including instructions for authors and subscription information:
http://www.informaworld.com/smpp/title~content=t725304176

An Exploratory Study of Radical Mindfulness Training with Severely Economically Disadvantaged People: Findings of a Canadian Study

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Online publication date: 12 August 2010

To cite this Article Hick, Steven F. and Furlotte, Charles(2010) 'An Exploratory Study of Radical Mindfulness Training with Severely Economically Disadvantaged People: Findings of a Canadian Study', Australian Social Work, 63: 3, 281 — 298
To link to this Article: DOI: 10.1080/0312407X.2010.496865
URL: http://dx.doi.org/10.1080/0312407X.2010.496865

Australian Social Work
Vol. 63, No. 3, September 2010, pp. 281–298

Routledge
Taylor & Francis Group

An Exploratory Study of Radical Mindfulness Training with Severely Economically Disadvantaged People: Findings of a Canadian Study

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Abstract

This article describes a two-phased research project that piloted a modified mindfulness-based stress reduction (MBSR) intervention developed specifically for a severely economically disadvantaged population. The terms severely economically disadvantaged (SED) and "severely marginalised" were used to describe the participants who experience socioeconomic disadvantage and social isolation as well as significant medical, psychological, physical, and learning challenges. Phase one of the project consisted of community focus groups to determine what types of mindfulness-based interventions would most benefit this population. Based on this feedback, the first author developed a modified MBSR intervention he called radical mindfulness training (or RMT). Phase two was a pilot study of RMT with 11 SED participants who accessed services at a local community health centre; eight participants completed the program, and seven of the participants completed Self Compassion and Satisfaction with Life scales and qualitative interviews. Results revealed an overall mean increase in self compassion and satisfaction with life after completing the program. Qualitative findings provided further evidence of the nature of the participants' perceived effectiveness of this program. The authors conclude that the findings from his limited exploratory study substantiate the need for further study of the RMT program.

Keywords: Mindfulness; Social Inclusion; Social Justice; Social Work Practice

This article presents the development and study of a modified mindfulness-based stress reduction (MBSR) intervention for severely economically disadvantaged (SED) people who are socially marginalised and living with multiple and severe difficulties. Mindfulness can be described as a process of bringing a certain quality of attention to moment-by-moment experience (Kabat-Zinn, 1990). It involves the self-regulation of attention, which involves sustained attention, attention switching, and inhibition of elaborative processing. The ability to evoke mindfulness is developed using various

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Accepted 8 November 2009

ISSN 0312-407X (print)/ISSN 1447-0748 (online)
DOI: 10.1080/0312407X.2010.496865

meditation techniques and exercises that originate from Buddhist spiritual practices. The growing interest in the social work applications of mindfulness was sparked by the introduction of MBSR, a manualised treatment program originally developed for the management of chronic pain (Kabat-Zinn, 1990).

The experience of Roth and Calle-Mesa (2006), Roth and Creaser (1997), and Roth and Robbins (2004) was the impetus to modify MBSR for the SED population. In personal communication with Roth (April 2006), the author stated that her program was modified "on the fly", or on the run, and their "inner-city" low-income participants had numerous distinct needs. For instance, she stated that social factors played a major role in their lives and this warranted further examination in the program.

There is longstanding evidence that some diseases are caused directly by social factors (Cockerham, 2007) and social structures (Whitehead, 2007; World Health Organization, 2007). Poverty has direct adverse health effects (Wilkinson & Marmot, 1998). Further, racial minorities, people with disabilities, and people living with mental illnesses are overrepresented among those economically disadvantaged or poor in both Australia and Canada. In the present article, we attempt to expand the readers' knowledge of SED beyond the idea of "complex cases", or "difficult" clients, and opt to explore the definition of "marginal" produced by Iris Marion Young (1990). We also acknowledge the contribution to this understanding of ideas like intersectionality (Collins, 1998), double or multiple jeopardy (King, 1988), and "interwoven" oppressions (Moreau & Leonard, 1989). For the present project, we acknowledged that mindfulness-based interventions are increasingly addressing a variety of health problems, and we wanted to see how it could be modified to address the specific needs of people experiencing barriers in the context of severe economic conditions. Based on a focus group with people with SED status, a modified mindfulness-based intervention was developed. Termed as radical mindfulness training or RMT, the modified program engages participants at the personal, interpersonal, and structural levels. The present article describes this project, but first offers a brief background on how we came to develop the idea of radical mindfulness training.

Background to Radical Mindfulness Training (RMT)

Radical mindfulness training (RMT) is an expanded version of the existing MBSR program (Kabat-Zinn, 1990). MBSR is the most widely used client intervention now being offered in hundreds of centres worldwide (Bishop, 2002). MBSR has been shown to be effective with numerous physical, psychological, and emotional difficulties (e.g., chronic pain) (Kabat-Zinn, Lipworth, Burney, & Sellers, 1987), disordered eating (Kristeller & Hallett, 1999), and suicidal behaviour (Williams, Duggan, Crane, & Fennell, 2006). A meta-analysis of studies testing the clinical effectiveness of MBSR found a significant effect size of $d = 0.50$ (Grossman, Schmidt, Niemann, & Walach, 2004). Within these interventions mindfulness has a twofold aim: first, to increase insight into how automatic and habitual patterns of over

identification and cognitive reactivity to sensations, thoughts, and emotions increase stress and emotional distress; second, to reduce the vulnerability of these mind states, thereby producing lasting improvements in emotional wellbeing (Hick, 2009; Lau, Bishop, Segal, Buis, Anderson, et al., 2006).

MBSR consists of clients engaging in eight weekly 2 to 3 hour classes and one daylong class. It includes formal guided instruction in mindfulness meditation and mindful body movement practices. In addition, it includes exercises to enhance awareness in everyday life, daily assignments lasting from 45 minutes to an hour, which are largely meditations, and methods for improving communication. The program emphasises being present with sensations within the body, and then expanding this to emotions and thoughts, and then ultimately to communication and life in general. MBSR aims to help people develop an ongoing meditation practice.

Worldwide, there are two published studies on the adaptation and delivery of MBSR to a population similar to what we are terming SED. Both were conducted in the United States, and were conducted with populations that previous authors have referred to as "inner-city populations" (Roth & Calle-Mesa, 2006; Roth & Creaser, 1997; Roth & Robbins, 2004). Roth and Robbins (2004) discussed the delivery of a bilingual Spanish and English MBSR course to 68 patients within inner-city New York. Their analysis established that the intervention groups, when compared with a comparison group with no intervention, showed significant improvement on five of the eight SF-36 (Short Form 36 item health survey) health status measures, and no improvement on sleep quality or family harmony. Using a medical chart review methodology, Roth and Stanley (2002) found a significant decrease in the number of chronic care visits and medical visits postmindfulness program with participants with significant comorbidity of medical and mental health diagnosis. In both cases, the delivery of MBSR was modified to accommodate the financial (e.g., child care and transportation), language, and cultural differences of the participants. While these deliveries expanded the interpersonal aspects of MBSR and directly addressed the practical needs of SED participants, they did not overtly examine the institutional or structural aspects of their participants' problems.

Conceptually, RMT is unique in two broad ways. First, the RMT program involves mindfulness training for relating to the personal, interpersonal, and societal issues and difficulties. While MBSR does deal somewhat with interpersonal issues and often touches on societal issues, RMT makes the interaction of the personal, interpersonal, and societal issues a core feature and emphasis. This is most consistent with the transformative- or social justice-oriented approaches to social work, such as structural social work theory (Lundy, 2004; Moreau & Leonard, 1989; Mullaly, 2007) or critical social work (Fook, 2002; Rogowski, 2008), which use critical analysis of power differentials, oppressions, and political or economic structures, or both, to suggest the need for the worker to instigate societal change as a concurrent process when assisting individual clients. The theoretical background of RMT as it related to social justice oriented approaches to social work was recently summarised by Hick and Furlotte (2009). Second, RMT encompasses sociological education helping

people to understand the systemic roots of their poverty. On the other hand, MBSR emphasises psycho-education and physiology as it explains the nature of stress and the fight or flight reaction. In most ways, RMT is the same as MBSR in that it is about promoting positive health, wellness, and resiliency, and a broader satisfaction with life. RMT is an expanded version of existing mindfulness approaches. However, the differences described above are important and it is worth studying how they might impact the target population.

Developing the RMT Course

The development of RMT involved two phases. Phase one consisted of conducting qualitative focus groups to determine what types of mindfulness-based interventions would most benefit a severely economically disadvantaged population. Focus group participants were shown the elements of MBSR and where asked to comment on applicability to their lives and feasibility as a practice. This defined how MBSR would be altered. In phase two RMT was developed and tested.

Stage 1: Defining the Parameters of RMT

In order to determine the parameters and features of RMT, two focus groups were conducted with people who presented to the first author as severely economically disadvantaged (or, SED). The focus groups were held in Ottawa, Canada, in July and August of 2006. Appropriate ethical approval and informed consent were obtained. Invitations to participate were placed in locations frequently accessed by our target population, for example, homeless drop-in centres, meal and food programs, and local shelters. The selection criteria for participation in the focus groups included: presenting to the researcher as currently experiencing two or more severe difficulties, such as mental illness, addictions, disability, living in tenuous housing or shelters, and receiving bare minimum social welfare benefits. Twenty-three people met the selection criteria for focus group inclusion. Of these potential participants, 16 individuals were selected based on a sample of convenience with eight people assigned to each focus group. At each focus group the overall perspective of MBSR was presented. Each practice component was detailed and feedback was requested on each element's applicability to their lives and appropriateness as a practice that they could envision doing in a course. The data were later transcribed and coded to identify reoccurring themes. Given the small sample, it was deemed unnecessary to electronically code (see Basit, 2003, for a discussion on this issue) and analyse, and hence we opted for a manual system and use of a word processor. To ensure reliability of text analysis, the qualitative data analysis method used was based on Miles and Huberman's (1994) four-phased approach: data reduction, data display, conclusion drawing, and verification.

Focus Groups Results

Analysis of the focus groups found that an adaptation of the traditional mindfulness-based program required the following seven components to be considered feasible in

application and practice with severely economically disadvantaged people. These components are:

1. address the social aspects of poverty, and not only the psychological;
2. emphasise working on personal, interpersonal, and structural issues;
3. start with inner self-awareness, but bring this understanding to work on interpersonal and institutional skills, or in other words, work from the inside out;
4. place more emphasis on communication and assertiveness;
5. place more emphasis on dealing with interpersonal conflict;
6. teach skills in mindful community work and social action directed at changing what participants see as "oppressive structures and institutions" in society; and
7. recognise the limited financial resources of the participants.

Focus groups with people with SED status in Ottawa, Ontario, Canada highlighted the need for practices and exploration of issues that the participants faced at the interpersonal and structural levels, which were less blame- and disorder-oriented. They felt that in so many ways their disadvantage or marginalisation was due to structural or systemic factors, and hence any mindfulness approach should address these explicitly and directly. Furthermore, they felt that dealing primarily with personal issues may reinforce the stereotype of blaming marginalised people for their predicament. In a sense, they felt that the emphasis on the so-called "disorders" identified the cause of their difficulties only at the personal level, glossing over the structural systemic causes. With this in mind, the first author set out to develop a training program to address these issues. From the above-mentioned list, it became evident that MBSR would need to be modified to respond to the needs of the targeted participants. We endeavoured to modify it while keeping the core underlying mindfulness aspects of MBSR intact.

Based on the information gathered through the community focus groups, the first author constructed an 8 week course curriculum with a day-long extended class in week 6. The first 4 weeks of the course followed the MBSR curriculum quite closely. The only alterations involved the introduction of the "social change triad" where participants identify goals at the personal, interpersonal and systemic levels in the first session and the inclusion of "nine instructions to overcome oppression" exercise (see Figure 1) in the fourth session. Both of the tools were developed by the first author to facilitate the connection of the personal, interpersonal, and structural elements. After week 4, the course departed significantly from the traditional MBSR program, engaging participants in exercises and discussions that related directly to mindful communication (e.g., Shafir, 2008), and mindfully engaging institutions in the society. Mindful communication involves being consciously aware of one's inner experiences (thoughts, emotions, and body sensations), while simultaneously being attentive to others' reactions and the felt sense of the dialogue. Mindful engagement is similar, except that it brings these skills to the systemic level and includes a critical sociological analysis. An exercise called "being a supreme community", is an example of the latter, where participants practice engaging within a community to

We have all had to face situations or institutions that might be described as unpleasant or oppressive. Just as you experienced obstacles in your take-home exercises, you experience obstacles or adversity in life. No therapy or meditation will prevent this, but often, how we relate to these events is central in determining how we will respond. Sometimes to get from A to B, we first have to be really present at A.

Here are nine suggestions for dealing with adversity or oppressive events.

Notice, Pause, and Breathe: Notice the tightening or anxiousness (or other tell-tale sign) in the body as an early warning that something is off. Pause and breathe for a moment and then meet whatever is happening inside you with unconditional kindness and acceptance. The pause also enables us to respond to unpleasant situations or oppressive institutions with clarity and wise action. Pausing is the gateway to radical mindfulness.

Accept Yourself, but not the Situation: Look deeply into the situation or event. Try to record the event without any interpretation, for the moment. Explore the body sensations, thoughts, and emotions that accompany the event. Stay present with yourself. Take the advice of psychologist Carl Rogers: "The curious paradox is that when I accept myself just as I am, then I can change."

Clarify with Clarity: Ask questions to clarify the event (without blaming yourself). Social analysis and brainstorming methods, such as Ah-hah, Wow or natural brainstorm may help illuminate the root causes of the situation.

Think Creatively: Trust your instincts and creativity. Think outside the box as with the 9 dots exercise. By pausing and just sitting in awareness of the breath, you have avoided reacting (on autopilot) from habitual patterns. This opens the possibility for new options.

Opening to Fear: Having courage does not mean that you are not afraid. Move from the mental stories about the fear and instead connect with the sensations of fear in the body (i.e., trembling, burning). Relate to the fear rather from the fear.

Take Action: With calmness and clarity, determine what action you can take and do it. Think about how the system could change to prevent this in the future.

Smile: Smiling and laughter always helps ease our suffering. It changes our physiology and how people respond to us.

Work in Solidarity: There is no need to do it alone. Remember that you and others are experiencing similar events.

Be Persistent: Among all the human qualities that allow us to overcome adversity, persistence may be the greatest.

Figure 1 Nine instructions to overcome oppression.

identify concerns and courses of action to address them. Furthermore, other specific interactive exercises were developed for both of these tasks. This novel approach was later named by the first author Radical Mindfulness Training (or, RMT). A more detailed description of its components and a presentation of a preliminary pilot program of its application with severely economically disadvantaged participants is outlined next.

Stage 2: Developing and Evaluating RMT

This phase consisted of two components: (a) the development of practice elements of a novel RMT intervention, and (b) an evaluation of a pilot program in which these components were attempted at a local community health centre. The development and subsequent and evaluation are described next.

Components of RMT

In the first session, each participant is asked to complete the "social change triad" where they list the changes they would like to see at the personal, interpersonal, and systemic levels. This assists the participants to identify why they are taking the course by identifying changes they would like to see. During the RMT program, the participants are asked to record these and then set them aside until the end of the course, when they are reopened to observe what has actually changed. The setting aside of goals and exceptions is consistent with MBSR with its emphasis on a non striving approach. Owing to space constraints, we will not discuss in detail why non striving is important. In brief, it can be stated that non striving is a key component of mindfulness, which allows people to step outside the usual driven and judgmental mode and enter into a more accepting and self-compassionate mode of being. The first 4 weeks of the RMT program involve training participants in (a) meditation and other experiential exercises, (b) dealing with obstacles, (c) connecting with the breath and body, and, (d) staying in the present with whatever is happening. As mentioned earlier, this is largely the curriculum of themes and exercises of MBSR.

Another novel element of the RMT that has been added to the traditional MBSR curriculum takes place in week 4, and is called the "Nine instructions to overcome oppression" (Figure 1), which represents the core instructions for RMT. The rationale and details of the exercise are not presented in this study owing to space constraints. Also, it would require a fairly developed understanding of the attitudes and activities of MBSR. In summary, we can conclude that this set of instructions enables participants to step out of autopilot mode (a mode of reacting in contrast to responding with discernment, which is covered in detail within MBSR) when confronted with difficulties in life. These instructions are proposed to then lead participants to investigate the root causes of the difficulty within personal, interpersonal, and structural dimensions. At the core of this exercise is the idea of beginning to pause and open up to what is happening in the present moment, in contrast to suppressing one's perceptions, thoughts, feelings, and body sensations. This is not a passive acquiescence, but rather opening up to the situation and our reactions so that we may understand them with clarity. Without habitual reactions, participants are able to respond better, based on a calm and balanced understanding.

Weeks 5 to 8 of RMT involve further meditation activities, in-class exercises, role-playing, and take-home assignments. Week 5 deals with letting go of reactive thoughts surrounding events in one's life. Here we used role-play for participants to work through how they might respond to people within institutions that cause fear to arise. By noticing reactions, participants learn that they can confront difficulties with clarity and balance, and perhaps even compassion. Finally, weeks 6 and 7 add significantly to the MBSR curriculum, involving participants in mindful communication and engaging institutions.

With the revised curriculum, the first author set out to investigate the effectiveness of RMT among SED participants in the city of Ottawa. The exploratory study of the pilot program is described, next.

Method

Recruitment and Descriptions of Participants

For the present study, participants were recruited through a local community health centre (CHC) as part of their programming. As with the earlier focus groups, appropriate ethical approval was sought and granted for this research. In terms of inclusion criteria to participate, no individual screening was done; instead, an orientation session outlined the course content with the aim of empowering people for self-screening or selection. It was emphasised that the course involved a significant time commitment. Three separate forms were required for participants' registration and providing informed consent.

Throughout this article, we have used the terms SED and "severely marginalised" to describe the participants. This is owing to the fact that the target populations were clients of the local CHC who experience poverty and one or more medical, psychological, physical, and learning challenges. Structural and critical social work theory has referred to this as "multiple marginalisations" (Mullaly, 2007, p. 260). The term marginalisation describes their feeling of exclusion from useful and meaningful participation in society (Young, 1990).

A total of 22 participants were present in the first informational class. Eleven participants (50%) dropped out after the first class, leaving 11 participants in the second class, of whom eight finished the course. Many of those who dropped out after the first class had not been present at the orientation session so for these people the first class was more of an information gathering exercise rather than a firm commitment to the course. The drop-out rate for the program from the second class to the last class was 27%. Of the 11 people who attended the second class, eight finished the course, seven of whom completed the research instruments. We considered this to be a comparable drop-out rate when compared with that of the mindfulness-based courses being delivered to inner-city populations in the United States (i.e., Roth & Calle-Mesa, 2006). For instance, Roth and Robbins (2004, p. 116) reported a 34% drop-out rate with their "inner-city" population.

The final sample consisted of six women and two men. Two participants were aged between 20 to 29 years of age, four were in the 30 to 39 years range, and one was in the 40 to 49 years range. All but one of the participants were either currently homeless or near homeless, which means they were living with friends or relatives in a temporary arrangement. Also, all had experienced one or more episodes of major depression: two participants were diagnosed with bipolar disorder and one had a mild learning disability. Two participants had physical mobility disabilities. All participants were receiving social welfare benefits. Five participants were collecting disability specific welfare benefits and two received regular welfare benefits. Most reported having relied on food banks to supplement their food requirements. Two of the participants reported being single mothers.

Measures

Our exploratory study of the RMT program involved the administration of two pre and post test scales to seven of the eight participants (one participant did not submit the pre test questionnaire). The scales administered were the Self-Compassion Scale (SCS; Neff, Kirkpatrick, & Rude, 2007) and the Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985).

The SCS is a self-report measure created by Neff et al. (2007). The scale has strong concurrent, discriminate, and convergent validity. In other words, it has significant correlations with therapist reports of self-compassion, positive correlations with emotional intelligence, and negative correlations with self-criticism. Higher levels of self-compassion have been associated with greater psychological wellbeing, social connectedness, self-determination, and self-concept accuracy, as well as greater emotional equanimity when confronting daily life events (Neff et al., 2007).

The SWLS is a short, 5-item instrument (Diener et al., 1985) designed to measure global cognitive judgments concerning one's own life. Life satisfaction is one factor in the more general construct of subjective wellbeing. Life satisfaction is distinguished from affective appraisal in that it is more cognitively than emotionally driven. The SWLS has been shown to correlate with measures of mental health and to be predictive of future behaviours (Diener et al., 1985). The SWLS measures the judgmental or cognitive component of subjective wellbeing, which has been conceptualised as consisting of two major components: the emotional or affective component, and the judgmental or cognitive component.

In addition, following the completion of the scales, each participant completed an overall ranking of the course on a scale from 1 to 10, and was asked the question "Why did you give the course this rating?", which provided the researchers with qualitative data. The same qualitative methods used in the phase one focus group data were used to analyse the evaluation data. We coded using a word processor and used Miles and Huberman's (1994) 4-phased approach of data reduction, data display, conclusion drawing, and verification.

Results

Quantitative Findings and Results

Analysis of participants' responses to the quantitative scales suggests that most of these SED people experienced positive results from the course. Although due to the small sample size we cannot say that these improvements were of significance, the overall findings demonstrated evidence for the feasibility of RMT. On average, participants gave the program 8 out of 10 as an answer to the question "How important has the [RMT pilot] program been to you?". In addition, the SCS scores increased for every participant. The average (mean) increased from 2.8 (out of 5) to 3.4. We cannot claim that the pre course and post course score differences were

statistically significant ($t = 1.94$; $p = 0.10$). The findings may reach significance with a larger sample.[0] In addition, all the participants with the exception of one, showed improvement on the SWLS data. The SWLS scores increased on average, as well, from 3.51 to 4.42.

Self-Compassion

We undertook a categorical analysis of the SCS. The SCS questions categorise into 6 categories: self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identified. Self-kindness refers to being accepting and understanding toward ourselves when we suffer, fail, or feel inadequate. Self-judgment is linked to self-kindness in that when we suffer or fail we do not ignore our pain or flagellate ourselves with self-criticism. Common humanity recognises that suffering and personal inadequacy is part of the shared human experience. Isolation is an irrational but pervasive sense of isolation—as if "I" was the only person suffering or making mistakes. Mindfulness is a nonjudgmental, receptive mind state encompassing a willingness to observe our negative thoughts and emotions with openness and clarity, without trying to suppress or deny them. Over-identified involves being swept away by negative thoughts and emotions by taking a self-critical and judgmental stance. Table 1 indicates that items relating to self-judgment (SJ) and not feeling alone or isolated (I) improved the most. Self-kindness (SK) scores increased the least. The other categories were somewhere in-between. These findings are not surprising as self-kindness requires time to develop as one lessens over time their tendencies to self-judge and feel alone. Perhaps with a longer course or a follow-up intervention beyond the 8 weeks of RMT, categories such as self-kindness would improve further.

Participants' responses to one of the specific statements on the scale, "When I fail at something that is important to me, I tend to feel alone in my failure" showed more change than the other questions. The question was scored negatively (a decrease in the score on this item was seen as positive). The lessening of this attitude indicates that some participants found that they are not alone in any failures—perhaps they realised that there are other people to whom they can go for help. This may signify

Table 1 Self-Compassion Scale Mean Scores

	Pre RMT		Post RMT	
N = 7	Mean	SD	Mean	SD
SK	2.94	0.39	3.29	0.56
SJ	2.60	0.41	3.26	0.38
CH	3.40	0.071	3.90	0.36
I	2.43	0.23	3.50	0.38
M	3.00	0.24	3.46	0.14
OD	2.50	0.47	3.07	0.34

Legend: SK = Self-Kindness Items, SJ = Self-Judgment Items, CH = Common Humanity Items, I = Isolation Items, M = Mindfulness Items, OD = Over-identified Items, SD = Standard Deviation.

that some participants felt less isolated and had developed or became more aware of their social support network after the course.

Several other questions relating to self-judgment (SJ) improved more noticeably than the others. For instance, changes on the following two items indicate that some participants became less judgmental towards themselves and more inclined to show self-kindness: "When I see aspects of myself that I don't like, I get down on myself" and "I'm disapproving and judgmental about my own flaws and inadequacies".

Several other high-scoring items indicate that participants developed a sense of shared humanity, which indicates an understanding that all people have difficulties and that this does not necessarily have to result in a negative mood shift, a sense of failure, or inadequacy. This was substantiated by participant statements such as: "When I'm really struggling, I tend to feel like other people must be having an easier time of it"; "When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am", and "When I'm feeling down, I tend to feel like most other people are probably happier than I am".

Overall, these participants' scores on quantitative measures showed some improvement in how the participants viewed themselves and their relations with others.

Satisfaction with Life

As mentioned, the SWLS scores had an overall mean increase from 3.51 to 4.42. The question-specific score increases are reported in Table 2. Again, the small sample size negated any tests of significance.

It is interesting that all question scores increased. Question 4 had a noticeably larger increase with a pre–post mean increase of 1.28. It seems that while the participants may not view their lives as excellent or ideal, that there is an increased likelihood that they believe they have got the important things they want in life after the program.

Together, participants' responses to the self-compassion and satisfaction with life measures suggest lower self-judgment and an increased sense of connectedness with others had an impact on their engagement with institutions and structures that

Table 2 Satisfaction with Life Scale (SWLS) Means and Standard Deviations.

SWLS Statement (**1 = Strongly disagree and 7 = Strongly Agree**)	Pre RMT **N = 7**		Post RMT **N = 7**	
	Mean	SD	Mean	SD
1. In most ways my life is close to my ideal.	3.29	1.37	4.28	1.37
2. The conditions of my life are excellent.	3.29	1.97	4.28	1.80
3. I am satisfied with my life.	3.86	1.21	4.71	1.17
4. So far I have gotten the important things I want in life.	4.00	1.97	5.28	1.50
5. If I could live my life over, I would change almost nothing.	3.14	1.76	3.57	1.97

SD = Standard Deviation.

influenced their lives. This was further indicated in the qualitative analysis of the study.

Qualitative Findings

For our study, qualitative data were made up of written responses to the evaluation question "Why did you give the course this rating?", which was completed after ranking the course on a scale of 1 to 10. Qualitative written feedback was positive overall. For instance, participants commented: "the program has changed the way I view myself, other people, and the world", "I am no longer depressed", "I now have much less anxiety and negativity towards my interacting in the world", "it helped me learn how to respond to difficult situations", "I acquired peace and happiness", and finally, "the program reminded me that I am OK just as I am, and only acceptance of that can lead to change". These qualitative responses indicate that all participants seemed to grasp the core teachings of RMT. In our further analysis of participants' comments, the following themes emerged: perceived personal benefits of the program, changes in participants' reports relating to others, and increased reperceiving. We describe these emergent themes next. (Please note the verbatim responses were edited for spelling, but not grammar.)

Perceived Personal Benefits of the RMT Pilot

Often participants wrote about the personal level benefits of the course. In particular, they discussed how they became more aware of their thought patterns and how this affected them as a person. One participant felt that she was more perceptive and a better person:

> It [the course] helped me become aware of what my mind does. It taught me how to notice my thoughts. I learnt how to be a better person and how to respond to difficult situations. I learnt what it is like to have some peace and happiness.

Another participant reported being less depressed after completing the pilot:

> The course helped me to look at emotional thought events in a more detached way. I feel more confident that I can integrate some of the techniques than before I took the [RMT] course —partly because I am not depressed now as I was then.

Another participant reported experiencing a higher level of acceptance:

> I realised during the course that I hold on to thoughts—I worried about not remembering my thoughts so I held on to them. The course taught me to let them be.

And another participant reported a renewed link to spirituality: "I linked many aspects of prayer with what I learnt in the course and have benefited in way[s] that I cannot put into words". Finally, one participant said the course helped cultivate an improved mind–body connection:

> The course has reminded me of how important it is to take time to meditate, stay in the present, and keep in touch with my body and what it is telling me. . . . I also appreciate being reminded that I am OK just as I am, and only acceptance of that can lead to change.

Overall, these comments suggest that some participants experienced personal benefits from the RMT course. These benefits also extended to the interpersonal.

Relating to Others: Interpersonal Benefits of RMT

Participants wrote about how the course helped them at the interpersonal level and how this was inextricably linked to the personal level. Participants described communication with family, those with whom they have negative relationships, and service providers. People found that it is only through self-acceptance that they could grow to accept others. As one participant put it:

> It [the course] helped me in my life day to day. It has changed the way I see other people and the world. I view people with more compassion and understanding, which helps me to have some compassion for the world and the shitty way the world is in. Also, compassion for myself —it has increased tremendously! It has helped me in my talking with my family and people that I have fight[s] with. I love the pause and breathe exercise instead of reacting; I don't yell so much and use it almost every day.

This participant speaks about being better able to relate to family and people he does not get along with through pausing. Other participants echoed this view, emphasising how the course taught them to notice and then pause when communicating with others, and how this pause affected their responses. They found that by pausing they were more likely to respond with clarity rather than react habitually. One participant said the following to describe his relationship with a welfare social worker:

> The communication component of the course was important. It helped me to see how a pause and little watching of my own reactions to others can [help me to] do my responses different and lessen my reactiveness. This helped me to face my welfare worker and ask for what I need like we discussed in the course.

In essence, this participant implicated the course in helping them to better express their needs within service relationships. Another participant said:

> I listen more. I am more open to people. I think more about my reactions. At one point, I was thinking about no longer coming, but looking back over the eight weeks I have learnt a great deal from RMT.

This participant echoes the notion that interpersonal communication can be improved by recognising one's own reactivity. Together, these statements suggest that the program was effective in effecting interpersonal change for these participants.

Reperceiving: A Shift in Perspective

RMT appears to have contributed to a shift in perspective concerning each participant's relationship to their lived experience. By intentionally cultivating nonjudgmental attention, they seemed to nurture a sense of connection with others, which in turn led to a capacity for self-regulation, and to greater health and wellbeing. In the mindfulness literature, this shift in perspective is known as *reperceiving*. Reperceiving is similar to the concepts of *decentering* (Safran & Segal, 1990) and *deautomatisation* (Deikman, 1982; Safran & Segal, 1990). In the RMT course, we practice nonjudgmental attention to the contents of consciousness. When we strengthen the capacity to observe the contents of consciousness, we are no longer completely embedded in or fused with such content. For example, consider the feeling of "feeling down"; if we are able to really see *it*, then we are no longer merely *it*. We may experience that we are *more* than *it*. This *it* may be depression, fear, or pain. The process of reperceiving allows us to disidentify from thoughts, emotions, and body sensations as they arise, and simply be with them instead of being defined by them. Through the reperceiving practiced in RMT, participants were able to realise that "this pain is not me", "this depression is not me", and "these thoughts are not me".

Interestingly, repercieving also was displayed in how one participant wrote about how the course changed the way that she views sufferings in the world. The RMT aims to integrate the personal, interpersonal, and structural levels. There was dialogue in class about how this understanding was manifesting, and one student summarised it as follows:

> I worry a lot about the world with so many people suffering and hurting each other. This program has helped me to somehow understand that everyone just wants to be okay and that life takes us on so many different paths. I still worry about the world, but now I have much less anxiety and negativity toward my working in the world, and find myself worrying less about the concerning state of the world as I find myself feeling more strong and on the ground in myself on my path in life.

In addition to this shift in relationship to inner experience, RMT seemed to facilitate a shift in how some participants related to others and the world. After RMT, some participants perceived themselves as more adaptive and flexible in responding to the environment. By being able to observe their internal commentary about the institutions and structures that they encounter in life, they felt that they were more likely to see the present situation more clearly. According to some participants, this allowed them to respond accordingly, rather than with reactionary thoughts, emotions, and behaviours triggered by prior habits and conditioning. This reperceiving afforded the participants a different place from where they could view the institutions and structures in society —a place from where they could respond with clarity.

In summary, these brief statements indicate a few of the areas where the participants felt an impact. There were no negative comments about the program. Their comments reflect changes in how they view and interact at the personal,

interpersonal, and structural levels. Discussion throughout the course showed how changes occurred at all the three levels. This may indicate that the course was somewhat successful in expanding the scope of conventional MBSR. At the same time, only one participant wrote in the evaluation how it changed her interactions with the world.

Discussion

In this exploratory study, RMT was slightly different from the past adaptations of MBSR for the intended target population (Roth & Calle-Mesa, 2006; Roth & Creaser, 1997). Most significantly, RMT explored mindfulness in relation to the personal, interpersonal, and structural levels. This exploratory study found that RMT may be effective in increasing the felt sense of wellbeing as measured by SCS and SWLS. The qualitative results indicated that an increased satisfaction with life may result from a positive shift in relating to what is seen as oppressive structures in society. Although our results are encouraging, the course involved a small number of participants. Nonetheless, the results are consistent with the view that it is beneficial to modify the mindfulness-based group interventions in very particular ways, when delivering it to people facing extreme poverty and associated difficulties. It should be duly noted that the findings of this pilot study are preliminary and a larger sample with a control group would be necessary to confirm the findings. It is one of the first mindfulness-based studies conducted with this particular target population. Further, the RMT pilot is the first mindfulness intervention targeted specifically at people who are SED, and work across practice modalities among this group warrants further attention and study. The fact that all participant measures increased on both scales does indicate a need for further study. However, it could also be the case that the participants were at a turning point in their lives, which prompted them to seek help by taking the course. In a sense, the course may have only fed into a dynamic that was already occurring in their lives.

The quantitative and qualitative results of this study indicate positive results for participants in the RMT program. The program aims to positively affect wellbeing by changing how the participants relate to cognitive and affective self-judgments, other people and institutions in society. By doing so, RMT aims to shift how people relate to their inner experience, to other people, and to the institutions and structures in the world. The survey results demonstrated that the participants showed a reduction in self-judgment and an increase in self-kindness, although the results cannot claim statistical significance due to the small sample size. They also felt more connected to others, felt less isolated and better able to interface and affect change in the institutions that prove challenging their lives (i.e. welfare office). These shifts enabled participants to increase their overall subjective wellbeing.

The results indicate several changes that could be attributed to the RMT program. The SCS scores improved the most, and this may be attributed to the way in which participants took the program. The course is participatory and experiential, and

participants greatly influence the direction of the discussion. All participants had significant and numerous mental health and other issues in their lives. They understandably steered the course, such that we were dealing with these issues. This left less time than anticipated, to deal with interpersonal and structural or other "life satisfaction" type issues. For this reason, it might be prudent to lengthen the course from 8 weeks to 14 to 16 weeks, but as two separate courses, the second of which would be dedicated to the interpersonal and societal-level issues. We believe that the logical next step would be to run a revised version of the course within a larger and more comprehensive study, perhaps introducing additional assessment measures and further qualitative analysis.

Limitations of the Study

Given that mindfulness as a clinical intervention is relatively new, findings in this paper are pertinent to the research evidence in this area despite its small sample size. Further, the selection of MBSR modifications was based on the expressed desires and input of target population participants and the experience of the program developer. There was no research conducted to ascertain the precise mechanisms of change within MBSR or the modified RMT. Furthermore, the study did not compare RMT and MBSR so it is impossible to ascertain if the additional RMT components added to MBSR had any additional value to the participants. Further research is also needed to determine reasons for attrition after the first class. It seems that a large cohort were initially interested in mindfulness, but for reasons unknown the program as presented in the first class did not resonate with many participants.

Future Directions

Knowledge in these relatively new interventions would benefit from further research into the efficacy of mindfulness-based social work interventions. For instance, the present pilot intervention could be expanded in a control study comparing RMT with traditional MBSR, which may effectively tease out how radical social justice approaches merge with mindful practice to produce improvements for clients. We suggest that more research be done by social workers at the community health centre level, and that provincial and national agencies lend funding to this very important and cost-effective form of social work intervention. It would be beneficial to distinguish characteristics between participants who opt to remain in the program and those who do not. In addition, future research may wish to include a longitudinal study of people who participated in this or similar programs to allow us to better investigate long-term benefits and perceptions.

This article provides evidence that mixed methods (i.e., qualitative and quantitative methods) is a valuable approach for this particular kind of treatment development. For example, while it is critical to document the efficacy of mindfulness-based interventions using valid measures, we must also tune into to the quality of the intervention our clients' experience. In addition, this article

identifies the ability of social work researcher–practitioners to be able to successfully implement exploratory treatment approaches and follow this up with rigorous evaluation techniques. Finally, as RMT develops, social workers will need to explore the role of theory surrounding the integration of mindfulness and social work practice methods, and implications for social work pedagogy. The authors welcome feedback of this nature, and hope this article begins a dialogue about the integration of structural and mindfulness-based interventions.

Acknowledgements

We acknowledge the insights garnered in the dialogue with several experienced MBSR instructors, including Lynette Monteiro, Frank Musten, Saki Santorelli, and Florence Meleo-Meyer.

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