Rainbow Mind
Radical Self-Care modality
RCT research project

Sept 2020

A partnership between City, Hackney and Waltham Forest Mind, Mind in Salford and City, University of London
Preface

Practitioners at Mind in the City, Hackney & Waltham Forest and academics of the Centre for Psychological Wellbeing and Neuroscience at City, University of London have for a number of years collaborated on projects with the aim to evaluate, understand and refine the delivery of mindfulness-based interventions and training programmes provided by Mind.

Rainbow Mind is an exciting new programme of services for the LGBTQ+ community led, staffed, and directed by LGBTQ+ people with a knowledge or experience of mental health issues. The Radical Self-Care programme developed by Rainbow Mind’s practitioners is a novel intervention bringing together compassion-focussed therapy, mindfulness and acceptance-based therapies which are thought to be particularly important for LGBTQ+ people. Internalised stigma within the LGBTQ+ community has been found to play a major role in poor LGBTQ+ mental health, so interventions that target shame and self-criticism can be expected to improve mental health and well-being.

The research collaboration for the Radical Self-Care programme evaluation has brought together researchers in the field of Social Psychology (Dr Andreas Kappes), Occupational Health Psychology (Drs Paul Flaxman and Lucie Zernerova) and Cognitive Neuroscience (Prof Tina Forster), and together with practitioners at Mind in The City, Hackney & Waltham Forest and Mind in Salford (Miia Chambers, Markus Greenwood and Stephanie Cerce), a research programme was developed following rigorous scientific standards to evaluate and assess the impact of the Radical Self-Care training programme on psychological health and wellbeing of the LGBTQ+ participants.

The following report gives an overview of the programme and research approach and shows the very positive outcomes of the Radical Self-Care programme in terms of psychological wellbeing and mental health. The data gathered will provide multi-faceted insights into the drivers and mechanisms of the Radical Self-Care programme which will inform future deliveries of the programme. It has been an exciting research journey for all who contributed to the conception and realization of the Radical Self-Care programme and of the research programme to evaluate its effectiveness.

Tina Forster
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Executive Summary

RadSec Background & Description

**Why RadSec?**
LGBTQ+ people experience higher prevalence of mental health issues such as depression, anxiety, self-harm and suicidality than general population.

**What is RadSec?**
Radical Self-Care (RadSec) programme is an 8-week training course designed by experienced LGBTQ+ practitioners to help build resilience, self-care and mindfulness skills to address mental health needs and experiences of LGBTQ+ individuals.

- Based on the theoretical and practical foundations of Compassion Focused Therapy (CFT), Mindful Self-Compassion (MSC) and Mindfulness (MF) methodologies.
- Focuses on strengthening two core capacities of mindful awareness and compassion.
- Supports individuals in relating to difficult experiences, emotions and mental and emotional challenges more skilfully.
- Specific components for helping participants respond skilfully to shame and self-criticism.

“RadSec taught me to be a better friend to myself.”
*RadSec Course Participant*

RadSec Study Methodology

- RadSec evaluation study designed as a randomised controlled trial with two conditions: RadSec training group and a waitlist control group.
- Study participants who self-identify as LGBTQ+ were recruited via partner organisations and wider network of LGBTQ+ groups and community members in London and Greater Manchester.
- A total of 118 participants were randomly allocated to a training group (59) and a waitlist control group (59).
- Participants’ age ranged between 20 and 69 years, with an average age of 38.
- Majority of participants identified as exclusively gay or lesbian (50%) or as gay/lesbian or bisexual plus an additional categorization, including queer, asexual, pansexual, polyamorous etc. (21.8%); see p. 18.

The training group received the RadSec training programme from October to December 2019 and the waitlist control group took part between January and March 2020.
**RadSec Study Results**

The impact of RadSec was evaluated by a team of researchers at City, University of London on a range of measures including participants’ general psychological well-being, depression, anxiety and other psychological processes targeted by RadSec.

**General Psychological Well-Being**

- RadSec training group experienced a statistically and clinically meaningful reduction in psychological strain as a result of attending the training (assessed by the General Health Questionnaire; GHQ-12); see p. 25.

**Anxiety and Depression**

- Similar statistically and clinically meaningful improvements recorded for symptoms of anxiety and depression; see p. 27.

**Other Psychological Skills and Processes Targeted by RadSec**

- In comparison to the waitlist control group, RadSec training participants reported a substantial increase in their mindfulness skills; see p. 30.

- Similarly, participants who received the RadSec training reported an increase in their ability to care for themselves with warmth and kindness (self-compassion); see p. 31.

- RadSec training group reported large reductions in their experiences of shame, self-critical perfectionism, and ruminative thinking patterns; see p. 32.

- RadSec training was found to improve an implicit protective mechanism serving as a buffer against stress and depression – the optimistic learning bias; see p. 35.

> “I am much more able now to notice my tone to self and, where previously I’d have been quite critical and berating, I now meet myself with a lot more compassion and acceptance.”

*RadSec Course Participant*
1. Project Background & Description

Radical Self-Care (RadSec) programme is a training course put together by the Rainbow Mind’s experienced LGBTQ+ practitioners, aiming to help build resilience, and teaching self-care and mindfulness skills to address some of the unique mental health needs and experiences of LGBTQ+ individuals.

1.1 LGBTQ+ Population’s Mental Health Needs

Extant evidence suggests that prevalence of mental health issues is higher for LGBTQ+ individuals than in the general population. LGBTQ+ people experience higher rates of depression, anxiety, self-harm and suicidal ideation and attempts\(^1\). Further, prevalence of mental illness is even higher for individuals who are trans or non-binary\(^2\). In fact, trends in national self-report surveys (e.g., GEO’s National LGBT Survey and Stonewall reports) consistently find higher mental ill health prevalence and incidences of discrimination among LGBTQ+ people with additional minority identities, including LGBTQ+ individuals from BAME communities, trans and non-binary individuals, and individuals with less common sexual orientation (e.g., queer, pansexual, bisexual, asexual).

Despite greater need for services, many LGBTQ+ individuals who are struggling with their mental health indicate significant barriers precluding their access to mental health services. Most LGBTQ+ individuals (71.7%) indicate that trying to access mental health services was not easy. Difficulties around accessibility was even higher for individuals with a less common sexual orientation, e.g. for individuals who identify as trans, or non-binary (76% indicating access was not easy)\(^3\).

Difficulties in accessing mental health services is further exacerbated by concerns about healthcare practitioner reactions to sexual orientation or gender identity. Many LGBTQ+ individuals (26.9%) express worry, anxiety, or embarrassment about accessing mental health services. Again, worry and anxiety was higher among trans (30%) and non-binary people (33%)\(^4\). These anxieties are often grounded in the reality of discrimination that LGBTQ+ individuals face in healthcare settings, with 13% of LGBTQ+ people experiencing unequal treatment by healthcare staff due to their gender identity or sexual orientation. Incidences of unequal treatment are higher still for trans (32%), non-binary (20%), disabled LGBTQ+ (20%) individuals.

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\(^3\) Ibid.

\(^4\) Ibid.
and BAME LGBTQ+ people (19%)\(^5\). A large percentage (22%) of LGBTQ+ clients indicate that their experiences of mental health services they accessed were mainly or completely negative\(^6\).

Furthermore, healthcare staff and services are often not appropriately trained or equipped to respond to LGBTQ+ specific needs. This includes healthcare staff acting discriminately (see above) or asking inappropriately curious questions of LGBTQ+ clients (with 25% of LGBTQ+ people indicating experiences of inappropriate curiosity, which rises to 48% for trans people). Additionally, 25% of LGBTQ+ clients expressed that healthcare staff exhibit a lack of understanding of LGBTQ+ specific health needs. This incidence is even higher for BAME and disabled LGBTQ+ clients (33%)\(^7\).

### 1.2 Why Radical Self-Care as a Tailored Mental Health Intervention?

To summarise, the following can be seen as a rationale for RadSec as a tailored mental health intervention for LGBTQ+ populations:

- high prevalence and evidence of higher mental health challenges within LGBTQ+ individuals than in the general population
- despite greater need for services evidence suggested that many LGBTQ+ individuals face significant barriers precluding access to mental health services
- research suggests that healthcare staff and services are often not appropriately trained or equipped to respond to LGBTQ+ specific needs
- research also shows that LGBTQ+ individuals with intersecting parts of their identities, i.e. other characteristics such as race, faith, class, educational background experience greater mental and emotional health challenges
- in addition, the wider societal and cultural context, such as increasing levels of hostility, microaggressions and hate crime, impacts mental health of LGBTQ+ people

The development of the Radical Self-Care programme has been all the more relevant against the backdrop of increased levels of hostility and hate crime against LGBTQ+ people and rising mental health needs recorded in recent years. The RadSec model has been contextualised to the intersectional lived realities of LGBTQ+ people and has been our springboard for the specific model that was tested out in this RCT study.

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1.3 Contextualisation of RadSec Programme for LGBTQ+ Populations Across Intersectional Aspects of Identity

Radical Self-Care has been developed to support people who may identify within LGBTQ+ with lived experience of gender and sexual relationships diversity. The programme explores lives in the context of societal, cultural, and family related challenges to living as LGBTQ+. Lives that for LGBTQ+ individuals have often meant environments and contexts do not feel safe or accepting. As LGBTQ+ individuals and practitioners, we are often working with societal legacy of shame and internalised homo-, bisexual or transgender negativity. For many of us this terrain is very complex and intersects with many aspects of our identities and areas of our lives. The RadSec approach emphasizes that all parts of participants and practitioners’ identities are welcome.

The Radical Self-Care model has been initiated and brought into being as a way of centering something seemingly as simple as caring. Bringing the concept of care centre stage in our intentions for wellness for individuals, communities and the planet. Radical Self-Care created by us honours the strong historical connection that self-care has had as an essential aspect of wellbeing enabling the rejuvenation of individuals and movements in the face of discrimination and oppression, such as the civil rights movements some decades ago. At present day, we draw strength from this historical connection as we expand access to the Radical Self-Care model in line with our values of anti-racism and principles of intersectional working that invites all engaged in the work to honour, respect and care for all parts of their own and others’ intersectional identities.

Radical Self-Care, within its wider Radical Caring framework, aims to strengthen individuals and communities as we seek to survive and address the health and other inequalities exposed by the current pandemics.

1.4 RadSec Programme Background

We have already outlined the motivation behind the development of the model and highlighted some of the key concepts underpinning the development and delivery of the model, such as intersectionality. The next section of the report will outline the background to the Radical Self-Care model and give a brief overview of the evidence-based foundations of the approach.

The impetus for the Radical Self-Care (RadSec) modality arose from the work initially carried out by practitioners working primarily at Mind in the City, Hackney and Waltham Forest and the NHS combining mindfulness and compassion-based methodologies. They saw the potential for

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8 Intersectionality definition by Oxford dictionary:

“The interconnected nature of social categorizations such as race, class, and gender as they apply to a given individual or group, regarded as creating overlapping and interdependent systems of discrimination or disadvantage.”
a modality that combined essential mechanisms of change from these approaches into one that could alleviate mental and emotional health issues for a range of populations.

The initial models tested in 2017-18 at Mind CHWF and the NHS were called Mindful Self-Care. The tested models ranged in length and depth depending on the context and target populations worked with. The development of this work was led by Miia Chambers who at the time was Mindfulness Lead at Mind CHWF.

Mind CHWF initiated Rainbow Mind in 2018. Late 2018 CHWF Mind invited Mind in Salford to form a partnership to increase reach, impact and innovation. Miia was appointed Director of Rainbow Mind and Markus Greenwood as lead in Greater Manchester. As part of funding secured from the Government Equalities Office (GEO) Rainbow Mind began the process, in conjunction with LGBTQ+ colleagues at both Mind CHWF and MiS, to target and contextualise the original Mindful Self-Care model for LGBTQ+ people as an intersectional approach as its foundation.

The potential of the model to alleviate the mental and emotional health challenges within LGBTQ+ populations became obvious to all in the partnership. This is when Radical Self-Care was born. Out of these discussions arose the intention to contextualise and focus the modality specifically to supporting marginalised communities, and in this case LGBTQ+ communities. Radical Self-Care owes its name to the civil rights movement in the 1960s and 70s, and to all those who saw the need for self-care as essential to survival in cultural contexts that discriminate and devalue. As detailed above, the incidences of mental health issues for LGBTQ+ individuals suggest that radical self-caring is still as urgent and relevant today as it was for marginalised communities some decades ago (see section 1.1 providing research findings and statistics on LGBTQ+ population mental health needs and vulnerabilities).

The quote below from Audre Lorde, a leading proponent of self-care, has inspired the development of RadSec:

“Caring for myself is not self-indulgence. It is self-preservation…” Audre Lorde

The Radical in this model refers also to what the project team termed our ‘birthright’, to exist as we are, with all aspects of our intersectional identities. In addition, we view placing something as ‘everyday’ as caring centre stage in our lives as radical in today’s society. Not just caring for others, but U-turning caring towards ourselves too as a necessity.

1.5 Key Principles of the RadSec Approach

- Based on the theoretical and practical foundations of Compassion Focused Therapy (CFT), Mindful Self-Compassion (MSC) and Mindfulness (MF) methodologies.
- Focuses on strengthening two core (innate) capacities of mindful awareness and compassion.
• Supports individuals in relating to difficult emotions and mental and emotional challenges more skilfully

• Specific components for helping participants respond skilfully to shame and self-criticism

• Generally seeks to ‘unblock’ flows of care, allowing our care for others to also be directed toward the self

The project team knew from the work they had carried out with the evidence based mindfulness- and compassion-based modalities (MBSR, MBCT, MSC and CFT), that this way of combining key content in an accessible and targeted approach had the potential to affect change and improve mental and emotional wellbeing of participants, and in the case of the present RCT study, of the LGBTQ+ people.

1.6 RadSec Approach: Working with Shame and Self-Criticism

RadSec has been deliberately designed to support working with shame and self-criticism, through the key foundational capacities of mindfulness and compassion.

The compassion and care-giving components of the RadSec approach have been specifically based upon the key theoretical and evidenced foundations of Compassion Focused Therapy (CFT) to support people with shame and self-criticism. CFT was originally developed for, and with, people who suffer high levels of shame and self-criticism (Gilbert, 2010). RadSec has borrowed from its CFT foundations and has continued working in a way that builds on developing the approach with those with lived experience of these difficult mental and emotional health challenges.

Foundational within the RadSec model is also mindfulness. Mindfulness is fundamental in developing the capacity for awareness of one’s experience, supporting new ways of relating to experience and learning to work with the mind and its thought content in more skilful ways. The capacity for mindful awareness can support the interrupting of unhelpful thinking loops and behavioural habit patterns. Once individuals are aware of their experience, for example, of shame, the compassion and care-giving related psycho-educational and practical components from CFT support them in coping with these difficult emotions.

1.7 Model Description

1.7.1 RadSec Programme Theoretical Foundations

RadSec draws from the evidence-based, theoretical and practical foundations of Mindfulness Based Interventions (MBIs) of MBSR and MBCT, and mindfulness- and compassion-based modalities of Compassion Focused Therapy (CFT) and Mindful Self-Compassion (MSC).
1.7.2 RadSec Programme Overview

The programme *structure* comprises:

- approximately two months in length
- eight weekly sessions, two hours per session
- working, most typically, with groups of 10 - 15 participants

The programme *themes* and corresponding *methodologies* are summarised below.
Figure 2. RadSec themes and corresponding methodologies.

Radical Self-Care: Being a Better Friend to Self and Others

<table>
<thead>
<tr>
<th>Be Caring</th>
<th>Theme</th>
<th>Practices &amp; Psycho Ed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be</td>
<td>Being aware of own experience</td>
<td>Body Based</td>
</tr>
<tr>
<td>C</td>
<td>Body, thoughts, emotions (in the context of LBGTQ+ other intersectional parts)</td>
<td>Breath Based Practices</td>
</tr>
<tr>
<td>A</td>
<td>Capacities of Awareness + Caring</td>
<td>Mindfulness Compassion</td>
</tr>
<tr>
<td>A</td>
<td>Allowing, turning towards experience with a caring and comforting inner voice, approaching our experiences with gentleness</td>
<td>Mindfulness Mindful Self-Compassion</td>
</tr>
<tr>
<td>R</td>
<td>Rebalancing mind and body/emotional regulation systems</td>
<td>CFT plus reflections</td>
</tr>
<tr>
<td>I</td>
<td>Interconnected flows of care and compassion</td>
<td>CFT plus worked with mindfulness</td>
</tr>
<tr>
<td>N</td>
<td>New ways of relating to experiences, self, and others</td>
<td>Mindfulness CFT / MSC</td>
</tr>
<tr>
<td>G</td>
<td>Giving ourselves what we need - Taking in the Good</td>
<td>CFT &amp; Rick Hanson</td>
</tr>
</tbody>
</table>

The key themes that run through the programme are founded in mindfulness and compassion-based approaches and are worked on through a range of methods, including:

- Psycho-educational content with theoretical underpinnings from MBIs, CFT and MSC
- Experiential components such as practices, exercises and reflections
- Group process, enquiry and discussion
- Week in-between suggestions – home practice

The principles and emphasis on trauma-informed ways of working with mindfulness and self-compassion are embedded in the process of working and engagement. Participants are encouraged to engage in ways that are safe and caring to them. All participation is encouraged from the perspective of self-care, not self-indulge but rather what would be caring to self, and if engagement in materials is not possible at any point in session or in the week in between the sessions, participants are encouraged to bring a compassionate attitude to that.
### 1.7.3 Brief session by session outline - with examples of content

<table>
<thead>
<tr>
<th>Session No.</th>
<th>Session Theme</th>
<th>Examples of didactic, reflective or practice content</th>
</tr>
</thead>
</table>
| Session 1   | Getting Curious about Becoming a Better Friend to Self | - Self-care principles and group culture Societal and cultural contextualising  
- FOFBOC - Feet on the Floor, Body on the Chair grounding mindfulness practice  
- Here & Now object - mindfulness |
| Session 2   | Foundational Capacities and Tone to Self | - Mindfulness and care capacities explored through didactic elements and practice e.g. Caring Body Scan  
- CFT foundations didactically + reflection on Tone to Self  
- Mindfulness and Self Care in Daily Life |
| Session 3   | Noticing and Rebalancing | - Caring Breath and Body practice  
- Three emotion regulation systems (3ERS)  
- Self-Caring Pause (activating care-giving) |
| Session 4   | Flows of Care | - CFT Didactic: Flows of care and compassion  
- Exploring experience through the 3ERS  
- Receiving and Offering Care to self and others, breath and body based practice |
| Session 5   | New Ways of Working with Anger | - Didactic and experiential Working with Difficult Emotions, anger in particular  
- Giving Ourselves What We Need, mindfulness and compassion based practice  
- exploring Meeting Ourselves with a Caring Gesture – CFT informed |
| Session 6   | Shame and Other Difficult Emotions | - Didactic and experiential Working with Difficult Emotions, shame in particular  
- Sea of Humanity exercise, mindfulness and compassion combined  
- exploring Taking in the Good, mindfulness informed practice |
| Session 7   | Choosing Caring | - revisiting and strengthening key mindfulness and care-giving practices and content |
| Session 8 & 9 | Being a Better Friend & the Rest of our Caring Lives | - gratitude and appreciation exercises  
- revisiting flows of care practice  
- course reflections and take aways for session 9 (i.e. rest of our lives)  
- appreciation for and from each other and closing |
1.8 Radical Self-Care Practitioner Community

Rainbow Mind is an LGBTQ+ led and delivered organisation. All the practitioners working within the LGBTQ+ RadSec programme are from the LGBTQ+ community. We are drawing on our lived experience as LGBTQ+ people in the conceptualisation, design and delivery of the model.

Key to the development and delivery of the model has been the pro-active nurturing and growing of a community of LGBTQ+ RadSec practitioners. There is a strong collective commitment to working in ways that honour embodiment, healing of trauma and welcoming each person’s multiple intersectional aspects of their identities and lived realities. The collective and supportive spirit have been what has carried the team through some demanding timescales during the development and delivery of the RCT project.

Want to find out more?

Anyone wishing to find out more about the RadSec model development please contact: miia.chambers@mindchwf.org.uk  Tel: 07500 879548

The RadSec practitioner training programme is being developed. If interested in training with us, you are invited to contact the relevant hub:
Southern Hub (London based): southernhub@rainbowmind.org
Northern Hub (Greater Manchester based): northernhub@rainbowmind.org
2. Study Methodology

2.1 Research Design

The design of the RadSec evaluation study was a randomised controlled trial with two conditions: the RadSec training group and a waitlist control group. RadSec was the target intervention condition as a novel 8-week mindfulness-based compassion intervention tailored to the unique lived experiences and psychological struggles of LGBTQ+ individuals. Effectiveness of the RadSec programme on participants' mental health and well-being was evaluated against a waitlist control group who completed the study questionnaires at the same time as the intervention group. The training group accessed the Radical Self-Care programme from October to December 2019 and the waitlist control group accessed the programme from January to March 2020. See Figure 3 for the project timeline. All participants completed the primary outcomes survey at three time points: before the training group started RadSec; after the training group completed RadSec; and one month after the training group completed RadSec. Additionally, participants completed eight online weekly assessments for the duration of their participation period in RadSec. The data collection was conducted via online hosted questionnaires and occurred simultaneously at two training sites, in London and Greater Manchester.

Figure 3: RadSec evaluation study timeline.

2.2 Recruitment of Participants

The research participants were recruited via a communications campaign delivered simultaneously by Mind in City, Hackney and Waltham Forrest and Mind in Salford. The campaign was directed by the Communications and Campaign Officer at Mind in Salford, under the supervision of Markus Greenwood and Miia Chambers. The recruitment campaign involved two launch events, one in London and one in Greater Manchester, with attendance of partner
organisations and other network LGBTQ+ groups and community members. At these events, recruitment flyers and leaflets were distributed to advertise the randomised controlled trial of self-care and mindfulness techniques for individuals who self-identify as LGBTQ+. The communications campaign also included advertisements via radio (Gaydio www.gaydio.co.uk), social media (e.g., twitter, facebook, instagram, etc.), flyers distributed to LGBTQ+ network groups in London and Greater Manchester as well as via the website of the partnership organisation, Rainbow Mind (www.rainbowmind.org).

2.3 Participant Screening

Participants were invited to express interest in taking part in the study by emailing a centralised email account, which was managed by the Impact Evaluation Lead at Mind in Salford. Queries for both course locations (London and Greater Manchester) were processed via this single email account to ensure consistency in the communication across both sites and to protect participants' personal information. Participants were included in the study on basis of their self-identified LGBTQ+ orientation, willingness to be randomly assigned to the active training or a waitlist control group and reporting not to have any current suicidal intentions (assessed in screening).

Before setting up a screening appointment, potential participants were given some details about the study (e.g., time commitment, basic information about the RadSec programme and the structure of the course) and confirmed their willingness and availability to attend both course dates, which was one of the criteria of participating in the study. At this point, potential participants were booked in for a screening phone call with one of the RadSec practitioners: Miia Chambers, Shane Mackay, Markus Greenwood or Karen Welsh. During the screening conversations, potential participants were asked their reasons for enrolling in the course, risk-assessed for self-harm and suicidal intentions, and had an opportunity to ask any questions about the course. A standardised Mental Health Screening Form was used by all practitioners. At this time, any individuals whose mental health presentation could not be sufficiently monitored or supported on the course were referred by the screening practitioners to alternative psychological services. The remaining participants were invited to enrol on the RadSec course.

2.4 Randomisation Process

Once participants enrolled in the study, they were randomised into one of the two conditions. Prior to recruitment, an excel document was created with an even split of condition codes to the target recruitment number (200). The condition codes were then randomised using a randomizer formula within excel. After randomisation, the random allocation list was split into three to accommodate the three participant groupings (two London groups and one Manchester group). Allocation concealment was achieved by limiting access to the randomisation document. The screening practitioners did not have access to the randomisation document. When a participant was deemed eligible to participate after screening, their details were given to a
researcher who confirmed that the potential participant could attend both possible course dates (intervention & waitlist control) and then notified the participant of their random assignment based on the next condition code from the randomisation document. As such, randomisation occurred on a rolling, ‘first-come-first-served’ basis.

Participants were blind to group membership. They were given the option to choose which group location to attend (London or Manchester) but not which course dates to attend. Participants were, however, notified that there were two course start dates and that they would have to be available for either course start date to be eligible to participate in the study.

2.5 Participants

One hundred and eighteen participants were recruited and randomly allocated to a group (intervention group = 59; waitlist group = 59). Ages ranged from 20-69 years, with an average age of 38. See Table 1 for demographics breakdown on basis of condition.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>INT (n = 59)</td>
</tr>
<tr>
<td>Number identify as males (%)</td>
<td>32 (58%)</td>
</tr>
<tr>
<td>Number identify as cisgender (%)</td>
<td>38 (69%)</td>
</tr>
<tr>
<td>Number identify as gay or lesbian (%)</td>
<td>30 (55%)</td>
</tr>
<tr>
<td>Age range in years (M; SD)</td>
<td>20-63 (38.12; 11.98)</td>
</tr>
<tr>
<td>Number identify as white (%)</td>
<td>40 (77%)</td>
</tr>
<tr>
<td>Number indicate relationship status as single (%)</td>
<td>36 (69%)</td>
</tr>
</tbody>
</table>

Table 1. Demographic characteristics for intervention (INT) and waitlist control (WLC) group at baseline

In order to accommodate for trans* and non-binary participants, participants were given two options to identify their gender. First was body description (Which of the following best represents how you would describe your body?), of which the majority of participants (55.5%) indicated they were male, with the next largest groups being female (30.9%) and other (5.5%); see Figure 4. All five clients who selected “other” indicated in the write-in a non-gendered body description (e.g., non-binary; androgynous). A small number of participants identified as trans* (2.7%).
Second was gender identity (Which of the following best represents how you would describe your gender identity and expression?), where most participants identified as cisgender (66.4%). The next largest group of participants indicated a non-binary gender expression, which included genderqueer, agender, genderfluid, and non-binary (22.7%). Other categorisations included writing-in another self-description (4.5%) or did not disclose (6.4%); see Figure 5.

Participants were given the option to select multiple categories for sexual orientation, which resulted in an interesting pattern of self-categorisation. The largest group identified exclusively as gay or lesbian (50%), meaning that was the only categorisation option chosen by individuals in this group. The next largest subgroup identified as gay/lesbian or bisexual plus an additional categorisation, including queer, asexual, pansexual, polyamorous or a write-in option (21.8%). Next, were clients that identified as “other,” which included identifying as one or more of the following: Queer, asexual, pansexual, polyamorous or write-in (10%). Smaller groups of clients also identified exclusively (meaning this was the only categorisation chosen) as bisexual (7.3%), queer (6.4%), or did not disclose (4.5%); see Figure 6.
Participants were predominantly white (72.4%). Smaller numbers of participants indicated their ethnic group as Black or Black British (5.8%), Asian or Asian British (12.5%), another mixed or ethnic background (8.3%), or did not disclose (1%).

Most participants stated their marital status as single (63.8%). Other subgroups included participants who indicated they were married or partnered (21.9%), divorced or separated (6.7%), other (5.7%) or did not disclose (1.9%).
Participants were also asked to indicate their reasons for enrolling on the course (participants could select multiple options). The most common reasons for enrolment were anxiety (76%), stress (56%), low self-esteem (53%), low mood (48%), depression (43%), sleep problems (36%), or trauma (25%). Other reasons included stress pertaining to Carer role (7%), personality disorder (7%), PTSD (6%), bipolar disorder (6%), chronic pain (5%), schizophrenia (2%), or another reason (20%). Of those clients who selected ‘other,’ common reasons for enrolling included relationship stress and struggles with other mental health issues (e.g., OCD, self-harm, mood swings, addiction). The majority of participants indicated that they were not currently accessing psychological services (71.4%).

Participants were also asked to indicate their previous exposure to mindfulness courses and content. Majority of participants had some exposure (70.9%), although this exposure varied in depth. Of those who indicated previous exposure to mindfulness content, most reported engaging in a personal mindfulness or meditation practice (42.7%) ranging from less than one month to 30+ years, or some other exposure to mindfulness (19.1%), which included yoga or workplace training courses, use of meditation apps, or attendance on meditation retreats. Only a small percentage had previously completed an 8-week mindfulness-based intervention, including MBSR, MSC, and MBCT (9.1%).
3. Measures

3.1 Psychological Well-Being

A primary goal of the evaluation conducted by the City, University of London research team was to assess the impact of the training on participants' general psychological well-being.

Improving general psychological well-being is considered particularly important, because plenty of evidence shows that higher psychological well-being leads to significant improvements in people's daily effectiveness and life quality, including better performance at work, improved physical health, and more satisfying social relationships.

To assess psychological well-being, we used a widely used and respected questionnaire known as the General Health Questionnaire (or GHQ-12). This questionnaire has 12 questions that ask people to report their recent experiences of low mood, anxiety, sleep difficulties, level of confidence, and general level of happiness; see table 2.

<table>
<thead>
<tr>
<th>Table 2. Example questions from the General Health Questionnaire (GHQ-12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Have you recently …been able to concentrate on whatever you’re doing?”</td>
</tr>
<tr>
<td>“Have you recently …Lost much sleep over worry?”</td>
</tr>
<tr>
<td>“Have you recently …Been losing confidence in yourself?”</td>
</tr>
<tr>
<td>“Have you recently …Been feeling reasonably happy, all things considered?”</td>
</tr>
</tbody>
</table>

Note. Participants are asked to answer these questions to reflect their experiences over the last few weeks.

When we calculate a person’s overall score on this general health questionnaire, a higher score represents a higher level of psychological strain. In other words, a higher score on this questionnaire indicates a lower level of psychological well-being. And conversely, a lower score indicates a higher level of psychological well-being.

A major advantage of using this questionnaire is that an overall score indicates the likelihood that a person has recently been experiencing a common mental health problem (such as a depressed mood, anxiety, or other stress-related difficulty). We will discuss this useful feature of the general health questionnaire in more detail in the results section of this report.

3.2 Anxiety and Depression

In addition to measuring general psychological well-being, we also assessed more specific symptoms of anxiety and depression. To ask about possible presence and severity of
participants’ anxiety symptoms, we used a widely used, reliable and well-validated seven-item questionnaire known as the Generalised Anxiety Disorder Assessment (GAD-7).

Table 3 shows example questions from the GAD-7. The response options include “not at all”, “several days”, “more than half the days” and “nearly every day”. Similar to the GHQ-12, a useful feature of the GAD-7 questionnaire is that it provides an indication of the recent level of severity of each person’s anxiety symptoms. Specifically, GAD-7 scores of 5, 10, and 15 are considered cut-off points for mild, moderate, and severe anxiety, respectively. Higher scores on this measure therefore indicate higher levels of anxiety and increased severity of the symptoms.

Table 3. Example questions from the Generalised Anxiety Disorder Assessment (GAD-7)

<table>
<thead>
<tr>
<th>“How often have you been bothered by the following problems?”</th>
</tr>
</thead>
<tbody>
<tr>
<td>“…feeling nervous, anxious or on edge?”</td>
</tr>
<tr>
<td>“…not being able to stop or control worrying?”</td>
</tr>
<tr>
<td>“…becoming easily annoyed or irritable?”</td>
</tr>
</tbody>
</table>

Note. Participants are asked to answer these questions to reflect their experiences over the last two weeks.

We also assessed participants’ specific symptoms of depression and depressive mood. To this end, we used the Patient Health Questionnaire (PHQ-9), a widely used nine-item instrument to assess the presence and severity of respondents’ depressive symptoms over the past two weeks. The PHQ-9 asks people to report their level of interest in doing things, whether they have been feeling down or depressed, difficulty with sleeping, energy levels, eating habits, self-confidence, ability to concentrate, speed of functioning, and thoughts of suicide. Table 4 below shows example questions from this measure.

Table 4. Example questions from the Patient Health Questionnaire (PHQ-9)

<table>
<thead>
<tr>
<th>“How often have you been bothered by any of the following problems?”</th>
</tr>
</thead>
<tbody>
<tr>
<td>“…little interest or pleasure in doing things?”</td>
</tr>
<tr>
<td>“…feeling down, depressed, or hopeless?”</td>
</tr>
<tr>
<td>“…feeling bad about yourself – or that you are a failure or have let yourself or your family down?”</td>
</tr>
</tbody>
</table>

Note. Participants are asked to answer these questions to reflect their experiences over the last two weeks.

Again, when we calculate a person’s total score, a higher score on the PHQ-9 questionnaire represents an increasing severity of depressive mood and other depressive symptoms. PHQ-9 scores of 5, 10, 15 and 20 are considered cut-off points for mild, moderate, moderately severe, and severe depression respectively.
In sum, a primary goal of the evaluation was to assess the impact of the RadSec training on participants’ general psychological well-being and more specific symptoms of anxiety and depression. The effect of the RadSec training was compared to a comparison group that had not yet received the RadSec training over exactly the same period of time. Seeing improvements on each of these measures would allow us to ascertain whether the RadSec training can be considered an effective way of improving the psychological well-being and mental health of the LGBTQ+ population.

3.3 Psychological Processes Targeted by RadSec Training

In addition to the main outcomes of general psychological well-being and symptoms of anxiety and depression, we evaluated the effects of the training on a set of psychological skills and processes. This part of the research is designed to reveal the main psychological mechanisms through which RadSec training influences people’s well-being and mental health. Hence, the research included measures of the following psychological skills and processes: Mindfulness skills; self-compassion; shame; perfectionism; and rumination.

Both mindfulness and self-compassion are considered core skills that are likely to be developed by RadSec training. Mindfulness is an ability to purposely bring one’s attention to present moment experience without judgment. It is a universal human capacity which can be cultivated via formal and informal training interventions and practices. Higher levels of mindfulness have been associated with greater well-being, lower levels of stress-related problems, improved cognitive functioning, and better quality of life.

To measure participants’ mindfulness before, during and after the RadSec training, we used a well-validated measure of mindfulness, the short version of the Five Factor Mindfulness Questionnaire (FFMQ-15). This instrument assesses mindfulness along the following five dimensions:

- ability to observe internal and external experiences,
- ability to describe one’s own feelings in words,
- ability to act with full awareness,
- a nonjudging attitude toward one’s thoughts and feelings, and
- ability to allow thoughts and feelings to come and go without getting carried away by them (non-reactivity).

Another core skill expected to be developed by the RadSec training is self-compassion, an ability to be sensitive to and motivated to relieve one’s own suffering; in other words, an ability to care for oneself with warmth, kindness and acceptance. RadSec training draws on Compassion Focused Therapy (CFT), which was specifically developed for people who have mental health problems linked to shame and self-criticism, and who often come from difficult (e.g., neglectful or abusive) backgrounds. The development of self-compassion skills through RadSec training is thought to be particularly powerful for LGBTQ+ individuals, given reports of higher than average levels of shame and self-criticism within this community.
To measure self-compassion, we used the **Self-Compassion Scale (SCS)**, which has 26 questions assessing three main dimensions or abilities:

- to be kind and understanding toward oneself rather than being harshly self-critical;
- to perceive one’s experiences as part of the larger human experience rather than seeing them as isolating; and
- to hold painful thoughts and feelings in mindful awareness rather than over-identifying with them.

In addition to the two core skills of mindfulness and self-compassion developed by the RadSec training, we also assessed a number of transdiagnostic psychological processes that have been linked to a range of psychological disorders such as anxiety, stress, and depression. We specifically focused on rumination, self-critical perfectionism, and participants’ experiences of shame. These processes can be highly detrimental to one’s mental and physical health in part because they continuously (over) activate autonomic, threat-based self-protection systems. Mind CHWF’s own programme of consultations with LGBTQ+ communities identified specific issues and needs of these communities which included poor mental health, social isolation, marginalisation, poor body image, high levels of shame and perfectionism, and low confidence, self-compassion, and self-esteem. The RadSec training was therefore specifically designed to develop compassion towards oneself and self-soothing skills to counteract and prevent the detrimental effects of these three transdiagnostic processes.

To assess the effect of RadSec training on participants’ experiences of shame before and after the training, we used the **Experience of Shame Scale**. The scale features 25 questions asking people to indicate how frequently they feel embarrassed, self-conscious or ashamed of any of their personal habits, their character or behaviours (e.g. “Have you felt ashamed of the sort of person you are?”)

We used 18 questions from the **Self-Critical Perfectionism** subscale of The Big Three Perfectionism Scale to assess the tone of the participants’ inner voice in their tendency to strive for perfection (e.g. “I feel disappointed with myself, when I don’t do something perfectly.”).

And we also used the **Rumination** subscale of the Rumination-Reflection questionnaire (RRQ-6) featuring 6 questions asking people to indicate their ruminative thinking patterns (e.g.: “I tend to "ruminate" or dwell over things that happen to me for a really long time afterward.”).

### 3.4 Optimistic Bias as a Protective Mechanism

Over the last decades, psychology and neuroscience have shown that people who suffer from mental health issues such as anxiety and depression lack protective psychological mechanisms. For instance, people who do not suffer from depression preferentially change the beliefs they have about themselves (e.g., I’m a good friend) and their future (e.g., I will not get cancer) when receiving good news (news that is better than expected), but not when receiving bad news (news that is worse than expected). This protective learning bias – preferring good news over bad news – helps people protect their optimistic views, thereby serving as a buffer against stress and depression.
This protective learning bias is related to dopamine levels in the brain which inhibit frontal brain areas to process bad news. However, when people experience stress, anxiety, and depression, this protective learning bias evaporates. Now, any piece of bad news indicating a potential personal insufficiency or failure has the power to change people’s beliefs, leaving people more vulnerable to negative information.

This protective mechanism might be especially important for people from the LGBTQ+ community. As one participant in the RadSec program noted, they are “always going against the current of society, and hence face a lot of negative feedback about who they are and what they do”. One of the aims of the RadSec training program was to help shift people’s processing of information away from the bad, and towards the good; techniques that might directly foster the protective learning bias.

To measure the protective learning bias, i.e. how people learn from good news and bad news, we presented participants with a series of 30 trials. On each of these trials, participants briefly imagined a negative life event (e.g., getting bullied, missing a meeting, domestic burglary) happening to them and then indicated how likely they thought this event might be happening to them in their future. For instance, a participant might suggest that their likelihood for being a victim domestic burglary was 50%. Thereafter, participants learned on each trial what the average likelihood was that this event might happen. The numbers were based on epidemiological surveys and represent the best available guess for each event. In the domestic burglary example, participants would see that the average likelihood is 32% in the UK. Finally, on each trial, participants had a second chance to enter their likelihood, based on what they now believed likelihood was. That is, they had the chance to revise their beliefs after receiving new information.

To calculate how much participants learned from good news compared to bad news, we first classified each trial of when it was good news or bad news. In the domestic burglary example, a participant that entered 50%, received good news when seeing the average likelihood is actually only 32%, because they just learned that a negative life event is less likely to happen to them. However, if the participants would have entered 20% likelihood, the actual 32% would have represented bad news, because they learned that a negative event is more likely to happen to them than they had thought.

Using this optimistic bias tool, we are able to calculate the degree to which participants change their beliefs after receiving good versus bad news. Also, because participants completed this tool before and after RadSec training, we are able to assess the degree to which the training helps to protect people’s mental health by improving the functioning of the optimistic belief system.
4. Results

4.1 Impact of RadSec Training on Psychological Well-Being

As discussed in the Measures section of this report, we used the general health questionnaire (GHQ-12) to assess changes in people’s general psychological well-being as a result of attending RadSec Training.

Figure 9 below illustrates how participants’ scores on the general health questionnaire (GHQ-12) changed from before to after RadSec Training (the solid blue line). For comparison, Figure 9 also shows how scores changed in the comparison group (which hadn’t yet received RadSec training) over exactly the same period of time (the dashed red line).

![Figure 9](image)

**Figure 9: Scores on the general health questionnaire (GHQ-12) in the RadSec training group (blue solid line) and the comparison group (red dashed line).**

**How to interpret Figure 9**

Looking at Figure 9, the first thing to notice is that the RadSec training group (represented by the solid blue line) experienced a reduction in psychological strain from before to after attending the training. And this reduction was generally maintained at the final follow-up assessment, which occurred one month after the RadSec group had completed the training.

Also, although the comparison group (represented by the dashed red line) changed a small amount over this same period of time, it is clear that their psychological strain did not reduce nearly as much as the group that had received RadSec training.

We performed further analysis on these general health questionnaire (GHQ-12) scores. We found that there was a statistically significant difference between the RadSec training group and the comparison group after the training had been completed, and at the final follow-up.
assessment. This means that we can conclude that the RadSec training resulted in a statistically significant improvement in participants' general psychological well-being.

Also, note the horizontal line in the middle of Figure 9, which represents a score of 4 on the general health questionnaire. A score of 4 is used as a validated cut-off value on this questionnaire. It indicates whether someone has recently been struggling with a common mental health problem (such as depressed mood, anxiety, or other stress-related difficulty). People who score 4 and above on the general health questionnaire are considered likely to have recently experienced a common mental health problem, whereas those who score below 4 have not.

Looking at Figure 9, it can be seen that the RadSec training group went from above 4 before the training, to well below 4 after the training and at the final follow-up assessment. This considerable decrease in GHQ-12 scores, from above 4 to below 4, means that the RadSec training group experienced a clinically meaningful improvement to their psychological well-being as a result of attending the training.

Another way to illustrate this trend is shown in Figure 8, the Sankey chart of the participant flow in the training group. Among the participants who completed RadSec training (and who returned their questionnaires to the research team), 45% were classified as having a common mental health problem before starting the training (that is, they had a score above 4 on the general health questionnaire). After the training, only 10% of this same group were still classified as experiencing a mental health problem. Figure 10 clearly shows this pattern. As can be seen the figure, majority of participants who scored above 4 (the blue colour) prior to the training has scored below 4 (yellow colour) after attending the training (see the Sankey chart below).

Figure 10: Sankey chart of training group participant flow based on change of the GHQ-12 scores from before to after the training
4.2 Impact of RadSec Training on Anxiety and Depression

Improvements in participants’ psychological well-being can be further illustrated by a decrease in participants’ more specific symptoms and severity of anxiety and depression. Figure 11 illustrates how participants’ scores on the generalised anxiety disorder (GAD-7) questionnaire decreased in the RadSec Training group (indicated by the solid blue line) but remained largely unchanged in the comparison group (the dashed red line) after the training had been completed.

The results of statistical analyses performed on these trends suggest that the RadSec Training resulted in a statistically significant reduction in participants’ symptoms of anxiety. This positive effect of the training on anxiety was maintained at the final follow-up assessment, one month after the training was completed.

Figure 11: Scores on the generalised anxiety disorder questionnaire (GAD-7) in the RadSec training group (blue solid line) and the comparison group (red dashed line).

These improvements in participants’ anxiety scores can be also described as clinically meaningful when referring to the suggested thresholds for severity of participants’ anxiety symptoms. Prior to RadSec training, both groups reported the severity of their anxiety symptoms on average just below the score of 10, which is the threshold for moderate anxiety. Following RadSec training, participants in the training group reported an average score that was close to 5 (i.e., the threshold for minimal anxiety).

This trend can be also illustrated by the Sankey chart (see Figure 12) showing how individual participants’ anxiety scores shifted from before to after the training. (based on data collected from participants who completed the training and responded to the research questionnaires).

Before the RadSec training, 17% of participants were classified as experiencing severe anxiety, 7% of participants were experiencing moderate anxiety, and 52% had mild levels of anxiety. After the training, only 3% of participants reported severe levels of anxiety, and a majority of the training participants moved into the lowest category suggesting minimal symptoms of anxiety.
(i.e., below the score of 5). This means that we can conclude that the RadSec training resulted in a clinically meaningful reduction in anxiety among many of the participants who started the training with severe or moderate anxiety.

**Figure 12**: Sankey chart of training group participants flow from before to after the training based on change of their anxiety (GAD-7) scores

Furthermore, we used the Patient Health Questionnaire (PHQ-9) to assess any changes in the presence and severity of participants’ depressive symptoms as a result of attending the RadSec Training. Figure 11 illustrates how participant’s scores on the Patient Health Questionnaire (PHQ-9) changed from before to after RadSec Training (the solid blue line). For comparison, Figure 13 also shows how scores changed in the comparison group (which had not yet received RadSec training) over exactly the same period of time (the dashed red line).

As indicated in Figure 13, before the training there was a small difference in PHQ-9 (depression) scores between the two groups. However, this was a very small difference that was not statistically significant. After the training, the RadSec training participants had significantly reduced symptoms of depression (the solid blue line in Figure X). In contrast, levels of depression in the comparison group remained largely unchanged (dashed red line).
Taken together, these results suggest that the RadSec Training resulted in statistically significant improvements in participants’ symptoms of anxiety and depression following their participation in the RadSec Training; and these changes were maintained at the final follow-up assessment one month after the training was completed. Overall, these are very encouraging findings, and they demonstrate that RadSec training is an effective and efficient method for improving mental health and well-being in LGBTQ+ participants.

4.3 Impact of RadSec Training on Psychological Skills and Processes

As discussed in the Measures section of this report, mindfulness and self-compassion are considered the two core skills developed by the RadSec training. We used the short version of the five-factor mindfulness questionnaire (FFMQ-15) and the self-compassion scale (SCS) to assess changes in these two skills as a result of attending the RadSec training sessions over the 8 weeks.

Mindfulness is an ability to be more aware of one’s own thoughts and feelings as they occur in the present moment in a non-judgmental and accepting way. Figure 14 below illustrates how the participants’ scores on the five-factor mindfulness questionnaire (FFMQ-15) changed from before to after RadSec Training (the solid blue line). And for comparison, this figure also shows how scores changed in the comparison group (which hadn’t yet received RadSec training) over exactly the same period of time (the dashed red line). We can see that participants who received the RadSec training reported an increase in their mindfulness skills whereas no such increase occurred in the comparison group.
Self-compassion, an ability to care for oneself with warmth, kindness, and acceptance, is considered a second core skill fostered by the RadSec training over the 8 weeks of the training programme. Figure 15 below illustrates how the participants’ self-compassion ratings on the Self-compassion Scale (SCS) changed from before to after RadSec Training (the solid blue line) and this figure also shows the self-compassion ratings in the comparison group (which hadn’t yet received RadSec training) over exactly the same period of time (the dashed red line). This figure shows that participants who received the RadSec training reported an increase in their ability to care for themselves with warmth and kindness whereas the self-compassion scores in the comparison group remained unchanged.

**Figure 14:** Scores on the short five factor mindfulness questionnaire (FFMQ-15) in the RadSec training group (blue solid line) and the comparison group (red dashed line).

**Figure 15:** Scores on the self-compassion scale (SCS) in the RadSec training group (blue solid line) and the comparison group (red dashed line).
In addition to the two core skills of mindfulness and self-compassion fostered by the RadSec training, we also assessed the impact of the RadSec training on a number of transdiagnostic psychological processes that have been linked to a range of psychological disorders. We specifically focused on participants’ experiences of shame, self-critical perfectionism and rumination.

First, we examined the effect of the RadSec training on participants’ experiences of shame before and after the training using the *Experiences of Shame Scale*. Figure 16 shows that participants who received the RadSec training reported a large, statistically significant decrease in their experience of shame with respect to their personal habits, character or behaviours following the training (the solid blue line). Although the comparison group also reported a small decrease in their experiences of shame (the red dashed line), this decrease was much smaller in size and was not statistically significant.

![Figure 16: Participants’ scores on the experiences of shame scale in the RadSec training group (blue solid line) and the comparison group (red dashed line).](image)

Similarly, participants in the RadSec training group reported a large reduction in their self-critical perfectionism (the blue solid line) following the training (see Figure 17). Self-critical perfectionism can be understood as the tone of one’s inner voice in their tendency to strive for perfection in order to avoid criticism or rejection from others, harsh self-judgmental thoughts and feelings of inadequacy which are all linked to high threat system activation.

Figure 17 shows that participants who received the RadSec training reported a large, statistically significant decrease in their self-critical perfectionism (the solid blue line) while the self-critical perfectionism scores in the comparison group (which has not yet received the training) remained largely unchanged (the dashed red line) over exactly the same period of time.
Figure 17: Scores on the self-critical perfectionism scale in the RadSec training group (blue solid line) and the comparison group (red dashed line).

And finally, we also used the **Rumination** subscale of the Rumination-Reflection questionnaire (RRQ-6) to assess how persistent were the participants’ ruminative thinking patterns before and after taking part in the RadSec training. Rumination is an important psychopathological process which maintains the threat system stimulation over time and interferes with psychological recovery processes. Hence, RadSec training intentionally fosters participants’ ability to disengage from these ruminative thinking patterns and refocus on more compassionate insights and feelings.

As Figure 18 shows, participants in the RadSec training reported a large, statistically significant decrease in their ruminative tendencies (the solid blue line) while the rumination scores in the comparison group (which has not yet received the training) remained the same (the dashed red line) over exactly the same period of time.
To summarise, these results suggest that the RadSec Training resulted in statistically significant improvements in a range of important psychological skills and processes and particularly increasing levels of mindfulness and self-compassion. Moreover, the RadSec training evaluation involved a closer examination of participants' experiences of shame, self-critical perfectionism and rumination as these are considered three transdiagnostic psychological processes which are associated with mental health problems in LGBTQ+ populations. The results of the randomized trial presented above suggest that the RadSec training resulted in reduction in participants' experiences of shame, self-critical perfectionism and ruminative thinking patterns.

4.3 Optimistic Bias as a Protective Mechanism

As discussed in previous sections of this report, the RadSec training evaluation also focused on an implicit protective mechanism – the optimistic learning bias. This can be understood as preferentially changing one’s beliefs (e.g., I’m a good friend; I will not get cancer) when receiving good news (news that is better than expected), but not when receiving bad news (news that is worse than expected). This protective learning bias – preferring good news over bad news – helps people protect their optimistic views, and it can serve as a buffer against stress and depression.

For this part of the evaluation we focused only on RadSec training group (i.e., the participants that had attended the training). We can see in Figure 19, that before the training started, participants did not have a strong protective learning bias (i.e., there was no significant difference between responding to good versus bad news). However, immediately after the training, participants showed a protective learning bias. After the training, participants could preferentially integrate good news into their beliefs.

One month after receiving the training, participants in the RadSec training group still showed a robust protective learning bias, while participants in the comparison group did not. There was a
statistically significant increase over time for the protective learning bias in the RadSec training group.

Figure 19: Scores on the protective learning bias in the RadSec training group (blue bars) and the comparison group (red bars).

These results are impressive, as this one of the first intervention studies to demonstrate that this protective learning bias can be significantly improved via this type of training, and this is the first study that we are aware of to enhance this process among LGBTQ+ participants.
5. Testimonials from RadSec Participants, Trainees and Practitioners

“I wasn't really sure what to expect when I signed up for the RadSec course. Over the first few weeks I found some of the ideas and exercises quite challenging. I found I had to abandon a lot of my ingrained skepticism if I was to really take something from this course. Thank goodness I did! I am much more able now to notice my tone to self and, where previously I'd have been quite critical and berating, I now meet myself with a lot more compassion and acceptance. The RadSec tools and techniques have become even more important during C-19/lockdown - though it's been tough, I've been mindful to keep taking in the good. I hope to continue to be a better friend to myself, and to others.”

RadSec Participant 1

“I attended The Radical Self Care course in 2019. I felt it was a very safe space to explore and go deeper into understanding, learning and practicing ways to deal from my PTSD and Anxiety. The practitioners Miia, Liv and Shane we're all welcoming and great at what they do... There was a nice diverse mix of people attending and everyone seemed to be engaging and enjoying the weekly sessions. I now have tools that help me everyday to stay On The healing path and to grow, feeling confident that I am managing my Mental Health challenges a lot better.”

RadSec Participant 2

“The Radical Self Care course was very helpful in improving my mental health and wellbeing. It has taught me to be a better friend to myself. The mindfulness exercises I have been taught have helped to ground me and reduce anxiety. The course was well run and supported with excellent weekly handouts and online content.”

RadSec Participant 3
“I found the Radical Self-Care course genuinely restorative. Beyond the course’s content, I found the opportunity to sit and reflect every week on the particularities of how my queer identity had impacted on my wellbeing in a safe, LGBT+ inclusive environment, both challenging and ultimately rewarding. I still use some of the exercises introduced to us throughout the course in my daily life, particularly when I catch myself being unkind to myself. I have also shared this knowledge with many of my LGBT+ friends and colleagues for whom I think it could be useful. I wish this kind of training was available and accessible to the entire community - it would do wonders.”

RadSec Participant 4

“Personally, the course enabled me to reconnect with a sense of wholeness and in doing so actively relax and release stress. It is a paradox that in order to relax, I have to actively and consciously let go. I noticed that attending the meetings I felt more relaxed, more calm and more centred.

Professionally, the course enabled me to recognise anxiety when supervising challenging behaviour in adults. Recognising the signs my body is feeling threatened, a dry mouth, a different breathing pattern or any other signs of my body increasing the fight or flight response. This enabled me to stop and consider what is happening and observe the responses as opposed to 'unconsciously' going with them. By naming the responses I could look at what was causing them and feel both detached and more able to deal with the situation. Furthermore, the self comforting technique of gently placing my thumb on my pulse has proved invaluable at supporting me in facilitating ease, while sitting in a meeting or adverse situation.

Being able to access compassionate self care in the LGBTQ context has been especially valuable. It has supported healing from the imposed cultural homophobia that I grew up in and that I continue to experience, both externally and from long term conditioning.”

RadSec Participant 5
“I am a trainee practitioner on the RadSec course and it was interesting to see how the course scaffolds week by week, a great structure and inviting participation and discussion alongside compassion based practices. I noticed, participants voice a deeper awareness, compassion and care for themselves and others during the experience, finding healthy coping mechanisms and kindness for themselves and their past, present and future selves.

As someone who has worked in the LGBTQ+ sector for over 10 years working with people who have issues of internalised homophobia / biphobia / transphobia, shame, historical collective trauma, mental health challenges, addictions and loneliness and isolation - all directly linked to their sexuality or gender identity (and other intersections of their identity) a space that is purely for LGBTQ+ folx who are being taken on a journey by compassionate, experienced LGBTQ+ practitioners is exactly what is needed. A safety, a sense of community and peers support makes this model a success. I feel a young people's focused RadSec project would be very beneficial for future explorations and support systems for our LGBTQ+ youth.”

RadSec Trainee Practitioner 1

“I was honored to be a part of the Rad Sec Mindfulness course. It’s something that I didn’t understand how much I needed until I was on the course myself. The course practitioners were so inviting and the content was so accessible. These simple tools to promote wellbeing and re-train your inner critic are tools I will hold on to for life. Sharing this journey with the other members of my group was heartwarming. In a short space of time we built a trust-based community that supported each other and allowed ourselves to be present in the moment and reflect inwardly. Although this was not always an easy journey, it was wonderful to watch the course attendees flourish, moving from being in their minds, to being present in their experiences. RadSec is a course that showed us our common humanity while teaching us ways to be kinder to ourselves.”

RadSec Trainee Practitioner 2
“I attended the RadSec course in early 2020 and it’s changed so much for me. When I started, I was experiencing low mood and anxiety and practicing the exercises has given me tools to be more self-compassionate and let myself experience my feelings instead of fighting it. I’ve since been able to join a course for LGBT BAME people which was wonderfully affirming and I’ve even began training to lead a RadSec course myself! I would highly recommend giving the course a go as I previously thought mindfulness was a buzzword that had no bearing on me or my life but have since learned that when doing it in a group of supportive people who understand your experiences, it can be really life changing.”

RadSec Trainee Practitioner 3

“Working as a practitioner on the RadSec Mindfulness program has been enormously rewarding both personally and professionally by enabling me to have a greater sense of connection with myself and within the LGBTQI community.

Witnessing people with quite pervasive mental health issues express their surprise and delight at having completed the course and that they are able to engage with feelings of shame and soften towards themselves with compassion has been very moving and humbling.”

RadSec Practitioner 1

“Running the Radical Self-Care course has been a tremendously positive experience for me both personally and in terms of witnessing the transformations experienced by participants.

Personally, I’ve felt the effect of this course on my own life, as, in order to embody the teachings, I’ve dived deep into my own practice of self-care and have found it to be a great support during challenging times. It’s been an honour to bear witness to the many insights gained by participants. I’ve heard individuals use the words transformative and life-changing as they describe how they have found new ways to navigate old patterns and pains and that this is the first time that they’ve been able to treat themselves in anything like the way they would treat a friend. This course helps individuals discover a radically caring approach to relating to their joys and sorrows, to life itself.”

RadSec Practitioner 2
6. Future of the Radical Self-Care Programme

The RadSec model has the potential to support:

- Improvements in capacity for mindful awareness, self-acceptance, self-compassion and a more self-caring, loving relationship to self
- Developing greater acceptance and supportiveness towards different parts of one’s intersecting identities
- Changes in self-critical perfectionism tendencies - less likely to experience as much harsh, debilitating self-critical perfectionism, and greater ability to tolerate imperfections, failures or mistakes
- Strategies for working with shame and other difficult emotions and supporting the ability to relate to difficult emotions in more helpful ways
- Supporting helpful strategies for defusion from ruminative tendencies

The model is being continued to be rolled out within London and Manchester, addressing health inequalities and responding to needs arising during Covid-19 at this point.

The LGBTQ+ community will continue to be one of the key audiences with whom we work to scale the model and continue research and building of the evidence base. In addition, we have begun delivery of RadSec specifically for Black, Asian and minority ethnic LGBTQ+ people as part of a collaboration with UK Black Pride and with HIV positive LGBTQ+ people in collaboration with George House Trust. Furthermore, we have continued with delivering RadSec to LGBTQ+ individuals at different stages of their life, with funding secured for young people and adults in their mid-life. We also have further Covid-19 response funding to continue roll-out to people at this intersection of identities, and targeted funding for young LGBTQ+ people.

Emotions such as anger, shame and experience of self-criticism are common challenges to all. Emotional challenges and thinking patterns that exacerbate our distress are common to all humans. Therefore, we have begun further roll out in general mental services and workforce in the care health sector. A workforce pilot has so far taken place in mental health settings and further roll-out is being funded both in London and Manchester for RadSec as part of Covid-19 responses among care home staff.

The Radical Caring model approach is potentially relevant to broader contexts

There is potential to consider applying RadSec to a range of other contexts, in part to focus more attention on the second circle of the model (care for others). Examples that have been expressed by collaborating organisations working outside mental health contexts include:

- Restorative justice - working with perpetrators of hate crimes to help them develop their understanding of and compassion for their victims
- Troubled families - working with families in contact with social care services to help them rebuild relationships and care for self and each other
Diverse workplaces - working with teams to build care for self and work colleagues, for example to repair workforce cultures affected by distrust and misunderstanding and/or with teams wishing to find ways to value workforce diversity / recognise and celebrate intersectionalities.

**Outcomes for communities and society**

- Addressing wider social, economic and political determinants of mental health
- Addressing system-level inequalities and injustices
- Building acceptance of our common humanity (reducing the sense that people have that they are alone with their pain)
- Reducing prejudice and internalised racism/homophobia
- Achieving political change that can come from greater care for each other across race/community lines
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