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**Title:**

“A Way of Waking Up To Whatever It Is”: The Experience of Counselling  
Psychologists Who Use Mindfulness in Their Personal Lives and Professional  
Practice

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Thesis Submitted in Fulfilment of the Requirement for the Award of Doctorate  
in Counselling Psychology (DPsych)

**at**

City University

Department of Psychology (School of Social Sciences)

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ISSUES:**

**pp 192-226:**      **Section C. Combined case study and process report.** 'Telling her what to do': How the therapeutic process and case formulation helped a client understand the causes and maintenance of her psychological difficulties: A cognitive-behavioural and mindfulness approach to depression.

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## Contents

Title	1
Acknowledgment	2
Declaration of powers of discretion	3
<b>Section A: Introduction to the Portfolio</b>	10
<b>Section B: Research</b>	14
<b>“A way of Waking Up To Whatever It is”: The experience of Counselling Psychologists Who Use Mindfulness in Their Personal and Professional Practice</b>	14
<b>Abstract</b>	14
<b>1 Introduction</b>	15
1.1 Introduction	15
1.2 Theoretical Background of Mindfulness	15
1.2.1 The Concept of Mindfulness	16
1.2.2 The Different Types of Meditation and Brain Activity	17
1.2.3 A Two-Component Model of Mindfulness	19
1.2.4 A Three Component Model of Mindfulness: Intention, Attention & Attitude (IAA)	22
1.3 Mindfulness-Based Approaches and Applications	24
1.3.1 Main Techniques Used in Mindfulness-Based Approaches	26
1.3.2 Mindfulness Meditation and other Constructs	28
1.3.3 Aims of Mindfulness-Based Approaches	30
1.4 Qualitative Research	30
1.4.1 Therapist’s Experience of Using Mindfulness-Based Approaches in Therapy	30
1.4.2 Client and Therapist Experience of Using Mindfulness in Therapy	33
1.4.3 Counsellor’s and Counsellor Educators’ Practice of Mindfulness	37
1.4.4 Long-Term Effects of Mindfulness Training on Counsellors and Psychotherapist	38
1.4.5 Health Care Worker’s Experience of Using Mindfulness	40

1.5	Mindfulness: Empirically Supported Benefits	44
1.5.1	Affective Benefits	44
1.5.2	Interpersonal Benefits	46
1.5.2.1	Effects on Therapist and Therapist Trainees	49
1.6	Conclusion	53
<b>2</b>	<b>Methodology Chapter</b>	<b>56</b>
2.1	Introduction	56
2.2	Epistemology, Methodology and Method	56
2.2.1	Rejection of the Positivist Position	56
2.2.2	Acceptance of Qualitative Methodology	57
2.2.3	Critical Realist Position	59
2.2.4	Method: Overview of Interpretative Phenomenological Analysis (IPA)	60
2.3	Reflexivity	63
2.3.1	Personal reflexivity	64
2.3.2	Epistemological Reflexivity	65
2.4	Research Design	67
2.4.1	Semi Structured Interviews	67
2.4.2	Interview Schedule	67
2.4.3	Pilot	68
2.5	Recruitment and Data Collection	69
2.5.1	Sampling plan and Sample Size	69
2.5.2	Inclusion/Exclusion Criteria	70
2.5.3	Participant Identification	70
2.5.4	Participants	71
2.5.5	Introducing the participants	72
2.5.6	The Interview/Procedure	74
2.6	Analytical Procedure	75
2.7	Evaluation of the Research- Issues of Quality and Validity	79
2.8	<b>Ethical Considerations</b>	<b>81</b>
2.8.1	Consent	82

2.8.2	Deception	82
2.8.3	Debriefing	82
2.8.4	Withdrawal from Investigation	82
2.8.5	Confidentiality	82
2.8.6	Protection of Participants	83
2.8.7	Obtaining Ethical Approval from Appropriate Sources	83
<b>3</b>	<b>Analysis Chapter</b>	<b>84</b>
3.1	Introduction	84
3.2	<b>“It lifts them up, their spirit and their soul”:</b> Mindfulness and Spirituality	86
3.2.1	A Way of Being	87
3.2.2	A Spiritual Journey of Psychological Growth	91
3.2.3	Opening Up to New Experiences	96
3.2.4	Letting Go of Expectations and Thoughts	100
3.3	<b>“Experiencing it together”:</b> Relational Components of Mindfulness	105
3.3.1	Enabling a Relationship with Self and Others	106
3.3.2	Doing Mindfulness Together	108
3.3.3	Enhancing the Therapeutic Relationship	112
3.4	<b>“Doing Mindfulness”:</b> Clinical Applications	116
3.4.1	The Difficulty of Defining Mindfulness	117
3.4.2	The Many Ways of Doing Mindfulness	120
3.4.3	The Dichotomy of Mindfulness- Specialisation vs Generalisation	122
3.4.4	Practising What You Preach- Advice for Therapists	126
3.5	<b>The case study</b>	129
3.6	Summary	134
<b>4</b>	<b>Discussion Chapter</b>	<b>135</b>
4.1	Introduction	135
4.2	Research Aims and Summary of Results	135
4.3	Discussion of Findings in Context and Contributions to the Field of Counselling Psychology	136

4.3.1	Mindfulness, Spirituality and Health	136
4.3.1.2	Spirituality: Implications for Counselling Psychology	140
4.3.2	Relational Components of Mindfulness: Empathic Connections	142
4.3.2.1	Empathy: Implications for Counselling Psychology	144
4.3.3	Doing Mindfulness: Advice for Novice Mindfulness Therapists	145
4.3.3.1	Advice for Novice Mindfulness Therapists: Implications for Counselling Psychology	147
4.4	Reflections on Quality and Avenues for Future Research	148
4.4.1	Reflections on Design and Future Research	150
4.4.2	Reflections on Analysis: Methodological Challenges	151
4.4.3	Personal Reflections: Impact of Author on Research	153
4.4.4	Reflexive statement	154
4.5	Conclusion	155
4.6	References	156
	<b>Appendices</b>	171
1	Advertisement and Recruitment Flyer	171
2	Information Sheet for Participants	172
3	Consent Form	174
4	Optional Socio Demographic Questionnaire	176
5	Interview Schedule	177
6	Debrief	178
7	Ethical Approval	179
8	Example Transcript	186
9	Example Transcript-Left and Right Margin Annotation	188
10	Example of Table of Themes, Supporting Quotation and Location	189
11	Table of Master Themes, Sub-Themes and Location	190
	<b>List of Tables and Figures</b>	
Fig 1	The Three Axioms of Mindfulness	22
Fig 2	Table Displaying Demographic Details of the Participants	71
Fig 3	An Illustration of the Three Master Themes and How they Relate to Each Other	84

Fig 4	An Illustration of the Three Master Themes from the Analysis	135
	<b>Section C: Combined Case Study and Process Report</b>	192
1	Introduction	192
2	Theoretical Framework	194
2.1	CBT	194
2.2	Mindfulness-Based Cognitive Therapy (MBCT)	194
2.2.1	Critical Evidence: Does MBCT Work?	195
3	Referral	196
3.1	Profile of Client/Biographical Details	196
3.2	Context, Referral/Presenting Problem	196
3.3	Initial Assessment and Case Formulation	197
3.4	Negotiating a Contract, Psychological Counselling Plan and Techniques Used	198
3.5	Key Content Issues and the Pattern of Therapy Leading Up to the Presented Session	199
3.6	Goals	201
4	Process Report	201
4.1	Lead into the Session	201
4.2	The Transcript	201
5	Treatment Review	219
5.1	Discussion/ Evaluation of the Work and What I learnt About Psychotherapeutic Practice and Theory	219
5.2	Difficulties in the work and the use of Supervision	220
6	Conclusion	221
7	Appendix 1- Formulation: Beck's (1979) Depression Model	222
8	References	223
	<b>Section D: Critical Literature Review</b>	227
	<b>What is the evidence that compassion and self-compassion can improve psychological well-being in a non-clinical population and in a clinical cohort diagnosed with a variety of mental health disorders? A critical literature review</b>	

1	Introduction	227
1.1	Leading Figures	228
2	Conceptualisations of Compassion	229
2.1	Evolutionary Conceptualisations of Compassion	229
2.2	Gilbert’s Social Mentality Conceptualisation of Compassion	230
2.3	Buddhist Conceptualisation of Compassion	232
2.4	Neff’s Conceptualisation of Self-Compassion	233
3	Studies of Self-Compassion: A Non-Clinical Population	234
3.1	Cognitive Restructuring & Emotional Well-Being	234
3.2	Motivation	237
3.3	Interpersonal Relationships/Functioning	238
3.4	Overview of Self-Compassion Research	240
4	Compassion-Focused Therapy (CFT)	241
4.1	The Premise and Core Principles of Compassionate-Focused Therapy (CFT) - A Multi-Modal Approach	241
4.2	CFT- Long-Term Mental Health Difficulties	243
4.3	CFT- Psychosis/Schizophrenia	244
4.4	CFT - Eating Disorders	247
4.5	CFT - Acute Patients	249
4.6	Overview of Compassion-Focused Therapy (CFT) Research	250
5	Conclusion	251
6	References	252

## **Section A: Introduction to the Portfolio**

### **1: Introduction to the Portfolio**

The fundamental themes pervading throughout the different sections of this portfolio, is mindfulness meditation and compassion. I have devoted a considerable amount of time and energy into this area because of my personal interests in the topics and because of my beliefs in their clinical and theoretical significance to counselling psychology.

My interest in meditation goes back to my childhood years where I was actively encouraged by my grandmother to find the stillness within myself. My grandmother instilled the belief in me that I possessed all the knowledge and wisdom within, teaching me at a young age to seek from within and never from without. Whilst growing up, my grandmother taught me that I could access this 'inner knowledge and wisdom', through the art of meditation, and so I meditated and soon noticed increased confidence and belief in my decisions. During my teenage years however, I stopped meditating. Without knowing, I began to place worth on the notion that meaning is not defined by who you essentially 'are', but by what you 'do' and so I gave up the time I took to meditate. It was only when I experienced dissatisfaction with life in my twenties that meditation re-entered my life once again.

During my twenties, I began to question the meaning of my existence and my relationship with a significant partner. Throughout these questioning times, I found myself sitting quietly to meditate in order to discern my life's meaning and purpose. Consequently, this led me to go on various meditation retreats, join meditation classes and join a Buddhist centre to increase my understanding of the topic, as well as increase my formal practice so that I could incorporate meditation into my everyday living.

As I increased my formal meditation practice, I began to notice increased levels of self-assurance and compassion for myself and others. I was starting to trust in my abilities and capabilities once again which allowed me to make some life changing decisions, such as break up with my partner of nine years. Although this decision was difficult at the time, my meditation practice enabled me to connect to my 'wiser self' and trust in the decisions I was making.

My personal experience and interest in meditation and compassion led me to think about its practical and clinical applications in counselling psychology. Additionally, my work in an NHS Trust where mindfulness meditation is taught to therapists to use in their work with clients further facilitated an introduction to the context of this study. During the first year of my clinical placement, I worked closely with a therapist who applied mindfulness into their own client work. I co-facilitated a Human Givens group with him and had the opportunity to experience how mindfulness meditation and compassion could be applied to help clients experiencing anxiety and depression. My interest in the clinical applications of mindfulness and compassion was spurred on from this and I became interested in how I could incorporate these aspects into my therapeutic work.

I was excited to encounter clinical literature on mindfulness meditation. The literature in this area documented how mindfulness meditation had been adapted into Western psychology to help alleviate depression and to help people manage stress. However, there was little research on the therapist who use them; I therefore, began to think about possible research that could explore the therapists' experience.

Over the time of studying on the course, I began to dedicate a significant amount of time to increasing my knowledge and experience of mindfulness meditation and mindfulness-based cognitive therapy. With time, I gained confidence in using a number of mindfulness techniques within a Cognitive Behaviour Therapy (CBT) framework. This led me to utilise mindfulness alongside traditional CBT with a client experiencing depression. My work with this client can be seen in the combined process report and case study included in PART C of this portfolio.

## **2 Section B Empirical Research Study**

During the course of training, my personal interest in the clinical applications of mindfulness-based approaches in therapy grew as a result of helping to deliver a group-based mindfulness-based therapy intervention to help clients experiencing depression and anxiety. In addition, during my placement in this NHS setting, I had the opportunity to attend various workshops on mindfulness where I was exposed to psychologists who were using mindfulness with their clients. A research study spurred from this. As I began to research mindfulness-based

approaches to therapy; I discovered very little research on the therapist's experience, and hence my research idea began from this gap in the existing literature.

By in large, I was interested in exploring counselling psychologists' experience of using mindfulness in their personal and professional lives. Using a qualitative methodology, eight counselling psychologists were interviewed to understand their experience of using mindfulness. These interviews were analysed using IPA. Three master themes emerged from the analysis, these were, mindfulness and spirituality, relational components of mindfulness and clinical applications. These themes are explored in more detail in the analysis chapter of this research. In addition, the implications and limitations of this study as well as future research are explored within the discussion section of this portfolio.

### **3 Section C Combined Case Study and Process Report**

This report combines a classic case study, which reports on the full course of treatment with the close analysis of interactions between client and therapist seen in a process report. The report examines in detail, the therapeutic work with a 38-year-old female client experiencing depression. It shows how I used Cognitive Behavioural Therapy (CBT) with mindfulness approaches. I chose to incorporate mindfulness approaches and techniques towards the end of the work with the client as the approach is mainly taught whilst clients are in remission. This is because mindfulness-based-cognitive therapy enables clients to learn how to bring awareness to body sensations, thoughts and emotions and to respond adaptively to the early warning signs of relapse.

As well as demonstrating how mindfulness approaches can be combined with traditional CBT, the report critically explores the therapeutic relationship with this client. It specifically demonstrates how using case formulation in CBT facilitated my client and me to have a coherent understanding of the nature of her psychological difficulties and the factors that contribute to cause and maintain her current problems. The report also highlights how the therapeutic relationship enabled the client to take a reflexive perspective and become aware of the patterns that contribute to maintain her depressive thinking. In addition, this combined report critically explores the advantages and disadvantages of working within a CBT framework, and issues such as collaboration versus client compliance are highlighted.

During my training, I have been fascinated by the complexity of the profession and I find totally enthralling the need to work at both a content and process level with my clients. The report demonstrates this in practice as I endeavour to entwine the practice of case formulation and mindfulness whilst attempting to address process issues as they occur during the session.

#### **4 Section D Critical Literature Review**

Having experienced the benefits of a loving kindness (metta-bhavana) or self-compassionate meditation for some time, and having witnessed the use of this concept in a group-based therapy with clients, I was keen to write a critical literature review in this area. I have therefore, conducted a critical review on whether self-compassion and compassion can be used as a psychological intervention to improve psychological well-being in a non-clinical population and in a clinical cohort diagnosed with a variety of mental health disorders.

Conceptualisations of compassion and self-compassion are identified within the review; in addition, various studies are systemically evaluated. The review found growing support for self-compassion and compassion as a psychological intervention to improve individual well-being. However, it also found a number of limitations that need to be improved to strengthen the studies. These limitations and implications are explored in more detail in the review.

## **Section B:           The Research Study**

### **“A Way of Waking Up To Whatever It Is”: The Experience Of Counselling Psychologist Who Use Mindfulness in Their Personal Lives and Professional Practice.**

#### **Abstract**

This study explores the experience of counselling psychologists who use mindfulness in their personal lives and professional practice. It aims to shed light on the lived experience of mindfulness for these individuals. The research took the form of a qualitative, idiographic inquiry and due to the relative lack of existing literature on the therapists' experience of using mindfulness, it was deemed important to remain rooted to the participants' experience.

Seven females and one male participant took part in in-depth, semi-structured interviews exploring their experience of using mindfulness. The interviews were transcribed and analysed using Interpretative Phenomenological Analysis. Three master themes emerged from the analysis, these are, mindfulness and spirituality, relational component of mindfulness and clinical applications of mindfulness. These master themes have a number of subthemes within them. The results of the analysis represent my interpretation of the participants' interpretation of their lived experience.

These findings are discussed with a focus on the spiritual component, empathic connections and advice for novice mindfulness therapists. The clinical implications specifically relevant to the practice of counselling psychology are also discussed.

# **1 Introduction Chapter**

## **1.1 Introduction**

In the last twenty years, counselling psychological research has seen a resurgence of interests in more integrative techniques that according to Jain et al. (2007) attempt to address not only a person's mental and physical ailments, but also their interpersonal, emotional and spiritual needs. Mindfulness meditation has been identified as one such technique. Far from being a new concept, mindfulness, according to Cigolla and Brown (2011), dates over 2500 years and is deeply rooted in the Eastern traditions, in particular Buddhism and Buddhist philosophy, where conscious awareness and attention were actively cultivated. Mindfulness meditation approaches according to Bishop et al. (2004) have however; become the focus of considerable attention for a large community of clinicians and to a lesser extent, empirical psychology.

As the interest in mindfulness-based interventions grows, the need to understand the experience of these interventions in therapy also develops. Currently extensive quantitative research on mindfulness and the effects it has on clinical populations exists. However, there is little qualitative research which explores the therapist's experience of using mindfulness in therapy. The aim of this study is to understand therapists' experience of using mindfulness in their personal and professional practice. Thus, using a qualitative methodology, eight counselling psychologists were interviewed in the current study to understand their experience of using mindfulness. It is useful to explore the therapists' experience of using mindfulness in a personal and professional context as it helps the field of counselling psychology to better understand the challenges and opportunities associated with using mindfulness approaches in therapy. The study therefore aims to add to existing qualitative research on therapists' experience of using mindfulness in their personal and professional lives.

## **1.2 Theoretical Background of Mindfulness**

The following literature review explores the influence of mindfulness, an Eastern philosophical concept on Western psychology. It discusses the concept and definitions of mindfulness and related constructs in the literature. In the second section, consideration is given to empirical research into mindfulness. There is a particular emphasis on therapists'

experience of using mindfulness as this is the focus of the research. Lastly, these elements are brought together in order to discuss the current study under investigation.

### **1.2.1 The Concept of Mindfulness**

Chiesa and Malinowski (2011) identify that mindfulness derives from the Pali word *sati* which means “to remember”. The researchers suggest that this original meaning of what is commonly translated as mindfulness often goes unnoticed and that such a link to memory may be surprising as mindfulness is usually understood as an awareness of the present moment, as opposed to dwelling in the past or future.

Analyo (2006) proposes that within the context of the Pali discourses, once *sati*/mindfulness is present, memory will function well. Accordingly, mindfulness has frequently been described as a state of “presence of mind,” as suggested by Chiesa and Malinowski (2011) and Davis, Jeffrey and Hayes (2011). This allows the practitioner to see internal and external phenomena as they really are (e.g. as impermanent, lacking a self and ultimately leading to suffering) and to distinguish between projections and misunderstandings of the practitioner.

Chiesa and Malinowski (2011) suggest that because mindfulness concerns a clear awareness of one’s inner and outer worlds, including thoughts, sensations, emotions actions or surroundings as they exist at any given moment, it has often been termed as “bare” attention by Gunaratana (1993) or as “pure” or “lucid” awareness by Das (1997). These terms emphasise that mindfulness is supposed to reveal what is occurring, before or beyond conceptual and emotional classifications about what is or has taken place. Mindfulness in this way, accords with Husserl’s (1982) phenomenological ideas. Husserl argued that experience should be examined in the way that it occurs and in its own terms. He suggested that we should ‘go back to the things themselves’, that is, go back to the experiential content of consciousness. Husserl (1982) further proposed that we should strive to adopt a phenomenological attitude which involves and requires a reflexive move, as we turn our gaze from objects in the world, and direct it inward, towards our perception of those objects. He argued that we need to disengage from the activity and attend to the taken-for-granted experience of it.

Currently, mindfulness has been described in Western psychological literature by Jon Kabat-Zinn as the ‘process of paying attention in a particular way, on purpose, in the present

moment and non-judgementally to the unfolding of experiences' (Kabat-Zinn, 1994, p.4). Mace (2007) identifies meditation as central to evoking this state, involving quiet contemplation of the body, particularly the breathing and the posture, of feelings, of the mind and of thoughts. Mindfulness meditation therefore, allows for awareness of thoughts while being able to concentrate on a particular object as identified by Williams, Teasdale, Segal and Kabat-Zinn (2007). Furthermore Ricard, Lutz and Davidson (2014) provide a helpful distinction between three types of meditation, these are outlined below. Neuroscientists such as Hasenkamp, Wilson-Mendenhall, Duncan and Barsalou (2012) have also begun to investigate brain activity during the different types of meditation. A summary of the brain activity during the three mediation practices are outlined below.

### **1.2.2 The Different Types of Meditation and Brain Activity**

Ricard et al. (2014) identify '**focused attention meditation**' as the first meditation practice. This is concerned with taming and aligning the mind in the present moment. During this meditation, the meditator develops the capacity to remain alert to distractions. The researchers suggest that this meditation practice typically directs the meditator to concentrate on the in-and-out cycle of breathing. According to Ricard et al. (2014) brain imagining has been used to identify the neural networks activated by focused attention meditation. During this form of meditation, the researchers suggest that the mind wanders from an object and the meditator must recognise this and then direct their attention to the rhythm of the in-breath and out-breath. In a study by Hasenkamp et al. (2012), meditators had to signal mind wandering by pressing a button. The researchers identified four phases of cognitive cycle; 1) an episode of mind wandering, 2) a moment of becoming aware of the distraction, 3) a phase of reorienting attention and 4) a resumption of focused attention.

Hasenkamp et al. (2012) found that each of the four phases involves particular brain networks. In the first phase of the cycle, when a distraction occurs, the researchers found an increase in activity in the wide-ranging default-mode network (DMN). This network includes areas of the medial prefrontal cortex, the posterior cingulate cortex, the precuneus, the inferior parietal lobe and the lateral temporal cortex. The DMN is activated during this phase and is known to play a general role in building and updating internal models of the world based on long-term memories about the self or others.

The second phase, becoming aware of a distraction, occurs in other brain areas such as the anterior insula and the anterior cingulate cortex, regions of what is known as the salience network (Hasenkamp et al., 2012). According to the researchers, this network controls subjectively perceived feelings and plays a significant part in detecting new events and in switching activity during meditation among assemblies of neurons that make up the brain's large-scale networks.

Hasenkamp et al. (2012) also found that the third phase activates additional brain areas such as the dorsolateral prefrontal cortex and the lateral inferior parietal lobe a section that "takes back" one's attention by separating it from any distracting stimulus. In the final phase, a resumption of focused attention, the researchers found that the dorsolateral prefrontal cortex continues to retain a high level of activity.

**'Mindfulness', or 'open monitoring meditation'**, the second meditation practice, attempts to cultivate a less emotionally reactive awareness to emotions, thoughts and sensations as they occur in the present moment in order to prevent them from spiralling out of control and to stop them from creating mental distress (Ricard et al., 2014). The researchers suggest that during this meditation, the meditator stays attentive, moment by moment, to experiences without focusing on anything specific. Ricard et al. (2014) suggest that in this meditation, the meditator is required to take note of every sight or sound and track internal bodily sensations and inner talk. The researchers investigated the influence of this form of meditation on mental functioning by measuring participant's capacity to detect rapidly presented visual stimuli. According to the researchers; this is a means to measure mindfulness meditation.

Ricard et al. (2014) asked participants to detect two numbers which were presented rapidly on a screen amidst a succession of letters. If the second number appears around 300 milliseconds after the first, the researchers suggest that participants do not often see the second number; this is termed the 'attentional blink' phenomenon (Ricard et al., 2014). However, if the second number is shown after a delay of 600 milliseconds, the researchers propose that it can be identified with ease.

Ricard et al. (2014) further suggest that the attentional blink reflects the brains limited ability to process two stimuli presented to participants at close intervals. The researchers hypothesise that mindfulness training could reduce the tendency to "get stuck" or absorbed

by seeing the first number. After three months of an intensive mindfulness retreat, Ricard et al. (2014) found that participants perceived both numbers more frequently than the control group (those who did not meditate). In addition, the researchers found that this improved perception was reflected in lessened activity of a particular brain wave in response to the first number. The researchers report that monitoring the P3b brain wave, used to assess how attention is allocated, showed that the meditators were capable of optimising attention in order to minimise the attentional blink.

Finally, the third, '**compassion and loving kindness**' meditation adopts an altruistic perspective toward others. Ricard et al. (2014) suggest that during this practice, the meditator cultivates a feeling of goodwill toward other people. Ricard et al. (2014) suggest that the meditator focusses on an unconditional feeling of kindness and love for others, accompanied by a silent repetition of a phrase which conveys this intent. The researchers found that volunteers who had studied this form of practice for thousands of hours showed an increase in activity in several brain regions while they listened to voices conveying distress. Ricard et al. (2014) report that the secondary somatosensory and insular cortices which are known to participate in empathetic and other emotional responses were more activated for experts in this meditation than the control group in response to the distressed voice. The researchers argue that this suggests that the experimental group have an enhanced ability to share the feelings of others without however, reporting any sign of becoming emotionally overwhelmed. In addition, Ricard et al. (2014) found that compassion or loving kindness meditation also produced more activity in areas such as the temporoparietal junction, the medial prefrontal cortex and the superior temporal sulcus, which they suggest are typically activated when we put ourselves in another's shoes.

### **1.2.3 A Two-Component Model of Mindfulness**

Whilst mindfulness has been described by numerous investigators such as Kabat-Zinn (1994) and Segal, Williams and Teasdale (2002) until 2004, it lacked an operational definition. As a result, Bishop et al. (2004) attempted to provide an operational definition of mindfulness that could be used consistently in the literature. Bishop et al. (2004) posit that mindfulness should be considered as a particular focus of attention characterised by two distinct components. The first component involves self-regulation of attention towards the immediate present moment, while the second component pertains to the adoption of an orientation marked by

curiosity, openness and acceptance. These components will be described below in terms of behavioural and experiential features and their implicated psychological processes.

**(1) Self-Regulation of Attention** - Bishop et al. (2004) suggest that mindfulness begins by first bringing awareness to current experience, by observing and attending to the changing field of thoughts, feelings and sensations from moment to moment through regulating the focus of attention. This leads to a feeling of being alert to what is occurring in the here-and-now. The researchers suggest that skills in sustained attention are required to maintain an awareness of current experiences. Sustained attention is defined as the 'ability to maintain a state of vigilance over prolonged periods of time (Posner & Rothbart, 1992).

Secondly, Bishop et al. (2004) suggest that sustained attention on the breath keeps attention anchored in current experience so that thoughts, feelings and sensations can be detected as they arise in the stream of consciousness. The researchers identify that skills in switching is important in mindfulness as it allows one's attention to focus on the breath once a thought, feeling or sensation has been acknowledged. Switching also involves flexibility of attention and this allows individuals to shift the focus from one object to another. Consequently, a prediction of this model is that developing mindfulness would be associated with improvements in sustained attention and switching.

Thirdly, Bishop et al. (2004) posit that the self-regulation of attention fosters non-elaborative awareness of thoughts, feelings and sensations as they arise. This allows individuals to disengage from ruminative, elaborative thought streams about experiences and its origins, implications, and associations. The researchers suggest that mindfulness is not a practice in thought suppression. For example, all thoughts and events are considered as objects of observation and not a distraction. Once they are acknowledged however, attention is directed back to the breath thereby, preventing further elaboration. Bishop et al. (2004) suggest that this inhibits secondary elaborative processing of the thoughts, feelings and sensations that arise in the stream of consciousness.

**(2) Orientation to Experience** - Mindfulness is further defined by an orientation to experience, which is cultivated in mindfulness meditation practices. According to Bishop et al. (2004) orientation begins with maintaining an attitude of curiosity about where the mind wanders whenever it inevitably drifts away from the breath as well as curiosity about the

different objects within one's experience at any moment. In this state, all thoughts, feelings and sensations that arise are initially seen as relevant and therefore, subject to observation.

Individuals are encouraged to adopt acceptance toward each moment of their experience. Roemer and Orsillo (2002) define acceptance as, 'being experientially open to the reality of the present moment'. This involves efforts to abandon one's agenda to have a different experience; it encourages the process of allowing current thoughts, feelings and sensations; see for example, Hayes, Strosahl and Wilson (1999). Bishop et al. (2004) postulate that mindfulness can further be conceptualised as a process of relating openly with experience. As such, Bishop et al. (2004) suggest that several predictions are made based on this model. Firstly, adopting a stance of curiosity and acceptance during mindfulness meditation should lead to reductions in the use of cognitive and behavioural strategies to avoid aspects of experience. Secondly, adopting a stance of acceptance toward painful or unpleasant thoughts and feelings would be expected to change the psychological context in which these objects are now experienced as proposed by Hayes et al. (1999). Fundamentally, emotional distress would be experienced as less unpleasant and threatening since the context of acceptance changes their subjective meaning; this may subsequently lead to improved affect tolerance.

In summary, mindfulness can be seen as a process of regulating attention in order to bring a quality of non-elaborative awareness to current experience and a quality of relating to one's experience within an orientation of curiosity, experiential openness and acceptance (Bishop et al., 2004). Mindfulness meditation can help to gain an insight into the nature of one's mind; by adopting a de-centred perspective on thoughts and feelings, they can be experienced in terms of their subjectivity versus their necessary validity and their transient nature versus their permanence (Bishop et al., 2004).

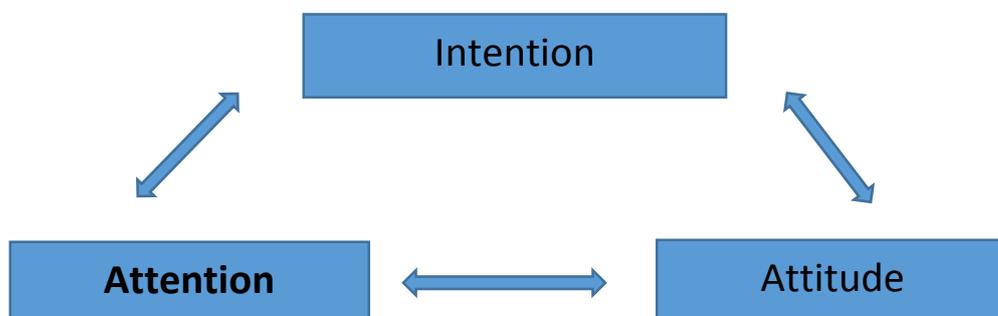
While Bishop et al. (2004) provide an operational definition of mindfulness, researchers such as Lau, Bishop, Segal, Buis, Anderson, Carlson et al. (2006) argue that the psychometric scale Bishop et al. (2004) developed to assess mindfulness, did not yield evidence in support of the active self-regulation of attention component. Moreover, Brown and Ryan (2004) also question the validity of Bishop et al.'s (2004) definition as to how one can sustain attention on a target object, while actively inviting and being open to other experiences at the same time. Cigolla and Brown (2011) further argue that Bishop et al.'s (2004) definition underplays some aspects that are emphasised in other definitions, such as the role of language and

cognition (Hayes et al., 1999), observing and describing (Linehan, 1993b). As such, Hayes and Shenk (2004) suggest that different conceptualisations of mindfulness will continue to be used in the literature. Due to these difficulties in defining mindfulness, Shapiro, Carlson, Astin and Freedman (2006) attempted to break mindfulness down into a simple, comprehensible construct. Attention is turned to their three component model of mindfulness.

#### **1.2.4 A Three Component Model of Mindfulness: Intention, Attention & Attitude (IAA)**

Shapiro et al. (2006) propose a three component model to explain how mindfulness affects positive change. In addition to attention and attitude which are similar to Bishop et al.'s (2004) definition, Shapiro et al. (2006) point out that intention, the personal motivation or vision why an individual engages with mindfulness practice needs to be considered. The three-components (axioms) model of mindfulness, proposed by the authors is derived from the general definition of mindfulness proposed by Kabat-Zinn (1994) as 'paying attention in a particular way; on purpose, in the present moment and non-judgementally' embodies the three axioms of mindfulness proposed by Shapiro et al. (2006), 1) "On purpose" or intention, 2) "Paying attention" or attention, and 3) "In a particular way" or attitude.

Shapiro et al. (2006) propose that axioms are essential building blocks out of which other things emerge. They suggest that from an understanding of IAA; we may begin to deduce how mindfulness might work. The researchers propose that, intention, attention and attitude are not separate processes or stages, but rather they are interlinked aspects of a single cyclic process and occur concurrently. Figure 1 below shows the three-component model.



*Figure 1: The Three Axioms of Mindfulness (Shapiro et al., 2006).*

**Axiom 1: Intention-** Shapiro et al. (2006) postulate that intention is important in the practice of mindfulness as it sets the stage for what is possible. Intentions remind you from moment to moment of why you are practising in the first place; intention is therefore, a dynamic and evolving process. The role of intention in meditation practice is demonstrated in a study by Shapiro (1992), which explored the intentions of meditation practitioners. The findings from this study showed that as meditators continue to practice, their intentions shift along a continuum from self-regulation, to self-exploration and finally to self-liberation. Self-liberation refers to the experience of transcending (i.e., becoming free of or dis-identifying from) the sense of being a separate self.

These findings seemingly correspond with Shapiro et al.'s (2006) definition of intention as dynamic and evolving, and that which allows meditators to change and develop with deepening practice, awareness and insight. The researchers argue that the inclusion of intention, as a central component of mindfulness is crucial in understanding the process as a whole.

**Axiom II: Attention** - In the context of mindfulness, paying attention involves observing the operations of one's moment-to-moment, internal and external experience. According to Shapiro et al. (2006), in phenomenology this is what Husserl (1982) referred to as 'a 'return to things themselves'. That is, suspending all the ways of interpreting experience and attending to experience itself as it presents itself in the here and now. Shapiro et al. (2006) argue that attention has been suggested in the field of psychology as critical to the healing process. For example Gestalt therapy emphasises present moment awareness. In addition, the researchers argue that the importance of attention can also be seen in Cognitive Behaviour Therapy (CBT), which is based on the capacity to attend, for example, observe internal and external behaviour. Shapiro et al. (2006) suggest therefore, that paying attention is at the core of mindfulness.

**Axiom III: Attitude** - Shapiro et al. (2006) postulate that how we attend is also critical, and suggest that the qualities one brings to attention have been referred to as the attitudinal foundations of mindfulness. The researchers suggest that attention can have a cold, critical quality, or it can include an affectionate, compassionate quality. As such, they argue that it is important to include 'heart' qualities in the attentional practice of mindfulness.

Additionally, the researchers suggest that through intentionally bringing the attitude of patience, compassion and non-striving to the attentional practice, individuals develop the capacity not to continually strive for pleasant experiences or to push aversive experiences away. The researchers suggest that attending without bringing the heart qualities into the practice may result in a practice that is condemning or judgmental of inner experience. This attitudinal component is referred to by Bishop et al. (2004) as orientation to experience, and involves curiosity, non-striving and acceptance.

Thus far, no consensus as to how mindfulness should be defined has been reached. Malinowski (2008) suggest that although there is general agreement regarding the involvement of sustained attention to the present moment, a broad range of differences exists between the proposed definitions and an clear operational definition of the construct of mindfulness is still lacking. In view of these discrepancies, Chiesa and Malinowski (2011) posit that it would not be surprising to observe significant differences in the way mindfulness is understood and practiced in different mindfulness-based approaches. It is therefore, important to outline below the different mindfulness based approaches and their applications.

### **1.3 Mindfulness-Based Approaches and Applications**

Chiesa and Serretti (2010) suggest that mindfulness-based intervention approaches include a broad range of meditation practices and psychological interventions linked by the concept of mindfulness. Modern standardised group-based meditation practices such as mindfulness-based stress reduction (MBSR; Kabat-Zinn, 1990) and mindfulness-based cognitive therapy (MBCT; Segal et al, 2002) as well as a number of psychological interventions including dialectical behaviour therapy (DBT; Linehan, 1993a) and acceptance and commitment therapy (ACT, Hayes et al, 1999) are commonly referred to as “mindfulness-based” approaches. While MBSR and MBCT are seen as interventions based on mindfulness training, DBT and ACT on the other hand, are seen as interventions incorporating mindfulness training (Baer, 2003).

Chiesa and Malinowski (2011) suggest that in recent years, mindfulness based approaches are being used as a means of treating a variety of psychological and physical disorders and for reducing stress levels in healthy participants. Mindfulness-based stress reduction (MBSR)

developed by Kabat-Zinn (1990) was the first to introduce mindfulness into the field of psychology and medicine. MBSR is an intervention initially designed for people suffering from a wide variety of chronic and painful physical illness. This secular intervention aims to introduce participants to a variety of mindfulness practices, which can be divided essentially into formal and informal practice.

MBSR has been taken as the foundation for the development of a number of other mindfulness-based therapies such as mindfulness-based cognitive therapy (MBCT, Segal et al., 2002). MBCT was developed as a method for the prevention of relapse in major depression. Similar to MBSR, MBCT was developed as a secular clinical intervention which does not require adopting any specific spiritual orientation or belief system. Segal et al.'s (2002) information-processing theory of depressive relapse suggests that individuals who have experienced major depressive episodes are vulnerable to recurrences whenever mild dysphoric states are encountered; because these states may reactivate depressive thinking patterns present during the previous episode or episodes thus precipitating a new episode. MBCT is influenced by cognitive-behavioural therapy (CBT) which is based on the assumption that the way we perceive events largely determines how we feel about them and, in turn determines how we behave (Beck, Rush, Shaw & Emery, 1979).

Other therapies that integrate mindfulness more or less explicitly are dialectical behaviour therapy (DBT; Linehan, 1993) and acceptance and commitment therapy (ACT; Hayes et al., 1999). DBT was originally developed as an intervention for patients who met criteria for borderline personality disorder, (BPD). DBT derives from behavioural science, dialectical philosophy and Zen practice. Linehan (1993) describes DBT as encompassing acceptance and change aimed at helping patients to build a life worth living. DBT interventions rely on the biosocial theory elucidated by Linehan (1993) which suggests that a client's emotional and behavioural deregulation is derived from the transaction between an invalidating rearing environment and a biological tendency toward emotional vulnerability.

The main dialectic for patients with BPD is the relationship between acceptance and change. According to the DBT model proposed by Linehan (1993) such dialectics as well as similar ones can be resolved by finding a synthesis between a thesis and antitheses. In accordance with the middle path approach of dialectics which is also an inherent feature of mindfulness, skills are hypothesized to work by encouraging non-reinforced engagement with emotionally

evocative stimuli, while blocking dysfunctional escape, avoidance behaviours, or other ineffective responses to the intense emotions ( Lynch, Chapman, Rosenthal, Kuo & Linehan, 2006).

ACT on the other hand, relies on the Relational Frame Theory (RFT; Hayes, 2004a) which is derived from a philosophical view called functional contextualism, (Gifford & Hayes, 1993). Although ACT does not describe its treatment method in terms of mindfulness or meditation, it is often included among the mindfulness-based interventions because several of its strategies are usually referred to as “consistent with the mindfulness approaches” (Baer, 2003, p.128). According to RFT, the core of human language and cognition is “the learned contextually controlled ability to arbitrarily relate events mutually and in combination, and to change the functions of specific events based on their relations to others (Hayes, Luoma, Bond, Masuda & Lillis, 2006, p. 5). Furthermore, it is assumed that “cognitions (and verbally labelled or evaluated emotions, memories or bodily sensations) achieve their potency not only by their form of frequency, but by the context in which they occur” (Hayes, 2004b, p. 45). An important implication of RFT is that verbally mediated relationships among objects can alter and limit behavioural processes.

As outlined, mindfulness based approaches have different historical and philosophical backgrounds. MBSR and MBCT are influenced by Buddhist philosophy and CBT. DBT is Zen oriented and influenced by behavioural science while ACT is influence by contextualism. This suggests that modifications have been introduced across different mindfulness-based approaches. Attention is now turned to the main techniques used in the mindfulness-based approaches.

### **1.3.1 Main Techniques Used in Mindfulness-Based Approaches**

In addition to differences in philosophical backgrounds, there are significant differences across the mindfulness-based approaches regarding the specific characteristics of a “correct” practice”. These will be outlined below.

MBSR and MBCT are brief meditation programmes based on three different techniques; 1) body scan, 2) sitting meditation and, 3) Hatha Yoga Practice. Body scan involves a gradual sweeping of attention through the entire body from feet to head, focusing non-critically on any sensations or feeling in the body regions and using periodic suggestions of breath

awareness (Baer, 2003). During the sitting meditation, the practitioner develops both mindful attention on the breath or on the rising and falling abdomen as well as on other perceptions, and state of non-judgemental awareness of cognitions and the stream of thoughts and distractions that continuously flow through the mind. The Hatha Yoga practice encompasses breathing exercises, simple stretches, and posture designed to strengthen and relax the musculoskeletal system (Kabat-Zinn, 1990; Segal et al., 2009). Typically, both MBSR and MBCT programmes usually include eight sessions of two hours each and homework for at least 45 minutes per day, for six days a week.

While MBSR and MBCT share similarities, a number of differences exist between them. Firstly, MBCT includes specific techniques and exercises derived from CBT (e.g., instructions on how to deal with the threat of depressive relapses, Segal et al., 2002). Secondly, MBCT provides material about major depression, and thirdly, it introduces a formal practice called the “three-minute breathing space”. This is a way of integrating formal practice into daily living (Segal et al., 2002). Initially, this is applied at regular pre-set times during each day, however, it can subsequently be applied to any times when unpleasant feelings are noticed.

Baer (2003) suggests that contrary to MBSR and MBCT, DBT and ACT do not involve formal meditation training. In DBT, clients are encouraged to accept themselves, their histories and their current situations exactly as they are, while working intensively to change their behaviours and environments to build a better life. DBT according to Linehan (1993), includes a range of cognitive and behavioural treatment procedures, most of which are designed to change thoughts, emotions, or behaviours. Mindfulness skills (such as observing and being non-judgmental) are taught so as to allow the practitioner to reach a synthesis between acceptance and change. These include among others, behavioural skills training, exposure-based strategies, psycho-education, homework and cognitive modifications. DBT clients learn mindfulness skills in a year-long weekly skills group, which also covers interpersonal effectiveness, emotion regulation, and distress tolerance skills.

Kohlenberg, Hayes and Tsai (1993) suggest that in ACT, clients are encouraged to recognise an observing self that is capable of watching its own bodily sensations, thoughts and emotions by seeing these phenomena as separate from the person having them. For example, clients are taught to say “I’m having the thought that I am a bad person”, rather than, “I’m a bad person” (Cognitive Defusion, Hayes, 2004). Clients are also encouraged to experience

thoughts and emotions, including unwanted ones such as anxiety, pain, and guilt as they arise, without judging, evaluating or attempting to change or avoid them. Hayes (2004) and Harris (2006) argue that ACT does not have symptom reduction as a goal. This is based on the view that the on-going attempt to get rid of 'symptoms' actually creates a clinical disorder in the first place. Harris (2006) argues that as soon as a private experience is labelled a 'symptom', it sets up a struggle because a 'symptom' by definition is something 'pathological', and implies that one needs to try to get rid of it. Harris (2006) therefore, suggests the aim in ACT is to try to transform our relationship with our difficult thoughts, and feelings, so that they are no longer perceived as 'symptoms'. ACT encourages individuals to learn to perceive thoughts as harmless, (even if they are uncomfortable) and as transient psychological events. Paradoxically, Harris (2006) suggests that it is through this process that ACT achieves symptom reduction; however, this is a by-product and not the goal.

In summary, mindfulness-based approaches encompass a wide range of practices. The common thread to all such approaches includes the explicit focus on present centred awareness. Both MBSR and MBCT are meditation based, however, DBT and ACT teach mindfulness skills without an explicit focus on formal meditation practice. As such, Chiesa and Malinowski (2011) suggest that significant differences exist in the way in which mindfulness is practiced across different mindfulness-based approaches.

### **1.3.2 Mindfulness Meditation and other Constructs**

It is important to mention briefly, other constructs within the same general field as mindfulness. One such example is Langer's (1989) mindfulness as a creative cognitive process. Although this construct involves attentional engagement, it differs from mindfulness as described in the context of mindfulness-based approaches. This difference lies largely in the fact that Langer's mindfulness involves the active construction of new categories and meaning when one pays attention to the stimulus properties of primarily external situations. In contrast, mindfulness defined by Kabat-Zinn (1994) and Bishop et al. (2004) emphasises the inhibitions of such elaborative process as one pays attention to primarily internal stimuli (for example, thoughts, feelings and sensations). Other similar constructs within the same general domain of mindfulness include, flow (Csikzentmihalyi, 1977) and absorption (Tellegen & Atkinson, 1974).

Mindfulness-based approaches described in this current research are similar within the general domain of constructs that describe the ability to observe the temporal stream of thoughts and feelings, including for example, introspection as described by James (1890), observing self as described by Deikman (1982) and deautomatization/decentering as described by Safran and Segal (1990). Notably, these various constructs have not always been conceptually developed nor explicitly operationalised. According to Bishop et al. (2004), each of these have been described as a process of stepping outside of the automated mode of perceptual processing and attending to the minute detail of mental activity that might otherwise escape awareness.

In addition, there are other related constructs variously labelled as psychological mindedness (Conte & Ratto, 1997) and insight (Tolor & Reznikoff, 1960). These constructs concentrate on the capacity to see relationships among thoughts, feelings and actions to understand meanings and causes of experiences and behaviour. The difference between these latter constructs is that although they involve self-observation, they emphasise the ability to construct increasingly complex mental representations of one's own (and possibly others) mind and behaviour, which is in contrast to mindfulness-based approaches described in the current research.

Mindfulness as defined in the current research is closer conceptually and operationally to those constructs that involve a process of self-observation for example, introspection and observing self rather than self-knowledge per se, for example psychological mindedness. Bishop et al. (2004) suggest that it is likely that those that involve self-knowledge may reflect the outcome of practicing many forms of intensive self-observation over time, whether from a daily practice of meditation or from psychotherapy and are therefore, distinct from the methods used to obtain them. Mindfulness-based approaches in the current research involve a quality of self-focused attention, characterised by openness and acceptance of experience, which differs from other constructs involving self-observation. This distinction is significant because research suggests that certain forms of self-focused attention can exacerbate distress and heighten or maintain psychopathology, see for example, Pyszczynski and Greenberg (1987) whilst other modes of awareness lead to a more adaptive self-focused style (Trapnell & Campbell, 1999). It is important therefore, to briefly outline the aim of mindfulness-based approaches below in order to distinguish it from other similar constructs

### **1.3.3 Aims of Mindfulness-Based Approaches**

The aims of mindfulness-based approaches according to Chiesa and Malinowski (2011) are to provide relief from unwanted physical and psychological symptoms such as chronic pain or depressive symptoms. Gilpin (2009) suggest that MBSR and MBCT are specifically concerned with achieving relief from negative symptoms by targeting the extra baggage that is piled onto the symptoms in the form of for example, negative thoughts/emotions by means of the development of an enhanced ability to cope with and/or relate differently to them. Similarly, the main aim of DBT and ACT is to help patients to manage their symptoms. At a basic level, Chiesa and Malinowski (2011) suggest that the primary aim of DBT is to help patients to reduce imminently dangerous or deadly behaviours such as suicidal behaviours. Linehan (1993) suggests that when the primary focus is achieved, further focus includes shifting from quiet desperation to emotional experiencing.

Lastly, the primary aim of ACT according to Hayes (2004) is to foster acceptance of unwanted thoughts and feelings and stimulate action tendencies that contribute to an improvement in circumstances of living. According to Hayes and Feldman (2004) the main goal of ACT is to discourage experiential avoidance, i.e., the unwillingness to experience negatively evaluated feelings, physical sensations and thoughts and substitute experiential avoidance with acceptance of things as they are. Having provided an outline of the main aims of mindfulness-based approaches, attention is now turned to empirical research in the field.

## **1.4 Qualitative Research**

### **1.4.1 Therapists' Experience of Using Mindfulness-Based Approaches in Therapy**

Qualitative research in the field of mindfulness and in particular on the therapists' experience of using mindfulness in therapy is still in its infancy. However, studies are beginning to emerge to in this area; some of these are discussed below.

Cigolla and Brown (2011) explored the experience of therapists who practice mindfulness and bring it into their individual therapeutic work. The study inquired about therapists' understanding of the concept and its role in different domains of their lives both within and outside the therapy room. In this qualitative study, the research question was kept broad to

be consistent with qualitative methodology. The data was analysed using IPA which the researchers argue captures the subtleties of an experiential concept like mindfulness.

Six qualified therapists consisting of two males and four females, with an age range from twenty-nine to fifty-five with a mean age of forty-three years participated in the study. All of the therapists had adopted the practice of mindfulness in their personal lives either formally or informally for four to twenty years and were also integrating mindfulness into their therapeutic practice. Three of the therapists described their theoretical approach as integrative, two as humanistic and one as person-centred.

Cigolla and Brown (2011) conducted semi-structured interviews with participants. Five main questions were asked. These included 1) “would you mind telling me what you understand by the term mindfulness”? 2) How did you become interested in mindfulness? 3) Can you tell me about your mindfulness practice? 4) I understand that you also bring mindfulness into your therapeutic practice. Would you mind telling me how you do that? 5) What would you say is the place of mindfulness in therapy?

Cigolla and Brown (2011) report that the findings show a common understanding of mindfulness as a way of being characterised by a particular attitude towards experience that permeated both the personal and the professional life of participants. This is brought into therapy both implicitly by modelling and embodying it in the therapeutic relationship, and more explicitly by encouraging a present-centred and accepting attitude through different means. The analysis revealed a number of themes. A major theme that emerged was that of mindfulness as a “way of being”. However, whilst viewing mindfulness as a way of being, the researchers report that all participants described their experiences of mindfulness in different domains captured by the following subthemes: ‘a way of being in personal life’, ‘a way of being in therapy’, and ‘encouraging a way of being in others’.

The researchers found a definition of mindfulness used by participants, which appear consistent with those used in the literature by Kabat-Zinn (2003) and Bishop et al. (2004). However, Cigolla and Brown (2011) report that by exploring mindfulness’ meaning in more depth, the theme “way of being” was developed, which according to the researchers indicates that mindfulness was described as an approach to life deeply embedded into participants’ sense of self and worldview. This way of being was evident in all of the sub-themes, in

particular in the first one, where mindfulness was described as an important part of therapists' private lives, something that resonated with them and that, with time and practice, was integrated within their sense of self. The researchers found that the journey into mindfulness was also described as having a spiritual component by participants that led to the incorporation of values and beliefs which contributed to the development of a particular outlook on life and experience.

Cigolla and Brown (2011) found that participants emphasised the experiential nature of mindfulness and the necessity to practice it in order to understand it. Participants highlighted the importance of formal practice such as sitting meditation, although finding time for it was seen as a challenge by many of the participants. Participants reported that informal practices were more easily integrated in their everyday routine. Participants reported that practising mindfulness regularly over a period of time made it easier to be mindful and connect with the experience. In addition, participants reported a sense of letting go that is, dis-identifying from the contents of their minds and becoming more aware of the conditioned patterns and automatic responses.

Cigolla and Brown (2011) report that as well as in personal life, mindfulness was seen as a way of being in professional life. The researchers found that mindfulness enhances awareness, both in terms of self-awareness and the ability to follow the relational process unfolding between therapist and client. Cigolla and Brown (2001) suggest that mindfulness appeared to facilitate awareness of therapist's reaction to the client and urges to react in ways that may be counter therapeutic, thereby, allowing the therapist to disengage from this and choose a more appropriate course of action. Furthermore, mindfulness was seen as having a critical impact on the quality of the therapeutic relationship, in terms of, depth, presence and immediacy.

A third subtheme that emerged was 'encouraging a way of being in others'. Cigolla and Brown (2011) found that as well as implicitly modelling a different way of being, therapists also integrated mindfulness more explicitly by encouraging a mindful attitude in the sessions. The researchers reported that participants explained how mindfulness can be fostered by encouraging clients to pay attention to different aspects of their present experience, starting from the breath and then shifting to emotions and physical sensations. To complement this, the same qualities that therapists bring to their own experience are fostered in clients,

including non-judgemental acceptance, openness, curiosity and compassion. All participants reported that mindfulness needs to be introduced gently, taking into account the clients' process and their readiness to engage with it.

Cigolla and Brown (2011) note a number of limitations of their study. Firstly, the study only looked at therapists who practice mindfulness regularly; therefore excluding those who regard it as a technique or a set of skills taught to clients. The researchers acknowledge that it would be interesting to interview therapists who do not have a mindfulness practice despite teaching it to clients, perhaps as part of interventions such as ACT or DBT. Secondly, Cigolla and Brown (2011) acknowledge that as the research is of a qualitative nature, the themes found reflect the subjectivity of the researcher and this is one of many possible interpretations of the complexities found in the therapists' accounts. As such, the research cannot be generalised to all therapists who practice mindfulness. It is also worth noting that only shared experiences are reported by the researchers.

#### **1.4.2 Client and Therapist Experience of Using Mindfulness in Therapy**

Horst, Newsom and Stith (2013) investigated how clients and therapists new to using mindfulness respond to the experience of mindfulness exercises. The researchers interviewed five client/therapist dyads regarding their experiences of using mindfulness in their sessions. This exploratory study is one of the first to investigate both client and therapist perspectives on using mindfulness interventions in session.

Ten participants consisting of five clients and five corresponding therapists were used in the study. Of the participating therapists, there were four females and one male. All of the participating clients were female. Participant therapists ranged in age from 23-44 years and client participants ranged from 19-56 years. Participants were recruited from a marriage and family therapy training programme in the Midwestern region of the USA. The selection criteria for the dyad included therapist participants who had used some sort of mindfulness exercise in session with client participants at least twice at the time of the interview.

Horst et al. (2013) conducted the interviews with both members of the participating therapy dyad that is, therapist and client together. Interviews were semi-structured including specific questions related to the experience of mindfulness in session. Interview questions included, "what was the experience of using mindfulness in session; 'when your therapist first

mentioned using mindfulness in session, what were your first reactions and how did the mindfulness experience meet your expectations. The data was analysed using Thematic Analysis.

Horst et al. (2013) reported that the analysis revealed several important themes related to client and therapist experience of mindfulness in session. The researchers organised themes into two overarching categories; “the experience of using mindfulness activities” and “therapist and client suggestions about how mindfulness can be successfully utilised in session.” The researchers reported that all participants had positive comments regarding the use of mindfulness.

Horst et al (2013) report that when asked about their experience of using mindfulness in session, participant clients and therapists mentioned several notable themes which included: 1) “Helpful with presenting problem,” 2) “Aided with in-session transitions,” 3) “Facilitated conversation,” 4) “Lack of confidence in ability to use or facilitate activities, ’and 5) “calming,’. These themes will be explored below.

**Theme 1 - “Helpful with presenting problem.”** Horst et al. (2013) reported that client participants discussed how positive it was to use mindfulness in response to managing pain. The researchers report that whether specifically related to their presenting problem or simply as an aid to treatment, participants found the experience of using mindfulness in session positive. Furthermore, the researchers found that therapist participants mostly agreed with their clients’ statements regarding how mindfulness related to presenting problems.

**Theme 2 - “Helpful with transitions”.** Another theme that emerged was that using mindfulness in session was “helpful with transitions” in therapy. The researchers found that participants viewed the use of mindfulness in session as a means to focus in session. Clients noted that mindfulness exercises eased that transition from whatever was happening prior (e.g. class, work, commuting, etc.) to the session.

The researchers found one participant therapeutic dyad mentioned using a mindfulness exercise to transition from talking into an experiential exercise. Both client and therapist noted how the two exercises “go together” and “dove-tailed one another.” The therapist participant went on to explain how mindfulness helped with this transition in that she wanted her client “to just start experiencing emotions instead of thinking about them so much.” Horst

et al. (2013) reported that both client and therapists recognised the value of the mindfulness exercises in transitioning into therapy and within different activities in session. The researchers however, reported that therapist participants seem to appreciate the value of this more overtly than client participants.

**Theme 3 - “Facilitated conversations”.** Horst et al. (2013) found that the use of mindfulness in session facilitated conversations. Participants reported that conversations about mindfulness concepts were helpful to the overall treatment. The researchers report that a client participant noted how mindfulness exercises changed the content of subsequent conversations as well as noted how the activity of mindfulness was shared with their therapist. Horst et al. (2013) argue that unlike other therapeutic techniques this shared experience seemed to be a common factors that facilitated conversation in many of the participant dyads.

**Theme 4 - “Lack of confidence in ability to use or facilitate activities”.** Horst et al. (2013) reported that when asked directly about their experience, therapists were able to talk about the reservations they had initially and anticipated reactions from the client. The researchers found that clients also felt a degree of self-consciousness using mindfulness for the first time. Horst et al. (2013) reported that all the participants talked about nervousness with initially using mindfulness; however, most also noted becoming increasingly comfortable with continued use of the exercises. The researchers found that many of the therapy dyads mentioned sharing their apprehension with one another, which in turn seemed to facilitate a more authentic conversation.

**Theme 5 - “Calming.”** Horst et al (2013) reported that all participants noted that using mindfulness activities had a calming effect on the session. The researchers reported that client participants recalled that the sessions that included mindfulness exercises were calmer and more thoughtful. Therapist participants also noted the calming effect of mindfulness in session, both on themselves and on the client. Horst et al. (2013) reported that these results seemed consistent regardless of the specific type of mindfulness exercise used or whether it was done at the beginning, middle, or end of session.

In conclusion, Horst et al. (2013) suggests that unique to the present findings is the indication that the experience of mindfulness in therapy is one shared by clients and therapists. The

researchers argue that much of the literature regarding the experience of mindfulness focuses on the individual's internal experience. However, these findings suggest that mindfulness may influence the session through an impact on the therapeutic relationship. The researchers found that both client and therapist participants recognized the influence of one another on their initial experiences of using mindfulness in session.

Horst et al. (2013) acknowledge that this is the first study to consider both clients' and therapists' joint experiences of mindfulness in session. However, the researchers acknowledge several limitations of their study. Firstly, the sample was small (only five therapist-client dyads). In addition, all therapist participants were still in training and relatively new to using mindfulness in therapy. Therefore, the researchers acknowledge that, results are reflective only of the experience of new therapists using mindfulness for the first time. Additionally, all of the therapists learned to use mindfulness in therapy from the same instructor as part of this research study. Only one therapist participant had prior experience with mindfulness. Thus, Horst et al. (2013) suggest that some of the results may be in part due to the instructor's methods of teaching mindfulness rather than the use of mindfulness alone.

A further limitation identified by the researchers is that therapist participants self-selected which clients to use mindfulness in session with, thus some bias as to the openness of the client to mindfulness might also be present. Similarly, therapist participants self-selected to be in the study. The researchers acknowledge that these participants were more likely to be open to concepts like mindfulness. In addition, information regarding the models of treatment used by each dyad was not collected; this may have influenced the experience of mindfulness in session. However, the researchers argue that this information was purposely excluded as they felt it may detract from the main aim of the study.

Lastly, Horst et al. (2013) argue that allowing for both the client and therapist participants to be interviewed together presents both strengths and limitations. The researchers suggest that this cooperative interview enhances our understanding of the relational aspects of using mindfulness thereby, allowing the dyad to process the experience together as it was experienced together initially. Horst et al. (2013) argue that few studies have considered both therapists' and clients' perspectives on using this technique in session, and to date, no study has gathered data simultaneously from client and therapist. The researchers further argue

that although some of the novelty of the study is maintained in their study design, some limitations may be assumed.

### **1.4.3 Counsellor's and Counsellor Educators' Practice of Mindfulness**

Rothaupt and Morgan (2007) suggest that mindfulness practices are being employed to help clients and to facilitate counsellor effectiveness. The researchers investigated how counsellors and counsellor educators incorporate mindfulness into their personal and professional lives. Six participants, (three men and three women) took part in a semi-structured interview. Participants self-identified as using mindfulness practices and varied in terms of their experience as both counsellors and practitioners of mindfulness. Participants also self-identified as White European American. Five initial questions were used to guide the interview. These included: (1) How do you define mindfulness? (2) What is the nature of your mindfulness practices? (3) How did you get started with the practices? (4) How do your mindfulness practices impact your counselling/supervision? (5) How do your practices impact your own self-care? Rothaupt and Morgan (2007) used a constant comparative method to analyse the data and synthesise themes. The findings are summarised below.

Rothaupt and Morgan (2007) report one overarching theme, which is, 'the need and effort to live in the present moment', summarised by a participant who said; "I think that being mindful in every moment and not living in the past and not living in the future is the power of living". The researchers also identified two other broad themes which contained several subthemes. They reported that participants spoke of (1) 'using a variety of tools or methods to incorporate mindfulness into their lives' and (2) 'the outcomes or results of their mindfulness activities'.

**Using a variety of tools or methods to incorporate mindfulness into their lives** - Rothaupt and Morgan (2007) found that all participants identified similar mindfulness practices. These practices included (a) **Regular rituals to cultivate mindfulness**. Here participants described a number of regular rituals to facilitate their mindfulness, these included, meditation, the use of breathing to focus awareness and mindful walking. One participant for example, said, "Breathing is really helpful to me. When I feel myself feeling the fragmented energy, then the breathing can really be a help to put me back into a peaceful way". (b) **'Body awareness'**; here participants felt that awareness of bodily cues provided vital information about their

current state, for example, what they might need to do to better care for themselves, or to remain mindful. (c) '**Practiced patience**', participants described the need to slow down and cultivate patience. Often, this was in direct contrast to the fast pace of life, which they felt discourages mindfulness. (d) '**Pursuit of solitude**'; here participants spoke of a need for isolation—time alone to meditate, reflect, and focus on being instead of doing, and finally, (e) **A mindful use of one's environment**. Participants spoke of decorating their office space with art and objects that invite mindfulness.

Stemming from these practices, Rothaupt and Morgan (2007) found that participants reported several outcomes of their mindfulness activities including (a) '**An intentional style of living**'. For the participants, this seems to involve active choices to live mindfully, to create a mindful way of being at all times. (b) '**A sense of connectedness**', here, participants' spoke of recognising and valuing connection to others, to a higher power, and to nature. The researchers found that a connection to a higher power and spirituality were evident in the interviews, although they found that participants' practices varied greatly. (c) '**Deep gratitude**', and (d) '**Inviting clients and students to live mindfully**'. Several participants spoke of directly inviting clients to use mindfulness practices, including body scans, breathing exercises, and a non-judgmental attitude.

There are several limitations of this research. Firstly, the researchers acknowledge that the non-random nature of the selection process as well as the small sample size means that the results cannot be generalised to other samples. As a result future quantitative studies could use larger numbers and more diverse participants, thus generating the statistical power necessary to draw more generalisable conclusions.

#### **1.4.4 Long-Term Effects of Mindfulness Training on Counsellors and Psychotherapist**

In another study, Christopher, Chrisman, Trotter-Mathison, Schure, Dahlen and Christopher (2011) utilised a qualitative design to explore how exposure to mindfulness training influenced the personal and professional lives of counselling students once they had graduated and were practising as counsellors. Sixteen European American participants (three men and thirteen women) were randomly selected from the pool of students ( $N = 54$ ) who took the course over the five-year period to take part in the study. Participants ranged in age from 25-55 years. Semi-structured phone interviews were conducted with the participants.

Questions such as, “What were the most important things you learned in the class? “How has the class affected your personal life in the areas of awareness, relationships, interactions with others, health, and psychological development” were asked. Participant’s responses were analysed using content analysis.

Two main themes emerged from the analysis. (1) Participants described persisting changes in both their personal lives and (2) their professional lives as counsellors and psychotherapists. Within their personal lives, the researchers found that participants indicated that they continued to engage in some form of mindfulness practice and that the class helped them to appreciate the importance of continuing to practice mindfulness throughout their lives. Some of the persisting changes participants reported in their personal lives included, practicing forms of self-care that positively affect them physically, emotionally, and cognitively or attitudinally. Christopher et al. (2011) report that these changes were often marked by improved awareness of themselves in these different domains, including how stress manifests in different areas of their lives. The researchers also found that this awareness was often accompanied by a reported ability to also preserve self-acceptance.

Participants reported positive changes in their interpersonal relationships as a result of their continued use of mindfulness practices. Positive changes included; increased awareness of their own patterns of anxiety and reactivity, increased acceptance and compassion of others and themselves, and included being less judgmental, less reactive, intentionally working to be compassionate with others, and accepting their own experience. The researchers found that participants indicated that these changes increased their sense of connection and promoted new forms of closeness that entailed more ease and clearer boundaries.

Within their professional lives as counsellors, participants reported positive changes in their phenomenological experience of themselves as counsellors, these changes included increased awareness and increased acceptance of both themselves and their clients. Consequently, this contributed to less fear of working with clients and of their clients’ symptoms, less fear of failure, less fear of the clients’ disapproval, more humility, and more willingness to seek help and consultation. Christopher et al. (2011 also) found that participants’ clinical practice was still influenced by their training in mindfulness. For example,

participants reported teaching their clients some of the mindfulness practices and principles that they learned.

Whilst this study suggests that mindfulness training offers a promising approach to therapist self-care, there are a number of limitations. Firstly the study used participants who independently decided to participate in the course; therefore, a limitation of the study could be self-selection bias. Secondly, participants in the study were European American and predominantly women; this limits the generalisability of the findings to individuals from other racial/ethnic backgrounds or across genders.

#### **1.4.5 Health Care Workers' Experience of Using Mindfulness**

Morgan, Simpson and Smith (2014) conducted a qualitative review which evaluated how health-care workers experience mindfulness. The inclusion criteria for the review included papers that had been peer-reviewed, reported a qualitative methodology and focused on the experience of health care workers or those in clinical training who had taken part in mindfulness training. Morgan et al. (2014) define health care workers as those who are in paid work, in physical or mental health provision or taking part in clinical training within a health care profession. The review also included studies that used MBSR, MBCT or training programmes that explicitly drew upon these approaches with the integration of core mindfulness practices such as sitting meditation, the body scan and mindful movement. Additionally, qualitative studies that used a content based approach such as thematic analysis or grounded theory and included some participant quotes were also included.

Morgan et al. (2014) selected fourteen papers which explored the experiences of 254 participants using mindfulness. Participants included trainees and qualified professionals in social work, counselling, nursing and clinical psychology as well as trainee occupational and family therapists and qualified physicians. The researchers note that four out of the fourteen papers selected for the review did not report the gender of the participants. However, the other ten papers reported that 84% of 181 participants were female. The purpose of the training in most of the studies reviewed was to reduce stress or increase well-being and to impact on the interpersonal skills of the participants.

Morgan et al. (2014) highlight that the analysis process for the review involved reading the papers and creating brief summaries of the main concepts and conclusions. The researchers identified two main themes from the review to make sense of participants' experiences; these are: (1) experiencing and overcoming challenges to mindfulness practice and (2) changing relationship to experience in (a) personal and (b) interpersonal domains. These themes are highlighted below.

**Experiencing and overcoming challenges to mindfulness practice** - Morgan et al. (2014) report that an important aspect of health care workers' experience in mindfulness training was meeting and responding to challenges in formal mindfulness practice. The researchers found that some of the participants described feeling guilty about looking after themselves, making a connection between this feeling and their identities as health care workers. For example, one participant said this, "I'm having trouble focusing on myself and not others' problems. It's the nurse in me." The researchers highlight that this was experienced as a barrier to formal practice and using self-care more generally. However, they also found that participants said they treated themselves more positively as the course went on and were able to cultivate self-compassion. Attending to their own self-care need through their mindfulness training therefore, led to a greater capacity to be present in a compassionate way with their clients.

**Changing relationship to experience** - Morgan et al. (2014) also found that health care workers reported changing their relationship to experiences. These changes occurred in both personal and interpersonal domains. The researchers found that participants reported personal benefits such as shifting the ways in which they coped with emotions and the ways in which they related to themselves. For example, participants felt more able to cope with difficult thoughts and "to an extent note and let go of arising emotions". This led to improvements in self-care, confidence and decision making. Participants also reported physical well-being, some reported changing their relationship to physical pain and many reported that their physical health had improved in terms of reducing symptoms of illness and improving sleep, eating habits, flexibility and strength. Morgan et al. (2014) argue that this highlights that mindfulness training can produce holistic changes that are not always measured in quantitative studies.

As well as personal benefits, the researchers found that participants reported interpersonal benefits such as becoming more aware when relating to others and being able to choose how to act. For example, the participants spoke about using mindfulness to ground themselves or gain focus prior to seeing clients. Some participants also reported increased empathy for their clients and others reported feeling more hopeful about the potential for therapeutic change. Morgan et al. (2014) however, highlight that the range of personal and interpersonal benefits was not experienced by all participants and there were variations both within and between papers.

Morgan et al. (2014) argue that their review provides evidence to suggest that mindfulness training can produce positive outcomes for a range of health care disciplines. However, they note that, not all participants reported all of the outcomes discussed. The researchers note that a possible limitation with the review is that strict criteria were not applied when selecting studies to include, as this would have limited the application of more interpretative synthesis methods. Future studies should therefore, be carried out using more formal procedures.

#### **1.4.6 Mindfulness Meditation and Developing Therapeutic Presence**

McCollum and Gehart (2010) investigated the impact of mindfulness meditation on students in a master's marriage and family therapy programme as a way to help them develop therapeutic presence. The researchers define therapeutic presence as having three components: 1) "an availability and openness to all aspects of the client's experience, 2) openness to one's own experience in being with the client and 3) the capacity to respond to the client from the experience.

The researchers integrated mindfulness meditation into the marriage and family therapy programmes. The students on these programmes were asked to complete a five-ten minutes of daily mindfulness practice and to reflect on the impact of their practice in their professional work and personal lives in the form of a weekly journal/log. Using opportunistic sampling, thirteen students who participated in the researchers two classes gave their consent for the researchers to use their weekly journal entries as data for the study. Of the thirteen students, there were seven men and six women, with an age range from 22-60 years.

McCollum and Gehart (2010) asked the students to reflect on the experience of learning mindfulness meditation as well as the effects they felt it had on their personal lives and their clinical practice in weekly journals. In their reflective journals the students were asked to address the following: (1) were you able to practice daily this week? (2) Describe your mindfulness practice. (3) Describe strategies you used for returning to your focus. Were you able to be patient with yourself during the practice? (4) Describe any insights you may have gained from observing your mind. (5) Describe any differences in your daily life and professional practice that may have resulted from this practice and (6) Describe new insights or experiences related to developing therapeutic presence.

The data was analysed using thematic analysis. The findings revealed that the students felt their mindfulness practice helped them to be present in their sessions. This had a number of dimensions which included; (a) being able to attend to their inner experiences during sessions as well as, (b) being aware of what was happening with their clients in the moment. McCollum and Gehart (2010) reported that the students were able to take their awareness of these two domains and bring them, together in their therapist-client interaction. The researchers found that students reported being able to attend to their own experiences and that of their client and further bring the awareness of both into the moment-by-moment interaction in session.

McCollum and Gehart (2010) also found that the students reported several effects of their meditation practice with their ability to be present as therapist. Students felt that their meditation assisted them to be calmer generally and specifically in their therapy sessions. In addition, students reported that they were able to become aware of their 'inner chatter' and either decrease or disconnect from it. The researchers further found that the students reported that their meditation practice enabled them to experience a sense of compassion and acceptance for themselves and their clients.

McCollum and Gehart (2010) conclude that it appears the practice of mindfulness may help novice therapists develop qualities such as therapeutic presence. However, the researchers identify some limitations of their study. Firstly, they were only able to collect data from those students who volunteered to give their journals. It could be argued that only those who found the mindfulness practice helpful volunteered to participate. Secondly, the researchers identify that since they were also the class instructors, students may have written what they

felt the researchers wanted to hear and may have therefore, emphasised the positive aspects of the practice.

## **1.5 Mindfulness: Empirically Supported Benefits**

Qualitative research into therapists' experience of using mindfulness in their therapeutic practice remains limited. As such, the current literature review will broaden out to include quantitative research into mindfulness. Davis et al. (2011) suggest that as research evidence begins to accumulate concerning the positive outcomes of mindfulness, it is possible to categorise these benefits along several dimensions. The researchers postulate three dimensions that are particularly relevant to psychotherapy; these relate to the 1) affective, 2) interpersonal, and 3) other intrapersonal benefits of mindfulness. Another empirically supported benefit of mindfulness, empathy, will also be reviewed when looking at research on therapists who practice mindfulness meditation.

### **1.5.1 Affective Benefits**

**Emotion regulation** - Corcoran, Farb, Anderson and Segal (2010) postulate that mindfulness helps develop effective emotion regulation in the brain. In terms of proposed mechanisms of change, Corcoran et al. (2010) hypothesize that mindfulness meditation promotes metacognitive awareness, decreases rumination via disengagement from perseverative cognitive activities, and enhances attentional capacities through gains in working memory. The researchers argue that these cognitive gains, in turn, contribute to effective emotion regulation strategies.

In support of Corcoran et al.'s (2010) model, Chambers, Lo and Allen (2008) found that mindfulness meditation is negatively associated with rumination and is directly related to effective emotion regulation. Chambers et al. (2008) compared 20 nonclinical novice meditators who participated in a 10-day intensive mindfulness meditation retreat to a wait-list control group on mindfulness, rumination, affect, and performance tasks for attention switching, sustained attention and working memory. The researchers found that following the meditation retreat, the meditation group had significantly higher self-reported mindfulness, decreased negative affect, fewer depressive symptoms, and less rumination compared to the control group. In addition, Chambers et al. (2008) found that the meditation group had significantly better working memory capacity and greater ability to sustain

attention during a performance task compared to the control group. However, there were no differences between the groups on self-reported anxiety or positive affect.

Chambers et al.'s (2008) findings that mindfulness training decreased rumination is consistent with research with participants having chronic mood disorders. For example, Ramel, Goldin, Carmona and McQuaid (2004) found that participants in an eight-week MBSR training had significantly less reflective rumination compared to: a) participants' initial rumination scores, and b) a control group matched on age, gender, and initial depressive symptoms. In addition, the researchers found that decreases in rumination scores were significantly predicted by participants' amount of meditation practice. Similarly, McKim (2008) compared pre-post scores after an eight-week MBSR intervention among a community sample that experienced ongoing anxiety, depression, and/or chronic pain. Following MBSR, McKim (2008) found that participants had significantly higher scores on self-reported mindfulness and significantly lower scores on self-reported rumination, psychological distress, depression, anxiety, and physical illness. Furthermore, mindfulness scores significantly predicted anxiety, rumination, medical symptoms, and psychological distress.

Farb et al. (2010) suggest that mindfulness meditation leads to increased positive affect and decreased anxiety and negative affect. In their study, participants were randomly assigned to an eight-week MBSR training group and then compared to a wait-list control group on self-report measures of depression, anxiety, and psychopathology and on neural reactivity as measured by functional magnetic resonance imaging (fMRI) after watching sad films. The findings showed that participants exposed to MBSR displayed significantly less anxiety, depression, and somatic distress relative to the control group. The researchers also found that fMRI data indicated that the MBSR group had less neural reactivity while exposed to the films than the control group; furthermore, the MBSR group displayed distinctively different neural responses while watching the films than they did prior to the MBSR training. Farb et al. (2010) argue that the findings suggest that mindfulness meditation shifts individuals' ability to employ emotion regulation strategies that enable them to experience emotion selectively, and that the emotions they experience may be processed differently in the brain. These research indicate that meditation may elicit positive emotions, minimize negative affect and rumination, and enable effective emotion regulation.

**Decreased reactivity and increased response flexibility** - Cahn and Polich (2009) have demonstrated that mindfulness meditation enables people to become less reactive. In addition, Moore and Malinowski (2009) have shown that mindfulness meditation enables individuals to have greater cognitive flexibility.

Cahn and Polich (2009) assessed the reactions of very experienced mindfulness meditators to distracting stimuli. A three-stimulus auditory oddball series was presented to experienced meditators during meditation and a control thought period to elicit event-related brain potentials (ERPs) in the two different mental states. The stimuli consisted of a frequent standard tone (500 Hz), an infrequent oddball tone (1000 Hz), and an infrequent distracter (white noise), with all stimuli passively presented through headphones and no task imposed. Cahn and Polich's (2009) found that while in a meditative state, practitioners displayed minimal emotional and cognitive reactivity to distracting stimuli. As a result, the researchers argue that a meditation state can decrease the amplitude of neurophysiologic processes that subserve attentional engagement elicited by unexpected and distracting stimuli. They therefore, argue that this supports the notion that mindfulness meditation contributes to decreased reactivity.

Moore and Malinowski (2009) investigated the link between meditation, self-reported mindfulness and cognitive flexibility as well as other attentional functions. The study compared a group of meditators experienced in mindfulness meditation with a meditation-naïve control group on measures of Stroop interference and the d2-concentration and endurance test. The results showed that meditators performed significantly better than non-meditators on all measures of attention. Furthermore, self-reported mindfulness was higher in meditators than non-meditators and correlations with all attention measures were of moderate to high strength. The findings suggest that attentional performance and cognitive flexibility are positively related to meditation practice and levels of mindfulness. Moore and Malinowski (2009) argue that this pattern of results suggests that mindfulness is intimately linked to improvements of attentional functions and cognitive flexibility.

### **1.5.2 Interpersonal Benefits**

The question of how mindfulness affects interpersonal behaviour has been investigated by researchers such as Carson, Carson, Gil and Baucom (2006). The researchers investigated a

novel intervention, mindfulness-based relationship enhancement (MBRE) with couples. Using a randomised wait-list controlled design, the study evaluated the effects of mindfulness-based relationship enhancement, designed to enrich the relationships of relatively happy, non-distressed couples. Carson et al's. (2006) findings suggested that the intervention was efficacious in (a) favourably impacting couples' levels of relationship satisfaction, autonomy, relatedness, closeness, acceptance of one another, and relationship distress; (b) beneficially affecting individuals' optimism, spirituality, relaxation, and psychological distress; and (c) maintaining benefits at three-month follow-up. Carson et al. (2006) found that those who practiced mindfulness more had better outcomes. In addition, the researchers report that within-person analyses of diary measures showed greater mindfulness practice on a given day was associated on several consecutive days with improved levels of relationship happiness, relationship stress, stress coping efficacy, and overall stress.

Barnes, Brown, Krusemark, Campbell and Rogge (2007) suggest that trait mindfulness (pertains to the personality domain) predicts relationship satisfaction and ability to respond constructively to relationship stress. Barnes et al. (2007) found that people with higher trait mindfulness reported less emotional stress in response to relationship conflict and entered conflict discussion with less anger and anxiety. The researchers conducted two studies that examined the role of mindfulness in romantic relationship satisfaction and in responses to relationship stress. Using a longitudinal design, study one found that higher trait mindfulness predicted higher relationship satisfaction and greater capacities to respond constructively to relationship stress. Study two replicated and extended these findings. Barnes et al. (2007) found that mindfulness was shown to relate to relationship satisfaction. Using a conflict discussion paradigm, trait mindfulness was found to predict lower emotional stress responses and positive pre- and post-conflict change in perception of the relationship. The researchers found that State mindfulness was related to better communication quality during the discussion. Both studies indicate that mindfulness may play an influential role in romantic relationship well-being.

Empirical evidence suggests that mindfulness protects against the emotionally stressful effects of relationship conflict as demonstrated by Barnes et al. (2007). Given that the therapeutic relationship is emotionally intimate, potentially conflictual, and inherently

interpersonal, Davis et al. (2011) suggest that therapists' trait mindfulness may aid their ability to cultivate and sustain successful relationships with clients.

Mindfulness meditation has been shown to improve well-being. Carmody and Baer (2008) investigated relationships between home practice of mindfulness meditation exercises and levels of mindfulness, medical and psychological symptoms, perceived stress, and psychological well-being in a sample of 174 adults in a clinical MBSR programme. Participants completed measures of mindfulness, perceived stress, symptoms, and well-being at pre- and post-MBSR. Participants were required to monitor their home practice time throughout the intervention. Carmody and Baer (2008) found that there were increases in mindfulness and well-being, and decreases in stress and symptoms, from pre- to post-MBSR.

The researchers also found that time spent engaging in home practice of formal meditation exercises (body scan, yoga, sitting meditation) was significantly related to extent of improvement in most facets of mindfulness and several measures of symptoms and well-being. In addition, increases in mindfulness were found to mediate the relationships between formal mindfulness practice and improvements in psychological functioning. The researchers suggest that the practice of mindfulness meditation leads to increases in mindfulness, which in turn leads to symptom reduction and improved well-being.

According to Lutz et al. (2009), the capacity to stabilize the content of attention over time varies among individuals, and its impairment is a hallmark of several mental illnesses. Lutz et al. (2009) suggest that impairments in sustained attention in patients with attention disorders have been associated with increased trial-to-trial variability in reaction time and event-related potential deficits during attention tasks. The researchers show that with dichotic listening task performance and electroencephalography, training attention, as cultivated by meditation, can improve the ability to sustain attention. The researchers found that three months of intensive meditation training reduced variability in attentional processing of target tones, as indicated by both enhanced theta-band phase consistency of oscillatory neural responses over anterior brain areas and reduced reaction time variability.

Lutz et al. (2009) further found that those individuals who showed the greatest increase in neural response consistency showed the largest decrease in behavioural response variability. The researchers also observed reduced variability in neural processing, in particular in low-

frequency bands, regardless of whether the deviant tone was attended or unattended. Lutz et al. (2009) argue that focused attention meditation may therefore, affect both distracter and target processing, perhaps by enhancing entrainment of neuronal oscillations to sensory input rhythms, a mechanism important for controlling the content of attention. The researchers suggest that these novel findings support the notion that mental training can significantly affect attention and brain function. Lutz et al.'s (2009) research implies that due to increased attentional skills and increased ability to manage distractions, therapists who practice mindfulness meditation may have an increased ability to be present to their clients.

### **1.5.2.1 Effects on Therapist and Therapist Trainees**

**Empathy** - Mindfulness meditation has been theorised to promote empathy. Aiken (2006) defines therapeutic empathy as the ability to accurately 'experience and understand the felt sense of a client's inner experience and perspective', and to communicate that awareness in such a way that the client perceives himself or herself as being recognized and understood. Empathy is further defined as "the attempt by one self-aware self to comprehend nonjudgmentally the positive and negative experiences of another self" (Wispé, 1986, p. 318). In a within-subjects study on meditation and empathy, Lesh (1970) found that counsellors in training demonstrated increased empathy after participating in a four-week Zen meditation training. Similarly, Shapiro, Schwartz and Bonner (1998) in a between-groups experiment, found that premedical and medical students who participated in an eight-week MBSR training had significantly higher self-reported empathy than a control group.

Aitken (2006) investigated whether psychotherapy practitioners who are also established mindfulness meditators believe that mindfulness practice contributes to the cultivation of the qualities required to successfully use empathy in their therapeutic work. Qualitative interviews were conducted with six mindfulness meditators who had attended at least ten mindfulness retreats of ten days or more, had maintained a daily mindfulness meditation practice for at least ten years, and had been licensed psychotherapy practitioners for at least ten years. Among the resulting themes were suggestions by the research participants that mindfulness contributes to a therapist's ability to: achieve a felt sense of the client's inner experience; communicate their awareness of that felt sense; be more present to the pain and suffering of the client; and help clients become better able to be present to and give language

to their bodily feelings and sensations. This suggests that therapists who were experienced meditators believed mindfulness meditation helped to develop empathy toward clients.

Similarly, Wang (2007) found that therapists who were experienced mindfulness meditators scored higher on measures of self-reported empathy than therapists who did not meditate. Wang (2007) examined whether the practice of mindfulness meditation would enhance psychotherapists' levels of awareness, attention and empathy. Two groups of psychotherapists, meditators versus non-meditators were investigated. Participants completed two validated instruments to measure awareness, attention, and empathy. Eight meditating psychotherapists also participated in semi-structured interviews. It was hypothesized that psychotherapists who practice MM would report enhanced levels of attention or awareness, and empathy than psychotherapists who do not practice MM. Wang (2007) found that quantitative results yielded no significant differences between meditating psychotherapists and non-meditating psychotherapists on the attention or awareness levels. However, the researchers found that meditating psychotherapists scored significantly higher levels of empathy than non-meditating psychotherapists.

**Self-Compassion** has been defined by Neff (2003) as involving being 'touched by and open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering and to heal oneself with kindness'. Neff (2003) also suggests that self-compassion involves a non-judgemental understanding to one's pain, inadequacies and failures, so that one's experience is seen as part of the larger human experience.

Shapiro, Astin, Bishop and Cordova (2005) found that MBSR training enhances self-compassion in health care professionals. The study examined the effects of MBSR in a population of health care professionals who were currently involved in clinical work. The primary hypotheses of the study were that MBSR would (a) decrease overall psychological distress, (b) decrease stress, and (c) decrease job burnout. The researchers hypothesized that MBSR intervention would have positive benefits of (a) increasing overall life satisfaction and (b) increasing self-compassion.

Participants were randomly assigned to an 8-week MBSR group or a wait-list control group. The control group received the identical MBSR intervention after the experimental group completed the program. Baseline and post-intervention measures were taken on both the

experimental and control groups; however, the control group did not complete post-intervention measures after they received the same treatment. Psychological distress was assessed using the Brief Symptom Inventory (BSI). The Maslach Burnout Inventory (MBI) measures three facets of job-related burnout: emotional exhaustion, depersonalization, and reduced personal accomplishment; stress was measured with the Perceived Stress Scale. The researchers also examined two positive outcomes, satisfaction with life and self-compassion. Life satisfaction was measured with the Satisfaction With Life Scale (SWLS). The Self-Compassion Scale created by Neff (2003) was used to measure self-compassion among the participants.

Shapiro et al. (2005) found significant between-group differences for the Perceived Stress and Self-Compassion Scales. Compared with controls, the intervention (MBSR) group demonstrated a significant mean reduction (27% vs. 7%) in perceived stress and increase in self-compassion (22% vs. 3%). The researchers further found that in the MBSR group, 88% of the participants improved their stress scores while 90% demonstrated increases in self-compassion. In addition, the MBSR condition demonstrated trends toward greater positive changes in all of the dependent variables examined.

Kingsbury (2009) investigated the role of self-compassion in relation to mindfulness. The study looked at three dimensions of empathy; perspective taking, which is the tendency to take on the point of view of others in interpersonal situations; empathic concern, which is the tendency to experience feelings of care and concern towards others; and personal distress, which is the tendency to react with discomfort to the emotional experience of others. One hundred and twenty-seven individuals took part in the study, which consisted of an online survey using self-report measures to assess levels of mindfulness, self-compassion, and the three dimensions of empathy. Kingsbury (2009) found that correlational analyses indicated strong correlations between mindfulness and perspective taking, and mindfulness and personal distress, in that, individuals with high levels of mindfulness were more likely to report high levels of perspective taking and low levels of personal distress. In addition Kingsbury (2009) looked at self-compassion as a potential mediator in the relationship between mindfulness and personal distress. The researcher found that when self-compassion was controlled, the relationship between mindfulness and personal distress decreased slightly however, it was still significant. Kingsbury (2009) suggests that although self-

compassion plays a role in the relationship between mindfulness and personal distress, it does not fully account for the relationship.

Kingsbury (2009) found that self-compassion was found to fully mediate the relationship between mindfulness and perspective taking, indicating that self-compassion is an important factor in an individual's tendency to take on the point of view of other individuals. Non-judging and non-reacting were the components of mindfulness that related most strongly to perspective taking, personal distress, and self-compassion, indicating that these two facets of mindfulness play an important role in compassion towards oneself as well as others. In addition, the researcher found that empathic concern did not relate significantly to mindfulness, but did have a strong positive correlation with self-compassion, supporting self-compassion's role in the development of compassion towards others. Kingsbury (2009) suggests that interventions aimed at cultivating mindfulness have strong potential in the area of interpersonal functioning and may enhance feelings of empathy and compassion for oneself and others.

**Decreased Stress and Anxiety** - Various studies have linked mindfulness meditation with decreases in anxiety and depression. One such study is that by Shapiro et al. (1998). The researchers examined the short-term efficacy of an eight-week meditation based stress reduction intervention on pre-medical and medical students. Thirty-seven participants took part in a mindfulness meditation class. The design was a matched randomised experiment in which participants were assigned to a seven-week mindfulness-based intervention or a wait-list control group. Participants in the intervention group were then split into two classes. The two intervention classes were equivalent except for the facilitator; this was done in attempt to determine generality across experimenters.

Participants in the intervention group and control group were measured two times, before intervention and shortly following the intervention, which was also scheduled to coincide with an exam period in an attempt to rigorously scrutinise the benefits of the intervention during an extremely high stress period. In order to control for random effects and increase consistency across groups, both intervention and control groups were assessed at the same time, date and location. To avoid bias induced by the meditative state of the class, there was a fifteen-twenty minutes interim between class and administration of post measures.

A final set of questionnaires was administered to the wait-list control group after receiving the equivalent intervention in an attempt to replicate the first session's results. The measures taken included: The Empathy Construct Rating Scale. Psychological Distress was measured using the Hopkins Symptoms Checklist. Subscale 4 of the SCL-90 was used to assess for depression. State and Trait Anxiety was measured using the State-Trait Anxiety Inventory. Finally, spirituality was measured using the Index of Core Spiritual Experience-INSPIRIT.

The data revealed that participants, (1) reduced self-reports of overall psychological distress including depression, (2) Reduce self-reported state and trait anxiety, (3) Increased scores on overall empathy levels and, (4) Increased scores on a measure of spiritual experience assessed at termination of the intervention. Furthermore, these results were replicated in the wait-list control group and held across experimenters as well as during the exam period.

Although Shapiro et al. (1998) found significant results using a well-controlled design, there are limitations in their research. The researchers acknowledge that the long-term effects of the intervention were not assessed. As a result, conclusions cannot be made that the short term changes produced will be helpful in helping students deal with future stresses associated with medical school. The results will only have implications for health care if the effects of the intervention are enduring. Further limitations identified by the researchers include, lack of generalisability, that is, it is difficult to generalise from a volunteer population of medical and premedical students to a normal population. In addition, the study did not include a comparison group receiving alternative treatment, (i.e., progressive relaxation), therefore, we cannot conclude if effects are specific to the mindfulness intervention or generalise across stress-management techniques. Lastly, the researchers acknowledge that all assessment measures were self-report psychological questionnaires; these are intrinsically limited and open to response bias. The researchers therefore, suggest that future research should explore the psychological as well as the physiological effects of mindfulness interventions.

Rosenzweig, Reibel, Greeson, Brainard, and Hojat (2003) found that when compared with a control group, MBSR has been shown to decrease total mood disturbance, including stress, anxiety and fatigue in medical students. The study examined the effectiveness of the MBSR intervention in a prospective, non-randomised, cohort-controlled study. 140 second-year students elected to participate in a ten-week MBSR seminar compared to 162 second-year students in a control group who participated in a didactic seminar on complementary

medicine. The Profile of Mood States (POMS) was administered as pre-intervention and post-intervention measures. The results showed that baseline total mood disturbance (TMD) was greater in the MBSR group compared with the control group. Despite this initial difference, Rosenzweig et al. (2003) found that the MBSR group scored significantly lower in TMD at the completion of the intervention period. In addition, the researchers found significant effects on Tension-Anxiety, Confusion-Bewilderment, Fatigue-Inertia, and Vigor-Activity subscales. The researchers conclude that MBSR may be an effective stress management intervention for medical students.

Cohen and Miller (2009) in a study of counsellor trainees exposed to interpersonal mindfulness training suggest that such interventions can foster emotional intelligence and social connectedness, and reduce stress and anxiety. The sample consisted of twenty-one clinicians-in-training within a graduate department of counselling and clinical psychology at an urban university. All students were in their first or second year of graduate school. Cohen and Miller (2009) investigated a novel six-week interpersonal mindfulness training (IMT) program modelled after the manualised MBSR intervention, with an added emphasis placed on relational awareness. The researchers suggest that IMT aims to reduce perceived stress and enhance interpersonal well-being and, as such, may be particularly well-suited for psychotherapy trainees. Cohen and Miller (2009) integrated IMT into a semester-long graduate course in psychology. A pre-post design was used to examine outcomes associated with participation in IMT. The researchers postulate that the results suggest that IMT with psychology graduate students is a feasible intervention that positively affects mindfulness, perceived stress, social connectedness, emotional intelligence, and anxiety.

## **1.6 Conclusion**

Having provided a comprehensive literature review on mindfulness, it is clear that gaps exist in the literature especially around therapists' experience of using mindfulness in their therapeutic practice. As such, the current research project aims to contribute to this area by employing a qualitative methodology to inquire about therapist's experience of using mindfulness. As discussed previously, only a handful of studies have utilised qualitative methodology to understand mindfulness in therapy. As such, eight qualified counselling psychologists were interviewed in the current study to understand their experience of using mindfulness in their therapeutic work with clients. The research question therefore states.

“How do qualified counselling psychologist experience mindfulness in their personal and professional practice? Attention is now turned to the methodology section to discuss how this was achieved.

## **2 Methodology Chapter**

### **2.1. Introduction**

This chapter aims to provide a description and explanation of the way that I have attempted to answer the research question; ‘How do Counselling Psychologists experience mindfulness in their personal and professional practice?’ The chapter begins by examining my broader epistemological assumptions, followed by detailed procedural descriptions and includes the steps I took to ensure that this is a valid, high quality and ethically committed piece of research. I have purposefully chosen to use the third person pronoun when describing the theoretical positions of psychologists and philosophers and the first person pronoun when reflecting my own thoughts.

### **2.2 Epistemology, Methodology and Method**

Conducting research involves pivotal questions such as ‘How, and what, can we know?’ Willig (2008) suggests that this involves thinking about the nature of knowledge itself, and about the scope, validity and reliability of claims to knowledge. This claim or theory of knowledge is described as ‘epistemology’ and is outlined by Ponterotto (2005) as being committed to describing ways in which humans have tried to make sense of the world around them and how we come to know things or believe them to be true. Silverman (1993) differentiates between ‘methodology’ (the general approach to studying research techniques), and ‘method’, (the specific research technique used). The former, is highlighted by Willig (2008) as being most directly related to the epistemological position held. In this section I will present the epistemological position chosen and describe the methodology and method that were employed, with a view to answering the research question.

#### **2.2.1 Rejection of the Positivist Position**

A quantitative approach was rejected for this study. Quantitative research presupposes that human behaviour occurs from generally applicable laws. It takes a positivist stance based on the belief that reality is knowable and objective (von Wright, 1993). In order to find the ‘truth’, quantitative research assumes that the ‘real’ world can become known and described through observable, measurable variables (Ashworth, 2008).

The current study rejects the quantitative realist position with its assumptions of a relationship of cause and effect between structures and objects in the world. Ponterotto (2005) highlights that counselling psychology recognises that positivist research methods do not place the 'participant in the line of inquiry'; therefore, the field calls for methods that do so. This has subsequently led to an increase in interpretative qualitative research studies that acknowledges the individual's perspective, as well as the interaction of researcher and participant (Finlay, 2006). Qualitative analysis in psychology does not position itself as 'outside human society looking in' (Ashworth, 2008, p22) but instead acknowledges its position as embedded within a culture. It aims to bring to awareness the implicit assumptions that a particular social group may have, and to contextualise this within a specific historical framework. As such, Ashworth (2008) suggests that qualitative research focuses on the person's construction of their life-world rather than on their perception of it.

Mindfulness meditation, the art of paying attention in a particular way, on purpose, in the present moment and in a non-judgemental way as described by Kabat-Zinn (2003) is a subjective experience and practice. Having engaged in the practice for some time, I believe that a qualitative approach is needed to understand the phenomenon and how the individual interprets and makes sense of it in their lifeworld.

### **2.2.2 Acceptance of Qualitative Methodology**

Choosing an epistemological position and philosophical foundation for the research challenged me to consider my identity as a counselling psychologist, and define my attitude towards psychological research. Counselling psychology according to Rafalin (2010) defines itself as being concerned with the individual's subjective experience, appreciating the complexity of difference and focusing on well-being rather than just cure. The discipline values a search for understanding, as opposed to demanding universal truths and engages with people in ways that attend to each individual's unique experience (Rafalin, 2010). Guided by this principle, I chose a methodology that reflected my identity as a counselling psychologist.

As a counselling psychologist, I acknowledge that different ways of knowing hold validity for different people at different times, and that different therapeutic method will also be more helpful for different clients at different moments. In this way, I accord myself with Lambert,

Bergin and Garfield (2004) that, 'there are many ways to health'; equally I believe there are many ways to do research. This understanding of my identity illuminated my choice of research methodology and epistemological position, as it allowed me to let go of the commitment to defending the argument that a particular position is the truth. For example, until recently, psychology generally and counselling psychology specifically, has been dominated by positivist and post-positivist research paradigms and associated quantitative methods. Such a narrow paradigmatic focus according to Ponterotto (2005) limits the profession's ability to advance the field in significant ways. As such, I chose to deviate from the positivist position in my research and instead, adopt a qualitative methodology to broaden my understanding of the individual's experience.

I am aware of the uniqueness of context, individual and circumstance. This holistic perspective according to Rafalin (2010) helps us to challenge research that takes a reductionist approach and challenge those that also ignore multi-dimensional complexity and reduce answers to extremist positions. I therefore, selected a qualitative methodology, as this perspective places the participant in the 'line of inquiry' and focuses on the 'how', and 'what' rather than 'why' and 'whether' (Finlay, 2006a).

In addition, a qualitative approach was chosen for the kinds of answers that it would provide to my research question. Willig (2012) suggests that this type of research is driven by a focus on meaning. This meaning is subjective, and is drawn from participants' accounts of their own experience and what their behaviours mean to themselves and to others. As such, Smith and Eatough (2010) highlight that a qualitative study will employ an inductive, "bottom-up" approach to explore the quality and texture of human experiences. Willig (2012) further suggests that it will seek to describe or interpret experience rather than to quantify a phenomenon or predict causal relationships. To me, this approach seemed to fit best with my research topic and question.

The application of qualitative methodology to illuminate or 'give voice' to the therapist using mindfulness in therapy is a relatively recent development. Only a handful of studies (Cigolla and Brown, 2011; Horst et al., 2013) have utilised a qualitative approach to understand this experience, as such I felt this method would enable me to produce work which would provide new insights into the individual, social and cultural aspects of counselling psychologists using mindfulness in their practice.

Lastly, I felt a qualitative approach would enable me to work with “the methodological horrors” identified by Woolgar (1988, p.10). These are issues of indexicality (how an explanation is tied to a particular circumstance), inconcludability (that no explanation is ever full or final) and reflexivity (that researcher characteristics shape attention and perception); such issues are worked with, rather than denied in qualitative research. Given my awareness that my personal experience of using mindfulness had stirred my research, this methodology would enable me to explicitly consider how I may have influenced the collection, selection and interpretation of data.

### **2.2.3 Critical Realist Position**

Madill, Jordan and Shirley (2000) assert that researchers should make their epistemological positions clear; conduct the research in a consistent manner with that position and present findings in ways that allows them to be evaluated appropriately. With this in mind, this study intends to produce Critical Realist knowledge.

Willig (2012) suggests that it is useful for the researcher to consider the assumption that you make about knowledge in relation to the continuum which has relativism at one end and realism at another. A realist position assumes that the world is made up of structures and objects that have cause-effect relationships with each other (Finlay, 2006 b). As such, phenomena are seen to consist of ‘real’ structures that can be identified and subsequently, described. I therefore, reject an extreme realist position because it is disputed that whilst actions and events do occur in reality, it is not possible for these to be accurately described by participants as they only have access to their own subjective experience of reality. In addition, I propose that in the analysis process, it is not possible for me, the researcher, to produce ‘accurate’ knowledge about the participant’s accounts without imposing my own experiential views on the data.

Relativists on the other hand, argue that all experience is relative, being mediated and constructed through language (Finlay, 2006 b). I do not align with an extreme relativist position because, even though the participant’s accounts are being mediated through language, it provides us with access to their experience of an actual reality, and not one purely constructed by language. It is argued that participants are indeed describing their experiences of real events. Accordingly, during the analysis, I suggest that whilst I am not able to produce

an 'accurate' description of the participants' subjective experiences, I will however, offer some insight into how they each experience their own reality. In this respect, I take a Critical Realist and pragmatic position.

A Critical Realist position is outlined by Willig (2012) as one which assumes that although our data can tell us something about what is going on in the 'real' world, it does not do so in a self-evident, unmediated manner. Rather this position suggests that the data needs to be interpreted in order to advance our understanding of the underlying structures which generate the phenomena we are trying to gain knowledge about. As such, the analysis in this study will be considered to be an account of me making sense of the participant making sense of an actual reality, and thus produce 'critical realist knowledge'.

#### **2.2.4 Method: Overview of Interpretative Phenomenological Analysis (IPA)**

Transcribed interviews will be analysed using Interpretative Phenomenological Analysis (IPA) to make sense of the subjective accounts of the participants.

IPA is a qualitative method founded by Jonathan Smith (1997). It is grounded in phenomenology and examines the ways in which people make sense of their lived experiences (Smith, Flowers & Larkin, 2009). Additionally, Larkin, Watts and Clifton (2006) state that, the phenomenological commitments of IPA 'give voice' to the concerns of the participants, whilst the interpretative requirement allows for the researcher to 'make-sense' of and contextualise these experiences from a psychological perspective.

Although IPA first appeared in the mid-nineties, Smith et al. (2009) propose that it draws on several philosophical traditions. They outline three main philosophies of knowledge that underpin IPA; phenomenology, hermeneutics, and idiography. These will be described below.

According to Reid, Flowers and Larkin (2005), the IPA researcher will invite accounts from participants, with the emphasis of such accounts often resting on events of special significance. Once recorded, these accounts are analysed by the researcher, whose findings are perceived not only to be grounded in the data (the participants' interpretation of their experience), but also to involve an interpretation by the researcher. Thus, IPA emphasises that research is a dynamic process with an active role for the researcher in that process. The researcher in part attempts to assume an insider's perspective, (Conrad, 1987) that is; they

attempt to understand what it is like stand in the shoes of the participant, whilst recognising that this is never completely possible.

Underpinning the interpretative aspects of IPA, Smith et al. (2009) ground the 'method' in the tradition of hermeneutics. According to Willig (2013) this is the notion that understanding cannot take place without us making some initial assumptions about the meaning of what we are trying to understand. Willig (2013) suggests that there is circularity built into the process of meaning making-'the hermeneutic circle'. This is the dynamic relationship between the part and the whole, in that, "to understand any given part, you look to the whole; to understand the whole, you look to the parts" (Smith, et al., 2009, p.28). IPA draws on the hermeneutic circle through the analysis stages in order to establish an interpretation grounded in original data.

In addition, Smith and Osborn (2003) have identified a process known as "the double hermeneutic", or two-fold aspect of meaning-making in which 'the participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world' (Smith & Osborn, 2003, p.51).

Extracting ideas from phenomenology, Smith et al. (2009) postulate that the experience is reflexive, situated, embodied and existential. IPA acknowledges the significance of Husserl (1982), the founding figure of phenomenology who claimed that 'we should go back to the things themselves' (Smith et al, p. 12) and that science should be grounded in personal experience. For Husserl, it was only through attentive, methodical inspection of awareness that science could develop second order knowledge. Husserl also suggested that this awareness is problematic, because to understand the things themselves, we need to strip away our pre-conceptions and 'bracket' customary ways of viewing phenomena. He argued that instead of focusing on the activity itself, that is taking a 'natural attitude' we need to make a reflexive move and turn our attention inward, to the subjective experience of the activity- the 'phenomenological attitude' (Smith et al., 2009).

Smith et al. (2009) further acknowledge that the ideas of Heidegger (1962) and Merleau-Ponty (1962) have been influential to IPA. The concepts of 'Dasein' (there being) and the body-subject suggest that human experience is shaped by our physical bodies, our social context and our capacity for self-awareness. Smith and colleagues (2009), outline that

Merleau-Ponty proposes that the individual physical unit of our body means that our relationship to others must begin first from a position of difference. We can never entirely share an experience, because our experience is rooted in our individual embodied position.

Smith et al. (2009) suggest that IPA is rooted in idiographic traditions. It is therefore, resolutely idiographic (Smith & Eatough, 2010) and involves a focus on the particular, both through a concern with detail and through the perspective of a particular person and context. Smith et al. (2010) suggest however, that this does not equate to an exclusive focus on the individual. They argue that although a person may be uniquely embodied, their experience is always situated, perspectival and relational. This idiographic focus means that while multiple accounts may be studied to gain understanding of a particular kind of experience, the distinctive voices within each account need to be preserved while considering shared themes.

Lastly, Smith and Eatough (2010) highlight that IPA recognises the importance of language in influencing how individuals make sense of lived experiences and then in turn researchers make sense of participants' sense making. An alternative qualitative method which, like IPA recognises the importance of language within analysis is Discourse Analysis (DA), (Potter & Wetherell, 1987). Since this research will pay attention to the language and tone participants use to describe their lived experience, it is important to briefly explain the choice of IPA over DA.

IPA differs from DA in its focus on cognition; the latter regards verbal reports as behaviours in their own right which should be the focus of functional analysis. Whilst the former by contrast is 'concerned with understanding what the particular respondent thinks or believes...' (Smith, Flowers & Osborn, 1997, p.70). Moreover, unlike DA, IPA aims to reveal internal processes which the participants might not necessarily be aware of (Lyons, 2007). Since this research intends to get a glimpse of the internal thoughts, beliefs and meaning making process of the participants rather than the ways in which social constructions could be drawn from the accounts; IPA was chosen as the preferred method of analysis.

### 2.3 Reflexivity

Qualitative research recognises that research is co-constructed, and that it is a joint product of participants, researchers and readers and the relationship they build (Finlay, 2006 a). It therefore, acknowledges that the researcher affects and shapes the research process. As such, a degree of reflexivity, awareness of influences on my ideas and actions should be considered. Willig (2013) suggests that reflexivity is vital in qualitative research as it encourages the researcher to 'foreground', and reflect upon the ways in which they are implicated in the research and its findings. This entails a constant examination of personal and professional influences on the research process – both in terms of collection of data and analysis (Finlay, 2002; 2006). Moreover, Willig (2013) argues that what we bring into analysis with us are in fact the 'necessary preconditions' for the researcher making sense of the participant's experience. She suggests that these should not be perceived as 'biases' that need to be shunned or eliminated but rather as aspects to be exploited and celebrated as they make possible certain insights and understandings.

Reflexivity in this study is conceptualised as:

"...the processes in which researchers are conscious of and reflective about the ways in which their questions, methods and very own subject position might impact on the psychological knowledge produced in a research study" (Langdridge, 2007, p. 58).

As a Counselling Psychologist, I consider reflexivity to be highly important and I am conscious of the critical impact it has on my clinical work, and personal life. As such, I also believe that the same level of attention to reflexivity should be paid in research. Therefore, throughout the project, I have endeavoured to engage in a process of reflexivity. The purpose of this was to consider my position and the steps taken to make explicit any preconditions that I bring into the research as suggested by Langdridge (2007). Here, I do not imply that in making these aspects explicit they will not impact on the project but that my increased awareness of them will assist me to be thoughtful about their influence on the psychological knowledge produced in this study.

Willig (2013) distinguishes between two types of reflexivity, personal and epistemological reflexivity. The former involves a reflection on the ways in which our own values/beliefs, interests, and political commitments in life have shaped the research, while the latter consists

of engaging in questions such as how the research question defined and limited what can be found out, in addition to how the design of the study and the method of analysis 'constructed' the data and the findings. In addition, Willig (2008) suggests that researchers should pay attention to critical language awareness as this also forms part of reflexivity. This is the idea that the words we use to describe our experiences play a part in the construction of the meanings that we give to such experiences. Using Willig's (2013) distinction between the two types of reflexivity, I will address both of these below.

### **2.3.1 Personal Reflexivity**

Looking back, I realise various aspects of my own sense of who I am shaped the direction of the study. Firstly, my interest in meditation stems back to a young age when I was encouraged by my grandmother to find the stillness within myself (this often involved sitting quietly, observing my breathing) so that I could become more aware of and connected to my thoughts, feelings and surroundings. As I got older, through the busyness of life, I lost this sense of connectedness to my 'inner self'. During my teenage years I began to place value on the notion that meaning is not defined by who you essentially 'are', but by what you 'do', and so I abandoned the time I took to 'meditate'. It was only when I began to question the meaning of my existence and my life's purpose in my twenties that meditation re-emerged in my life again. I was reminded of how in the past, it had helped me connect with my inner wisdom and knowledge, which in turn had helped me discern my creativity and my meaning in life.

This personal experience of meditation led me to think about its applications in counselling psychology. During my training, I encountered literature on mindfulness meditation and how this Eastern philosophy was influencing Western psychology. The literature in this area, documented that mindfulness meditation had been adapted into Western psychology to help people cope with depression and manage stress. In my clinical practice, I was being exposed to psychologists who were incorporating it into their practice. Thus I began to think about a research project that could potentially explore the therapists' experience of using forms of meditation.

Since I engage in a form of mindfulness meditation, I consider myself as an 'insider' in this research, as I share an element of 'sameness' with the participants. One of my concerns

adopting this position was how my own experience of using mindfulness may resonate with those experiences being articulated by the participants, and whether it may lead me to seek out similarities that could influence the interview and analysis process. This position has been described by Oguntokun (1998) and Hurd and McIntyre (1996) as ‘the seduction of sameness’ between researcher and participants and that which can hinder a critical reflexive research.

Reflexivity however, allowed me to keep insight into how my own experience of the phenomenon could influence the research. I was aware that a ‘sameness’ with the participants could allow them to feel more comfortable sharing certain aspects of their experience with me, and also assist me to apply my knowledge to place their material into context. Yet, I was also mindful of the dangers of this ‘insider’ position. For example, over-identifying with the participants group as a whole, or with particular views, could diminish the sharpness of my insights. This might mean that I could fail to explore difference, and result in inferior interpretations. Therefore, whilst sharing a ‘sameness’ with the participants in the study, I was conscious of my overall duty as a researcher, and ultimately my outsider status as the interpreter of their experience. Mama (1987) (quoted in Hollway, 1989, p.130) when talking about being multiply positioned, stated that it enabled her to “abstract myself enough to be able to identify with discourses, yet empathise enough to recognise them and identify with participants”. This encapsulates the position I saw myself as being in within in this research

### **2.3.2 Epistemological Reflexivity**

During the data collection and analysis process, I was conscious of the relationships that developed between me and the participants. I was pleasantly surprised by the participants’ readiness to engage and share aspects of their private thoughts, feelings and experiences with me. My participants became very real and important to me as I realised just how much they brought the phenomenon into light and meaning. This awareness of my relationship with participants led to a recognition of the interviews being a joint product of our interaction (Finlay, 2006 a). This does not mean to suggest that my participants’ experience did not exist outside of our interaction, but that it was presented in a certain form in the interview. To an extent, this made me even more aware of the reality of my impact on the phenomenon both in data collection and analysis, and this confirmed to me my epistemological position, that

whilst my participants' experience occurred in reality, the interview was the combined product of their making sense of their experience in a particular social context with me.

During the data collection and transcription, I kept a reflexive diary in which I made notes of any thoughts and feelings that came up for me about the interviews as well as comments made by participants relating to their experience of mindfulness. I also made notes relating to the impact of my 'insider' status on the interview process. One such situation of note was a comment made by Ewan during the interview. When asked to tell me how he brought mindfulness into his sessions with clients, he stated, 'you know, kind of like concept practices that you'd be familiar with'. Ewan assumed that because I was familiar with mindfulness, I would 'know' and understand the 'concept practice' he was referring to. This seemed to be an illuminative and powerful communication regarding the impact of my 'insider' status.

During the analysis stage, I met with my supervisor to discuss the various categories and themes that were emerging from the data. I was concerned at times, that I was moving away from the data and wanted the categories as much as possible to stay grounded in the data participants had provided. My supervisor encouraged me to reflect upon the themes and how they had emerged. In doing so, I was able to acknowledge that these were co-constructed themes, and that although they were real, they were provoked by me. This confirmed the importance of critical language awareness in the research. I was aware therefore, that the labels and themes I use will shape my findings.

Another concern of mine was that during the early stages of analysis, participants were seen as giving me data. In essence, their individual stories and experiences were lost. Discussions with my supervisor led me to reflect about the ways in which each participant's story and voice could be heard. Consequently, I chose to include case studies for all the participants in the analysis to further illuminate their individual experiences. This is a new movement in IPA which Eatough and Smith (2008) advocate which I aspire to be a part, where the researcher is encouraged to include case studies within the data. Once I had returned to these case studies, I felt closer to hearing my participant's voices and they did not simply become 'data providers' for the research.

## **2.4 Research Design**

Informed by the epistemological position, a qualitative design is being employed to attempt to answer the research question, 'how do counselling psychologist experience mindfulness in their personal and professional practice'? Eight one-to-one semi-structured interviews were conducted with qualified Counselling Psychologists who have been using mindfulness in their professional practice for at least one year. These individual interviews took between forty-five and sixty-five minutes. I conducted the interviews, which were digitally recorded, and then I transcribed them at a later date.

### **2.4.1 Semi Structured Interviews**

Smith et al. (2009, p.57) propose that interviews are flexible and individually focussed tools that enable "a conversation with a purpose" to illuminate the participant's experience. Willig (2008) suggests that interviews are the most widely used method of data collection in qualitative research in psychology. In addition Eatough and Smith (2008) suggest that they offer a context in which the participant is positioned as the expert on their experience and the researcher is able to facilitate the participant in exploring their lived experience. As such, interviewing was deemed an effective way to access the lived experience of the participants in this study.

Although I examined the use of diaries in the work of Boserman (2009), I decided that semi-structured interviews would better enable me to find answers to my research question. In addition I felt that the inter-subjective context of the interview would provide an opportunity to explore ambiguous and contradictory statements (Kvale & Brinkman, 2009) and raise or legitimise the more sensitive topics that might be ignored in diaries. This aspect also drew me to using interviews, as I felt that my experience as a trainee counselling psychologist equipped me to create a dialogue where topics could be explored and expanded.

### **2.4.2 Interview Schedule**

The interview schedule was developed using guidelines offered by Smith & Osborn (2003). The order and content of the initial schedule were based on my research question. Questions were designed to be neutral rather than one-sided in order to tap into the participants'

experience, while staying as close as possible to the research agenda. They were also designed to enable participants to elicit their own process of meaning making.

The schedule started with a relatively broad opening question about the meaning of mindfulness, intended to invite any material which first comes to mind for the participant, and to help them feel comfortable approaching the topic as suggested by Smith and Eatough (2006). This was followed by questions and prompts relating to their personal and professional use of mindfulness and the impact it has on relationships, daily life, as well as challenges associated with mindfulness. These questions aimed to elicit a detailed picture of the phenomenon under investigation, yet allow the participants to feel comfortable sharing their experience in their own way. Consequently, the interview changed from one participant to the other. At the end of the interview, the question, 'is there anything else you would like to add about your experience of mindfulness that I may have omitted to ask you' was asked to allow the participants to revisit their response and add anything which was raised while reflecting on the topic.

### **2.4.3 Pilot**

My primary objective for running a pilot study was to apprehend whether the interview schedule would allow me to gain the rich and detailed accounts I was looking for within an appropriate time frame and to ensure that the schedule was interesting but also comfortable for the participants.

I chose to do this pilot work with two friends who had qualified as counselling psychologists and who were using mindfulness in their clinical practice. I had hoped that they would be able to provide frank feedback on the questions in terms of their clarity, meaningfulness, neutrality and focus on the topic. Steve and Kay<sup>1</sup> were representative of my proposed sample. In telephone discussions prior to meeting with them separately, they both felt that, although they would be helping me test and critique the interview schedule that they would also benefit from exploring their experience in a detailed way. I ensured that full recruitment and consent procedures were followed, despite the more informal contact.

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<sup>1</sup> Not their real names to preserve anonymity

The pilot study was run exactly as the interview study described below. Feedback from the pilot was constructive. Steve and Kay both felt that the open-ended and non-leading questions allowed them to tell their own story in a rich and detailed way. Steve provided feedback on one of the questions, suggesting that it could be modified<sup>2</sup>. In his feedback, he also said that he felt he had said “everything that I needed to say”. Both he and Kay expressed that taking part in the interview had been insightful for them. They stated their enjoyment in partaking in the pilot and that they were not very often asked to talk about and reflect upon their experiences in therapy.

In summary, the pilot study showed me that the interview schedule was able to provide detailed and meaningful data for both the researcher and the participant, and that this data addressed the main research questions identified for my study.

## **2.5 Recruitment and Data Collection**

### **2.5.1 Sampling Plan and Sample Size**

IPA is concerned with the “detailed examination of personal change” (Smith et al., 2009, p. 164). This means that it takes an idiographic position in relation to knowledge formation. Smith et al. (2009) suggest that there is a commitment to understanding how an experiential phenomenon is understood from the subjective perspective of particular individuals in a particular context. For this reason a small and relatively homogenous participant group is required to shed light on the phenomenon.

Participants were recruited in a purposive sampling manner. Advertisement flyers were distributed to counselling and clinical psychologist colleagues and a number of flyers were placed at a Social Anxiety workshop which contained over 100 counselling and clinical psychologists (see Appendix 1 for Advertisement flyer). Brocki and Wearden (2006) suggest that there is a wide range of sample sizes used in previous IPA studies; however, they also observe that a consensus towards smaller numbers is emerging. Considering the objectives of this research, I felt a sample size of eight participants would allow me to adequately explore each person’s experience, while also providing the opportunity to consider convergent and divergent perspectives of the research phenomenon. This total of eight interviews fell within

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<sup>2</sup> Original question: ‘What advice if any, would you give to a therapist using mindfulness for the first time’?  
Modified to: ‘What advice if any, would you give to a novice therapist using mindfulness for the first time’?

the range of four to ten interviews suggested by Smith et al. (2009) as being suitable for the scope of practitioner doctorate research.

### **2.5.2 Inclusion/Exclusion Criteria**

Smith et al. (2009) recommend that homogeneity is sought among participants in IPA studies, to advance the method's objective of illuminating a particular experience. However, they also suggest that the criteria for homogeneity depend on each individual study. With this in mind, the inclusion criteria for the current study included: qualified counselling/clinical psychologists, irrespective of gender or age. Additional selection factors were for participants to use mindfulness in their clinical practice and be willing to talk openly about their experience with the phenomenon under investigation.

### **2.5.3 Participant Identification**

The flyer provided interested participants with my City University email address and research contact telephone number that was used only by me for the purposes of this research study. No names or numbers of participants were recorded on the mobile phone. If I did not answer the participant's call, the participant was redirected to an answer phone message asking them to leave their contact details and a convenient time for them to be contacted.

Four participants were recommended through counselling psychologist colleagues, while the remaining four came from the anxiety workshop. On receipt of contact from the participant (either by email or telephone message) I contacted the participant by telephone. Participants were asked if this was a convenient time to speak, all said 'yes'. I then introduced myself and offered the participants the opportunity to ask any further questions. I went through the information sheet over the phone with them and they all stated they had understood the information provided (see Appendix 2 for Information sheet for participants). All participants stated that they were still interested in partaking in the study; we then collaboratively arranged a convenient time and meeting place suitable to both the participant and me.

Two male clinical psychologists showed an interest in taking part in the study, however, due to other commitments; they were unable to take part in the end.

### 2.5.4 Participants

Seven female adults and one male took part in this study. The participants' age range was between 28-54 years. Figure 2, displays the demographic information collected from the sample. This information was gathered to enable a description of the population. All of the participants described themselves as white; two defined themselves as Buddhists, while the remaining six did not. Three participants described that they practiced both formal and informal mindfulness on a daily basis, while another four described practicing informal mindfulness on a daily basis. Only one participant described that she was currently not using mindfulness, although she described that she had periods of either intensively using it or not.

<b>Age</b>	<b>Gender</b>	<b>Year Qualified</b>	<b>Number of Years Using MM With Clients</b>	<b>Theoretical Orientation</b>	<b>Ethnicity</b>
32	Female	2012	1.5 years	Psychodynamic	White British
40	Female	2013	3 years	Cognitive Behaviour Therapy Integrative	White Danish
34	Female	2004	2 years	Cognitive Behaviour Therapy	White British
54	Female	2011	3 years	Cognitive Behaviour Therapy Integrative	White British
49	Male	2010	3 years	Mindfulness-Based Therapy Integrative	White British
47	Female	2006	8 years	Integrative	White British
31	Female	2012	1 year	Cognitive Behaviour Therapy Integrative	White Scandinavian
28	Female	2012	1 year	Cognitive Behaviour Therapy	White British

*Figure 2: Table displaying demographic details of the participants.*

### **2.5.5 Introducing the Participants**

The participants' pseudonyms were assigned randomly using names from A to H (e.g. 1st participant to be interviewed was assigned a random name beginning with 'A', 2nd participant to be interviewed was assigned a random name beginning with 'B' etc.). I will outline below some information given to me by participants to help to place them into context.

#### **Amy**

I met with Amy in her home. She told me that she had just returned from attending a yoga class to help with pain she was experiencing in her back. Amy informed me that she had been practising mindfulness in her personal life for three years and that she had been using it in her professional practice for a year and a half. She told me that she was not 'a regular practitioner of formal mindfulness practice herself'. Amy said that she had 'gone through phrases of practicing formal practice regularly', and that currently, she used 'informal practice' on a daily basis. She also told me that she did not 'sit down and meditate, in my day to day life at the moment', although she also said, 'I have gone through periods of it'. Amy informed me that she enjoys cycling and walking on her own and with her partner and that the time spent doing these activities was very 'special' to her. She said that although she does not 'mindfully walk in terms of her physical self', she is always looking around, 'smelling and noticing'. She also said that she engaged in a yoga practice and that during this time, she is mindful about bodily sensations including any pain she may be in.

#### **Beth**

I met with Beth in her home. As she was heavily pregnant, we agreed that this was the most convenient and suitable place to meet. She informed me that she had been using mindfulness in her professional practice for three years. She also told me that she had only recently (six months) started using it in her personal life and that she is attending a local meditation centre and was finding it 'interesting'. Beth told me that during her meditation class, the group discussed the difference between mindfulness and meditation. She said that at times, she could not differentiate between the two as they share similarities. Beth also informed me that during her meditation class she often noticed things in her body and in her mind.

## **Chloe**

I met with Chloe at her practice. She told me that she has been using mindfulness in her personal life for three years. She informed me that in the past, she had some body image issues; believing she was fat when in fact she was not. Currently, Chloe is a slim lady. She told me that she used mindfulness to help her with these body images issues, and that because she found it powerful for herself; she became curious about its clinical applications. She also informed me that she has been using mindfulness in her professional practice for two years. Chloe told me that she practiced mindfulness on a daily basis and that it brought a peaceful quality to her life.

## **Diana**

I met with Diana in a room at City University. She told me that she came across mindfulness while she was in training and had been interested in its applications. She informed me that she had gone on various workshops and had been applying mindfulness in her professional practice. Diana said that she had been using mindfulness for three years, although she also said she had a tendency to forget to use it both in her personal and professional life.

## **Ewan**

I met with Ewan in a room at City University. He told me that he has been practising mindfulness in his personal life for over twenty years. He informed me that he was a Buddhist and that he practised both informal and formal mindfulness practice on a daily basis. He said that his mindfulness practice 'enriched his life'. Ewan told me that he had been using mindfulness in his clinical practice for three years and is interested in the 'relational aspects' of it.

## **Felicity**

I met with Felicity in a room at City University. She told me she had been practising mindfulness in her personal life for over sixteen years. She informed me that she was a Buddhist and that she practiced both informal and formal mindfulness on a daily basis. Felicity said that mindfulness 'follows her everywhere she goes' and that it enabled her to be present in her lived experience. She informed me that she has always used mindfulness in her professional practice; however she officially named it as such in the last eight years.

## **Gabby**

I met with Gabby in a room at City University. She told me that she started using mindfulness in her personal life fifteen years ago, to help her with difficulties in her life. She told me that she used to have a formal mindfulness practice; however, she said that she currently uses informal practice on a daily basis. She told me that she feels she no longer needs to have a formal practice as mindfulness is now ingrained in her. She said that she will always go to mindfulness whenever she needs it most. Gabby told me that she has been practising mindfulness in her professional practice for one year.

## **Holly**

I met with Holly in a room at City University. She told me that she first came across mindfulness in her professional practice and has been using it both personally and professionally for one year. She informed me that she feels mindfulness helps her to become aware of herself, including her thoughts and bodily sensations, and that it helps her to acknowledge and sit with uncomfortable feelings. Holly said that she incorporated both a formal and informal practice to her everyday life and that mindfulness is uplifting.

### **2.5.6 The Interview/Procedure**

The following procedure was replicated for all participants regardless of where the interview took place: Five took place at a booked room at the University, two were conducted in the participants' home and one took place in the participant's private therapy clinic.

Upon meeting the participant, they were given the opportunity to ask questions and I answered all questions to the best of my ability. I went through the consent form (see Appendix 3 for Consent Form) with participants to ensure that the consent given was fully informed. Two copies of the consent form were signed by both the participant and me; one copy remained with the participant. This form also included consent to audio-tape the interview. Participants were asked if they were comfortable, I then reminded them that they were free to terminate or take a break from the interview at any point. At this point, participants were given the opportunity to ask any further questions. I then asked them to complete a questionnaire concerning demographic information (Appendix 4 for Optional Socio Demographic Information).

With the participants' permission, the digital recorder was turned on and I re-stated the aims of the interview; informing the participant that it was their personal experience that was important and that my questions were simply a guide (see Appendix 5, for the Interview Schedule which served as a framework). I stated that if their thoughts led them away from the question then this was fine and that they should follow it. The purpose of this was to position the participant as the expert on this experience as suggested by Reid, Flowers and Larkin (2005) and to ensure this remained an inductive process. The interviews ranged from forty-five to sixty-five minutes. Although the length of the interviews seems to be relatively short, the material generated in such a 'short time' was surprisingly rich. This may reflect the participants' real need to share an experience which is ever present in their awareness, yet rarely spoken about. At the end of the interview, the participant was fully debriefed, (see Appendix 6 for Debrief).

When the interview took place at the University a space was booked. When the interview took place at the participants' home or workplace we agreed in advance that it would be important for us to meet in a private, quiet place. This was to protect the participant and reduce distractions. Moreover, I also set up the necessary safeguards for my personal safety. I carried a rape alarm and provided my partner with the address of my participant, asking my partner to telephone me on my 'research phone', ninety minutes after the start of the interview.

I transcribed each interview; this enabled me to get to know the data. Interviews were transcribed verbatim, (including, pauses, false starts and other aspects worth noting, e.g., laughter, as suggested by Smith et al., 2009).

## **2.6 Analytical Procedure**

An advantage of using IPA as the analysis tool is that procedures for the process of analysis have been clearly illustrated by Smith et al. (2009). My analysis is chiefly influenced by the most recent and thorough guidelines to date, which is outlined by Smith et al. (2009). I valued being provided with a detailed and clear set of guidelines, whilst at the same time being encouraged to retain individuality and creative ideas.

On the whole, IPA analysis is a process which moves continually from detailed description of the text to interpretation, and from looking at the particular lived experience, to the shared.

It has been described by Smith (2007) as an iterative and inductive cycle. Six stages of the analysis were engaged in and are outlined in chapter 5 of Smith et al.'s. (2009) book. I will describe below how I engaged with the data in all six stages. The stages are described for transparency and openness.

### **Step One: Reading and Re-reading**

Smith et al. (2009), alongside Willig (2006) highlight the importance of 'immersing' oneself in the data in the IPA literature. Eatough and Smith (2006) suggest that each reading helps the researcher to become more responsive to what is being said. As such, I transcribed the data myself (see Appendix 8 for an Example Transcript). I listened to the interview once more whilst reading the transcript and then read through the transcript once again. I found that listening to the tapes alongside reading the transcripts, helped me to re-familiarise myself with the experience of the interview. It also helped me to consider the process issues relating to the interview itself. I carried out this process for each interview before analysing it individually. This enabled me to engage with and have knowledge of the text and this helped me to view it as a whole when I moved on to the next level. As suggested by Willig (2001) I recorded my thoughts and observations in response to the text in my research diary.

### **Step Two: Initial Noting**

During this stage, my aim was to produce a "comprehensive and detailed set of notes and comments on the data" (Smith et al., 2009, p.83). I made efforts to remain open minded and note anything of interest that arose in the transcript. As suggested by Smith et al., (2009) I began by developing descriptive comments which captured the content of the conversation.

I then noted linguistic and conceptual comments. The former considered how content and meaning were presented, and included attention to language use and non-verbal elements. I paid close attention to the language and tone participants used to describe their lived experience because I believe language is an integral part of the way individuals experience the social world. This however, does not mean to imply that I believe it is the sole or primary constructor of reality, but that I acknowledge the part it plays in the construction of the meanings that we attribute to such experiences (Willig, 2013). Conceptual comments assessed the participant's implicit and overarching understanding of the matters under discussion. Importantly, these wider and more abstract interpretations remained grounded

in the participant's account. All these exploratory comments were handwritten in the left hand margin of the transcript (see Appendix 9 for example of Left Hand Margin Annotation). This was a lengthy process; I found that making different types of notes helped me to be disciplined about exploring different aspects of the text.

### **Step Three: Development of Emergent Themes**

During this stage, my aims were to decrease the volume of detail of the notes whilst keeping the complexity and richness of the material. My initial notes therefore, became the focus of the analysis and I paid particular attention to discrete chunks of the notes, whilst keeping the content from the whole of the transcript in mind as suggested by Smith et al. (2009). In addition, this stage also involves producing "a concise and pithy statement of what was important in the various comments attached to a piece of transcript" (Smith et al., 2009, p.92). This requires balancing description and interpretation. For a period of time, the transcript is momentarily fragmented into parts, in the hope that it will be brought back together in a 'new whole' at the end of the analysis which, as Smith et al., (2009) point out, represents a manifestation of the hermeneutic circle.

Although themes emerged located at a particular point in the transcript, their significance within the whole of the account was also considered. Additionally, these themes drew not only on the participant's words but also upon the psychological interpretations of the researcher. I noted these themes in the right hand margin of my transcript (see Appendix 9 for example of Right Hand Margin Annotation).

### **Step Four: Searching for Connections across Emergent Themes**

At this stage, my aim was to map the relationship between emergent themes. Consistent with suggestions from Smith et al. (2009), I explored a number of alternative connections. Abstraction involved considering whether a number of themes could be subsumed under a new over-arching theme, while subsumption observed whether several themes could be grouped under an existing but more all-encompassing theme. Polarisation involved exploring differences between themes, while contextualisation required considering whether themes linked to particular contextual or narrative aspects of an account. Numeration led me to review the frequency with which themes emerged, while a review of function helped me assess how themes were implicated in the participant's presentation of self.

Emergent themes were typed up into a table and cut out on to separate pieces of paper (see Appendix 10 for an example of a typed table of emergent themes). A large floor space was then used so that I could observe the themes together and consider how they might relate to each other. This is one of a number of methods suggested by Smith et al. (2009) and fitted best with my personal preference of using spatial methods to make connections. I then labelled the resulting clusters of themes. The label intended to capture the essence of all the themes within it. A summary table containing the cluster themes, and subordinate themes that shed light on the phenomenon under investigation for each transcript, alongside citations representing these themes in the text was constructed. I discussed some of the theme titles with my supervisor with a view to checking and validating my analysis process.

#### **Step Five: Moving to the Next Case**

In keeping with the idiographic process proposed by Smith et al. (2009) I engaged with each interview individually using steps one to four. Once I had done this for one transcript, I then moved on to analysing the next case in its own terms. To the best of my ability I aimed to 'bracket' prior assumptions and ideas that had emerged from previous transcripts in order to do full justice to each particular account, allowing myself to be surprised by it.

#### **Step Six: Looking for Pattern Across Cases**

When all transcripts had been analysed using steps one to four, I considered the cluster themes from the different transcripts in relation to each other to form master themes as described by Willig (2008). Cases were integrated in a cyclical manner, this means that when broader, higher level themes were reached; they were required to be grounded in the text of the transcript. In order to do this, I printed out summary tables, cut out individual rows of cluster themes, and the emergent themes within it, spread them out on a floor space and considered them in relation to each other.

A table illustrating how emergent themes are grouped under master themes, quotes and references of where this master theme is expressed from the participants' transcripts was constructed. This process led to the relabeling and reconfiguring of themes. Here the aim was to produce overarching themes that captured both the individual lived experiences of each participant whilst representing higher order theoretical ideas. As suggested by Smith et al. (2009), the recurrence across cases was taken into account when grouping and naming a

master theme (see Appendix 11 for example of Master themes, subthemes and location of quotes).

## **2.7 Evaluation of Research- Issues of Quality and Validity**

Assessing the quality of qualitative research is a contested issue. While traditional criteria for research quality are often inappropriate as suggested by Yardley (2000) and the ethos and plurality of many qualitative methodologies are incompatible with fixed, universal procedures and standards, Yardley (2000), nonetheless, argues that some way of evaluating the quality of research employing qualitative methodologies is absolutely necessary. Yardley (2000) has outlined four characteristics of good qualitative research, which have been considered throughout this research. These are 'Sensitivity to context', 'Commitment and rigour', 'Transparency and coherence' and 'Impact and importance'. These guidelines set out by Yardley (2000) are not in the form of rigid rules or prescription; instead they are themselves open to flexible interpretation. I have considered the four characteristics as I believe them to be sufficiently flexible to be adapted to this specific study. I will briefly summarise and discuss these characteristics in relation to the present project.

The first criterion identified by Yardley (2000) is 'sensitivity to context'. This entails that research has an awareness of the relevant literature and previous related empirical work. This criterion requires that research is sufficiently grounded in related theory and in the philosophy of the approach. It also asks that a study be appropriately aware of its socio-cultural setting, with attention given to the norms, ideologies, historical, linguistic and socio-economic influences on beliefs and expectations. Lastly, it requires sensitivity to the social context of the relationship between researcher and participant, and consideration not only of the information given by the participant but the way in which, both generally and specifically, this information has been shaped by the researcher.

I have aimed to address these issues in several ways. Firstly, the Introduction section has set out this study's connections to the existing research literature. The review of the literature on the phenomenon ensured an initial sensitivity to context. This enabled me to be competent in the current conceptual ideas in the area, and to also engage with the current dialogues in the field. My work in an NHS Trust where mindfulness meditation is taught to therapists to use in their work with clients also facilitated an introduction to the context of

this study. Through personal reflection I endeavoured to remain aware of the social context of the relationship between myself and the participants. In addition, ethical issues have been considered to ensure that this study is sensitive to the experiences of the individual participants and protects them from harm. The Methodology section has highlighted the theoretical principles underlying the implementation of this research. In addition as encouraged by Yardley (2000), in the discussion chapter further scholastic tools such as philosophical theory, have been drawn from in order to address findings in a wider context that make the analysis more profound and far reaching.

The second criterion identified by Yardley (2000) is 'commitment and rigour'. This requires that the research demonstrates prolonged engagement with the topic, and competence in the research approach. This also asks for completeness in both data collection and data interpretation.

Evidence of 'commitment and rigour' is provided throughout this thesis, particularly in here, the Methodology chapter. This has primarily been evidenced through the in-depth engagement with the topic both in interviews and particularly during analysis. In addition to wide reading on mindfulness in the research literature, I also attended workshops for therapists on applying mindfulness in therapy. To improve my understanding and skills in interpretative phenomenological work, I attended research seminars and groups where I practised the work of analysis, and read philosophical theory and IPA studies. I ensured that my data collection was complete; the number of participants was appropriate both to the aims of the study and the scope of this work, and the interviews provided the rich, textured accounts necessary for analysis. In the process of analysis I strived to pay attention to the voices of all participants and to ground my comments in data. However, I also developed my interpretation of the phenomenon to a satisfactorily deep level, aware of the drawback of the too-basic analysis raised by Smith et al. (2009).

Finally, to increase the rigour with which the analysis was completed, supervision took the form of triangulation. I met with my supervisor on numerous occasions throughout the analysis stage and explained my process of getting to the themes. My supervisor questioned these processes and provided feedback on the labelling of the themes. Whilst my supervisor had an awareness of the topic, she had not engaged fully with the transcripts. I believe that

this gave her an alternative and outsider perspective, which I found invaluable to the analysis and research process overall.

The third criterion which Yardley (2000) identifies is 'transparency and coherence.' This is addressed in several ways throughout this study. I have aimed for a strong fit between the research question and the epistemological perspective and method used in this study. The transparency of the analysis process is illustrated particularly in the methodology and analysis chapter and in the presentation of the exemplar. In presenting the analysis and the data, I have detailed all aspects of the collection process in the methodology section, and provided access to data both through tables and samples in Appendices and through frequent excerpts within the Findings, so that the reader can discern relevant patterns. Lastly, I have stated, reflexively, the thoughts, feeling and predictions I held coming into this research with the intention of being transparent and explicit about what I have brought to the research. I recognise that despite my best intentions, an evaluation of this research's persuasiveness can rest only in the hands of its reader.

The fourth and final criterion proposed by Yardley (2000) is 'impact and importance'. An aspect of this is that research offers a new way of understanding a topic. As will be addressed in the Discussion chapter, I believe that my research questions have elicited information which creates new information about the ways in which Counselling Psychologists can use mindfulness in their clinical practice in an ethical and informed way.

## **2.8 Ethical Consideration**

The British Psychological Society (BPS) defines 'Ethics' as 'the science of morals or rules of behaviour' (BPS 2009, p6). As such, the British Psychological Society's code of ethics (BPS, 2009) was adhered to throughout the research. As a scientist practitioner and member of the British Psychological Society, I am committed to ensuring that this study adhered to the ethical guidelines outlined by the BPS. I hope a 'transparent and coherent' account of the ethical commitment, in line with Yardley's (2000) guidelines, is presented. The four general principles described in the British Psychological Society's Code of Ethics and Conduct which influence the researcher's day to day clinical practice were considered at every point of the research. These are 'Respect', 'Competence', 'Responsibility' and 'Integrity'. Following the 'essential principle' outlined by the BPS (2009), care has been taken to consider all aspects of

the study from the viewpoint of the participant. More specifically the 'Ethical principles for conducting research with human participant's (BPS, 2009) were followed closely and are outlined below.

### **2.8.1 Consent**

Informed, written consent was obtained upon meeting participants (see Appendix 3). To ensure participants were appropriately informed, each participant received an information sheet prior to being interviewed (see Appendix 2) detailing their involvement in the study.

### **2.8.2 Deception**

I was honest and open about the aims of the research project from the first point of contact with participants (see Appendix 2) and did not withhold any information from them.

### **2.8.3 Debriefing**

Considerable effort was made to ensure that participants had an accurate understanding of the research. They were given the researcher's telephone number and email address if they required further support (Debrief sheet, Appendix 6)

### **2.8.4 Withdrawal from investigation**

Participants were made aware at every stage that they were entitled to withdraw from the study at any time (including during interview) without giving a reason.

### **2.8.5 Confidentiality**

Participants were assured of their right to anonymity and of the efforts that were taken to protect their confidentiality. To preserve the confidentiality of the participants, all transcriptions were stored anonymously. With participant consent, excerpts from the transcripts will be included in the presentation of the research findings, however all identifying material will be omitted.

### **2.8.6 Protection of Participants**

Much thought went into protecting the participants. The risks of psychological distress were kept to a minimum. However, if participants experienced some psychological distress whilst talking about their experiences, I felt skilled and equipped to discuss these issues in a sensitive and empathetic manner, and to contain distress that may be triggered by the interview process.

### **2.8.7 Obtaining Ethical Approval from Appropriate Sources**

Ethical approval for the study was granted by City University (Ethics form, Appendix 7).

### 3 Analysis Chapter

#### 3.1 Introduction

This chapter presents the three master themes derived from interpretative phenomenology analysis, which aim to offer a rich and illuminative insight into the lived experiences of the participants. What is presented in this analysis is my interpretation of participants' interpretation of their own lived experiences.

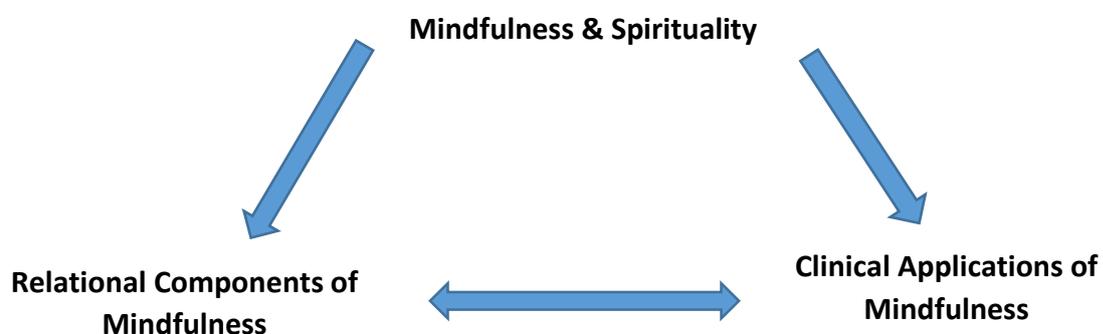
Quotations are cited with the participants' pseudonym and the line number of the quote from the transcript.

Three master themes emerged from the data, these are;

- 1 "It lifts them up, their spirit and their soul": Mindfulness and Spirituality
- 2 "Experiencing it together": Relational Components of Mindfulness
- 3 'Doing' Mindfulness, Clinical Applications.

The three master themes have a number of subthemes within them; while the master themes were expressed by all participants, not all of the subthemes apply to all participants.

Please refer to the diagram below to consider the master themes in relation to each other. As is evident from the diagram, the master theme mindfulness and spirituality impacts the relational component and clinical applications of mindfulness. A summary of this process is provided below



**Figure 3:** An illustration of the three master themes and how they relate to each other.

The diagram above shows that the spiritual component of mindfulness impacts participants' relationship with themselves and their clients; hence it contains a relational dimension. This relational component also affects the ways in which mindfulness is applied in clinical settings, hence the doing mindfulness.

The master themes and their sub-themes will be outlined and quotes are provided to illustrate how these master themes were communicated by the participants.

### 3.2 "It lifts them up, their spirit and their soul": Mindfulness and Spirituality



Participants described their lived experience of mindfulness as encompassing a spiritual dimension. This spiritual component contained experiences of a greater sense of peace, seeing the beauty in one's environment and letting go of the struggle with one's thoughts for example. I believe that this master theme is best communicated by describing the four sub-themes that are embedded in it. Spirituality is a way of being for some, as well as being a journey of self-discovery, which seems to result in an opening up of consciousness/thoughts,

feelings and physical sensations. This appears to facilitate many to let go of thoughts and expectations, and as one participant says, provide a metaphorical 'box', that they can put their painful thoughts into, thus detach from it. This results in the relief for many of emotional pain and brings on a sense of peace and gratitude. It seems overall, that mindfulness is regarded as a very important spiritual way for participants to carry on in their personal and professional practice.

### **3.2.1 A Way of Being**

Many of the participants described their experience of mindfulness as a way of being. For many, mindfulness is amalgamated into their everyday lives. Consequently, they did not regard it as an external or separate phenomenon from the rest of their lives. This is summarised here by Ewan:

“For me, imperfectly but to some degree it’s the way that, you know, it informs everything I do”. (Ewan, 215-218).

The term, 'it informs everything I do', suggests that mindfulness characterises Ewan’s entire existence, suggesting that mindfulness plays a significant role in every aspect of his personal and professional life. Ewan goes on to describe that mindfulness is about integration, thus it is not a separate or external phenomenon from the rest of his lived experience.

“I mean for me, it’s about integration. Erm, it’s not about something that we do, it, it may have a formal component which is, you know practice bound and, but, but, really it’s not something that is external or separate from, you know the rest of our life”. (Ewan, 242-247).

The terms 'not separate from the rest of our life', suggests that mindfulness is an integral part of his life. The opposite of 'not separate', is 'combined' or 'joined', suggesting that mindfulness is joined to, or embedded in his lived experience, it is a quite simply, a way of being. This way of being is portrayed even further when he says:

“Erm, we immerse ourselves in a practice, we seep ourselves in a way of being” (Ewan, 163-164).

The use of language in particular, the word ‘seep’, suggests that mindfulness has permeated Ewan’s entire existence; and further implicates that mindfulness is for him a ‘way of being’. Consequently, he describes that:

“It’s on board with us twenty-four seven”. (Ewan, 780-781).

This implicates that mindfulness is a constant presence and a fundamental part of his lived experience. Ewan uses the first person plural, (‘we, us and our’) throughout his account. In using this language, he appears to be constructing mindfulness as a communal practice. This suggests a sense of being or becoming connected to something greater than just oneself, and denotes an element of spirituality.

Similar to Ewan, Gabby also describes her experience of mindfulness as a way of being. Unlike Ewan however, she expressed this with less certainty at the beginning of her interview.

“I don’t know if I want to call it (mindfulness) a tool because it’s a way of being, (pause) yeah”. (Gabby, 135-136).

At the start of this excerpt, it seems Gabby may be conflicted about the way in which she experiences mindfulness, indicated by the term ‘I don’t know’. This uncertainty was also communicated by the tone Gabby used. This alongside her pause, indicates that she is possibly making meaning of her experiences for the first time. Consequently, she seems to be in two minds about whether she experiences mindfulness as a tool, or as a way of being. As the interview progressed it seems however, that Gabby becomes clearer in her views as she expresses:

“I see it (mindfulness) as a way, you know as a way of being”. (Gabby, 295).

“Well, coming back to what I said at the start, because I guess it is a way of being and you know if, I think it feels more authentic if you can actually (pause) the clients see that this is actually something that you also (pause) you know, believe in, that you also try and do for yourself. So I think it sends a different sort of message than just going in and saying ok I am going to teach you about this tool and you know, it’s a very different, yeah (pause) I guess in your relationship with the client it’s (pause) a different way of being”. (Gabby, 691-699).

These quotes suggest that she has resolved her earlier conflicted message about whether she experiences mindfulness as a tool or a way of being. Her sentence, 'it feels more authentic if the clients see that this is something that you use also try and do for yourself', suggests that there is perhaps a professional expectation that she should practice mindfulness. Gabby also she uses 'feel' then switches to 'see', possibly indicating a self- expectation that others (clients) see her as a 'good therapist'.

Towards the end of her interview, Gabby emphasises that she experiences mindfulness again as a way of being.

"I just want (pause) also just really want to highlight that it's not really a tool, although sometimes I guess the way I've talked about it, it sounds like a tool but it's more that kind of way of being". (Gabby, 813-816).

Here, I think that Gabby wants to ensure that her experience of mindfulness is captured as a way of being. Her language suggests that she has resolved her earlier conflicted message about how she experiences mindfulness. Quite clearly she seems to experience mindfulness as a way of being; this is explicit at the end of her sentence.

Gabby's uncertainty at the beginning of her statement however, raises the question of why she should orientate to the construction of mindfulness as a 'tool'. Perhaps she is simply following the dominant discourse (Cognitive Behaviour Therapy) in psychology and in her profession, which is that interventions are seen as tools; therefore, she begins with the obvious discourse. It seems as though the interview process allowed an ongoing reflexivity for Gabby, in which she was able to construct meaning and review her thoughts and feelings. In doing so, she seems to be able to direct her gaze inwards and reject the dominant discourse in her profession and check in with her own experiences.

Many of the participants described their experience of mindfulness as an integral part of their way of being. Below, Felicity describes this experience as a way of being, which is a central part of who she is. In this way, her account is comparable to Ewan's, in that mindfulness is an integral part of their sense of who they are.

“I don’t think it’s something that you, (small sigh) I would hope it’s not something that I switch on, switch off. I live in a very mindful place, so within myself, I feel that not only with my work, but also, yeah, I am Buddhist, so I’m very much in that state of being, and I meditate, you know regularly. Erm, so I think it’s definitely, for me, it’s a way of being, very present, very present”. (Felicity, 56-63).

Implicit in Felicity’s statement is the idea of being genuine in all aspects of her lived experience. The term ‘not something I switch on, switch off’, as well as, ‘I live in a very mindful place within myself’, suggests that mindfulness characterises her total existence and not simply her professional life. At the same time, Felicity’s language, in particular the word ‘hope’, communicates her desire to be this way (mindful). ‘Hope’ implies that she is yearning or striving to be mindful, however, she is not quite there yet. This constructs mindfulness as a spiritual phenomenon in that the individual continually endeavours to reach for a certain way of being, however, this seems to be unattainable.

While the majority of participants described their experience of mindfulness as a way of being, Beth and Diana both described mindfulness as a therapeutic technique/tool. These experiences are reported below.

Diana describes her experience of mindfulness as a therapeutic technique:

“And in any case, I think it’s a really good, I think it’s really important because it is a technique, it is a good technique”. (Diana, 698-700).

The word ‘technique’, implicates that mindfulness is not necessarily a way of being for Diana. She goes on to suggest that mindfulness is not integrated into her lived experience.

“I sometimes forget about mindfulness.” (Diana, 366).

This is very honest and communicates that mindfulness is not integral to her way of being. A possible explanation for this forgetfulness could be that as an integrative counselling psychologist, it is possible that Diana has acquired many ‘techniques’. Mindfulness could be amongst these many techniques; and as such it can be easily ‘forgotten’ about. As the interview progressed, Diana states:

“At the moment I seem to be in a bit of a not mindful place”. (Diana, 423-424).

This implies that mindfulness is separate from her way of being. The term, 'at the moment', communicates that Diana has a tendency to weave in and out mindfulness, implying that it is not integral to her sense of self or rooted in her lived experience.

Similar to Diana, Beth describes her experience of mindfulness as a tool:

"So I think for some it can be a really helpful tool". (Beth, 322).

Beth talks in generalised terms using 'some' rather than 'I'. I suggest that she uses this generalised term to also refer to herself. She explicitly states that, mindfulness is a tool, this is similar to Diana's account and communicates that mindfulness is not entrenched in her way of being.

This theme shows the ways in which mindfulness is embedded in many of the participants' lived experience. A way of being suggests that for some, mindfulness is an integral part of their sense of who they are. Perhaps as counselling psychologists, participants experience mindfulness as a way of being in their lived experience in order to be congruent in both their personal and professional identities. However, for some like Diana, this way of being is perhaps more of a challenge. Mindfulness also had a communal feel for some, which suggested being connected to something bigger than just the self. Others also showed a desire to be a certain way, which appeared unattainable. These idiosyncratic descriptions and experiences suggest that mindfulness can contain a spiritual component for some of the participants.

### **3.2.2 A Spiritual Journey of Psychological Growth**

Several of the participants described their experience of mindfulness as a journey. This journey can be a special place of discovery in which there is a sense of psychological growth. Along this journey several participants described a process of 'stopping momentarily' to listen, and observe experiences as they occur in the moment and this seems to enable them to view things from different perspectives which gave some a sense of relief and peace.

Amy describes her experience below:

"It's a, it's a very special place once it's, (pause) once it's there, it's a very, very special place". (Amy, 692-693).

“That’s such a special place isn’t it? Very sacred”. (Amy, 716).

The words ‘special place’, and ‘sacred’, brings to mind an image of a pilgrimage. A pilgrimage can be seen as a journey or search of moral or spiritual significance. Typically, it is a journey to a shrine or other location of importance to a person's beliefs and faith, although sometimes it can be a metaphorical journey into someone's own beliefs. Here, I believe that Amy experiences mindfulness as a special place of spiritual significance and that this ‘sacred place’, represents a metaphorical journey into her own beliefs. Thus Amy’s experience of mindfulness appears to contain a spiritual component. Her tone of voice was emotional when she made these statements, she seemed surprised. It could be that she was reflecting and making meaning of her experiences for the first time. As the interview progressed, she states:

“The more that you’re with it, er, erm, the more that you talk about it, the more you’re reminded of how special it is”. (Amy, 729-731).

Amy’s tone here was emotional. This suggests that recollecting that mindfulness is ‘special’ may have had more of an emotional impact on Amy than she was previously aware. She also talks in generalised terms using ‘you’re’ rather than ‘I’. This could be a functional narrative, in that it stops her from becoming overly emotional. For example, avoiding stating, ‘the more that I am with it, the more I am reminded how special it is’, might have been a more emotionally charged statement. At the beginning of her interview, Amy stated that talking about her experience of mindfulness was emotional, (“*so it feels erm, gosh, a little bit emotional actually*”, Amy, 46-47). Perhaps she was even more aware at this stage of the interview that she was becoming emotional, thus chose to talk in generalised terms to avoid becoming too emotional.

Felicity describes her experience of mindfulness as an ongoing and continual journey, one in which she is able to learn and grow as a practitioner and as a human being.

“I think I’m continually learning, continually reading, continually growing, I feel that there is so much more I need to learn and know about myself, erm, as a practitioner, but also as a human being. And I think, I think being aware that we are all on a journey and it doesn’t ever, I don’t think it ever ends”. (Felicity, 607-612).

Here, Felicity is referring to how mindfulness enables her to be on a journey. It could be that most counselling psychologists value and embrace continual growth; as demonstrated by the professions use of Continual Professional Development (CPD). It is possible that for Felicity both personally and professionally, mindfulness offers the prospect of being on an exciting journey of learning and growing, conveyed by her uplifting tone. It could be that for the psychologist, the work on the self can never be complete. Perhaps Felicity sees the profession's obligation to keep on growing as an exciting invitation to live life to the full. She may be excited to continue on a journey of self-discovery knowing that many of the most delectable places are yet to be visited. Perhaps she also feels good about 'doing the right thing' and meeting her professions expectations.

Ewan also describes mindfulness as a journey; his account of this journey is notably different to Felicity's and Amy's in terms of the language used. This is examined below.

"I have noticed that people are able to erm, travel to deep places within themselves remarkably swiftly at times through mindfulness". (Ewan, 1254-1257).

The term, 'travel to deep places within themselves', constructs mindfulness as a journey. This journey seems to enable a process of self-reflection through which an individual may discover and discern meaning in their lives, and this has spiritual implications. Ewan shifts his language moving from speaking in the first person ('I have'), to using a generalised, plural 'people' ('people are'). This suggests that this 'deep place' is not yet accessible to him, that others have been able to reach it swiftly, but he has not. This portrays mindfulness as being an unreachable spiritual journey for Ewan.

Later on in his interview, Ewan implies that this mindfulness journey can also offer the possibility of peace. He suggests that individuals and society as a whole, yearn for peace and it seems for him, mindfulness offers the possibility of gaining a sense of quietness.

"But simplicity is still something that most of us yearn for, peace, quietness, space, simp... you know these things, there's some part of us that's still around as an attractive idea. So mindfulness does offer the possibility of that". (Ewan, 888-892).

The word 'possibility', suggests that he has yet to find this peace for himself on his mindfulness journey and further portrays mindfulness as an unreachable spiritual journey for Ewan.

For several of the participants, being on a mindfulness journey appears to facilitate a process of 'stopping momentarily' in which they are able to notice and observe experiences as they take place. Stopping temporarily also seems to enable some participants to break out of negative habits and unconscious responding. Ewan describes this:

"So I suppose in formal mindfulness practice there is, to some degree, a kind of a cleared space, and an experience of stopping momentarily. And then in that space (pause) in that stopped space, there's a process of immersion, there's a process of stopping and listening and noticing". (Ewan, 131-136).

The word 'stopping' and 'space', invoke a travel and movement experience, and constructs mindfulness as a spiritual journey. It could be that in his everyday life, Ewan does not get the opportunity to 'stop, listen and observe'. However, when he is travelling on his mindfulness journey, he is able to stop briefly and engage in a process of noticing experiences as they occur; this may enable him to discern meaning.

Comparably, Chloe describes an experience of pausing and stopping momentarily:

"It was just like pressing a pause button, it kind of just stopped everything for a moment". (Chloe, 336-337).

This also suggests a travelling experience and builds mindfulness as a journey in which Chloe is able to pause temporarily. Later on in her interview, she goes on to talk about stopping and scanning her body:

"Another thing I do quite a lot is I do mindful body scans but not body scans in the kind of meditation sense, but scanning physically my body, my body image problems and I think because I've had a personal kind of journey with my own body image. I think what I tend to do, is I tend to look at my body mindfully to say this is a leg, this isn't a fat leg, this is a leg and this how it kind of, is how it's shaped and this is it's contours, and this is the muscle part and this is this part, and the this is the joint, rather

and detach myself from my appraisal of it which is that it is a fat leg or whatever. (Chloe, 678-687).

It seems that stopping for a short time along this 'journey' enables Chloe to view her body in a mindful and rational manner. Pausing momentarily along her mindfulness journey appears to empower her to break out of her negative habits and unconscious responses to her body. Consequently, she is able to adjust her behaviour accordingly. Mindfulness seems to enable Chloe to experience her body in a less critical and more compassionate way; this implies a process of self-transformation; which adds a spiritual flavour to her experience.

Amy describes that mindfulness enables her to stop and notice her defences without enacting them. She implies that stopping along her journey, enables her to put her runaway thoughts into a 'box' and manage them, and this seems to release her from suffering.

"...If I'm in my defences and if I'm enacting them, I can't see them, because I'm in them. But in mindfulness, if I'm stopping and I'm watching, I don't, I'm not in them, I'm observing them". (Amy, 42-46).

The words 'stopping', 'watching' and 'observing', again invoke a sense of mindfulness as like a voyage. Along this expedition, Amy is able to stop, observe her defences and break out of negative habits and unconscious responses. This seems to imply a process of self-reflection and can be said to contain a spiritual flavour. As she continues speaking, she expresses that her mindfulness journey enables her to manage her thoughts more easily.

"My mind in particular feels like an absolute treadmill. Erm, it's just always going on, and on and on, including with defences. So my defensive thinking, thinking, thinking, thinking, wanting something to be different, wanting something to be resolved in my mind, so that I don't have to be with uncertainty, or be with erm, anxiety, or trepidation, or anticipation. But if I'm stopping and just sitting, Well suddenly, it's not, it's not, you know like a helmet on my head, somehow it's like a box in front of me yeah, which then feels, erm, let's just say, much more manageable and ok, as well. Yeah". (Amy, 58-70).

Amy suggests that ordinarily, she is unable to stop her mind/thoughts from running away from her, reflected in her repeated use of the term "thinking". It is possible that the 'helmet'

she is referring to could also be an extension of her mind and particular thoughts which perhaps at times she finds difficult to manage. It seems however during Amy's mindfulness journey; she is able to put her thoughts into a metaphorical "box" where they become easier to handle. In this sense, mindfulness seems to provide some relief from difficult thoughts. This is reiterated later in Amy's interview when she says:

“Yes, it’s (mindfulness) like a present that you give yourself that releases you from so much suffering”. (Amy, 696-697).

It is suggested that the "present" of mindfulness described by Amy, depicted as the box, could also be a release from a sense of "suffering" from her own thoughts, which she experiences as like being on a "never-ending treadmill". In this sense, mindfulness contains a spiritual element, as the language Amy uses to describe her experience could be viewed as similar to that used in the practice of some religions for example.

Many of the participants used the words, 'place, 'travel', and 'journey' quite frequently when attempting to describe their mindfulness experience. The use of these words constructs mindfulness as a 'spiritual journey' in which the 'traveller' is able to transport themselves to deep places within themselves, with the possibility of transforming and changing the self in positive ways. Several of the participants described 'stopping momentarily' along this journey. This process seemed to enable them to break out of habitual responses.

### **3.2.3 Opening Up to New Experiences**

This theme is diverse as it manifests in many areas; therefore, opening up occurs in many different modalities, making it complex. It describes participants' accounts of how mindfulness enables them to open their eyes to things as they are. It also describes participants' accounts of becoming consciously aware of their thoughts, feelings, physical sensations and their environment and this seems to enable them to open up to new experiences. Some of the participants described how a consequence of the process of opening up (e.g. to new possibilities) enabled the experiencing of a deepening sense of gratitude and appreciation for things that they do not ordinarily perceive, or perhaps appreciate. These experiences are described below.

Beth provides an account of mindfulness as 'waking up', the opposite of this is being asleep. Therefore, suggests that mindfulness she enables her to gain consciousness and open herself up to new possibilities and experiences.

"Well I think, I think being mindful also means, erm, a way of waking up to whatever it is". (Beth, 334-335).

Similar to Beth, Amy also provides an account of mindfulness as 'waking up'. For Amy, mindfulness, is like seeing with clearer eyes and becoming consciously aware.

"Trying to see with clearer eyes. Erm. (Pause). That's probably about the most concise I can be actually. Yes, if it was even just two words, it would just be; waking up". (Amy, 32-35).

'Seeing with clearer eyes' and 'waking up', suggests that there is an opening up in perception and awareness and this contains a spiritual flavour. These quotes also suggests that perhaps Amy and Beth feel in their normal lives that they are on 'auto pilot', or are asleep in some way. Thus mindfulness may allow them to take a moment ('pause momentarily'); and become more aware/awake of themselves.

Correspondingly, Chloe echoes this idea of waking up and opening herself up:

"And it's kind of opening your eyes really to things". (Chloe, 35).

This communicates that Chloe is becoming consciously aware and possibly opening herself up to new impressions. As the interview progressed, she seems to confirm this by describing how mindfulness enables her to open up to new experiences, in the sense of being more present in her lived experience:

"I was driving past a roundabout that I drive past every single day, my whole life and I didn't notice there were blossom trees on it and I just, I just found it so powerful and it didn't really teach me anything, it didn't you know, it was just powerful... Well, I guess it did teach me something obviously (laughter) but I think it was just, it was powerful because I guess I hadn't being noticing it as much as I could be so I guess I could had concluded that, that I'm just kind of cruising through life sometimes on auto pilot and not embracing some of the beauty that is around me and I ....it was a

beautiful tree and I felt quite sad actually in the moment thinking this tree is really beautiful and I hadn't seen it before". (Chloe, 659-674).

Mindfulness appears to enable Chloe to stop her automatic mode of responding and open herself up to notice the beauty in her environment. It seems that by 'opening her eyes', Chloe is able to stop 'cruising through life on auto-pilot' and become consciously aware of her surroundings. This opening up enables her to 'embrace' some of the beauty in her environment. Chloe also implies a sense of sadness and possible disappointment in her inability to notice the beauty in her environment prior to mindfulness. However, it appears that presently, mindfulness enables her to disengage from autopilot mode and bring to the fore background experiences, such as seeing the beauty in her environment. Currently, she appears to be engaged in a much broader view of interconnectedness with her environment. Such an experience is often associated with spirituality and therefore, suggests that Chloe's mindfulness experience contains an element of spirituality.

Similar to Chloe, Holly also describes an account of mindfulness in which she is becoming more consciously aware. This conscious awareness enables her to physically open up and sit with anxious feelings. While Chloe describes a sense of sadness with her inability to notice the beauty in her environment prior to mindfulness, Holly in contrast, describes a sense of achievement and acknowledges the 'vast improvement' in her present moment awareness of her feelings since engaging in mindfulness.

"I think it helped, it's helped me, um (pause) become more aware of how I'm feeling (pause) I think that is something that, years ago before I had any counselling or anything, I used to find very difficult, I don't think I was consciously aware of how I was feeling, so, you know, it's a vast improvement, you know, sitting here and being aware of the fact that I'm anxious, is a, is a big difference to what I used to be because I used to think (pause) I think I used to just push it down and pretend that I was fine all time, whereas now I'm, you know, the way that I'm feeling anxious but that's alright". (Holly, 1070-1078).

Holly suggests that mindfulness enables her to open up, and accept unpleasant feelings as they arise in the moment. In doing so, she seems to experience these feelings as less threatening, suggested by her statement, "I'm feeling anxious but that's alright". In addition,

the words 'vast improvement', shows a desirability of the changes she hopes for in her mindfulness journey. It implies a 'stepping up', and/or aspiring to reach a 'higher level', and this has a spiritual flavour to her experience.

The majority of participants described an account of mindfulness as one that enables them to become conscious of their thoughts, feelings, and physical sensations. This physical sensation is described below by Ewan and Felicity.

"Yeah And it's embodied as well, which I, you know, you really, really, I suppose when you're facilitating that you really notice, you know that kind of, those embodied qualities". (Ewan, 526-529).

Ewan describes noticing an embodied quality when he is facilitating a mindfulness exercise. This embodied quality suggests a physical opening up of the senses to new experiences. This embodied quality is also conveyed in Felicity's account of mindfulness.

"I always say to my clients, not you know, how are you? But not in your head, how are you in your body"? So, how are you? How do you experience yourself? How do you observe yourself? So, it's taking it out of more of the automatic thought of I'm ok, but in to a feeling and a sense, so it's, it's more a felt sense, if that makes sense"? (Felicity, 79-86)

Felicity describes that she asks her clients, 'how are you in your body'? This implies that mindfulness may have a physical quality. Additionally, asking her clients, 'how do you experience yourself', leads me to believe that mindfulness may enable her and her clients to open up to new experiences of themselves.

Some of the participants also spoke about how a by-product of the process of opening up (e.g. to new possibilities and experiences) enabled the feeling of a growing sense of gratitude and appreciation for things that they do not normally notice. For example, Gabby describes how mindfulness enables her to notice the many things she has:

"I mean we have, most of us have so much and we just don't even notice it and when we do (pause) well I'm often filled with a strong sense of well-being and it's lovely". (Gabby, 831-834).

Here although Gabby does not explicitly state what it is that she has ‘so much’ of, it could be implied that she is referring to material possessions or unnoticed personal qualities. She states how being able to take note of what she has leads to being filled with a strong sense of ‘well-being’. It is important to pay attention to Gabby’s language. She shifts from speaking in the third person/ ‘we’ (‘we have so much’) to using the first person, (‘I am filled with’). Perhaps she realises how much she has and is suddenly grateful. It is possible that she is comfortable acknowledging her blessings, her change in language could therefore, be an attempt to bring herself closer to the feeling of appreciation and gratitude for the things in her life.

Holly also reports how this consequence of the process of opening up engenders a deeper appreciation of life in general.

“I think it (mindfulness) helps um (pause) I think it helps you appreciate life a lot more”. (Holly, (538-539). Holly goes on to say:

“You know, appreciating (pause) you know, it doesn’t matter, you can appreciate anything in life, like just in this moment, it could be anything. Yeah, maybe being more grateful as well, or ultimately having gratitude because often we’re anxious or depressed, we’re not grateful for what we are experiencing right now”. (Holly, 560-565).

Here it seems that Holly is appreciative of her present moment experience, indicated by, ‘you can appreciate anything in life, like just in this moment’. It could be that her mindfulness experience enables her to open up and become aware of her feelings in the moment (Holly, 1070-1078) be it anxious or otherwise and she could be grateful for this.

### **3.2.4 Letting Go of Expectations and Thoughts**

Participants described their experience of mindfulness as ‘letting go of expectations and of thoughts. As such, they were able to have a ‘pure’ experience, that is, an experience which contains no additions. Letting go of expectations and of thoughts seems to free participants from distress, and for some this provided a sense of relief.

Amy describes her experience of mindfulness as letting go of expectations:

“That there is no bad or good, there is just what you experience. The very essence, the very pureness of what you experience, and it isn’t getting it right or getting it wrong”. (Amy, 254-256).

Her statement communicates that she may experience mindfulness as a non-striving practice which may allow her to let go of expectations. Amy made this statement with a soft and gentle tone, her facial expression was free from tension. This alongside her use of the term, ‘it isn’t getting it right or getting it wrong’, leads me to believe that she experiences mindfulness as ‘letting go’ of trying to have a desired effect, and in doing she may experience a possible sense of peace, which is often associated with spiritual practices.

Comparably, Chloe describes her experience of mindfulness as ‘not trying to do anything’. To a degree, the language she uses implies an element of letting go, possibly of expectations.

“What’s nice about for me about mindfulness and the way I see it... Is that we are not trying to do anything other than we just notice and that kind of almost takes some of the pressure off”. (Chloe, 258-263).

This suggests that mindfulness may be a non-goal orientated experience and that for Chloe; it is simply about experiencing things as they occur in the present moment. It could be that in ‘not trying to do anything’, Chloe is able to let go of expectations, and this enables the release of some of the pressure on her which may give her a sense of relief, as indicated by ‘almost takes some of the pressure off’.

Holly also describes her experience of mindfulness as letting go of thoughts and this is uplifting for the spirit and soul.

“I think it’s the fact that the realisation of (pause) er, and also letting go or of, of maybe things that they’ve been thinking. It lifts them, their spirit and their soul. I think (pause) but often you come back with a sense of calmness in, in bring, turning to how things are right now rather than things in the future”(Holly, 349-353).

Here Holly describes her experience of mindfulness as letting go of thoughts. She pauses and talks in generalised terms using ‘them’ rather than ‘I’. This can be interpreted as her way of making sense of her experience for the first time, pausing and using generalised terms may have given her time to reflect upon the meaning of her own experiences.

Gabby describes mindfulness as letting go of worrying/ruminating.

“So erm, I suppose a lot of the time when we do things like worry or ruminate... What we tend to do is get into a fight with our thoughts and feelings. Maybe try and problem solve our way out of it. Or we’re kind of, we’re fighting against them. Wrestling with them, yeah and to me mindfulness is kind of letting go of that wrestle”. (Gabby, 46-58).

Here, Gabby implies that she is in conflict or perhaps even at war with her thoughts, indicated by, ‘fight with our thoughts’ and ‘fighting against them’ (thoughts). This suggests that she possibly perceives her thoughts as the ‘enemy’ whom she has to overthrow. However, mindfulness enables her to walk away from the fight or as she states, ‘let go of that wrestle’. In this way Gabby seems to see mindfulness as a ‘peacemaker’ that enables her to stop struggling and let go of the fight with her thoughts.

For Diana, letting go of her negative automatic thoughts seems to give her a sense of relief.

“Like, say one of my negative automatic thoughts might be something like erm, ‘god I didn’t do that very well, or that was really, really unhelpful, or god I’m so rubbish at that or whatever’, and then I think ‘oh, you know, here we go again’. Then I’ve thought what else can I do, you know. You must go and do something else... So, you sort of have got a choice even if you, yeah I think it sort of just gives you a relief from that”. (Diana, 598-607).

It appears as though Diana has many self-expectations and is also self-critical; perhaps mindfulness gives her permission to let go of her thoughts and be kinder to herself, which seems to give her sense of ‘relief’.

Many of the participants described their experience of mindfulness as letting go/ detaching from their thoughts. Beth describes this experience:

“But, erm, but no I do think that it can be a great way of erm, of erm, erm, of letting go and of stopping the identification with your thoughts or feelings, or whatever it is, yeah the distress”. (Beth, 392-394).

Beth suggests that the process of dis-identification with her thoughts allows her to disengage with the distress that may be experienced. From this quote, it seems as though she is almost

describing a process similar to praying – that mindfulness helps her to be able to stop feeling a sense of distress. As the interview progressed, Beth described detaching herself from her thoughts.

“It’s so much nicer to be able to detach oneself and to, than to have to start arguing with the thoughts, if that makes sense”. (Beth, 469-471).

The term ‘nicer to be able to detach oneself’, implies that Beth may experience a sense of relief from the process of detachment from her thoughts. This can be seen to be similar to the process of praying, in that mindfulness enables her to free herself from her thoughts which at times is experienced as distressing (Beth, 392-394). It also suggests that Beth sees her thoughts as separate from the rest of herself and thus she is able to detach from them.

These experiences seemingly imply that the aim of letting go of expectations and detaching from thoughts is to liberate oneself, in this sense, the participant’s experience of mindfulness appears to contain a spiritual flavour.

Similar to Beth, Chloe also describes her experience of detaching from her thoughts.

“And actually it helps to detach yourself from it because you’re saying “this is an entity that I have noticed that I am mindful of it I know it’s there but it doesn’t necessarily have to have control over me again in a way that it does”. (Chloe, 572-575).

Here, Chloe uses language that constructs her thoughts as an ‘entity’, a de-humanised form and therefore, separate from her sense of self. It appears however, that mindfulness enables her to detach from her thoughts and regain control. This implies that the purpose of detachment is to free oneself from pain or distress and this adds a spiritual flavour to Chloe’s mindfulness experience. It could also be that letting go of her thoughts gives her a sense of peace as seen later in her interview when she says:

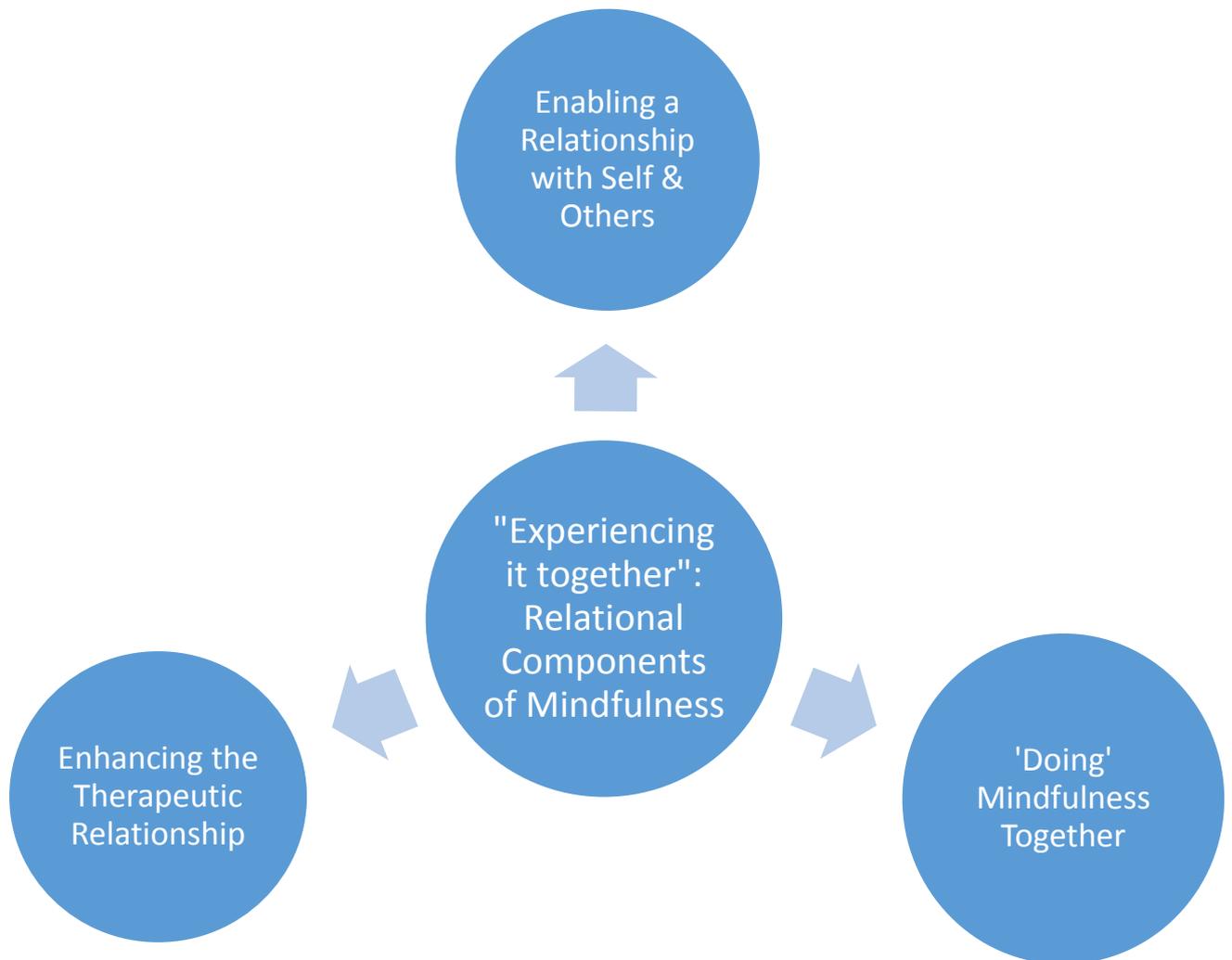
“Whenever I talk about mindfulness, I get a sense of peace. There’s something so peaceful about it. (Chloe, 759-760).

This theme, ‘letting go of expectations and of thoughts’, portrays participants’ experience of mindfulness as a non-striving, non-goal orientated practice. Letting go of expectations seems to enable the participants to stop striving for a particular/desired experience. It seems the process of letting go of their thoughts helps participants to be able to stop feeling a sense of

distress. By seeing thoughts as a separate 'entity' from the self, some like Chloe, are able to remove the negative appraisals of the body and experience the body as it is in the moment. Letting go of thoughts and expectations appears to uplift the spirit and soul, and this adds a spiritual flavour to participant's experience of mindfulness.

This master theme has been able to illustrate the role that spirituality plays in participants' accounts of mindfulness. Participants varied in the ways in which they described and experienced mindfulness, nonetheless, there seemed to be a shared feeling that mindfulness contained an element of spirituality. Spirituality in this sense came across as a broad concept with room for many perspectives. In general, it included a sense of becoming consciously aware or 'waking up' and opening oneself to seeing the beauty in the environment for example. It further included, opening up to new possibilities and experiences. Spirituality was also portrayed as a search or journey for meaning in life, which involved self-transformation, letting go of thoughts and expectations, liberating oneself and deepening a sense of gratitude.

### 3.3 “Experiencing it together”: Relational Components of Mindfulness



This theme discusses how participants’ personal experience of mindfulness impacts their relationship with their clients. It relates to the way in which mindfulness is first experienced on a personal level by the participants. This personal experience was often described in positive ways and this motivated the participants to share it with their clients, hence ‘experiencing it together’. The experiencing it together seemed to enhance the therapeutic relationship. This theme has three sub-themes which will be described below to illustrate the lived experience.

### 3.3.1 Enabling a Relationship with Self and Others

Some of the participants described their lived experience of mindfulness as one that enables them to develop a relationship with themselves. They described that using mindfulness had a positive impact on their personal lives; this provided the motivation to introduce it to their clients and share the experience together in the therapeutic space.

Several of the participants described a lived experience of mindfulness as one that enables a sharing and experiencing of mindfulness with their clients. For example, Chloe describes how her own personal use of mindfulness particularly helps to detach from negative appraisals of her body. This “powerful” experience leads her to use and share mindfulness with her clients, particularly in group work (Chloe, 678-691).

Holly describes this theme in a slightly different way. She reports how her personal use of mindfulness enables her to become more aware of her clients’ physical discomfort. Such discomfort is highlighted and expressed back to her clients, and in this way they experience it together, as Holly explains in the following quote:

“It also helps me myself as well because (pause) because I can start getting, picking up on their headache and um, it effects the session in that I get (pause) I can get lost as well, so it’s really useful to use it, if I start to feel that way (pause), erm and become aware of that myself, then I can use it to help highlight that to the client (pause) and for myself how I’m feeling as well”. (Holly, 253-259).

In this expert, Holly’s use of the term ‘it also helps me myself as well’ suggests she is engaging in a mindfulness exercise at the same time as her clients, thereby implicating that they experience it together. Later in her account however, Holly goes on to say how using mindfulness is not purely for the client and that it is also for herself as a practitioner. She describes this experience:

“Wellbeing for myself and for the client as well, so (pause) um, because I think it is useful but also I just such a, I get a good feeling from useful mindfulness as well, it’s not just, just for the client, it’s not (pause) you know, it’s for me as well”. (Holly, 627-630).

Here Holly describes a personal feeling of ‘wellbeing’ from using mindfulness, suggesting that mindfulness is not just for her clients, but for her as a practitioner as well. Although this may seem to contradict the relational nature of mindfulness, similar to Chloe’s experience, I suggest Holly’s positive personal experience of mindfulness, a ‘knowing from within’, actually enables her to share mindfulness and experience this phenomenon together with her clients.

Gabby describes how her personal experience of mindfulness enables her to share this experience with her clients.

“If I as a practitioner has also has experience of, you know, using mindfulness myself or being mindful, and kind of believe in it (pause). It feels more authentic (pause) to bring that to, to a client, if that makes sense? Erm, so (pause) although I am not (pause) I’m not always mindful, I’m not always able to do it it’s still something that I believe in, that I try and do for my myself (Pause). So I think that side of things feel, then it feels more natural to (pause) to use in the sessions as well”. (Gabby, 148-155).

Here, Gabby states that her personal experience/use of mindfulness enables her to bring mindfulness to her therapeutic practice. Furthermore, this personal experience allows her to share and experience mindfulness in an authentic way with her clients. The word ‘try’ suggests that Gabby is striving to achieve a mindful way of being, and this communicates that perhaps one can never be mindful at all times. In addition, the word ‘authentic’, also suggests that perhaps Gabby is describing how she thinks she ought to be rather than how she feels she is.

Several of the participants described how mindfulness allowed them to develop a relationship with themselves and reflect upon their own vulnerabilities. This enabled them to be more empathic to their client’s difficulties. Beth for example, describes how her personal use of mindfulness ‘humbles’ her to her own vulnerability. She describes that mindfulness enables her to sit with her own pain; as a result, she is able to share the experience with clients.

B<sup>3</sup>: And I do think that doing mindfulness, doing the practice yourself as a therapist really makes you humble in a way to, yeah doesn’t it. (Beth, 611-613)

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<sup>3</sup> Initial of pseudonym of participant.

R<sup>4</sup>: What does it make you humble to?

B: Well it makes you humble to erm, your own vulnerability and being able to sit with that, with your own pain, or your own stress or your own inability to stop the thoughts, or your own... So when your client tells you that it was so difficult, you can say 'yes I know! I know, that's very normal. That's very normal. Keep trying!' (Beth, 617-622).

This personal use of mindfulness seems to place Beth in a position of 'knowing from the inside' or knowing from within. As a result, she is able to understand and empathise with those clients who experience difficulties with their mindfulness experience. Beth's tone was jubilant when she said, "yes I know"! It could be that the experience of seeing herself in the other leads to this jubilant feeling. Her statement, 'so when your client tells you that it was so difficult, you can say', "yes I know! I know, that's very normal. Keep trying", suggests that her personal experience of mindfulness enables her to experience it together with her clients; and that this personal experience may increase her empathic responses to her clients. In a way, perhaps 'meeting' herself in the other also helps her to normalise her own difficult emotions/thoughts.

### **3.3.2 'Doing' Mindfulness Together**

All of the participants described their experience of mindfulness as a shared experience between themselves and their clients. It seems that for all of the participants there was a shared experience of engaging in mindfulness techniques alongside the client. For example, Chloe says:

"I always do mindfulness exercises with clients, so I don't ever kind of ask them to do something, I do it with them". (Chloe, 356-357).

'Doing' mindfulness with her clients implies that it is a shared experiential phenomenon between her and her clients. By modelling mindfulness exercises with her clients, Chloe may be demonstrating her willingness to be 'exposed' to her clients. The purpose of this could be an attempt to strengthen the therapeutic alliance.

As the interview progressed, Chloe described this shared experience even further.

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<sup>4</sup> 'R' introduces something said by the 'researcher to the participant.

“So actually there is something about that process when you are doing that exercise together and experiencing it together that is part...I don’t know something... Yeah, it is something shared, exactly”. (Chloe, 361-366).

Chloe explicitly states that mindfulness is ‘experienced together’; implicating that it is a shared experience between the therapist and client. A possible interpretation for ‘doing/experiencing it (mindfulness) together’ with her clients is that Chloe wishes to relate to her clients on a basis of equality and not become trapped in the role of the diagnostic or treatment expert. In this way, she may be attempting to shift the balance of power between her and her clients. She states that, ‘there is something about that process when you are doing that exercise together’. This seems to suggest that there is something elusive or difficult to put into words about this process. The process she may be referring to could be the counselling process. Experiencing mindfulness together could therefore, be her attempt at demystifying the counselling process, which is that of the view of the therapist as the expert.

Similar to Chloe, Gabby also describes mindfulness as something she experiences together with her clients. Gabby’s language here is very similar to Chloe’s; she uses the term, ‘experience it together’, this is almost identical to Chloe’s term, ‘experiencing it together’.

“Sometimes I would also do some, you know, mindfulness with them like in a session to kind of (pause) you know, experience it together”. (Gabby, 313-315).

By ‘experiencing it together’, Gabby also might be trying to demystify the counselling process, where the therapist is seen as the expert. While this interpretation is entirely plausible, in retrospect, a deeper interpretation may have been achieved if I had asked both Gabby and Chloe to expand on the importance of experiencing mindfulness exercises together with their clients.

The description of mindfulness as a shared experience between participants and their clients is further reported by Ewan. He describes below an account of assembling his clients together after he has lead a mindfulness exercises in a therapeutic group setting. I suggest that his group setting is also another relational dimension to the mindfulness experience.

“And then the group come back and there’s a space opened up there for us to wonder together what happened or didn’t, what did we notice, what did we observe, what did we feel”. (Ewan, 457-460).

Ewan’s language, in particular, the words, ‘us’, ‘together’, and ‘we’, constructs mindfulness as a communal activity, thereby, implicating that it is a shared phenomenon between him and his clients. It is interesting to observe the dichotomy in Ewan’s statement. He describes that he has led a mindfulness exercise to clients in a therapeutic group, thereby, positioning himself as the ‘expert’. He may have had to assume this ‘expert role’ in order to lead clients who may be unfamiliar with the exercises. However, at the end of the exercise, he tries to distance himself from this expert position, by assembling the group to ‘wonder together’ about the experience they have just had. This joint ‘wondering’, implies a process of collaboration and shows Ewan’s attempt to relate to his clients on a basis of equality once again.

Amy’s account also depicts mindfulness as a shared experience between her and clients. She suggests how mindfulness is immensely rewarding when done with others in a group. Amy describes an advantage of mindfulness within a group is the resulting effect of a ‘shared energy’ (Amy, 427-429). This communicates a qualitative difference in the experience in a group and the experience with clients in one-one settings.

Overall it seems participants experience mindfulness as a shared experience between them and their clients. The ‘experiencing it together’, could be a way of relating to their clients on an equal basis so that they distance themselves from the role of the therapist as the expert in order to demystify the counselling process. Also Ewan and Amy imply that the sharing of the experience in groups generates something new, such as ‘a space’, and ‘energy’.

Several of the participants described how engaging in a mindfulness practice together enabled them to receive immediate client feedback during sessions. It appears as though experiencing mindfulness together enables clients to find their voice and give immediate feedback to their therapist regarding their mindfulness practice. For example, Diana explains her experience of feedback:

“It’s quite common to get some immediate feedback from the client, you know, after going ‘that was really great’, ‘I really liked that’, ‘I really found your voice very

soothing', or 'I didn't think I was going to like that but I really liked that". (Diana, 261-263).

Diana's use of the term, 'it's quite common', suggests that she has received immediate feedback from her clients on more than one occasion. She goes on to describe in more detail the content of such client feedback:

"They often, immediately say it, in fact actually, I would say more often than not they will say 'yeah that was really great', 'I really liked that', or 'no I didn't really like that, that wasn't really my sort of thing". (Diana, 286-289).

The term, 'immediately say it', leads me to believe that Diana experiences mindfulness together with her clients, as her clients are able to instantly give feedback on their experience of the mindfulness practice, be it positive or negative.

Similarly, Holly also describes the immediate feedback she receives from clients after engaging in a mindfulness exercise:

"Sometimes, the first few times that I use it with clients I have asked them how they've found it (pause). I would like to know whether it is difficult for them, whether (pause) you know, what they experienced with it and (pause) sometimes without even asking the client, they will open their eyes and then immediately say, you know, how they found it anyway without prompting". (H426-431).

By asking her clients for feedback after the exercise, Holly may be checking in with her clients' experience in order to modify/tailor the mindfulness practice to their specific needs in order to increase its effectiveness. However, she could also be seeking validation from her clients.

### 3.3.3 Enhancing the Therapeutic Relationship

All of the participants described their experience of mindfulness as having a positive impact on their relationship with clients. For some, there was a sense of empathic connection, and bonding between them and their clients. For others, mindfulness enabled a human element in that it enabled them to show their emotions to their clients. Some also described that mindfulness increased confidence and trust in the relationship. Below, Diana describes a sense of connection that can be experienced through using mindfulness.

“I think it’s (mindfulness) a very calming experience and if it, if that client enjoys that experience I think they can feel very connected”. (Diana, 256-257).

Holly describes that mindfulness builds confidence and trust within the therapy.

“I think it (mindfulness) builds a lot of confidence within the therapy, the practitioner itself as well... “I think it kind of builds that, a level of trust between the client and the therapist”. (Holly, 217-226).

When asked what she thinks mindfulness does to the relationship between her and her clients Chloe responds by saying:

R: What do you think that does to your relationship with clients?

C: I think it just, it binds you. (Chloe, 115).

The use of the word ‘bind’ is powerful; it suggests that the relationship is glued together so strongly that it cannot be broken. Chloe goes on to describe the positive impact doing a mindfulness exercise has on the therapeutic relationship by saying:

“I think they know that I am doing that, they know that I have my eyes closed as well... And I can tell them what I experience and what I notice... You know, what did they notice. It allows them to kind of open up to share as well sometimes I find”. (Chloe, 366-372).

Chloe states that doing mindfulness together with her clients enables her to tell them about her own experiences. This act of sharing her own experiences enables her clients to ‘open up to share’ their experiences, suggesting that there is a level of trust between the therapist and

client, as both are able to openly share their experiences. This is similar to Holly's account in that mindfulness engenders trust between the client and therapist.

Beth offers an alternative view of how mindfulness impacts her relationship with her clients. She describes that mindfulness adds a 'human element' to her relationship with clients. By human element, I believe that Beth means the ability to bring herself and her own experiences into the therapeutic work. One aspect of this human element is the ability to express her own difficulties with her mindfulness practice to her clients and to relate them on equal basis.

"Yes. Well, obviously then you're, erm, yeah I like it if you step out of the expert role telling the client how it should be... ..I'm not advocating that you should just kind of be a bit matey. Do you know what I mean? But erm, although sometimes that can be good as well I think. I think that's absolutely fine. But erm, I think it can add to a, kind of a, human element of it, we're all just very normal and fallible". (Beth, 626-632).

Here Beth describes how mindfulness enables her to step out of the therapist as the expert role. She describes this adds a 'human element' to the relationship, and allows her to be seen as 'just normal and fallible'. It seems from these comments that Beth is attempting to relate to her clients on the basis of equality.

Similar to Beth, Felicity describes that mindfulness adds a human element to her relationship with clients:

"So I think it's more because I'm not there to tell them what to do. I'm not there to give them an answer. Erm, I am there without judgement and I think that's probably the biggest thing, is that there's, there's no patient-therapist relationship, it's I'm seeing another human being". (Felicity, 201-206).

From this quote it seems Felicity considers that mindfulness allows her to relate to her clients on an equal basis and to step out of the role of the therapist as the expert. As the interview progressed, she reports on the impact of such a therapeutic relationship by describing feedback she received from a client as a result of using mindfulness in the client work:

"Perhaps one of the biggest things anyone has ever said to me, that made me really realise how powerful mindfulness is, is a young girl who's been in and out of suicide and the whole thing, bit of all, psychotic and a real history and she said to me, 'I feel

like you're the first person who's ever seen me' and she's had years, and years, and years of therapy. And I think mindfulness allows you to be seen". (Felicity, 280-288).

From this quote it is apparent that Felicity perhaps perceives mindfulness as a powerful tool which allowed her to connect with, or to be able to 'see' a particularly troubled client in ways in which it seems other therapists had not been able to, reflected in her comment that the client had had "years and years and years" of therapy. Felicity's statement, 'mindfulness allows you to be seen', could be interpreted as a level of transparency in the therapeutic relationship where both therapist and client are seen respectively, which may improve and strengthen the relationship. In addition, Felicity sounds quite proud of her achievement, indicated by her use of, "She's had years and years and years of therapy".

Several of the participants suggested that mindfulness enhances the therapeutic relationship by seeming enabling empathic connections with their clients. In Felicity's case, this empathic human connection is her ability to feel and share her clients' emotions, she describes this below.

"And where there is an emotional response I will allow myself to say, 'I am really saddened' by that and allow them to know that perhaps I am touched, but also I'll always allow them to know and to see that it won't emotionally affect me, but it doesn't mean to say I'm not connected to them, that I'm feeling". (Felicity, 268-274).

Giving an emotional response to her clients could possibly dissolve alienation felt by her clients and may make them feel a connected part of the human race. It also suggests her attempt to connect empathically with her clients; suggesting that she is able to step into her clients' shoes and see the world through their eyes without however, losing touch with her own reality. It could be that her own mindfulness practice enables her to recognise her own internal state without losing sight of her client's experience.

Beth also describes an empathic connection with clients and describes how employing mindfulness helps to her to be able to normalise particular client's difficulties.

"So when your client tells you that it (mindfulness) was so difficult, you can say 'yes I know! I know, that's very normal. That's very normal. Keep trying"! (Beth, 620-622).

From this quote it seems that perhaps Beth has experienced her own challenges with mindfulness and therefore, she is able to be open and transparent with her clients; this could also increase her empathic connection with clients.

The presented theme, “Experiencing it together” has thus far illuminated participants’ lived experience of mindfulness as one that is relational. Participants describe how such an experience enhances their relationship with themselves which enables them to share it with their clients and this seems to have a positive impact on their therapeutic relationship with their clients. ‘Experiencing mindfulness’ together with their clients was overall depicted as a powerful and positive experience.

### 3.4 “Doing Mindfulness”: Clinical Applications



The final master theme to be presented is, “Doing Mindfulness: Clinical Applications”. This theme describes the various ways in which mindfulness is brought to or incorporated into participants’ therapeutic practice with clients. This theme has four sub-themes which are presented below.

### 3.4.1 The Difficulty of Defining Mindfulness

Participants provided descriptions of the meaning of mindfulness. There were rich descriptions of this experiential phenomenon and participants' meaning making of this lived experience. At the same time as describing the meaning of mindfulness, some participants described the difficulties they experienced in defining an experiential phenomenon into a conceptual understanding. I chose to include this sub-theme within the current master theme as I felt participants described it in a rather clinical way.

Ewan describes the meaning of mindfulness below:

“Erm, so, yeah, so mindfulness is a kind of, like a method, a tool that kind of brings us in to those present moments and gives us a moment clarity, gives us something to reflect upon, gives us something to wonder about, where it might go in the future”.  
(Ewan, 27-32).

Ewan describes mindfulness as a 'method', this is rather clinical. The word 'wonder', implies that there is an element of curiosity contained within the meaning of mindfulness for Ewan. He repeats 'gives us', three times. This indicates that he possibly perceives mindfulness as being like a 'gift'. It seems that he sees that mindfulness, (the 'gift') contributes so much to his practice and perhaps to the counselling psychology profession as a whole and even to the human race, given his use of 'us' repeatedly.

As the interview progressed, he goes on to describe that mindfulness also means being aware:

“Erm, mindfulness is about awareness isn't it”? (Ewan, 181).

Although he is able to describe the meaning of mindfulness, his tone of voice was hesitant, this alongside the use of 'erm', and question at the end of the statement, suggests that he is perhaps finding it difficult to define mindfulness. My interpretation seems to be confirmed later on in the interview when he states:

“It's like nailing jelly, you, how, mindfulness is kind of subtle process and erm, quite, quite difficult to say what it is in fact”. (Ewan, 311-313).

The metaphor, 'Like nailing jelly', to describe having to provide a meaning of mindfulness, implies that he finds it difficult and challenging to reduce an experiential concept into

something that makes 'common sense'. He voices the challenge of defining mindfulness even further when he says:

"You know maybe talking about it, in erm, very, very specific exacting terms doesn't really serve, or doesn't really best capture the lived experience of mindfulness practice". (Ewan, 328-331).

Perhaps for Ewan, mindfulness is difficult to define, because essentially, it is an experiential concept and therefore, describing it in 'specific exacting terms', does not capture the lived experience of the practice for him.

Similar to Ewan's description, Beth also describes that mindfulness means present moment awareness, with attention.

"So for me being mindful means being in, being... you know, it's about awareness, isn't it, erm, of what's going on in the moment. Erm, so that can be around you but I think it's particularly within you, in a way. So, for me mindfulness is erm, yeah, it's like intentional isn't it? It's about asserting attention in a way of, erm, (pause) of doing things with a mindful intention. So, with, yeah with attention". (Beth, 42-49).

The term, 'within you', suggests that mindfulness also means internal awareness for Beth. Here, Beth's speech is interrupted; this alongside the four 'erms' and her questioning of whether it is intentional or not, also indicates that perhaps she is unsure about the definition of mindfulness. This leads me to believe that similar to Ewan, she also found it challenging to define this subtle experiential phenomenon.

Chloe describes mindfulness as observing and experiencing without judgment.

"It means observing, noticing, erm, experiencing without judging, without trying to change but just be present in the moment". (Chloe, 28-29).

For Chloe, mindfulness contains present moment awareness. The term, 'without trying to change', implies that mindfulness could also mean letting go of expectations or of ideals for Chloe. However, unlike Ewan and Beth, Chloe seems assured in her definition.

Amy and Felicity provide descriptions of mindfulness that involve stopping the automatic mode of being. Amy describes mindfulness as:

“It means waking up somehow, from something that feels very (pause) automatic”.  
(Amy, 31-32).

To wake up from automatic pilot mode implies a level of focused awareness and attention. This bears some similarity to Beth’s description. However, despite her ability to define mindfulness, Amy goes on to express the difficulties she finds in explaining this to her clients.

“And my experience, of, of that, is of having to explain something very abstract, extremely abstract, and so difficult to get your mind around to people who are very unwell”. (Amy, 94-97).

Similar to Ewan and Beth, Amy also implies that she finds it challenging to explain this intangible experiential phenomenon into ‘common conceptual’ understanding particularly to her clients.

Felicity describes mindfulness as:

“Awareness. Awareness of being, so if someone is to say, you know, oh, something I always say to my clients, not you know, how are you? But not in your head, how are you in your body? So, how are you? How do you experience yourself? How do you observe yourself? So, it’s taking it out of more of the automatic thought of I’m ok, but in to a feeling and a sense, so it’s, it’s more a felt sense, if that makes sense. (Felicity, 78-86).

For Felicity mindfulness means taking herself out of the automatic mode of responding and into being present. She states that she asks her clients’, ‘how are you in our body’? This alongside the term, ‘more a felt sense’, suggests that mindfulness contains an embodied quality for her. When asked how she brings mindfulness into her sessions, she says:

“Erm, I would, in very many ways, I think it’s a felt sense, between myself and the, it’s very difficult to say, I’d have to book you in a session”. (Felicity, 330-332).

Felicity states that mindfulness is a ‘felt sense’ which is difficult to explain. Her suggestion of ‘booking me in for a session’, implies that mindfulness is experiential and therefore, she would need to show me rather than tell me what it is. This suggests that mindfulness is

difficult to define and that it is about 'doing' (experiential) rather than talking about it (intellectualising).

Holly describes that mindfulness means present moment awareness. For her mindfulness is also about an awareness of physical sensations. In this respect Holly's description is similar to Felicity's in that it contains an embodied quality.

"Erm. Mindfulness means to me erm, about being aware of, and erm being in the present moment, so not just erm, not just your thoughts but with your feeling physically, erm so physical sensations, erm so it might be, erm, becoming more aware of how you feel from your toes to any particular part of your body, your mind, what's going on in your mind physical sensations but also thoughts". (Holly, 34-39).

The use of the term, 'becoming more aware of how you feel from your toes to any particular part of your body', suggests that mindfulness has an embodied quality to it.

All the participants provided rich descriptions of the meaning of mindfulness. Although described in varying ways, participants provided accounts which contained awareness of the present moment. Some however, used words like, 'difficult', and one in particular used the metaphor, 'like nailing jelly', to describe the challenges associated with defining mindfulness. The use of these words highlights participant's difficulties in defining mindfulness and the potential for language to fall down in its ability to adequately communicate this experiential phenomenon into something that makes sense.

### **3.4.2 The Many Ways of 'Doing' Mindfulness**

Participants described the varying ways in which they brought mindfulness techniques into their therapeutic work with clients. There was a real sense of variation in their lived experience of mindfulness techniques, this included, imagery, metaphors, breathing and relaxation exercises for example. I was particularly struck by some of the creative ways in which participants introduced mindfulness techniques into their therapeutic practice.

For example, Diana calmly describes some imagery techniques she brings into her clinical practice with clients:

"Just for a moment imagine a thought that's troubling you, and if you can, just imagine what that thought might look like, what colour might it have, what structure might it

have, and then just imagine taking that thought out, or that structure, that shape and just considering it a bit. And then maybe placing it to the side and then what reaction do you have to that thought, so I might go into that". (Diana, 394-400).

Many of the participants described using the mindfulness of breath technique with their clients. Beth describes this:

So, I've got a few; mindfulness of breath...try and follow your breathing and be mindful of whatever happens while you're, while you're, erm, doing it and try and be, erm, friendly to your thoughts, in a way, but at the same time stay with the breath. Erm..." (Beth, 245-252).

The language used, 'be friendly to their thoughts', suggests a gentle flavour to the mindfulness exercise; it implies a non-challenging and friendly approach.

Felicity describes that she uses guided meditation as a mindfulness technique with her clients.

"More guided meditation and more than silent meditation, but more being present in meditation so really using mindfulness to get in touch with the body. Out of the head, in to the body, so more, I would say, guided meditation". (Felicity, 352-358).

Felicity suggests that mindfulness exercises contain an embodied element which appears to be important for her. This embodied quality was only highlighted during the analysis. On reflection, perhaps exploring this with her would have allowed for further understanding of how mindfulness is perceived by Felicity to be important for detaching the mind from the body.

Gabby describes that she uses metaphors as a mindfulness technique with her clients who are stuck in rumination.

"Sometimes I use (pause) more metaphors. You know, so kind of maybe thinking about if someone is ruminating about something and there are lots of thoughts going by, there's lots of distressing thoughts (pause). I might introduce a different type of metaphors...you know there's one about thinking of the thoughts as cars driving by or standing on a platform thinking of like kind of a train (pause) going by". (Gabby, 332-342).

It could be that using metaphors for her clients who ruminate, enables them to see the problem from a fresh and new perspective, thereby, casting the experience in a new light.

It is suggested that the many and creative ways that participants describe using mindfulness techniques is possibly due to participant's reports of such techniques being applied in both individual and group client work settings for a range of different difficulties, including, weight management, low self-esteem and medically unexplained symptoms. Some participants however, seem to consider the impact of mindfulness techniques is more 'powerful' in a group context. For example, Chloe compares the use of individual and group use of mindfulness tools:

"It can be really powerful I find in one to one, but in the group it's just amazing, I mean it just works brilliantly". (Chloe, 85-86).

From this quote, it could be interpreted that perhaps there is something about being in a group that enhances the use of mindfulness techniques, which reinforces the previous master theme of the relational nature of mindfulness.

### **3.4.3 The Dichotomy of Mindfulness-Specialisation vs Generalisation**

Participants described using mindfulness with a specific disorder in their therapeutic practice. At the same time, many also described that mindfulness can be used with non-specific disorders, and that mindfulness 'speaks to people from all different walks of life'. These experiences are described here by Chloe:

"Yeah I mean I guess it works very well with addiction, hugely. Erm it works very well with erm eating disorders; erm particularly with anorexia and things like that, the kind of anorexic voice, and listening to the voice and being mindful of the voice". (Chloe, 554-557).

Here Chloe describes that mindfulness works with addiction and with eating disorders. However, earlier on in her interview, she stated that mindfulness fits in with everything:

"I think it fits with everything. I don't, I don't think there is anything that I have found that I just couldn't work" ... (Chloe, 215-216).

The term, 'fits in with everything', implies that Chloe also experiences mindfulness as a non-disorder specific intervention. Chloe's experience seems to elevate mindfulness to a status of being able to 'cure everything'. It rather feels like a panacea for every disorder. This raises the question, to what extent can an intervention fit the needs of every individual and every disorder?

Diana describes mindfulness as a specific intervention used for specific groups of clients such as clients with tinnitus for example.

"So, I think it's quite a specific thing, for specific clients, and specific groups of clients". (Diana, 120-121).

"I had a really good experience with a man with tinnitus, he had really bad tinnitus. he really liked it, because it focused him away from the tinnitus, focused him on his breathing. So I think for medically unexplained symptoms I think it's probably great actually". (Diana, 310-313).

She explicitly states that mindfulness is 'great' for 'medically unexplained symptoms', suggesting that it is a disorder-specific intervention. On the other hand, as the interview progressed, she states:

"Actually I think everybody can benefit from, at the lowest level, just a relaxation exercise". (Diana, D524-526).

This implies that mindfulness may be a general 'tool' and not a disorder-specific intervention for Diana after all. Here, she also seems to reduce its (mindfulness) status to just a 'relaxation' exercise. It seems that for Diana as well as for Chloe, mindfulness on one hand remains a disorder-specific intervention and on the other, an intervention which can be used for everybody. This dichotomy is interesting, and raises the question about the discourse currently being had in the mindfulness field.

This dichotomy is also seen in Holly's account. She describes using mindfulness with anxious clients. At the same time, she goes on to suggest that mindfulness can be used with every client group.

“Typically when I use it, er, it (pause) it’s more or less more with clients who are anxious because their thoughts are like GAD say (pause). Their thoughts are so off here there and everywhere”. (Holly, 250-253).

“I think it’s really useful with any, with any client group really. I don’t think there’s a specific one that I’d say yes, if you’ve got depression use it, if you’ve got GAD, I’d say use it full stop”. (Holly, 816-819)

From these quotes, it seems that Holly perceives mindfulness as a ‘magic pill’ that can be taken to cure ‘all people of all things’.

While, Chloe, Diana and Holly appear to describe mindfulness as both a disorder specific intervention and a non-disorder specific intervention, other participants present an alternative account, which is that, mindfulness is an intervention that is useful for any and everyone. Ewan, Gabby and Felicity describes this:

“But I just feel that if it, that mindfulness speaks to people from all walks of life and all conditions of life”. (Ewan, 1086-1087).

“I really don’t think that this is just something for mental health; I think it is something for everyone”, (pause). (Gabby, 819-820).

“I think it can be used in any presenting problem. I really do”. (Felicity, 313-314).

Ewan, Gabby and Felicity suggest that mindfulness is useful for everyone. Gabby in particular states that mindfulness is ‘not just for mental health’; but rather, it is ‘for everyone’. This suggests that mindfulness is not even an ‘intervention’ but rather asking a way of life.

There appears to be a dichotomy for some participants about whether mindfulness is experienced as a disorder-specific or a non-disorder specific intervention. On the whole, however, all participants described that mindfulness is useful for any presenting problem and therefore, it is helpful to people from all walks of life. These experiences seem to suggest that mindfulness is the ‘magic pill’ that solves all problems, the panacea for all things.

Although most participants seem to agree on this, some actually reported having negative experiences of using mindfulness with their clients. This clearly contradicts the view that mindfulness is for ‘people from all walks of life’ and dispels the view that it is the magic

solution to the counselling psychology field. For example, Diana describes a negative experience with a client after completing a mindfulness exercise.

“So we did the physical relaxation beforehand, you know a little bit of progressive muscle relaxation and the start of a mindfulness exercise, and I’d explained to him that I was going to close my eyes but if he didn’t want to close his eyes that was absolutely fine, and by the time we finished he was actually shaking with anxiety”. (Diana, 203-207).

Diana’s experiences seem to suggest that mindfulness exercises can potentially exacerbate anxiety symptoms in clients. This seems to communicate that consideration is needed when using mindfulness with each individual client.

Equivalently, Chloe and Ewan describe negative experiences of using mindfulness with their clients.

Actually I’ve had a few clients who have been panicked by it and they’ve kind of said I can’t do this anymore”. (Chloe, 421-423).

“When they immerse from the formal practice, which may leave them with a sense of, you know a real kind of shock or disorientation”. (Ewan, 1260-1263).

The terms, ‘I can’t do this anymore’, and ‘shock’ and ‘disorientation’, suggests that some clients can feel vulnerable after a mindfulness exercise. The fact that these negative experiences exist, seems to suggest that mindfulness is not for everyone. It also highlights the idiosyncratic nature of clients’ problems and also perhaps the idiosyncratic nature of mindfulness application. It is interesting therefore, why participants should lean towards this discourse.

#### **3.4.4 Practicing What You Preach-Advice for Novice Mindfulness Therapists**

This is the final subtheme to be presented. All participants provided advice they would give to novice mindfulness therapists. While there were varying degrees of advice, the most common entailed the therapist having a personal experience and practice of mindfulness before introducing it to clients. The other most common advice was that mindfulness takes time to understand and do. Ewan describes this:

“... Kind of get a practice together and taste it, and experience it and know what it’s about from your own experience before you go and share it with others”. (Ewan, 1170-1176).

Ewan suggests that it is important for a therapist to have ‘tasted’ or had some personal experience before sharing it with clients. The word ‘taste’ constructs mindfulness as being like ‘food’, and that you (therapist) should ‘taste’ it before you give and ‘share’ it with others. This suggests that perhaps, Ewan does not want to harm his clients by giving them something he himself has not yet tried. It also suggests a kind of nurturing quality of ‘feeding’ his clients something that is good enough for him also. He goes on to say:

“when we guide somebody else in mindfulness, we’re guiding them in an experience, aren’t we... so it seems to me, more than helpful for us to have had that experience, ourselves. And for me, when I say more than helpful, for me that would seem to be to kind of more ethical, more responsible because on some level, even though we know that the experience that we have isn’t the same experience that we guide, at least we have entered similar terrains”. (Ewan, 1216-1224).

Here Ewan seem to be constructing mindfulness as an adventure/exploration, indicated by ‘terrain’ in which people need ‘guiding’. Again, this implies a nurturing quality to the experience. It could be that he is aware embarking on a mindfulness journey and engaging with the exercises can leave some people (clients) feeling vulnerable, ‘shocked and disorientated’ even (Ewan 1260-1263). Therefore, having a personal mindfulness practice may equip the therapist to ‘nurture’ and manage clients’ uncomfortable feelings and difficulties experienced during their mindfulness journey.

Beth also advocates that a personal experience of mindfulness is vital before introducing it to clients. Her statement below is almost identical to Ewan's in the sense that they both acknowledge that while each individual's experience will differ, it is important to have had entered similar territories.

“Otherwise you have no idea, and I think it's so important to erm... Even though your client's process might be, obviously, completely different but you'll have, to really know from the inside just as much as from your kind of intellectual learning, what's, yeah, what happens really”. (Beth, 589-593).

Beth suggests that a personal experience of mindfulness enables the therapist to know from the inside what really happens, rather than having an intellectual understanding of it. This 'knowing from the inside', could enable the therapist to have a better understanding of the client's experiences.

Similarly, Amy shares this view of a therapist having a personal practice of mindfulness before introducing to clients:

“I would say don't get caught up in the intellectual, in the intellectualisation of mindfulness. So, someone's always going to try and intellectualise the concepts, I think in their first time, to try as best to not get caught up in that, and just keep coming back to the experience”. (Amy, 545-550).

The term, 'just keep coming back to the experience', suggests that mindfulness is an experiential rather than an intellectual concept. She advocates that therapists should try as much as possible to return to the experience itself. It could be that in getting caught up in the intellectualising of mindfulness, the therapist is moving away from the experience itself.

This idea of a therapist having a personal practice of mindfulness before introducing it to clients is echoed by Diana and Chloe.

“I'd definitely say practice. Yeah practice it. I would say practice, practice the dialogue of it because you don't want to be sounding, you want, your client needs to feel really trusting of you, that you're competent, so you don't want to be falling over your words. Erm, and I suppose also, enjoy it”. (Diana, 631-635).

Unlike Ewan, Beth and Amy who emphasise that a personal practice is valuable to the therapist, Diana seems to suggest that a personal practice is important so that the therapist 'sounds competent'. This suggests that she may be anxious about being 'found out' that she may not be competent in her use of mindfulness.

Chloe also describes her views below:

"I think to have experience of it is essential and also you might, sometimes you might want to share your experience of it with a client. If they're very reluctant. But you know I generally think it's just about, you need to kind of walk the talk I think sometimes". (Chloe, 649-652).

The term, 'you need to kind of walk the talk', implies that Chloe believes it may be important for the therapist to show a level of consistency between their words and actions, that is, they should do the things they advise other people to do. Earlier in her interview Chloe, stated that consideration is needed for using mindfulness in the therapy session:

"I think there is always a right place for it, you know, you don't want to just kind of throw it in there as a tool in a toolbox". (Chloe, 437-439).

Chloe seems to imply that a therapist needs to develop a rationale for introducing mindfulness into the sessions, and that mindfulness should not simply be thrown in the session as a 'tool in a toolbox', some consideration is needed for its use.

Participants advocated that having a personal experience of mindfulness before introducing and sharing it with clients is important. It could be that participants are aware of the potential challenges of doing a mindfulness exercise; therefore, they advise a therapist using mindfulness for the first time to have a personal practice/experience of it. This may possibly equip the therapist to manage any distress or discomfort a client may experience in the sessions.

### 3.5 The case study

Having presented the master themes and their subthemes, I will now introduce case studies for each participant. I am presenting this because there were differences in participants' accounts, whilst this has been picked up and commented on throughout the analysis, I would like present brief case studies to further 'give voice' to each individuals' experience. During the analysis, it appeared that participant's accounts fell into two types, those who experienced mindfulness as a way of being and those who experienced it as a therapeutic tool. In presenting these case studies, I hope to illuminate participant's lived experience of mindfulness even further.

The analysis revealed that for Amy, Chloe, Ewan, Felicity and Gabby whom the personal mindfulness journey came before the professional application, mindfulness is described as qualitatively different. For these participants, mindfulness contains a spiritual component; it is also a 'way of being' that is embedded in their lived experience. This way of being has subsequently seeped into their professional practice. Mindfulness encompasses a spiritual dimension for these participants, this dimension impacts their personal lives and professional practice. Attention is turned to the cycle for each participant.

**Cycle for Amy** - For Amy, mindfulness is embedded in her lived experience, this is exemplified when she says: *"Erm, well, we walk a lot. We walk a lot. And it's so special to, not, I don't mindfully walk in terms of my physical self, but I am looking around, I'm smelling, I'm noticing"*. (Amy, 615-617). Mindfulness is a 'special' practice which is incorporated in her everyday life.

Mindfulness contains a spiritual component for Amy. She describes it as a sacred place where she sees things with clearer eyes and a degree of wakefulness. *"Trying to see with clearer eyes...if it was even just two words, it would just be; waking up"*. (Amy, 32-35). *"That's such a special place isn't it? Very sacred"*. (Amy, 716). The terms 'waking up', alongside, 'very sacred', implies that mindfulness has a spiritual flavour. In addition, she describes that mindfulness releases her from suffering: *"Yes, it's like a present that you give yourself that releases you from so much suffering"*. (Amy, 696-697). The language used here resonates with language that is normally used in other disciplines like religion ideologies for example, and implicates that mindfulness contains a spiritual dimension for Amy.

Amy's personal use of mindfulness is brought into her clinical practice; currently she facilitates a group at the hospital where she works. *"I run a, well I co-facilitate a mindfulness group at the hospital I work at".* (Amy, 79-80). This suggests that the personal lived experience of mindfulness is currently infused in her professional practice.

**Cycle for Chloe** - Mindfulness is an automatic part of Chloe's lived experience: *"I guess I do it automatically now. I'm not, I wouldn't say I'm an expert, but, I, erm, I definitely. I do it a lot".* (Chloe, 750-752). Mindfulness is an 'automatic' part of her being, implicating that for Chloe, mindfulness is a way of being.

Chloe experiences mindfulness as a powerful influence in her personal life, knowing its powerful or transformative impact for herself, she integrates it into her professional practice. *"And I find that really powerful for myself, so knowing how powerful I find that, I use it in groups".* (Chloe, 690-691). This exemplifies that Chloe's personal use of mindfulness has pervaded her professional practice.

Mindfulness also contains a spiritual dimension for Chloe. She experiences it as peaceful: *"There is a sense of peace that comes from the word and I guess from where it comes from, but I, I find it quite peaceful, term to use".* (Chloe, 33-35). In addition she describes mindfulness as, *"and it's kind of opening your eyes really to things".* (Chloe, 35). This suggests that she is opening herself up to becoming awake or enlightened.

**Cycle for Ewan**- Ewan describes that he started practising mindfulness over twenty years ago; this personal journey now informs everything he does. *"I started practicing mindfulness about twenty years ago, so for me, imperfectly but to some degree it's the way that, you know, it informs everything I do".* (Ewan, 215-218). This implies that mindfulness defines his entire existence; mindfulness is therefore, integral to his lived experiences.

He describes that his personal and lived experience of mindfulness permeates his professional/clinical practice. This is highlighted when he says: *"So the idea of me engaging in therapeutic practice that lacks mindfulness is a bit of an unusual thought".* (Ewan, 234-236). This implicates that the personal experience of mindfulness is interwoven with his professional practice.

Mindfulness also contains a spiritual dimension for Ewan; *“I have noticed that people are able to erm, travel to deep places within themselves remarkably swiftly at times through mindfulness”*. (Ewan, 1254-1257). This implies that mindfulness is a spiritual journey that enables him to travel to deep places within himself. He also describes that, *“Mindfulness is like a form of wakefulness”*. (Ewan, 1352-1353). This suggests that mindfulness contains a spiritual dimension for him.

For Ewan, mindfulness enriches his life: *“Erm, it’s something that enriches life”*, (Ewan, 12-13) and *“I think it’s a wonderfully enriching practice”*. (Ewan, 1359-1361). When asked whether he thinks it has enriched his life, he says: *“Yeah, for sure, definitely, and that enrichment might be found... the richness of our self, the richness of our experience, the richness of our erm life path, the richness of our relationships”*. (Ewan, 1365-1369). Ewan communicates that he finds mindfulness to be an enriching practice which has a positive impact on all aspects of his life and thereby denoting an element of spirituality.

**Cycle for Felicity** - Felicity describes herself as a Buddhist and that she lives in a state of being present: *“I don’t think it’s something that you, (small sigh) I would hope it’s not something that I switch on, switch off. I live in a very mindful place, so within myself, I feel that not only with my work, but also, yeah, I am Buddhist, so I’m very much in that state of being...for me, it’s a way of being, very present, very present”*. (Felicity, 56-63). Mindfulness is embedded in her lived experience; suggested by the fact that it is not something she switches on and off. Felicity communicates that this personal way of being, has pervaded her professional practice, implying therefore, that her personal practice of mindfulness impacts her clinical experience.

Mindfulness also contains a spiritual dimension for Felicity. She describes that mindfulness enables her to be on a journey where she is able to grow and develop. *“I think I’m continually learning, continually reading, continually growing, I feel that there is so much more I need to learn and know about myself, erm, as a practitioner, but also as a human being. And I think, I think being aware that we are all on a journey and it doesn’t ever, I don’t think it ever ends”* (Felicity, 607-612). This suggests that mindfulness is a spiritual journey that offers her the possibility of growing and developing as a human being.

**Cycle for Gabby** - Gabby describes starting her mindfulness journey fifteen years ago before she embarked on her professional journey to become a psychologist. Mindfulness has a spiritual flavour for Gabby. *“I think um, I starting doing a lot of meditation, um, and that to me (pause) this is before I was a psychologist, it was just, you know it was fifteen years ago perhaps...Then I start to, to kind of think actually it’s more about the journey rather than the end goal so to speak”*. (Gabby, 738-744). Gabby’s language resonates with that used in religion for example and implicates that her mindfulness journey contains a spiritual flavour.

Gabby describes her experiences of mindfulness as a way of being. *“I see it as a way, you know as a way of being”*. (Gabby, 295). This way of being in her personal life influences her professional practice. *“If I as a practitioner has also has experience of, you know, using mindfulness myself or being mindful, and kind of believe in it (pause). It feels more authentic (pause) to bring that to, to a client...”* (Gabby, 148-151). This shows that her personal use of mindfulness enables her to bring it into her therapeutic practice.

Another example where Gabby’s personal experience of mindfulness impacts her professional practice is where she says, *“It is one of the things that you kind of (pause) you introduce that you use yourself... And, whereas maybe let’s say in CBT there might be lots of different sort of tools erm, that I don’t necessarily use for myself”*. (G181-187). Gabby demonstrates here that her personal experiences impact her professional practice. This is further highlighted when she says: *“It feels like erm (pause) mindfulness is more of a way of being that we can both understand (pause)”*. (Gabby, 194-196). This highlights that her personal experience of mindfulness impacts her professional practice.

**Cycle for Holly** - Holly first came across mindfulness through her professional practice. She describes that she initially began using mindfulness within a therapy group: *“I began using it initially within therapy groups”*. (H73-74). For Holly, the professional experience of mindfulness came before, her personal use. Mindfulness is a way of being for her and contains a spiritual dimension. *“I think it’s the fact that the realisation of (pause) er, and also letting go or of, of maybe things that they’ve been thinking. It lifts them, their spirit and their soul.”* (Holly, 349-359). Holly experiences mindfulness as uplifting to the soul and spirit.

For Holly mindfulness is a way of being in everyday living. *“The whole idea of it is becoming more mindful in the moment to moment, not just once every two weeks or once every*

*week...So, so it's about, you know, practicing it more regularly because the whole idea behind it is that if we practice it more regularly, then it will have a positive impact on their wellbeing and our recovery". (Holly, 513-519). This experience of mindfulness as a way of being is fed back into her professional practice, as seen by this: "Especially with this style of therapy, it is more about what you do outside of the sessions, than what you do in the session. So, again encouraging the client to use it. It is really important". (Holly, 501-504).*

Holly experiences mindfulness as being helpful for her personal well-being. *"Wellbeing for myself and for the client as well, so (pause) um, because I think it is useful but also I just such a, I get a good feeling from useful mindfulness as well, it's not just, just for the client, it's not (pause) you know, it's for me as well"* (H627-630).

At first, it appears that Holly is not comfortable with owning her mindfulness experience, indicated by her avoidance of personal pronouns. She often mixes between the personal and the general, ('you', 'we', 'their', 'our', 'I' and 'me'). This suggests an unwillingness to commit to her experience. However, it seems the interview process enabled her to make sense of her own mindfulness experience and at the end, she owns and commits to the experience, "it's for me as well".

Beth and Diana do not experience mindfulness as a way of being, but rather see it as a therapeutic tool. Their experiences are described below.

**Cycle for Diana-** Diana describes that she first became aware of mindfulness while working in a drug and alcohol placement. *"I first became aware of it when I was working in a drug and alcohol placement and I found it really appealing". (Diana, 113-115). This professional experience of mindfulness led to some personal use.*

For Diana, mindfulness remains a therapeutic technique as exemplified by this: *'And in any case, I think it's a really good, I think it's really important because it is a technique, it is a good technique'* (Diana, 698-700). This implies that she does not experience mindfulness as a way of being; consequently, she appears to weave in and out of mindfulness. *"I sometimes forget about mindfulness". (Diana, 366). This implies that mindfulness is not integral to her way of being; thus, she seems to weave in and out of it both in her professional practice and personal life, as seen by: "I need to get back in to using it, because I don't, I tend to not use it that often at the moment". (Diana, 418-419).*

**Cycle for Beth** - Beth describes mindfulness as a therapeutic tool rather than a way of being. *“Yes, so when, so I think for some it can be a really helpful tool”*. (Beth, 322). She seems to suggest that mindfulness is a therapeutic tool that she passes on to her clients. This is illustrated in the way in which she describes how she introduces mindfulness to clients. *“So I would usually talk about it with them, or give them exercises, or give them a C.D. Er, erm, but I would not, very often do it in the session with them”*. (Beth, 55-157). Here Beth implies that mindfulness is a tool that is used in therapy.

Although Beth seems to experience mindfulness as a therapeutic tool, she seems to suggest that her professional experience of mindfulness is trickling into her personal life as demonstrated by: *“Whereas I think if you’re, if I’m doing my meditation, or whatever, and I’m noticing things in my body, or in my mind, then that’s a different kind of mindfulness isn’t it?”* (Beth, 94-97). Beth implies that her professional experience of mindfulness is beginning to infiltrate her personal life, at the same time, she seems keen to differentiate between her meditation and the mindfulness she does with her clients.

Despite the fact that Beth regards mindfulness as a therapeutic tool, it is beginning to have a spiritual dimension for her, this is seen when she says, *“Well I think, I think being mindful also means, erm, a way of waking up to whatever it is”*. (Beth, 334-335). This idea of waking up implies a conscious awareness of some kind and this has a spiritual flavour. We can therefore, begin to speculate that mindfulness is beginning to have a spiritual element for Beth.

### **3.6 Summary**

This chapter has presented an interpretative phenomenological analysis of the interview transcripts of eight participants. Three master themes were identified: 1) “It lifts them up, their spirit and their soul”: Mindfulness and Spirituality, 2) “Experiencing it together”: Relational Components of Mindfulness, 3) “My experience of using it with clients: ‘Doing’ Mindfulness, Clinical Applications. For many of the participants, mindfulness contains a spiritual dimension, it impacts their personal lives in positive ways, it is then brought into the therapeutic space and experienced as a shared phenomenon between therapist and client.

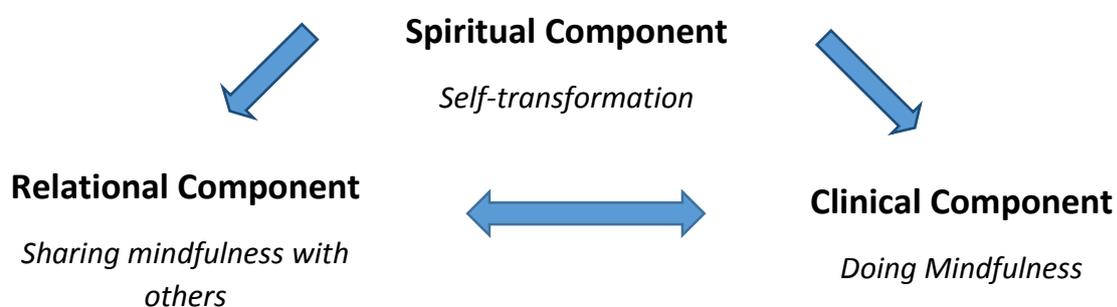
## 4 Discussion Chapter

### 4.1 Introduction

This final chapter presents a comprehensive review of the research study. I will begin by reviewing a summary of the findings in relation to the research aims. The findings will then be considered in the context of the wider literature and its implications for the counselling psychology field. I will reflect on the quality of the research project by considering the strengths and limitations of the design and analysis method as well as identifying avenues for future research. Lastly, I will explore my impact on the research, followed by the conclusion.

### 4.2 Research Aims and Summary of Results

This study aimed to illuminate the lived experience of counselling psychologists who use mindfulness in their practice. It aspired to shed light on the personal and professional experience of mindfulness for the psychologists who use it, in the hope that the findings will help the counselling psychology field to better understand the challenges and opportunities associated with using mindfulness approaches in therapy. The findings suggest that for almost all of the psychologist, using mindfulness contains a spiritual dimension which involves a process of self-transformation. This spiritual dimension was unique to each participant and defies a single, widely agreed definition. The spiritual component of mindfulness is experienced as a positive personal impact on the psychologists and as such, acted as motivation for them introducing and sharing it with their clients in their professional practice. The findings can be summarised in the diagram below.



**Figure 4:** An illustration of the three master themes from the analysis.

The diagram is an illustration of the three master themes derived from the analysis. Mindfulness contains a spiritual component which can be seen as a process of positive self-transformation. This positive personal transformation motivated the participants to share and experience it together with their clients, and thus a relational component of mindfulness emerges. Mindfulness is then brought into the therapeutic space, hence the clinical component. The themes contain an element of circularity, as they all impact one another. Below is a discussion on the major findings of the study in relation to the wider literature and the implications for the field of counselling psychology.

### **4.3 Discussion of Findings in Context and Contributions to the Field of Counselling Psychology**

What follows is a discussion of the significant findings of this study in relation to existing literature, alongside implications for the counselling psychology field. Whilst there has been an upsurge of development and interest in clinical applications of mindfulness, little has been studied on the therapists who use it and their experience of mindfulness in both their personal and professional lives. It is reasonable to say therefore, that this study reflects the experience of an under-researched group in this topic. As such it has the potential to add to the understanding of how this group use mindfulness in their personal lives and professional practice. The three findings that will be discussed are mindfulness and spirituality, relational component of mindfulness with a particular emphasis on empathic connections and lastly, doing mindfulness with a specific focus on advice for novice mindfulness therapists.

#### **4.3.1 Mindfulness, Spirituality and Health**

Kornfield (1993) suggests that mindfulness meditation can offer a method of cultivating spirituality irrespective of religious association, or non-affiliation. Participants in this study constructed mindfulness as having a spiritual dimension; this spiritual component was experienced as a meaningful venture for the participants in that it had a positive transformative effect on their personal lives. However, they each constructed it in unique and varying ways. As such there was no single, widely-agreed definition of spirituality.

The analysis revealed that spirituality was an important component in participants' experience of mindfulness. This finding resounds with those reported by Cigolla and Brown (2011). The researchers also found in their study, that participants described the journey into

mindfulness as having a spiritual component, one that led to the incorporation of values and beliefs and contributed to the development of a particular outlook on life and experiences. According to Yogesh, Mohan, Roy and Basu (2004) spirituality has been considered by the World Health Organisation (WHO) as an important aspect of health, in addition to physical, psychological and social health. Before discussing the role spirituality played in the lived experience of the counselling psychologists who took part in this study and of the role it can play in therapy, a brief outline and definition of the term, as well as how it differs to religion is provided. As noted by Van Deurzen (2010) and Larimore, Parker and Crowther (2002) often there is confusion surrounding these constructs, therefore, it is necessary to provide a clear definition.

Thoresen and Harris (2002) propose that religion and spirituality are complex multidimensional constructs, which Hart (2008) suggests makes it difficult to define in the context of health. It was highlighted in the analysis that mindfulness contained a spiritual dimension for the majority of the participants; however, they each constructed it in idiosyncratic ways and without an agreed definition. This supports an argument by Miller and Thoresen (2003) and Yogesh et al. (2004) that spirituality as a concept is multifaceted and defies simple clear-cut boundaries.

Thoresen and Harris (2002) and Miller and Thoresen (2003) nonetheless provide a definition and distinction between religion and spirituality. Thoresen and Harris (2002) propose that religion is often perceived as a societal phenomenon, involving social institutions which consist of members who abide by various beliefs and adhere to certain rules, rituals, covenants and formal procedures. Similarly, Argyle and Beit-Hallahmi (1975, quote from Pargament, 1997, p. 25) suggest that spirituality can be seen as “a system of beliefs in a divine or superhuman power, and practices of worship or other rituals directed towards such a power”. By contrast, Thoresen and Harris (2002) suggest that spirituality typically refers to the individual’s personal experience, and is commonly seen as connected to some formal religion but increasingly perceived as independent of any organised religion. Williams and Sternthal (2007) further suggest that spirituality refers to an individual’s attempt to find meaning in life, which can include a sense of involvement with the transcendent outside institutional boundaries.

Other researchers such as Walsh (2000) see spirituality as primarily relational, that is, a transcendent relationship with that which is sacred in life; whilst Emmons (1999) views it as something divine, beyond the self. These differing views support the notion that spirituality defies simple clear-cut boundaries as noted by Yogesh et al. (2004). However, I subscribe to the definitions offered by Thoresen and Harris (2002) and Miller and Thoresen (2003).

Miller and Thoresen (2003) debate that any scientific definitions of spirituality are likely to differ from the individual's subjective meanings and conceptualisations. The researchers argue that scientists for example, study beliefs or feelings or perception about spirituality, or behavioural practices and effects related to religion, all of these from an individual's perspective are essentially physical manifestations that according to the researchers fall short of representing or understanding the 'real thing', the essence of what the individual experiences as spirituality. To this end, Thoresen (1998) suggests that spirituality is usually understood at the level of the individual within specific contexts. In addition, Thoresen and Harris (2002) suggest that beyond the idiosyncratic personal beliefs, spirituality may also involve seeking a sense of being or becoming connected to something greater than just oneself.

The definitions of spirituality put forward by Miller and Thoresen (2003), Williams and Sternthal (2007) and Thoresen and Harris (2002) seem to reflect the experience of the participants in this study; in that they conveyed mindfulness as having a spiritual dimension, they did this in idiosyncratic ways. In the current study, Amy for example, constructed mindfulness as a special place, which held spiritual significance for her, in that it symbolised a metaphorical journey into her beliefs; in addition mindfulness was seen as releasing her from suffering<sup>5</sup>. In a different way, Holly constructed mindfulness as enabling her to let go of the things she had been thinking, and this was uplifting to her spirit and soul<sup>6</sup>. In this sense, Holly also constructed mindfulness as consisting of a spiritual dimension. Throughout their accounts, many of the participants constructed mindfulness as having a spiritual element; however, they all did this in distinctive ways. This finding resonates with Rothaupt and Morgan's (2007) study in which they found that participants spoke of a connection to a higher power, and to nature. The researchers highlight that although a connection to a higher power

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<sup>5</sup> Refer to quote in analysis, Amy, 692-693, 696-697, 716.

<sup>6</sup> Refer to quote in analysis, Holly, 349-353.

and spirituality were evident in the interviews, participants' experiences varied greatly. This seems to support Thoresen's (1998) suggestion that spirituality is indeed idiosyncratic and generally understood at the level of the individual within specific contexts.

Van Dierendonck and Mohan (2007) suggest that spiritual inner resources give the individual a feeling of strength in times of crisis, when dealing with the uncertainties of life. This seems to support some of the participant's experience. For example, Holly described that before using mindfulness, she found it difficult to sit with uncomfortable emotions; often she would pretend that she was 'fine' when in fact she wasn't. However, mindfulness enabled her to sit with uncomfortable feelings and acknowledge that it is 'alright to feel those feelings'<sup>7</sup>. Van Dierendonck and Mohan (2007) propose that inner spiritual resources can be instrumental in experiencing a sense of secondary control over the situation, and thus, giving a greater trust that everything will turn out for the best. Holly's account seems to support this, in that although she still experienced uncomfortable emotions in certain situations, ultimately she trusted that she would be 'alright'.

Pargament (1997) argued that part of the power of spirituality as a resource lies in its ability to appraise events from a different vantage point. Part of Chloe's experience supports this. For example, she described how mindfulness enabled her to detach from her thoughts and engage with her body in a more rational way. Consequently, she was able to appraise her body from a different vantage point. Additionally, Chloe described how mindfulness enabled her to 'embrace the beauty' in her environment<sup>8</sup>. This inner resource seemed to assist her to appraise her environment from a different view point. This also bears a slight similarity to a principle in Gestalt psychology, the figure/ground perception. Without claiming extensive Gestalt transformations for Chloe, I speculate that her mindfulness experience may have enabled her to shift her view, moving more easily between the foreground and background of experience in ways that made her personal awareness and experience of the 'spiritual' in her life, in this case seeing the beauty in her environment as more apparent.

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<sup>7</sup> Refer to quote in analysis, Holly, 1070-1078.

<sup>8</sup> Refer to quote in analysis, Chloe, 659-674 & 682-687

#### **4.3.1.2 Spirituality: Implications for Counselling Psychology**

Whilst the World Health Organisation has identified spirituality to be an important component of health, Hart (2008) states that it divides clinicians on the role it plays and should play in therapy. For example, Lawrence and Min (2002) view the joining of spirituality and medicine as 'facile and ill-defined', in contrast to Puchalski (2001) who suggests that a dialogue about spirituality can contribute towards understanding the patient, as well as strengthen the therapeutic relationship. In addition, Miller and Thoresen (2003) argue that spirituality as a term tends to elude tight operational definition with which I agree. For example, whilst many of the participants constructed mindfulness as involving a spiritual dimension, at times, it was difficult to adequately define the ways in which they did this. Miller and Thoresen argue, therefore, that it is often easier to point to what is not (i.e., something material) than to what it is, and this too contributes towards dividing clinicians on its use in therapy.

Southwick, Vythilingam and Charney (2005) suggest that there is consistent evidence that spirituality can contribute to emotional well-being and can provide resilience to stress. A small number of clinical studies have shown that mindfulness-based stress reduction is associated with increased aspects of spirituality, including personal faith, meaning and peace, and a sense of engagement and closeness with some form of higher power or God (Astin 1997; Birnie, Speca, & Carlson, 2010; Carmody, Reed, Kristeller, & Merriam, 2008; Shapiro et al. 1998). Underwood and Teresi (2002) for example, found that spiritual experiences also may be related to greater quality of life. Carmody et al. (2008) reported that a change in spiritual well-being following mindfulness-based stress reduction was correlated with a change in mindfulness and distress.

These studies show that spirituality can play a role in promoting health. As counselling psychologists are concerned with promoting well-being in the individual, a dialogue on spirituality may be helpful to clients during the course of their therapy. Therefore, the question, "what training if any should psychologist and other health professionals receive on spirituality", is currently being asked by Thoresen and Harris (2002) for example. The researchers argue that the topic deserves at least some attention in professional training. According to Larimore et al. (2002) part of the problem with the incorporation of basic spiritual interventions into health care has been the confusion associated with the terms

spirituality and religion. Miller and Thoresen (2003) and Thoresen and Harris (2002) propose that religion and spirituality can be described as overlapping constructs, sharing some characteristics, yet retaining non-shared features. As described earlier, spirituality is multi-layered and therefore, involves multiple definitions, which contributes to the lack of incorporation into health care.

However, Hart (2008) suggests that having a dialogue about spirituality can enable the clinician to begin to learn whether or not the client uses spirituality as part of a coping and support system and what role spirituality may play in medical and/or therapy decision making. In terms of the client's beliefs and practices, the primary goal of the therapist according to Liebert (2008) should be to define what the client finds supportive or important and then to encourage such healthy practices; rather than introducing one's own thoughts or belief systems into the client's life. Liebert (2008) further suggests that having a clear and ethical plan about how to address the issue of spirituality with clients is important. She suggests that it is not the role of the therapist to shape the spiritual life of the client; however, it is the therapists' role to inquire about the spiritual life of the client as a person who cares about their beliefs and support systems.

In the National Institute of Health Research (NIHR) report, Mathews, Koenig, Thoresen and Friedman (1998) cited studies which provided some evidence to link spirituality (broadly defined), with health factors. One study by Harris, Dew, Lee et al. (1995) examined the impact spirituality had on forty adult heart-transplant patients. The study found improved self-esteem and lower anxiety and health related worries for those participants who engaged in religious/spiritual activities one year after surgery. Another study by Frankel and Hewitt (1994) found a better perceived health and less medical service utilisation by patients who engaged in spiritual activities. However, there are a number of limitations with these studies, many were based on selective samples in terms of participants' characteristics (e.g., ethnicity, education and health status) in addition to the area from which they were drawn, (e.g., southeast region of the United States) therefore, it is hard to generalise the results to the wider population.

### **4.3.2 Relational Components of Mindfulness: Empathic Connections**

Having discussed the spiritual dimension of mindfulness, attention is now turned to its relational component, a master theme derived from the analysis. Attention is paid to one subtheme in particular, 'enhancing the therapeutic relationship', with a focus on empathic connections. As highlighted in the analysis, some of the participants described their experience of mindfulness as increasing empathic connections with their clients. Given the importance of empathy in therapeutic work, I felt it was important to pay attention to this in my discussion section. Empathy has been defined as "the attempt by one self-aware self to comprehend nonjudgmentally the positive and negative experiences of another self" (Wispé, 1986, p. 318). Block-Lerner, Adair, Plumb, Rhatigan and Orsillo (2007) observe that inherent in Wispé's definition, is a degree of self-awareness, which the authors note is also a crucial component of the process of mindfulness.

Empathy as a construct has received considerable attention in the counselling literature generally, but specifically within the domain of humanistic therapeutic approaches such as client-centred therapy, developed by Carl Rogers. Rogers (1992) considered empathy to be one of several "necessary and sufficient conditions" of psychotherapeutic change and defined it as, "to sense the client's private world as if it were your own, but without ever losing the 'as if' quality", (Rogers, 1992, p. 829).

Taking the construct further, Davis (1983) identified four distinguishable components of empathy. The first, Perspective-Taking (PT) is the cognitive ability to take on the psychological perspective of another person. The second, Empathetic Concern (EC) is experiencing "other oriented" feelings of sympathy and concern for others' misfortune. The third, Personal Distress (PD), involves one's own feelings of discomfort and anxiety in emotional social situations; and the fourth, Fantasy (FS) is the tendency for one to transpose oneself into the thoughts and feelings of fictitious characters in books, plays, and movies. It is commonly agreed that mindfulness involves awareness which is non-judgmental and grounded in the present moment (i.e., Kabat-Zinn, 1994). According to Block-Lerner (2007) each of these facets of the process of mindfulness (i.e., attention or awareness, non-judgmental or accepting nature of this awareness and present moment focus) may be seen as fostering the development and/or maintenance of aspects of empathic responding.

In the current study, Felicity demonstrated that mindfulness enabled her to develop the Empathic Concern (EC) component identified by Davis (1983). She described that she was able to feel concern for her client's experience, and sense their sadness without ever losing the 'as if' quality<sup>9</sup>. In a different way, Beth presented an account which showed that mindfulness enabled her to develop the Perspective-Taking (PT) component identified by Davis (1983). She described that she was able to take on the psychological perspective of her clients, in particular in their struggle with their mindfulness practice<sup>10</sup>. Block-Lerner et al. (2007) suggests that mindfulness, the non-judgmental present-moment awareness of one's own emotions would seem to facilitate aspects of empathic responding. In particular, the capacity to take another person's perspective (PT) and to feel concern for others (EC), elements central to Davis's (1983) depiction of empathy. These aspects of empathy were demonstrated in Beth and Felicity's accounts of mindfulness, supporting Block-Lerner et al.'s. (2007) assumption that mindfulness can facilitate empathic responding. The findings from the current study support those reported by Morgan et al. (2010). In their qualitative review, the researchers found that some participants reported increased empathy for their clients through the practice of mindfulness. In addition, although Rothaupt and Morgan (2007) did not specifically discuss empathy in their findings, they did however; report that participants experienced feeling more connected to others through the practice of mindfulness. This highlights the importance of the relational aspect of mindfulness reported in the current study.

Empathy is of particular interest to counselling psychologists. For example, Block-Lerner et al. (2007) suggests that the capability to empathically respond puts one at a greater advantage in the development of deeper interpersonal relationships. Establishing deeper interpersonal relationships is paramount in therapy as research has consistently shown that effective therapists are best distinguished in terms of effectiveness by their ability to relate to their clients (Lambert & Barley, 2001; Lambert & Okishi, 1997). The psychologists in this study reported an increase in their empathic connections with their clients while using mindfulness. As such, introducing mindfulness in training courses for therapists has the potential to help them develop deeper interpersonal relationships with their clients.

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<sup>9</sup> Refer to quote in analysis, Felicity, 268-274

<sup>10</sup> Refer to quote in analysis, Beth, 620-622

To date, two preliminary studies support the efficacy of mindfulness-based methods on empathy. The first of these is a study by Shapiro, Schwartz and Bonner (1998). The researchers evaluated the efficacy of an 8-week Mindfulness-Based Stress Reduction (MBSR) programme in pre-medical and medical students. The researchers found that in addition to reducing anxiety and overall psychological distress, MBSR significantly increased participants' levels of empathy, relative to a wait-list control group.

The second is a study by Carson, Carson, Gil and Baucom (2004). The researchers used a randomised wait-list controlled design, to evaluate the effects of a novel intervention, mindfulness-based relationship enhancement, designed to enrich the relationships of relatively happy, non-distressed couples. Carson and his colleagues adapted the MBSR protocol to include mindfulness exercises specifically aimed at enhancing intimate relationships. These included an emphasis on loving-kindness meditation, partner yoga exercises, and mindful touch exercises. This innovative intervention approach was demonstrated to increase couples' reported satisfaction, relatedness, and acceptance, among other relationship related and individual (e.g., optimism, spirituality) positive outcomes. It is important to note that while these researchers did not specifically measure empathic responding, Block-Lerner et al. (2007) suggest that one can imagine that their intervention led to increased perspective-taking and empathic concern between members of the couple.

Whilst these studies demonstrate efficacy of mindfulness-based methods on empathy, they were not based on the therapists' experience, therefore, it is suggested more research on therapists' experience of mindfulness and its impact on empathic responding to their clients are needed.

#### **4.3.2.1 Empathy: Implications for Counselling Psychology**

Mindfulness-based methods have the potential for developing and optimizing clinically beneficial relational qualities in a therapist such as empathy. Empathy has been of interest to therapists of all orientations, given its reputed positive effect on the therapeutic relationship (e.g., Greenberg, Watson, Elliott & Bohart, 2001). Burns and Nolen-Hoeksema (1992) for example, found that empathy strongly predicted clinical improvements among depressed patients receiving CBT. In addition, empathy is proposed to be a necessary, though not sufficient condition, for therapeutic change and growth (Hubble, Duncan, & Miller, 1999).

Participants' accounts of mindfulness in the present study suggested that it increased empathic connections with their clients. This advocates that mindfulness approaches might be valuable and useful adjuncts to existing empathy training in counselling psychology.

#### **4.3.3 Doing Mindfulness: Preaching What You Teach - Advice for Novice Mindfulness Therapists**

The analysis revealed that participants believed it was important for the therapist to have their own personal practice or 'taste' of mindfulness before introducing/sharing it with clients. In this way, the findings from the current study resonate with those reported by Cigolla and Brown (2011). The researchers found that participants emphasised the experiential nature of mindfulness and the necessity to practice it in order to understand it and encourage a way of being in others. Crane, Kuyken, Hastings, Rothwell and Williams (2010) propose that this personal 'taste' or experience on the part of the therapist can be regarded as the 'embodiment of mindfulness' by the therapist.

To date, only one quantitative study by Grepmaier, Mitterlehner, Loew, Bachler, Rother and Nickel (2007) has examined whether, and to what extent, promoting mindfulness in psychotherapists in training (PiT) influences the treatment results of their patients. The researchers compared the therapeutic course and treatment results of 124 inpatients, who were treated for 9 weeks by 18 psychotherapists in training. The psychotherapists in training were randomly assigned to 1 of 2 groups: (i) those practicing Zen meditation (MED; n = 9 or (ii) control group, which did not perform meditation (noMED; n = 9). The results showed that, psychotherapists in training, practising 30-min Zen meditation at the beginning of the day, were more positively evaluated by their patients than therapists without daily meditation practice.

Only one qualitative study to date by van Aaldern, Breukers, Reuzel and Speckers (2014) has explored the role of the mindfulness-based therapist from the perspective of both client and therapist. By reporting the findings of the research, I am only concerned with the therapist perspective as this is most relevant to the current research. Aaldern et al. (2014) found that therapists in their study emphasised the importance of 'internalising', 'embodying or living' the method, some underscored the importance of formal meditation or exercises, while other therapists spoke about having a 'mindful attitude'. For example, the findings showed that

some therapists viewed that meditation experience is essential for the therapist and that “You can only embody mindfulness when you practice yourself”. This is very similar to the experiences of the participants in the present study in that they also accentuated the importance of the therapist having their own personal ‘taste’ of mindfulness practice. This finding from the current study resounds with those reported by Christopher et al. (2011) who found that counsellors and psychotherapists indicated the importance of continual engagement with mindfulness practices throughout their lives. The researchers found that participants reported that engaging with their own mindfulness practices enabled them to teach their clients some of the mindfulness principles that they had learned.

Crane et al. (2010) suggest that having a personal practice of mindfulness is important and that it is through their own personal mindfulness practice that the therapist develops familiarity and confidence in the use of mindfulness as an effective and tenable way of working with personal challenges. The researchers argue that this confidence gained from a personal mindfulness practice becomes an important ingredient, which enables the therapist to persist when supporting clients who are struggling with the challenges inherent with bringing mindfulness to their experience. Crane et al. (2010) suggest that the depth of experience that the therapist has in exploring their own personal process through their mindfulness practice is thus held to be directly related to their ability to ‘meet’ their clients in a session. This means the therapists ability to create a space in which clients can explore their experience in compassionate ways.

Participants in the current study emphasised the importance of personal practice on the therapists’ part. Beth for example, advocated this and acknowledged that while the therapists’ process might be ‘completely different’ to the client’s, she highlighted that is important for the therapist to “know inside just as much as from your kind of intellectual learning”<sup>11</sup>. Beth suggests that a direct knowing or personal experience is crucial to understanding a clients’ experience.

Crane et al. (2010) suggest that therapists are effectively not in a position to facilitate others in cultivating mindfulness, if they themselves have not brought it into their personal way of living and working. This provides support for Ewan’s view on the importance of a therapist

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<sup>11</sup> Refer to quote in analysis, Beth-589-593.

having their own mindfulness practice. He views it as an 'ethical duty' for the therapist to have a personal practice of mindfulness before sharing it with clients. Similar to Beth, although he recognises that the therapists' experience is different to that of the clients', he acknowledges that by having a personal practice, the therapist will have at least "entered similar terrains" as the client<sup>12</sup>.

Finally, participants in the current study expressed that it takes time to understand mindfulness. Amy for example, said: "And it really takes time for them to truly understand, you know, as it took me a lot of time as well"<sup>13</sup>. Van Aaldern et al. (2014) found that therapists in their study said that internalisation is not achieved at once, but has to be recaptured by daily practice; for example, that: 'The method must become part of yourself, that does not happen overnight'. This suggests that using mindfulness ultimately takes time.

#### **4.3.3.1 Advice for Novice Mindfulness Therapists: Implications for Counselling Psychology**

According to Crane et al. (2010) all psychological approaches place a strong emphasis on the importance of rigorous therapist training. For example, in a review of several studies, Shafran, Clark, Fairburn, Arntz, Barlow, Ehlers et al. (2009) found evidence to suggest that certain training methodologies and longer trainings for Cognitive Therapy trainees deliver more effective outcomes for clients. Crane et al. (2010) argue that mindfulness-based interventions are no different. The researchers argue that Kabat-Zinn placed importance on the quality of the teaching (and therefore the training of the therapist) as a key ingredient associated with the delivery of successful outcomes for clients. As such, emphasis is placed on the therapist's embodiment of the key therapeutic ingredient of mindfulness, and their personal practice supports this.

Alongside developing competence in the 'technicalities' of delivering the approach, Crane et al. (2010) suggest that therapists engage in a highly personal process of exploring their own experience through the lens of their mindfulness practice on a continuing basis. The researchers argue that this signifies a shift in emphasis from a CBT approach for example, in which there is a strong emphasis on the therapist developing skill and expertise, but less on

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<sup>12</sup> Refer to quote in analysis, Ewan, 1219-1224.

<sup>13</sup> Refer to quote in analysis, Amy, 395-397.

personal practice as an essential aspect of the therapeutic encounter. Participants in the present study advocated the importance of the therapist having a personal experience of mindfulness. However, van Aaldern, Breukers, Reuzel and Speckers (2014) note that despite the literature emphasising the importance of the therapist having an ongoing experiential engagement with mindfulness practice as well as theoretical knowledge in order to be effective as a therapist, there has been little systematic investigation of the role of the mindfulness therapist. As such more research is needed in this area.

#### **4.4 Reflections on Quality and Avenues for Future Research**

As outlined in the methodology chapter, evaluating the quality of qualitative research is a contested issue, as traditional criteria for evaluation are often inappropriate. In addition, Yardley (2000) argues that the ethos and plurality of many qualitative methodologies are incompatible with fixed, universal procedures and standards. Yardley (2000) nonetheless, argues that, some way of assessing the quality of research employing qualitative methodologies are essential. As such, Yardley (2000) has outlined four characteristics of good qualitative research, which have been considered throughout this research. These are 'sensitivity to context', 'commitment and rigour', 'transparency and coherence' and 'impact and importance'. I have considered these four characteristics, as I believe them to be appropriately flexible to be adapted to this specific study. I will briefly summarise and discuss these characteristics in relation to the present project.

##### **Sensitivity to Context**

Reviewing the comprehensive literature on the phenomenon ensured an initial sensitivity to the theoretical context. This facilitated me to be familiar with the current conceptual ideas and discourses in the field of mindfulness. My work in an NHS Trust where mindfulness meditation is taught to therapists to use in their work with clients as well as my own personal experience facilitated an introduction to the context of this study. Through personal reflection, I have strived to remain aware of the social context of the relationship between myself and the participants. In addition, ethical issues have been considered throughout to ensure that this study is sensitive to the experiences of each individual participant and protects them within the context of this study. As encouraged by Yardley (2000), in this chapter additional scholastic tools, such as theory, have been drawn from in order to address

findings in a wider context that hopefully makes the analysis more thoughtful and far reaching.

### **Commitment and Rigour**

Evidence of 'commitment and rigour' has been provided throughout this thesis, particularly in the Methodology chapter. This has predominantly been demonstrated through the in-depth engagement with the topic both in interviews and particularly during the analysis stage. The rigorous and committed process is illustrated in the analysis chapter for example, where themes remained rooted to the texts of the participants. I also met with my supervisor on numerous occasions throughout the analysis stage to explain my process of establishing themes. In essence our meetings took on the form of triangulation, whereby; my supervisor interrogated these processes and provided feedback on the labelling of the themes. My supervisor had an awareness of the topic, however, she had not engaged fully with the transcripts, I believe this gave her a different and an outsiders perspective, which I found invaluable to the analysis and research process overall.

### **Transparency and Coherence**

The transparency of the analysis process is clearly shown in the methodology and analysis chapter. Additionally, I have stated, reflexively, the thoughts and feelings that I came into this research with, with the intention of providing a transparent and explicit account of my position as the researcher. Lastly, coherence is demonstrated in the clear fit between the theory and method that were employed in this study and the presentation of a clear rationale for them.

### **Impact and Importance**

The impact and the importance of this study remains a key aspect of the research. Whilst there has been an upsurge of development and interest in clinical approaches based on mindfulness meditation, there has been little research on the therapists who use them and their experience of the phenomenon. As such, this research has the potential to produce clinical implications for counselling psychologists using mindfulness in their clinical practice. It is hoped therefore, that articles will be published in psychology journals for this reason.

Therefore, the clinical implications for the field of counselling psychology have been highlighted throughout discussing the findings of the study.

#### **4.4.1 Reflections on Design and Future Research**

The current study has several limitations, one being the small scale of it. However, it is argued that the willingness of the participants to open up and share their experiences provided a rich quality of data in spite of its small scale. In addition, the resolve to complete rigorous and in-depth analysis of every transcript ensured quality was not sacrificed for the generation of more data. It is however, important to consider that those who participated were either recommended or came through via a poster distributed in a workshop. It might be that these individuals were highly motivated and may have had a particular experience with the topic; as a result, the study may have possibly appealed to a group of people who may have had a more positive view towards mindfulness.

It is also worth mentioning that only one man participated in the study. This may very well reflect the gender disparity in counselling psychology. Whilst this research aimed to give voice to counselling psychologists who use mindfulness in their practice, the male voice is less represented. In addition, all of the participants described themselves as Caucasian, although other ethnicities were included in the recruitment criteria, none volunteered for participation. This also limits the extent to which this research represents the voices of counselling psychologists who use mindfulness in their clinical practice. It is suggested therefore, that future research could potentially carry out a similar study to this one, to include more male participants as well as the inclusion of participants from other ethnic backgrounds. This diversity could shed further light on the phenomenon and provide additional insights into a wider range of experiences, and therefore account for these limitations.

Smith et al. (2009) advise that a relatively homogenous sample is used in IPA studies. The sample in this study was homogenous in respects of being counselling psychologists with a shared experience of mindfulness; however, the participants were also heterogeneous in some ways. One of these was the length of time they had been using mindfulness in their personal lives and professional practice. As this study was looking into the experience of qualified counselling psychologists who had been using mindfulness for at least one year, it

was assumed that the length of practice was not deemed to be relevant. However, after the analysis it was found that those who had been using it for a longer period of time describe it in qualitatively different ways. A larger scale investigation could compare these two groups when considering the meanings participants make of their mindfulness experience.

The use of the interview proved to be an adequate tool for data collection. It enabled me to establish a good rapport with the participants and hear their lived experience. As the knowledge that I have produced was intended to be my interpretation of participants' subjective experience, I suggest that my experience of establishing a good rapport with the participants enabled me to add texture to the analysis. Overall, I believe that the participants and I developed a rapport which was characterised by trust, acceptance and kindness in the interviews. I believe that this contributed to make them feel more comfortable, and as the interviews evolved, they were able to openly share their experiences with me. This drew from my skills (empathy, reflective listening) as a practitioner and I consider it to be a strength of the study.

However, I also recognise that there may be some limitations to being warm and accepting of participants' accounts. For example, I observed myself not challenging Beth during her interview. At the beginning of her interview, Beth made a reference to first, second and third waves of therapy, her reference however, was unclear. Rather than challenge her to provide a clearer explanation, I let her continue her account without a challenge. A deeper meaning and interpretation may have been achieved if I had been able to challenge Beth's account.

#### **4.4.2 Reflections on Analysis: Methodological challenges**

As already discussed in the methodology chapter, IPA was chosen for its potential to provide meaningful answers to my research question and for its propensity to generate the type of knowledge that I hoped to produce. I adopted a critical realist perspective, with the view to produce an account of my meaning making of the subjective experiences of individuals located in a 'real' world. Despite this zest, I am mindful of its limitations. Willig (2013) suggests that like all forms of phenomenological research, IPA has conceptual and practical limitations and identifies three major limitations to IPA. These will be outlined and responded to in relation to the current study.

Willig (2013) argues that a significant limitation of IPA is its reliance on the representative validity of language; that language does indeed provide participants with the tools to conceptualise and describe their lived experience. Additionally, it assumes that language provides the researcher with the tools to sufficiently capture participant's experience. It is fair to say participants in the study were highly educated and given the nature of their profession were very able to articulate their experiences. Nonetheless aspects of their accounts showed that language did seem to fall short of communicating their experiences at times. For example, when asked to provide a meaning of mindfulness, participants communicated difficulties in defining this experiential concept. One used the metaphor, 'like nailing jelly', to communicate his struggle, suggesting that participants did not always have the language to adequately give meaning to their experiences.

In addition to this, I found it difficult at times to find suitable words for some of the themes that would adequately, describe my participants' experience. At times I felt that the language I was using did not sufficiently capture participant's experience of the phenomenon, for example, subtheme 3.2.3, 'opening up to new experiences. This highlights the potential for language to fall short of capturing the essence of the experience. As such, the development of more creative and imaginative methods of including non-verbal data such as pictures and sculptures in analysis would be welcomed, although I cannot conceive how this might have been done in relations to the present study.

An additional limitation with the IPA method is the challenge of obtaining suitable accounts. Willig (2013) argues that participants' creation of these accounts requires insight and sophistication of understanding from the participant. Whilst I recognise the pertinence of this challenge, I believe however, that it is an issue relevant to most qualitative approaches. The difficulty of achieving and accessing reflexivity, and of gaining nuanced accounts which sufficiently capture lived experience, is not unique to IPA. Therefore, even if another approach was chosen, this problem would still remain. I believe however, that the sample group (counselling psychologists) selected for this research were able to provide suitable accounts. This is due to the fact that the profession requires individuals to have insight and a sophisticated understanding; thus, while there is a limitation with obtaining a suitable account, I believe participants in the study were successfully able to communicate the rich texture of their experiences to me.

A final limitation with IPA raised by Willig (2013) and Langdridge (2007) concerns the phenomenological status of IPA. The researchers suggest that this problem seems to lie in the role of cognition. Langdridge (2007) proposes that cognition is not properly a part of phenomenology, which is more appropriately focused on the pre-reflective characteristics of experience such as feelings and moods on the edge of consciousness. I however, agree with the arguments put forward by Smith et al. (2009); that experience contains both pre-reflective and reflective activity, and both are proper subjects of attention in phenomenology. Therefore while research may strive to uncover perceptions which have previously not received conscious attention by participants, it will also attend – as part of the effort to understand being-in-the-world – to those embodied cognitions with which an individual approaches a phenomenon.

#### **4.4.3 Personal reflections: Impact of author on research**

##### **My position as an ‘insider’**

Coming into the research, I engaged in a process of reflexivity by keeping a reflexive diary during the data collection and analysis. This was in an attempt to remain aware of my own pre-existing knowledge, attitude, and assumptions, and how I could prevent them influencing the results. However, I am convinced that my position as an ‘insider’ to the experience of my participants influenced both data collection and analysis.

As a person who uses mindfulness in my daily living, and as a clinician who is interested in its clinical applications, it is fair to say that I have a personal and intimate knowledge of the research subject. In some respects, I believe this closeness to the subject and personal experience enabled me to have a genuine interest, whilst adopting curiosity towards the participants’ experience. I believe that my personal knowledge of the subject and ‘sameness’ or ‘similarity’ with the participants allowed them to feel more comfortable sharing certain aspects of their experience with me, and also assisted me to apply this knowledge to place their material into context.

It is important to note however, that at times during the analysis stage; my knowledge of the subject affected the themes being generated. For example, I had to refrain from quickly categorising participants’ experiences and allow myself to be led by the data. Through reflexivity I was, however, able to step away and let my participants experience guide me in

establishing the themes. I had to pay close attention to the descriptions and language participants used to ensure that the themes were grounded in the data provided by my participants.

During reflexivity, I also considered what my impact on the interview might have been if I had been an 'outsider' to the participants' experience. Perhaps they might have been more descriptive in their accounts. However, it could have also made it more difficult for the participants to open up about their mindfulness experience, particularly on the spirituality dimension as they might have feared being judged. It seems therefore, that whatever form it takes and however it reveals itself, researchers do indeed influence their results. Thus, rather than identifying my impact as positive or negative, I regard it as the 'necessary preconditions' for me making sense of the participant's experience and because it has been mindfully considered, I position it as an important part of the findings.

#### **4.4.4 Reflexive statement**

Engaging in this research topic had a number of personal effects on me. Firstly, I had not previously considered that my own mindfulness experience contained a spiritual dimension and how this might have influenced my outlook on life. Hearing my participants' accounts has, therefore, made me reflect more deeply and thoughtfully about my own experience. I acknowledge that my mindfulness experience has led to a personal transformation which I now regard as spiritual in nature and which I believe to be the most profound of my own experiences.

Participant's description of how a consequence of the process of opening up enabled a deepening sense of gratitude and appreciation had a particularly strong impact on me. This is because for the past few years I have been future focussed with regards to my career and qualification as a counselling psychologist, rather than accepting my present situation as a trainee. At times, this has contributed to experiences of self-criticism, anxiety and frustration. However, I have learnt from my participants' experiences of gratitude and appreciation that 'I have so much' in the present moment, as Gabby pointed out in her own experience. This realisation has allowed me to 'let go' of future striving and become grounded in my present moment experiences. This brings a sense of calmness and peace to my present moment experiences and consequently, I am able to appreciate how things are right now.

#### **4.5 Conclusion**

The analysis presented in this study revealed that mindfulness can contain a spiritual component for the majority of the psychologists who practice it and that this spiritual dimension involves a process of self-transformation for the individual. The spiritual component was constructed in varying ways, suggesting that spirituality is multidimensional and defies simple clear-cut boundaries, yet affects participants' personal and professional lives in important ways. Participants conveyed their mindfulness experience as a journey of psychological growth which had transformative effects and as such mindfulness was brought into their clinical practice and 'experienced together' with their clients. This had a positive relational impact such as enhancing empathic connections between the therapist and their clients. The analysis also revealed that it may be helpful for the novice mindfulness therapist to have a personal or 'embodied' practice of mindfulness before introducing it into the therapeutic space and sharing it with their clients.

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## Appendices

### Appendix 1: Recruitment Flyer Advertising for Participants

- **Are you a qualified Counselling/Clinical Psychologist?**
- **Do you use Mindfulness-based approaches in your personal life and therapeutic practice?**
- **Would you be willing to talk about your experiences of using mindfulness-based approaches with me?**

My name is Jennifer Opoku. As part of a doctorate in Counselling Psychology at City University, I am carrying out research into qualified Counselling/Clinical Psychologists' experience of using mindfulness-based approaches in their therapeutic practice, prompted by my own interest in using this approach in my therapeutic work with clients. All my research is confidential and would involve an interview carried out on a one-to-one basis. The research findings will help us to better understand the challenges and opportunities associated with the use of mindfulness approaches in therapy.

If you think you might be interested, or would like to find out more, please contact me on [REDACTED] or email me at [REDACTED]. Thank you!

This research is supervised by Professor Carla Willig, Chartered Counselling Psychologist (telephone [REDACTED]; email [REDACTED]).



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## **Appendix 2: Information sheet for participants**

### **The researcher**

My name is Jennifer Opoku. This research project is being carried out as part of my doctorate in Counselling Psychology at City University. I am undertaking a research project on qualified Counselling/Clinical Psychologists' experiences of using Mindfulness-based approaches in their personal lives and therapeutic practice.

### **Purpose of the study**

The research aims to explore qualified Counselling/Clinical Psychologist's experience of using mindfulness-based approaches in their personal lives and therapeutic practice. The research findings will help us to better understand the challenges and opportunities associated with the use of mindfulness approaches in therapy.

### **What does participation involve?**

Participation is entirely voluntary and free. Should you decide to participate, you will be asked to sign the research consent form, which complies with the British Psychological Society's guidelines. You will be asked to complete some background information and we will explore your experiences of using Mindfulness-Based approaches in your personal life and therapeutic practice in a one-to-one research interview which will take approximately 1 ½ hours. The interview will take place in a room at City University. I will ask you some questions and you will have the opportunity to share your experiences about using mindfulness based approaches in your personal life and therapeutic practice. This may include ways in which mindfulness based approaches has negatively or positively impacted on your therapeutic practice. You are free to refuse to answer any question, and can withdraw from the study at any time, including in the middle of the interview, should you wish.

## Information sheet for participants (cont.)

### **What will happen to the information collected and confidentiality?**

The interviews will be audio-taped so I have an accurate record of our conversation.

Everything which we talk about in our interview will be treated as confidential, and will be guided by professional standards laid down by my professional body, the British Psychological Society. This means that your identity and participation will be known only by me. When the research is written up and sent for publication, no names or identifying details will be included in any document. With your consent, I will delete your identifying details following completion of this research.

### **Who can take part?**

Qualified Counselling/Clinical Psychologist who uses Mindfulness-Based Approaches in their therapeutic practice.

### **What are the benefits of taking part?**

By partaking in this research, you will have the opportunity to share your experiences of using mindfulness-based approaches in therapy. Furthermore, the research findings will help us to better understand the challenges and opportunities associated with the use of mindfulness approaches in therapy.

### **Appendix 3: Consent Form**

This research project is being carried out as part of my doctorate in Counselling Psychology at City University. It is guided by the research principles of the British Psychological Society, and the project is supervised by Professor Carla Willig, Chartered Counselling Psychologist. I am interested in hearing about your experience of using Mindfulness-Based approaches in your therapeutic practice.

Thank you for taking part in this research project. We will explore your experiences of using Mindfulness-Based approaches in your therapeutic practice in a one-to-one research interview which will take approximately 1 ½ hours. So that I have an accurate record for the research, the interview will be audio-taped. This audio-tape will then be transcribed.

The tape and transcript will only be listened to and read by those directly involved in the research project. Short passages from the interview may be used in the final write-up of the research. However, in all such instances – including tape, transcript and final write up – your confidentiality will be preserved. All identifying details such as names will be removed from all relevant items. The data you provide will be treated and stored in a confidential manner.

Finally, I would like to emphasise that your participation in this research is voluntary. You are free to refuse to answer any question, and can withdraw at any time.

**I agree that the purpose of this research and the nature of my participation in this research have been clearly explained to me in a manner that I understand, and that I have had the opportunity to ask any questions that I might have. I therefore consent to take part in an interview about my experiences of using mindfulness-based approaches in my therapeutic practice and consent to this research being audio-taped, transcribed and used for the purpose of research.**

Signed: .....

Printed: .....

Date: .....

Consent form (cont.)

On behalf of those involved in this research, I undertake that confidentiality will be ensured with regard to any material presented from this research. This material will be used for the purposes of research only and the anonymity of this interviewee will be protected at all times.

Signed: .....

Jennifer Opoku

As discussed, I would be very happy to share the findings of this research with you, and would welcome your feedback on the findings.

Would you like a report of the results of the project? Yes/No

How would you like to receive this report? Email/Post

Postal or email address for those asking for a report:

.....  
.....

I would be grateful if you would sign both copies of this consent form. One copy will be for you to keep.

Contact Information:

Researcher: Jennifer Opoku

.....  
.....

Supervisor: Professor Carla Willig

.....  
.....

## Appendix 4: Optional Socio-Demographic Questionnaire

This research aims to explore qualified Counselling/Clinical Psychologists' experience of using mindfulness-based approaches in their therapeutic practice. In order to help me explain the characteristics of participants as a group, I would be grateful if you would complete the following questionnaire. Your answers will be anonymous and all information will be confidential. Please feel free to leave blank any questions which you do not wish to answer.

D.O.B .....

Qualifications (please tick any you have obtained):

- |                             |                          |                        |                          |
|-----------------------------|--------------------------|------------------------|--------------------------|
| None                        | <input type="checkbox"/> | GCSE/equivalent        | <input type="checkbox"/> |
| Trade Apprenticeship        | <input type="checkbox"/> | A/AS Levels/equivalent | <input type="checkbox"/> |
| Diploma in Higher Education | <input type="checkbox"/> | First Degree           | <input type="checkbox"/> |
| Postgraduate Qualification  | <input type="checkbox"/> | Don't Know             | <input type="checkbox"/> |

How would you describe your ethnic origin? (Please state below)

---

When did you qualify as a Counselling/Clinical Psychologist?

---

How long have you been using mindfulness-based approach in your therapeutic practice?

---

Thank you for completing this form

## **Appendix 5: Interview Schedule**

Thank you for working through all those details for me, do you feel ready to start? As mentioned before, in this interview, I am looking at qualified Counselling/Clinical Psychologists' experience of using mindfulness in their personal and professional lives. I want to understand this from your point of view and try as far as I can to understand the meaning of your experience. So while I will be asking questions, it will be you who is helping me understand your experience of this phenomenon as closely as I can.

I have some questions which I am going to ask you, there is no right or wrong way of answering them. The only thing I am interested in is understanding your experience as much as possible. This means that I may ask you to explain something that appears obvious so that I can get a sense of what it means to you in particular. As well as the questions I will ask you, please feel free to add anything you feel is important to you about your experience of using mindfulness in your practice that I may have omitted to ask you. Please take time to think about what you want to say and do not feel rushed to give an answer straightway.

1. What does the term mindfulness mean to you?
2. Please tell me about your mindfulness practice (-what is it like to use mindfulness personal life, -impact on the therapeutic dynamic, presenting problem, pace of the session etc.)
3. I understand that you bring mindfulness into your therapeutic practice. Would you mind telling me how you do that?
4. How do you think your clients view mindfulness in your sessions?
5. How easy/difficult is it for your clients to apply mindfulness in their everyday living?
6. Are there any advantages/disadvantages of using mindfulness with your clients? - Have you come across any challenges of using mindfulness in your clinical practice?
7. From your experience of using mindfulness in your clinical practice do you think mindfulness works better with a certain client group? If so which?
8. What advice if any would you give to a novice therapist using mindfulness for the first time?
9. Is there anything else you would like to tell me about your experience of using mindfulness before we finish the interview? Thank you so much for taking the time to speak with me.

## **Appendix 6: Debrief**

How have you found taking part today?

Check if participant is showing signs of distress or discomfort.

Consider if he/she looks as if he/she did on arrival, and if not, gently explore (e.g. you are looking a little concerned/upset – has anything we have talked about left you feeling anxious/upset?)

What did you feel, talking about these experiences?

Familiar/unfamiliar thoughts?

Helpful/not helpful?

Do you have any feedback for me about the interview?

Questions make sense? Any parts could have been more clearly explained?

Any questions you feel I should have asked?

Any feedback on ways I handled things that were helpful/not helpful to you?

Ask if happy with current support.

Remind of option to contact me or supervisor in meantime if any issues.

Thank participant for taking part!

## Appendix 7: Ethical Approval

### Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.**

#### Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc  M.Phil  M.Sc  **D.Psych**  n/a

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

**Counselling/Clinical Psychologists' Experience of Using Mindfulness-Based Approaches in their personal and professional lives.**

2. Name of student researcher (please include contact address and telephone number)

**Jennifer Opoku.**

3. Name of research supervisor

**Professor Carla Willig.**

4. Is a research proposal appended to this ethics release form?      Yes

No

5. Does the research involve the use of human subjects/participants?

Yes

No

If yes,

8/12

a. Approximately how many are planned to be involved?

b. How will you recruit them?

**Participants will be recruited through an advertisement placed with the British Psychological Society (PBS). Participants will also be recruited by word of mouth.**

c. What are your recruitment criteria?

*(Please append your recruitment material/advertisement/flyer)*

**Qualified Counselling/Clinical Psychologist who uses Mindfulness-Based Approaches in their personal and therapeutic practice with clients.**

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent?

Yes      No

d1. If yes, will signed parental/carer consent be obtained?      Yes

No

d2. If yes, has a CRB check been obtained?      Yes      No  
(Please append a copy of your CRB check)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? (If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).

Participants will be required to take part in a one-to-one research interview which will take approximately 1 ½ hours. In addition, participants will be asked to complete demographic information.

7. Is there any risk of physical or psychological harm to the subjects/participants?

Yes      No

If yes,

a. Please detail the possible harm?

N/A

b. How can this be justified?

N/A

c. What precautions are you taking to address the risks posed?

N/A

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes          No

*(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)*

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

Yes          No

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes          No

If no, please justify

N/A

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

12. What provision will there be for the safe-keeping of these records?

**I will be keeping a record of participants' demographics, and audio-tape recordings. All records will be password protected, all identify names will be changed in addition; laptop will be locked in a padlocked case.**

13. What will happen to the records at the end of the project?

**All paper records will be destroyed at the end of the research project. All electronic records will continue to be password protected**

14. How will you protect the anonymity of the subjects/participants?

All identifying details such as names will be removed from all relevant items to ensure anonymity.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

Participants will be fully de-briefed. The researcher will ensure that a significant amount of time is available for the provision of psychological support and debriefing at the end of the interview. This will include asking participants about their experience of taking part in the interviews. A full exploration of how participants are feeling and discussion of any areas which they found helpful or uncomfortable will be discussed. The focus of this session may differ for each participant; however, every effort will be made to ensure that participants leave feeling fully supported and positive about their experience of taking part in the research. All participants will be given contact details of the researcher and supervisor, in case they have any further questions post interview. Finally, all participants will be contacted by the researcher 48 hours after the interview to ensure they have all the support they need.

*(Please append any de-brief information sheets or resource lists detailing possible support options)*

If you have circled an item in **underlined bold** print or wish to provide additional details of the research please provide further explanation here:

N/A

Signature of student researcher: .....Jennifer Opoku-----Date ...03/01/2014--

**CHECKLIST:** the following forms should be appended unless justified otherwise

- Research Proposal
- Recruitment Material
- Information Sheet
- Consent Form
- De-brief Information

## Section B: Risks to the Researcher

1. Is there any risk of physical or psychological harm to yourself? Yes

**No**

If yes,

a. Please detail possible harm?

N/A
-----

b. How can this be justified?

N/A
-----

c. What precautions are to be taken to address the risks posed?

N/A
-----

## Section C: To be completed by the research supervisor

*(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to*

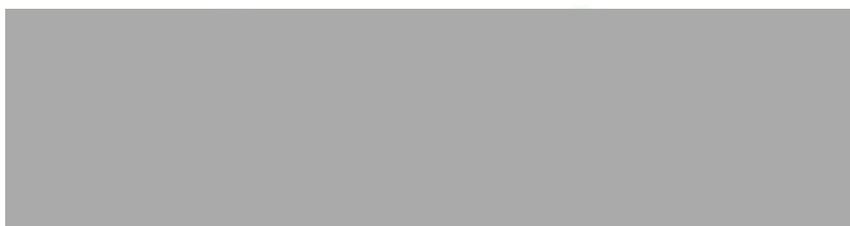
*be appended to this form. If in any doubt, please refer to the Research Committee.)*

Please mark the appropriate box below:

Ethical approval granted

Refer to the Department's Research and Ethics Committee

Refer to the School's Research and Ethics Committee



Signature ----- Date: 24/1/14

**Section D: To be completed by the 2<sup>nd</sup> Departmental staff member**  
*(Please read this ethics release form fully and pay particular attention to any answers on the form where underlined bold items have been circled and any relevant appendices.)*

I agree with the decision of the research supervisor as indicated above

Signature -----  Date -----24/1/14

---

## Appendix 8: Example Transcript

Transcript: Gabby, Duration, 46: 07

34 Mmm. You mean me personally or in work with patients?

35

36 You personally.

37



66 well is one of the things erm, so if you kind of notice that you are  
67 getting into say a kind of rumination cycle, so I just stop and either  
68 remind myself or clients to be erm mindful and then it is easier to  
69 do. When you take that step back.

70

71 Mmm. So you're stopping you're saying and observing?

72

73 Yeah. And I guess, because sometimes maybe you have to  
74 consciously stop first (pause), to remind yourself. Other times it is a  
75 bit more automatic (pause). But I guess it becomes more automatic  
76 with practice (pause)

77

78 Uhm.

79

80 I think you still, there are still, there are still times when you have to  
81 be quite conscious before you go into

82 the kind of (pause).

83

84 So mindfulness is about conscious stopping as well.

85

86 Yeah, I suppose, yeah. Being conscious of, although it's not, the  
87 process of mindfulness is about not sort of necessarily trying to stop  
88 anything, you know it is (pause). So it sounds perhaps like I'm  
89 contradicting myself a bit but, but um, I think it is just that we  
90 sometimes tend to forget, to do that so yeah when we stop it is  
91 easier to then start. Just be in that present and observe.

92

93 Absolutely, thank you.

94

95 Yeah.

96

**Appendix 9: Example Transcript: Left and Right Margin  
Annotations on a Section of Beth's Transcript**

Initial Noting	Interview Transcript	Emergent Themes
<p><i>Power dynamics between therapist and client. Use of 'role of the expert'. Suggests that role of mindfulness therapist is to empower the client.</i></p> <p><i>Doing mindfulness practice for herself seems important, makes her humble, but to what?</i></p>	<p>Yes. And I mean obviously then it would keep you as a therapist in a role of the expert rather than of erm the person empowering the client. Erm, (pause) yes. And I do think that doing mindfulness, doing the practice yourself as a therapist really makes you humble in a way to, yeah doesn't it.</p>	<p><b>Impact of mindfulness on the client/therapist relationship</b></p> <p><b>Therapist's personal practice of mindfulness-Humble</b></p>
	<p>What does it make you humble to?</p>	
<p><i>Makes her humble, this almost feels like mindfulness brings her closer to her feelings and it also helps her to stay/sit with pain or uncomfortable feelings</i></p> <p><i>Her own experience of mindfulness seems to help her 'know' / (repetition of 'know x 2) understand/ identifies with her clients' struggles/difficulties-seems to be encouraging clients not to give up. Sense of a relationship here. Tone is animated.</i></p>	<p>Well it makes you humble to erm, your own vulnerability and being able to sit with that, with your own pain, or your own stress or your own inability to stop the thoughts, or your own... So when your client tells you that it was so difficult, you can say 'yes I know! I know, that's very normal. That's very normal. Keep trying!' whatever.</p>	<p><b>Ability to sit with own pain/vulnerability</b></p> <p><b>Mindfulness helps the therapist to understanding clients' difficulties.</b></p>
	<p>And what does that do to the therapeutic relationship?</p>	
<p><i>Doesn't want to be seen as the 'expert' – step out of this role, or to tell her clients what to do.</i></p> <p><i>Can be good to be <u>matey</u>? What does this mean? Feels like she wants to relate equally to her clients, i.e., almost like a friend/<u>mate</u>. Relationship dynamics?</i></p> <p><i>Adds to a human element, what does this mean? Normal and fallible, suggests that she has her own difficulties with the practice perhaps?-Human element to the relationship ship with clients maybe.</i></p>	<p>Yes. Well, obviously then you're, erm, yeah I like it if you step out of the expert role telling the client how it should be... ..I'm not advocating that you should just kind of be a bit matey. Do you know what I mean? But erm, although sometimes that can be good as well I think. I think that's absolutely fine. But erm, I think it can add to a, kind of a, human element of it, we're all just very normal and fallible.</p>	<p><b>Therapist steps out of the expert role.</b></p> <p><b>Relating equally to clients</b></p> <p><b>Human element to mindfulness</b></p>

## Appendix 10: Example of Table of Themes, Supporting Quotation and Location

Emergent Themes	Transcript Extract	Line No.
Meaning/definitions of mindfulness	It means observing, noticing, erm, experiencing without judging, without trying to change but just be present in the moment	C28-29
Mindfulness as having a peaceful connotations	There is a sense of peace that comes from the word and I guess from where it comes from, but I, I find it quite peaceful, term to use	C33-35
Mindfulness as an awakening	And it's kind of opening your eyes really to things	C35
Mindfulness as a specific-disorder Intervention Use	I use it a lot in the weight management group	C42
Mindfulness techniques	We use it for erm mindful eating, so...but not the raisin exercises everybody kinda knows about, but actually, we eat chocolate mindfully and we eat erm a piece of apple or something afterwards mindfully	C42-45
One-one clinical impact	It can be really powerful I find in one to one	C85
Mindfulness as a group-based intervention	But in the group it's just amazing, I mean it just works brilliantly	C85-86
Mindfulness as fitting with every disorder	I think it fits with everything. I don't, I don't think there is anything that I have found that I just couldn't work	C215-216
Helpful for therapist	And I think sometimes it helps me to be honest, it kinda I find it helpful to me to stop and just be present with them, with what's going on for them in their body, in their mind, just, just to be there	C229-232
Impact on therapeutic relationship	It helps me know them if I'm honest. It helps me to really know them because I think, I think you can learn a lot from someone about from their thoughts but I think you can learn so much more by their experiences in a moment	C237-240
Mindfulness as being peaceful	I think it's there's a peace about it...it just feels very peaceful, yeah it's just peaceful	C249-250
Mindfulness is non-task driven	What's nice about for me about mindfulness and the way I see it... Is that we are not trying to do anything other than we just notice and that kind of almost takes some of the erm pressure off	C258-263

## Appendix 11: Table of Master Themes, Sub-Themes and Presented Evidence

Master Theme	Sub-Themes	Location of Included Quotes
<b>“It lifts them up their spirit &amp; their soul”: Mindfulness &amp; Spirituality</b>	‘A way of being’	E:215-218, E: 242-247, E: 163-164, E: 780-781, G: 135-136, G: 295, G: 691-699, G: 813-816, F: 56-63, D: 698-700, D: 366, D: 423-424, B: 322.
	‘A Spiritual Journey of Psychological Growth’	A: 692-693, A: 716, A: 729-731, F: 607-612, E: 1254-1257, E: 888-892, E: 131-136, C, 336-337, C: 678-687, A: 42-46, A: 58-70, A: 696-697.
	‘Opening up to New Experiences’	B: 334-335, A: 32-35, C: 35, C: 659-674, H: 1070-1078, E: 526-529, F: 79-86, G: 831-834, H: 538-539, H: 560-565.
	‘Letting Go of Expectations and Thoughts’	A: 254-256, C: 258-263, H: 349-353, G: 46-58, D: 598-607, B: 392-394, B: 469-471, B: 392-394, C: 572-575, C: 759-760,
<b>“Experiencing it together”: Relational Component of Mindfulness</b>	‘Enabling a Relationship with Self & Others’	C: 678-691, H:253-259, H: 627-630, H: 148-155, B: 611-613, B: 617-622,

	'Doing Mindfulness Together'	C: 356-357, C: 361-366, G: 313-315, E: 457-460, A: 427-429, D: 261-263, D: 286-289, H: H426-431.
	'Enhancing the Therapeutic Relationship'	D: 256-257, H: 217-226, C:115, C: 366-372, B: 626-632, F: 201-206, F: 280-288, F: 268-274, B: 620-622).
<b>'Doing' Mindfulness: Clinical Applications</b>	'The Difficulty of Defining Mindfulness'	E: 27-32, E: 181, E: 311-313, E: 328-331, B: 42-49, C: 28-29, A: 31-32, A: 94-97, F: 78-86, F: 330-332, H: 34-39.
	'The Many Ways of 'Doing' Mindfulness'	D: 394-400, B: 245-252, F: 352-358, G: 332-342, C: 85-86,
	'The Dichotomy of Mindfulness-Specialisation vs Generalisation'	C: 554-557, C: 215-216, C: 120-121, D: 310-313, D: D524-526, H: 250-253, H: 816-819, E: 1086-1087, G: 819-820, F: 313-314, D: 203-207, C: 421-423, E: 1260-1263
	'Practicing What You Preach-Advice for Novice Mindfulness Therapists'	E: Ewan, 1170-1176, E: 1216-1224 B: 589-593, A: 545-550, D: 631-635, C: 649-652, C: 437-439,

## **PART D: Critical Literature Review**

### **What is the evidence that compassion and self-compassion can improve psychological well-being in a non-clinical population and in a clinical cohort diagnosed with a variety of mental health disorders? A critical literature review**

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**Keywords:** Self-Compassion, Compassion, Well-being, Counselling Psychology.

#### **1 Introduction**

The past decade has seen an increasing interchange of ideas between Buddhism and Psychology (see for example, Epstein, 1995; Molino, 1998; Watson, Batchelor & Claxton, 1999) broadening our existing understanding of mental well-being and leading to new ways of researching and treating mental disorders (e.g., Kabat-Zinn's Mindfulness-Based Stress Reduction programmes; Kabat-Zinn, Massion, Kristeller & Peterson, 1992). The current review is an attempt to contribute to the dialogue by examining how the concept of self-compassion and compassion might expand our existing understanding of healthy self-attitudes. Allen and Leary (2010) highlight that although self-compassion has been discussed in Buddhist philosophy and even though the importance of compassion to the therapist-client relationship has been suggested (for example, Wispe, 1991) it is only recently, that it has received greater attention in the psychological literature.

Recently, the nature and importance of compassion and self-compassion, though relatively new in Western psychological circles has been reconsidered. An increasing range of novel research is beginning to emerge to indicate that compassion and self-compassion can improve psychological well-being and functioning, (Neff, Kirkpatrick & Rude, 2007). Self-compassion as a psychological intervention is therefore, worthy of further exploration due to its potential contribution to our understanding of mental health. In addition, greater insight of the power of compassion as a psychological intervention has wide-ranging significance for counselling psychology. Even at such an early stage, compassion research can both inform individual strategies with clients and contribute to the development of more sustained programmes of intervention. Compassion research can also amplify thinking within current theoretical models including Cognitive Behavioural Therapy (CBT) approaches. Finally,

compassion and self-compassion research can contribute to the field of counselling psychology by providing ideas for interventions with a range of client groups; from those experiencing depression, substance (food) abuse and psychosis to individuals who are not experiencing clinical issues but are seeking simply to enhance their state of well-being.

In assessing the therapeutic use of self-compassion and compassion to increase psychological well-being, this review covers three areas. Firstly, it introduces conceptualisations of compassion and self-compassion. Secondly, it reviews studies which explore the use of self-compassion in promoting psychological well-being in a non-clinical population. It also reviews studies that have used Compassion-Focus Therapy (CFT) in clinical settings to encourage psychological well-being in individuals diagnosed with a variety of mental health disorders. Thirdly, the review identifies conclusions from existing self-compassion and compassion research, considering implication for the practice of counselling psychology as well as future research directions.

### **1.1 Leading Figures**

Before reviewing the literature, it is worth highlighting two key figures in this area within the United Kingdom and the United States as their work offers a platform from which many research studies have spurred. The first is Dr Kristin Neff, who, working out of the University of Texas in the USA, has been researching the concept of self-compassion for over sixteen years and has created the Neff Self-Compassion Scale (SeCS; Neff, 2003), which is currently used worldwide by the majority of researchers in the area.

The other figure in the UK is Professor Paul Gilbert. Professor Gilbert has focused on evolutionary models and the nature of shame amongst other research areas. His work includes working with people who have a very negative experience of self, are self-critical and come from neglectful or hostile backgrounds. Since 2006, he has set up the Compassionate Mind Foundation with a mission statement of: 'Promoting Well-being through the Scientific Understanding and Application of Compassion'. Attention is now turned to conceptualisations of compassion and self-compassion.

## 2 Conceptualisations of Compassion

The construct of compassion can be understood from a number of different perspectives. It is however, beyond the scope of this review to explore each perspective in great detail, therefore, a summary of the main views are provided below.

**2.1 Evolutionary Conceptualisations of Compassion** - Goetz, Keltner and Simon-Thomas (2010) delineate compassion as “a distinct affective experience whose primary function is to facilitate cooperation and protection of the weak and those who suffer” (p.351). This distinctive affective state arises from seeing another’s suffering and that motivates a consequent desire to help. As such, Goetz et al. (2010) place compassion within a broader system of compassion-related states including sympathy, empathy and pity. The researchers argue that although these states share a focus upon amelioration of the suffering of others, they differ in terms of their cognitive and behavioural components (Keltner & Lerner, 2010).

Within this framework, compassion is regarded as a ‘distinct affective state’, with a response profile that differs from those of distress, sadness, and love. An evolutionary approach therefore, presupposes that emotions are adaptations to particular survival and reproduction related situations (Goetz et al., 2010). Different components of emotion, antecedent appraisal process, nonverbal display, experience, and autonomic physiology, serve specific functions in facilitating the individual to meet the survival or reproduction related problem or opportunity (Keltner & Gross, 1999). Thus, compassion is defined as a distinct state that differs from related states like love, and that it motivates specific patterns of behaviour toward others in need.

Evolutionary conceptualisations of compassion propose three lines of reasoning that explain the development of an affective state that is focused toward enhancing the welfare of those who suffer (Frank, 1988 and Keltner, 2009). These hold that compassion can be seen as, (1) a distinct affective state and trait because it enhances the welfare of vulnerable offspring, (2) a desirable emotion or attribute in mate selection processes, and (3) a cooperative relations with non-kin. These are summarised below.

**Vulnerable offspring** - Within this perspective, compassion is believed to have emerged as the affective element of a caregiving system, intended to help nurture vulnerable offspring to the age of viability and ensure that genes are more likely to be reproduced. From this

perspective, the caregiver is attuned to reducing the harm and suffering of vulnerable offspring.

**A sexual selection perspective** – This outlines the processes by which certain traits are selected for through the mate preferences of females and males (Buss & Kenrick, 1998; Miller, 2007). Here, the emphasis is on compassion as a trait like tendency to feel the emotion and to act altruistically. This perspective suggests that compassionate reproductive mates are more inclined to feel compassion during times of others' need and suffering. Thus, compassionate reproductive partners should also be more likely to devote more resources to offspring, provide physical care, protection, affection, and create a cooperative, caring community which is vital to the survival of the young.

**Cooperative relations with non-kin** - This perspective hypothesises that the compassionate preferences of others are an important criterion in the development of cooperative relations with non-kin (Nesse, 2007). Here compassion is thought to have evolved within a multifaceted system of emotional states, involving liking, gratitude, anger, and guilt, which enable non-kin to initiate, preserve, and regulate mutually altruistic relationships. Goetz et al. (2010) argue that within this system of emotions, compassion emerged as a state to motivate altruism in mutually beneficial relationships and contexts.

**2.2 Gilbert's Social Mentality Conceptualisation of Compassion** – Gilbert (2014) conceptualises compassion in evolutionary terms, focussing on the interaction between threat, motivational and soothing systems which have created neuro-physiological substrates. Gilbert (2014) defines compassion in Compassion-Focused Therapy (CFT) as, 'a sensitivity to suffering in self and others, with a commitment to try to alleviate and prevent it' (Gilbert, 2014, p. 19). CFT was developed with and for people who have chronic and complex mental-health problems linked to shame and self-criticism, and who often come from difficult (e.g., neglectful or abusive) backgrounds. Whilst the CFT approach to compassion borrows from many Buddhist teachings (especially the roles of sensitivity to and motivation to relieve suffering) it conceptualises compassion from an evolutionary perspective by focusing on the evolution of the mammalian affiliative system (Gilbert, 2014). The foundations of this model lies in the neuroscience behind these affect systems. Gilbert (2014) argues that basic motivational systems (sex, status and attachment) have evolved in humans and other mammals that enable us to seek out specific resources and avoid

harm/threats. These systems are responsible for a range of corresponding emotions, including (1) competing and social ranking, (2) cooperation/sharing, (3) caring and nurturing, and (4) seeking and responding to care, which are described below.

**Emotion Regulation Systems** - Gilbert (2014) suggests that motives evolved to help animals survive and pursue things that are important to them (e.g. food, shelter). Alongside motives, emotions are also significant as they help to guide our motivations and goals by responding in different ways to whether we are successful or threatened in some way. CFT therefore, takes an evolutionary functional view to emotions. Gilbert (2014) proposes that CFT focuses on three main evolved functions of emotions: (1) alert to threats and activate defensive strategies, (2) provide information on the availability of resources and rewards and activate 'seeking-acquiring' strategies and (3) provide information on safeness, allow for 'rest and digest' and relative non-action in the form of contentment and openness. CFT uses a three emotion-systems approach which is supported by a review of positive and affiliative emotions by Depue and Morrone-Strupinsky (2005) and studies of threat-based emotions (LeDoux, 1998) to educate clients. Whilst recognising that there are more complex models of emotions (e.g., Panksepp, 2010), Gilbert (2014) argues that this simplification of the tripartite system in CFT is easily understood by clients who readily identify with it, and helps to guide the insight into the value of compassion. The three emotion regulation systems are briefly described below.

**(1) The threat and protection system** – This evolved to detect and respond to threats appropriately. Activation of this system is postulated to give rise to attention focusing/bias, and results in negative emotions such as anger, anxiety and disgust. These emotions further lead to fight, flight or submission behaviours (Gilbert, 2014).

**(2) The seeking and acquiring /drive system** - This has a motivational function in that it directs our attention towards rewards and resources (e.g. food, sexual opportunities), and gives rise to the positive emotions of drive, excitement and vitality (Gilbert, 2014).

**(3) The contentment/soothing affiliative system** – This developed alongside attachment/affiliation (Depue & Morrone-Strupinsky, 2005). Although this system also gives rise to positive emotions, these are different to those produced by the drive system, and include emotions such as, peacefulness, well-being, not-seeking and contentment, or 'rest

and digest'. Depue and Morrone-Strupinsky (2005) propose that our contentment system can be thought of as a specialised affect regulation system with its own behaviour regulators, physiological infrastructures, and range of effects on other systems such as attention and reflections. This system is linked to the mammalian evolution of attachment system. It is a social mentality that becomes focused by intention and motivation to alleviate distress in others, recruiting key attributes for attentional sensitivity, sympathy, distress tolerance, empathy and non-judgement. In this model compassion has its roots in the capacity for mammals to co-operate and engage in kinship caring, and the formation of attachment bonds (Bowlby, 1973; Gilbert, 2005; 2014). Therefore, compassion is understood as an evolved motivational system designed to regulate negative affect through attuning to the feelings of self and others, and expressing and communicating feelings of warmth and safeness (e.g. Gilbert, 1989; Spinks, Rutherford & Needham, 2010).

**Balancing of the systems** - CFT aims to restore imbalances within these three affect regulation systems, and seeks to help individuals who have trouble accessing the soothing system in response to threat (Gilbert, 2014). This difficulty may have an environmental or a biological basis, for example under stimulation of the soothing system in early life. CFT aims to assist such individuals to respond to self-criticism with self-kindness and compassion, with the goal of treatment being improved psychological well-being. Gilbert (2014) suggests that a fundamental part of this process is to help individuals understand that many cognitive biases are built-in biological processes, constructed by genetics and the environment. CFT therefore, encourages individuals to develop compassion motivation and practise compassionate behaviours to access the soothing systems.

**2.3 Buddhist Conceptualisation of Compassion** - Buddhist approaches such as those by Buddhaghosa (1975) and Hofmann, Grossman and Hinton (2011) focus on attentional sensitivity to suffering and a commitment to relieve it. Within this perspective, intentionality and motivation are central and compassion is not seen as an emotion as such. Buddhist traditions place compassion within a system of motivational constructs including loving kindness, sympathetic joy and equanimity. In this conceptualisation, compassion can be understood as an attention to and intention towards alleviating interpersonal distress (The Dalai Lama, 2001).

## 2.4 Neff's Conceptualisation of Self-Compassion

Neff (2003a) differentiates between compassion and self-compassion, she suggests that self-compassion is 'simply compassion directed inward, relating to ourselves as the object of care' (Neff, 2003a). In this conceptualisation, self-compassion involves being 'touched by and open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering and to heal oneself with kindness' (Neff, 2003b p.87). Self-compassion also involves offering non-judgemental understanding to one's pain, inadequacies and failures, so that one's experience is seen as part of the larger human experience.

Neff (2004; 2009) conceptualises self-compassion as comprising of three interconnected components; (1) self-kindness versus self-judgement. Self-kindness refers to the tendency to be caring and understanding with oneself when one encounters suffering, inadequacy or failure instead of ignoring one's pain or being harshly self-critical or judgemental. (2) A sense of common humanity versus isolation. This entails recognising that all humans are imperfect, fail and make mistakes. It therefore, connects one's own flawed condition to the shared human condition rather than seeing them as separating and isolating so that greater perspective is taken towards personal shortcomings and difficulties. (3) Mindfulness versus over-identification. Mindfulness consists of being aware of one's present moment experience in a clear and balanced way so that one neither ignores nor ruminates on disliked aspects of one's life or over-identifying with painful thoughts.

Neff (2003; 2009) identifies that while these aspects of self-compassion are conceptually distinct, and are experienced differently at the phenomenological level. They also interact so as to mutually enhance and engender one another to create a self-compassionate frame of mind. For example, a degree of mindfulness is necessary in order to allow enough mental distance from one's negative experiences so that feelings of self-kindness and common humanity can arise.

As highlighted above, the theoretical models of compassion and self-compassion accentuate different facets. An evolutionary perspective highlights that compassion is linked to care and caregiving/receiving, whilst Neff (2003b; 2009) emphasises self-compassion and healthy self to self-relating. Buddhist perspectives on the other hand, focus on compassionate attention

and intentionality while, Gilbert's (2014) social mentality highlights compassionate qualities to attune to and alleviate distress in others. Whilst these models differ in their conceptualisations of compassion, they all predict that compassion would be associated with improved wellbeing and reduce emotional distress.

### **3 Studies of Self-Compassion: A Non-Clinical Population**

Having outlined conceptualisations of compassion and self-compassion, attention is now turned to research studies on self-compassion. The majority of research conducted on self-compassion has utilised the Self-Compassion Scale (SeCS) developed by Neff (2003*b*). This is a self-report measure consisting of 26 items that explore the degree to which individuals display the three components of self-compassion, self-kindness versus self-judgement, common humanity versus isolation and mindfulness versus over-identification.

The studies on self-compassion discussed below have been grouped under broader headings including, cognitive restructuring and emotional well-being, motivation, and interpersonal relationship/functioning in order to provide an overview of the research. The studies selected have been conducted with a non-clinical population. Additional inclusion criteria were studies that were published on the subject of self-compassion within the last 10 years. In the later part of this review research studies that have used CFT with individuals who have been diagnosed with a mental health disorder in clinical settings will be explored.

#### **3.1 Cognitive Restructuring & Emotional Well-Being**

According to Allen and Leary (2010) positive cognitive re-structuring involves shifting one's perspective of a stressful situation in order to see it in a more positive light. The researchers suggest that self-compassion involves a degree of positive restructuring as people who are high in self-compassion interpret negative events in less catastrophic terms than those who are low in self-compassion.

In a series of studies Leary, Tate, Adams, Allen and Hancock (2007), investigated the cognitive and emotional processes by which self-compassionate people deal with unpleasant life events. Participants were 59 male and 58 female undergraduate psychology students, with an age range between 17–21 years. Participants in this study reported on negative events in their daily lives, responded to hypothetical scenarios and reacted to interpersonal feedback.

The studies revealed that self-compassion was associated with lower negative emotions in the face of real events and with patterns of thoughts that typically facilitated people's ability to cope with negative events.

In one particular study, Leary et al. (2007) asked participants to report on a negative event they had experienced over the previous four days on four different occasions. On each of these occasions, participants were asked to describe a recent negative event, rate how bad it was, and report their thoughts and feelings about the event. The researchers found that those participants who were higher in self-compassion as measured by the SeCS were less likely to have negative thoughts such as "Why do these things always happen to me?" and "I'm such a loser." Moreover, participants who were high in self-compassion were also less likely to generalise the negative event to opinions about themselves than those who were low in self-compassion. For example, they were less likely to think that their lives were more "screwed up" than other people's lives were. To an extent, this study demonstrates that positive cognitive restructuring helped participants view their situation with greater self-directed compassion.

In a second study, Leary et al. (2007) led the research participants to use a self-compassionate mind-set when thinking about their problems. The researchers asked participants to recollect a negative event that they had experienced and to answer three questions that led them to think about it in a self-compassionate way (corresponding with the three components of self-compassion identified by Neff (2003)). Essentially, this experimental manipulation focused on a cognitive reframing of the situation. The self-compassion induction led participants to take greater responsibility for the event yet to experience less negative affect and to report stronger feelings of similarity with other people. This suggests that self-compassion may be beneficial when coping with negative interpersonal events, thereby promoting individual psychological well-being.

In a different study, Adam and Leary (2007) examined the effects of a very brief self-compassion induction on eating among women who scored high in eating guilt. Participants were 84 female undergraduate psychology students who had not been diagnosed with or treated for a clinical eating disorder within the past three years. After participants were directed to eat a doughnut (a food that women high in eating guilt regard as forbidden), the researcher led some participants to think about overeating in a self-compassionate manner.

The findings revealed that highly restrictive eaters who were given the self-compassion induction were less distressed and subsequently ate less in a follow-up taste test compared to restrictive eaters who did not receive the self-compassion induction. This suggests that self-compassion may be useful in promoting psychological well-being particularly for those who are experiencing eating guilt.

The intervention techniques described above focused primarily on positive cognitive restructuring to help participants view situation with greater self-directed compassion. The studies demonstrate that there may be benefits to applying cognitive restructuring within a self-compassion induction. These findings may be of importance to counselling psychologists. For example, given that clients in therapy who present with depression for example, often interpret negative events in catastrophic and self-blaming ways, they may be likely to benefit from developing greater self-compassion.

It is important to highlight that although the reviewed research indicates that educating people about what it means to be self-compassionate may help them show more self-compassion in the future, the studies do not show the degree to which these effects are maintained after treatment has been completed. As such, further research is needed to assess the degree to which these effects continue after treatment has ended. Moreover, studies have yet to ascertain the specific length of treatment needed in order to have long-lasting effects.

Furthermore, the studies relied heavily on self-report measures. This presents limitations for the data as self-report measures have a number of problems including; 'response biases'. This is the tendency for participants to respond in a certain way, regardless of the evidence they are assessing. Another limitation is honesty/image management, the extent to which participants are honest in their responses and the degree to which they are concerned about being seen in a favourable light. Introspective ability is a further limitation of self-report measures in that some participants may lack the introspective ability to provide an accurate response to a question. As such, future research should aim to provide other forms of assessments that could include objective measures of individuals' cognitions/cognitive processes. Finally, as counselling psychologists are concerned with understanding the individuals' lived experience, studies that employ a qualitative design may be helpful to shed

further light on how self-compassion enables individuals to view situations with greater self-directed compassion. Attention is now turned to self-compassion and its role in motivation.

### **3.2 Motivation**

**Academic Motivation** – Several Educational psychologists have made a distinction between mastery-based and performance-based learning goals (e.g., Ames & Archer, 1988; Dweck, 1986). Mastery-based goals are related to intrinsic motivation for a genuine understanding of the material, whereas performance-based goals focus on evaluations of success and failure and are motivated by a desire to enhance one's self-worth or public image.

Consistent with the notion that self-compassionate people are motivated to do things that help themselves, Neff, Hsieh and Dejitterat (2005) suggest that self-compassion is positively correlated with mastery-based goals and negatively associated with performance-based goals. To the extent that people high in self-compassion are more intrinsically motivated, they should be more motivated to continue to learn after receiving negative feedback than people who are low in self-compassion. In their study of undergraduate students, Neff et al. (2005) found that the relationship between self-compassion and mastery-based goals was mediated by lower fear of failure and greater perceived competence among self-compassionate individuals. In addition, Neff et al. (2005) report that self-compassion is associated with adaptive academic motivational patterns; self-compassion was positively related to the adoption of mastery goals in a learning context. The researchers conclude that self-compassionate individuals may be better able to view failure as a learning opportunity and maintain their motivation on accomplishing the task at hand.

**Health Motivation** - Researchers such as Kelly, Zuroff, Foa and Gilbert (2009) have found that self-compassion can motivate health-related behaviours such as stopping smoking, whilst Magnus, Kowalski and McHugh (2010) found that self-compassion can help to motivate women to start a new exercise regime. These studies are highlighted below.

Kelly et al. (2009) examined whether self-compassion could help people stop or reduce cigarette smoking. Participants were 64 females and 55 males with a mean age of 24.4 years. Participants self-identified as having smoked for at least one year, and also described themselves as current smokers (smoking an average of one cigarette per day or more). They indicated that they were looking to stop smoking in the next six months. Participants were

randomly assigned to one of four interventions, one of which involved engaging in a self-compassionate imagery and self-talk each time they had an urge to smoke. The researchers found that over three weeks, the self-compassion intervention reduced daily smoking more quickly than a baseline self-monitoring condition. Kelly et al. (2009) also report that moderators of self-compassion training emerged. That is, the self-compassion intervention reduced smoking more rapidly if participants were low in readiness to change; were high in the trait of self-criticism; and had vivid imagery during the intervention exercises. The findings of this research suggest that training oneself to self-regulate from a self-compassionate position might be especially effective for individuals who are able to visualise a compassionate image and whose personality and motivation would be expected to undermine the impact of traditional treatments.

Magnus et al. (2010) explored how self-compassion is related to, and explains unique variance beyond self-esteem in women's motives to exercise and exercise-related outcomes. 252 women who exercised took part in the study. The researchers found that self-compassion was positively related to intrinsic motivation and negatively related to external and introjected motivation, ego goal orientation, social physique anxiety, and obligatory exercise behaviour. This study provides evidence that self-compassion is related to well-being in the exercise context, and raises the possibility that the development of self-compassion may be important for women who exercise.

These studies demonstrate that self-compassion does not undermine motivation; rather, it enhances motivation. Self-compassion may therefore, provide a safe and non-judgmental context to challenge negative aspects of the self and strive to be better. The findings from these studies suggest that self-compassion may be an effective method of motivating change. This is of significance for counselling psychologists in their work with clients who may be finding it difficult to motivate themselves to change. Counselling psychologist could employ self-compassionate interventions to help motivate such individuals to make personal changes to their lives.

### **3.3 Interpersonal Relationships/Functioning**

Although researchers have examined the impact of self-compassion on individual well-being, there has been little research on the role of self-compassion in the context of interpersonal

relationships. Nonetheless, studies are beginning to emerge to show that not only does self-compassion help oneself, but that it also improves interpersonal functioning. In one study, Crocker and Canevello (2008) found that self-compassionate university students tended to have more compassionate goals in their relationships with friends and roommates, meaning that they tended to provide social support and encourage interpersonal trust with friends. Similarly, Yarnell and Neff (2013) found that people who were high in self-compassion were more likely to resolve relationship conflicts with romantic partners using compromise solutions that balanced the needs of self and other. The researchers found that self-compassionate partners were also less likely to experience turmoil and more likely to be authentic when resolving conflicts. This suggests that the constructive relationship behaviour of self-compassionate individuals may produce personal as well as interpersonal benefits.

The findings from these studies have particular importance for counselling psychologists working with clients with relationship/interpersonal difficulties. Self-compassionate interventions can be incorporated within their treatment to enable them to resolve interpersonal conflicts and achieve a greater sense of psychological well-being in their relationships.

Neff and Beretvas (2012) examined the role of self-compassion in the context of adult romantic relationships. 104 heterosexual couples completed a survey which included measures on self-compassion, self-esteem, relational well-being, care and control, autonomy and relatedness, verbal aggression, relationship satisfaction and attachment style. The researchers found that self-compassionate individuals were described by their romantic partners as being more emotionally connected, accepting, and autonomy-supporting while being less detached, controlling, and aggressive than those lacking self-compassion. The findings also revealed that self-compassion was linked with greater relational well-being in terms of feeling worthy, being happy, feeling authentic and being able to express opinions in one's romantic relationship.

The findings from these studies suggest that the sense of care, connectedness, and resilience provided by self-compassion is not only associated with greater emotional well-being more generally (Neff, 2009), but also greater well-being within the context of interpersonal relationships. Whilst these studies show that self-compassion may be helpful in interpersonal functioning, more research is needed to understand how self-compassion is linked to

functioning in interpersonal relationships. This could be a potential avenue for future research. It is also important to highlight that self-reports of conflict resolution behaviour were retrospective in the Yarnell and Neff's (2013) study for example. It is possible therefore; that in looking back on previous conflicts, participants may have judged resolutions more positively than if their descriptions of the conflicts were more immediate for example. As such, the findings from these studies need to be applied with caution as one cannot be certain that memories of past conflict resolutions are accurate.

### **3.4 Overview of Self-Compassion Research**

Overall, the reviewed studies provide evidence to support the notion that self-compassion may be able to help with positive cognitive restructuring; decrease negative emotions, maintain motivation and improve interpersonal functioning in a non-clinical sample. The findings from these studies indicate the potential value in incorporating self-compassionate work in the therapeutic process to improve individual psychological well-being and are of significance to the work of counselling psychologists.

It is important to highlight that several of the reviewed studies (e.g., Neff & Beretvas, 2012; Yarnell & Neff, 2013; Leary et al., 2007) used self-report measures and did not include any observations of behaviour. As previously discussed, self-report measures suffer from a number of limitations including, response biases, honesty/image management and introspective ability. As such, future research should aim to provide other forms of assessments that could include objective measures of cognition and behaviour.

In the studies looking at interpersonal functioning for example, individuals may have been subjective when constructing self-reports of their relationship behaviour. As equality and justice are valued ideals in Western society, these individuals may have had a tendency to inflate the degree to which they compromised in their relationships. Future research could therefore compare self-reports of conflict resolution behaviour to partner reports to inspect whether they are consistent. However, partner reports of behaviour also suffer from their own biases and cannot be assumed to be more accurate than self-reports.

Finally, studies that employ a qualitative approach are also needed to help to understand in more depth how individuals experience self-compassion. For example, how self-compassion

is able to change negative emotions, maintain motivation and improve interpersonal relationships.

#### **4 Compassion-Focused Therapy (CFT)**

Having reviewed research studies on self-compassion in a non-clinical sample, attention is now turned to CFT and studies that have used CFT within a clinical setting with clients experiencing a variety of mental health problems.

CFT is a form of psychotherapy that was developed by Gilbert (2009b; 2014) for people who have mental health problems primarily linked to high shame and self-criticism, and with early histories of neglect and various other forms of abuse (Gilbert & Irons, 2005). CFT aims to help people to cultivate affiliative emotions and compassion. As previously mentioned, CFT defines compassion as 'a sensitivity to suffering in self and others, with a commitment to try to alleviate and prevent it' (Gilbert, 2014, p. 19). As such, Gilbert (2014) proposes that CFT recognises that compassion flows in three directions: (1) compassion we can feel for another or others, (2) compassion we can feel from others to ourselves, and (3) compassion we can direct towards ourselves (self-compassion). Gilbert (2009; 2014) highlights that CFT describes the 'underpinning theory and process of applying a compassion model to therapy'. Whilst Compassionate Mind Training (CMT) describes 'specific activities designed to develop compassionate attributes and skills' (Gilbert, 2009b).

##### **4.1 The Premise and Core Principles of Compassionate-Focused Therapy (CFT) - A Multi-Modal Approach**

Gilbert and Proctor (2006) highlight that Compassionate Mind Training (CMT) is at the centre of CFT. CMT primarily aims to assist clients to learn the vital skills required to develop the key aspects and attributes of compassion, which Gilbert (2009b) names as care for wellbeing, sensitivity, distress tolerance, empathy and non-judgement. Gilbert (2009b; 2014) suggests that specific skills needed to achieve these attributes are multi-modal and common to other psychotherapies. These skills include compassionate reasoning, compassionate behaviour, compassionate imagery, compassionate feeling and compassionate sensation. Some of the key steps involved in sessions of CMT are the use of imagery, compassionate thinking to the self and others, responding to self-criticism through self-compassion and practising compassionate behaviour, often complimented with letter or diary writing. Gilbert and

Proctor (2006) suggest that CFT encourages the client to focus on, understand and feel compassion to the self during negative thought processes, with a strong focus on nurturing compassion within the self.

Gilbert (2009b) argues that CFT may be used as a framework within which to focus other psychological interventions, as these may become more effective once the affiliative system has been stimulated. Gilbert (2014) also suggests that individuals with a highly self-critical 'inner voice may struggle with other evidence-based therapies, therefore, helping these individuals develop a more compassionate, encouraging 'inner voice' may enable better engagement. CFT is therefore proposed for use as a multi-modal therapy, (Gilbert, 2009b; 2014) and according to Heriot-Maitland, Vidal, Ball and Irons (2014) it is not 'wedded to any particular school of psychotherapy'; rather, it is based on a scientist-practitioner model. Heriot-Maitland et al. (2014) suggest therefore, that CFT is applicable as a trans-diagnostic, group-based therapy that can be applied in many clinical settings.

Attention is now turned to studies that have used CFT in clinical settings with clients experiencing a variety of mental health diagnoses. Inclusion criteria were studies that used CFT as their core in clinical settings within the last seven years and with clients experiencing a variety of mental health diagnoses, including, depression and anxiety, eating disorders, psychosis, and those in acute inpatient settings. As CFT research is still in its infancy, studies that used both quantitative and mixed methodology approach were included in the review.

Hoffmann et al. (2011) highlight that there is growing evidence to suggest that assisting people to cultivate compassion for themselves and others can significantly alleviate a range of mental health problems. CFT has been found to reduce depression and anxiety in patients with long-term mental health problems (Gilbert & Proctor, 2006), and those in a high security psychiatric setting (Laithwaite, O'Hanlon, Collins, Doyle et al., 2009). CFT has also been shown to be effective for people with psychosis (Braehler, Gumley, Harper, Wallace et al., 2013); and has been demonstrated to be effective for patients with eating disorders (Gale, Gilbert, Read & Goss, 2014) and for acute inpatients (Heriot-Maitland et al., 2014). These studies suggest that there is now a growing evidence base for CFT that supports the value of helping people develop affiliative and prosocial emotions and competencies, including developing compassion for the self and other to help improve mental health. It is beyond the scope of

this review to discuss all the studies that have utilised CFT, as such, only the studies mentioned above will be discussed. For an in-depth review of CFT studies, please see Leaviss and Uttley (2014).

#### **4.2 CFT- Long-Term Mental Health Difficulties**

Gilbert and Proctor (2006) developed the first group-based version of CFT for day hospital patients with long-term chronic mental health difficulties. Nine volunteer participants, (four men and five women) who had previously been diagnosed as suffering from personality disorders and/or chronic mood disorders took part in the study, however three later dropped out (two men and one women) leaving six participants with an age of 39-51 years who completed the full study.

The researchers report that some participants had engaged in serious self-harming behaviours and all participants described histories of emotional difficulties since childhood. Participants had also previously received psychological and drug treatment, in addition, they were also familiar with the CBT approach, although they all continued to struggle with an intense sense of shame and self-criticism.

Following twelve-weekly group sessions of CFT, participants completed a series of self-report questionnaires, covering forms and functions of self-criticism, depression, anxiety and shame. The measures included, the Hospital Anxiety and Depression Scale (HADS), weekly diary measuring self-attacking and self-soothing, The Functions of the Self-Criticising/Attacking Scale (FSCS) the Forms of the Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS), Social Rank Variables, External Shame, the Other as Shamer Scale, (OAS) Social Comparison Scale and the Submissive Behaviour Scale (SBS).

The results of the study revealed that there was a significant reduction in HADS scales (mean score at week one = 14.67, mean score at week twelve= 6.83). All participants reported feeling less depressed and anxious. The self-monitoring dairies revealed that some participants found their self-critical thoughts had become less frequent, less powerful and less intrusive, while their self-soothing thoughts became more powerful and accessible. The results also showed that there was a significant drop in self-persecution (mean score at week one = 17.5, mean score at week twelve = 9.6) but not self-correction (mean score at week = 28, mean score at week twelve = 21.67). There were significant drops in criticism focused on

inadequacy (mean score at week one = 31.33, mean score at week twelve = 14.5) and criticism focused on self-hatred, (mean score at week one = 15.17, mean score at week twelve = 5.67), in addition to a significant rise in self-reassurance (mean score at week 1 = 6.17, mean score at week twelve = 19.83).

In terms of the social rank variables, results revealed that CMT had a significant impact on helping to reduce people's sense of external shame (mean score at week one = 48.5, mean score at week twelve = 36.33). That is, they were less likely to endorse beliefs that others looked down on them. In regard to social comparison, there was a major reduction of feelings of inferiority, with social comparison scores moving into a non-clinical range (mean score at week one = 34.88, mean score at week twelve = 58.67). Finally, there was a reduction in submissive behaviour (mean score at week one = 42.67; mean score at week twelve = 30). Participants reported being more assertive as they began to become more compassionate and value themselves, as well as reports of feeling less isolated and alone in the world.

A two month follow up with four of the participants revealed that two felt they had been able to generate compassionate images when they were distressed and this had significantly contributed to their abilities to get through times of perceived crisis. Four participants reported continued use of the CMT practice and felt they had developed compassionate thinking; however, the researchers were unable to obtain sufficiently reliable data for analysis. This study seems to indicate that incorporating CFT within therapy can help to improve psychological well-being in individuals experiencing long-term chronic mental health difficulties. Subsequent studies have examined the use of CFT in other diagnostic groups and clinical settings. These are discussed below.

### **4.3 CFT- Psychosis/Schizophrenia**

Braehler et al. (2013) assessed the safety, acceptability, potential benefits, and associated change processes of using group CFT with people recovering from psychosis. Forty adult patients (22 males and 18 females) with a schizophrenia-spectrum disorder were randomised to CFT plus treatment as usual (TAU; n = 22, mean age of participants = 43.2 years) or to TAU alone (n = 18, mean age of participants = 40 years). Group CFT comprised of 16 sessions, (two hours on a weekly basis). Participants were assessed prior to randomisation and at the end of treatment. Assessments included semi-structured interviews to prompt narratives of

recovery from psychosis and self-report measures. At the end of treatment, participants were rated on the Clinical Global Impression Scale, (CGI-I). This is a self-report measure of improvement/exacerbation relative to baseline, which assigns a score on a 7-point scale ranging from 'very much worse' to 'very much improved'. Narratives were coded using the Narrative Recovery Style Scale (NRSS) to provide measures of change in compassion and avoidance. Change processes were correlated with changes in depression, personal beliefs about illness, fear of recurrence, and positive and negative affect.

Braehler et al. (2013) found that CFT participants showed significantly more compassion in their narratives compared with TAU participants ( $U = 75$ ,  $Z = -2.43$ ,  $p = 0.015$ ,  $r = -0.42$ ). In addition, in the CFT group, an increase in compassion was significantly associated with a decrease in the Beck Depression Inventory- II (BDI) ( $r = -0.77$ ;  $p = 0.001$ ). The researchers suggest that their findings support the feasibility of group CFT in psychosis and suggest that changes in compassion can be achieved, which appear to reduce depression in particular. The results of this study seem to suggest that CFT appears to be a safe, acceptable, promising, and evolving intervention for promoting emotional recovery and psychological well-being from psychosis.

In another study, Laithwaite et al. (2009) evaluated the effectiveness of a recovery group intervention based on compassionate mind training for patients with a primary diagnosis of schizophrenia or bipolar affective disorder. Eighteen male participants with a mean age of 36.9 years took part in the study. Participants were patients at a maximum-security state hospital for Scotland and Northern Ireland. The hospital 'provides treatment and care in conditions of special security for individuals with mental disorder who, because of their dangerous, violent or criminal inclinations, cannot be cared for in any other setting' (Laithwaite et al., 2009, p. 514).

The mean duration in hospital for these participants was eight years. Five of the participants had received a diagnosis of schizophrenia; ten were diagnosed with paranoid schizophrenia and three had been diagnosed with bi-polar affective disorder (these three participants had also experienced auditory hallucinations when elated, although at the time of the group, these had remitted). Eight of the participants also had a co-morbid personality disorder, namely anti-social personality disorder. One participant was considered to be in the "borderline" intellectual disability range.

The main objective of the study was to evaluate the specific aims of the Recovery after Psychosis Programme which aims to improve depression, improve self-esteem, develop compassion towards self, and improve social comparison and reduce external shame. The intervention programme was based on three modules of CFT which were, 1) understanding psychosis and recovery, 2) understanding compassion and developing the ideal friend, 3) developing plans for recovery after psychosis. Laithwaite et al. (2009) used a within-subjects design with participants being assessed at the start of the group, at mid-group (five weeks), at the end of the programme, and at a six weeks follow-up.

Six clinical outcome measures were used. These included, the Social Comparison Scale (SCS) which is an 11-item scale that taps global comparisons to others in the domains of attractiveness, rank and group fit (feeling similar or different to others). The External Shame (the Other as Shamer Scale – OAS) scale was also used. This measures external shame (how an individual thinks others see him/her). The Self Compassion Scale (SeCS) was also used to explore an individual's self-compassion. The Beck Depression Inventory II was used as a self-report measure of mood. The Rosenberg Self-Esteem measure (RSE) was also used to assess self-reports of self-esteem. Lastly, the Self-Image Profile for Adults (SIP-AD) was also used. This self-report questionnaire consists of 30 self-descriptions. Participants are invited to rate themselves as they are and how they would like to be (ideal) along each self-description. A self-image score (SI) represents how the individual feels about him/herself. A high self-image score suggests the person has a positive view of him/herself. Self-esteem (SE) reflects an individual's evaluation of him/herself.

Laithwaite et al. (2009) report that overall, there were significant changes in the SCS, OAS, BDI-II, and RSE. There were significant changes on the SCS between the start and end of the group ( $Z=1.96$ ,  $n$ -ties=11,  $p<.05$ ,  $r=0.3$ ) and this change was maintained at follow-up ( $Z=2.148$ ,  $n$ -ties=10,  $p<.05$ ,  $r=0.36$ ). In addition, there was a small change on the OAS scale between the start of the group and six-week follow-up ( $Z=.801$ ,  $n$ -ties=11,  $p>.5$ ,  $r=0.15$ ). Significant changes were also found on the BDI-II at the end of treatment ( $Z=2.332$ ,  $n$ -ties=15,  $p<.05$ ,  $r=0.38$ ) and at six-week follow-up ( $Z=-2.825$ ,  $n$ -ties=16,  $p<.01$ ,  $r=0.47$ ). Additionally, an overall significant change was found on the RSE. There was a significant change at six-week follow-up ( $Z=-2.80$ ,  $n$ -ties=15,  $p<.01$ ,  $r=0.47$ ) from baseline. The researchers found that there was no significant change on the SeCS, or the SIP-AD.

Laithwaite et al. (2009) highlight that self-critical thinking biases are influential in the development and maintenance of psychopathology; therefore a programme such as this recovery programme, which focuses on developing compassionate responses to shame, self-critical and self-attacking thoughts, will likely lead to a reduction in depression and shame and increase levels of self-esteem. The results of this study provide initial indications of the effectiveness of a group intervention based on the principles of CFT for this population.

#### **4.4 CFT - Eating Disorders**

Gale et al. (2014) explored the outcome of introducing CFT into a standard CBT programme for people diagnosed with eating disorders (ED). In particular, the researchers intended to evaluate the principle that CFT can be used with people with ED and improve ED symptomatology. 99 participants took part in the study; there were 95 females and four males with an age range of 17-62 years. 54 participants were given a diagnosis of EDNOS (Eating disorder not otherwise specified), 19 were given a primary diagnosis of anorexia nervosa and 26 were given a primary diagnosis of bulimia nervosa.

To maximize clinical efficiency, the researchers provided group-based treatments with a two-step treatment programme. In step one, patients are offered a 4-week, 2 hours per week, group-based psycho-education programme. The programme is designed to help patients increase their understanding of their ED and be actively involved in deciding if they are ready to engage with step two of the treatment programme. Step two consists of a 20-session group-based recovery programme. This takes place over sixteen weeks, with two sessions a week for the first four weeks, followed by weekly sessions over twelve weeks. The original recovery programme was based on the principles of CBT for ED; however, CFT techniques were incorporated into the programme.

Gale et al. (2014) used a repeated measures design to examine the impact of the treatment programme and to establish whether CFT can be used with people with ED. The researchers acknowledge that the study was not originally set up as a specific research trial, but rather as an audit of routinely collected data and an exploration of the acceptability and therapeutic engagement with CFT. However, the researchers report that they were able to gather sufficient data over the past 5 years to enable retrospective analysis of outcomes.

The following questionnaires were used to assess cognitive and behavioural aspects of ED and social functioning/well-being. 1) The Eating Disorder Examination Questionnaire (EDE-Q) consists of 28 questions about the frequency of eating disorder behaviours and severity of the psychopathological aspects of eating disorders over the last 28 days; 2) The Stirling Eating Disorder Scale (SEDS), is an 80-item questionnaire designed to assess the cognitive and behavioural symptoms of eating disorders; 3) The Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM) is a 34-item, self-report questionnaire relating to the past week. The CORE-OM assesses psychological distress. There are four main factors: subjective well-being, social/life functioning, commonly experienced problems or symptoms, and risk to the self and to others.

These questionnaires were given at five different time points as part of the treatment programme: Time 1, initial assessment; time 2, pre-psycho-education programme; time 3, post-psycho-education/pre-recovery programme; time 4, at the end of session eight of the recovery programme; and time 5, at the end of the programme. The questionnaires from times 1 to 5 were included in this study. The researchers note that the other time points were not included due to the reduced number of completed questionnaires.

Gale et al. (2014) found that there were significant improvements on all questionnaire measures during the programme. The analysis for the EDE-Q, showed significant main effects of Time (Wilks' = 0.42,  $F(4, 90) = 30.92$ ,  $p < 0.001$ , partial  $\eta^2 = 0.58$ ) and Time  $\times$  Diagnosis (Wilks' = 0.84,  $F(8, 180) = 2.09$ ,  $p = 0.039$ , partial  $\eta^2 = 0.085$ ). There was however, no significant effect for Diagnosis (Wilks' = 0.95,  $F(8, 180) = 0.57$ ,  $p = 0.80$ , partial  $\eta^2 = 0.025$ ). For SEDS, there were significant main effects of Time (Wilks' = 0.62,  $F(5, 52) = 4.03$ ,  $p = 0.001$ , partial  $\eta^2 = 0.38$ ), Diagnosis (Wilks' = 0.55,  $F(16, 104) = 2.31$ ,  $p = 0.006$ , partial  $\eta^2 = 0.26$ ) and Time  $\times$  Diagnosis (Wilks' = 0.56,  $F(16, 104) = 2.20$ ,  $p = 0.009$ , partial  $\eta^2 = 0.25$ ). The CORE-OM showed significant main effects of Time (Wilks' = 0.63,  $F(4, 89) = 13.26$ ,  $p < 0.0001$ , partial  $\eta^2 = 0.37$ ) and Time  $\times$  Diagnosis (Wilks' = 0.81,  $F(8, 178) = 2.15$ ,  $p = 0.013$ , partial  $\eta^2 = 0.10$ ). There was no significant effect for Diagnosis (Wilks' = 0.93,  $F(8, 178) = 0.85$ ,  $p = 0.56$ , partial  $\eta^2 = 0.037$ ).

A noteworthy findings of the study was that Gale et al. (2014) also found that 73% of those with BN made clinically significant improvements at the end of treatment (compared with 21% of people with AN and 30% of people with EDNOS). The researchers also note that that

there was only a small change in self-directed hostility in the AN group. This is interesting; however, this difference between the groups can be explained in terms of the critical 'voice' in people with anorexia. In their study looking at the critical voice of people with AN, Tierney and Fox (2010) found that participants felt they were reliant on the voice, believing that they were unable to function without it, and they experienced a sense of loss when they started to fight back against the voice. This suggests that the attachment to the critical 'voice' may be strong for people with AN and may explain the difference in improvement between the two groups.

The study nonetheless, shows the potential benefit of using CFT with people with eating disorders; however CFT was not used as a stand-alone treatment in this study. It is therefore, difficult to conclude which aspects of the programme led to the improvements or, indeed, if it was a mixture of the two. Thus, future research could explore whether CFT is a more effective intervention than CBT for this clinical population.

#### **4.5 CFT - Acute Patients**

Heriot-Maitland et al. (2014) observed the possibility of running and evaluating a CFT group modified for acute inpatient settings. In this pilot study, the researchers used a mixed method design to assess the impact of offering CFT-informed group sessions on an acute inpatient unit. 57 participants took part in the study. Quantitative measures of within-session change in distress and calmness, and post-session measures of understanding and perceived helpfulness of the group were given to participants over a six-month period (22 sessions). Participants anonymously rated their pre-and post-session levels of distress and calmness on a six-point bubble Likert scale. Participants also they rated their understanding of the group content and its perceived helpfulness for everyday life also on a six-point bubble Likert scale. Qualitative semi-structured interviews were conducted with four of the participants to explore their experiences of the CFT modules. The researchers highlight that as this was a preliminary study of the feasibility of the group, lengthy measures of compassion and self-criticism were not used in order to minimize potential impact on engagement.

The analysis revealed that there was a significant decrease in distress ratings for participants (from mean 3.6 to 3.1;  $Z = -2.619$ ,  $p = .005$ ). There was also a significant increase in participant levels of calmness overall post-session (from mean 3.9 to 4.3;  $Z = -2.211$ ,  $p = .014$ ). Further

analysis of the understanding and helpfulness ratings revealed that participants reported that they had understood the majority of session content irrespective of the topic covered. There was an average rating of 5.1 out of 6. Most sessions were perceived as being 'very' or 'extremely' helpful to participants' everyday life, with an average score of 5.0 out of 6.

In their qualitative data, Heriot-Maitland et al. (2014) found that a thematic analysis of the four interviews, identified themes relating to (1) the experience of common humanity. Here participants reported that they valued the opportunity to learn from other group members and relate to people such that they could see their own stories mirrored in the stories of others. This led to feelings of validation and acknowledgments of the normality of their sufferings without belittling it. (2) Understanding compassion; here, participants spoke about the importance of gaining a better understanding of the nature of compassion. (3) Experience of positive affect; participants reported positive emotions of being in the CFT group, particularly feeling comforted or soothed, and (4) experiences of the group; participants reported that overall, they found the group helpful.

Heriot-Maitland et al. (2014) are the first researchers to explore the effects of a CFT-informed approach in acute mental health settings. A potential benefit of this approach is that these groups can be open and trans-diagnostic, and can offer stand-alone topics and practices that have positive impacts on distress and calmness.

#### **4.6 Overview of CFT Research**

The studies reviewed indicate that CFT can significantly improve psychological well-being in a clinical population diagnosed with a variety of mental health disorders. The findings suggest that CFT may be an effective treatment for those experiencing long term chronic mental health difficulties, psychosis, acute mental health issues and eating disorders. Whilst these studies show the potential benefits of using CFT in a clinical population diagnosed with a variety of mental health disorders, there is still insufficient evidence to demonstrate that CFT is more effective than current standard treatments, for example, CBT or other imagery-based interventions. In addition, it could also be argued that these positive effects seen in CFT studies could simply be the result of taking part in a supportive group irrespective of what type of therapy is practiced within the group, (e.g., Oei & Dingle, 2008; Craig, Hancock, Chang & Dickson, 1998). Therefore, a potential avenue for future research could investigate whether

CFT can be a competing treatment to CBT. Similar to the research studies on self-compassion, the majority of the CFT studies reviewed used self-report measures, (e.g., Braehler et al., 2013; Laithwaite et al., 2009; Gale et al., 2014) in addition, many of the studies only reported short-term outcomes. As such, well-designed larger-scale studies with adequate follow-up sessions are needed; these studies could aim to establish where CFT might fit into the care pathway for people undergoing therapy in order to improve their well-being.

## **5 Conclusion**

This review has endeavoured to introduce conceptualisations of compassion and self-compassion in the existing literature. It has sought to provide an evaluation of self-compassion research in a non-clinical population whilst also looking at CFT studies in clinical settings with individuals diagnosed with a variety of mental health disorders (e.g., psychosis, ED and depression and anxiety). The literature reviewed is able to demonstrate the potential benefits of including self-compassionate and compassion interventions in the therapy process. Self-compassion and compassion has a wide ranging relevance to counselling psychologists working across diverse client groups. Endorsing the development of self-compassion and compassion could benefit individuals by helping them to counter destructive self-critical tendencies, acknowledge their interconnectedness with others and deal with their emotions with greater clarity.

The review has demonstrated the effectiveness of using CFT a multi-modal therapy with different clinical populations. Since CFT incorporates aspects of other evidence-based therapies, it can be used by therapists from a range of disciplines. Therapists' can use an understanding of the biological basis of the affect regulation systems, and how these may be affected by early development as a frame within which they can deliver effective psychotherapy.

Overall, the literature review has provided evidence to suggest that self-compassion and compassion can improve individual psychological well-being in a non-clinical cohort and in a population diagnosed with a variety of mental health issues.

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