Abstract

In the past decade the healing potential of mindfulness and its practice has gained widespread recognition across various health disciplines and institutions, especially mental health. Past and current research on mindfulness interventions have focused almost exclusively on the beneficial effects for clients. However, there is a serious shortage of research on how mindfulness practice influences therapists and their work. The current study looked specifically at how the influence of mindfulness meditation (MM) was experienced by therapists in the context of their work.

An interpretive description methodology was used to guide the research process. Semi-structured in-depth interviews were conducted with six therapists who practiced MM regularly. A thematic analysis of interview transcripts highlighted commonalities and differences among participants’ perceptions of the influence of MM on their work. Eleven themes emerged from the data analysis. Thematic findings were considered in relation to key issues in psychotherapy, master therapist traits and other contemporary qualitative research addressing the influence of MM on practitioners. The results are discussed with an emphasis on the practical implications for future research, therapist training and clinical practice.
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CHAPTER 1: INTRODUCTION

Although the term ‘mindfulness’ and the practice of mindfulness meditation are relatively new to the West, they have been slowly gaining momentum. In the past decade the healing potential of mindfulness (formally practiced as mindfulness meditation) in treating a diverse set of mental and physical health problems (e.g., anxiety, depression, fibromyalgia, chronic pain) in various populations (e.g., clinical, student) has gained widespread recognition as an effective intervention across health disciplines and institutions, especially within mental health (Kabat-Zinn, 2003). The ways of cultivating mindfulness originated in the spiritual traditions of the East, specifically Buddhism. The long-established Buddhist tradition of mindfulness meditation has shown that regular practice can help develop qualities such as compassion, equanimity, awareness, insight and wisdom (Goldstein, 2002; Kabat-Zinn, 2003).

However, the extent to which meditative practices (i.e., mindfulness meditation) can actually change practitioners at the physiological, psychological and emotional levels over time has only recently been explored seriously by Western science. One of the most promising leads demonstrating the organic effects of meditation (i.e., mindfulness meditation) on practitioners has been brain electroencephalogram (EEG) studies that have shown
that meditation practitioners undergo changes in various regions of their brain that affects their moods, affect regulation and attention allocation (Austin, 1999; Cahn & Polich, 2006; Davidson et al., 2003; Lutz, Greischar, Rawlings, Ricard, & Davidson, 2004). These studies will hopefully begin to shed some light on the physiological processes that underlie the tangible benefits and changes evoked through meditative practices, demystifying some of the ‘mystery’ in which these practices are traditionally shrouded. The question of whether meditation, or in this case mindfulness meditation, has an influence on practitioners has already been answered by the many studies showing its significant impact on various mental and physical ailments (Allen et al., 2006; Baer, 2003; Kabat-Zinn, 2003; Grossman, Niemann, Schmidt, & Walach, 2004), not to mention the already noted physiological changes taking place in the brains of practitioners. Therefore, a reasonable next question might be, ‘how is the practice of mindfulness meditation affecting or influencing the experiences of the practitioner in relation to various contexts (e.g., work) or specific situations (e.g., listening to someone talk)?’

Mindfulness has been described as an intrinsic attentional attribute of consciousness that can vary in strength and continuity across subjects (Brown & Ryan, 2004). The simplest conceptualization of mindfulness may be as “the nonjudgmental
observation of the ongoing stream of internal and external stimuli as they are” (Baer, 2003, pg. 125). However, Brown and Ryan (2004) argue “that mindfulness consists of a single factor described as attention to and awareness of what is taking place in the present” (p. 28).

Although the conceptualization or operational definition of mindfulness is still undergoing development (see Bishop et al., 2004; Shapiro, Carlson, Astin, & Freedman, 2006), the implementation of mindfulness training as an intervention in its own right (e.g., Mindfulness-Based-Stress-Reduction [MBSR], Mindfulness-Based-Cognitive-Therapy [MBCT]), or as one of several treatment procedures within multifaceted therapy approaches, (e.g., Dialectical-Behavior-Therapy [DBT], Acceptance-Commitment-Therapy [ACT], Relapse-Prevention-Therapy [RPT]), has already taken place within a variety of therapy modalities (Baer, 2003). Within most of these therapy modalities, therapists who are teaching their clients mindfulness skills are encouraged, or even expected, to have their own mindfulness practice so they are familiar with both technical and personal process issues (Kabat-Zinn, 2003).

The potential benefits of mindfulness practice have been investigated from the client’s perspective; recently, a growing number of authors (Day & Horton-Deutsch, 2004; Kabat-Zinn, 2003; Walsh & Shapiro, 2006) have suggested that the benefits of a
mindfulness practice could be of equal advantage to the therapists themselves and that MM should be a mandatory prerequisite for those therapists who wish to teach mindfulness to their clients. In particular, the research evidence suggesting that mindfulness practice can enhance certain traits relevant to therapy (e.g., empathy, self-awareness, self-compassion) has led some authors (Walsh & Shapiro, 2006) to claim, “that a personal meditation practice can benefit both clinicians and researchers” (p. 235). Another potential benefit of therapists having their own mindfulness meditation practice would be their deepening understanding of contemplative experiences, which could aid in the diagnosis and treatment of meditators’ problems as well as enhance overall therapeutic effectiveness (Germer, Siegel, & Fulton, 2005; Kabat-Zinn, 2003; Segal, William, & Teasdale, 2002).

The field of mindfulness research, and psychotherapy’s growing interest in this area is fairly new, which may explain why past and current research on mindfulness interventions has focused almost exclusively on the beneficial effects gained by patients and clients. However, there is still much to learn and explore with regard to mindfulness meditation’s relationship to therapists and their work and the potential benefits it may provide for both. This line of investigation is also important to consider, given the growing number of therapists who are
beginning to practice mindfulness meditation as a pre-requisite for teaching it to patients and clients.

Since no published research has been done looking exclusively at how the influence of mindfulness meditation is experienced by therapists in the context of their work, the current study addresses this paucity of research and is considered by the researcher to be a necessary and important first step in this area of investigation. The researcher also chose this issue in order to better understand and discern what value, if any, mindfulness meditation has for both counselling theory and practice.

**Objectives**

This research explores how therapists who practice mindfulness meditation experience its influence in relation to their work. I asked therapists to give both general and specific examples of how they perceived the influence of mindfulness meditation to be manifesting in their work. It was also expected by the researcher that the study would indirectly look at those qualities (e.g., empathy) that were believed to be essential for competency or mastery as a therapist and their perceived relation to mindfulness practice.

The literature review will first look at mindfulness and mindfulness meditation and the relevant research findings to date, followed by a review of the literature on master therapist
characteristics/traits, identified as characteristics of a skilled therapist. The literature review will conclude by bringing these topic areas together, reviewing both theoretical and empirical literature relevant to the relationship between mindfulness meditation, therapists and therapist qualities (i.e., self-awareness, compassion, empathy).

An interpretive description methodology (Thorne, Kirkham, & MacDonald-Emes, 1997; Thorne, Kirkham, & O’Flynn-Magee, 2004) was used to guide the research process. Twelve semi-structured in-depth interviews were conducted with six therapists (2 interviews each) who had a regular mindfulness meditation practice. A thematic analysis of interview transcripts highlighted commonalities and differences among participants’ perceptions of how mindfulness meditation’s influence was experienced within their therapeutic work context. Results are discussed with an emphasis on the practical implications of research findings for therapists and practice knowledge.

In this research project the aim was to investigate, understand and describe how therapists experience the influence of their mindfulness practice in relation to their therapeutic work and to illustrate this with concrete examples.

This research project begins with a review of literature that describes mindfulness and the practice of mindfulness
meditation, followed by a brief summary of important research findings generated in this area.
Brief History of Meditation

Meditation has been going on for at least the last 2500 years, if not much longer. Authorities contend that the art of meditation can be traced back to Egypt and the construction of the first pyramid around 2650 B.C. (Johnson, 1987; Loori, 1999). Meditation has a cross-cultural history, being practiced in many different societies over time, e.g., First Nations, Japanese, East Indian, Inuit, Chinese, Europeans and South American peoples (Johnson, 1987). As well, meditation or a similar contemplative practice is a foundational practice in many, if not all, forms of religion, e.g., Hindu, Sikhism, Buddhism, Judaism, Taoism, Islam/Sufism, Christianity (Ibid). Due to its widespread use and various forms there can be problems defining meditation in a generic sense. There are different theories of meditation and many varying definitions depending on the goal of meditation within specific contexts. Following is a range of definitions and conceptualizations of what meditation consists of, including multiple definitions of what ‘mindfulness’ and mindfulness-meditation entails.

Goleman, in his book ‘The Meditative Mind’ (1988), lists and describes various types of meditation techniques found across traditions, including:

• Sitting quietly in an attempt to produce a quiescent and restful state (relaxation meditation)
• Sitting quietly in an attempt to produce a state of excitement and arousal (e.g., Tantric Yoga meditation)

• Movement meditations that can induce states of excitement (Sufi whirling dervish) or relaxation (tai chi, hatha yoga etc.)

• Attention may be actively focused on one object of concentration to the exclusion of the other objects (e.g., Mantra repetition or observing the breath)

• Attention may be focused on one object, but as other objects, thoughts, or feelings occur, they too may be noticed and then attention returned to the original focal object (e.g., Mindfulness meditation)

• Attention may not be focused exclusively on any particular object (Zen’s Shikan-taza or vipashyana/insight meditation)

A general conceptualization of meditation as described by earlier writers can be thought of as an amalgamation of the following two definitions:

Meditation refers to a family of techniques which have in common a conscious attempt to focus attention in a non-analytical way and an attempt not to dwell on discursive, ruminating thought. (Shapiro, 1984, pg 6).

Meditation may be defined as an exercise in which the individual turns attention or awareness to dwell upon a single object, concept, sound, image or experience, with the intention of gaining greater spiritual or experiential
What is 'Mindfulness' and Mindfulness-Meditation?

The term or expression ‘Mindfulness’ originated some 2500 years ago in one of the Buddha’s most notable and popular discourses, the Satipatthana Sutta, which translates roughly into the ‘Foundations of Mindfulness’ or the ‘Way of Mindfulness.’ Other interpretations of the title include ‘The Presence of Mindfulness’ and ‘The Domain of Mindfulness’ (Thera, 1965). The compounded Pali term ‘sati-patthana’ breaks up into two separate words: sati, which within Buddhist scriptures usually refers to the present as ‘attention’ or ‘awareness,’ or more specifically to a kind of attentiveness which “is good, skillful or right” (Thera, 1965, p. 9). The second word patthana is a shortened version of the word upatthana, which literally means ‘placing near’ one’s mind, i.e., staying present, being aware, or setting-up awareness (Thera, 1965).

Though the teachings of the Buddha offer a wide range and variety of meditations suited to the many different temperaments, needs and capacities of the individual practitioner, they all eventually lead back to ‘The Foundations of Mindfulness’ (Satipatthana Sutta) called ‘the Only Way’ by the Buddha. Therefore, ‘The Foundations of Mindfulness’ can rightly be called the heart of both Buddhist meditation and the entire Buddhist doctrine. Nyanaponika Thera, an eminent Western Buddhist monk, states, “This

and existential insight, or of achieving improved psychological well being. (West, 1987, p.10).
great Heart is in fact the centre of all the blood streams pulsating through the entire body of the doctrine” (Thera, 1965, p. 7). He goes on to say that “All the implications of the Buddha’s healing message as well as the core of his mind-doctrine are included in the admonition ‘Be mindful!’ that pervades the Buddha’s great sermon on the ‘Foundations of Mindfulness’ (Satipatthana Sutta)” (Thera, 1965, p. 23).

Mindfulness, when associated with Buddhism or meditation in general, may mistakenly be thought of as a mystical or altered state of mind when, in its most elementary form or manifestation, it is a trait and experience both familiar and common to all of us, that of attention or awareness. Thought of as attention/awareness, it is one of the primary functions of consciousness, without which perception of any object would be impossible. Attention in this regard can be thought of as the first ‘taking notice’ of an object or the turning of consciousness towards it (Thera, 1965). Nyanaponika Thera (1965) refers to this initial attention or germinal mindfulness as still being a fairly primitive process.

Nyanaponika Thera (1986) believes mindfulness is best understood and systematically developed in its most basic form of ‘bare attention.’ He describes bare attention as “the clear and single-minded awareness of what actually happens to us and in us, at the successive moments of perception” (p. 51). He describes it as ‘bare’ because it is present to the bare facts of perception, not reacting
to them in any manner. Such a purely receptive mental state is rarely present for any significant length of time in the regular thought process. However, when methodically developed through the practice of mindfulness meditation to increase mindfulness and tap its latent powers, the sustained practice of ‘bare attention’ then becomes the key to the meditative practice of mindfulness—meditation based on the satipatthana sutta, i.e., The Foundations of Mindfulness (Thera, 1986).

Others have also described mindfulness as “bringing one’s complete attention to the present experience on a moment-to-moment basis” (Marlatt & Kristeller, 1999, p. 68) and as “paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally” (Kabat-Zinn, 1994, p. 4). The ability to direct one’s attention in this way can be developed through the practice of mindfulness meditation, which is defined as the intentional self-regulation of attention from moment to moment (Goleman & Schwartz, 1976; Kabat-Zinn, 1982).

The current mindfulness literature describes numerous meditation exercises and techniques designed to develop mindfulness skills (Bishop et al., 2004; Hanh, 1976; Kabat-Zinn, 1990, 1994; Linehan, 1993b). Mindfulness meditation can be thought of as a general label for the various forms and techniques of Buddhist meditation, particularly within western research literature, which has yet to reach a consensus in defining 'mindfulness' (Bishop et al, 2004).
Therefore the way people are taught and practice mindfulness meditation can vary according to what definition or procedural directions are followed. On a recent meditation retreat I attended, the meditation instructor explained that 'mindfulness meditation' was in fact a synthesis of two types/styles of Buddhist meditation (S. Armstrong, personal communication, Loon Lake retreat, March 2006). The two types blended in mindfulness meditation are 'calm abiding' or 'shamatha' meditation, which is concentrative or exclusive in nature (narrows attentional scope) and 'insight' or 'vipashyana' meditation, which is all encompassing or inclusive in nature (widens attentional scope). Contemporary mindfulness meditation therefore takes aspects from both 'calm abiding' and 'insight' meditation styles. Mindfulness meditation uses the breath as an anchor to come back to when lost in thought, similar to concentrative styles of meditation. However it does not limit itself to just the breath; when other phenomena come up in the stream of consciousness, they can be noticed as well, not automatically pushed away, thus the scope of attention or awareness slowly widens to include all phenomena, not just the breath.

One problem with all this diversity is that the general descriptions of what 'mindfulness' entails have been somewhat irregular. As Bishop et al. (2004) point out:

Although mindfulness has been described by a number of investigators (Kabat-Zinn, 1990, 1998; Shapiro & Swartz, 1999, 2000; Segal, Williams & Teasdale, 2002) the field has
thus far proceeded in the absence of an operational definition (Bishop, 2002). There have been no systematic efforts to establish the defining criteria of its various components or to specify the implicated psychological processes, and general descriptions of mindfulness have not been entirely consistent across investigators. (p. 231)

Lately researchers have been working towards synthesizing and operationalizing the term ‘mindfulness’ for the purpose of consistency across research (Bishop et al., 2004). Most forms of mindfulness meditation encourage individuals to attend to the internal experiences occurring in each moment, such as bodily sensations, thoughts, and emotions. Attention to aspects of the environment, such as sights and sounds can also be stressed (Kabat-Zinn, 1990; Linehan, 1993a). All suggest that mindfulness should be practiced with an attitude of non-judgmental acceptance. That is, phenomena that enter the individual’s awareness during mindfulness practice, such as perceptions, cognitions, emotions, or sensations, are observed carefully but are not evaluated as good or bad, true or false, healthy or sick, important or trivial (Brown & Ryan, 2003; Marlatt & Kristeller, 1999). Thus, mindfulness is the open/receptive and nonjudgmental observation of the ongoing stream of internal and external stimuli as they arise and pass away. Chogyam Trungpa, (1995), a Tibetan Buddhist meditation master, acknowledges the difficulty of explaining the nature of mindfulness; in spite of this
he comments it is “taking an interest in precision of all kinds, in the simplicity of the breath, of walking, of the sensations of the body, of the experiences of the mind, of the thought process and memories of all kinds” (p. 21).

It is worth noting that the term ‘mindfulness’ and the practice of ‘mindfulness meditation’ have more specific origins and components than are sometimes alluded to in mainstream media and current research studies (Wallace & Shapiro, 2006), which may sometimes overlook or simplify the connection (in part or whole) of ‘mindfulness’ and mindfulness meditation within the greater context of the 2500 year old Buddhist tradition. The term or label ‘mindfulness’ and the tradition of ‘mindfulness meditation’ have been separated from Buddhism as a whole and to some extent adapted to meet western scholars’ conceptions of it, which has included disassociating it from its religious and cultural origins (Walsh & Shapiro, 2006; Baer, 2003). Unfortunately, in the attempts to ‘re-frame’ and ‘decontextualize’ meditation from its greater religious tradition, the spiritual goals and inherent richness and uniqueness of some important elements have probably been lost (Walsh & Shapiro, 2006; Baer, 2003). This in turn may have impoverished the actual practice and benefits of mindfulness meditation. Another perspective on mindfulness’ decontextualization from its greater socio-religious context is championed by Leigh, Bowen, and Marlatt, (2005) who suggest that mindfulness can be seen as a technique within Buddhism
that helps the practitioner pursue and fulfill spiritual goals, but it could just as easily be seen as a way of ‘being’ with experience, not necessarily related or exclusive to spirituality or a particular religion.

**Mindfulness: A Working Definition**

Although the controversy about what to keep or set aside regarding mindfulness and the practice of mindfulness meditation will no doubt continue, for the purposes of this study, which will be based on current scholarly research, the term ‘mindfulness’ and the practice of ‘mindfulness meditation’ will follow the tentative definition outlined by Bishop et al. (2004) in their article entitled, “Mindfulness: A Proposed Operational Definition” (p. 230). Bishop et al. (2004) recommend a model of mindfulness that consists of two parts: (a) self-regulation of attention and (b) assuming a specific orientation to experience. The ‘self-regulation of attention’ involves “sustained attention, attention switching, and inhibition of elaborative processing” (p. 233). The ‘orientation to experience’ involves an “orientation of curiosity, experiential openness, and acceptance” (p. 234) towards all that manifests in the body and mind.

Bishop et al. (2004) claim that even though various meditation techniques exist and are used to teach mindfulness, they all basically share similar procedures and goals. The example of sitting meditation is given:
The client maintains an upright sitting posture, either in a chair or cross-legged on the floor and attempts to maintain attention on a particular focus, most commonly the somatic sensations of his or her own breathing. Whenever attention wanders from the breath to inevitable thoughts and feelings that arise, the client will simply take notice of them and then let them go as attention is returned to the breath. This process is repeated each time that attention wanders away from the breath. As sitting meditation is practiced, there is an emphasis on simply taking notice of whatever the mind happens to wander to and accepting each object without making judgments about it or elaborating on its implications, additional meanings, or need for action. (p. 232)

Bishop et al. (2004) go on to describe the post-meditation experience and further elaborate on the concept of mindfulness:

The client is further encouraged to use the same general approach outside of his or her formal meditation practice as much as possible by bringing awareness back to the here-and-now during the course of the day, using the breath as an anchor, whenever he or she notices a general lack of awareness or that attention has become focused on streams of thoughts, worries, or ruminations. These procedures ostensibly lead to a state of mindfulness. Broadly conceptualized, mindfulness has been
described as a kind of nonelaborative, nonjudgmental, present-centered awareness in which each thought, feeling, or sensation that arises in the attentional field is acknowledged and accepted as it is. In a state of mindfulness, thoughts and feelings are observed as events in the mind, without over-identifying with them and without reacting to them in an automatic, habitual pattern of reactivity. This dispassionate state of self-observation is thought to introduce a “space” between one’s perception and response. Thus mindfulness is thought to enable one to respond to situations more reflectively (as opposed to reflexively). (p. 232)

*Conceptual Approaches: How Mindfulness Skills May Help*

Several psychological mechanisms have been proposed to explain how mindfulness practice may lead to behavioural change and symptom reduction (Baer, 2003; Shapiro et al., 2006). These include: exposure, cognitive change, self-management, relaxation and acceptance.

Exposure works by desensitizing practitioners to phenomena (e.g., painful/unpleasant sensations or emotions) that would normally incite a reaction. Through repeated exposure to the phenomena with a non-judgmental, non-reactive attitude of observation, the practitioner learns to experience formally unpleasant phenomena without reacting as strongly or trying to avoid the experience. Over
time the mental distress and suffering that would normally accompany the unpleasant phenomena lessen.

Cognitive change works by changing patterns of thoughts and attitudes towards one’s thoughts. As mindfulness practitioners begin to learn that aversive or reactive thoughts are ‘just thoughts’ and do not necessarily reflect reality, they are not as likely to base their actions on them. The non-judgmental, decentered attitude towards thoughts cultivated in mindfulness practice may also “interfere with ruminative patterns believed to be characteristic of depressive episodes” (Baer, 2003, p. 129). By noticing these depressing thoughts the practitioner can avoid getting caught up in them and instead skillfully redirect attention to other aspects of experience (e.g., breath, body, environment).

Self-management and coping skills are enhanced through the practice of self-observation, which is cultivated through mindfulness practice. Improved self-observation may allow practitioners to notice potential signs of trouble early on and implement previously learned strategies/skills to handle them more effectively. As well, recognition of problematic, maladaptive or impulsive behaviours through self-observation may help reduce them and “lead to more effective behaviour change” (Baer, 2003, p. 129). Attention and its control can be significantly improved through mindfulness practice, which can help individuals who might otherwise be distracted
frequently by “worries, memories, or negative moods” (Baer, 2003, p. 129).

Relaxation has been associated with various meditation techniques; however, in relation to mindfulness practice it should be seen as a side effect rather than one of mindfulness' principal goals. Nevertheless, relaxation may contribute in unspecified ways to the overall benefits of mindfulness practice.

Acceptance is a major factor in the practice and conceptualization of mindfulness. The basic practice of mindfulness includes the acceptance of thoughts, sensations, and emotions whether painful or pleasant, “without trying to change, escape, or avoid them” (Baer, 2003, p. 130). The inherent benefit in cultivating a stance of acceptance is apparent when considering the alternative stance of denial or avoidance, which can lead to numerous maladaptive behaviours, strategies and their subsequent detrimental effects, all for the sake of altering or rejecting reality. If one can learn to cultivate acceptance towards life circumstances and changing phenomena, then any unpleasantness one may encounter can be seen as a temporary condition that can be tolerated “rather than fearsome and dangerous experiences to be avoided” (Baer, 2003, p. 130).

Contemporary Applications of Mindfulness: Developments in Research

Interest in the potential benefits and application of mindfulness meditation has been growing at an unprecedented rate over
the past decade in various fields, especially within mental health (Bishop et al., 2003; Kabat-Zinn, 2003). Following is a brief summary of some of the more rigorous and comprehensive studies that have been conducted to date on the effects and efficacy of mindfulness meditation. A variety of populations (e.g., medical patients, prisoners, students, health professionals) suffering from a range of mental, emotional and physical afflictions such as depression, anxiety, stress, fibromyalgia, mixed cancer diagnoses, coronary artery diseases, and obesity have been investigated (for reviews see Baer, 2003 and Grossman, Niemann, Schmidt, & Walach, 2004).

In their meta-analysis, Grossman, Niemann, Schmidt, and Walach (2004) conducted a comprehensive review of both published and unpublished studies, which investigated the effectiveness of mindfulness-based stress reduction (MBSR) programs on a wide range of health benefits (both physical and mental). Of the 64 studies found during the initial review, only 20 (1605 subjects in total) ended up meeting the acceptance criteria for quality or relevance. Studies were excluded generally because of poor methodology, e.g., “insufficient information about interventions...[and] inadequate statistical analysis” (p. 35), or because mindfulness was not the main component of the intervention under investigation.

Data selection and extraction were guided by the goal of the meta-analysis, which was to assess the effect mindfulness meditation has as an intervention on strictly defined mental and physical health
status measures. Only data from standardized and validated measures with previously established internal consistency was used (e.g., Beck Depression Inventory).

The meta-analysis suggests that mindfulness practice and training could improve efficacy when dealing with the problems and disabilities of ordinary life as well as in the more extreme cases involving acute disorders and stress (Grossman et al., 2004). This finding is associated with a comparatively strong probability level across a variety of different types of samples. As well, the various types of studies (i.e., controlled, observational) reviewed in the meta-analysis also shared similar effect sizes suggesting that there is some support for the “specificity of the mindfulness intervention” (Grossman et al., 2004, p. 40).

Though the results of the meta-analysis are promising, the authors caution that there are several limiting factors such as insufficient diversity of the types of sample diagnoses, a reduced number of randomized studies and the inclusion of certain unpublished research studies. A further criticism put forward by the authors was that certain studies were methodologically deficient and lacking information regarding participant drop out, the mindfulness training period, therapist adherence to the intervention program and the lack of an operationalized construct of ‘mindfulness’ itself.

(MBSR) is in fact a useful intervention for a wide range of problems and disorders.

Other recent studies have provided further support for the usefulness of mindfulness meditation as an effective intervention for a wide variety of physical and mental health ailments (Baer, 2003; Kabat-Zinn, 2003; Chang et al., 2004; Smith, Richardson, & Pilkington, 2005). In one such study, Baer (2003) performed a conceptual and empirical review of mindfulness-based interventions using meta-analytic techniques to investigate their utility. Several current interventions using mindfulness training were singled out in the study. These included mindfulness-based stress reduction (MBSR); mindfulness-based cognitive therapy (MBCT); dialectical behaviour therapy (DBT); acceptance and commitment therapy (ACT) and relapse prevention (RP). However, only studies using MBSR and MBCT interventions ended up meeting the meta-analysis requirements for inclusion because the DBT, ACT and RP studies didn't clearly separate the behaviour change interventions from the mindfulness-based interventions. Therefore, results from these studies would not be directly attributable to mindfulness interventions alone.

Overall, findings from this meta-analytic study supported the effectiveness of mindfulness-based interventions in the treatment of several physical and mental afflictions, e.g., chronic pain, fibromyalgia, anxiety/panic disorders and depression to name a few. As Baer (2003) notes, “the current literature suggests that
mindfulness-based interventions may help to alleviate a variety of mental health problems and improve psychological functioning” (p. 139), thereby helping to reduce psychological distress to normal levels.

Other studies have found that mindfulness meditation ameliorates phobic anxiety, insomnia and eating disorders while enhancing perception, empathy, synesthesia and interpersonal functioning (Walsh & Shapiro, 2006). Personality variables have also been shown to change with meditation. Many positive qualities such as openness, emotional stability, agreeableness and extraversion have all been shown to increase with meditation practice (Travis, Arenander & DuBois, 2004). Andresen (2000) reported that meditation practitioners report feeling they have better self-control and self-esteem (not at all surprising considering the self-regulatory nature of meditation).

Table 1

<table>
<thead>
<tr>
<th>Summary of Mindfulness Meditation Effects</th>
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<tbody>
<tr>
<td>1. Reduced anxiety (Grossman et al., 2004)</td>
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<td>2. Improved well-being and coping skills (Grossman et al., 2004)</td>
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<tr>
<td>3. Decreased tendency to take on others’ negative emotions (Beddoe &amp; Murphy, 2004; Goleman, 2003)</td>
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<tr>
<td>4. Increased self-awareness and self-acceptance; allowance and awareness of all feelings, sensations and thoughts (Beddoe &amp; Murphy, 2004)</td>
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<td>5. Cultivation of wisdom through the development of non-judgmental observation, active listening, flexibility, presence, insight and compassion (Santorelli, 1992)</td>
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</table>
6. Improvement in behavioural self-regulation and management (Andresen, 2000; Brown & Ryan, 2003; Shapiro et al., 2006)

7. Increased openness to experience (Kristeller & Johnson, 2005)

8. Promotes empathy and compassion (Kristeller & Johnson, 2005)

Summary

Having reviewed some of the most current research findings on the efficacy of mindfulness training and the various benefits derived by its practitioners, the question of how mindfulness practice could be of significance and benefit to therapists can be considered. Up until now therapists have focused mainly on administering the practice to their patients or clients instead of considering the inherent benefits of practice for themselves and their work. In contemplating the relevance of mindfulness practice to therapists and therapeutic schools, Walsh and Shapiro (2006) boldly state:

A more provocative question may be whether there are mainstream therapies that would not benefit from the addition of mindfulness training given that enhanced awareness (mindfulness) may be a common therapeutic factor across meditations and psychotherapies and that meditation enhances awareness. (p. 234)

In the next section the qualities and traits deemed essential by master therapists and the field of psychotherapy in general will be
investigated to see whether there is, in fact, any conceptual overlap or connection between these qualities and those cultivated by mindfulness practice.

*Master Therapists*

One of the most widely recognized findings in psychotherapy research is that the counsellor/therapist plays a critical role in affecting client treatment and outcomes for better or for worse (Crits-Cristoph et al., 1991; Henry & Strupp, 1994; Lambert, 1989; Luborsky et al., 1986; Orlinsky & Howard, 1980; Ricks, 1974; Skovholt & Jennings, 2005; Teyber & McClure, 2000; Wampold, 2001). After a thorough review of the research, Wampold (2001) succinctly expressed the clear influence of the therapist’s person on successful therapy:

> We have seen that the particular treatment that the therapist delivers does not affect outcomes. Moreover, adherence to the treatment protocol does not account for the variability in outcomes. Nevertheless, therapists within treatment account for a large proportion of the variance. Clearly, the person of the therapist is a crucial factor in the success of therapy. (p. 20-21)

Having established the significance of the therapist’s effect (as opposed to the client’s effect or a specific orientation’s effect) on therapy outcomes, it seems reasonable to ask what therapist characteristics affect treatment outcomes positively, or are considered desirable by competent practitioners.
The idea that therapists (e.g., counsellors/psychologists) should have certain characteristics or qualities in order to effectively perform their roles seems reasonable. However, we should be careful not to assume we already know what these characteristics are and that they are indisputable. As Hackney and Cormier (2005) point out:

Research on the effectiveness of counseling does not provide clear evidence of the relative contributions of factors that influence counseling. Nevertheless, the professional literature is consistent in its emphasis on counselor characteristics as important to the success of counseling. (p. 13)

What are these characteristics and to what degree do they have to be present in the therapist for them to be effective? To begin exploring these questions and others we can start by looking at what being an ‘Expert’ or ‘Master’ therapist involves. By looking at what is considered masterful or what defines ‘expertise’ within the field of therapy, we can see what traits or qualities master therapists ideally embody and begin to delineate what makes a master therapist unique.

As might be expected, there doesn’t appear to be one all-encompassing theory or recipe for what a ‘Master/Expert’ therapist should be that is unanimously accepted. Nonetheless there is quite a bit of overlap between different views and definitions, so a rough or
A tentative picture can be established. Most of these models or definitions of a ‘Master’ or ‘Expert’ therapist are found in introductory text books that are concerned with a general overview of what being a professional therapist entails and the traits that are deemed desirable for the professional therapist. More specifically, though, these books tend to include various ‘lists’ or roles and qualities that a professional therapist should engender and hopefully cultivate (Hackney & Cormier, 2005; Jennings & Skovholt, 2004; Johns, 1996; Lauver & Harvey, 1997; Long, 1996; Mearns & Thorne, 1999; Noonan & Spurling, 1992; O’Donohue, Cummings, & Cummings, 2006; Wheeler, 1996). Qualities such as empathy, active listening, self/other awareness (e.g., distinguishing their ‘stuff’ from clients’), self-care/control (e.g., managing and containing their own personal issues and emotions), compassion, emotional intelligence, unconditional positive regard or a non-reactive/non-judgemental attitude are emphasized as essential qualities and skills for a professional therapist.

One such list that has endured the test of time is presented in Hackney and Cormier’s book “The Professional Counselor” (2005) under the sub-heading “Characteristics of Effective Helpers.” The list provides the characteristics that are thought to be important for successful counselling. These include self-awareness and understanding; good psychological health; sensitivity to and understanding of various factors in both self and others that may
influence the therapeutic relationship (e.g., race, ethnicity and culture); open-mindedness; objectivity; competence; trustworthiness; interpersonal attractiveness. In addition, striving for internality, the ability to be empathic, genuine and accepting are mentioned as well.

Though the various lists and summaries regarding beneficial therapists traits are helpful and can be used as a starting point to deepen our understanding, they likely reflect the author’s individual conceptualizations of what a ‘master therapist’ is or should be. In order to avoid relying solely on these conceptually based ‘lists’ it is essential to consider current research, which directly addresses the question of ‘master therapist’ characteristics.

Len Jennings and Thomas M. Skovholt have presented some of the leading research addressing the issue of master therapist characteristics. In their landmark study on the cognitive, emotional and relational characteristics of master therapists (Jennings & Skovholt, 1999), they interviewed 10 peer-nominated master therapists using qualitative research methods. Purposeful sampling was used as the strategy for identifying master therapists. In purposeful sampling, exemplars of or experts on the concept/subject being investigated are identified and recruited to provide information-rich accounts of it (Patton, 2002). Jennings and Skovholt (1999) used a type of purposeful sampling called “snowball sampling” to recruit ‘exemplars’ or ‘experts.’ This method involved asking ‘well situated’
people (in this case admirably regarded therapists) “to nominate colleagues whom they considered to be master therapists” (Jennings & Skovholt, 1999, p. 4). Those individuals who were repeatedly nominated by the other therapists then constituted the core of the subject-pool for the study.

Selection criteria for Master Therapists was guided by the subsequent list (Jennings & Skovholt, 1999):

(a) This person is considered to be a “master therapist”;
(b) this person is most frequently thought of when referring a close family member or a dear friend to a therapist because the person is considered to be the “best of the best”; and (c) one would have full confidence in seeing this therapist for one’s own personal therapy.

Therefore, this therapist might be considered a “therapist’s therapist.” (p. 4)

The interview design included an initial interview with a second follow-up interview 2 months later. From these interviews and the subsequent data analysis, twenty-six themes within nine categories emerged and were divided into three general domains (cognitive, emotional, and relational).

The three domains labelled cognitive, emotional, and relational (CER) are broken up into nine categories as follows (Jennings & Skovholt, 1999):

(a) The cognitive domain includes the categories 1-3, which are:
• Master therapists are voracious learners
• Accumulated experiences have become a major resource for master therapists
• Master therapists value cognitive complexity and the ambiguity of the human condition

(b) The emotional domain includes categories 4–6, which are:

• Master therapists appear to have emotional receptivity defined as being self-aware, reflective, non-defensive, and open to feedback
• Master therapists seem to be mentally healthy and mature individuals who attend to their own emotional well-being
• Master therapists are aware of how their emotional health affects the quality of their work

(c) The relational domain includes categories 7–9, which are:

• Master therapists possess strong relationship skills
• Master therapists believe that the foundation for therapeutic change is a strong working alliance
• Master therapists appear to be experts at using their exceptional relationships skills in therapy

In summary, Jennings and Skovholt (1999) see their CER model of the master therapist as a blend of cognitive, emotional and
relational domains, which ‘master therapists’ have developed “to a very high level and have all three domains at their service when working with clients” (Jennings & Skovholt, 1999, p. 9). Therefore the master therapist is seen as someone who is constantly benefiting from and developing a number of characteristics in order to improve professionally. Jennings and Skovholt (1999) point out that very few researchers have seriously investigated the abundant wisdom and knowledge possessed by experienced, well-regarded therapists. As well, research on the expertise of therapists has tended to focus solely on the cognitive processes of the therapist, whereas in Jennings and Skovholt’s (1999) CER model, the cognitive processes of the therapist are considered to be only one leg of a tripod, and suggest that expertise in psychotherapy includes more than just a cognitive dimension.

Jennings and Skovholt’s findings are of particular interest when considering the conceptual similarities between these ‘Master Therapist’ traits and the attitudes, skills and qualities developed through the practice of mindfulness meditation.

Although the Jennings and Skovholt (1999) study is considered to be a good step in the right direction on master therapist research (Orlinsky, 1999), Jennings and Skovholt still point out several limitations with their study such as generalizability (this is to be expected since a qualitative research design was used); the sampling method (purposeful/snowball sampling) might have inadvertently
excluded therapists who were outstanding but not as well known among colleagues; though efforts to minimize subjectivity such as experimenter bias were taken throughout the research study, it was present nonetheless to some degree; as well, there was a lack of variety in the research sample.

Even though Jennings and Skovholt’s (1999) findings may be tentative due to several aforementioned limitations (see Jennings & Skovholt, 1999; Orlinsky, 1999), they claim there is still convergence between their research findings and those of others investigating the characteristics and qualities of competence and expertise (Skovholt & Ronnestad, 1995; Ward & House, 1998), which remains promising.

In a more recent study by Jennings, Sovereign, Bottorff, Mussel, and Vye (2005), the authors reanalyzed interview data from Jennings and Skovholt’s original 1999 study, using the ‘Consensual Qualitative Research method’ (Hill, Thompson, & Williams, 1997). The purpose of Jennings et al.’s 2005 study was to discern the core/primary ethical values of master therapists. Nine principal values related to the master therapists’ clinical practice emerged. These were then divided into two categories. The first “building and maintaining interpersonal attachments” (p. 37) included relational connection, autonomy, beneficence, and nonmaleficence. The second category “building and maintaining expertise” (p. 37) included competence,
humility, professional growth, openness (to complexity and ambiguity), and self-awareness.

As Jennings and Skovholt (1999) pointed out, if their findings are replicated by future research, the characteristics delineated in their study may be used as “guideposts for therapists and therapist training programs seeking to promote optimal therapist development” (p. 9). This newfound interest in master therapist characteristics appears to have started an ongoing dialectic of what being a ‘master therapist’ actually entails. How this might affect the promotion and development of specific desirable therapist characteristics/traits is still uncertain. However, considering the overlap between master therapist qualities in at least a couple of domains (i.e., general and ethical), there seem to be certain qualities such as self-awareness that are considered vital for mastery.

Summary

Taking into account the previous literature concerning the effects of mindfulness meditation on practitioners (and its ability to enhance or reduce certain desirable and undesirable traits/qualities), it would appear that many of the qualities/traits/attitudes that mindfulness meditation cultivates may be those exemplified by master therapists and sought after by those attempting to develop mastery. Is it possible that what Jennings and Skohvolt have uncovered as essential qualities for therapists to develop and master are similar, at least in part, to those cultivated
through the practice of mindfulness meditation? Next, the relationship between master therapist qualities, effective therapeutic work and mindfulness practice will conclude the literature review.

Mindfulness and Therapists

It has become quite apparent through past and ongoing research that mindfulness meditation and the adaptations born from it, including the various therapeutic interventions already listed (i.e., MBCT, MBSR, DBT etc.), have proven its usefulness as a technique for ameliorating a wide range of ailments (e.g., depression, stress and anxiety etc.), not to mention its ability to act as a potential "vaccine" against these very ailments before they get a real chance to cause significant distress.

The fruits of mindfulness practice are legion when considering the long list of returns one gets from sustained practice. Many of the acclaimed benefits such as greater cognitive, emotional and behavioural flexibility, recognition of unconscious conflicts (due to increased access to the unconscious), ability to detach and observe fears and worries in a relaxed manner, loosening of defenses, increased self-awareness of mental and emotional states and improved self-regulation and management (Bogart, 1991; Shapiro et al., 2006) are likely to enhance both therapists personally and their professional skills. Walsh and Shapiro (2006) make comparisons between the qualities developed through meditation and those
acclaimed as essential therapist qualities including “Roger’s ‘accurate empathy,’ as well as attentional qualities such as Bugental’s ‘presence,’ Freud’s ‘evenly hovering attention,’ and Horney’s ‘wholehearted attention.’ ... Other capacities enhanced by meditation, such as calm, self-actualization, and self-acceptance, may also benefit clinicians” (p. 235).

Rubin (1985) has also made the connection between Freud’s ‘evenly-hovering attention’ and ‘optimum listening’ to the process of mindfulness meditation. The meditative process of being attentive and not succumbing to distractions are also guiding elements in proper psychoanalytic listening.

There are other shared components between meditation and therapy as well, for instance telling the truth, preventing self-deception, trust and authenticity, integrity and wholeness, release of negative emotions, forgiveness of oneself and others, opening of the heart to give and receive greater love, awareness of limiting self-concepts, freedom from fear and delusion and a nonjudgemental attitude (Vaughan, 1989).

Keefe (1975) argues that “greater awareness of feelings, enhanced interpersonal perception, and increased present-centeredness are behaviours transferred from meditation, and helpful both to the psychotherapist and to interpersonal functioning” (p. 484). He stresses the importance to the helping professions of a technique like meditation that can enhance empathy, improve interpersonal
functioning and act as a means to enhance these essential qualities that are so vital to being a good therapist. Keefe (1975) delineates the main products of meditation that facilitate therapy as:

1) enhanced awareness of one’s own feelings; 2) increased ability to hold complex cognitive processes in abeyance in order to enhance perception; and 3) enhanced capacity to maintain a focus of attention and awareness upon present events--in other words, to be in the here-and-now. (p. 487)

In conclusion, Keefe (1975) sums up his position by stating "Meditation may be found to be a potent tool for the psychotherapist in the facilitation of his or her own effectiveness and in the enhancement of interpersonal functioning in general" (p. 489). Kakar (2003) also insinuates the usefulness of meditation as a potential training technique for therapists. He suggests, “analysts need to remain open to the possibility that an Eastern meditative discipline could become a part of their training” (p. 674).

Many other authors (Connelly, 2005; Cooper, 2004; Epstein, 1999; Hirst, 2003; Kakar, 2003; Pettinati, 2001; Schmidt, 2004) have supported the view that mindfulness meditation in its various forms can be useful to the practicing health-care professional or therapist and by extension to the clients/patients in a number of ways. Among the benefits cited are improved self/other care in a way that attends to all levels of the body, mind, emotions and spirit; increased attention/focus allowing the health provider to generate a better
narrative between patient and physician; improved ability to listen attentively, recognize one’s own errors and clarify values so that care-providers can act with compassion, presence and insight.

Knowing the inherent value of meditation (and specifically mindfulness meditation) for people’s mental, emotional and physical health, and the increasing number of users world-wide (Walsh & Shapiro, 2006), there now appears to be an equally rapid growth and interest in research, especially within Western psychology (Walsh & Shapiro, 2006). Even as far back as 1977, the APA had already begun to recognize the potential significance and usefulness of meditation for facilitating the “psychotherapeutic process” (Kutz, Borysenko, & Benson, 1985).

Given this growing interest in the benefits and usefulness of meditation for psychotherapy and the therapist, it is important to take a closer look at how this ancient spiritual practice could benefit not only clients but the therapists themselves in coping with various ailments, while also enhancing desirable traits in them and increasing their skills as therapists.

Another reason why MM in relation to therapists should be investigated is because of the growing number of therapists who are teaching or implementing MM into therapy with clients. As many of the original MM therapists have pointed out, it is imperative that those who wish to teach MM have their own personal practice if they wish to teach it to clients or at the very least have more than a superficial
understanding of its mechanisms (Dimidjian & Linehan, 2003; Gazella, 2005; Kabat-Zinn, 2003; Teasdale, Segal, & Williams, 2003). In some cases having a personal MM practice is even considered a requirement of teacher training and effective therapeutic practice, e.g., MBSR and MBCT (Kabat-Zinn, 2003; Teasdale, Segal, & Williams, 2003). Since little is known about how MM practice will personally/subjectively affect therapists practicing it, it seems even more important to begin investigating the potential effects a personal MM practice will have on therapists, and in particular, how it will affect their work.

Following is a brief summary of a few studies conducted by researchers that have taken the time to look at the potential benefits and effects of practicing MM for the actual ‘health providers’ or ‘healers’ in various settings. This researcher did not locate any studies looking specifically at counsellors or ‘therapists;’ the studies identified focused on the more general category of ‘health providers/professionals’ (i.e., nurses, doctors, social and hospice workers).

Quantitative Studies

In a number of recent quantitative studies investigating the effects of Mindfulness-Based Stress Reduction (MBSR) on current and future health care professionals (Beddoe & Murphy, 2004; Galantino, Baime, Maguire, Szapary, & Farrar, 2005; Shapiro, Astin, Bishop, & Cordova, 2005; Shapiro, Schwartz, & Bonner, 1998), a variety of positive outcomes were listed including: reduction in both state and
trait anxiety, decreases in overall psychological distress (including depression), increased empathy, decreased tendency to take on the negative emotions of others, greater well-being and improved coping skills, a decrease in emotional exhaustion, increased quality of life and self-compassion. These findings highlight the potential usefulness of MBSR and mindfulness training for health care professionals. In addition, the benefits derived from mindfulness practice may indirectly have a positive affect on the patients/clients of health and mental health care professionals (Epstein, 1999; Gazella, 2005; Grepmair, Mitterlehner, Loew, Bachler, Rother, & Nickel, 2007).

Qualitative Studies

The only qualitative study found which approximated the current study’s investigation of the experience of mindfulness for therapists at work was Bruce and Davies’ (2005) interpretive study exploring the experience of mindfulness for hospice caregivers who have a personal mindfulness meditation practice.

Bruce and Davies (2005) highlighted the lack of research that looks at the “lived experience of mindfulness and its meaning for those who practice it” (p. 1329). They also acknowledged that, up until recently, the majority of research involving mindfulness meditation has been guided by quantitative research designs, not qualitative ones that can look at ‘meaning’ and ‘lived experience.’ Research has also focused more on mindfulness meditation as a
clinical intervention and its effectiveness rather than on how it is subjectively experienced by practitioners (Ibid).

Overall the method used was a form of narrative inquiry. The location for data collection was a unique hospice that integrated Zen Buddhist philosophy with Western palliative care. Both hospice staff and volunteers practiced mindfulness meditation on a daily basis. Data for the study was collected through reflexive participation, open-ended conversations, and field writings (i.e., journal and field notes). Nine meditation practitioners consisting of hospice staff, volunteer caregivers and community members with HIV/AIDS participated in the study. The data analysis was guided by “an iterative process rather than a direct application of any particular method” (Bruce & Davies, 2005, p. 1334). Peer debriefing, prolonged immersion in the data set, talks with caregivers, review by five university faculty members and mindful reflexivity were implemented to ensure trustworthiness (Ibid).

Four main themes and accompanying sub-topics emerged from the data. The following table contains excerpts from each of the four main themes from Bruce and Davies’s study (2005, p. 1335):
Table 2

Practicing Meditation-in-Action

<table>
<thead>
<tr>
<th>Meditation-in-action</th>
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<tbody>
<tr>
<td>Anchoring awareness in ordinary activities</td>
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<tr>
<td>An approach to being present</td>
</tr>
<tr>
<td>Relaxing into the immediacy of what is happening</td>
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<table>
<thead>
<tr>
<th>Abiding in liminal spaces</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sense of separation dissolves</td>
</tr>
<tr>
<td>Appreciating opposing tensions</td>
</tr>
<tr>
<td>Integral to empathy and compassion</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Seeing differently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceptions shifting</td>
</tr>
<tr>
<td>Vivid sense of appreciation and beauty</td>
</tr>
<tr>
<td>Cultivating openness without agendas</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Resting with groundlessness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Letting go of wishing things were otherwise and fearing what might be</td>
</tr>
<tr>
<td>Becoming intimate with fear</td>
</tr>
<tr>
<td>Practicing abiding in the midst of emotions</td>
</tr>
<tr>
<td>Practicing continuously opening to experience</td>
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</tbody>
</table>

Bruce and Davies (2005) point out the potential benefits of enhancing awareness of disruptive/disturbing patterns (most notably
those involving fear, avoidance and discomfort) through the practice of mindfulness. This was described as having the potential to help caregivers, their patients and their patients’ families deal more effectively with existential fears, improving the palliative experience for all involved.

It is worth noting that at least a few of the benefits listed in the previous table, such as ‘practicing continuously opening to experience,’ ‘cultivating openness without agendas’ and ‘practicing abiding in the midst of emotions,’ are similar to some of the categories listed as master therapist characteristics in Jennings & Skovholt’s (1999) study.

A research program by Cohen-Katz, Wiley, Capuano, Baker, and Shapiro (2004), with both quantitative (Cohen-Katz, Wiley, Capuano, Baker, Kimmel, & Shapiro, 2005a) and qualitative (Cohen-Katz, Wiley, Capuano, Baker, Deitrick, & Shapiro, 2005b) elements, looked at the effects of Mindfulness-based Stress Reduction (MBSR) on nurse burnout and stress. This study produced findings (both quantitative and qualitative) suggesting that the MBSR treatment for nurses was promising. More explicitly, the authors found it to be “an effective strategy for reducing burnout” as well as “reductions in emotional exhaustion and depersonalization” (p. 32). These findings are particularly significant because emotional exhaustion is usually considered to be one of the strongest variables linked to burnout (Cohen-Katz et al., 2005b). The results from the qualitative,
interview portion of the study described some of the benefits that nurses acquired through the program, such as increased patience, relaxation, calmness, release of negative pent-up emotions of which they had been previously unaware, increased confidence, improved sleeping and eating patterns, better self-care practices (e.g., exercising), significant increases in self-acceptance and self-awareness. The MBSR program appears to have deeply affected their relationships as well, both personal and professional. Participants reported that it increased their ability to be less reactive or defensive, fairer, more consistent in relationships and to have greater presence with patients. Empathy and an appreciation of others was enhanced also. One nurse from the study was so impressed by the changes she observed that she described the MBSR program as “Absolutely awesome! Should be mandatory for all employees at least every five years” (Cohen-Katz, 2005b, p. 85).

Summary

Having discussed some of the potential ways MM could benefit or be of use to health and mental health-care professionals, as well as looked at a brief review of quantitative and qualitative studies that actually investigated the potential effects and benefits of MM for health-care professionals, it is not hard to make the inference that these same benefits may also apply more specifically to psychotherapists. To summarize, a few important reasons for considering the usefulness/benefits of MM for therapists have been:
(a) The increasing evidence that MM is of great benefit to its users in a variety of ways (i.e., mental, emotional, and physical).

(b) The potential ability of MM practice to enhance certain desirable therapist characteristics such as attention and empathy, while decreasing or regulating less desirable ones such as depression and anxiety.

(c) The growing number of therapists using MM with clients, leading some training programs to require trainees to have their own regular MM practice.

(d) The potential value of using MM as a training technique for future and current mental health-care providers for self-care and as a professional skill for enhancing service to clients or patients.

To explore the potential benefits and usefulness of MM for therapists and their work, an appropriate method that will capture the subjective experience of MM on therapists’ work is needed, one that not only investigates and describes the personal experience of therapists who practice MM, but also looks for common themes among therapists-practitioners that may then be used purposefully within the field, both clinically and theoretically. For these reasons, the method of Interpretive Description (Thorne et al, 1997; 2004) was chosen. The next chapter describes the method and procedures that guided the investigation throughout the research process.
CHAPTER 3: METHOD

The present chapter will outline the methodological design of this study, the rationale for using this particular method, the central assumptions and biases of the researcher, the participation criteria, participant characteristics and the research procedures and data analysis.

To answer the research question, “How do therapists who practice mindfulness meditation experience its influence within the context of their work?”, the qualitative method of Interpretive Description (Thorne et al., 1997, 2004) was used.

Qualitative methodologies such as Interpretive Description are particularly suited for studying, describing, clarifying and understanding subjective human experiences or ‘lived experiences’ (Polkinghorne, 2005; Schwandt, 2001; Streubert, 1999). As Schwandt (2001) so eloquently puts it, “Qualitative inquiry deals with human lived experience. It is the life-world as it is lived, felt, undergone, made sense of, and accomplished by human beings that is the object of study” (p. 84).

The main reason for using the qualitative methodology of Interpretive Description instead of a quantitative methodology is due to the nature of the research question, which looks to investigate therapists’ lived experience. As well, the experiential nature of mindfulness-meditation, and therapy in general, makes qualitative inquiry an ideal choice under the circumstances.
Within the qualitative family, Interpretive Description was a particularly good fit for the research question. Interpretive Description’s research goals and strategy (Thorne et al., 1997, 2004) attempts to understand and describe both what is particular to the individual case (i.e., a participant’s experience of mindfulness meditation’s influence within the context of his/her work), as well as what is common among individual cases (i.e., what aspects of participants’ experiences of mindfulness meditation’s influence on their work were shared). Interpretive Description addresses both these domains, individual and shared, in a unique and pragmatic way by expressing “a respect for knowledge about aggregates in a manner that does not render the individual case invisible” (Thorne et al., 1997, p.171). In addition, it argues that experiential knowledge can be both relevant and directly applicable to clinical practice and theory, helping to develop them (Thorne et al., 1997, 2004).

Interpretive Description was chosen over other qualitative research methods because of its pragmatic emphasis on the bi-directional and mutually informative relationship between research findings and implications for applied practice within the specific field(s) of interest, in this case, counselling psychology. In Interpretive Description, prominence is given to the subjective experiences of participants and the kinds of broad-based knowledge derived from these experiences, which may then be used to improve “particularization in practice” (Thorne et al., 1997, p.171).
The goal of this research project was to begin exploring and understanding the way therapists describe and experience mindfulness meditation in relation to their therapeutic work and what, if any, implications and applications this may have for counselling practice and theory. Ideally, the results of this Interpretive Description will contribute directly to our understanding of how therapists who practice mindfulness meditation experience it within the context of their work, and how this knowledge can enhance clinical practice, training and theory.

Therefore, the researcher first got a general sense of what this experience entailed through in-depth interviews with therapists who had been ‘purposely selected’ based on their ability to meet specific criteria such as being knowledgeable or practiced in the field(s) under investigation, and able to articulate it in detail (for further detail see criteria for participation section).

In short, a qualitative method that captured both the more general and subjective aspects of the experience under investigation, while simultaneously stressing the pragmatic value of findings for practice and theory, turned out to be a perfect fit for the research question and the discipline of counselling psychology.

**Personal Assumptions/Biases**

Explicit disclosure by the researcher of personal biases and assumptions going into a research project is common practice when doing qualitative research (Morrow, 2005) and is recommended when
using the method of interpretive description (Thorne et al., 1997) in order to help identify any assumptions, expectations or biases that may negatively impact or interfere with the researcher’s impartiality while conducting the study. Following is a brief description of the biases and personal assumptions I was aware of as I undertook this research study.

A key assumption I hold regarding the influence of mindfulness meditation on therapists’ work is that it tends to have a positive effect. This assumption is grounded in my own personal experience as a mindfulness-meditation practitioner and counsellor. What initially drew my interest to this topic was my own transformative experience, which involved both mindfulness-meditation and counselling. I came to professional counselling training and mindfulness-meditation at about the same time (though I had been involved in para-professional/peer counselling prior to my first ‘meditation’ experience). However, I didn’t begin to practice mindfulness-meditation daily until August 2003 following my second 10-day silent retreat. By this time I had already noticed some positive changes in my personality (i.e., greater tolerance for unwanted circumstances) and counselling style (i.e., increased capacity to be present with the client), which I attributed to my growing experience with mindfulness-meditation.

However, by the time I began to practice mindfulness-meditation more seriously and daily (2 hrs per day) I had already finished my year-long clinic course and was already logging hours for my
practicum. Nevertheless, I was able to see how more regular and longer ‘sittings’ influenced my practice as a counsellor over time. I found a definite correlation in my experience between the regularity and duration of my mindfulness-meditation ‘sits’ and my ability to be ‘present’ with a client, as well as an increased capacity in other counsellor-specific attributes such as empathy and compassion.

Another assumption I held is that registered therapists should be required to complete basic training in some form of self-monitoring/self-awareness in order to prepare them for the difficult dilemmas and situations they will encounter in practice. It is my belief that challenges such as ethical dilemmas require a certain degree of self-awareness to be successfully navigated and addressed. Further, I believe there is a consensus that heightened awareness of both ‘self’ and ‘other’ is both necessary and beneficial in a therapeutic relationship.

I also hold an assumption that certain therapeutic skills or qualities such as empathy, self-awareness, unconditional positive regard, concentration, active listening and genuineness are paramount in fostering a healthy and beneficial therapeutic relationship.

An assumption I hold with implications for the current study is that practicing mindfulness-meditation regularly might help develop the aforementioned therapeutic qualities over time and with proper training.
I also hold the assumption that, while contemporary therapeutic disciplines such as counselling psychology advocate the development and use of the aforementioned traits and skills, they do not necessarily teach adequate practical methods to develop them in any consistent and fundamental way.

Participants

Description of Sample

Six people were interviewed for the current study. The sample included 4 women and 2 men, ranging in age from 49-65. The average number of years the participants had been working as therapists was 23.5 and the average number of years they had been practicing MM was 11.5. In view of the fact that the community of therapists who also practice MM is relatively small and intimate, a general overview of the sample is provided here, in order to better maintain the confidentiality and anonymity of the participants, as delineated in the consent contract. To further insure anonymity participants selected a pseudonym for the purpose of the study; they were: Paul, Richard, Janet, Alison, Susan and Simone.

The ethnicity of the participants in the study was Caucasian. This is not uncommon in my experience, as the vast majority of practicing therapists who also attend MM retreats and workshops in Vancouver tend to be Caucasian.

All of the participants except for one had a Masters level degree or higher. This broke down into two M.S.W.’s, one M.A. in
clinical psychology, one M.Ed and one Ph.D in counselling psychology. The principal theoretical orientations cited by participating therapists were as follows: Psychodynamic, Rogerian/Client centered, Buddhist, Cognitive Behavioural, Gestalt, Jungian and Existential. Most participants listed an eclectic orientation.

The main populations that participants work with are: terminally ill (or suffering from a potentially terminal illness); varied population including children, adolescent, adult, senior, couples and families; youth at risk and street youth. Four participants worked for an agency and two had their own private practice.

Criteria for Participation

All but one participant had obtained at least a Masters degree in their respective mental health field. An exception was made for the one participant who did not have a Masters level degree based on the person’s considerable level of experience in both counselling (the participant had formal gestalt training) and MM. In addition, all but one participant was registered within a recognized organization encompassing the fields of Social Work, Clinical Counselling and Psychology. These requirements were in place in an attempt to establish a basic level of consistency regarding training and certification standards among participants. Participants also had to be fluent in English.

Purposeful selection was used to recruit participants who were most likely to provide ‘information rich accounts’ about the ‘issues
of central importance to the purpose of the research” (Polkinghorne, 2005, p. 140). Purposeful selection also had the added advantage of contributing to the credibility (internal validity) of the study by ensuring that the participants selected were likely to possess and be able to share in their understanding of the research topic (Tuckett, 2005).

Participants had to have an established ‘Mindfulness’ practice, based on the definition adopted for this study. This entailed having a minimum of one year practicing weekly for at least a 10-minute period (almost all participants however had been practicing daily between 10-60 min for more than ten years). These figures were selected to insure that participants’ mindfulness practice was relatively stable, regular and well established so they could “serve as providers of significant accounts of the experience under investigation” (Polkinghorne, 2005, p.140).

Ideally, mindfulness meditation would have been the only technique used by participants in the study to reduce the chance of participants potentially mixing their descriptions of the experience of mindfulness meditation in the context of their work with other similar practices. However because of the pervasiveness of other ‘meditative’ practices now found in the West (e.g., Yoga), it was not possible to find therapists who only practiced mindfulness meditation in exclusion of all other forms of ‘meditative’ practices. Nonetheless, when present, participants’ involvement in other
peripheral meditative practices was limited to the physical exercises or ‘asanas’ which are found in Westernized Yoga and frequently used in mindfulness-based-stress-reduction (MBSR) programs to bring mindfulness to daily movement/activity (Kabat-Zinn, 1990).

Only volunteers were accepted. Participants did appear, however, to gain a great deal from the process of sharing their experiences and of hearing of others’ experiences.

Procedure

Recruitment and Sample Selection

This study employed several methods of participant contact in order to reach the set goal of six qualified participants. These included posters, announcements and sign-up sheets at ‘mindfulness meditation’ related events as well as word of mouth. Interested participants who believed they met the participation criteria were asked to contact the researcher at a secure e-mail address or answering machine number.

Word of mouth (i.e., from newly recruited participants as well as other meditators/therapists who couldn’t participate for one reason or another) was also used to make contact with further candidates. This recruitment strategy is used in qualitative research and can be very effective when used to generate a pool or list of potential participants from which the researcher can ‘purposely’ select those to be interviewed (Polkinghorne, 2005). Informed participants were asked to pass on the relevant information to anyone
they knew who they thought might be suitable and willing to participate in the study, but it was up to the potential participants to initiate contact with the researcher. Participants were not paid or compensated in any direct way for their participation in the study, although they were offered a summarized copy of the research study upon completion.

Six therapists were interviewed for this study. As Thorne et al. (2004) stipulate, Interpretive Description “studies often build upon relatively small samples, using such data collection methods as interviews” (p. 5). Therefore, an in-depth inquiry of two interviews was conducted with the six participants. The goal of this strategy was to have an opportunity to go into greater depth with individual participants, furthering the exploration of the research question and increasing the likelihood of reaching ‘saturation’ in the interviews.

The first six participants who met the study criteria and contacted the researcher were given a place in the study and an interview time was scheduled accordingly. Extra candidates beyond the target of six set for the study were kept on record in case the need arose because a saturation point of novel information had not been reached by the twelfth interview or in case of participant dropout.

Sources of Data

The First Interview

The specific goal of the first interview was to have therapists openly and clearly describe the ways in which mindfulness meditation
(MM) is experienced within the context of their work. The first interviews took place between June – July of 2007 at a mutually convenient location, typically in the researcher’s private study. The interviews were recorded on a digital recorder in order to take advantage of higher quality recording, and later transcribed by a professional transcriber other than the researcher, as specified in the confidentiality agreement with participants. The interview process went as follows with individual participants:

The initial introduction was followed by small talk, to establish rapport with the participant, until both parties were relatively comfortable. Next, an overview of the research project and format of the interview was described (i.e., open-ended question to begin with and some follow-up ones to end). The researcher then clarified the confidential nature of the interview and its time constraints, followed by the selection of a pseudonym by the participant for the purposes of the research. The participant then read and signed the ethical consent form only after all questions and concerns regarding the main components and overall process of the study were answered.

The interview began with the reading of the study’s central or orienting question “How have you experienced the influence of mindfulness meditation within the context of your work?” Other similar versions of the question were used to clarify if there was any confusion (i.e., “How has being a Mindfulness Meditation
practitioner changed your work as a therapist?”). A further orienting statement was used to introduce and clarify the nature of the research project to the participants (see Appendix ‘A’). As the participant proceeded to describe his/her experience, clarifying questions such as ‘What do you mean by…?’ and ‘Please tell me more about…’, as well as ‘Can you give me a specific example of…?’ were used as deemed appropriate. This practice was intended to remind the participant of the central question if she/he got too far off topic or forgot what the topic was, and helped to keep the focus of the interview on the central topic of the study as well as flesh out answers and passing remarks.

After the open-ended segment of the interview, the participants were asked a series of five follow-up questions (e.g., ‘Is there anything you would like to add?’ see Appendix A for the other questions) to help insure no relevant information was overlooked or forgotten. Participants were also given the option of contacting the researcher after the interview should they come to realize there was something they forgot to mention.

The Follow-Up Interview

As outlined by Thorne et al. (1997), a study design using the methodology of interpretive description typically allows for repeated interviewing in order to challenge and refine developing conceptualizations. The initial conceptualizations, based on the sample as a whole, were brought back to each participant for critical
consideration (Ibid). These findings were then adjusted and changed as deemed necessary by participant feedback, thus strengthening the trustworthiness of the results (Ibid).

In addition to challenging and refining developing conceptualizations from the first interview, the second interview provided the participants and researcher with an opportunity to delve even deeper into new insights that only arose in the interim between the first and second interview. Originally, the participants were told that a four to eight week period would transpire before the researcher would conduct the second set of interviews. Unfortunately, due to unforeseen health conditions, the researcher was unable to conduct the second interviews within the original designated time frame. The second interviews were postponed until the end of December 2007 and the beginning of January 2008. The unforeseen delay did not turn out to be a problem for the participants or the study and in fact, worked better for two of the participants who were relatively new to the practice of MM and felt the extra time had given them a better appreciation of it. In the original proposal, the time estimated for second interviews ran between 30 and 60 minutes. In actuality the second interviews ran between 70 and 90+ minutes (the average time was longer compared to the first interviews).

The second interviews turned out to be a significant undertaking that merits mention, since they were not just a review of the first interview’s emerging themes, with confirmation of the accuracy of
transcription. Instead, they were in-depth summaries of both the individual participant’s account as well as those of the other participants. This was followed by a renewed effort to delve into areas already mentioned that still required further elaboration, as well as to discuss new ideas and insights based on the learning that was present throughout the collective descriptions of the other participants. By the end of the second interviews the participants expressed a feeling of completion with regard to their descriptions of the research topic. At the conclusion of the interview, participants were thanked and asked if they would like a summary of the final manuscript mailed to them.

Data Analysis

The data analysis for the study took an inductive approach, as described by Thomas (2006), in order to:

(a) condense raw textual data into a brief, summary format;
(b) establish clear links between the evaluation or research objectives and the summary findings derived from the raw data; and (c) develop a framework of the underlying structure of experiences or processes that are evident in the raw data. (p. 237)

The advantage of using an inductive approach for qualitative research is that it provides a relatively simple and systematic protocol for the analysis of the data and can produce trustworthy and valid findings (Thomas, 2006).
Although the encompassing framework and central guidelines used for the data-analysis came from Interpretive Description (Thorne et al., 1997, 2004), parts of Lieblich, Mashiach and Zilber’s (1998) book, “Narrative research: reading, analysis and interpretation,” were also used when needed to provide greater procedural structure and specificity to the complex process of data analysis. In particular, the ‘Categorical-Content Perspective’ helped guide parts of the data analysis by outlining “a prototypical series of steps” (p. 112) taken in content analysis. There was also a complementary and shared outlook with Interpretive Description regarding the process by which content categories are defined “from an ongoing interpretive dialogue with the text” (Lieblich et al., 1998, p. 127).

Interviews were first listened to as audio recordings. After being transcribed by a professional, all interviews were then individually read. This was followed by the reading of transcripts while simultaneously listening to the corresponding audio recording and looking for inconsistencies between the two, correcting any variances. The varied forms of immersion in the data (i.e., audio vs. written) was recommended by Thorne et al. (2004) as a strategic way to use technological supports to help the researcher’s mind engage in the analysis process from diverse angles, conceivably evoking different insights. The successive stages of immersion into the data were also supplemented with intermittent periods of reflection during which the researcher had time to assimilate the interview content.
This was done in accordance with the methodology’s mandate of “repeated immersion in the data prior to beginning coding, classification, or creating linkages” (Thorne et al., 1997, p.175).

Throughout the analysis process the researcher came back to the guiding questions “what is happening here?” and “what am I learning about this?” as recommended by Thorne et al. (1997, p.175). This helped capture a better overall picture and a more coherent analytic framework from which to operate (Ibid).

After having become intimate with the individual cases through the previous ‘immersion’ in the data, the researcher then abstracted both common and individual themes which were relevant from within the separate interviews, generating a “species of knowledge that will itself be applied back to the individual cases” (Thorne et al., 1997, p.175).

Specifically, this involved first identifying ‘meaningful phrases’ within the first set of transcribed interviews that were of relevance to the research question. By printing out the full-length transcripts and then reading over them repeatedly, marking phrases for consideration, then cutting out the marked segments I was able to get a detailed overview of the full data set and extract all potentially meaningful phrases. All clippings were then pooled together before being separated into the various emerging theme categories (the phrases were identifiable by their interview number and line number from the corresponding transcript). In some cases
‘meaningful phrases’ evolved into ‘emerging themes’ and in other cases they were simply noted as interesting anecdotes. The main factor when deciding which phrases were included was whether the investigator felt they answered the research question “How do therapists who practice mindfulness meditation experience its influence within the context of their work?” As previously mentioned, returning over and over to the questions “what is happening here?” and “what am I learning about this?” as recommended by Thorne et al. (1997, p.175) proved to be very helpful in separating the ‘meaningful phrases’ with direct relevance to the research question from others that fell outside the scope of the research question.

The researcher looked specifically for phrases or accounts that described the ways MM was influencing therapists in their work and how this process could be explained. Longer, more elaborate participant accounts that gave rich and practical case examples of how MM was influencing their work (i.e., with a real client) were given precedence in many instances over more general or abstract descriptions. This was done in order to emphasize and illuminate both contextual elements and practice-specific ways MM influenced therapists’ work. This strategy was based on the Interpretive Description (Thorne et al., 1997, 2004) mandate of looking for real life examples that could or might have practical implications and application value for training and practicing health professionals.
In some cases there were ‘meaningful phrases’ that were deemed relevant even though they did not answer the research question directly. As Thorne et al. (2004) points out, “the product of a good interpretive description may depart slightly from the original question” (p. 15) as long as a clear and reasonable rationale for this departure is given. In these cases the ‘meaningful phrases’ were put aside for further contemplation. Eventually the most pertinent ‘meaningful phrases’ from this group were collected and included under the theme category “Surrounding Issues.” Moreover, ‘meaningful phrases’ were not necessarily selected based on their prevalence within the data set. As Thorne et al. (2004) makes very clear, it is dangerous to assume that just because something has been “reported with some prevalence... that it is either accurate or relevant” (p. 16).

As ‘meaningful phrases’ accumulated and were considered as primary examples of potential ‘emerging themes,’ they were summarized into concise maxims and written down on Q-cards. The ‘meaningful phrase’ Q-cards as well as the ongoing immersion in the data lead me to conceptualize eight initial ‘emerging themes’. For this to be effective I had to consider and engage in both the world of theoretical abstractions and the concrete practical realities of the practice context (i.e., therapeutic practice context), to better insure the creation of reliable and practical knowledge (Thorne et al., 1997).
These themes were then assigned numbers (1-8) and written down on individual pieces of paper that were spread out over a table. ‘Phrase’ Q-cards were then shuffled and dealt out to one of the eight initial theme categories based on my initial response as to where they should go. This process was repeated multiple times, each time a tally of which Q-cards ended up on which pile was taken. Eventually a pattern emerged where specific Q-cards repeatedly ended up in one particular pile (the ones that didn’t were kept for further deliberation, ultimately finding their place). The original categorization of ‘meaningful phrase’ cards as well as the emerging themes was further established following consultations with my supervisor, who provided critical feedback regarding my provisional process and choices.

I then tentatively wrote down the emerging themes on a magnetic dry board and placed their corresponding ‘phrase’ cards underneath them. This allowed me to see the ‘big picture,’ which further helped my continued conceptualization and organization of the emerging themes and the ‘phrase’ cards.

The analysis of the second interview data followed the same process, although more streamlined, since I had already created a tentative set of themes for second interview ‘meaningful phrases’ to fall under. However, not all of the ‘meaningful phrases’ from the new data set fit under the previous themes. Furthermore, some of the ‘phrases’ from the first interviews were given greater credence after
similar phrases showed up in the second interview data set. Participant endorsement of others’ descriptions, led to new emerging ‘themes’ with corresponding ‘meaningful phrases’ (for an overview of the data analysis process see ‘Appendix E’).

Thus, to summarize, core themes were identified based on the first interviews. New material and participant comments in the second interviews led me to revise and expand upon the emerging themes.

**Rigor & Trustworthiness**

“Because the design in qualitative research will necessarily be somewhat emergent, attention to rigor in the process is critical to an interpretive description” (Thorne et al., 1997, p.175). For this reason the ‘trustworthiness’ criterion of Guba and Lincoln, which in its current edition (Guba & Lincon, 1989) consists of the categories of credibility, transferability, dependability and confirmability, as well as the accompanying research strategies and techniques (i.e., journaling, purposeful selection, member checking), was used to guide the research process.

However the reliance on these guidelines and practices did not constitute the only means by which to insure the overall integrity of the interpretive process, since they can be “generally quite meaningless” (Thorne et al., 2004, p.15) in themselves. To a large extent the credibility of the research findings draws on the way logical choices have been explained and linked to the bigger picture, clearly placing them within the overall framework (Thorne et al.,
Thorne et al. (2004) point out that the requirements of credibility cannot be met unless complexities are made explicit throughout the research process and not ‘streamlined’ or oversimplified. Instead, they should be articulated in a transparent, cautious manner that more accurately reflects the tentative nature of any ‘final’ research conclusions. Therefore attention to the overall integrity of the interpretive description process will always yield more credible findings than will a strict devotion to the “gamesmanship of rigor” (Thorne et al., 2004, p.17).

One of the ways the researcher attempted to strengthen the overall integrity of the interpretive description, while making complexities more visible and the analytic process more open in general, was by journaling and taking field notes. Journaling of thoughts, ideas, developing interpretations, impressions, observations, reactions, critical reflections and biases was therefore a significant and continuous part of the research project. This was done to counter biases that may have gone otherwise unnoticed within the research process as well as to help document the “reactive processes of interpreting” (Thorne et al., 1997, p.175).

Besides the act of journaling, the researcher engaged in other reflexivity practices such as weekly consultations with his research supervisor regarding the research process and findings. The research supervisor served as a “mirror, reflecting the investigator’s responses to the research process” as well as playing “devil’s
advocate, proposing alternative interpretations to those of the investigator” (Morrow, 2005, p. 254). Furthermore, the investigator also used his own MM practice as a reflexive tool and aid to heighten his awareness of biases and assumptions that he held while conducting the research project, which helped him remain “focused and grounded in the process” (Bentz & Shapiro, 1998, p.161) of ‘mindful inquiry.’ He found his own MM practice facilitated his ability to see the participants and the emerging data with a greater degree of openness, freshness and objectivity, qualities of mind or perspective that were actually described by participants and called ‘beginners mind’ (see “Perspective” theme in Findings Chapter for review).

Morrow (2005) calls attention to “the crisis of representation,” which asks, “Whose reality is represented in the research?” The investigator did his best to embody the aforementioned attitude of ‘beginners mind’ and take “the stance of the naïve inquirer” (p. 254), which was especially important given his status as an ‘insider’ in respect to the culture and phenomenon under investigation. This ‘naïve’ stance allowed the researcher to ask for clarification and elaboration without assuming anything. In fact, the researcher repeatedly reminded participants to describe concepts and terms as if he was a complete novice to the practice of MM and therapy.

The researcher also engaged in thorough member checks as part of the second interviews. As stipulated by Morrow (2005), “the researcher has the responsibility to learn from the interviewee how
well the researcher’s interpretations reflect the interviewee’s meanings” (p. 254). This, of course, is very similar to the idea behind bringing back budding conceptualizations to participants for critical consideration, a fundamental aspect of the interpretive description process (Thorne et al., 1997, 2004). Participants expressed a sense of thoroughness and completion with regard to their accounts of the research topic and concurred with the investigator’s initial interpretation and representation of their thoughts.

Another essential factor when considering the criteria for trustworthiness is the adequacy of the interpretation itself, both during the data analysis process and in subsequent stages (Morrow, 2005). This rests heavily on the ability of the researcher to immerse himself in the data. Concerning this matter, the researcher was systematically immersed in the data from its inception. By way of conducting the interviews; listening repeatedly to the audio files; detailed reading and correction of the transcripts; the cutting and labeling of transcripts into ‘meaningful phrases’ and the subsequent organizational process involving the conceptualization of themes and the allocation of phrases into them; review of journal/field notes and other data; the researcher reached a place of complete and total immersion in the data set “which lead the investigator to a deep understanding of all that comprises the data corpus (body of data) and how its parts interrelate” (Morrow, 2005, p. 256). The successful conclusion of this process further strengthened the integrity of the
study and the researcher’s confidence in his understanding and presentation of the findings.

In addition to the thorough immersion in the body of data, a clear and concise audit trail was established for the purposes of making the decision-making processes more transparent for the reader to follow and judge, as suggested by Thorne et al. (1997, 2004).

Lastly, the interpretive description was given the “thoughtful clinician test,” as recommended by Thorne et al. (2004), in order to strengthen the overall credibility and integrity of the study’s findings. This consisted of asking two experienced therapists with extensive knowledge of the phenomena, population and context under investigation to evaluate whether the claims made were “plausible and confirmatory of ‘clinical hunches’ at the same time as they illuminated new relationships and understandings” (p. 17). The aforementioned therapists had between 20 to 30 years’ experience in both MM and psychotherapeutic practice (one with a Master’s degree and the other with a PhD in counselling psychology). Each of the therapists was interviewed for 1.5 - 2 hours regarding the thematic findings.

The therapists reported that they found the findings and claims to be both comprehensive and detailed. There was nothing in the thematic findings that they found to be inaccurate. One of the therapists described the findings as “very complete” and added he “would agree with everything mentioned.” The second therapist stated
the findings “sound comprehensive... I’m trying to think of what you left out and I can’t think of anything.”

Concerning new relationships and understanding, the two therapists talked about the significance of participants’ descriptions and practical examples as well as the diversity of reference points (i.e., themes) captured by the findings. For instance, one of the therapists said the “participants were obviously very thoughtful in their responses...[the] accounts showed a lot of depth and understanding.” The other therapist commented on the uniqueness of the findings, stating, “you’ve taken the great rope of what’s going on and really teased out the threads very well... you have creatively captured angles of reference that are very difficult to [distinguish]... you’ve got some really good specifics, making it [the relationship between MM and psychotherapeutic practice] tangible, which is hard to do....”
CHAPTER 4: FINDINGS

The findings presented in this chapter were the result of over 230 minutes of recorded interview dialogue, across two interviews with six therapists who answered the question, “How do therapists who practice mindfulness meditation experience its influence within the context of their work?” The recorded minutes eventually translated into just over 370 pages of transcribed discourse, which following a rigorous and exhaustive data analysis were distilled into a cohesive set of thematic findings that answered the research question. Thus, the following pages are a representation of participant accounts that best illustrate the various themes while simultaneously answering the research question.

The results reported throughout this chapter were mainly obtained from the first set of interviews. Nevertheless, the second interviews were fundamental in verifying participants’ descriptions and solidifying the emerging themes from the initial interviews, often adding new or refined descriptions that strengthened the findings.

The researcher’s initial understanding of the emerging themes was confirmed and participants felt their accounts had been accurately and credibly represented. What participants generally expressed after the second set of interviews was a mixture of satisfaction with the fullness of their descriptions
and an interest in other participants’ differing accounts and insights. Participants also found the similarities among their descriptions to be validating.

The thematic categories in this chapter emerged from the data analysis of participants’ descriptions and provided clear examples of how MM was influencing participants within the therapeutic context, thereby answering the research question. Often, participants’ descriptions converged or overlapped, clearly highlighting a particular issue, which later became a theme. Alternatively, individual cases or examples were given equal attention when considered important in addressing the research question. Therefore, the prevalence of a given theme or example throughout the various interviews was never a prerequisite for its inclusion. As suggested in the methodology of Interpretive Description (Thorne et al., 2004), prevalence of an example was not a prerequisite for its consideration as a theme or its inclusion under an already established categorical theme. This suggestion was adhered to throughout the data analysis.

It is worth noting that most participants expressed difficulty in articulating the experience of MM in general, and even more so when describing it within the context of their work (examples of the difficulty of talking about MM will be presented under the “Surrounding Issues” category). With this in
mind, the researcher was able to extract eleven major themes, each with multiple examples, that answer the research question: “How do therapists who practice mindfulness meditation experience its influence within the context of their work?”

In the end, based on the researcher’s two interviews with the participants, his thorough immersion in the interview data, and his own personal experience as a MM practitioner and therapist, he was able to observe, identify and extract the following eleven themes: 1) Surrounding Issues; 2) MM as Foundational Structure and Paradigm for Therapeutic Practice; 3) Shift in Perspective; 4) Self-Awareness and Its Process; 5) Self-Care; 6) Harm Reduction; 7) Less Reactive/More Responsive; 8) Helping and Teaching Clients; 9) Greater Confidence/Trust in Self and Other; 10) Gives a Sense of Openness/Connection/Space; 11) Enhancement of Positive Traits and Skills. For in-text reference the themes are abbreviated as follows:

Table 3

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<tr>
<th>Themes</th>
<th>Abbreviations of Theme Names</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Surrounding Issues</td>
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<tr>
<td>2</td>
<td>Foundational Structure</td>
</tr>
<tr>
<td>3</td>
<td>Perspective</td>
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<tr>
<td>4</td>
<td>Self-Awareness</td>
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<tr>
<td>5</td>
<td>Self-Care</td>
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</table>
Each theme is described below with subsequent examples supporting their relevance to the research question (for an overview of the findings see ‘Appendix F’).

**Surrounding Issues**

The category of ‘Surrounding Issues’ emerged from therapists’ descriptions of their MM practice in ways that did not necessarily fall within the parameters of the research question but that, nonetheless, were deemed of interest or relevant to the research topic. This theme category included anything that was considered important but which seemed to “surround” rather than fall clearly within the other theme categories, yet provided important contextual information. These ranged from participants revealing that they had a hard time clearly separating the influence of their ongoing MM practice from the influence of their training and many years of experience as therapists, to participants expressing the difficulty of putting their experience of MM into words.
Participants also mentioned that they felt mindfulness was being practiced informally in various ways (as part of their lives) prior to their taking it up formally. Several participants also stressed the importance of their ‘loving-kindness’ practice (traditionally called ‘Metta’ and taught with MM), which is often used in conjunction with MM and is considered a complimentary practice (Kornfield, 1993).

The first quote is representative of the inherent difficulty participants experienced at times, when trying to separate the influence of their MM practice, within the context of their work, from the influence of their many years of therapeutic training and experience:

But whether I can say “Yeah, I can see that my therapy has, is better, now” [sighs]- I’m not sure. It’s really hard to say. I also feel like I’ve been working for twenty-five years almost... I still feel like I get better as I get older and more experienced, you know, so then that gets mixed up in it, too; am I just more mature? Or is that mindfulness has made me more centred? (Janet)

The next quotes reflect the difficulty participants encountered when attempting to describe their experiences of MM practice in words:

It’s just so hard to formulate, in words, what goes on in - in experiences. It’s like... it’s like the great teachers
have said, it—it’s words are just—Krishnamurti or any of them have said that, you know words are so inadequate because we take words to be—to mean so much when—when they’re just such a meager attempt; they don’t really tell you the experience... because you can’t describe an experience, to tell you something in words, eh? So—so it’s difficult. (Richard)

“Well, this is it right here, but I don’t know how to talk about that.” (Paul)

The following quotes are examples of participants’ recognition that prior to the formal commencement of their MM practice they had already been practicing mindfulness informally in their lives (in some shape or form):

I hadn’t really [heard about MM] and then I thought “Oh, this kind of—seems to kind of—this is like, it’s—it articulates what I have sort of felt I’ve been practising informally on my own and—in—in a more—in another form with patients.” Because I knew practising relaxation, just from my own experience I knew practising some form of relaxation... and sitting quietly and calmly and breathing and focussing on your body. (Susan)

And I asked myself the question, which was like—which, you know, exactly how long have you been in my life? And I really—I’ve been doing this since I’m 16 years old. So,
m-my understanding of mindfulness meditation practice coming out of Herman Hesse and Siddhartha and the yoga boys has been influencing my practice probably for most of my life. (Paul)

An example of participants’ describing the importance within the therapeutic context of the ‘loving-kindness’ (traditionally called ‘Metta’) component of their MM practice is captured by this quote:

I often tell them, you know, that most of this work is really for you to learn how to care for yourself and look after yourself in a better way. And then very specifically I tell them okay, so, when you’re having these difficulties, be kind to yourself, remind yourself that you care about this feeling... too, you know, and I care about what I’m feeling and I care about this experience. So it’s, yeah, so it’s definitely helped me to, uh — lead my clients to that, too. To care, yeah, most definitely, yeah, to care about themselves more. (Richard)

In the ‘Surrounding Issues’ category participants brought up significant points that were closely associated with the other themes but did not fall clearly within them.
Mindfulness Meditation as Foundational Structure and Paradigm for Therapeutic Practice

The category ‘Foundational Structure’ emerged from therapists’ descriptions of how their MM practice acted as a unifying framework and paradigm, which both informed and gave structure to their therapeutic practice. Mindfulness was seen as an underlying element, that cuts across the various therapeutic modalities. Participants also mentioned specific ways in which their MM practice gave their therapeutic work structure, such as its ability to provide an organized framework from which to articulate and understand different human processes useful to both therapist and client. Therefore, this theme category included anything that was related to the practice of MM and its foundational and informative role within the therapeutic context.

The following are examples therapists gave of different ways MM practice can help develop pre-existing therapeutic frameworks, or provide a structure for therapists to fall back on when trying to articulate certain human processes:

The gestalt was kind of like a springboard for me into the mindfulness practice, is the way I would put it, yah, it was like a springboard, yah provided the groundwork and then the mindfulness has helped me go much further and deeper. (Richard)
It didn’t happen because, you know, when those thoughts came and those urges came I paid attention to them, and I paused and I sat with them, and, you know, recognize that they would go, um, and, you know, thirty years later - that, to me, is mindfulness - only it’s articulated, and that’s - if you’re a therapist, to have something articulated, for me, anyway - very helpful because then it’s a lot easier to recognize it in other people or to recognize when they’re, you know, to what degree it’s not happening with them, and to articulate it for them and tell them this is what you can try to do. (Susan)

Next, a therapist using the sense of structure he had discovered in his MM practice describes how it transferred into his therapeutic work with clients:

If we take the structure that mindfulness practice occurs in with the bells and-and, umm, the time limit, 45 minutes, 20 minutes, an hour, whatever it is. Now we take getting used to that structure and legitimizing that structure then I can turn to somebody in the middle of them really working up a big rage with their partner and go, “You know what? We only got another 15 minutes and we don’t have time to do all of this and I need you to back off”. (Paul)
Another participant talks about how fundamental awareness training is to therapists. Literally an extension of being a therapist:

Your real job is to be present. And then it’s stylistic how we’re present but basically most of us all come together, the psychiatrists, the psychologists, the therapists, the body-workers, we all come together in exactly the same place... the training and the ideology is just what makes it possible for psychologists or therapists to sit in the room with a total stranger and be comfortable enough to be present for the benefit of that other person, right... like you know awareness training is an extension of being a psychotherapist. (Paul)

Most participants believe that their MM practice informs their therapeutic practice and acts as the foundation for their work as illustrated in the following examples:

If I was to do a study on that in my practice, um, in my therapeutic work... my experience tells me with my clients... that mindfulness practice informs my therapeutic practice. And that’s the bottom line. Everything else is icy. (Simone)

Yeah, it was, uh - if I think about it now, um, when there’s so many things in my life that, you know, eclectically came together and it all works nicely. But I
think mindfulness is the foundation of all. I mean if I’m not mindful then, again it comes back to, you know, I can - I can do EMDR with people but it’s just not, you know, it’s a technique. You have to have the foundation of being there. You know, without it, it’s not - it doesn’t make sense. So it’s all in there but I think mindfulness has been the - probably the major thing that has really made the change in my therapeutic work. (Simone)

I feel the same way; that it’s becoming the framework or the foundation [for therapy]. (Susan)

It’s a paradigm. You know, it’s a way of approaching situations and things. Breaking it down to what’s happening in this moment. (Alison)

Well, uh, I - I do kind of a microcosm of my practice with the client... so it’s like I’m-I’m practicing within a microcosm of what - what I do - how I’ve adopted the practice for myself. (Richard)

I think-but I’m pretty sure that mindfulness practice in fact has become my practice in here and one of the things I have to share with the way I work... and in the presence of a client in a lot of ways they’re that for me. They are, uh, a presence occurring within-within the framework of mindfulness, within the framework of awareness, everything
that’s occurring is occurring within the framework of mindfulness. (Paul)

The ‘Foundational Structure’ category addressed the use of MM as a foundational structure or paradigm that underlies, supports and informs participants’ therapeutic practice.

**Shift in Perspective**

The category of ‘Perspective’ emerged from therapists’ descriptions of how their MM practice helped them change their perspective significantly in relation to the way they see themselves and their clients. One example relates to working with transference, counter-transference and resistance. A shift in perspective or view owing to MM practice was also linked with the attitude of “beginner’s mind,” when working with clients. This was described as having a fresh, immediate and untainted view of whatever was being perceived. Therefore this theme category included examples of the ways MM practice influenced therapists’ perspective within the therapeutic context.

One therapist detailed how her perspective had shifted in relation to clients when considering psychological constructs such as ‘resistance:’

I don’t find any resistance any more with, okay, patients – and clients – like I just – I remember resistance was such a big thing when I first started to work, it was like how do you get around a resistant patient and I just don’t – I
don’t look at things like that anymore, that person is resistant and it used to be like, you know, working with a difficult client or, you know, working through resistance and transference and counter-transference and it just, you know, maybe I’m in denial, I don’t know, but I – it’s like... For me, it just doesn’t exist anymore and I think it’s because I’m looking at people very differently, so it’s perspective, right? It’s – yeah, it’s perspective. (Susan)

Other participants referred to the shift in perspective associated with MM as “beginner’s mind” and recounted how MM changed their perspective when working with clients:

Shifts - a big shift in perspective. Because of the training and the practice... with “beginner’s mind,”... I can bring in a sense as if for the very first time, he sits down, he might have said - he might be doing the same old stuff, but I’m looking at it differently now. I’m not - I’m not sort of making any assumptions or already have a - a story before he starts talking and go “here he goes again, he’s going to tell me how everybody else is wrong and he’s the only right person.”... So to hear that story with a beginner’s mind is way different than just “here he goes again.” (Simone)

It’s about who is this person and what do I have that would be useful to them individually. That’s mindfulness again,
“Ohhh, you’re not like the last person that came in. Look at that. Hello.” (Paul)

The ‘Perspective’ category focused on the important ways MM influenced and shifted participants’ perspective with regard to their therapeutic work.

_Self-Awareness and Its Process_

The category of ‘Self-Awareness’ emerged from therapists’ descriptions of how they experienced the actual process and mechanics of MM and how it helped them see and understand the various aspects of their personal experience (i.e., mind, body, heart) within the context of therapeutic practice. Therefore, this theme category included anything that was linked to the practice of MM and its relation to increased awareness of important components within the self, such as the body, mind and heart and their corresponding processes and content (i.e., sensations, thoughts and feelings). MM was credited with helping participants be more aware of subtle processes within themselves, allowing the therapists to experience them more objectively by depersonalizing and externalizing them.

The next quote is an example of how a therapist’s MM practice increased her awareness of internal processes and how she experienced the actual course of mindfulness:

As a therapist, you’re listening and you’re experiencing in the moment and so mindfulness has helped me be right here,
uh, with somebody, but also with an awareness that when I “leave”... when the person is speaking to me about a particular concern, and my thoughts go - I can watch my thoughts go out of the room, back over to the past, or back somewhere else, or forward to somewhere else, and then I notice when they come back and I’m here and I just heard the person say something. Now, that’s nothing new but it’s with much more acute awareness that I’m aware I’m going back and forth with that... Um, so, over the years in my - with mindfulness practice, it’s helped me be, I think, anyway, much more aware of when my mind comes and goes and what’s going on in mind; and what’s going on in my body; and what’s going on in my heart. (Simone)

The upcoming examples demonstrate how therapists’ MM practice increased their internal awareness of their own body/somatic intelligence within the therapeutic context:

Well, the classic one is erections, right? The classic one is-is like, umm, like a highly sexually aroused and completely sadistically oriented. Umm, and that’s about, hmm - over ninety percent validity probably that I’m in the presence of somebody that was seriously abused when they were a kid. Umm, that would be - become the question of whether or not they’re aware of it ‘cause that charge is operating in the room and I’m simply-I’m simply picking up
on it. Umm, and that I no longer take as being a personal interest. I simply take that as being a barometer of what’s going on. Umm, a lot of chest stuff. A lot of solar plexus, chest stuff. Uh, almost always translates into anxiety or deep, deep sorrow and grief. Umm, my throat will get real dry and that will be, uh, that will just be somebody cutting off from themselves. (Paul)

Say, I’m just doing something, and, you know, work can be stressful, especially if you’re busy and, you know, you get a whole bunch of things happening all at once. Well, then, you know, if I’m aware that – say I’m holding my breath a little? So it’s like the body is – you’re more in tune with the, uh, the signals your body is giving you – it’s – then it’s like “Okay, just take a minute.” (Susan)

Next, an example is given of how one therapist’s MM practice helped her see the process by which potentially harmful things, such as anger, manifest within oneself. Her MM practice showed her how to depersonalize and externalize things like anger, giving her insight into her relationship with it:

I don’t know if I talked - if I sort of stressed it enough this time, but, um, the de-personalization. You know, I know I talked a bit about it, but that’s another sort of mindfulness tool. You know, sort of externalizing anger, for example. You know, have as - what are the pieces of the
puzzle that help to create the picture of anger or the experience of anger. What are the threads? (Alison)

One therapist’s account provides a concise summary of how MM helped him become more aware and connected to his own process:

It’s helped me to just be more connected to myself through the - in the session with the client - to just be more connected with my own process, just to notice, not just impatience, but whatever might be happening. (Richard)

The ‘Self-Awareness’ category was made up of participants’ accounts of the influence MM had on the ability to see and understand their inner experience with greater clarity.

Self-Care

The category of ‘Self-Care’ emerged from therapists’ descriptions of how their MM practice helped them improve their self-care, which they believe helped them be better therapists. The accounts ranged from direct/practical examples of how participants’ MM practice experience has helped them take better care of themselves within the context of their therapeutic practice, to less defined examples and attributions of how their MM practice has assisted them in staying sane and healthy within the larger context of their lives, such as being more kind and compassionate with themselves. Therapists also mentioned what happened when they stopped practicing MM regularly.
To begin with, an example is presented of how the practice of MM by a participant helped promote self-care by bringing attention to the need to take time off for her well-being and to avoid burnout:

Very much self-care. You know, it’s like a real awareness of I can’t - how - I had to be - sort of thinking to myself “How am I going to be able to be here the rest of the week and deal with people’s needs when I need a holiday now?” you know. That’s what I admitted, I need a holiday, like, today. I should’ve started last week. I went a bit too far, um, to stop and to restore, and replenish, and to take care of me in the bigger picture. So, with mindfulness being with me and I’m going- okay, I’ve got Tuesday, Wednesday, and Thursday to do, right? So how do I do that? Well, if mindfulness is with me; I’ll be able to actually do it and do it as best I can and be able to be there for people without completely going over the edge and feeling like I’m burnt out. (Simone)

The next quote is a clear example of self-care in action and how the practice of MM helps a therapist reconnect and feel sane again after a really hard day:

If I can get to the cushion, I’ll be alright. If it’s been a really hard day and I remember... a really hard day means that there’s been a lot of horror stories and inadvertently
each person has taken a chip out of me, which—which is just part of business. Umm, if I can get to the cushion, I’ll be alright. If I don’t get to the cushion, I’ll be a mess.

(Paul)

Additional participants’ statements on how MM facilitated self-care for the therapists are as follows:

What I have noticed and I don’t know if it is connected with mindfulness or not, you never know right, is, it’s much easier for me to maintain the - my own disciplines in my life that I need to for my health than I, than was the case before. (Janet)

I think the mindfulness is really good for people with anxiety, and really over the last year – two years – I’ve recognized how – how much anxiety I’ve carried around, you know. And I haven’t really wanted to admit that, but that’s okay too, now. (Susan)

Yeah, it’s really profound self-care. The meditation is simply on the arising and passing away of whatever is going on, and if I do that, I won’t burn. And before doing that, I used to burn a lot and it was—it was pretty much crispy critters… And when I stop doing mindfulness in a formal way, I get f**ked up. And when I go back to doing mindfulness in a formal, sit down, don’t fool myself, you
know, just pay my dues kind of way, things clear up... In the business of insanity, it keeps you sane. (Paul)

Participants described their experience of what happened when they forgot to practice MM for a while:

Yeah. [Mindfulness is] sort of cleaning the glasses. You know, I don’t meditate I’m not cleaning the glasses. So that, you know after seven days, it’s like “Oh, okay, lots of fingerprints and stuff on there.” Something that’s sort of creating silence, and just being quiet. That’s why I do at least one residential retreat a year, you know; it’s spring-cleaning. And you know to me it’s so true. You know, we spend times washing our external selves, you know, with toothbrushes and face creams and hair stuff and body stuff, and, you know, clean clothes, and - and our minds, we do nothing. (Alison)

If too long a period of time - for me it’s about a week and a half - goes by and I haven’t done anything [any mindfulness practice], I just get that really squirrelly feeling. So then I, you know, I start setting aside - deliberately setting aside time [for MM]. (Susan)

The ‘Self-Care’ category consisted of participants’ descriptions of the various ways MM influenced their practice of self-care in relation to their work, as well as the consequences on their well-being of not practicing MM.
Harm Reduction

The category of ‘Harm Reduction’ emerged from therapists’ descriptions of how their MM practice helped them be more acutely aware of potentially harmful situations in therapy and the ways in which they could possibly harm their clients through their actions. Therefore, this theme category included anything that was related to the practice of MM and the increased awareness and implementation of a harm reduction attitude within the context of therapeutic practice.

The following are descriptions of how MM helps therapists be more aware of and practice ‘Harm Reduction’ within the therapeutic context:

[To] recognize the inter-connectedness of everyone. I mean, it didn’t hurt me as much as it hurt other people as well, so to see that ripple effect. And to be really cognizant of that. And understanding, you know, whatever we do or say - that includes me - has a ripple effect. (Alison)

And it doesn’t matter what I said, by the end of the session, she said, “You hate me”. And it was kind of like... it was all... it was that place where it’s all confused. I couldn’t figure out where she was. I couldn’t figure out where I was. I just kept trying to not hurt, to not... support her notion that I hated her. I didn’t have to be a good guy but I really didn’t want to hurt her... So, I
think mindfulness brings us to a place where I can acknowledge, ah, the potentially politically incorrect desire on my part not to be part of something that I don’t want to be part of, and still give me enough distance that I don’t make it worse, the notion of harm reduction.... So it does—it does create even there. Yeah, a harm reduction kind of model. (Paul)

A therapist, after hearing another therapist’s comments on the issue, details some of the important ways MM helps harm reduction within the therapeutic context:

Oh yah, I agree and I would add to that, that uh, that it’s uh, that it would make the therapist much more, much more aware of uh, of the impacts and that the statements, um, that it would have, it could have on the client, so that, so that it would reduce that harmful impact, yah, definitely. (Richard)

The ‘Harm Reduction’ category covered participants’ reports of the ways MM affected their awareness and implementation of a harm reduction attitude and model within therapy.

Less Reactive and More Responsive

The category of ‘Reactive/Responsive’ emerged from therapists’ descriptions of how their MM practice helped them be less reactive and more present in various ways and situations within the context of therapeutic practice, thus enabling them
to respond effectively. Examples ranged from participants’
descriptions of greater tolerance and patience with their own
thoughts and emotions as well as those of their clients, to more
specific cases of participants’ dealing with
‘difficult/challenging’ clients to whom they would normally
react or try and avoid altogether. The increased awareness of
both transference and counter-transference was also brought up
as another attribute of MM practice within the therapeutic
context. This included awareness of both values and judgments
the therapist held while working with clients. There was also a
greater ability to handle difficult and uncomfortable
situations, as well as the poise to sit through ‘storms’ that
arose within the therapeutic context. Participants’ descriptions
also included the notion of ‘space’ in terms of having a greater
ability to see one’s own reactivity surfacing and having a wider
and freer perspective and relationship with whatever was being
experienced, allowing the participants to act or respond in a
less reactive way.

One therapist’s understanding of how the method of MM
reduces reactivity within the context of therapeutic practice,
was as follows:

That allows you to be present, connected, intimate to the
moment and non-reactive. It’s not that we’re non-reactive,
it’s that we don’t act on our reactivity. We are aware of
the reactivity coming up in our body. Then because of the mindfulness we don’t necessarily take it personally any more. (Paul)

Next, examples are given of how therapists credit their MM practice with the enhanced ability to weather clients’ storms, be less reactive in the midst of their chaos and more tolerant or understanding when dealing with particularly challenging clients:

I’m just thinking of this other client that I’ve been seeing, been seeing for almost a year. Uh ya, definitely I’m sure the practice has helped me to - to keep my cool with her and not uh, you know and still uh, and still be helpful in some way. (Richard)

If you are in the midst of somebody else’s chaos, that mindfulness training that over and over and over and over again coming to the moment, gives you the ability to sit in that moment and not get blown away. (Paul)

I was working with a teenage girl who was living in the house and her father was part of a motivational group, I think, men’s group, which from my understanding was quite misogynist. And he ran a pornographic video store and his daughter worked in it. I don’t know, it was just - he was just not somebody who I would want to have contact with, or - and finding a way to be able to be present for him. Um,
you know, I think the mindfulness, like, really helped me to do that. (Alison)

Well, yeah. And it’s how to - it’s kind of like how to - to mindfulness helps me sit in life’s storms without, um, unconsciously or automatically reacting to them. I will respond rather than react is what it’s taught me. It’s, um - I may notice the thoughts of wanting to get rid of them, to get them out of my office, but I - I also - mindfulness has helped me be in the storm of it and have more compassion for what’s going on. And have more sensitivity and empathy with this guy who hasn’t learned life skills.

(Simone)

The next quote shows how a therapist’s MM practice helped her spot counter-transference taking place while she was counselling another woman whose mother had cancer, thereby helping her to be less reactive and more responsive:

Another example would be - and again, this is transference - counter-transference stuff, too. But I remember being with a woman - this was a number of years ago - sitting in my office and her Mum was in the hospital unit, and so she was in tears and struggling and anxious and stuff and, when I wasn’t mindful. When I wasn’t paying attention - what I suddenly noticed half-way through the session was I was actually speaking to this woman as if her mother was going
to die. But it was nothing to do with her or her mother, that was to do with my stuff. Because my generalization is all mothers die of cancer because mine did. So I – right in the middle of it I shifted my whole way of being – with just being with where she was at, maybe her mother was going to die, maybe not – in fact, she didn’t. So, um, that whole shift in perception of what’s happening here right now and what’s my stuff and not hers? And, again, transference stuff. But mindfulness was ‘Hoo’ right there, as my companion going, “Wait a minute, Simone! What are you doing? You know, you’re talking to this woman as if her mother’s going to die and you have no idea what’s going to happen.” So that’s another, I think, example of mindfulness being right there going “Simone! Hello!” (Simone)

The following are examples of how therapists credit their MM practice with their enhanced ability to be less reactive and more calm when dealing with clients. Alison, for instance, talks about being more aware of her own stuff (i.e., preconceived ideas, judgments, worries) when working with youth at risk:

“I think I’d be more reactive to the kids. I don’t know that I’d be able to see my own stuff as much.” (Alison)

I think, I probably said then [speaking of first interview] but I feel more sure now, that uh, I’m just becoming less reactive, uh, in general and therefore, to clients. Some of
the things around, around the process, like clients cancelling or not showing, or sometimes problems with payment or stuff like that - that can, you know, can really eat at you, like I’m being used, you know, I’m not being respected here and having difficulties seeing, remembering, you know, this client is in a lot of a mess, it’s got nothing to do with me, really, you know, um, and that’s much easier for me to see now, uh, on my good days. (Janet)

They’re coming in with an expectation to take their tears away or their struggle away. So, I will notice “I almost went into reactive mode.” And sometimes I actually do, and then I’ll notice afterwards “I just reacted”, I just gave them a book and I wanted it to be fixed, or I gave them this or told them how to do something, or suggested something so that we could be done and they will go. I may backtrack into more of a response, or if I notice before I react, I’ll respond in a way of sitting with them for a longer period of time, getting to know them more, um, understanding what they’re really needing, wanting from me etc., and then responding in a way that’s not going to set us both up. (Simone)

The ‘Reactive/Responsive’ category was comprised of participants’ descriptions regarding the influence MM had on
their ability to recognize and reduce their reactivity within therapy.

Helping and Teaching Clients

The category of ‘Helping/Teaching’ emerged from therapists’ descriptions of how their MM practice helped them assist and teach their clients in various ways, both intentionally and unintentionally. This theme category included participant statements that were related to the use of MM as a helping tool with clients. It also includes points associated with the use and teaching of MM within the context of therapeutic practice, such as reactions to teaching and how therapists felt about teaching MM.

The accounts included examples of how participants’ MM practice experience was useful as a helping tool for clients in both direct (e.g., teaching clients aspects of MM) and indirect ways (e.g., by mirroring/modeling certain attitudes and behaviours). There were also examples related to the participants’ ideas of teaching MM within the therapeutic context, including various thoughts on their desire to share MM with clients. Finally, opinions on the necessity of having a personal MM practice before using it with or teaching it to clients, as well as concerns regarding the proper use and teaching of MM within the therapeutic context were addressed.
Therapists use aspects of MM practice in a more direct/intentional approach to help teach clients, for instance, how to come back to their experience no matter what is happening (to be in the moment):

...because of the practice, I wasn’t trying to solve any problems... I really worked a lot with him, and with just coming back, okay, just, I mean this is happening, and when that happens just come back to your experience, to the moment, with what you’re — and that’s it. There’s nowhere to run, you know, and anything that comes to you, to do or say, if that can come after you’ve come back to your experience. Again, I’m thinking... here’s a specific case where it was really helpful because uh, it really was good for him because he — he uh worked with it, and he’d tell me about how he’d do that when he came back to the next session, you know, how he would actually practice what I’d suggested... (Richard)

You know, and I’ll just give little mini sections of it — of, uh, the relaxation and mindfulness, and give them ways to fit it into their day-to-day life, that, you know, they can do it in the hospital, or they can do while they’re convalescing... It’s just amazing, you know. People come in and are just like — blech! They are so stressed and crying and, you know, they’re thinking about dying and — and how
awful things are and, like, and, you know, you just put
that framework for them. “Okay, for the next week, think
only about what you’re going to have for supper tonight,
don’t think about the future anymore than that. Just be in
the moment.” (Susan)

Two examples follow of indirect ways in which MM was being
taught to clients by therapists:

What it means... I’m picking up on all these non-verbal
cues that they’re telegraphing into the world before they
are. So-so I’m mirroring and letting the mirror be... be an
internal process of my own. Umm and then of course the way
I work is-is to communicate that back so I’m really
teaching that as well, right? So it’s-so it’s kind of
pedagogy of awareness that-that’s occurring within here.
(Paul)
The practice is definitely not to take this life quite so
seriously and then, so that’s helped me to work with a
client in a way that, you know - in ways that, in ways that
maybe would assist them in seeing it - taking it less
seriously. (Richard)

Here is an example of one therapist’s awareness of her
strong desire and eagerness to share MM with everyone, including
her clients, after taking a Mindfulness-Based-Stress-Reduction
(MBSR) course:
Uh, so I was really enthusiastic about it, it’s like I really wanted to kind of convert everybody. “You gotta do this, it’s so great! You don’t know what you’re missing, really.” And, uh, anyway. So, you know, that phase is kind of the honeymoon phase - it’s kind of over with. But I tell people that now, too, you know, so - and I think probably I brought some of that when I first started formally doing it - into my practice, like - I’ve got something for you. Now I’m more like “You might want to try this,” I know it has the word meditation in it and to some people that’s like, you know, there’s something weird about you. “You’re asking me to do something strange and - cultish.” So I don’t know if that’s a negative side. I don’t think so. (Susan)

There was consensus among participants of the absolute necessity to have a well-established personal MM practice before teaching others in any capacity. The following quotes are examples of therapists’ reasoning for this prerequisite:

Really in terms of being specific, you know, and, I think when I’m specific I can help people better because, I can say, this is, like, you know, when you actually like, you know it’s like bike riding or something, when you actually learn how to shift gears and that, you can tell somebody else how to do it... And you can - see where they’re - where they’re, you know going wrong or whatever. (Susan)
Your teaching comes from your practicing... if you don’t know, don’t teach it... how am I supposed to tell somebody and teach it to them if I don’t know it?... They’ll know if it’s not coming from you. They’ll know that it’s not authentic. I think it’s like an art, I mean I can’t teach you how to play the clarinet if I’ve never played the clarinet. (Simone)

There was concern among some of the therapists about the potential misuse or incorrect teaching of MM within the therapeutic context; the following quote exemplifies some of these concerns:

This stuff that I’ve read from people that are like popularizers of Buddhist meditation technique like - like, it just seems like bad therapy to me and I’m at a place now where I’m willing to say that I know something about therapy and I know something about Buddhism and meditation and uhhh it ain’t coming together the way it’s supposed to be coming together, or at least the way I would want it to. I really think it’s something that the less spoken of in the room, the better.

[Paul goes onto discuss his concerns with some of the therapists who are teaching MM to clients]...

I have two problems with it. 1. most of the people who are teaching it don’t know what... they are doing. 2. They
don’t realize the decompensation potential and power of it.

3. They don’t realize that sitting ‘zazen’ meditation - sitting mindfulness meditation it’s not only not for everybody, it’s downright dangerous for certain people, especially if they’re borderline, especially if they’re walking through a - a really potentially chaotic period in their life. They shouldn’t be doing mindfulness training. They should be raking leaves in a courtyard; they should be doing something very physical, very sweaty. Very detoxifying. They should not be doing mindfulness. Mindfulness will drive them crazy. The other problem about teaching mindfulness training is it’s “dharma” [Buddha’s teachings]. I can’t teach dharma and get money. I mean it’s like, dharma should be given away. It’s also kind of like religion and I don’t wanna, I don’t wanna proselytize.

(Paul)

In the ‘Helping/Teaching’ category participants described the ways they used their MM practice to teach and help clients both directly and indirectly. Cautionary notes regarding proper training in MM and its potential misuse with clients were also mentioned.

Greater Confidence and Trust in Self and Other

The category of ‘Confidence/Trust’ emerged from therapists’ descriptions of how their MM practice helped them have a
heightened sense of faith/trust in the self-other dynamic of therapy and the overall therapeutic process. It was experienced more personally as a general feeling of confidence in themselves and their abilities within the context of therapeutic practice. This manifested specifically as greater trust in their intuition, hunches and premonitions. It was also experienced as having less fear and greater trust when facing the unknown, asking difficult questions, challenging clients or intervening in other ways. As a result of increased trust and confidence there was less need to get involved in ‘fixing’ clients, as well as a sense of greater acceptance regarding therapeutic outcomes with clients.

Therefore, this theme category included examples of greater trust in the overall process and dynamic of therapy; allowing one to remain unperturbed when facing the unknown, uncertain and ambiguous; or, more specifically, trusting the information and insight that arose in session with a particular client.

The subsequent examples illustrate how the practice of MM helped participants have more confidence in their hunches (and the enigmatic information they embody), perspective, and in their ability to intervene with clients when necessary:

It’s made me much more confidant. Yeah, I guess that’s where the mindfulness practice has... you know because of especially now what it’s done for—for me and my life, it’s—
it’s made me more confident to know that yes, it really actually does work. So I feel much more confident, so I - it allows me to - to do that more, to intervene more... uhh my part in the therapeutic session with a client would be, like, my, uh, my ways of trying to be that nice guy, to be liked... so that plays out with the client too so, uhhh it will tend to not, maybe, uh... uh call them on stuff as much, whereas the practice has helped me do that because it has given me the confidence. (Richard)

While you’re talking I was thinking that maybe something that’s a factor that maybe has - is changing is, um, my level of confidence in myself is probably.... I don’t know quite what the relationship is with sitting but I think it’s related, um, it’s not quite like self-confidence. That word doesn’t quite capture it but um, I just trust my... my perspective, my understanding and that... might be true when I’m sitting with a client too that I’d be less inclined to, uh second guess myself and get myself hung up, you know, should I - shouldn’t I, I’ll just be more likely to go with it and if I, if I feel an ambivalence, I might just express it. (Janet)

And she kind of looked at me and, uh, she was saying things like “Well, it’s good. Yeah, we’re really happy.” I was just - I thought... anyway, I sort of thought “Well, what’s
going on here?” and, um, I said “What is – what is going-” so I asked her “You don’t really seem happy with – with what’s happened. That he’s – that he’s getting three – that he’s getting months more to live.” And, um, whereas before I don’t think I would’ve asked a question like that because it would’ve seemed – like, how can you ask someone if they’re actually unhappy that their spouse has survived. They’ve been married for, you know, thirty years or something like that. So I asked her and she said “I’m not happy.” She said “He’s changed and I don’t like him.” So... so I think picking up on that and asking her gave her permission to say that, and I think that was very hard for her to say. (Susan)

I might have it distorted because it’s coming through my filter, but basically I know what happened and-and I’ll hold-I’ll hold that knowledge. Not as an interpretation but I’ll-I’ll hold that knowledge as-as just [a] piece of that theatre and-and they’ll come to that. The mindfulness practice has definitely done that. That I wouldn’t have come to it as mindfulness. Mindfulness deepens that and deepens it and deepens it and deepens it... So there’s a depth of container as a depth of knowing of trusting and knowing... it’s a notion of identifying with the container more than like this isn’t really something I know or I
figured out it’s something I’m in the presence of and I’m picking up on... and that comes out of the mindfulness. That definitely comes out of the training and it definitely comes out of the rigor of the training... (Paul)

The following quotes were examples of how the practice of MM helped participants cope with the feeling of not knowing what to do or where to go in difficult times when working with clients:

One thing that comes up for me is, uh, as you ask that is, often in my - in my sessions with clients, I’ll insert - not often, but, yeah, at times - I’ll come to a place of just, uh, just not knowing what to do, where do we go from here. And that just, uh, just, you know like, yeah, I really don’t know where to go from here. And just, actually the practice has helped me to really see that and face that and that it’s okay, that I don’t have to know, you know? It’s like, it’s just I don’t have to have all the answers.... So it’s my job just to be there for the client in this “don’t know place” which, I think can be very powerful because then it helps me to be there with the client in a more genuine way, instead of just “Oh, well, this is uncomfortable” (Laughs)... So I’ll just be there in that - “don’t know place”, and I think that’s - that’s the coolest thing... (Richard)
Well, the trust is one of the qualities that you’re supposed to bring to your practice, so the trust is that trust in yourself that you will - that this will make sense to you, or that you will find some sense in what you’re doing, even though - in the moment – things can be really confusing and you’re struggling and they’re not clear and you don’t know really what you’re doing. (Susan)

Ensuing are examples of how the practice of MM helped therapists trust both their own and their clients’ process and pace within the therapeutic context:

So it’s helped me, for example, to, to trust for that client, you know, to have uh, that uh - that there’s - that actually there’s nothing, really... knowing deep down right, right deep down, that there is really nothing uhh, that he has to, or she has to - to fix or figure out. Just trust from being - just being more uhh- more present with their experience. That in itself will be what the practice of mindfulness is all about of course... that I can trust in this process, as well, and that’s all I have to do, if I can... So because of, because of my own practice, it carries through that with the client, I can - I can have more trust in his or her ability to, uh - to, uh - to heal, self-regulate, without my trying to fix anything or change anything. (Richard)
Not getting attached where - it really helps in not getting involved in fixing. Just about being with whatever it is - “I’m not going to - this guy is going to go as fast as he goes with his human skills and I can’t do anything else about it.” It’s like - so I don’t get attached to wanting him to be more mature. (Simone)

Well that’s the other thing, I have no idea what I’m talking about. You know and and more and more I trust that in the therapy situation that I don’t have any idea what I’m talking about and then people call me up and tell me that I did all this great sh*t and I think, “Wow, I’d like to meet that guy!” (Laughter) So I’m very aware that the - that I’m - mindfulness is also very much aware that I’m being created in the moment... that any intelligence that’s really being created in the therapy situation is being created in the moment and and is so much a part of your wisdom or somebody else’s wisdom or transactional wisdom that I’m simply articulating. And the ability to be comfortable with that comes out of mindfulness... the notion of trusting the process, you definitely get that from the mindfulness, it’s like you’re sitting in process, when you start to trust the process. (Paul)

In the ‘Confidence/Trust’ category participants commented on the differing ways MM had heightened their sense of trust and
confidence in themselves, the client and the therapeutic process.

*Gives a Sense of Openness/Connection/Space*

The category of ‘Openness/Connection’ emerged from therapists’ descriptions of how their MM practice helped them create and dissolve boundaries with clients. Regardless of circumstances, participants were able to ‘hold’ and contain the therapeutic space, acting as an anchor making it safe for clients to experience whatever needed to come up. This allowed both therapist and client to become more open and porous, altering their individual and collective experience of the therapeutic space. The ability to be more open and porous also had a positive influence on the quality of connection therapists experienced with their clients. Therefore, this theme category included anything that was attributed to the ability of MM to contribute to an enhanced sense of safety, openness, connection and space within the context of therapeutic practice.

Here is a case of how a therapist, who practices MM and who works with terminally ill clients, experienced the way it connected her with her clients without letting her become caught up in attachment:

So mindfulness in a practice like, here, in my counselling practice, people die. And I get attached. And that’s okay. That’s – that’s an okay attachment. I don’t get attached to
- I mean, I still want them not to die, but, if they do, I’m with that, too, in their own process, so that they’re not - and then that might be part of what mindfulness really helps me with, is that people don’t feel so alone when they die. “Simone didn’t leave, even though I was dying, even though there was nothing she could do about my life. Simone stayed.” (Simone)

The subsequent quotes are examples of how a therapist who practices MM described its qualities of dissolution and containment in relation to his therapeutic work:

Mindfulness creates more porousness and it creates a sitting with more porousness, umm, in terms of what’s me and what’s other... There’s—there’s a real dissolution of-of self... and other in the training, and which... when you got the door shut and you understand the social context and-and you get... you’re bound, I’m bound by a set of ethics that makes that self and other confusion safe. It makes it okay to—to be... to have other people’s secrets even when they don’t have their secrets. That it makes it okay to have other people’s pains and sorrows because I’m not taking it on... (Paul)

“Get out of the way”, it’s not about me. (Pause)
Mindfulness creates a... a kind of container of everything that’s just kind of passing through. (Pause) And there are
people who just want and need that witnessing, passing through, letting go, moving through me… relationship, and mindfulness makes that easy to do. So you don’t need me to be Paul and be their friend and-and-and be more personal and more caring and more involved. Just need me to be a witness to a process and mindfulness makes that relatively easy to do… (Paul)

Here examples are shown of how therapists’ MM practice improves their ability just to be present, transparent, vulnerable and connected with their clients:

What it absolutely has to do with is the equation that basically therapy is two people in a room and mindfulness takes care of you – and anything that takes care of the therapist, allows him or her to be that much more present and that much more transparent and vulnerable and that much more [capable] of holding Karen Horney’s container [psychoanalytic therapist]. More power to it, mindfulness gives me that. (Paul)

I think I talked a little bit about, before – of really hearing what people have to say and – and being very present for the patient and, you know, reminding myself over and over again that that’s, you know – you know, that’s my job. That’s what I should be doing, and that if you’re really present for a person, well, then you have a
connection and people want – I – I’m assuming people want – maybe not everybody – but, and the ones who don’t, then you are present for the ones who don’t want any connection with you and you leave them alone. (Susan)

“It allows me to be just really be right there more with the client.” (Richard)

The following quotes show how therapists described the ways in which MM practice has helped them create a safe space for their clients in therapy:

I was - would be a kind of an anchor for them to go through whatever, when they could see for them - that it is safe for them to do, yah, yah, because I’m not going to get swept away with them and their emotions. (Richard)

I’m pretty intensely involved, and what the mindfulness creates is a permission… it’s a state of permission for them, I think. A state of feeling understood and a state of permission that they really can come here and say just about anything. Umm, and... but that, any good therapist should be, probably be able to create, but when most therapists talk about it, most of their language sounds a lot like the mindfulness language. (Paul)

So, mindfulness training, the formalized mindfulness training, gave me the ability to let them be them and let me be me, and make it ok, ironically, to have that intimacy
but have that distance. And it’s the paradox, of safely having that distance, that created even more safety for them to have whatever experience, that was going on that needed to pass through them. (Paul)

In the ‘Openness/Connection’ category participants illustrated the varied ways they felt MM helped them be present, open and connected with the client while also creating and maintaining a safe therapeutic space.

Enhancement of Positive Traits and Skills

The category of ‘Enhanced Traits’ emerged from therapists’ descriptions of how their MM practice helped them develop and maintain particular positive attitudes and traits that they deemed necessary, desirable and complimentary to their therapeutic practice, such as the attitudes or traits of compassion, openness, non-attachment and non-judgment. Participants also mentioned how the practice of MM had honed their therapeutic skills, for instance the ability to listen and follow with more sensitivity and focus. Participants improved delivery of various interventions and techniques was also brought up as a noteworthy benefit of their MM practice. This assertion underlies the basic assumption that a technique or intervention is only as effective as the presence one brings to it. One participant, for example, described the potential difference and effectiveness between practicing therapeutic
touch (or any other technique, for that matter) on a client with and without mindfulness. Therefore, this theme category included anything that was related to the practice of MM and its contribution to the enhancement of certain positive traits and skills within the context of therapeutic practice.

The following quotes are an example of a therapist detailing some of the important attitudes and qualities she attributes to her MM practice and how these helped her deal more effectively with both herself and her clients:

Okay, sitting and paying attention, all these qualities that come with mindfulness, will come with practice. The patience – be patient with myself, okay... Um, patience with my own emotions and thoughts, openness to whatever is going to come next and then not getting caught up in another story and not being able to let it go – being obsessed about it... Because if I didn’t include that as part of the qualities of my own practice for myself, how can I be in my office with somebody? I might as well not bother. (Simone) So all this comes rushing in and then with mindfulness you bring the attitude of compassion and openness and non-judgment and all those qualities that come with mindfulness are able then, to allow me to be, actually be with him [the client] and maybe do something therapeutic. (Simone)
In these quotes participants attest to the importance of MM practice in enhancing the delivery of a wide range of therapeutic interventions and techniques:

“That’s it, it’s like mindfulness helps to shine the other tools up...” (Alison)

No matter how many skills and techniques I learn as a therapist and, you know, EMDR [Eye Movement Desensitization and Reprocessing] or cognitive behavioural or, all those names and labels of different techniques and therapy – brief therapy – you can go on – strategic therapy, etc. Um, no matter how many of those I can – my brain can handle and do with somebody, it – it has no therapeutic benefit if I’m not aware of my part. And mindfulness does that. It’s real simple. It’s a way simpler way. (Simone)

Next are accounts of participants’ speculations and observations regarding the enhancement of certain therapeutic skills due to MM practice, such as listening respectfully and sensitively to clients, being comfortable with silence, greater focus and detail detection, skillfully facilitating the expression of clients’ difficult emotions, and a clearer sense of one’s own strengths and weaknesses within the therapeutic context:

It’s possible that I’m – I’ve become – over the last, over many months it’s been, slightly better person [laugh] and
that I’m therefore doing, you know, I’m following more respectfully [Mm-hmm] or more sensitively. (Janet)

What people say to me in my therapeutic practices, or in the feedback I get from clients, is that “You were there, and you helped so much.” and I’m thinking “Well, I didn’t do anything. I’m just there.” “But you did all these things” - They think I did all these things and I didn’t do anything, I was just present and mindful. Um, so I didn’t have any, like, fancy things that went on other than simply being there and listening with awareness. (Simone)

“Yeah, [mindfulness helps] to be able to be with the silence.” (Alison)

It has helped me with being focussed, though, and concentration... like, when I have to sit down and do my notes - something I don’t - I still don’t really like to do it. It’s not my favourite part of my work. Um, I know what’s going to help is to be very focussed. So I can do that more deliberately. (Susan)

“Yeah, noticing smaller details, you bet, kind of like being able to really pick up on any little nuances, you know.” (Richard)

“Especially - helping people express difficult emotions like, you know, hate, revulsion...” (Susan)
I would say that my mindfulness practice has helped me to see where my — more so where my strengths and weaknesses are.” (Richard)

Participants’ accounts refer to their enhanced ability to be more tolerant, accepting, equanimous and peaceful within the therapeutic context owing to their MM practice:

Tolerance would be - my tolerance levels are probably higher than they have been in the past. Um, but I also - because of mindfulness - notice when my tolerance level is at its brink, when I’ve had enough - then I leave - leave the situation. Breathe. (Simone)

It’s helpful in my practice... it helps me at work and it helps me in other areas. Uh, I think it definitely is the mindfulness or different aspects of it - and different aspects of it seem to kind of, uh, um, be stronger than other aspects at different times, so I guess it just depends on where I’m at. So the thing that lately I’ve noticed is, um, for instance, acceptance is a big one.

(Susan)

“It helped me to build equanimy. Equa- equanimity.”

(Alison)

I think, uh like I said I think it’s just - it’s made, uh - it’s made me much more peaceful; I think that comes through for the clients. So when I’m with them it’s made me much -
to be able to stay with my peacefulness despite whatever the client might be going through. (Richard)

Therapists’ quotes describe how they attribute to their MM practice the ability to be more genuine and less tolerant of insincerity within themselves and their clients:

Yah - it’s exactly what I was talking about... You can’t - you suffer bullsh*t a lot less, you can’t just stand the bullsh*t any more. You get to recognize what’s bullsh*t. Mindfulness lets me see when I’m being fraudulent - or when others are, and I have less tolerance for it in therapy. (Paul)

I would say the practice helps me to, uh, to, uh, to put the client on a - more of a common - a - even level with - more of an even level with me... Let me add this to it: that, uh, it helps me - the practice has really helped me to - to really, uh, uh, be genuine with the client as one human being to another. So it’s almost like it helped me to be real with that client just like I would be with a friend that I really cared about. Only with boundaries, of course, because I’m a therapist, certain boundaries naturally. (Richard)

Participants’ MM practice helped strengthen and clarify their compassion and empathy for their clients:
It’s brought up more compassion, but for my clients too, yah definitely. Genuine, true compassion rather than pity or whatever... it has helped me to be a little more clearer, not that I have so much more of it, more compassion but it’s... helped me to be compassionate in a, in a more - in a better way that’s more effective way maybe that would be more helpful to the client, yah. (Richard)

“More compassion. But again, it’s all been there - was there before I started mindfulness... [Mindfulness] made it more vivid. Clearer. Strengthened it.” (Simone)

Oh yeah empathetic, much more able to do - oh, definitely. It’s a lot - I’m - I’m sure the practice has allowed me to be much more - has helped me to be much more empathetic, because I’ve noticed how difficult this process of healing and so forth has been for me, you know? (Richard)

The following quotes are examples of therapists’ accounts of how their MM practice has helped them be more humble in regards to their work and not exaggerate their own importance or that of their clients:

I think it comes from uh you know, a very slowly developing insight that uh, I’m not that important. It’s not about my ego. My ego is the enemy here, right, um, that, uh...you know the whole thing just doesn’t have that much weight... which doesn’t mean that I’m not, you know, that I don’t want to
be totally present when I’m working, of course, but I really, I’ve always known, it’s only a small part of people’s lives, you know, sometimes it can have a major impact but I don’t have a lot of control over – of when it does really. It certainly isn’t 100% attributable to how skillful I am, it has to do with all kinds of circumstances. (Janet)

Mindfulness practice has helped. I guess to summarize that just basically the mindfulness practice has helped me not to take this life, my life, the emotions, whatever my state might be, my feeling state whatever, as serious. And also it helps me, although I have more compassion for the client, but it also helps me not to take the client’s states and what they are going through as serious either, you know, it’s just to kind of see them also as an actor that’s totally immersed in their part, you know, yah, yah, so it’s uh, just uh, to not to get – helped me not to take this life so seriously. It’s uh a paradox again. Yah, just to be able to let go of this life and just let it happen instead of thinking I have to make it happen, same thing, in a session with the client. (Richard)

The ‘Enhanced Traits’ category chronicled participants’ descriptions of the ways MM enhanced various beneficial and desirable therapeutic attitudes, characteristics and skills.
The above findings indicated that participants’ MM practice was having an impact within the context of their therapeutic work. The participants’ accounts clearly had both shared and unique aspects. In general, though, the researcher was surprised by the largely overlapping descriptions among the individual participants. Other than Janet, who was more cautious and tentative in her assertions about the influence of MM on her work, participants were quite certain that their MM practice was influencing them in various ways within the therapeutic context. The implications of the current findings in relation to past, present and future research will be discussed in the following chapter.
CHAPTER 5: DISCUSSION

Introduction

At the inception of this research project in 2003, the term ‘mindfulness’ and its use in mindfulness-based practices and programs were still relatively new to the scientific body of literature. Since then a fair amount of research has come out presenting a diverse range of benefits with an equally diverse set of populations (Baer, 2003; Grossman et al., 2004). Although the topic of mindfulness has been growing swiftly ever since, research has typically been focused on the applicability and effects of mindfulness meditation on clients and patients.

Consequently, this study has focused on the specific and general ways mindfulness meditation influences the working therapist by asking the question, “How do therapists who practice mindfulness meditation experience its influence within the context of their work?” This question was dealt with by conducting a qualitative inquiry using six experienced therapists who also practiced MM. Subsequently the researcher identified 11 themes that emerged from the data analysis of therapists’ in-depth descriptions. In short, the 11 themes were: (1) the ‘Surrounding Issues’ theme which included relevant issues that were connected with the research question and the other themes but did not fall clearly within them; (2) the
'Foundational Structure' theme which addressed MM as a foundational construct that underlies, supports and informs therapeutic work; (3) the 'Perspective' theme which focused on the ways MM influences therapists' perspective within the therapeutic context; (4) the 'Self-Awareness' theme which dealt with the influence of MM on therapists' understanding and experience of their inner lives within the context of their work; (5) the 'Self-Care' theme which described the influence of MM on therapists' ability to care for themselves in relation to their work; (6) the 'Harm Reduction' theme which covered the ways MM influences the development and maintenance of a harm reduction attitude/model in therapists at work; (7) the 'Reactive/Responsive' theme that discussed the influence MM has on therapists' ability to recognize and reduce their reactivity within the therapeutic context; (8) the 'Helping/Teaching' theme which involved issues concerning the proper use of MM with clients and the ways it can be taught indirectly/directly by therapists to help clients; (9) the 'Confidence/Trust' theme which recounted the influence of MM on therapists' heightened sense of confidence and trust in the various aspects of the therapeutic process; (10) the 'Openness/Connection' theme that reported on the various ways MM helped therapists create a sense of openness, connection and safe space within the therapeutic context; (11) the 'Enhanced Traits' theme, which depicted the
ways MM influenced the growth and preservation of positive therapist attitudes, traits and skills.

It is worth noting that not all participants experienced each of the eleven themes. There was also some overlap among the 11 themes, which were never intended to stand alone. Instead, they were construed as being interconnected with shared elements.

In this final chapter, the importance and meaning of the thematic findings will be considered in relation to several crucial issues within psychotherapy, focusing on some of the ways MM practice could be of benefit. The findings will then be compared with the master therapist CER model (Jennings & Skovholt, 1999) and ethical values model (Jennings et al., 2005) to see whether the qualities and characteristics said to be enhanced by MM have any resemblance to those claimed by master therapists. Further on, the findings will be considered in light of the latest research dealing with related questions and populations. To conclude the chapter, the implications for future research, counsellor training and practice will be discussed, as well as the limitations of the research findings.

**Connections Between Themes and Key Issues in Psychotherapy**

The 11 themes drawn from the findings can be discussed relative to three general issues that are of particular significance to psychotherapy. Issues regarding
psychotherapeutic frameworks and perspectives, psychological ethics and therapist self-care are addressed.

Mindfulness Meditation as a Unifying Meta-framework and Perspective for Psychotherapeutic Modalities

One of the most prominent ways MM influenced participants within the therapeutic context was by acting as a foundational practice that became a unifying meta-framework and perspective, which shaped and informed their therapeutic work in multitudinous ways (i.e., by helping them understand and articulate human processes through direct experience). Participants described MM as a paradigm or foundation for all experience, as “a way of approaching situations and things,” breaking them down “to what’s happening in this moment” (see ‘Foundational Structure’ theme). Imbedded in the framework of MM was a basic attitude or outlook that was itself described as a kind of meta-perspective which influenced the way participants perceived their direct experience within the therapeutic context. Participants described this shift in perspective as being more open, curious, non-reactive and non-judgmental. Several participants also labeled it as “beginner’s mind,” because of its qualities of freshness and immediacy.

The potential benefit and applicability of mindfulness practice as a basic training method for psychotherapists (regardless of theoretical orientation) is gaining attention and
there have been several articles and books suggesting this possibility (Germer et al., 2005; Grepmair et al., 2007; Trungpa, 2005; Walsh & Shapiro, 2006; Welwood, 2003). This should come as no surprise given the widespread importance of mindfulness to the psychotherapeutic process. Even a quick synopsis of current psychotherapeutic models (Fall, Holden & Marquis, 2004) shows that therapists’ practice of self-awareness and their ability to interact mindfully with clients is consistently emphasized as an important part of psychotherapeutic practice, in spite of other conceptual/theoretical differences.

Martin (1997) has said as much by advancing the idea that mindfulness is a common factor and process in psychotherapy, independent of individual orientations. Mindfulness may in fact be a ‘common denominator’ underlying all forms of psychotherapy. The current participant statements supported this possibility. They believed that mindfulness was a universal quality, and that being present in a mindful way was in fact vital to all forms of therapy. Some participants believed that the mindful quality of mind that a therapist brings to their therapeutic work is paramount to their ability to facilitate healing. In other words, a mindful base was essential to the healing potential of therapeutic activities. One participant described the vast difference in effectiveness between using a technique
‘mindfully’ with a client versus just “going through the motions.” Other investigators have also highlighted the centrality of the therapist’s intention and ability to be present in a particular way, which fosters healing within the therapeutic relationship (McDonough-Means, Kreitzer, & Bell, 2004; Schmidt, 2004). Mindfulness is considered an important mediator in both the therapist’s healing intention and presence (Ibid.); this is just one of the examples of how mindfulness cuts across psychotherapeutic modalities.

It is not hard to see why mindfulness may be considered a shared and vital aspect of all forms of psychotherapy by participants when reflecting on Shapiro et al.’s (2006) description of mindfulness as bringing about a fundamental shift in perspective through “the process of intentionally attending moment by moment with openness and non-judgmentalness” (p. 378) to internal and external experience, which can then help one see “experience with greater clarity and objectivity” (p. 377). A practice that fosters an attentional perspective and attitude of openness, curiosity, clarity, non-judgmentalness and kindness and which leads to a major shift in perspective that may have further positive effects (Shapiro et al., 2006) clearly has relevance for psychotherapy. Consequently there have been an increasing number of attempts to integrate mindfulness training
into new and established psychotherapeutic systems (Lau & McMain, 2005).

Mindfulness-based cognitive therapy (MBCT) is one of the more recent and successful incarnations of a mindfulness-based psychotherapy and gives us a sense of how mindfulness (and mindfulness practice) can be successfully integrated into an established psychotherapeutic model. The case of MBCT, which was accomplished by combining core CBT principles with sustained mindfulness practice (Segal, Williams, & Teasdale, 2002), exemplifies, in my opinion, the versatile and universal nature of mindfulness and MM with regard to psychotherapeutic theory and practice. The multiple examples given by participants in the ‘Foundational Structure’ theme as well as the case of MBCT, attest to the ability of MM to act as a unifying meta-framework (from which to understand experience) and a meta-perspective (from which to perceive experience) that transcends specific psychotherapeutic models.

Beneficence and Nonmaleficence

“It is better to live one day ethically and reflectively than to live a hundred years immoral and unrestrained” (The Buddha’s words; in Cleary, 1994, p. 40). The beneficence and nonmaleficence issue was linked to a conglomeration of themes from the current study. Although the spirit of beneficence and nonmaleficence ran throughout the 11 themes it was most apparent
and clearly described in the ‘Harm Reduction’ and ‘Reactive/Responsive’ themes. It was also a factor in the ‘Self-care’ theme for therapists. However, therapist self-care was considered a key issue unto itself and for that reason discussed separately.

The accounts of participants under the different themes explicitly outline some of the many ways therapists’ MM helped them recognize and implement the essential ethical principles of beneficence and nonmaleficence within the therapeutic context. That MM supports and enhances beneficence and nonmaleficence in practice is hardly surprising given the Buddha’s many sermons on the value of these ethical principles (Cleary, 1994; Bodhí, 2005; Keown, 2005). I remember reading a brief statement by the Buddha that summarized the core of his entire teaching as “Not to do any evil, to accomplish good, to purify one’s own mind - this is the teaching of the enlightened” (Cleary, 1994, p. 63). Thus beneficence and nonmaleficence have been at the root of Buddha’s teaching since its inception. More recently, the ethical framework that underlies MM has been illustrated by Kabat-Zinn (2003), who stated, 

The actual practice of mindfulness is... always nested within a larger conceptual and practice-based ethical framework oriented towards nonharming. ... This ‘view’ includes a skillful understanding of how unexamined behaviours ... can
significantly contribute directly to human suffering, one’s own and that of others. (p. 146)

Although current forms of MM may not always be taught with all the traditional trappings and ethical principles, it is nonetheless important to realize that MM was built on the core ethical principles of benevolence and nonmaleficence. These ethical principles give integrity to the practice of MM and MM in turn heightens the awareness and sensitivity necessary to monitor their presence or absence from moment to moment.

The enhanced ability to be aware of potentially harmful situations and less reactive to personal triggers that could lead to negative judgments, counter-transference or other possibly damaging circumstances, could be a great asset in the psychotherapist’s ethical arsenal. The relevance of a practice that can help maintain and implement the principles of beneficence and nonmaleficence in ‘real’ life situations, by bringing greater awareness and attention to therapists’ thoughts, feelings and actions within the therapeutic context, should therefore be evident.

Besides being tacitly accepted as a prime directive for counselling, beneficence and nonmaleficence are core principles at the heart of both the CPA’s and APA’s code of ethics (APA, 2003; CPA, 2000). In her book ‘Foundations of Ethical Practice, Research, and Teaching in Psychology’ (2000) Karen Kitchener
describes the importance of being able to fall back on foundational ethical principles such as beneficence and nonmaleficence when in doubt about specific ethical codes or situations. She also talks about the importance of developing a virtuous or good character as the foundation for being a psychologist who is sensitive to the moral and ethical components of his or her work. I believe therapists’ systematic practice of MM with its foundation in ethical awareness and action is one very good method to ensure that therapists develop and maintain a virtuous or good character over time that will give them the motivation to be aware of and act on ethical issues in a responsible way.

Kitchener (2000) goes on to express her concern that current methods of instilling virtuous or good character for the purpose of strengthening ethical awareness and practice appear to be weak at best and ineffective at worst. How timely, then, that the current findings suggest that MM may be a solid practice for therapists who want to ensure an ongoing awareness of learned ethical principles in real life (in other words not just an intellectual but a visceral awareness of ethical principles). The findings suggest that there is a cumulative effect of practicing MM over time with regard to developing character traits such as virtue and goodness, which has always been an intended outcome of its continued practice (Cleary,
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1994; Bodhí, 2005; Keown, 2005). In fact, one participant, Richard, explicitly described a main benefit of MM as “becoming a better person”.

Another example of how MM could help therapists and psychotherapy is in the CPA’s ethical decision-making process, which illustrates the importance of self-awareness in its third step, “Consideration of how personal biases, stresses, or self-interest might influence the development of or choice between courses of action” (CPA, 2000). Although this step emphasizes the importance of therapist self-monitoring when engaged in ethical decision making, it does not go far enough, in my opinion, in suggesting practical training methods that could develop this beneficial state of self-awareness to the degree necessary to ensure its effectiveness in the ethical decision making process. These decisions can, at times, involve highly charged situations with a great number of complexities and subtleties that can be hard to discern for an untrained mind. Participants descriptions of MM’s beneficial influence on self-awareness within the context of their therapeutic work suggests that MM may be an effective self-monitoring/self-awareness practice that could greatly enhance therapists’ ability to navigate the subtle complexities inherent in many of the ethical dilemmas they face on a daily basis.
The importance of self-awareness to therapists’ ethical practice has not gone unnoticed and was addressed by Stoll (1999), who investigated counsellors’ self-monitoring of day-to-day ethical practice. Stoll found that the counsellor’s ability to self-monitor ethical practice was divided into ‘proactive’ and ‘reactive’ components, with their corresponding strategies. According to Stoll’s (1999) findings, the development and expansion of self-awareness played a principal role in both sets of strategies for self-monitoring ethical practice. For instance, one strategy from the ‘proactive’ component of the monitoring process was described as “expanding self-awareness by engaging in routine self-reflection” (Stoll, 1999, p.114). Whereas in the ‘reactive’ component of the monitoring process, the strategy of self-reflection was preceded by the awareness of an internal cue “that included a thought, an emotional reaction, or a physical sensation” (Stoll, 1999, p.116) that alerted the counsellor to the need for self-reflection. The current participants’ descriptions of their MM practice also included proactive and reactive elements. Participants not only engaged in an ongoing process of expanding self-awareness by way of their daily MM practice but they were also more attuned to internal cues such as thoughts, emotional reactions and physical sensations, which alerted them to ethically dangerous
situations, thereby avoiding them altogether or stopping them short if they were already underway.

In any case, when considering participants’ descriptions of how MM practice helped them develop greater self-awareness, a less reactive mind and a growing sense of harm reduction with clients, it appears that MM practice can seriously help the ethical therapist’s commitment to upholding moral tenets within therapeutic practice.

*Mindfulness Meditation as Self-Care Practice*

Self-care is a growing topic of interest and concern amongst health and mental health care professionals. An increasing number of studies are looking at burnout and stress in health and mental health care providers and the various symptoms that have been documented in relation to them, such as increased risk of psychiatric and medical illness, depression, depersonalization, emotional exhaustion, decreased job satisfaction (Epstein-Lubow, Miller, & McBee, 2006; Shapiro et al., 2005), to name a few.

Burnout and stress are not only dangerous and debilitating to mental health care-providers, but they can also insidiously affect the quality of care provided to clients. Shapiro et al. (2005) discuss how, in health care professionals, stress and burnout can negatively impact professional care and service by way of decreased attention, reduced concentration, weakened
decision-making abilities and a decreased ability to establish strong relational bonds with patients or clients. Research participants declared that their MM practice enhanced and deepened the quality of their attention, concentration and clarity of mind, which consequently helped them feel more connected to clients, and helped their clients feel more connected to them. It would thus appear that MM can have an antidotal effect on some of the common ailments that impinge on health care professionals’ ability to provide quality service and care.

In addition there are other forms of burnout common to psychotherapists such as ‘compassion fatigue,’ which has also been linked with detrimental effects to both therapists and their work with clients (Figley, 2002). Engaging in certain coping actions can prevent or reduce compassion stress, which unchecked leads to ‘compassion fatigue,’ a form of caregiver burnout that can adversely affect a therapist’s interest and ability to bear witness to client suffering, as well as causing feelings of helplessness and confusion.

One of the principal coping actions a therapist can take to counteract the damaging effects of compassion stress is called ‘disengagement’ (Figley, 2002), described as the psychotherapist’s ability to distance or disengage himself or herself from the clients ongoing misery outside of sessions.
This requires that the psychotherapist recognize the need to make a deliberate and conscious effort to “’let go’ of the thoughts, feelings, and sensations associated with the sessions with the client in order to live his or her own life” (p. 1438).

It appears that the coping action of disengagement that Figley (2000) prescribes is something that the practice of MM addresses and instills in practitioners. Participants clearly articulated the ways in which MM taught and helped them to accept and ‘let go’ of thoughts, feelings and sensations within the context of their therapeutic work, allowing them to be less troubled by cumbersome thoughts, feelings and sensations. Therefore MM could be a new coping action or practice that prevents or weakens compassion stress and fatigue in psychotherapists, improving their ability to maintain self-care while still being capable of bearing clients’ suffering in healthy measure.

Although it is reassuring that researchers, like Figley (2000), are bringing greater awareness to the vital topics of self-care, compassion fatigue and burnout, there still appears to be less research assessing practical skills that health care providers can learn in order to avoid or reduce burnout and improve stress management (Epstein-Lubow et al., 2006). Even in the cases where preventative solutions are being suggested, they may not be as effective in practice as desired, given the
continued and increasing problem of dissatisfaction and distress affecting health care professionals (Shapiro et al., 2005).

Burnout and stress are almost inevitable, but the current findings suggest that the practice of MM can be an effective and steadfast way to combat stress and burnout within the therapeutic context. This may explain why some are advocating the addition of mindfulness-based programs (e.g., MBSR) to the core curriculum of graduate studies in counselling psychology (Newsome, Christopher, Dahlen, & Christopher, 2006). This suggestion seems necessary and practical, considering that most, if not all, future counsellors will face at some point in their career the challenges incurred by stress and burnout. The testimonies of therapists in this research project unequivocally support the usefulness and benefits of having a regular MM practice as an effective self-care strategy for both their personal lives and their work.

In short, regarding the issues of psychotherapeutic frameworks and perspectives, psychological ethics and therapist self-care the thematic findings of the current study highlighted specific ways that MM practice can be of great benefit to both the practicing therapist and the field of psychotherapy alike. In the following section the findings of the current study will be compared with master therapist traits and ethical values to see whether the qualities and characteristics said to be
enhanced by MM have any resemblance to those claimed by master therapists.

Master Therapists and Mindfulness Meditation Revisited

As noted in the review of the literature, the conceptual link between mindfulness meditation and master therapists was a good starting point to begin considering the potential applicability and usefulness of MM to psychotherapy. Jennings and Skovholt’s (1999) CER model (Cognitive, Emotional and Relational) of master therapist characteristics, as well as Jennings et al.’s (2005) subsequent follow-up research on master therapists’ core ethical values, was discussed relative to the question of whether these essential qualities and skills for therapists could be similar, at least in part, to those cultivated through the practice of MM. In the following paragraphs this question is answered in light of the current findings.

To begin with, Jennings and Skovholt’s (1999) CER model (see Chapter 2 ‘Master Therapists’ for review) starts off with the cognitive domain, that consists of three categories, two of which address master therapist qualities relating to MM practice. The first cognitive quality mentioned as significant to master therapists was the importance of learning more about yourself as a developing therapist. Clearly the desire to learn more about oneself is at the heart of MM practice and requires
an ongoing exhaustive look at the self and all its processes and components. For example the ‘Self-Awareness’ theme in this study addresses some of the ways therapists learn about themselves by being mindful of the various components and processes that make up their experience both internally and externally.

The second cognitive quality that describes master therapists and which matches the current findings is the ability to tolerate and even welcome ambiguity, complexity and the unknown (Jennings & Skovholt, 1999). This resonates with what research participants said as well. In the ‘Confidence/Trust’ theme, therapists talked about how their MM practice had helped them be more trusting, comfortable and less afraid when facing ambiguity and the unknown within the therapeutic context. Watching the mind, body and heart through MM exposes one to many complexities, ambiguities and unknown spaces, without a doubt. In the current study, the therapists indicated that their MM practice gave them the ability to tolerate and even welcome these potentially unsettling experiences.

After the cognitive domain of the CER model comes the emotional; it also consists of three categories, all of which address qualities similar to what participants said about their MM practice. One aspect of the emotional that was echoed strongly in the current findings concerns the importance of gaining self-awareness and the need for continuous self-
reflection and feedback. One of Jennings and Skovholt’s (1999) master therapists described self-awareness as needing to be “fully aware of myself and my own motivational system, what’s moving me inside…” (p. 7). This statement reflects a basic tenet of MM, that of being fully aware, especially of things like internal motivation or intention. An example of this was articulated by one of my participants who explained how MM had helped him stay in touch with his experience from moment-to-moment so that when he had to intervene with a client during therapy he was aware of the intention and motivation behind the intervention, clarifying whether it was for his benefit or his client’s.

In the emotional domain, Jennings and Skovholt (1999) also addressed the importance of the master therapist’s ability to maintain mental and emotional health. One indicator of emotional health is the therapist’s perspective regarding his/her sense of importance. Master therapists showed genuine humility and were able to strike a healthy balance between humility and self-confidence (Jennings & Skovholt, 1999). This parallels what some of my participants described as feeling more ‘humble,’ ‘less important,’ ‘not as self-centered’ and more ‘human,’ which they attributed in various ways to their MM practice (the qualities of humility and confidence showed up most predominantly in the ‘Confidence/Trust’ and ‘Enhanced Traits’ themes). In addition
master therapists maintained their mental and emotional health in order to protect their most valuable therapeutic asset, themselves. Master therapists understood that preserving their personal health required ongoing up-keep. They accomplished this by engaging in reliable self-care practices; for instance, one master therapist stated “I have quiet time every day, where I have a chance just to be with myself... to not do it would not be good self-care, I think” (p. 8). Participants in this study paralleled the emphasis master therapists placed on the value and necessity of proper self-care, especially when it involved spending quiet time with oneself. They also unanimously championed the usefulness of MM as a practical and dependable self-care practice (in the previous sections we have already seen some of the many ways MM can help therapists maintain self-care).

The final aspect of master therapists’ emotional health that parallels the current findings consists of master therapists’ awareness of how their emotional health and reactivity can affect their work. One master therapist stated: The only hope we have of becoming good therapists is if we’re willing to look at our own stuff. Because we can learn all the skills in the world and if we’re in this long enough, we learn plenty of skills, but if we haven’t gotten our stuff cleared out of the way, we’re going to be acting
that out on our clients over and over and over again. (Jennings & Skovholt, 1999, p. 8)

The above statement touches upon several important themes; however, the most obvious one is the ‘Reactive/Responsive’ theme, which is replete with accounts of how MM helped participants be more aware of and deal with their own issues in order to avoid reacting clumsily, and in a potentially harmful way to the client.

Finally, after the emotional domain comes the relational domain, the last domain in the CER model. It also consists of three categories, all of which address qualities with relevance to MM practice. The first category in the relational domain talks about master therapist strong relationship skills. Master therapists exude qualities such as warmth, care and empathy. Their relationship skills help them create a safe space where clients feel comfortable enough to visit their pain because they know the master therapist will be there for them “both in terms of time and space, and be predictable” (Jennings & Skovholt, 1999, p. 9). The principal relationship skills that master therapists cite as essential to their work, such as empathy, caring and warmth have not only been linked with MM practice in non-therapist samples (Shapiro et al., 1998), but also listed by the current sample of therapists as being enhanced by MM. Participants, in the ‘Reactive/Responsive’ and
'Openness/Connection' themes described how MM had helped them feel more grounded, allowing them to act as an anchor for clients going through pain and emotional turmoil, without getting swept away in the process.

Another category in the relational domain notes the importance of the therapeutic relationship to master therapists. Master therapists believe a strong working alliance is crucial for therapeutic change and one of the qualities that master therapists have that can strengthen the working alliance is their trust in the client’s process and ability to change. This quality of trusting the client’s process, pace and ability to change was also clearly expressed by participants in the ‘Confidence/Trust’ theme. After bearing witness to their own process of change through the practice of MM, they were better able to trust in their clients’ ability to do the same.

A final area within the relational domain explains how master therapists are gifted at using their expert relationship skills in therapy. The master therapist is able to strike a balance between creating a sense of safety for the client while still being able to challenge him or her when necessary. Master therapists also have a good sense of timing and measure with regard to their use of interventions (Jennings & Skovholt, 1999). This mirrored research participants’ descriptions of how their MM had helped them be more confident and comfortable when
challenging a client, as well as trusting their hunches and timing when intervening (examples of this show up in the ‘Confidence/Trust’ theme). Master therapists also feel comfortable addressing very painful and difficult client issues. Master therapists expressed little fear of clients’ strong emotions and were ready and willing to be present with clients during difficult and intense circumstances (Jennings & Skovholt, 1999). This master therapist relational skill also corresponded strongly with research participants’ statements of how their MM practice gave them an enhanced ability to be present with clients during thorny and turbulent times. They also described how MM had strengthened their capacity to bear witness to and not turn away from others’ pain in therapy. MM taught them to remain present in what would otherwise be unbearable cognitive, emotional and somatic suffering (see ‘Reactive/Responsive’ and ‘Openness/Connection’ themes).

This concludes the discussion of master therapists in the original CER model (Jennings & Skovholt, 1999). Next, a brief look at a more recent study conducted by Jennings et al. (2005); which built upon Jennings and Skovholt’s original 1999 study of master therapist characteristics by re-analyzing interview data from the initial study (see ‘Master Therapist’ section in literature review). The later study highlights some of the parallels between the nine core ethical values held by master
therapists and the enhanced qualities and skills the current
participants attributed to their MM.

The nine ethical value themes (Jennings et al., 2005)
master therapists held in relation to their clinical practice
had some overlap with the aforementioned CER model (Jennings &
Skovholt, 1999). They were divided into two main categories,
‘Building and Maintaining Interpersonal Attachments’ and
‘Building and Maintaining Expertise.’

The first main category ‘Building and Maintaining
Interpersonal Attachments’ included the ethical values of
relational connection, autonomy, beneficence, and
nonmaleficence. As previously discussed, MM has been linked with
an enhanced ability to practice ethically within the therapeutic
context. The ethical themes most relevant to the current
discussion were those of autonomy, beneficence and
nonmaleficence, in which the current participants provided
examples of qualities and skills developed by MM.

For instance, the practice of ethical concern for the
client’s autonomy by way of noticing and stopping the imposition
of the therapist’s own views, beliefs, ideals and judgments is a
mindfulness practice described by participants in the
‘Reactive/Responsive’ theme. They also talked about the improved
ability to be aware of counter-transference in their therapeutic
work, thanks to their MM practice. The participants’ expression
of ethical concern for the client’s autonomy is very closely related to the efforts made by Master Therapists to ensure that they didn’t impose their values and beliefs on their clients (Jennings et al’s, 2005).

Unsurprisingly, beneficence and nonmaleficence were also core ethical values of master therapist. Both have already been linked with MM. However, it is still important to acknowledge that this is yet another factor MM and master therapists share. For example, master therapists were aware of the great potential to do harm within the therapeutic relationship (Jennings et al., 2005). The principal framework used by participants in this study to minimize both harm to themselves and their clients was MM. The use of MM to support the ethical value of nonmaleficence was described in most of the eleven themes. However, it was most predominant in the ‘Harm reduction’ and ‘Reactive/Responsive’ themes. Master therapists believe good self-care is paramount to being an ethically aware therapist who curtails potentially harmful stressors through self-monitoring and takes a proactive stance to well being. This is equivalent to how participants described the importance of practicing MM in the ‘Self-care’ theme for both their self-care, and indirectly for the quality of care passed onto their clients.

In the second category of ‘Building and Maintaining Expertise’ the master therapist ethical values of ‘Humility,’
'Openness to complexity and ambiguity,' and 'Self-awareness' were of particular relevance to the practice of MM.

The importance of humility has already been touched upon in the previous discussion of the CER model (Jennings & Skovholt, 1999). However, in this article (Jennings et al., 2005) humility is further revealed as a principal ethical value of master therapists. Humility was described by master therapists as being aware of one’s limitations as both a therapist and a human being. As already mentioned, participants believed that MM had helped them to become more humble and not to use their role as therapists to give themselves importance, embracing their 'humanness' and being more aware of their weaknesses and strengths (see the 'Enhanced Traits' theme for review).

The next theme of 'Openness to complexity and ambiguity' was also similar to a previous category in Jennings and Skovholt’s CER model (1999). Conceptualized as an ethical value that master therapists hold, it was described as a deep commitment to openness and an appreciation of complexity and ambiguity. The theme was believed to have ethical implications because of what could happen if a therapist was not able to remain open. Master therapists developed the ability to distance themselves and not react, in order to avoid making sudden decisions or acting prematurely. Research participants also mirrored this attitude and felt MM had helped them be less
reactive and more open to the complexity and ambiguity integral to the therapeutic process (see the ‘Reactive/Responsive’ and ‘Confidence/Trust’ themes for review).

The last ethical theme of ‘Self-awareness’ is the most obvious candidate for a harmonious match with MM. The ethical value of self-awareness was described as master therapists’ deep commitment to the awareness of their own issues (Jennings et al., 2005). These were considered to be divided between “(a) understanding and fulfilling their personal emotional and physical needs; and (b) awareness of their personal conflicts, defenses and vulnerabilities” (p. 42). Master therapists were aware of the many ways that these issues could interfere with their therapeutic work. Self-awareness helped master therapists counteract the negative and harmful effects of personal biases, judgments, problems and conflicts that can hinder their ability to be effective therapists. The current participants also strongly believed in the importance and centrality of self-awareness for their therapeutic effectiveness, and found enhanced self-awareness to be one of the main benefits they accrued through their MM practice (see especially the ‘Self-awareness’ and ‘Reactive/Responsive’ themes). Being able to see and deal with personal problems, biases, judgments, and counter-transference were all benefits of having a MM practice according to participants.
In summary, according to the findings of the current study, there appears to be a fair amount of overlap between those qualities developed and enhanced by therapists practicing MM and those qualities attributed to master therapists. The potential significance of this finding is considerable because it may establish, for the first time, that the practice of MM helps enhance a wide spectrum of desirable therapist skills and traits that have been declared paramount to becoming a master therapist (Hackney & Cormier, 2005; Jennings & Skovholt, 2004; Johns, 1996; Lauver & Harvey, 1997; Long, 1996; Mearns & Thorne, 1999; Noonan & Spurling, 1992; O’Donohue, Cummings, & Cummings, 2006; Wheeler, 1996). In the following section the findings of the current study will be compared with several recent qualitative studies that looked at MM, to highlight commonalities and differences.

Connections to Contemporary Research

At the time I designed this research project there was, to my knowledge, no empirical literature that had investigated the influence of MM on practicing therapists within the context of their work. Nevertheless, since the last comprehensive literature review, three qualitative studies with particular relevance to the present study have been published. In view of these new qualitative studies it is important to consider how current findings compare with the most recent and related
research investigations. The three studies in question had a similar focus on the perceived influence of mindfulness training on practitioners’ lives, albeit with noteworthy differences from the current study (e.g., the method used and the specificity of the research question). The following discussion highlights some of the ways the current study was both similar to and distinctive from the three recent qualitative studies. To begin, two of the studies addressed questions related to the one posed by the current research project, using comparable participant samples.

The first study, conducted by Rothaupt and Morgan (2007), used a constant comparative method (Merriam, 2002) with counsellors and counsellor educators. A 1-hr interview with a follow-up telephone call was employed to ask participating counsellors (among other questions) “How do your mindfulness practices impact your counselling/supervision?” and “How do your practices impact your own self-care?” (Rothaupt & Morgan, 2007, p. 44).

A more recent study conducted by Schure, Christopher, and Christopher (2008) used cross-case analysis (Huberman & Miles, 1994) and a mix of qualitative methods (Guba & Lincon, 1992; Strauss & Corbin, 1994; Patton, 1987, 2002) to analyze written journal responses from a sample of counselling graduate students taking a mindfulness-based curriculum course. Of the four
questions given to counselling students in the journal assignment, two were particularly relevant for the current study. They were: “How, if at all, has this course affected your work with clients, both in terms of being in the room and thinking about the treatment?” and “How do you see yourself integrating, if at all, any of the practices from class into your clinical practice (or career plans)?” (Schure et al., 2008, p. 49).

A third qualitative study by Mackenzie, Carlson, Munoz and Speca (2007) using grounded theory analysis (Strauss & Corbin, 1990) investigated cancer patients’ self-perceived effects of adding mindfulness meditation to their lives. Even though it differed from the first two studies in both the type of question asked and the type of participant sample used, its focus on the impact of mindfulness meditation produced important thematic links to the present study’s findings and is therefore included.

Next, the aforementioned studies will be discussed in light of the current findings, with an eye to similarities and differences (for a full overview of the current study’s thematic links with the other three qualitative studies’ findings, see ‘Table 4’ below).
Table 4

Thematic Links to Contemporary Qualitative Research

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* = Lower convergence  
** = Higher convergence

Findings from many of the current study’s themes had connections, to varying degrees, with those in Mackenzie et al.’s (2007), Rothaupt and Morgan’s (2007), and Schure et al.’s (2008) studies. The greatest congruence amongst studies as noted in ‘Table 4’ was seen in relation to the ‘Perspective,’ ‘Self-Awareness,’ ‘Self-care’ and ‘Enhanced Traits’ themes. As an example the ‘Perspective’ category will be used to illustrate
what was considered to be a theme with strong congruence across all three studies.

In the ‘Perspective’ theme identified in the current study, participant responses supported the idea that MM practice was beneficially influencing their perspective within the therapeutic context, shifting it towards viewing experience in a new, open, curious, fresh and non-judgmental way. This shift in perspective, due to mindfulness practice, was also reported by participants in the other three qualitative studies as: “a way of looking at others and events from a perspective of appreciation and gratitude” (Rothaupt & Morgan, 2007, p.50), “opening to a new way of understanding… experience” (Mackenzie et al., 2007, p. 66), and as finding “new ways of relating to themselves and their worlds” (Schure et al., 2008, p. 53).

Despite the above similarities in participants’ reports, there were no concrete examples in the two studies where researchers used counsellors as participants (Rothaupt & Morgan, 2007; Schure et al., 2008), of how this ‘shift in perspective’ would actually manifest in clinical practice. A particular strength of the current study is that the findings did include some specific examples with clinical practice value, such as Susan’s description of how her shift in perspective from mindfulness training changed her relationship to the concept of ‘resistance’ when working with clients.
Other themes with links between the current findings and those of the three qualitative studies appeared in the themes of ‘Reactive/Responsive,’ ‘Helping/Teaching,’ ‘Confidence/Trust,’ and ‘Openness/Connection.’ In these cases, though, the connections were less pronounced, only present in two of the three studies at most. Following, the ‘Confidence/Trust’ category will be discussed as one of the thematic examples with both similarities and differences in comparison to Rothaupt and Morgan’s (2007) and Schure et al.’s (2008) findings.

In the ‘Confidence/Trust’ theme of the current study, participants credited their MM practice with increasing their level of confidence and trust in themselves, their clients and the therapeutic process. Their enhanced sense of confidence and trust allowed them to feel sure that the therapeutic process would unfold as it needed to without their rushing it, or fixing it.

This reflected in part the mindful attitude towards clinical work described by one of the counsellors in Rothaupt and Morgan’s (2007) study as, “not rushing to evaluate or draw conclusions about what is going on” (p. 47). Schure et al. (2008) also reported similar findings concerning the influence of mindfulness practice on confidence and trust in counselling students. In fact some of the students’ responses from Shure et al.’s study corresponded quite closely with the statements of
the current participants. For instance, students in Schure et al.’s (2008) study talked about being “more comfortable with confronting clients now” and feeling “less pressure to ‘fix’… [or] ‘do’ something to change the client” (p.52). These statements paralleled comments made by Richard and Simone in the current study. Richard described how MM enhanced his confidence, which then allowed him to “intervene more… in the therapeutic session with a client,” and Simone discussed how her MM practice “helps in not getting involved in fixing” the situation or client.

In contrast to the connections noted above, current findings also included clinically relevant points regarding confidence and trust that were not mentioned in the other two studies. Paul’s description of how MM helped him understand and trust the process of ‘transactional wisdom’ that occurs in therapy between the client and the therapist was one such account (see ‘Confidence/Trust’ theme for full quote).

Despite the many parallels seen in ‘Table 4’ between the current study’s thematic findings and Mackenzie et al.’s (2007), Rothaupt and Morgan’s (2007), and Schure et al.’s (2008) findings, there were a number of key issues that were not clearly identified by these studies that did, however, appear in the current study. These key issues have relevance for the practice of MM by psychotherapists and therefore merit mention.
Consider, for example, the topics that emerged from participants’ descriptions in the ‘Surrounding Issues,’ ‘Foundational Structure,’ and ‘Harm Reduction’ themes respectively. These included accounts of: (a) how participants felt they were practicing mindfulness informally in various ways prior to taking it up formally as MM; (b) seeing their MM practice as a foundational framework which grounded and informed their therapeutic practice; (c) the beneficial influence MM practice was having on their ability to implement a harm reduction attitude/model by preventing or discontinuing potentially harmful thoughts and actions directed toward the client.

Apart from the key issues that were not identified in the three other studies, there were additional factors that distinguished the current study’s findings. For instance, the degree of detail and variety given in participants’ descriptions and the number of ‘in vivo’ clinical examples, which illustrated the influence of MM on practicing therapists’ work, were not found in the other studies.

It is worth paying attention to these differences because they may be a reflection of the methodological variation among research designs. For instance, some of the research design features that made the current study distinctive and its findings unique by comparison, were, (a) the use of an
identifiable and coherent methodology, i.e., Interpretive Description, that values practical, in-depth descriptions of the research topic (Thorne et al., 1997, 2004); (b) two full length interviews with mature therapists experienced in MM; and (c) a single research question designed specifically to focus on the therapist within the therapeutic context.

It is encouraging that the findings of the three recent qualitative studies, which investigated the influence of mindfulness training with distinct groups and settings, appear congruent with many of the current study’s thematic findings. This convergence of findings not only strengthens the trustworthiness of the themes and issues identified by the present study, it also offers “evidence of the reliability of these study findings” (p. 54), as pointed out by Schure et al. (2008). Still, even though there was a fair amount of congruence between the current study’s findings and those of Mackenzie et al. (2007), Rothaupt and Morgan (2007), and Schure et al. (2008), as previously noted, there were some important differences, which also contributed to the originality and significance of the current study.

Next, the significance of the current findings will be discussed in terms of their implications for future research, counsellor training and practice.
Implications and Limitations

Implications for Research

Mindfulness-meditation is a fairly recent addition to the world of research in the social sciences. This study has contributed to the growing literature needed to help determine whether mindfulness-meditation has practical value in a professional practice for mental health care professionals. In the next section, implications derived from the present study’s findings will be considered with a pragmatic outlook in the areas of future research, counsellor training and counsellor practice. To begin, a list of recommendations for future research will be outlined.

One of the implications for future research was first seen in Janet’s case. Although she had been a therapist for 25+ years she had only recently started practicing MM regularly. Of all the participants, she had the hardest time discerning what, if any, influence MM was having on her therapeutic practice. However, even though she was still ambivalent about making any definitive claims about the effect of MM on her therapeutic work, by the second interview several months later (she had attended a longer residential retreat in the interim), she felt more certain it was having an impact within her work environment and was able to give more specific examples, e.g., how her MM practice helped her be less reactive when dealing with clients
cancelling, or problems with client payment. Her comments point to the importance of time and experience when considering the relationship between MM practice and its subsequent effects/influence. What Janet’s case highlighted for me was the difference she had noticed between the first and second interviews. How much more noticeable would the influence of MM have been if there had been a third interview months later? Therefore a recommendation for future research is to conduct longitudinal studies that could capture the subtle relationship between the length and frequency of MM practice and its subsequent influence on therapists within the context of their work.

A second recommendation for future research concerns clearer operational definitions for mindfulness and the growing number of practices associated with it. I found that having a clear operational definition of what mindfulness and mindfulness practice entailed helped reduce any confusion that might otherwise result. During my literature review I found the term “mindfulness” to be used quite loosely at times, perhaps because of its mounting popularity as a catch-word for all kinds of activities and practices. Also, because MM is often practiced in conjunction with other different forms of meditation, it is not always clear what is being measured, or if these extraneous practices are being considered part of MM in some cases and not
in others (see Toneatto & Nguyen, 2007). Consequently, future researchers should strive to clarify what they mean by ‘mindfulness’ and ‘mindfulness’ practice, including the duration of practice (e.g., 30 minutes twice a week) and the form of mindfulness practice (i.e., sitting, walking). Otherwise, a great deal of misleading information and inconsistency could ensue, making it difficult to compare results across investigations.

A third recommendation for future research involves conducting further qualitative studies to see whether the themes that emerged from this study are found in other studies using a different sample of therapists (and in different contexts). Another possible variation would be to break down the themes individually and take a look at one specifically in greater depth; for example, just focusing on how therapists who practice MM believe their mindfulness training influences their ability to practice harm reduction at work. One of the advantages of using a qualitative method is that it can generate a lot of new information about an unknown topic or phenomenon, which can then be used to guide more specific quantitative studies with larger samples and control groups (increasing the possibility of generalizing such findings). Therefore, the present study may be used as a bridge to link qualitative findings with future
quantitative studies interested in investigating the relationship between therapists and MM.

Implications for Counsellor Training and Practice

In addition to the implications for future research, the current study also has implications for counsellor training and practice. Since some of the implications and recommendations for counsellor training and counsellor practice overlap, they will be addressed together to avoid repetitiveness. Following is a list of implications and recommendations for counsellor training and practice based on the current findings.

The first implication for counsellor training and practice was based on the findings that most participants said that MM acted as a meta-framework and perspective at the center of their therapeutic practice. This is not surprising, considering that mindfulness has been described as a common thread which runs through the various models of psychotherapy (Martin, 1997). Thus, MM as a meta-framework and perspective could be taught as an underlying precursor to specific/individual models of psychotherapy, ensuring that the importance of recognizing and developing what Martin (1997) has described as a basic component of psychotherapeutic process, is not overlooked in the ongoing training of student and practicing counsellors. Therefore, another recommendation for training and practice is to consider the usefulness of MM as a potential unifying framework and
method for training new and experienced therapists in mindfulness that cuts across all psychotherapeutic modalities.

The second implication, more specific to practice based on the findings, is concerned with the direct teaching of MM by therapists to clients. This includes two interrelated issues, 1) the potential dangers of teaching MM without proper training and 2) using it with clients who may not benefit from it (or may even be harmed by it). In the first instance, proper training and experience in MM was unanimously endorsed by participants as an essential prerequisite before trying to teach it directly to clients. Several participants expressed concern that the current level of fidelity and consistency in training standards was erratic at best. This concern may be a reflection of the inconsistencies and variability seen in the adherence to the MBSR program across mindfulness studies (Toneatto & Nguyen, 2007). According to participant responses, proper training is not only essential for teaching MM effectively, but also essential for having the expertise necessary to answer both general and specific questions that will no doubt arise from clients’ own MM practice (Kabat-Zinn, 2003). I think it is important to remember that, in most cases, a higher level of training or expertise is needed before deciding to teach a practice. I concur with participants that it may not be sufficient or advisable to teach MM after taking only a
relatively short course for personal practice. Currently there are different levels of MBSR training, those for new students and those for experienced MM practitioners that want to learn how to teach others (see Center for Mindfulness in Medicine, 2008). Therefore an important recommendation for both counsellor training and practice is to ensure that training standards are established and upheld for MM.

As a second issue related to teaching clients MM, a research participant emphasized the real and present danger of teaching this practice to certain clients. Paul believed, based on personal experience and client accounts, that the practice of MM is very powerful and can have a negative effect in some cases when used with people who are already feeling destabilized, on the edge, or going through a particularly chaotic period in their lives. In these cases it may be preferable to refrain from getting clients too intensely involved in traditional MM practice. Instead, engaging in more concrete physical exercises might be more appropriate. Yoga may also be an effective alternative that gets clients to focus on their bodies while still being mindful (Kabat-Zinn, 1990). Another cautionary note mentioned by Paul and other mindfulness therapists (Welwood, 2003) is the use of MM training in the service of suppression, using it to bury unwanted experiences or aspects of the self. Thus a further recommendation would be to consider a client’s
mental and emotional state and disposition before using MM with
him/her.

A third implication for training and practice that emerged
from research participants’ accounts was the value of self-
monitoring based on a heightened awareness and sensitivity to
potentially harmful actions and thoughts. This awareness
increased participants’ active engagement in harm reduction
within the therapeutic context. Self-monitoring has already been
described as an essential part of both proactive and reactive
strategies in counsellors’ ethical practice (Stoll, 1999). MM is
a powerful self-monitoring practice that could help training and
practicing therapists alike deepen and maintain their awareness
of and adherence to vital ethical principles (i.e., beneficence
and nonmaleficence), as well as ethically mandated codes.
Consequently, it is recommended that MM be considered as a
method that could be taught to enhance self-monitoring of
ethical practice and harm reduction within the therapeutic
context.

A fourth implication for training and practice is the use
of MM as an effective and reliable self-care practice for the
therapist. Therapist self-care not only benefits the therapist,
but also indirectly benefits the client (Figley, 2002). As Paul
stated “mindfulness takes care of you – and anything that takes
care of the therapist, allows him or her to be that much more
present and that much more transparent and vulnerable [with the client].” Stoll (1999) also brought up the benefits of therapist self-care for clients. She understood self-care to be an important proactive ethical self-monitoring strategy which counteracted the effects of burnout, exhaustion and inattention that could adversely affect a therapist’s ethical awareness and judgment.

Counselling programs also often advocate learning and practicing good self-care. However it may not be specifically addressed or taught within their curriculum (Newsome et al., 2006). As Newsome et al. (2007) point out “The importance of providing counselors with tools for self-care while they are being trained and early in their careers has been increasingly recognized” (p. 1882). Considering the growing emphasis on learning and practicing good self-care for therapists, there should be an equal weight placed on discovering efficient and reliable tools with which to attain this goal. Therefore, based on the findings of the present research, MM is being recommended as a beneficial, simple and dependable self-care practice and tool that could be taught to and used by training and practicing counsellors to improve and maintain proper self-care.

A fifth implication that arose from the findings was the enhancement of various qualities, which participants accredited to their MM practice. The qualities participants reported as
being enhanced by MM, also happened to be, in many cases, those attributed to master therapists (Jennings & Skovholt, 1999; Jennings et al., 2005). As such, it may be useful to consider MM training and practice as an additional or alternative method of developing the kinds of qualities that have been deemed essential to therapeutic mastery.

A sixth recommendation for counsellor training based on the findings of the current study would be to investigate possible ways MM training could be effectively integrated into the existing curriculum of counselling programs. One possible way to do this that has already been suggested (Schure et al., 2008) would be to incorporate MM through a mindfulness-based program (i.e., offered as an elective course to counselling students).

Limitations of Research

The present study used a qualitative paradigm to investigate MM influence on practicing therapists’ work. The main purpose of qualitative research is not to create findings that are transferable beyond the participants who produce them. The focus is on the personal experience or ‘lived experience’ of the participants and the descriptions generated from these. Any transferability beyond the initial participants will be at the discretion of the readers based on their own interpretation of the research findings.
The responsibility of the researcher lies in giving enough detailed information about the study (i.e., regarding researcher as instrument, research context, participants, processes and the researcher/participant relationships) so that the reader can draw his/her own informed conclusions about transferability (Morrow, 2005). Therefore the responsibility for credible transferability claims is shared between the reader and the researcher.

Another limiting factor imbedded in the research project is the very nature of the subjective self-reports given by participants and researcher alike. As well, biases and assumptions cannot be completely eliminated as influences in the research process, and to think otherwise would be naïve (Thorne et al., 1997). Co-constructed results were expected and appropriate; however, researcher reflexivity (e.g., mindfulness-meditation, journaling, consulting with a research supervisor and other knowledgeable colleagues) was employed to help keep track of biases/assumptions as much as possible.

An additional limitation of this study may be in the manner in which the researcher conceptualized mindfulness, and mindfulness-meditation. The conceptualization and operational definition of mindfulness and mindfulness meditation is still undergoing development (Bishop et al., 2004; Shapiro et al., 2006). Therefore it is important to consider whether the current
study’s conceptualization and operational definition of mindfulness and mindfulness meditation (see Bishop et al., 2004; Shapiro et al., 2006) are congruent with others in the field investigating ‘mindfulness’ and mindfulness-meditation.

One last potential limitation of the study’s findings was already brought up indirectly under the ‘Surrounding Themes’ category. It was related to participants’ recognition of the difficulty in discerning the influence of MM within the context of their work from another major influence affecting their work, i.e., their ongoing training and experience as therapists. Since there appears to be quite a bit of overlap between the skills and qualities developed by becoming a more experienced therapist and those developed independently through the practice of MM (see ‘Master Therapists Revisited’ section), it is not surprising that this was a conundrum and concern for research participants. Nevertheless, there appears to be a growing number of research studies (Grepmair et al. 2007; Rothaupt et al., 2007; Schure et al., 2008) supporting the benefits of MM for therapists who have differing levels of training and practice experience as therapists. This suggests that MM may have an influence on therapists within the context of their work regardless of their level of previous training and experience.

In light of the preceding limitations, the research findings should be considered tentatively. The goal of the study
was to be an initial, exploratory attempt at investigating the research topic. Rather than viewing the findings as definitive, it is hoped they will be generative, and lead to further research and understanding.

**Conclusion**

Up until now there has been no published empirical research exclusively documenting the ways mindfulness meditation (MM) influences therapists within their work context. The present study undertook to address this gap in research in order to understand and discern what value, if any, MM has for counselling theory, training and practice. As the themes that emerged from therapists’ descriptions demonstrated, MM may prove to be a source of considerable worth with implications for counselling theory, training and practice. Although MM should not be mistaken for a psychotherapeutic panacea, its relevance to counselling psychology is unmistakably reflected in the most pertinent points that emerged from the findings: (a) the use of MM as a reliable and effective self-care practice for the therapist; (b) the ability of MM to act as a unifying framework and perspective for psychotherapeutic practice; (c) the capacity of MM to serve as a powerful self-monitoring practice which heightens awareness of potentially harmful and unethical situations; (d) the ability of MM to help cultivate and maintain
certain beneficial attributes that are essential for therapeutic mastery and competence.

Lastly, it appears that the present study’s findings are timely, given both the paucity of research addressing the influence of MM practice on therapists and the growing attention and interest this topic is receiving in psychological journals. E. N. Williams ‘Early Career Award’ address, “A psychotherapy researcher’s perspective on therapist self-awareness and self-focused attention after a decade of research” (March, 2008), highlights this interest and the importance of the current study. She calls attention to the scarcity of research on this topic, but also suggests that studying the relationship between therapists and mindfulness “would be very useful... [and] answers to these questions might help us fine-tune our training programs and be better prepared to assist therapists experiencing job burnout” (p. 144).

It is hoped that the current findings and implications make a contribution to the limited knowledge of the influence of mindfulness meditation on therapists within their work context, while, at the same time, stimulating additional research into this promising and burgeoning field of inquiry.
References


Center For Mindfulness In Medicine, Health Care, And Society. Retrieved March 14, 2008, from University of Massachusetts Medical School Web Site: http://www.umassmed.edu/Content.aspx?id=41252&linkidentifier=id


based stress reduction on nurse stress and burnout. Part II. 

*Holistic Nursing Practice*, 26-35.


APPENDIX A: Orienting Statement and Follow-up Questions for Interviews

“I’m interested in how you experience the influence of your MM practice within the context of your work. So with that in mind could you please tell me any of the ways you feel it shows up in your work, or influences it”

1. Can you think of any specific examples that illustrate that?

2. How do you know that ____ is attributable to your MM practice and not something else?

3. Do you notice any changes when you stop practicing MM regularly as far as your work is concerned?

4. Are there any other questions I may have forgot to ask you that help answer the research question?

5. Is there anything else you would like to add?
Participant Recruitment Poster

Therapists who Practice Mindfulness Meditation (MM): Implications for Therapy

Purpose:
I invite you to participate in a study on therapists who practice mindfulness meditation (MM). This is an area that has grown significantly over the last decade and deserves more attention and research as little is known about the actual experiences of therapists who practice mindfulness and how it may be experienced within the context of their work. Therefore the purpose of my study is to document, describe, and understand the experiences of therapists who have a mindfulness-meditation practice in addition to being working therapists. It is expected that the accounts emerging from the study will lead to a better understanding of how mindfulness-meditation (MM) may or may not be interacting/influencing therapists’ work, as well as to practical implications and applications for therapy and therapists. It is hoped that this information may benefit both practicing therapists and practice theory/education.

Basic criteria for participation:
Being a practicing and registered therapist (i.e. clinical counselor, social worker or registered psychologist) who has also been practicing mindfulness meditation regularly (minimum 3x a week) for at least a year. Potential participants who contact the researchers will be asked a series of questions to ascertain that they are eligible for the study (i.e. How often do you practice mindfulness meditation). If you have any further questions or concerns regarding the inclusion criteria please do not hesitate to contact the researchers for clarification (contact info is provided at the bottom).

Study Procedures:
If you choose to participate in this study, you will be interviewed twice for about 1.5 hours each time with a waiting period of up to two months in between interviews. In total, you will be committing about 4 hours to this research.

Contact information for interested participants
If you are interested in participating in the study or have any questions or require more information with respect to this study, you may contact Dr. Beth Haverkamp at 604-822-5354 or beth.haverkamp@ubc.ca or John Alvarez at 604-876-1192 or jwadel@interchange.ubc.ca

Principal Investigator: Dr. Beth Haverkamp, Department of Counselling Psychology, (604) 822-5354.

Co-investigator: John Alvarez de Lorenzana, Department of Counselling Psychology, UBC, (604) 876-1192. This research is being conducted as part of the thesis requirement for a Masters degree in Counselling Psychology.

Version 2 April 24/2007
APPENDIX C: Participant Consent Form

Participant Consent Form

Title: Therapists who practice Mindfulness Meditation (MM): Implications for Therapy

Principal Investigator: Dr. Seth Havercamp, Department of Counselling Psychology, (604) 822-5354.

Co-investigator: John Alvarez de Lorenzana, Department of Counselling Psychology, UBC, (604) 876-1192. This research is being conducted as part of the thesis requirement for a Masters degree in Counselling Psychology.

Purpose:
I invite you to participate in a study on therapists who practice mindfulness meditation (MM). This is an area that has grown significantly over the last decade and deserves more attention and research as little is known about the actual experiences of therapists who practice mindfulness and how it may be experienced within the context of their work. Therefore the purpose of my study is to document, describe, and understand the experiences of therapists who have a mindfulness-meditation practice in addition to being working therapists. It is expected that the accounts emerging from the study will lead to a better understanding of how mindfulness-meditation (MM) may or may not be interacting/influencing therapists’ work, as well as to practical implications and applications for therapy and therapists. It is hoped that this information may benefit both practicing therapists and practice theory/education.

You have been selected to participate because of your relevant experiences.

Study Procedures:
If you choose to participate in this study, you will be interviewed twice for about 1.5 hours each time with a waiting period of up to two months in between interviews. No later than six weeks after the initial interview, you will receive the first draft of my interpretive analysis of the interview transcript. Following this, during the second interview, you will be given the opportunity to comment and give any feedback you deem relevant or necessary to the ongoing process of the interpretive description i.e. you may wish to comment on whether the findings seem 'plausible' or confirm.validate your own clinical hunches etc. In total, you will be committing about 4 hours to this research.

The interviews will be audio-taped, with your consent, and will be used for the interviewer’s purposes only. The interview questions concern how you experience mindfulness meditation in relation to your work as a therapist.

Confidentiality:
Transcriber Confidentiality Agreement

Confidentiality: The interviews are confidential and only myself (John Alvarez de Lorenzana), and my supervisor, Dr. Beth Hoverkamp will have access to the raw data (audiotapes and transcriptions). Therefore you must also agree to uphold the confidentiality agreement already in place between the researchers and their participants before the raw data can be shared with you.

Essentially this consists of taking the utmost care to keep all transcripts and audio files in a private and safe place where only you will have access to them (i.e. keep hard copies under lock and key and insure access to computer files requires a password). All raw data is confidential and should not be shared or discussed with anyone other than the researchers. At the end of the contracted work period all necessary files and hard copies will be given back to the researchers. Anything that remains i.e. old files must be erased, leaving no trace.

I ______________________ understand the requirements of confidentiality and hereby agree that I will take all the necessary precautions to avoid intentionally or unintentionally sharing or otherwise compromising the confidentiality of the research data left in my care.

Signature: ____________________________

Date: ______________

Contact Information (Address/E-mail & Tel#):
__________________________________________
Appendix E: Data Analysis at a Glance

Methodological Design: Interpretive Description

Journaling and consultation with supervisor was ongoing.

1. Interviews 1st and 2nd Set.
   - Researcher listened to interview audio recordings.
   - A professional transcribed interviews.
   - The researcher read individual transcripts.
   - The researcher simultaneously read transcripts while listening to interview recordings, looking for inconsistencies.

2. Inductive Approach to Data Analysis.
   - Condenses raw textual data.
   - Develops clear links between data.
   - Develops research framework.
   - Provides a relatively simple and systematic protocol for the analysis of the data and can produce trustworthy and valid findings.

   - Researcher printed out full-length transcripts of interviews to re-read.
   - Identified meaningful phrases from interviews.
   - Marked relevant phrases and cut them out.
   - Clippings were pooled together and separated into various emerging theme categories.
   - The clipping phrases were identifiable by their interview number and line number from the corresponding transcript.

4. Questions Related to Data Analysis.
   - Researcher reflected on two questions while reading/listening to interviews.
   - Question #1: What is happening here?
   - Question #2: What am I learning about this?
   - These questions helped capture a better overall picture of the responses given by the interviewees.

5. Meaningful/Phrases/ Emerging Themes.
   - Meaningful phrases accumulated and were considered as primary examples of potential emerging themes; they were summarized and written down on Q-cards.
   - Emerging themes were assigned numbers 1-8.
   - Phrase Q-cards were shuffled and dealt out to one of the 8 emerging themes. This was repeated multiple times and a tally of which Q-Card ended-up where was taken.
   - Emerging themes were tentatively written down on large magnetic dry board and their corresponding phrase cards were placed underneath.

6. Data Analysis of Second Set of Interviews.
   - 2nd interviews were in-depth summaries of both the individual participant’s account as well as those of the other participants.
   - Some of the ‘phrases’ from the first interviews were given greater credence after similar phrases showed up in the second interview data set.
   - Participants’ endorsement of others descriptions lead to new emerging themes.
   - Three new themes were added. Total emerging themes were now 11. The thematic findings were subsequently given the ‘thoughtful clinician’ test.
Appendix F: Findings at a Glance: Themes, Elements & Quotations

1. Surrounding Issues:
   - Participants had a hard time clearly separating the effects of MM practice from the influence of their therapeutic training and experience.
   - "I still feel like I get better as I get older and more experienced, you know, so then that get's mixed up in it, too. Am I just more mature? Or is that mindfulness has made me more centered?" (Janet)

   - Importance of the loving-kindness practice called 'Metta' to therapists (which often is used in conjunction with traditional MM)
   - "Oh, there's a - God, a big one I forget, too. It's, uh, the - the love - the Metta, the loving kindness that I've learned how to practice with it from the mindfulness and for myself and how I pass that on to my clients." (Richard)

   - Therapists informally practiced a kind of mindfulness in their lives before they took up formal MM
   - "Because I knew practicing relaxation, just from my own experience I knew practising some form of relaxation... and sitting quietly and calmly and breathing and focusing on your body." (Susan)

2. MM as Foundational Structure and Paradigm for Therapeutic Practice:
   - Gave therapeutic work structure and ability to provide an organized framework from which to articulate and understand different human processes useful to both therapist and client.
   - "If we take the structure that mindfulness practice occurs in with the bells and, umm, the time limit, 45 minutes, 20 minutes, an hour, whatever it is. Now we take getting used to that structure and legitimizing that structure then I can turn to somebody in the middle of them really working up a big rage with their partner in session and go, "You know what? We only got another 15 minutes and we don’t have time to do all of this and I need you to back off" (Paul)

   - Informs therapeutic practice
   - "My experience tells me with my clients and, uh, and whatever has come from those is that mindfulness practice informs my therapeutic practice. And that’s the bottom line. Everything else is icy." (Simone)

3. Shift in Perspective:
   - Helped them change their perspective regarding the way they see themselves and their clients in significant ways.
   - A shift in perspective or view due to MM practice is linked with the attitude of "beginner’s mind.”

   - Helps to look at situations and people differently, i.e. when working with resistance in clients.
   - "I remember resistance was such a big thing when I first started to work, it was like how do you get around a resistant patient and I just don’t - I don’t look at things like that anymore..." (Susan)
Appendix F: Findings at a Glance.
Continued

4. Self-Awareness and Its Process

- How the awareness process can be described or experienced: the mechanics of it.
- Ability to recognize and externalize internal process.
- Greater awareness of body intelligence and non-verbal cues. The body acts as a source of info. in therapy.
- "I simply take that as being a barometer of what’s going on. Umm, a lot of chest stuff. A lot of solar plexus, chest stuff. Uh, almost always translates into anxiety or deep, deep sorrow and grief. Umm, my throat will get real dry and that will be, oh, that will just be somebody cutting off from themselves." (Paul)

5. Self-Care

- It helps with Self Care. Increases kindness and compassion for the self.
- Notice a negative shift when not practicing MM.
- "I’m at that stage now where I don’t always want to do it and yet, if too long a period of time - for me it’s about a week and a half - goes by and I haven’t done anything, I just get that really squirrely feeling. So then I know, I start setting aside - deliberately setting aside time." (Susan)

6. Harm Reduction

- More acutely aware of potentially harmful situations and the ways in which they could harm their clients through their action or inaction.
- "The potentially political incorrect desire on my part not to be part of something that I don’t want to be a part of, and still give me enough distance that I don’t make it worse, the notion of harm reduction." (Paul)
- "(To) recognize the interconnectedness of everyone. I mean, it didn’t hurt me as much as it hurt other people as well, so to see that ripple effect. And to be really cognizant of that. And understanding, you know, whatever we do or say - that includes me - has a ripple effect." (Alison)

7. Less Reactive/More Responsive

- Ability to be with discomfort and uncomfortable situations.
- Generates patience/tolerance with others, own emotions, thoughts, co-workers and the system.
- Helps with transference and counter-transference. Clients stuff vs. Therapist’s i.e. projections, judgments
- "It’s um - I may notice the thoughts of wanting to get rid of them, to get them out of my office, but I - I also - mindfulness has helped me be in the storm of it and have more compassion for what’s going on. And have more sensitivity and empathy with this guy who hasn’t learned life skills." (Simone)
Appendix F: Findings at a Glance.
Continued

8. Helping and Teaching Clients

Need to have own MM practice if teaching others

Problems with mindfulness: How it is taught. It’s not for everyone.

Helps to teach clients aspects of MM in direct & indirect ways, which can assist them in various predicaments.

“Here’s a specific case where it was really helpful because uh, it really was good for him because he…worked with it, and he’d tell me about how he’d do that when he came back to the next session, you know, how he would actually practice what I’d suggested.” (Richard)

9. Greater Confidence/Trust in Self and Others.

Trust info/intuition/insight one has while doing therapy.

Freedom to be genuine with client

No need to be liked

Ability to be with the unknown/ambiguity.

MM helps in not getting involved in fixing. Helps not to get overly attached to outcomes, clients will go at their own pace.

“I just trust my…my perspective, my understanding and that…might be true when I’m sitting with a client too that I’d be less inclined to oh second guess myself and get myself hung up…” (Janet)

10. Gives Sense of Openness/Connection/Space

Ability to have/set and dissolve boundaries.

Creates space for therapist and client to open up.

Helps creates safe space for client to experience whatever they need to.

“I’m pretty intensely involved, and what the mindfulness creates is a permission… it’s a state of permission for them, I think. A state of feeling understood and a state of permission that they really can come here and say just about anything.” (Paul)

11. Enhances Positive Traits

Helps bring MM attitudes to therapy, i.e. compassion, openness, non-judgment, non-attachment.

Builds humbleness, humility and tolerance. Therapist is just playing a small part in the overall scheme of things; it’s not about therapist.

Develops and enhances a wide range of qualities and skills.

“It would seem to apply to an enormous, subtle range of interventions and enhance them. It builds center… it builds confidence in yourself… it builds a trust in the ability to handle whatever is coming up” (Paul)
APPENDIX G: Ethics Board Certificate of Approval

The University of British Columbia
Office of Research Services
Behavioural Research Ethics Board
Suite 102, 6190 Agronomy Road, Vancouver, B.C. V6T 1Z3

CERTIFICATE OF APPROVAL - MINIMAL RISK RENEWAL

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<td>Beth E. Haverkamp</td>
<td>UBC/Education/Educational &amp; Counselling Psychology, and Special Education</td>
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<td>John Alvarez de Lorenzana</td>
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The Annual Renewal for Study have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approval is issued on behalf of the Behavioural Research Ethics Board

Dr. M. Judith Lynam, Chair
Dr. Ken Craig, Chair
Dr. Jim Rupert, Associate Chair
Dr. Laurie Ford, Associate Chair
Dr. Daniel Salhani, Associate Chair
Dr. Anita Ho, Associate Chair