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# Mindfulness with adults with autism spectrum conditions

Mindfulness meditation can be thought as a way of being that helps us be in contact with our experience on a moment to moment basis. This allows people that practice mindfulness to be more present in the moment rather than concentrating on what may happen in the future or what might have happened in the past, which can often lead to anxiety or depression. Mindfulness can also help people become less judgemental, as it encourages people to view their experiences without assigning labels or interpretations to internal or external events that occur.

There is a lot of research evidence on the benefits of mindfulness. For example, there is evidence that it can help you:

- to cope with pain,
- to relieve stress,
- to improve sleep,
- manage depression and/or anxiety,
- manage anger,
- improve memory,
- aid learning,
- improve emotional stability.

In recent years the use of mindfulness in mental health settings has become widespread. Stemming from its use in pain management, introduced by Jon Kabat-Zinn, mindfulness has been used for more generic mood management (e.g. Mindfulness Based Stress Reduction, MBSR) and for specific applications of Cognitive Behaviour Therapy (CBT) to certain mental health conditions (e.g. Mindfulness Based Cognitive Therapy, MBCT). These interventions have been widely researched for use in depressive and anxiety disorders with some very positive results. More recently the use of mindfulness has been applied for use with people with Autism Spectrum Conditions (ASC); initial research findings are proving to be promising.

I have been developing CBT based interventions with adults on the Autism Spectrum with co-morbid mental health problems for many years now. During this time I have used several styles of CBT, usually matched to the people that I have worked with. I first became aware of the use of

mindfulness techniques in its use with adults with psychosis. Having read much of the research and finding out about other people's experience of using mindfulness it soon became clear that in order to use mindfulness in my clinical practice I would need to learn to practice it myself. This led to me attending an initial 8 week course designed for staff in the South London and Maudsley NHS Trust.

During the 8 week course I found the experience to be immensely rewarding and immediately asked if I could sign up for co-facilitation of such a group in order to gain further experience. Over the next two years I continued to practice mindfulness and attended a teacher training retreat with Bangor University (one of the leading mindfulness training universities in the UK). Fully immersed in the practice I then started to apply the techniques to my clinical work. Working with adults with autism and co-morbid mental health problems for the National Autism Unit (Inpatient and Outpatient services) allowed me opportunities to collaboratively use these techniques on a one to one basis over the past few years.

At first I tended to use MBSR techniques in individual therapy sessions as a way of providing a basic emotional management technique. Eventually I started to weave in more CBT techniques in my approach, for example, to assist with the management of difficult trauma based memories. Please note, when I say trauma, this is in the context of a person with autism who may have vivid memories that cause them subjective distress rather than post-traumatic stress disorder (PTSD) type memories, although my clinical experiences suggests to me that they're very similar in nature.

When working with such memories I tend to use what is termed "imaginal exposure", which involves going over the memory and experiencing the emotion rather than trying to avoid associated negatively perceived emotions. This is usually carried out once a person has a full CBT based understanding of their difficulties and mindfulness practice is fully established. We then start a session with a mindfulness practice and in the middle of the practice the difficult memory is introduced and the person is asked to focus on the sensations that they feel in the body. These sensations are then experienced rather than avoided allowing for more objective processing of the experience. In most cases this eventually leads to a resolution of the difficult memory.

In my experience of using mindfulness with adults with an ASC, as with the condition itself, I have found some extremely varied responses ranging from an utter distaste to the experience to full immersion in mindfulness practice. I am still a little unclear to what variables predict engagement in mindfulness practice but there are some common themes emerging from my clinical experiences. For example, many people who have difficulties monitoring their internal states quite often struggle to establish a regular mindfulness practice, whereas people who are able to introspect a little more tend to be more able to use the techniques. It also seems that people with alexithymia (a sort of dyslexia of emotions or unawareness of emotional states) tend to have more difficulties engaging with the recognition of sensations in the body. This tends to lead to difficulties in initial practice but gains can be made if the person remains engaged and motivated to continue the practice.

It's clear from my own experiences of using mindfulness that regular practice is difficult to keep up, particularly when you have completed a course and no longer have others to share your enthusiasm/difficulties with. Many people that I have worked with find the same in their practice.

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It's quite often that we set out with good intentions for regular practice but find that other priorities take over and the practice tails off. Although, research in the Netherlands (Kiep, Spek & Hoeben, 2013) indicates longer term gains (9 weeks post ASC adapted mindfulness group) in emotional management in adults with an ASC, in my experience the impact effects quite often reduce when practice is not consistently applied. It should be noted in their research that they only included people that consistently attended the group, which seems to support my opinion.

Individual MBCT sessions also appear to work well when it is adapted in terms of tailoring the approach to the individual who is not ready to attend a group. I have found that when I have used this approach the person is likely to attend a group at a later stage, ideally when they have gained a little more control over their emotional states. In the Individual sessions and groups we run from the NAU CBT outpatient service at the Maudsley Hospital we have found this to be the case on many occasions. I believe the reason for this may be connected to an increase in self-esteem and a building of social confidence resulting from the individual intervention but further research would be needed to check if this is correct.

Overall, there seems to be an acceptance that mindfulness works with emotional management. Further adaptations have been made to apply mindfulness to conditions such as ASC but the main component of such interventions appears to be to adapt the delivery method of the treatment rather than the treatment itself. This is much the same for most psychological interventions that are used for treating adults with an ASC. The relationship in which the treatment is delivered is often as, if not more important that the application of certain therapeutic techniques. From my clinical practice this seems to bear true in the delivery of all CBT based therapies adapted for use for the ASC population.

**References**

Kiep, Michelle; Spek, Annelies A. and Hoeben, Lisette. (2014) "Mindfulness-Based Therapy in Adults with an Autism Spectrum Disorder: Do Treatment Effects Last?" Mindfulness: 1-8 , March 28, 2014.

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