# INTRODUCTION

## 0.1 Preamble

Between September 2007 and September 2008, I worked as a clinical assistant psychologist and participated in a therapists' personal development forum about Acceptance and Commitment Therapy (ACT). I then joined a Mindfulness Based Cognitive Therapy (MBCT) group at a local Buddhist centre in order to practice and learn more about mindfulness. Thanks to that course I started my exploration of MBCT, and then Mindfulness Based Interventions (MBIs), including Dialectical Behavioural Therapy (DBT) and Mindfulness Based Stress Reduction (MBSR)[1].

In mental health work, the use of meditation is not a new concept. Models that have incorporated Eastern philosophies or Buddhism and Western psychology have been utilized for many decades (Epstein, 2007; Brazier, 2001). However, it was only 39 years ago that Kabat-Zinn started MBSR in a Massachusetts hospital while at the same time Linehan commenced DBT at the University of Washington. MBSR was presented as a secular therapy for stress or borderline personality, so that it would appeal to the average American and would not risk being thought of as 'new age' (Kabat-Zinn, 2011). At that time, the definition of mindfulness had to be constructed and communicated, however, this was a paradoxical undertaking, as mindfulness must be experienced in order to be understood. Mindfulness is an embodied state of being that cannot be accurately described using only language. Mindfulness is a complex construct and Western science has had difficulties in agreeing on a definition (Bruce, Shapiro & Constantino, 2010). Currently, there are many definitions of mindfulness, and its numerous interpretations of its impact on the Therapeutic Relationship (TR). For the

[1] MBIs will refer to the four main Mindfulness Based Interventions currently utilised by psychologists: Mindfulness Based Stress Reduction (MBSR), Mindfulness Based Cognitive Therapy (MBCT), Additionally, this research will refer to mindful-meditation, which is the type of meditation practiced as part of these interventions, which is also practiced by the participants in their private lives. In the context of this study, when discussing the professional domain the term MBIs will be used, while the term mindful-meditation will be used when discussing the personal domain. Since this study is about psychological work with MBIs, the terms psychologists/therapists, will be used rather than teacher/instructor.

purpose of academic exploration the definition often recited in literature is "The awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding experience, moment by moment" (Kabat-Zinn, 2003: 145). The research around mindfulness based interventions (MBIs) has moved on since the early days of MBSR and DBT in the 1990s, with an explosion of material attending to almost any aspect and implementation area around MBIs (Kabat-Zinn, 2011; O'Driscoll, 2009). According to David & Hayes (2011: 198, 201), the key findings from this large body of research are that mindfulness helps to enhance the following qualities: self-control (Bishop et al., 2004; Masicampo & Baumeister, 2007); objectivity (Brown, Ryan & Creswell, 2007); tolerance of difficult emotions (Fulton, 2005); improved flexibility (Hayes & Feldman, 2004); equanimity (Morgan & Morgan, 2005), enriched concentration and mental clarity (Young, 1997); emotional intelligence (Walsh & Shapiro, 2006); ability to relate to others and to one's self with kindness, acceptance and compassion (Fulton, 2005); enhanced emotional regulation and cognitive flexibility (Wallin, 2007); effective regulation of emotions in the brain (Corcoran, Rab, Anderson & Segal, 2010); reduction of symptoms of anxiety and depression (Hoffman, Sawyer, Witt & Oh, 2010); improved working memory (Jha et al., 2010); self-insight, morality, intuition and fear reduction (Siegel, 2009) and increased immune functioning (Grossman, Nieman, Schmidt & Walache, 2004); neuroplasticity and distinct grey matter concentration (Lazar et al., 2005; Holzel et al., 2008); fostering empathy (Shapiro & Izett, 2008); compassion and self-compassion (Shapiro, Brown & Biegel, 2007); feeling more attuned with oneself and clients (Schure, Christopher and Christopher, 2008).

However, within the literature there is a scarcity of research focusing on how the TR is influenced by a therapist/psychologist working with MBIs. Hick & Bien's seminal book (2010) was the first to discuss the relationship between mindfulness and the TR. Prior to this, there have been four studies within which my own work is located (Grepmair et al., 2007; Nanda, 2005; Shapiro et al., 1998 & Rauthaup & Morgan, 2007;) and three unpublished PhDs (Wexler, 2006; Aiken, 2006; & Wang, 2006). Two other studies

(Stratton, 2005 & Stanley, 2006) have demonstrated that mindfulness did not have a positive effect on therapeutic outcome. This research will be discussed in relation to these studies and further literature review (see section 1.3.1).

An important methodological question underlies the present research. If mindfulness is inevitably a subjective, pre-symbolic process, it is questionable whether empirical methods provide the best way to study it. For counselling psychologists, the influence of mindfulness on the psychologist, on therapeutic work and therefore on outcome is of critical importance, and is inseparable from their work. This research aims to explore the potential of mindfulness to contribute to further developments in counselling psychology. In the existing literature, there is currently a gap with regard to the potential contribution of mindfulness to the TR - a gap which this research aims to address. Currently, no study looks at psychologists working with MBIs in the context of the TR. Due to the centrality of the TR to counselling psychology (Woolfe, Dryden & Strawbridge, 2003), this research should be of particular interest to the profession.

## 0.2 THE PURPOSE OF MY OWN RESEARCH AND RESEARCH QUESTIONS

The purpose of this research is to examine the lived experiences of psychologists working with MBIs in the context of the TR. The study is located within the framework of Rogers' (1961) core conditions of the Therapeutic Relationship (TR), as well as Bordin's (1979) Working Alliance (WA) and Clarkson's (2003) inventory model of the psychotherapeutic relationship (see section 1.2.3).

The relevance to counselling psychology is multi faceted. Rogers' TR is embedded in counselling psychology since this profession stresses the centrality of humanistic psychology, as opposed to a natural sciences approach.

MBIs and mindful-meditation originated from Buddhist psychology, but they share conceptual affinity with ideas advanced by a variety of philosophical and psychological traditions, including phenomenology, existentialism, transcendentalism and humanism (Brown Ryan & Creswell, 2007). Mindfulness also highlights the notion of being in the present moment. Humanistic psychology (Rogers, 1961) has emphasised the importance of immediacy of experiencing in full as a central therapeutic change process. Therefore, this topic of research is relevant to counselling psychology. Additionally, the methodology of interpretative phenomenological analysis is suitable and fits the subject matter as mindfulness and MBIs share a phenomenological view of reality.

This research will attempt to describe and interpret the following topics. Firstly, qualities of the therapeutic relationship that were felt by the participating psychologists with their clients. Furthermore, it will highlight the quality of the relationship the participants developed with themselves, as a result of practicing mindful-meditation, and other relationships that developed within the group work of MBIs. Secondly, in line with counselling psychology's significant thinkers such as Maslow, Rogers and May (Woolfe et al., 2003) who saw human beings in a holistic manner. Participants in this research described mindfulness experiences as dichotomies but bridged those into an integrative whole (see 3.4.1). Additionally, an integrative view of linking the participants' private lives with professional lives, in a way that the participants felt aligned within both domains, will be illustrated. Finally, a balanced view of mindfulness will be presented. The overall message of this research is that mindfulness is beneficial, but also presents psychologists with challenges (see 3.5.2).

**The main research questions that will be addressed are therefore**:

1. How and what does the TR feel like when working with MBIs?
2. What is the experience of working with MBIs like?
3. What are the benefits/difficulties of working with MBIs?

# CHAPTER ONE: LITERATURE REVIEW

Throughout this chapter, the researcher has drawn upon the available literature and research relevant to psychologists working with Mindfulness Based Interventions (MBIs) within the context of the Therapeutic Relationship (TR).

In the discipline of counselling psychology the TR is construed as essential to successful therapy (Woolfe et al., 2003). The emphasis upon building an effective TR demonstrates counselling psychology's ethos in comparison to adjunct professions. The researcher was particularly interested in the way mindfulness work might impact upon the TR, and examined how psychologists made sense of and experienced mindful-meditation practice.

## 1.1 Mindfulness and mindfulness-based interventions

Mindfulness, as a way of relating to experience, has long been used to lessen self-imposed intra-psychic life difficulties (Germer, Siegel & Fulton, 2005). Mindfulness enables individuals to notice and work with the vulnerabilities that are an inherent part of being human and thus links to existentialism (Mace, 2008). Mindfulness awareness is neither religious nor esoteric in its nature and is potentially accessible to all (Grossman et al., 2004; Kabat-Zinn, 2003). Avenues for the integration of mindfulness and psychotherapy differ by the degree to which mindfulness is overtly introduced into treatment. They range from the implicit influence of the meditating therapist, to theory-guided mindfulness psychotherapy, and explicit teaching of mindfulness practices to patients.

### 1.1.1 Mindfulness: operational definitions

Attempts to represent different definitions of mindfulness have been made from the standpoints of Buddhism and psychology. Offering a definitive definition is an illusive endeavour (Kabat-Zinn, 2011), yet for the purpose of this research, two operational definitions are presented in Figure 1.

Theorists have prioritised diverse aspects of the concept of mindfulness thus creating subtle but significant differences. Mindfulness means paying attention in a particular way: on purpose (attention), in the present moment (intention), and non-judgementally (attitude) (Kabat-Zinn, 1994). Defined by Germer (2005: 7) “mindfulness is awareness of present experience with acceptance”. In all cases there is an emphasis on awareness being focused onto what is immediately present, at the expense of other kinds of experience, and on acceptance without judgement (Mace, 2008). Mindful-awareness’ main quality is a focused and deliberate/intentional effort directed by the meditator (Kabat-Zinn, 1994). In contrast, others have defined it as attention that results from concentration (Goleman, 1988).

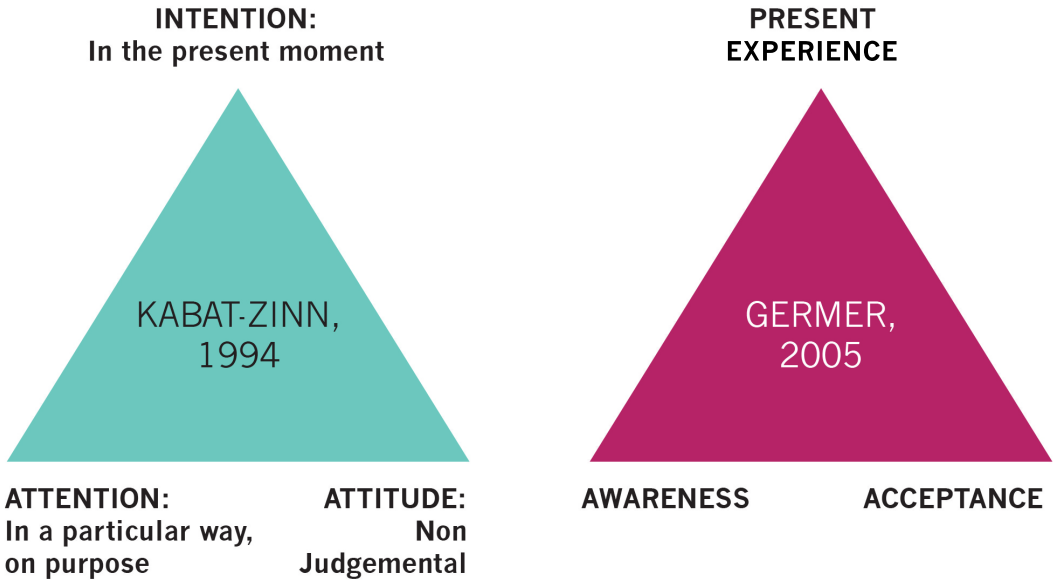


**Figure 1:** Definitions of Mindfulness (Kabat-Zinn, 1994; Germer, 2005)

### 1.1.2 Mindfulness Based Interventions

The advent of mindfulness-based treatment programmes and therapies, also referred to as ‘treatment packages’, are treatments that collate together a set of different mindfulness exercises to be learned or applied over several sessions. They entail traditional mindfulness exercises or strategies that encourage mindfulness (Hayes & Shenk, 2004). Treatment packages have allowed for a manualized approach to teaching these methods and to carrying out research. Kabat-Zinn’s (2003) Mindfulness Based Stress

Reduction (MBSR) programme teaches clients how to use and integrate traditional mindfulness skills such as body scanning and mindfulness of breath in order to alleviate stress. Similarly, Mindfulness Based Cognitive Therapy (MBCT) uses mindfulness methods in conjunction with Cognitive Therapy to prevent recurrence of depression (Segal, Williams & Teasdale, 2002). The most commonly used packages outside of MBSR and MBCT are Acceptance and Commitment Therapy (ACT) and Dialectical Behaviour Therapy (DBT). These latter two have been called third-wave CBT therapies because they are seen as the new wave of developments in behavioural therapy, following the original behavioural and then cognitive behavioural approaches (Hayes, 2004).

Although each clinical model of the four interventions uses slightly different terminology to describe the key components of mindfulness, the researcher would argue that the considerable conceptual overlap among the models supports an overarching conceptualization (Dimidjian & Linehan, 2003).

There are several reasons for selecting these interventions. Firstly, they are the most researched and manualized, and have a clear rationale regarding the client group and procedures for the process. Secondly, they all have a record of evidence-based research to show their efficacy. Thirdly, the fact that they have concisely defined constructs has helped the present research to be focused. Lastly, all of the above facilitated a deeper exploration of the TR since the settings were clearly defined. Other mindfulness-based interventions do exist (e.g. mindfulness based relationship enhancement; Carson et al., 2004), but are more novel and have a smaller body of evidence-based research to demonstrate their efficacy.

### 1.1.3 Comparison of the four Mindfulness Based Interventions: MBSR, MBCT, DBT & ACT

Table 1 outlines the four most commonly used and researched MBIs in order to provide an understanding of the processes these interventions offer

the client, since it is their usage and possible impact on the TR that is at the core of this research.

**Table 1: Differences in approach and treatment techniques used in Mindfulness Based Interventions**

(Kabat-Zinn, 1990; Teasdale, Segal & Williams, 1995; Linehan, 1993; Hayes, Strosahl & Wilson, 1999)

| | **Mindfulness Based Stress Reduction (MBSR)** | **Mindfulness Based Cognitive Therapy (MBCT)** | **Dialectical Behavioural Therapy (DBT)** | **Acceptance and Commitment Therapy (ACT)** |
|---|---|---|---|---|
| Originator | Kabat-Zinn (1990) | Teasdale, Segal & Williams (1995) | Linehan (1993) | Hayes, Strosahl & Wilson (1999) |
| Aim | Stress reduction | Avoidance of depression relapse | To treat people with Borderline Personality Disorder (BPD) | To ameliorate psychological issues |
| Client group | Chronic pain, terminal illness, back pain, primary mental health | Recurrent depression | BPD<br>Eating disorder<br>Sexual abuse | Wide range of psychological problems |
| Length of programme | 8 weeks | 8 weeks | 1 year | Varies |
| Length of session | 2 or 2.5 hours, 1 full day | 2.5 hours | 2.5 hours group, 1 hour individual | Varies |
| Setting | Group, up to 30 participants | Group, up to 24 participants | Individual and group | Individual or group |
| Content | * Training in mindfulness meditation (formal sitting)<br>* Skills to protect from stress<br>* Mindfulness in every day, e.g. walking and eating<br>* Body awareness: Hatha yoga | * Formal and informal mindfulness techniques (e.g. formal meditation, walking meditation, mindfulness of everyday tasks) | * Mindfulness practice short & informal<br>* Mindfulness is only one skill module of four<br>* Dialectic framework of opposing poles: the intersection of emotion and reason leads to wise mind | * Mindfulness used to encourage noticing and observing present experience without judgement, for meaningful life<br>* Values and goals examination<br>* Based on Relational Frame Theory |
| Educational interventions | * Psychological model of stress | * CBT elements regarding depression e.g.: thoughts are not facts.<br>* Protective skills against depression<br>* Highlights interpretative stance of client<br>* Awareness of warning marks | * Four skill modules: core mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance<br>* 'What' skills: Observe, Describe, Participate<br>* 'How' skills: Non-judgmentally, One-mindfully, Effectively | * Acceptance and mindfulness strategies with commitment and behaviour-change strategies<br>* Focus on language and change processes<br>* Experiential avoidance highlighted<br>* Short informal tasks |
| Homework tasks | 45 minutes meditation daily | 30 minutes meditation per day | - | - |
| The therapist as | Has to practice by | Has to practice | Does not have to | Does not have to |

| | | | | |
|---|---|---|---|---|
| meditator | self | by self | practice meditation | practice meditation |

For further clarification of each intervention see Appendix 2

### 1.1.4 Critique of research on mindfulness

Research into MBIs has increased exponentially over the past two decades (Kabat-Zinn, 2011). Prior to that, there were difficulties in drawing strong conclusions due to the poor methodological design of the studies which often were not conducted double blind and did not include a treatment as usual (TAU) group for comparison. In a meta-analysis of 21 mindfulness-training studies, Baer (2003) reported a positive efficacy mean effect size of 0.59 (any value above 0.05 is statistically significant). Yet, only a handful included calculations that possess methodological rigour such as control trials with clinical populations. Most of the studies used data from pre-post designs, nonclinical populations, or both. This was problematic as there was no comparison to TAU and the research was not conducted upon clinical populations. This meant that the findings could not be generalised (Dimidjan & Linehan, 2003).

As mentioned earlier (section 1.1.1), another area of criticism in the literature around MBSR concerns the definition of mindfulness itself which has given rise to ambiguity particularly in early studies (Bishop et al., 2004). For example, the equation of mindfulness with acceptance (e.g. in ACT) and its confusion with relaxation was an issue. Additionally, some consider the meditator's act of 'describing' as part of the concept (e.g. in DBT) and others consider it to be a subsequent ability rather than part of the definition. This lack of consensus has hindered the progress of research in determining the active ingredients of mindfulness interventions (Dimidjian & Linehan, 2003).

Grossman et al. (2004) discounted many studies from their meta-analysis due to the scarcity of information about the mindfulness procedures that were followed. Although most studies that they reviewed began by introducing mindfulness and giving a brief generic description, they rarely provided a definition of the specific procedure used or attempted to record

or measure faithfulness to the protocol (e.g. Astin, 1997). Hardly any information was given as to the professional qualifications of those teaching the mindfulness techniques. Similarly, there was little information about the degree of observance of the procedure, thus it was difficult to determine whether the mindfulness training *per se* was the operating agent of change. Equally, without any measurement of adherence, it was impossible to evaluate the consistency of the training between different groups or different trainers. It is possible that those studies that reported a larger effect size did so due to a positive group dynamic; a protocol followed more closely by the trainers; or more experienced trainers. However, it is equally conceivable to argue that changes seen in some groups might be due to other techniques the trainers used which had nothing to do with mindfulness.

Despite the above-mentioned problems, over the last five years Kabat-Zinn's definition of mindfulness for MBSR has been taken as the operational definition in fMRI brain scan research, which apparently has demonstrated how mindfulness practice leads to increases in regional brain gray matter density. Left hippocampus gray matter has been found to thicken in the MBSR group (Hölzel et al., 2011a) and research has described how mindful-meditation works from a neural perspective (Hölzel et al, 2011b). These findings of the fMRI studies focus on one particular type of research question (can visual brain changes be detected after an MBSR course) but do not explore other research questions regarding whether and how MBSR influenced the participants.

Nevertheless, the above studies were significant as they provided scientific evidence as to the efficacy of the intervention and were replicated in other studies (e.g., Ott, Holzel & Vaitl, 2011). Furthermore, there is evidence that the amygdala (Goldin & Gross, 2010), involved in stress management of the individual, gets smaller and thinner with MBSR - a positive progress that demonstrates that stress is coped with better.

Similarly, within MBCT more scientifically sound studies have been conducted. Early studies have shown that MBCT is effective for the

prevention of depression in people who were diagnosed with more than three episodes of clinical depression (Teasdale et al., 2000). However, recent studies have highlighted that MBCT would be useful for anybody with depression, as it is not the number of episodes but rather the timing of the onset of the first episode of depression that makes the best predictor for a positive outcome. Late onset is associated with a better outcome (Williams, 2013). Additionally, for people with suicidal ideation (Williams, 2012), recent research has demonstrated that MBCT significantly reduces suicide cognitions more effectively than TAU or psycho education[2]. However, the findings also revealed that half of the effect of MBCT is related to psycho education and the group/class setting. The other half is due to the mindfulness practices.

Counselling psychologists utilise all of the above-mentioned four interventions. However, if research on mindfulness as an intervention strategy follows the direction of research on other psychotherapeutic techniques, then it will reveal that the intervention plays only a small role in positive outcome - the larger share of outcome being attributed to the 'common factors' such as the TR (Hick & Bien, 2010). It is the therapeutic relationship (TR) that is the source of change (Bordin, 1979; Rogers, 1961) and at the core of this research. Therefore, an exploration of the TR will take place in the following section.

## 1.2 The therapeutic relationship

Counselling psychology as a profession places the Therapeutic Relationship (TR) at the heart of its philosophical belief and practice (Woolf et al., 2003: 11). The relationship or the interconnectedness between two people has been significant in all healing since the time of Hippocrates and it seems to be one of the principal features in any major change affecting people's lives (Clarkson, 2003).

[2] Psycho education refers to the part of MBCT in which clients are taught psychological theories such as CBT, explaining the reasons for the depression.

Many studies (Martin, Garske & Davis, 2000) have demonstrated that it is the relationship between the client and the psychotherapist, more than any other factor, that determines the effectiveness of psychotherapy. That is, success of psychotherapy can be best predicted by the properties of the client, of the psychotherapist and their particular relationship (Norcross & Goldfried 1992, Hynanm 1981).

### 1.2.1 The therapeutic relationship: definition

The systematic use of the dynamics of the relationship between therapist and client is so central to psychotherapy in general, and to counselling psychology in particular, that it is one current definition of psychotherapy. Psychotherapy is about the relationship between the therapist and the client, and it enables the production of change in cognition, feelings and behaviours (Holmes & Lindley, 1989). When working with MBIs, in the majority of cases, both client and therapist meditate together and this creates a shared experience and shared exploration. This might involve disclosures, and relationship formation. In order to clarify the therapeutic relationship process, three theories will be discussed: the therapeutic relationship (TR) (Rogers, 1961), the working alliance (WA) (Bordin, 1979) and the psychotherapeutic relationship (PTR) (Clarkson, 2003).

A major conceptual shift in emphasis towards the importance of the TR came about with Rogers' (1961) focus on the healing properties of the core conditions for the relationship. The emphasis was on 'real' rather than the transference elements of the encounter. The three core conditions were: unconditional positive regard; empathic understanding; and congruence/ genuineness (Mears & Thorn, 2007). Critique of Rogers' (1957) definition of the TR acknowledges that this approach does not address the possibility of variations in the clients' ability/motivation to respond to the therapist's offer of the core conditions (Horvath & Luborsky, 1993) but it is still used widely.

Bordin's (1979) model of the Working Alliance (WA) consists of the bond, task and goals. The bond specifically is a replication of Roger's TR. The WA is included in Clarkson's model as the first facet of the relationship.

Clarkson's (2003) model of the psychotherapeutic relationship consists of five elements: WA; developmental relationship; transference-countertransference; person-to-person and transcendental relationship.

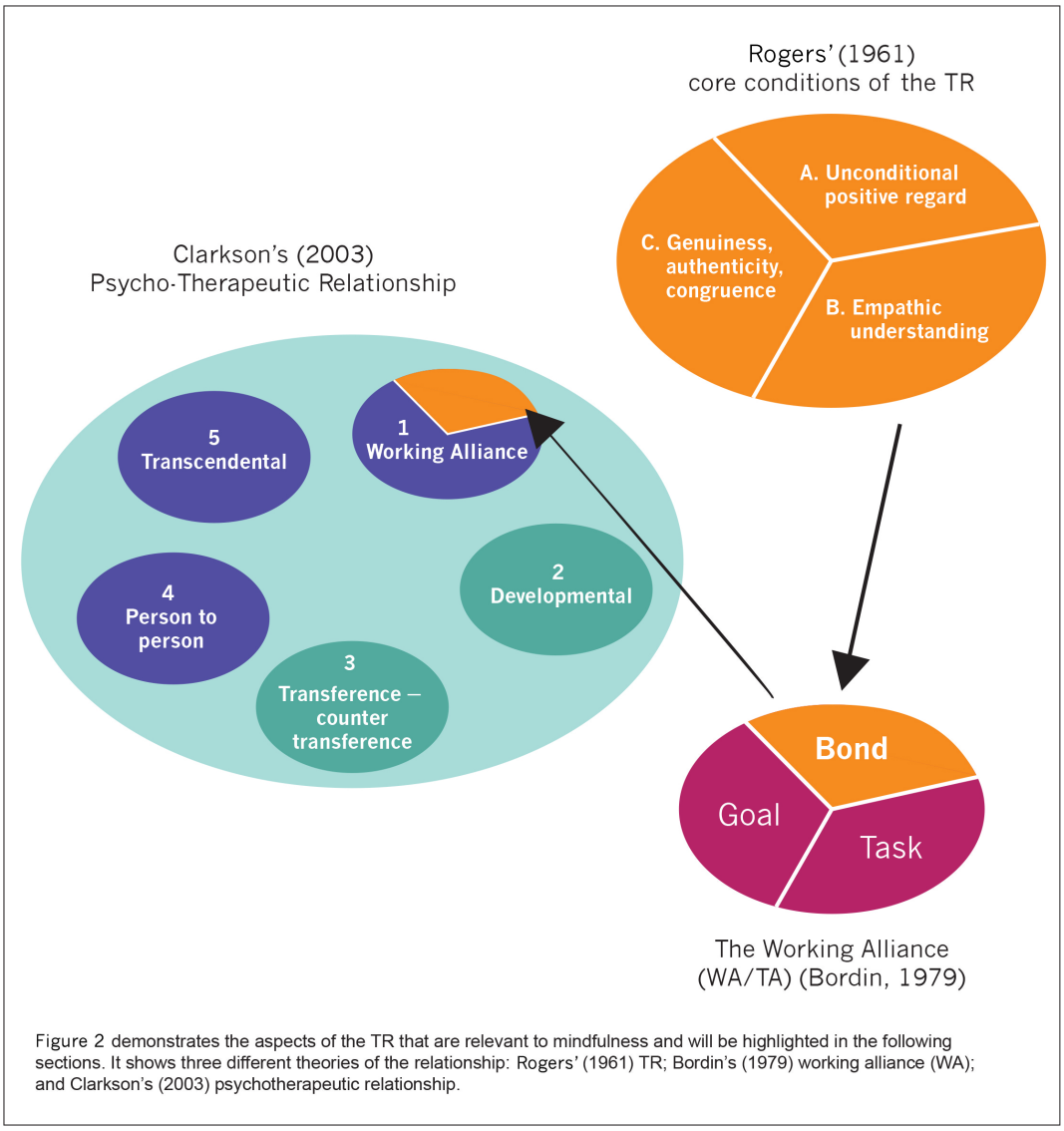


Figure 2 demonstrates the aspects of the TR that are relevant to mindfulness and will be highlighted in the following sections. It shows three different theories of the relationship: Rogers' (1961) TR; Bordin's (1979) working alliance (WA); and Clarkson's (2003) psychotherapeutic relationship.

### 1.2.2 The importance of the relationship for therapy outcome

The relationship between the facilitative conditions of the person-centred school (Rogers, 1961) and therapy outcome have been reviewed by many (e.g. Lambert, DeJulio, & Stein, 1978). These reviews suggested a modest

relationship between factors such as Rogers' (1961) core conditions and measures of outcome. These findings are firmly established. Similarly, researchers who have used psychodynamic theories have produced research on the working alliance (WA) and found that it is a robust predictor of positive therapeutic outcomes (e.g. Horvath & Greenberg, 1994; Horvath & Luborsky, 1993). Additionally, behavioural and cognitive-behavioural therapies have been measured by the therapeutic alliance scales[3] and found that the therapeutic alliance works (De Rubeis & Felley, 1991, Hick & Bien, 2010). It is important to note that the therapeutic alliance also emphasises client variables such as the client's ability to participate in therapy. Because they include more elements such as the goals and tasks, working alliance measures (Bordin, 1979) would be expected to correlate more highly with client outcome than measures of facilitative conditions (Rogers, 1961).

Looking across thousands of studies over 60 years (e.g. Martin, Garske & Davies, 2000), it has been concluded that the WA is the most important factor for prediction of therapy outcome. Since this large body of research has repeatedly confirmed the findings, the implication of relationship research for successful psychotherapy has been confirmed. Measures of therapeutic relationship variables consistently correlate more highly with client outcome than specialized techniques (Lambert & Ogles, 2004). The consistency of the findings confirms that the research is robust and reliable (Hick & Bien, 2010: 26).

### 1.2.3 The Working Alliance

Historically, the client-therapist relationship developed into the concept of the Working Alliance (WA) by Freud (1913/1958) who noted the importance of the client -therapist relationship. The relationship's aspects were noted in

[3] These scales measuring therapeutic outcome are the Working Alliance Inventory (WAI) and the California Psychotherapy Alliance Scale (CALPAS) which measure the alliance's strength via variables such as agreement about the goals, tasks of the therapy and the bond between the client and therapist for the WA and four sub scales: patient working capacity, patient commitment, working strategy consensus, and therapist understanding and involvement for the CALPAS.

psychoanalysis (e.g. the 'real' relationship and transference, see: Meissner, 2006). The concept of the Therapeutic Alliance (TA), a phenomenon shared by the patient and analyst, has made a distinctive contribution by aiming to foster the collaborative relationship process (Ponsi, 2000; Hick & Bien, 2010).

Following the 1960s shift of defining the construct through its alignment with Roger's core conditions of the TR, since the 1990s the WA has become the central construct employed in published research in both counselling/clinical psychology. The client-centred operational conception of the TR was replaced by renewed efforts to discuss the relationship in terms of the WA or Therapeutic Alliance (TA).[4] Research scales were largely informed by psychodynamic formulations, but in a format that intended to be pan-theoretical and hence applicable to all psychotherapy.

The working alliance (WA) involves cooperation between the patient and therapist, which underpins all effective helping. Greenson (1967) and Bordin (1979) have defined it as: goals, bond, and tasks (Bordin, 1979), three aspects that seem to be required for any form of therapy to be successful. The goals must be agreed first, then tasks need to be established collaboratively, and lastly, a personal bond that is a therapeutic relationship[5] should exist. The three aspects of the WA are also called the 'common factors'. Further common factors in this conceptualisation include the importance of the early stages of therapy work (Luborsky, 1976) and the patient's ability to form a meaningful relationship with the therapist (Strupp & Hadley 1979).

The Therapeutic Alliance (TA) (Horvath & Luborsky, 1993) is used as an alternative label to the WA. Four decades of research (using the California

[4] TA is defined as (a) the collaborative nature of the relationship, (b) the effective bond between patient and therapist, and (c) the patient's and therapist's ability to agree on treatment goals and tasks (Martin, Garske & David, 2000)

[5] Measures such as Horvath and Greenberg's (1994) Working Alliance Inventory (WAI) and Luborsky's (1994) Helping Alliance Questionnaire, attempt to assess the degree to which client and therapist concur on the purposes of their work together, as well as goals to be achieved. These measures include items that try to capture the affective bond.

Psychotherapy Alliance Scales: CALPAS) has consistently confirmed that the quality of the TA predicts treatment outcome (Horvath & Symonds, 1991; Martin et al., 2000). Thirty percent of positive outcomes are due to the quality of the alliance (Safran & Muran, 2006). However, one criticism of this body of research concerns the separation between the alliance and the transference (the latter being a psychoanalytical construct first noted by Freud, 1958/1912[6]). The issue might be that the therapist could leave some aspects unanalysed (e.g., Brenner, 1979). What might seem as a 'bond' may be a compliance/collusion of the client with the therapist; what might look like a strong alliance may be a subtle withdrawal rupture (Safran & Muran, 2000). On the positive evaluative side, Bordin's (1979) definition implicitly highlights the interdependence of technical and relational factors, hence the usefulness of an intervention is always mediated by its relational meaning. Any attempt to disentangle relational and technical dimensions is problematic (Safran & Muran, 2006).

As can be seen in Figure 2, part of the WA includes the 'bond', within which are the Rogerian core-conditions. Psychotherapy accepts the notion that the core-conditions are important for significant progress in psychotherapy and are fundamental in the formation of a WA. (Lambert 1986). A large body of research (e.g. Lambert & Barley, 2001), with strong validity and reliability has shown the significance of the WA and includes studies of therapists' techniques (e.g., use of interpretation, self-disclosure) and relational capacity or attachment styles. However, there is not yet consensus about the most efficacious factors influencing the development of the alliance. Despite decades of research, the psychology community has still not decided upon a common term, nor a shared definition that is accepted by all.

In summary, the WA's 'bond', that is one third of the three aspects, contains within it Roger's three conditions but not exclusively so. Factors such as therapist credibility, ability to engage with the client, and early engagement

[6] The transference is defined as "The inappropriate repetition in the present of a relationship that was important in a person's childhood".

are considered vital to the bond too. Focus on the client's problems and the collaboration aspect is also highly related to outcome (Lambert & Barley, 2001). Despite the differences between the alliance conceptualisations and names, most theoretical definitions of the TA have three themes in common: collaboration; the bond; and goals-tasks agreement (Bordin, 1979; Horvath & Symonds, 1991; Martin et al, 2000).

### 1.2.4 The psychotherapeutic relationship

Clarkson (2003) identified an inventory of five facets of the Psychotherapeutic Relationship (PTR) (see Figure 1). The reason to include Clarkson's model is that this captures the complexity of what was to be examined in this research. Clarkson's taxonomy entails first, the Working Alliance (WA); second, the transference-counter transference relationship; third, the developmental relationship; fourth, the person-to-person relationship; and fifth, the transpersonal relationship (see definitions in Appendix 2B). These facets are descriptions of types or possibilities of relationships. Three of them are pertinent to mindfulness (see previous page for the WA), therefore the remaining two will be further elaborated upon.

#### 1.2.4.1 The person-to-person relationship

Clarkson's (2003) fourth classification of the 'person-to-person' relationship borrows its essence from humanistic philosophy and therapy (e.g., Rogers, 1987). Clarkson's potentially tautological definition of this relationship is 'the dialogic relationship' or 'core relationship'. It concerns 'real' dimension or the authentic humanness shared by both client and therapist. It obtains a sibling-like connection to MBIs because when the client and therapist meditate together, there is a shared exploration of each individual experience. This exploration might involve disclosure from the therapist (e.g. how was the meditation experienced by him/her) at which point the relationship is being formed.

Similar to MBIs, within the humanistic/existential tradition there is an appreciation of the person-to-person relationship since its ability to heal is demonstrated in ordinary life. Buber (1970) called it the 'I-Thou' or 'I-You' relationship in contrast to the 'I-it' relationship. The 'I-You' relationship is referred to as the real relationship (Clarkson, 2003: 15). Ordinary relationships which humans have experienced as healing have the qualities of 'I-You', and have been valued for their transformative potential in the psychotherapeutic arena if used ethically (Rogers, 1961; Laing 1965). Object relations theory (Klein, 1952) is the opposite of Buber's 'I-You' TR. For Buber the other is a person, not an object or a part object. Existential and humanistic orientated therapies (such as Gestalt which emphasizes the here-and-now context) have amplified the value of the person-to-person encounter. As mentioned above, for Rogers, (1967) genuineness and respectful congruence are conditions to facilitate growth. Critics of the Rogerian person-to-person argued that it is naïve to look at the TR without acknowledgment of the power dynamic. However, Rogers wrote about the risk the psychologist has to take when encountering a genuine person-to-person encounter (Kirchenbaum, 1989) and demonstrated that for some psychologists descending from the 'expert' position could be difficult.

### 1.2.4.2 The transpersonal relationship

The definition of the transpersonal relationship is "the timeless facet of the psychotherapeutic relationship, which is impossible to describe, but refers to the spiritual, or currently inexplicable dimension of the healing relationship" (Clarkson, 2003: 187). This inexplicable aspect is relevant to mindfulness since the latter is interlinked with the transcendental aspects of human lives (see 3.3.1.1). This approach refers to the spiritual-religious aspect of life. Spirituality found in philosophies such as Buddhism, psychosynthesis, Jungian psychology and humanistic/existential psychology acknowledge certain qualities, which transcend the limits of our understanding (Clarkson, 2003). Some recognition of the transpersonal relationship between the healer-healed in the TR is gradually gaining more acceptance.

In the transpersonal relationship, the unconsciousness of the client and the unconsciousness of the therapist meet and are not mediated by consciousness (Clarkson, 2003). Peck (1978) mentioned the concept of grace as a quality that exists in such relationships. Implied is a 'letting go' of skills, of knowledge, of experience, of preconception and even the desire to heal. It is essentially allowing passivity and receptiveness, for which preparation is always inadequate. The researcher's evaluation is that in this domain science is left behind, while the focus moves onto a philosophical level. Through a phenomenological interpretative perspective, the researcher finds it difficult to ascertain the parameters of this relationship.

The literature covered so far has revealed that mindfulness has links with humanistic psychology, existentialism and transcendentalism. Since Rogers' core conditions and Clarkson's model contain different aspects of the TR that are relevant to mindfulness, these theories will be utilised as the underlying theories for examining the research question. In the following section, research about the connection between MBIs and the TR will be explored.

## 1.3 Mindfulness and the Therapeutic Relationship

So far four different MBIs and three angles of the TR have been outlined. These constructs will allow the examination of the convergence between mindfulness and the TR, as the purpose of this study is to investigate psychologists' experiences of working with MBIs in the context of the TR.

### 1.3.1 Research literature on mindfulness and the TR

In contrast to the numerous studies on the efficacy of MBIs, there is little research on how mindfulness training for the therapist may impact on the TR or client outcome via the TR (Hick & Bien, 2010). However, the present research is not examining the outcome per se, but is looking at the lived experiences of psychologists working with MBIs in the context of the TR.

The emphasis of research within mindfulness has been to provide evidence for specific techniques, correlating them positively to outcomes. The emphasis within mindfulness research may be concentrating on packaging mindfulness as a therapeutic technique and focuses less often on the nature of mindfulness, which entails elements that are not technical (Hick & Bien, 2010).

Mindfulness guides the person to be deeply present with self and others. It also cultivates a way of paying attention to variations in emotions, thoughts and perceptions. This kind of awareness can enable psychologists to be present in the TR in a different way that is more about being with the client than about being a detached expert. Most discussions about MBIs strongly suggest that the people who teach the programmes should practice mindfulness themselves (Kabat-Zinn, 1990). However, thus far, there is little evidence to support the assumption that psychologists who practice mindfulness deliver better outcomes (Hick & Bien 2010). This, in part, is the reason for this current research, which explored the experiences of psychologists practicing mindful-meditation in both their private and professional lives in the context of the TR.

In one of the few mindfulness studies on the TR, Wexler (2006) used a correlational design to examine the relationship between therapist-mindfulness and the quality of the TA. Therapist mindfulness was measured using the Mindfulness Attention Awareness Scale (MAAS; Brown & Ryan, 2003) and the TA was measured using dyadic ratings from the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). Data from 19 therapist-client dyads revealed significant correlations (0.59) between both clients' and therapists' perceptions of the alliance, (measured by the WAI), and therapist mindfulness, (measured by the MAAS), both in and out of therapy. However, the sample size of only 19 client-participant dyads was small, hence the validity of the results needs to be cautiously considered. Second, the sample was 100% Caucasian participants. Wexler has suggested that this homogeneity might have led to the significant correlation between therapists' mindfulness and client/therapist perceptions of the

alliance (Wexler, 2006). Third, the WAI was designed to measure an early stage of the alliance (sessions three-to-five), but Wexler's therapists chose clients who had been seen for months/years, and it is thus possible that this selection bias has influenced the positive results, as it might have been that the alliance scores were confused with therapy benefits, and thus exaggerated the alliance. In summary, the limitations of Wexler's study made the results less generalisable. It left the researcher unclear as to whether or not her research variables were accurately measured, what role mindfulness played, and how therapists can develop mindfulness. The WAI and MAAS are self-report measures, and thus bias was highly likely. Additionally, correlational design does not prove causation (Brewer, 2000). How and to what extent the therapist as a variable plays an important role in the development of the TA remains to be investigated.

Mindfulness with trainee therapists and the therapeutic outcome was explored by Grepmair et al., (2007). This was the first large-scale study of the effects that mindfulness in psychotherapists in training (PITs) can have on treatment results. They examined the therapeutic treatment course and the results of 124 inpatients using a randomised, double-blind controlled study. Grepmair et al. (2007) compared the outcome of 18 different therapists, nine of whom undertook a nine-week Zen-meditation course at 7am prior to providing therapy to clients, compared to nine who did not meditate before their work. All 124 inpatients had treatment as usual and did not meditate with their PITs. They found that compared to the group with non-meditating therapists (n=61), the outcome of the inpatients of the meditators (n=63) was significantly higher using a variety of scales: Session Questionnaire for General and Differential Psychotherapy (STEP; Krampen, 2002); the Questionnaire of Changes in Experience and Behaviour (VEV; Zielke & Kopf-Mehnert, 1978), and the Symptoms Check List (SCL-90-R; Franke, 2002). Furthermore, the inpatients of the meditators showed greater symptom reduction, better assessment of their progress, greater rate of change, and higher subjectively perceived results. The limitations of the study are: first, the Zen training was not tested against a placebo intervention, hence it could be that any act of attention-focus just before

work would produce a special effect. Second, whether the potency of the meditation effect would increase with increased meditation time needs to be investigated so that a 'prescriptive' amount for positive outcome could be recommended for PITs. Lastly, the sample size of the PITs was small and thus the results can be generalized only with great caution. It is interesting to note that on the relationship perspective both patient groups performed similarly well on the STEP[7] measure. Hence in the context of this research this implies that, although the psychologists' early morning meditation did contribute to a positive outcome, it did not necessarily make a difference to the development of the alliance.

There are very few studies that have examined directly the impact of mindfulness practice on the cultivation of the relationship. However, as discussed earlier, empathy is part of the TR as constructed by Rogers (1961). The following three studies will detail research on empathy and mindfulness.

Shapiro, Schwartz & Bonner (1998) assessed the efficacy of MBSR in enhancing the doctor-patient relationship through the cultivation of empathy. Two hundred medical medical students were tested on the Empathy Construct Rating Scale (ECRS: La Monica, 1981) after receiving mindfulness training. The study showed a significant increase in levels of empathy (alpha coefficient of 0.89)[8]. The study includes various limitations. First, it is a pre-post study with no control group as a comparison. Second, the ECRS is a self-report scale; hence it is possible that bias may have occurred. Self-assessment of empathy by students did not correlate significantly with any of the behaviour-based measures. Third, the study did not measure the patients' perceptions or used standardised patients measures to assess physician empathy. For empathy to be effective, it must be perceived by the patient (Horvath & Luborsky, 1993). Whether patients perceive a trainee as empathic should be an important standard for MBIs.

[7] STEP measures influencing factors in psychotherapy from the patient's perspective. It has three subscales: clarification, problem solving and relationship perspectives.
[8] This means nearly excellent internal consistency that demonstrated the reliability of the psychometric test.

Walsh (2010) asserted that there is a paradoxical relationship between therapists' perceptions of empathy and therapists' ability to be empathetic: it is in particular those who think they understand/feel empathic towards the client who seem to understand very little. Furthermore, whether this would have similar results on experienced medical doctors cannot be assumed, as some argue that empathy may degrade with time (Walsh, 2010).

In her Ph.D. study, Wang (2006) examined the impact of mindful-meditation practice in psychotherapists' private and professional lives with regards to awareness and empathy levels. This was a mixed methods study. Two groups of psychotherapists (21 meditators versus 35 non-meditators) were compared using self-report measures (MAAS; Brown & Ryan, 2003) for awareness/attention and the 'Balanced Emotional Empathy Scale' (BEES; Mehrabian & Epstein, 1972) for empathy. Eight meditating psychotherapists also participated in semi-structured interviews. The study found no significant difference between meditating psychotherapists and non-meditating psychotherapists on their self-perceived attention/awareness levels. However, meditating psychotherapists scored significantly higher on levels of empathy (85 percentile range for the meditators versus 47 percentile rage for the non-meditators). This result indicated that psychotherapists' practice of mindfulness-meditation enhanced their levels of empathy, which might lead to cultivation of a strong TA. Qualitative data also supported enhanced levels of attention and awareness, empathy, non-judgemental acceptance, love and compassion. Nevertheless there are various limitations. First, the study utilised self-report measures that might lead to bias. Second, this was a causal-comparative[9] study, hence no cause and effect could be determined. Third, the researcher did not control confounding variables such as the psychotherapists using yoga and guided imagery which could have affected the participants to be more empathic.

[9] Causal comparative research attempts to determine the cause or reason of existing difference in the behaviour or status of groups of individuals. It attempts to establish a cause- effect relationship among groups. The weakness is that the cause under study has already occurred; the researcher has no control over it. It produces limited cause-effect information.

In a similar vein, Aiken's (2006) qualitative Ph.D. utilised phenomenological analysis and examined how mindfulness practice might influence the therapists' ability to cultivate an empathic orientation. Aiken's interviews with six psychotherapists who had over ten years of mindful-meditation practice found six self-reported enhanced features: empathy; body & feelings awareness; ability to articulate body sensations and feelings; non-judgemental attitude and greater tolerance of pain; equanimity; and compassion. Furthermore, it was found that participants believed that mindfulness contributes to the therapist's ability to achieve a felt sense of the client's inner experience and to communicate his/her awareness of that felt sense. However, Aiken's research lacked a standardised practice of mindful-meditation. Furthermore, Aiken (2006) had already identified certain psychological qualities typically cultivated during the practice of mindful-meditation at the literature review stage, which may have led to Aiken's bias by asking the participants leading questions. Lastly, the study relied heavily on Buddhist philosophy and spirituality. Since these constructs have very vague definitions, it is hard to evaluate them critically with scientific tools.

There are also two studies that showed that mindfulness did not have a positive effect on outcome. Stratton's (2005) PhD measured the mindfulness of the therapist using the MAAS and the mindfulness/mindlessness scale (MMS; Bodner & Langer, 2011). This was correlated with the client outcome score as measured by the Outcome Questionnaire 45 (OQ 45; Lambert & Finch, 1999). Stratton found no correlation between therapists' mindfulness and positive outcome. While this study did not directly measure the impact of mindfulness on the TR or its variables, it does emphasise the need for additional studies.

Stanley et al (2006) who investigated the relationship between mindfulness in psychologists and clients' outcomes found similar negative effects. Twenty-three trainee clinical psychologists were assigned an individual 'mindfulness score' using the MAAS (self report measure). One hundred and forty four clients were seen and asked to fill in self-report measures of Clinical Global Impressions (CGI; GUY, 1976), and Global Assessment of

Functioning (GAF; APA, 1994) at intake and termination. These revealed consistent significant negative correlations between therapists' levels of mindfulness and clients' global functioning at termination of therapy. Some explanation for this result might be that participants in the study were trainees in their very first placement, where integrating technique with monitoring attention may have been difficult. Perhaps enhanced awareness interfered with treatment outcome, in that it distracted from adhering to manual-based empirically supported therapies. Critique of this study includes the fact that despite the statistical significance, the authors noted that the variance in treatment outcome accounted for on the basis of therapist mindfulness was limited. In addition, the results were therapists' mindfulness that predicted less symptom amelioration as rated by the therapists but when rated by the clients, this was not significant. Previous research demonstrated that it is client's rating that is a better predictor of outcome (Horvath & Luborsky, 1993). Hence it is possible that these results need to be treated cautiously. Additionally, it is imported to note that the MAAS is no longer accepted as a measure of mindfulness. This might explain some of the negative results mentioned above (Grossman, 2011).

An important study that emphasised the positive elements derived from mindful-meditating psychotherapists was Nanda's (2005) qualitative study. Nanda explored the impact of therapists' meditation upon their therapeutic practice. It was found that therapists experienced meditation as "being with what is". Four main 'being' qualities emerged with the practice of meditation in relation to themselves: acceptance and non-judgement; openness; letting go of expectations; and being present. In addition, therapists experienced a transformational relational shift in all aspects of their lives including their interaction with their clients and connecting to the clients with love and compassion. Nanda concluded that the experience of meditation enhanced the quality of the encounter in the therapeutic relationship. The therapists were better able to connect with love/compassion, experience empathy, feel grounded and stay with the client's suffering, and be present to the process of therapy. Limitations of the study are that participants practiced different types of meditation,

different spiritual traditions, and different therapeutic orientation - hence the homogeneity of the study was compromised. Given Nanda's finding of the 'being' qualities, since 'being' is a construct derived from existentialist philosophy (Sartre, 2003), and her orientation as an existential counselling psychologist, there is a question whether her existentialist orientation biased the results. Furthermore, the emphasis on love and compassion may be seen as an overly positive portrayal of the state of the therapists' emotions. Indeed some definitions of mindfulness include the intention of compassion to self and others (e.g., Shapiro, 2013) but these results seem strongly stated.

Lastly, similar to Nanda's, the qualitative study by Rothaupt & Morgan (2007) studied how counsellors and counsellor educators incorporated mindfulness into their personal and professional lives. Semi-structured interviews with six participants were conducted. A grounded theory constant comparative method was utilised[10]. The research found that the participants used a variety of tools to incorporate mindfulness into their lives. The results of the counsellors' mindfulness activities were defined as 'intentional living' and 'connectedness'. However, the study had a major limitation in that it did not clarify which mindfulness practice related to which result.

Overall this study outlined a list of things that the counsellors did to cultivate mindfulness such as using a singing bowl[11], walking slowly and doing body scans. This provided suggestions of ways to enhance mindfulness. However, at times the use of constructs was vague in that, for instance, the authors stated that 'intentional living' meant 'being centred on life' which did not clarify the finding and left the research somewhat obscure.

[10] A process in which any newly collected data is compared with previous data that was collected in one or more earlier interviews.
[11] Singing Bowls are a type of sitting bells whose sides vibrate to produce sound.

Assuming that good qualitative research is based on openness to possibilities and to provide novel results (Wang, 2006), Aiken (2006), Nanda (2005) and Rothaup & Morgan (2007) could be criticised for having demonstrated circular reasoning. Their premises were restated as the conclusion of their argument. For example, the definition of mindfulness included intentionality/awareness/acceptance. The results of these authors found elevation in such constructs. In this case, the concern would be that the researchers found what they predicted and looked for. For summarised findings of the studies see Figure 3.

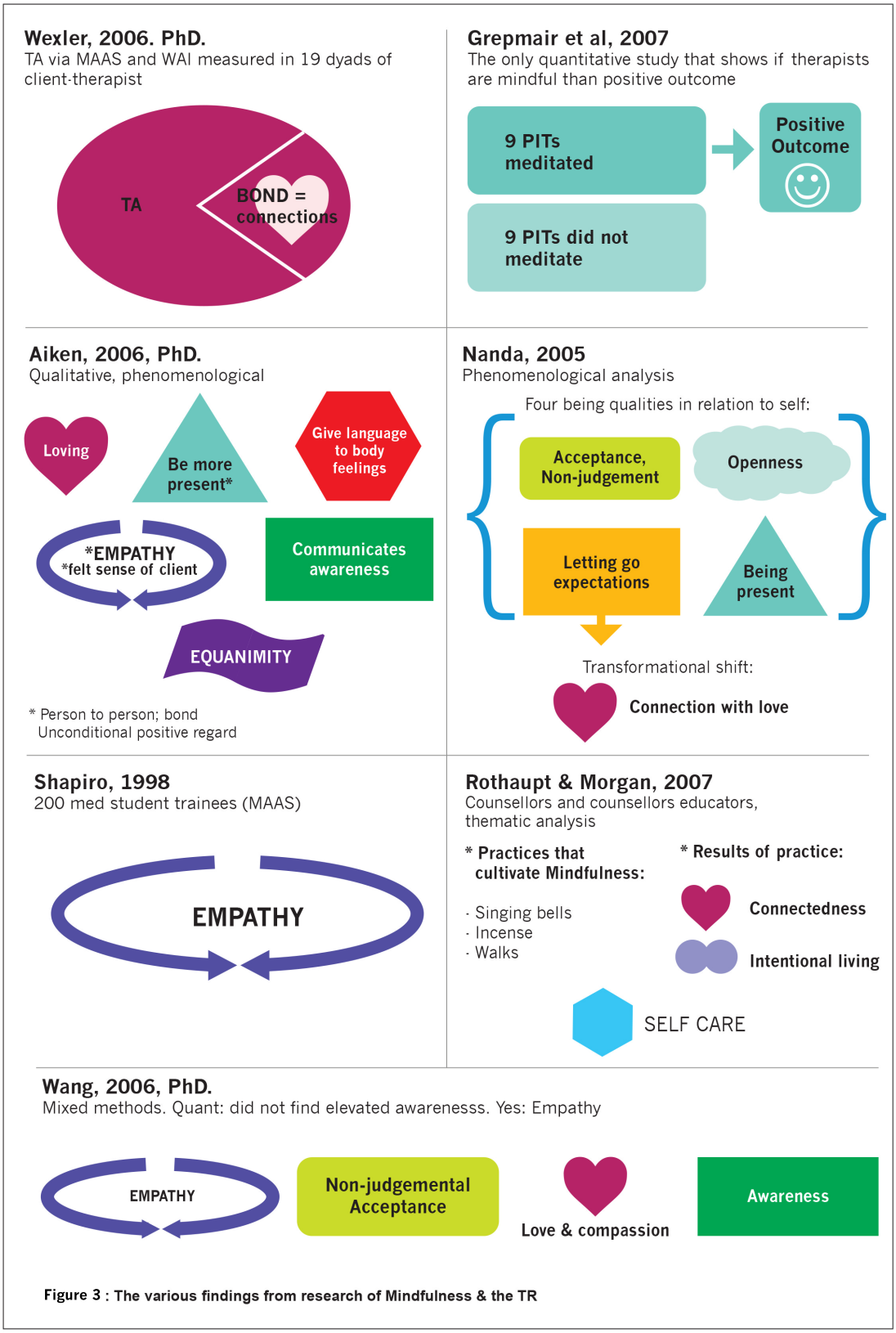


**Figure 3 : The various findings from research of Mindfulness & the TR**

The literature has highlighted that research on mindfulness and the TR is in its early stages. Despite the numerous studies on the efficacy of mindfulness (Davis & Hayes, 2011) there is little research examining the impact on the therapist, and even less research on how mindfulness might have an impact on the TR or on the therapeutic outcome due to the TR (Hick & Bien, 2010). There is convergence between studies such as Wexler, Nanda, Aiken, Wang and Rothaup & Morgan, that all described the presence of 'connection' and between Aiken, Shapiro & Wang that found empathy. At the same time there is also divergence in the studies reviewed: for example, Aiken emphasised 'articulation of body feelings, and Rothaup & Morgan highlighted 'intentional living'.

## 1.4 Rationale for current study

Mindfulness is utilised via MBIs by psychologists. A highly reliable body of research indicated that common factors (variables found in most therapies) such as the TA/WA and the person-centred facilitative conditions (TR) correlate more highly with client outcome than specialised treatment interventions (Lambert & Barley, 2001). Therefore it is important to study the influences and connection between MBIs and the TR. The use of MBIs in the therapeutic context may well improve the TR and thus the client's outcome.

The suggestion is that it is the quality of the TR that will enhance the client's outcome. Additionally, the psychologist who practices mindfulness in her/his private life may find that it impacts on her professional life thus indirectly contributing to the TR and thus the client's outcome.

As demonstrated throughout, there remains a paucity of literature/empirical research exploring how psychologists experience working with MBIs from the perspective of the TR[12]. The studies that have attempted to measure mindfulness outcomes rely heavily on inventories of

[12] Seven studies, out of which only four are qualitative (See Figure 3).

mindfulness skills, scales and questionnaires (e.g. MAAS; Brown & Ryan, 2003). These scales have some validity and reliability but due to the short time they have been used, their extent is yet to be verified as they suffer from a paucity of construct and predictive validity (Brown, Ryan & Creswell, 2007).

Since mindfulness is described as a pre-conceptual phenomenon, which the individual embodies, it seems that the push to objectify it appears paradoxical (Hick & Bien, 2010). Mindfulness seems to approach knowledge and understanding from a more phenomenological perspective: asserting that inquiry should focus upon the encountering of objects as lived experience. The psychological literature revealed considerable variance in descriptions of the nature of mindfulness on both theoretical and operational levels (Dimidjian & Linehan, 2003). The above statements supported the methodology that this research followed: Interpretative Phenomenological (see Chapter 2).

The present measures of mindfulness used by the previously reviewed studies also reflect a diversity of definitions, with self-report cases ranging in complexity from one factor (Brown & Ryan, 2003) to five (Baer et al, 2006). There is a clear need of conceptual agreement on the meaning of mindfulness not only to facilitate communication but also to create a stable platform of applied research. The meaning of mindfulness can be quite nuanced and is subject to interpretations and selective highlighting. This makes researching mindfulness complex.

### 1.4.1 Relevance for counselling psychology

Although the concept of mindfulness is rooted in Buddhist psychology, it shares conceptual kinship with ideas advanced by a variety of philosophical and psychological traditions including phenomenology, existentialism, transcendentalism and humanism (Brown Ryan & Creswell, 2007). Mindfulness also highlights the notion of being in the present

moment. Humanistic psychology (Rogers, 1961) has emphasized the importance of immediacy of experiencing in full, with direct contact with experience as a central therapeutic change process. This is partly the reason that this research topic is relevant to counselling psychology, which aligns itself with ideas of humanistic psychology (Rogers, 1961) and existentialism (Sartre, 2003). Additionally, the methodology of interpretative phenomenological analysis is suitable and fits the subject matter as mindfulness and MBIs share a phenomenological view of reality[13].

The researcher argues that given that the use of MBIs is growing (Kabat-Zinn, 2011), it seems desirable that counselling psychologists practice MBIs in ways that affect the TR and thus are beneficial for therapy outcome (Nanda, 2005). However, this research did not attempt to measure the outcome, nor to explore the connection of the TR to outcome. This research concentrated upon the lived experiences of the psychologists practicing MBIs. For psychologists new to mindfulness, personal involvement in mindful-meditation prior to its use clinically had emerged as very important (Mussell, 2007; Kabat-Zinn, 1990). As demonstrated by research, the practice of mindful-meditation can help the therapist to engage deeply with the context of one's personal self-development (Rothaup & Morgan 2007; Grepmair, 2007). Therefore, it seems as if a potential benefit to the profession could be to map systematically the attributes of MBIs and the TR.

There is a large body of research that shows that MBIs are effective in terms of positive therapeutic outcome (Kabat-Zinn, 2013). Significant additional research shows that the largest predictor of positive outcome/effective therapy is the TR/TA (Lambert & Barley, 1994). For counselling psychology as a discipline, the TR is a core focus (Woolfe et al, 2003). Additionally, research has demonstrated that the outcome is mostly determined by the quality of the relationship rather than by the

[13] See Chapter Two for more details.

specific intervention. Therefore, it seemed highly relevant for the profession to explore psychologists' experiences of the quality of the relationship when working with MBIs.

*The rationale for conducting this research was to alert the profession to the positive effect that MBIs often have on therapeutic outcome, and furthermore, to alert the profession about incorporating MBIs in the training and practice of counselling psychologist trainees and clinicians. My own personal experience of working with MBIs suggested to me that it has a positive effect on the TR and therefore also on the outcome, and this suggested the need to research it.* (For further reflexive thoughts see Appendix 3)

## 1.5 Aims and research questions

This study aims to gain an in-depth understanding of the experiences of psychologists who work utilising MBIs in the context of the TR. To date there are no studies into the experiences of psychologists, and a void relating specifically to the experiences of the TR in MBIs applied in the work setting. Since so little is known about a psychologist's experience in this particular context, the main research question was:

What are the experiences of psychologists working with MBIs in the context of the TR?

Related to this main research question, the following areas were explored:

1. How and what does the TR feel like when working with MBIs?
2. What is the experience of working with MBIs like?
3. What are the benefits/difficulties of working with MBIs?

# CHAPTER TWO: METHODOLOGY

This chapter explains the rationale for choosing to use Interpretative Phenomenological Analysis (IPA); it details the participants and their recruitment, data collection and analysis; and it summarises the points required in order to meet research quality parameters.

## 2.1. Paradigmatic and epistemological position

The vast majority of research in the area of Mindfulness Based Interventions (MBIs) has been conducted from within the realist/post-positivist paradigm. Within this framework, the key problem for the researcher is that individual experiences of participants have been marginalised in favour of hypothesis verification/falsification. The literature reviewed in Chapter One revealed the paucity of research looking at the experiences of psychologists who are working with MBIs[14].

Langdridge (2007: 2) asserted that qualitative methods are the most appropriate for rich explorations of an individual's experiences, in terms of the meanings that these have for the people experiencing them. The rationale for this study was to investigate the subjective experiences of psychologists working with MBIs, in the context of the therapeutic relationship (TR). Utilising qualitative methods allows the exploration of meanings and perceptions from the participants' perspective with recognition of the historical and cultural influences that add to the understanding of the context of the research. Additionally, it contributes to an appreciation of how knowledge is constructed inter-subjectively.

Counselling psychology has roots in humanistic and existential – phenomenological psychology, where the focus is of engagement with subjective experience (Strawbridge & Woolfe, 2003). Therefore, the

[14] To date, the researcher has not been able to find literature concerning psychologists who have worked using MBIs in the context of the TR.

present paradigmatic approach of the study aligns itself with the philosophical underpinnings of counselling psychology.

## 2.2 Methodological position

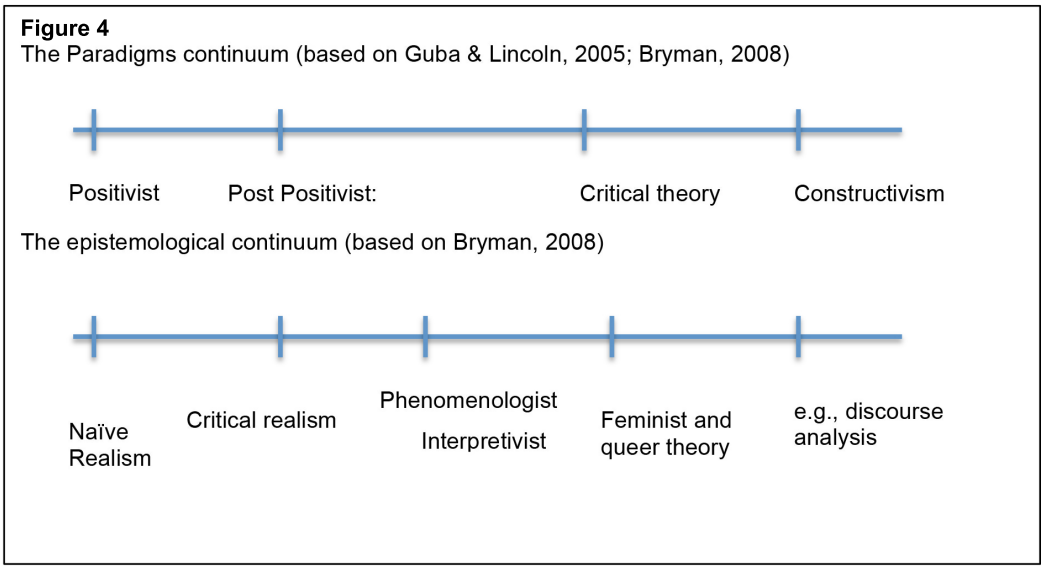


**Figure 4: paradigms and epistemological continua**

The goal of the interpretative paradigm is to understand 'lived experience' from the perspective of the research participant (Guba & Lincoln, 2000). This paradigm subscribes to an ontological post positivist stance[15], where there might be objective reality, but where one can never fully understand other people's experiences, since the observer is always implicated in interpreting others' accounts. Reality cannot be directly observed, but it is co-constructed through interactions between persons. It is an Interpretivist Phenomenological epistemology because the researcher views the participants' accounts as true to them; however, the researcher adds his/her own interpretation. Inevitably, the understanding of reality is being mediated via the social, cultural, psychological and cognitive positions of both people.

[15] See Figure 4 of epistemological continua.

Interpretative Phenomenological Analysis (IPA) is epistemologically located within the 'interpretative' paradigm, within an array of qualitative research approaches that maintain that reality is socially constructed and subscribe to a subjectivist epistemology (Ponterotto, 2005). IPA attempts to examine the psychological significance of phenomena in the lived experience of the participants (Smith, Flowers & Larkin, 2009: 32). IPA is probably the most widely known approach to phenomenological psychology among psychologists in the UK. Jonathan Smith (2009), who was one of the founders of IPA, asserted that IPA was founded upon three main domains of the philosophy of knowledge: phenomenology, hermeneutics and ideography. The following sub-sections will clarify the decision to use IPA over other research methods and explain its theoretical underpinnings.

### 2.2.1 Reasons for utilising IPA over other research methods

The research attempted to understand the lived experience of working with MBIs and to understand the meaning or purpose that a psychologist attaches to its use.

A qualitative approach was chosen as it best suited the exploration of how people make sense of the world and how they experience events (Willig, 2009: 8). Previous to the researcher's decision to utilise IPA, other qualitative methodologies were considered. An outline of other research methods will be presented in order demonstrate that IPA was most appropriate.

Descriptive phenomenology (Girogi, 1997) is interested in examining the general structure of a phenomenon, as opposed to IPA, which examines each individual case. Grounded theory (GT) in either Glaser & Strauss (1967) or Charmaz's (2006) versions would have not been appropriate as I

am not interested in developing an explanatory theory of a social process, nor to study it in its natural environment. GT aims to develop a conceptual explanation based on large data sets and samples. Since the researcher is more interested in individuals' experiences and does not intend to have a large sample of participants, this would not be appropriate. Charmaz's (2006) constructionist version of GT would not fit the researcher's aim as it utilises a more discursive form of analysis.

Therefore, given the above aim, Smith et al.'s (2009) assertion of IPA as a method dedicated to understanding individual's lived experiences and meaning-making of these experiences means that it fits most closely with the researcher's aim.

### 2.2.2 The theoretical philosophy underpinning IPA

Phenomenology is the study of human experience and the way in which things are perceived as they appear to one's consciousness (Langdridge, 2007). Phenomenology began with Husserl (1927) who emphasised 'going back to the things themselves', to the idiographic and transcendental concepts. Transcendental phenomenology attempts to understand what the content and 'pulse' of human consciousness is (Smith et al., 2009: 14). It is concerned with how an individual experiences a phenomenon and the meanings that are ascribed to it. It tries to understand what it is like to 'be' in a certain position or role and 'go back to the things themselves'. It utilises an attitude of reflexivity, gazing inwardly (Langdridge, 2007: 11).

Hermeneutics**,** the theory of interpretation, is another area underpinning IPA. Heidegger (1927) initiated the hermeneutic move to include the interpretation of text and emphasised the 'being' in the world idea: all people are inseparable from the world they inhabit and thus it is not possible to separate one's way of seeing the phenomenon from the world within which the phenomenon is located (Langdridge, 2007: 27). He sought to examine what is, what exists and thus focused on existential questions. Hermeneutics, therefore, focuses on the meaning that people,

or the participants, attribute to their experiences (Willig, 2001). People can experience the same event in many valid ways. Immersion in the participant's world is invited. IPA recognises that the explorations and interpretations of the participants' experiences will be influenced by the researcher's thoughts, beliefs, and assumptions. This is called 'double hermeneutics'. The researcher's interpretations of the participant's own interpretation is a second level of making sense of the phenomenon (Smith et al., 2009).

Lastly, idiography is the philosophical foundation of IPA. It advocates a small sample size in order to focus on each individual's account in depth. It does not encourage conducting generalizations to larger populations, but to concentrate on the detailed comprehension of a small sample (Smith et al., 2009). IPA is particularly useful when the research focuses on complexity, process or novelty. Since there is little qualitative literature about the experiences of psychologists working with MBIs, and even less research examining these experiences in the context of the TR, using IPA fits with the aim of this research. The findings will be discussed in relation to wider existing literature.

### 2.2.3 The epistemological underpinning of MBIs

Although MBI is not transcendental meditation, it shares with existentialism the wish to observe the content and pulse of human consciousness. MBIs, located within the Buddhist tradition, encourage the practice of meditation and thus enhance the 'being qualities' of the person. Subjective validation based on subjective experience is prioritised (Kulananda, 2003). Therefore, choosing the epistemological stance of interpretative phenomenology fits with these underpinnings.

For *personal reflections*[16] on the conceptual elements of this study, see Appendix 5.

[16] Personal reflections will be indented throughout the thesis

## 2.3 Participants

An IPA study should aim to have a reasonably homogenous sample of participants (Smith et al., 2009). Hence, professional occupation, age, gender, and ethnicity of the participants were deliberated upon. Additionally, the length of MBI work experience and mindful-meditation personal practice was taken into consideration, too. Due to the small number of previous studies in the area, it was not necessary to use very tight homogeneity criteria. A purposive sample[17] was used; all the participants were psychologists who had worked for more than two years with MBIs, and have practiced mindful-meditation for longer than two years in their private lives. This established sufficient homogeneity since this is a new area of research with recruitment limitations (see Appendix 5).

### 2.3.1 Recruitment

Recruitment procedures were based on the BPS code of ethics (2004) and the NHS code of conduct for research involving human participants. Since counselling psychologists often work in an NHS setting or private practice, initial contact was made via writing to heads of psychological departments of various NHS trusts in the UK, as well as advertising on the BPS counselling psychologist division website. The research was outlined, and discussed with heads of psychological services, who agreed to help with recruitment. This understanding was based on the psychologists' anonymity.

A record of this email is provided in Appendix 6. Alongside this, an information sheet for participants (Appendix 7) and a poster (Appendix 8) were distributed, too. Initial response was slow, with only one psychologist responding who met the criteria. This was a counselling psychologist recruited through discussions with a head of a psychology department

[17] Purposive sampling is a form of sampling in which the judgment of the researcher is used as to which subjects best fit the criteria of the study

whom the researcher knew personally (hence not via the general advertising or standard emailing). No response was received from general advertising via the BPS division of counselling psychology, nor via heads of psychology departments. A reminder email was sent 4 weeks later to the NHS trusts contacted initially, together with an approach to similar other NHS trusts. These emails as well as phone calls still generated no further results while the criteria specified that the research was seeking only counselling psychologists. In light of this lack of response, I decided to narrow the recruitment focus, and contacted psychologists whom I knew worked utilising MBIs directly (Appendix 6B). Additionally, a snowball recruitment was utilised. This proved to be effective, as psychologists who were approached directly, initially via email, all agreed to partake in the research. As a result of broadening my recruitment criteria the sample composition changed and included a majority of clinical psychologists (5:2). Smith et al. (2009) recommend between 4 and 10 participants, and once I had 7 participants, I decided to stop recruiting.

### 2.3.2 Inclusion/exclusion criteria

The participants needed to be psychologists working with one of the four MBIs specified, due to the differences in the literature and practice regarding other mindfulness based interventions. The four MBIs outlined all have a solid basis of evidence-based research supporting the efficacy of the practice. Due to the varying types of therapeutic disciplines, and the scope of this research, participants needed to be psychologists. This stemmed from the researcher's wish to contribute to counselling psychology as a discipline.

Due to the researcher's work within specific departments in NHS trusts utilising MBIs, it was planned that psychologists who had experience but were working within these departments would be excluded, as well as psychologists who had less than two years experience of work/practice of MBIs/mindful-meditation. However, none of the candidate participants needed to be excluded. The condition of two years experience was

decided upon based on the two years supervision rule. Psychologists can become supervisors after two years of work experience as they develop a greater capacity to reflect on their own and others' work.

### 2.3.3 The Sample

The participants were requested to fill in a short demographic form at the beginning of the interview (Appendix 9). The sample consisted of a total of seven psychologists, (four males, three females). Two were counselling psychologists, and five were clinical psychologists. All had worked for at least two years using an MBI such as MBSR, MBCT, DBT or ACT and have practiced mindful-meditation in their private lives for at least two years. Two used MBCT, two used ACT, two used DBT and one used MBSR. The age range of participants was 31 – 65 years, and two identified themselves to have spiritual affiliations.

All of them worked in the past or present for the NHS. Six of them were white, and one of other background.

**Table 2: Participant's characteristics and demographics**

| Participant | Gender | Age group | Ethnicity | Profession | MBI type | Spirituality * |
|---|---|---|---|---|---|---|
| 1 Matt | M | 61- 70 | White British | Counselling psyc | ACT | N |
| 2 Marcus | M | 61-70 | White British | Clinical psyc | MBCT | Y |
| 3 Dermot | M | 41-50 | White British | Clinical psyc | DBT | N |
| 4 Nick | M | 41-50 | White British | Clinical psyc | ACT | Y |
| 5 Tabitha | F | 31-40 | White British | Clinical psyc | MBCT | N |
| 6 Charlotte | F | 51-60 | White British | Clinical psyc | MBSR | N |
| 7 Cleo | F | 51-60 | Other. | Counselling psyc | DBT | N |

* Spirituality refers to participants who have been officially practicing as priests.

## 2.4 Ethical considerations

Ethical approval was gained from the University of East London research committee (Appendix 10).

### 2.4.1 Informed consent

Prior to seeking consent, the purpose of the study was explained verbally and/or by email to the participants, ensuring that they understood the nature of the research, and what the interview might involve. It was made clear that they could withdraw from the research at any time. The participants' information sheet was provided, highlighting the aims and anonymity aspects of the research. Once contact was established, an opportunity to ask more questions by the participants was provided before arranging an interview date and time. Upon meeting, informed consent (Appendix 11) was sought from all participants. At that point, another opportunity to ask questions was given. They were reminded again of their right to withdraw their consent.

### 2.4.2 Confidentiality

Confidentiality was fully explained to the participants who were informed that although verbatim extracts would be utilised, identifying information would be removed and pseudonyms would be provided. All data would be stored under a locked cabinet or lockable storage device. After the interview, the tapes were numbered to maintain anonymity. Since the participants were psychologists, and the topic was their work/life domain, it was not expected that the interview would cause distress. They were asked to be mindful regarding what they chose to share.

## 2.5 Data collection

The interview schedule design was informed by Smith et al.'s (2009) guidelines, the literature review that was read and influenced by the research questions that were:

1. How and what does the TR feel like when working with MBIs?
2. What is the experience of working with MBIs like?
3. What are the benefits/difficulties of working with MBIs?

The initial interview schedule was taken to the London IPA group[18] in order to receive clear feedback from other IPA researchers and to enable the researcher to ask questions that would allow participants to share their lived experiences. It was felt that there were too many questions in the initial draft, some of which could be seen as leading and therefore the questions were changed. Furthermore, a question that could be viewed as trying to elicit positive narrative about the quality of the TR was reconstructed.

### 2.5.1 Research interviews

Semi-structured interviews were utilised as they are a dynamic process where meaning is co-constructed, and focus on the subjective experience was sought, in line with counselling psychology's concerns (Strawbridge & Woolfe, 2003). Interviews were carried out and recorded using a digital recorder. Each participant took part in one interview lasting between one to two-and-a-half hours. The interview schedule (Appendix 12) consisted of three main areas: the TR; personal and professional experiences of MBIs/mindful-meditation and issues concerned with benefits/difficulties. These were influenced by the research questions and informed by Smith et al.'s (2009) guidelines for examining lived experience. The schedule was designed to guide the interview yet be open enough so as not to

[18] The London IPA group (2009-2012) consisted of 30 members and met bi-monthly at UEL, was led by two reputable IPA experts (Hefferon, K. & Rodriguez, H.), aimed to help researchers to be further familiar with IPA principles

dictate it. Interviews took place at the participants' preferred place of conduct: in their private homes or offices (although one was delivered in the cafeteria of a teaching institute). Following completion of interviews, participants were verbally de-briefed, and offered a verbal explanation of the study. A summary of the analysis was offered to all participants. They all indicated an interest. Following the interviews, extensive notes were made by the researcher in order to reflect on the interview process and dynamics. The tapes were transcribed verbatim by the researcher, to facilitate an intimate interaction with the data, as is in line with the idiographic approach taken throughout the study.

## 2.6 Data Analysis

IPA was used as the methodology for analysis of the transcripts of the interviews. IPA research employs inductive, flexible data analysis by starting with broad questions and allowing unforeseen themes to emerge. Guidelines to ensure quality were additionally employed (Smith, 2011) to assist the analysis process.

The analysis started with detailed examination of one transcript, in line with the idiographic aspect of IPA, until saturation was achieved. Subsequent transcripts were analysed. Finally, cross-case analysis where individual themes were explored for similarities and differences took place (Smith et al, 2009). The stages will now be outlined in detail.

The first stage involved reading and re-reading transcripts and producing notes that reflected the initial observations. Initially the tape of the interviews was played alongside the reading so immersion in the participant's world could take place. Early thoughts were written on the right hand margin of each transcript (Appendix 13). Smith et al.'s (2009) three task areas for observation were followed: descriptive comments of content were marked in black pen, linguistic comments in blue pen, and conceptual comments (more interrogative, psychological) were noted in red pen. Those emerging comments were written on the right margin.

The second stage entailed finding and labelling emerging themes and recording those on the left margin and then copying all the emerging themes onto colourful sticky notes, noting the name of the emerging theme at the top and the example of the text with line numbers at the bottom part of the sticky note. Each participant had different coloured sticky notes. I placed the sticky notes onto A4 sheets of paper divided to content, language or psychological ideas (Smith et al. 2009). This second stage involved the move to a higher, interpretative level of concepts, although remaining grounded in the actual accounts and words of the participants (Appendix 14).

The third stage involved finding themes by identifying connections between the emerging themes, and creating theme clusters. In practice, it entailed transferring all sticky notes with similar issues onto A5 sheets of white paper, noting the theme at the top of the A5 sheet. Each interview was analysed individually. At times, theme clusters got merged into a further higher abstract level of division (Appendix 15).

In the fourth stage, super ordinate themes were identified, some themes were discarded and others reviewed. The researcher moved through the other transcripts and revisited old ones through an iterative process (Appendix 16).

All ordinate and subordinate themes were typed into a large Excel sheet, with examples and line numbers (Appendix 20, on CD). The researcher produced a summary table of the super ordinate and ordinate themes (see Chapter 3).

## 2.7 Validity and quality

Over the past decade there has been much deliberation within the qualitative research field regarding the assessment of quality. Several guidelines have been developed, and there is a move towards a ‘checklist’

that can be utilised by reviewers. However, this might not allow one to take into consideration the subtleties of the research (Smith et al, 2009). The guidelines as suggested by Smith (2012) were followed (see section 4.5 evaluation of research).

The following six items guideline (Smith, 2011) has been taken into account for evaluation of the quality of the study. First, clear focus has to be provided. By emphasising MBIs and the TR, hopefully such focus has been demonstrated. Indeed the research dealt with four mindfulness interventions but the similarities between them are greater than the differences, and hence they could be viewed as a coherent group.

Second, Smith (2011) recommended that the research has strong data. This was hopefully demonstrated through the extracts utilised in the analysis chapter and through the provision of the interview example (Appendix 18).

Third, the research should be rigorous. Commitment to rigour is hopefully demonstrated through the paper trail of the analysis that can entail the measure of prevalence for each theme (Appendix 20; Table 3). A researcher at a university's psychology department, who utilises IPA professionally, carried out an audit of the analysis chapter. He understood the rationale of the themes and was clear on how they were detected from the transcripts. This further enhanced the validity and quality of the data.

Fourth, elaboration of each theme has to be given sufficient space. It is hoped that the subset of the emergent themes that was chosen for elaboration provides enough room for each theme. Two themes were discarded since they were irrelevant to the overall narrative (but see Appendix 19).

Fifth, the analysis should be interpretative, not just descriptive. Smith et al. (2009: 104) provided an example of three levels of interpretation-depth, and accordingly the researcher aimed to offer these levels. Smith also

asserted that IPA involves a middle position between a hermeneutic of empathy and a hermeneutic of suspicion. An example of interpretation of suspicion is provided in the critical analysis of a participant who talked about respect towards her client while emphasising the client was 'mentally ill' (see chapter 3, extract 7)[19].

Sixth, the analysis should point to both convergence and divergence (Smith et al., 2009). In the analysis, an attempt to demonstrate both patterns was made. The participants manifested the same themes in different ways and often integrated them via the narrative of the 'middle path'/'middle way' (Kulananda, 2003: 17). The middle path is a Buddhist concept according to which individuals should aim to view phenomena from a balanced perspective that takes into account contradicting perspectives (Brazier, 2001). The participants in the research conveyed an overall narrative of balanced perspective with regards to the impact of MBIs on the TR. The balanced manner in which MBI impacts on the TR is not idealised nor condemned. A message of balance and ambivalence materialised from the analysis and was reported, as will be illustrated in the next chapter.

# CHAPTER THREE: ANALYSIS

## 3.1 Overview

[19] Despite the above assertion, the author is aware that there might be other ways of interpreting this 'mentally ill' labeling, as a professional might respect their client and still name them with this label.

This research examined psychologists' experiences of working with Mindful- Based Interventions (MBIs) in the context of the Therapeutic Relationship (TR). The research questions were:
First: what does the TR feel like when working with MBIs?
Second: what is it like to work with MBIs?
And third: what are the benefits/difficulties of working with MBIs?

This chapter presents the interpretative phenomenological analysis (IPA) of semi-structured interviews with seven psychologists. Through this analysis, three super-ordinate themes were identified:

* Theme 1 - Ways of Relating
* Theme 2 - Integration
* Theme 3 - The process of mindfulness

The construction outlined is only one possible structure of the phenomenon of being a psychologist who has worked with mindful-meditation intervention (MBI) and practiced mindfulness meditation in his/her private life. Smith et al (2009) have asserted that, when using IPA, the discovery of themes is based upon the researcher engaging in a double hermeneutic. Therefore, the researcher acknowledges that these themes are a subjective interpretation, and another researcher may have found a different assembly of these descriptions. The super-ordinate themes and the contributing sub-themes are presented as a written narrative in the following parts of the chapter. While the three super-ordinate themes are common across the seven interviews, some are areas of difference and deviation, which are also examined. Selected verbatim quotes from the interviewees are presented to illustrate these themes.

**Table 3: Super ordinate themes, Sub themes and prevalence**

| Superordinate themes | Ordinate themes | Prevalence |
|---|---|---|
| **Theme 1** | **The Therapeutic Relationship:** | 33 |

| | | |
|---|---|---|
| **Ways of Relating**.<br><br>*"We together are all this" (Matt, line 1150)* | **core conditions and ambivalence.** | |
| | **Transcendental relationship** | 7 |
| | **Relating with self** | 32 |
| | **Relating in groups: the insight of interconnectedness** | 20 |
| **Theme 2 Integration**<br>*"Mindfulness approaches could be understood in a cognitive science perspective. And… talking about not just modes of mind, doing and being, … but actually … saying: … integrated 21st century psychological theory of the mind. … how cognitions and emotions interact, with bodily sensations" (Marcus, lines 124-134).* | **Struggling with Dichotomies: Spirituality-science; belief-technique; body-mind** | 75 |
| | **Linking between personal practice and professional work** | 21 |
| **Theme 3**<br>**The process of mindfulness**<br>*"You need to stop. Just notice and observe" (Cleo, lines 658-659).* | **Becoming** | 11 |
| | **Accepting Challenges** | 26 |

| ***Quotes*** |
|---|
| **The Therapeutic Relationship:** *"I really felt that we have connected…appropriate to be crying" (Tabitha, lines 1284-6).* |
| **Transcendental relationship** *"Authenticity in person-to-person in ACT and even trans-personal relationship" (Matt, lines 1102-4).* |
| **Relating with self** *"What mindfulness has done is that it has allowed me to … I suppose …almost in a way to be OK with being 'me' (Tabitha, lines 1684-1686).* |
| **Relating in groups** *"It is almost like creating an account which acknowledges a shared experience that we are all having together in the moment so, I think there is that sense of ...maybe there is a sense of...of some bonding or some therapeutic alliance or something happens (Nick lines1183 – 1188).* |
| **Struggling with Dichotomies:** **M.M can have different "entry" points spiritual or as tool/technique" (Tabitha, lines 491-511).* |
| **Linking between personal practice and professional work** ** Since doing DBT, self-mindful meditation is more invoke for me. Because I have to do it as part of the DBT clinician's contract of work (Cleo, lines 343 – 346).* |
| **Becoming** **Mindfulness is a process of becoming open to an innate source of well being" (Nick, lines 362 – 7).* |
| **Accepting Challenges** ** Complaints about meditation are necessary for insight like grits for the mill" (Marcus, 314 – 7).* |

## 3.2 Introduction to themes

Table 2 represents super-ordinate themes, encapsulating the themes shared by all the participants and their respective subordinate themes.

The three super-ordinate themes arose from the analysis and provide an overall account of what it is like to be a psychologist working with MBIs in the context of the TR.

## OVERALL NARRATIVE

This research has three main themes: ways of relating; integration; and the process of mindfulness. All three are characterised by a balance or 'middle way' description of the elements within them. In Buddhism, the 'middle path' is a pertinent construct (Kulananda, 2003). In this research, the participants are psychologists who embody some knowledge from this body of Asian philosophy. The way the psychologists viewed their work was informed by the philosophy that underlined it. In other words: they did not argue that mindfulness is the only way but offered a balanced analysis. Hence, the participants were aware of and remained in contact with a 'middle path' that took into account adjunct elements of mindfulness (e.g. other ways of work, other methods that supplemented MBIs). The first theme, 'ways of relating', had three facets: the TR; relationship with the self and group relationship. However, mindfulness was never presented as the gateway to a perfect relationship but rather as a state that at times enhanced the empathic, genuine and equal aspect of the dynamic of the therapy. In contrast, at other times the participants challenged the centrality and the importance of the TR in a group work context. They argued that in a group setting there is no time to develop the TR in its typical one-to-one characteristics, therefore it is not an essential element of MBIs.

The second theme was about the integrative nature of mindfulness. Integration of dichotomies such as: body and mind; private versus professional parts of the psychologists' lives; and the ability to contain the paradoxes within the mindfulness construct.

The first sub-theme "struggling with dichotomies" portrayed how the participants integrated opposing constructs such as science and belief. They defined themselves as scientists working with MBIs but at the same

time were aware of the spiritual underlying framework of Buddhism that contributed to the creation of MBIs. Hence even if they did not explicitly mention to clients the origins of MBIs, they were aware of it.

The second sub-theme concerned linking the participants' personal and professional lives. This was demonstrated by the psychologists practicing mindfulness in their private lives since they believed this added to their well-being. Consequently, they felt that they embodied mindfulness and therefore were in a good position to teach it to their client: they "practiced what they preached". This helped them to see their professional and personal lives as one integrated balanced whole, and thus this sub-theme contributes to the overall narrative of mindfulness providing a balance between two domains that are very often in conflict with each other.

The third theme continues the 'middle path' narrative: the process of mindfulness; provides a way to feel how mindfulness is being done; and reveals the nature of the process of mindfulness. It therefore highlighted the 'becoming' aspect of the process, a continual striving to be mindful, while being aware that it is not possible to fully attain. Being mindful remains forever an ongoing process, a 'becoming' process. The message of balance that lies underneath this sub-theme is about integrating the practical and the ideal, taking into account that despite aiming to be completely focused, aware and present, one can only do the best one can. Hence it is a balance between accepting where one is while still aspiring to change.

Lastly, the process of practicing MBIs, like any other endeavour, is not without its weaknesses; it has its own shadows. Fraught with difficulties, the participants invited the reader to be aware of these too, and by doing this added once again the element of balanced accounting for the construction of mindfulness as a process. The participants are expressing an integrative perspective of the benefits and challenges of working with mindfulness. This is embodied in mindfulness itself that never promises to be a panacea for life's woes.

## 3.3 Theme one: ways of relating

"*We together are all this",* Matt, lines: 1138-1164.

This super-ordinate theme captures the participants' different experiences of relating that resulted from the process of working with MBIs. During this process, the psychologists encounter authenticity, intimacy and deep connection with their clients. In addition, they talk about a change in the power dynamic, which makes the TR different from other therapeutic encounters. As was noted by Tabitha: "*that is different from…sort of…just being the one that asks questions, or just being the one that has information*" (lines: 1903-1905). Outlined in the sub-themes, the actual nature of the relationship incorporates four main facets that are unique to the relationship within the context of MBIs, (the therapeutic relationship, transcendental relationship, relationship with the self and relationship in a group) and a general reflection that psychologists working with MBIs have a different therapeutic experience.

### 3.3.1 The Therapeutic Relationship

This sub-theme illustrates the first aspect of the participant's experiences of working with MBIs in the context of the TR. It captures the nature of this 'different' experience. This sub-theme includes three parts. First, the TR entails deep connection, intimacy and compassion. Second, the issues of disclosure, and a sense of equalness (absence of power dynamics) with the clients are discussed. Third, in contrast, other attitudes towards the TR are discussed.

#### 3.3.1.1 Deep connection, intimacy and compassion

This sub-theme illustrates the first aspect of the participants' experiences of the quality of relating therapeutically while using MBIs.

Tabitha, who was practicing MBCT with a dying cancer client in a hospital setting, experienced a strong sense of connection with her client:
Extract 1:
*"……You know I really felt that we had connected, aaa…… I had a genuine deep relationship with this person. It was in the context of the therapeutic setting, but I really felt we were kind of two humans connecting through that process, ummm….and yes, she has kind of always stuck with me, actually, as being just one of my best teachers."*

*Tabitha, lines 1276-1297*

Tabitha's account indicated a powerful experience highlighted through her description of bursting out crying (line 1283). The strength of the bond transcended the therapeutic relationship and moved into an existential realm of shared humanity. She further went on to call the client 'my teacher', which highlights how moving and important this experience was for her.

Tabitha also made clear that a sense of positive regard is echoed throughout the process. This account illustrated the acceptance and support in the TR:

Extract 2:
*"I guess it comes out in the work, in a number of ways, but they are not always how you model the acceptance of all the experiences, and the thoughts that the person is having, "yes, I am really in this cancer", and she is going to die, and "yes, it is scary, you know, let's talk about it, let's get it out on the table", that, that is the compassionate bit…there is the compassion in that".* *Tabitha, lines 1426-1434*

From the description it emerged that compassion permeated the session, and Tabitha moved to reflect on how difficult it was to 'model' acceptance of death. Seamlessly, the discourse moved again to an existential realm of reflection and then continued further into compassion. Tabitha asserted that allowing the client to gaze at the terrifying prospects of her own death

was an act of compassion: deep awareness of the suffering of another, coupled with the wish to relieve it.

Complementing Tabitha, Dermot gave an account that captured working with members of staff in children and adolescents mental health services, teaching members of staff mindfulness and Dialectical Behavioural Therapy (DBT). The quality of the relationship described manifests genuineness, with an emphasis on caring attachment:

Extract 3:
*"For a lot of them that would be about primary re- attunement, about actually working with and around containing those …kind of …outbursts that they have, where they are still kind of two or three, or whatever it is, aa…and actually showing through the relationships and the genuine way that they interact with these young people, that they actually care about them, and that they are actually worth something."*
*Dermot, lines 1360-1368*

Dermot's language ('*containing', 'showing through the relationship' 'care'*) and reference to the clients' sense of self-worth indicated a sense of authentic deep attention and positive regard. Attunement means being or bringing into harmony; a feeling of being "at one" with another being. Dermot's account captured the attempt to return the young clients into such a harmonious state of relating. From there, he moved to describe the relationship as one that will hold the children and provide validation for their self-esteem. This relationship is a reparative relationship that can help the children to develop trust and validate a sense of self.
So far the TR was described in terms of the Rogerian 'core conditions' such as genuineness and care. Another element that all participants described was the power dynamics as presented below.

### 3.3.1.2 The (absence of) power dynamics within the TR

In the title, the term power dynamics is used, despite the fact that in the following two extracts power is absent in an explicit way. The term 'power-dynamics' de-constructs the relationship between power and the TR. In the following two extracts it is very clearly absent, but this in itself is important in conveying the difference from the common TR, as there the therapist is the powerful expert.

In this sub-theme, the therapeutic relationship's dynamic was experienced to be different from other TRs. The power imbalance between the psychologist and the client changed due to sharing the meditation experience and the post-meditation discussion while using MBCT and Mindfulness for psychosis (in DBT, and MBSR self-disclosure by the therapist is also common). The latter may include some disclosure from the psychologist, which adds to the overall theme of the TR being 'different'[20].

Extract 4:
*"You are disclosing, but you are not disclosing your own stuff, clearly, but you are describing your mental experiences, aaaa…you know, so that is very different for people, ha-ha-ha, they are not expecting that. Ha-ha-ha-ha, So that…that feels different."*
*Tabitha, lines 1781-1786*

*She carries on to say:*
Extract 5:
*"You (1:38:08) are walking the walk and talking the talk as a therapist. And that is different from…sort of…just being the one that asks questions, or just being the one that has information that you are sharing… I am not quite sure but ……. walking along the side…yes…so you are both walking alongside into unknown territory"…*
*Tabitha: lines 1903-1912*

[20] The models of MBIs do not explicitly suggest self disclosure on behalf of the therapist, but implicitly once the therapist is actually practicing the interventions and leading by example disclosure to some degree does tends to take place.

In the opening extract, Tabitha described the disclosure and moved on to talk about the surprise that the clients felt. The therapist is not the 'knower', thus the dynamic is less unequal; the description referred to a space in which the therapist and client were walking next to each other, not one guiding the other. 'Walking the walk' reflected how she saw the meditation as joint practice and pivotal to the quality of the relationship. However, her laughter may have indicated her feeling embarased, realising this is controversial within certain psychology circles. Indeed, in contrast, psychoanalytically-trained Charlotte talked about the difficulty that these fuzzy boundaries presented for her:

Extract 6:
*"I do not feel it is appropriate for me as their therapist, because I work with such strong boundaries as a therapist. So for me they know nothing about me. I do not share my personal experiences with them. ….. So for me it still has to remain as therapy. And I think as I start doing these practices with people in the session, it changes the whole dynamic".*
*Charlotte, lines 1246-1255*

Charlotte explained how meditation-related disclosure problematised the power dynamic, hence she does not practice meditation in sessions with her clients. Charlotte is a South-African trained clinical psychologist and her main method of work is psychodynamic/psychoanalytic. These approaches focus around boundaries, and this is how she explained her concerns regarding less-boundaried situations. (See interview 6, lines: 1285-1292).

### 3.3.1.3 In contrast – power imbalance, no space for the TR

Some participants' questioned the above stance of equality and close connection due to the use of mindfulness.

Cleo, who practiced DBT, a very structured therapy at its core, discussed

the TR from an unequal position. She asserted that her clients are mentally ill hence emphasised the power dynamic. Despite what she explicitly said, lack of equality was implicated.

Extract 7:

*Cleo: "I am not saying that I am perfect…but I put a lot of emphasis on building good therapeutic relationship with people, I do not care who my client is, I treat them as a human being, I treat them with respect, I speak to them in a respectful way, we have our bumps like everybody else, but I can also be very flexible if I need to, ……You treat people with respect. Even though they are mental health patients. They have rights and feelings like the rest of us. That is how I practice".*

*Cleo, lines 1307-1322*

The psychologist was 'close to perfection', she decides about the agenda, although she was willing to be flexible if she absolutely must. Cleo also talked about being respectful despite the client's mental health situation, but her choice of statement "*I speak to them in a respectful way*" indicated a stance that emphesised absence of equality.

Additionally to Cleo's unequal stance, another issue that contributed to a confounded and ambivalent picture of the TR when working with MBIs was the issue of working in groups. Since mindfulness is conducted in groups for MBCT and MBSR, the TR in a one-to-one form is only secondary in level of importance for Marcus. In a one-to-one context, the TR does not occur due to the 'business' of the interaction.

Extract 8:

*"My experience of using it in a one-to-one situation is that there is so much business to be done, in terms of actually the meditation, the investigation, the setting up the homework for next week, that actually I think that ummm…the relationship in the one-to-one mindfulness situation – ironically might be not so close as you get in a class,,.. I think that the …it feels busy for that to happen, I think. So I think that might be an irony.*

*Marcus, lines 1171-1199.*

Marcus's description of the relationship as "not so close" implies that he did not feel comfortable teaching MBCT in the one-to-one context, and preferred to stay in the group setting. He critically reflected on taking the intervention out of its usual group setting.

The following sub-theme differs from the first because it involves a sense of transcendence as a result of the TR created by practicing mindfulness.

### 3.3.2 Transcendental relationship

This sub-theme highlights the second aspect of working with MBIs in the context of the TR. It outlines the unique aspect of transcendence, which emerges due to working with MBI.

Dermot linked the transpersonal therapy (that he was engaged in for his own personal development) to his client work with mindfulness. It made him realize how similar he is to his clients; hence a sense of equality, and sharing is emphasized:

Extract 9:
*"That is the one really important thing for me, is that we are all in this together, I do not see myself as qualitatively different from the people that I work with. Ummm…you know, just that whatever condition their lives…to be…where they are at the moment, is different, but things we use to make sense of them are pretty much the same universally, so I think that…yes, yes, so that is really important to me. So I think I like that transpersonal …any barrier at all… the transpersonal thing for me is about how you constantly get out of that feeling, that mindset, because it is very comfortable to think that you are …in a place. And you are going to stay there for a while and things will remain the same for a bit".*

*Dermot, lines 2045-2061*

Dermot suggested that ‘we are all in this together’, in the struggle, the pain, the not knowing. He emphasized it by using the term ‘universally’ later on in the paragraph. Additionally he noted that the transpersonal method allows one to transcend barriers, and realize that life is about movement and change, rather than remaining the same. The discourse is pulling towards a deeply existential state of transition and of being as part of a group, a group that is sharing its existence together.

Additionally, Dermot explained the idea of transpersonal psychology by linking it to mindfulness work. He asserted that as a result of such a focus on mindfulness, the individual grows beyond his or her personal boundaries.

Extract 10:
*“They are interested in that kind of whole huge range of whatever…so the personal development in the sense that it is a kind of personal growth but the idea that you grow in relationship to other people, and that that takes you beyond a sense in which you are a sort of boundaried ego, within the confines of one’s body so I think transpersonal is anything which is not that, really”.* *Dermot, lines 2000-2008*

Personal boundaries define one as an individual; defining one’s personal-zone of comfort, and setting out how far one allows others to approach. They include physical, mental, psychological and spiritual boundaries, involving beliefs, emotions, intuitions and self-esteem. Here, Dermot included personal growth, which goes beyond one’s limitations as a result of a transcending relationship. Something new emerges which would not have developed without the meeting of the two: psychologist and client. He further noted that this growth ‘*goes beyond the confines of the body’,* thus strengthening a sense of transcendence into the non-material.

Like Dermot, Matt, who worked using ACT, also asserted that ‘we are all this together’

Extract 11:

*"I think I am probably talking about the quality of aaa…relationship. Almost a de-personalised, strangely enough, quality of relationship. You know. Step on from authenticity, really. A trans-authenticity…ha-ha, umm…(quiet, thinking) Yes. It is a bit 'trite' in the wording of it, you know….if authenticity, if authentic relationship is…you know: we are all in this together, hhh…then that transcendental or trans personal flavour…is…we are all this together. Aaa..aa..aa……We together are all this…ha-ha-ha……It is that sort of shared experience of 'chess board'. Ha- ha ha ha ha, it is this transpersonal kind of container of experience. ummm…witnessing of experience". Matt, lines 1138-1164.*

Matt referred to the transpersonal quality of the relationship, which moved the individual into a space of 'togetherness'. *'We are all in this together'* referred to how, when meditating together, a sense of closeness and sharing takes place, hence we can face struggles together, and be comforted by sharing them. However, later he moved on to note 'we together are all this', thus a Gestalt notion of 'the whole is larger than its parts', of strength derived from unity, and not just the 'shared pain' is captured. Transpersonal experiences may be defined as experiences that extend beyond the personal, usual ego boundaries and the limitations of time and space. In the extract above, such experience was felt. Matt noted the aspects of 'togetherness' and wonder. Thus, his personal experience linked the transcendental aspect with closeness to others and a sense of inexplicability. To him, the transcendence allows one a movement '*away from self identity to being the observer of the self',* becoming a witness. Matt emphasises that going beyond the personal allows mindful observation of the self, and contains this out of body witnessing experience.

Unlike Matt, for Tabitha, (MBCT practitioner) mindfulness transcended attachment issues and provided a way to reflect on such issues.

Extract 12:

*"My understanding is that mindfulness sort of transcends all of that, you know, you all learn to begin to become aware of whatever attachment schemas, or whatever you want to call them are being triggered, that is what we will work with. You know, it might come out in this relationship, it might be happening elsewhere, but, you know, we will deal with it in the moment when it comes"…* *Tabitha, lines 1959-1966*

Despite being a scientist and a psychologist, Tabitha is not a 'devout scientist'. She practiced various kinds of mindfulness activities and interventions enthusiastically. She noted that this had swayed her towards affiliation with spiritual aspects of the practice. Here, Tabitha referred to the transcending, overarching capacities that mindfulness can evoke, which therefore go beyond specific core problems. There is a strong sense of belief that mindfulness can deal with anything, no matter what it is. The use of the words 'begin to become aware' highlighted the process that is involved in mindfulness. It is not a one-off action. In contrast to Dermot and Matt, Tabitha does not place the transcendent element in the therapeutic relationship but in mindfulness itself. She did not reject the TR but claimed that transcendence can take place elsewhere, too.

In conclusion, psychologists practicing MBIs feel that these have implications for transcendence relationship, either with themselves or with others. However, some psychologists noted that the transcendence occurs due to mindfulness and does not have to occur in the TR. This other theme of relating to and within the self is discussed in the next section.

### 3.3.3 Relating with self "OK being me", Tabitha, line 1684

The participants reflected on the impact of practicing mindful-meditation on their relationships with themselves. The participants described a general consensus of it having a positive effect on their existence. Additionally, three main facets were discussed. First, it facilitated self-acceptance; second, it seemed to have been central to their way of managing their

sanity. Third, it helped them to model awareness as therapists since they first attuned to themselves.

In the extract below, Tabitha reflected on criticism from her supervisors when she was a trainee clinical psychologist. The supervisor asked her "*to be less visible and high energy*". Mindfulness practice helped her to find a balance between professionalism and personality.

Extract 13:

*Tabitha: Well, it might, but again, I suppose this …my process of how (unclear) …you know…I got feedback while I as training about basically turning down Tabitha, and being more clinical psychologist.*

*Interviewer: Yes. Who said that?*

*Tabitha: Supervisors. Which, you know…and I…I understood the rational, and I suppose what I feel that…what mindfulness has done is that it has allowed me to … I suppose …almost in a way to be OK with being 'me'. (1:25:40) but then also more mindful about when I might need to pull back a bit in the interest of …actually this is the client. You know. I mean: I am still not 100% comfortable with that, but…yes. So something about being as much as close to maximum myself …ha-ha-ha…but always an awareness that, you know, OK, I also need to be appropriate, and mindful, and boundaried. Tabitha, lines: 1679-1696*

Tabitha exposed the conflict she had between 'being herself' and being 'boundaried'. She noted that mindfulness provided a tool for being aware of '*when she needs to pull back'*, and give more space to the client, by being more of a blank slate. The conflict is still highly present, hence mindfulness is not experienced as a 'solution' but as a way to better manage how much of herself to expose in the TR.

Complementing the above self-acceptance, participants alluded to the 'Me time' or 'gift to self'. Participants talked about how mindfulness helped

them to have stability, focus, take high energy down, stay calm, have sanity and perspective as well as stillness and insight. Charlotte talked about being stable and focused due to meditation:

Extract 14:
*"It simply is a time for me to focus on me and be focused. On not me, I mean myself sort of thing but on what is going on. Right now. And just bringing some kind of stability".* *Charlotte, lines 986-989*

Charlotte portrayed a connection with what is 'going on' for herself, hence bringing a sense of constancy of character or purpose, and stability.

Practicing mindful-meditation by the psychologists was further explained as an activity done in order to be able to **model** mindfulness back to the client. Nick talked about self-practice as an attunement process.

Extract 15:
*This is...for me, personally, it is something around how I attune to myself, it is almost like seems like I need to feel that I achieve it in myself before I can feel that I achieve it with a client.*

*Nick, lines 927-933.*

To attune means 'to adjust or accustom, to bring into a harmonious or responsive relationship" (OED, 2006). Nick humbly asserted that the task of being harmonious with himself has to precede his attempt to assist the client, because otherwise there is a lack of congruence and integrity. He seems to be saying that if the domain of the self is not 'sorted' how can he achieve 'anything else' outside the self? Thus it appears that there is an underlying assumption of a unified self that can get 'sorted', at least once daily, and brought into a balance due to meditation.

In contrast to this, some participants emphasised the power of group meditation to be the focus of the relational paradigm. This will be explored in the ensuing sub-theme.

### 3.3.4 Relating in a group

Several participants emphasised an alternative mode of relational stance in which a relationship was formed within a group and not within the TR. First, qualities of intimacy, equality and an attitude of "host to guests" were reported. Second, an account about the group providing power to service users, and third, sharing experience in a group was noted.
When group meditation was being practiced on the MBCT course, it harboured intimacy, equality and a humble, humane manner of teachers towards the clients-'guests'. Marcus described how MBCT teachers connected to the clients as if they were guests and consequently intimacy had risen within the group members.

Extract 16:
*"I think that the experience of mindfulness teachers is that they find themselves treating their clients differently from what they have been taught to do. Much more…I think humanely and humanly. Much more…I would say as guests, rather than clients. (52:11) ……. You lay out the tea and the biscuits, and the coffee. You make provisions for them. …….. And that feels very different to what is usually done ……..….you, you ring people up if they are not there. Not because you are checking up on them, but because you are concerned about them, and you want to know if they are OK, and you want to send them materials perhaps, they might have missed. So it is a very different spirit, (53:02) there is a sense of real equality. I think. …… So it is very…ammm….very intimate, I think. Now. (unclear) That intimacy, rises, I think, from a class".*

*Marcus, lines 1141-1171*

In contrast to usual psychotherapeutic work, which is done in a one-to-one context with a 'blank slate' attitude, Marcus described a cultural practice of hosting the clients, like guests, in the spirit of sameness and concluded with a sense of intimacy, alluding to closeness between people. He asserted that this arises from the class situation. The following extract

takes this notion a step further and suggests that the group provides power for service users.

Tabitha noted the power the group provided for (bi-polar) service users when the group was led by a peer member.

Extract 17:
*"If this is a person who has experienced psychosis, who has themselves have been able to use a mindfulness technique or a tool or some kind of mindfulness in a moment of like...hearing voices or extreme anxiety or paranoia, you know, this person knows... ha-ha-ha what to do and how to do that, more...than me.*
*Interviewer: First hand experience.*
*Tabitha: and peer support is really kind of how the health services are going, so … this particular guy, who has done his own mindfulness 8 weeks course, he uses it regularly, he is really involved with service users...*

*Tabitha, lines 136-153*

Tabitha started by describing how having a first-hand experience of psychosis had been helpful to the leader of the group of bi-polar clients, because 'he knows how to do that'; how to use mindfulness while hearing voices, for example. Later she mentioned the peer support that this member provided to other service users. These horizontal learning processes seem to take place when vertical relationships have a discrepancy or gap within them. Therefore this bi-polar client might be able to help his peer group as a guide who shared so much of their difficulties.

The use of the word "*involved*" alluded to the way the client was connected or concerned with the group, on an emotional or personal level. A sense of peer learning was demonstrated above, and a sense of empowerment and validation will be discussed below. Nick referred to benefits of mindfulness group work in the context of a hospital ward. The shared experience and acknowledgment of the group seem to validate the patients' experiences.

Extract 18

*"I have been doing mindfulness on the ward, ummm..... …. it is kind of quite unusual place to be doing mindfulness group, because of the noise outside so... we just kind of tried to bring in acknowledgment about what has been going on somewhere else. So if someone is shouting, we are going to be aware of someone shouting out there, and...just noticing that. So it is almost like aaa...it is almost like creating an account which acknowledges a shared experience that we are all having together in the moment so, I think there is that sense of ...maybe there is a sense of...umm...of some bonding or some therapeutic alliance or something happens...cause its...yes...it's is a bit of a shift from them being pretty much the factors of the conversation obviously to something shared in a way".* *Nick, lines 1174-1192*

Above, Nick noted that listening together to the shouting in the ward bonded the group. Furthermore, it changed the focus from the group being the problematic clients to being the custodians of the shared experience. Although he does not elaborate on the quality of the bond, referral to the therapeutic alliance hinted at the nature of the shared focus; staying with the task, and working simultaneously towards the goal of being more aware.

### 3.3.5 Summary

Overall, this super-ordinate theme has presented the various types of relationships which evolved while working with MBIs. The participants reported a 'different' kind of connection: deeper, intimate, highly open, 'like hosts to guests', and one which presented questions around the correct boundaries, due to disclosure in post – meditation discussions. Transcendence to a different quality of relationship was reported too: a process that emerged from shared meditative space, into something that was elevated above a regular TR, into a realm of shared 'togetherness'.

Additionally, a relationship with themselves was evoked to enhance sanity, calmness and self-acceptance. A need to know 'what is going on within myself' was emphasized as a cause for the psychologists to meditate, since that seems to be a preliminary condition in order to be able to attune to their clients. Lastly, group relationship was described, and it was suggested that peer learning and sharing is seen more powerfully than a two person connection due to validation processes: if a whole group shares a certain phenomenon, the acknowledgement to the individual is highly powerful.

## 3.4 Theme two: integration

### Introduction

This super-ordinate theme captured the psychologists' accounts of going beyond the common dichotomies such as mind versus body, treatment versus healing and spirituality versus science. The psychologists' statements suggested that mindfulness is a complex construct that exceeds those binary separations. However, analyses of the transcripts demonstrated that the participants become caught in challenging situations due to the clinical or academic context of their MBIs practice. For example: the necessity of being regarded as professionals by their colleagues required that the psychologists leave their spiritual and more holistic stance behind when they enter their professional persona. This reinforces the role of MBIs as a 'tool' or technique rather than a belief system.

Analysis of the transcripts indicated that there might be a way out of these dichotomizing polarities via the acknowledgment that there is more than one 'entry point' into mindfulness, and it can play a wider role at different points in time for different people. For example: a beginner of mindfulness may view it as a secular endeavour but as their practice becomes deeper, they may find that some sense of spirituality accompanies it. Practicing and teaching mindfulness with patients and clients within academia,

private practices or the NHS made these attempts to integrate dichotomising elements a challenging endeavour. The transcripts revealed that the psychologists often employed specific pragmatic strategies in order to be taken seriously and at times they chose to divorce themselves from the more holistic perspectives.

### 3.4.1 Struggling with dichotomies: Spirituality-science; belief-technique; body-mind; treatment-healing

This sub-theme highlights the second aspect of how participants perceived the essence of mindfulness. It outlines the professed clashes between various constructs and illustrates well what Kabat-Zinn called the 'delusions of separateness' (Kabat-Zinn, 1990: 165). The very word 'health' implies 'whole'. 'Whole' implies integration, an interconnectedness of all parts of a system or organism, a completeness (Kabat-Zinn, 1990: 162). Despite variations in topics, the splitting into opposing positions was evident in the participants' extracts and seemed to reflect the participants' Cartesian Western way of viewing the world through dichotomies. Nevertheless, they attempted to bridge and integrate those splittings.

Various accounts regarding dichotomies/integration were noted: first, spirituality- science; second, belief- technique; third, body - mind, and fourth: treatment -healing.

Dermot talked about how he is a secular man who valued rational thought, yet spirituality is part of his life too:

Extract 19:
*I take (unclear) the secular rational approach to life ummm…I think, Buddhism helps me and I think spiritually I retain the sense that …being human is a bit of a mystery, so I like that idea that…you know…our experience is …it …a bit of it remains mysterious, despite how much you study or what you think you know*

*Dermot, lines: 204-210*

Dermot's account indicated a conflicting experience of rational knowledge that seemingly does not embrace mystery. The word 'mystery' alludes to something that is difficult to explain (OED, 2013). At times, it can be connected to religion or faith too: "A religious truth that one can know only by revelation and cannot fully understand" (OED, 2013). Hence, the use of the word 'mystery' may imply an internal struggle between the secular rational-scientist and his belief in the inexplicability of parts of life. However, despite the external appearance that the two contradict each other, Dermot embodied them both, and seemed to have been able to contain and integrate them, as he stated in two consecutive sentences that he is both taking a secular rational approach yet simultaneously Buddhism and spirituality enriches his life.

Similarly, Marcus asserted that science and religion are not incompatible, as they both share a sense of wonder. In the account preceding this extract he stated that the reason for the word 'spirituality' to be taken out of MBSR and MBCT was due to a strategic attempt not to alienate secular audiences, and then he added:

Extract 20:
*P: Yes. And aaa…and therefore, aaa…it seems to me there is no incompatibility, between the wonder you see when you look at (a) little child examining their own hand, ummm….and the one that you see when you look at a brain scan, of what is happening there, when a child does that, and when you see adults responding to their own trauma in totally new ways. There is a wonder in that, which is about a sort of healing, wholeness which you would expect all religions if they are getting to the heart of things, would be exploring, advocating, (30:56) and, and sharing.*

*Marcus, lines: 657 - 667*

Mirroring Dermot's 'mystery', Marcus' account used the word 'wonder' twice. He compared child-hand and scientist-brain to a child's curiosity and adult's trauma response. This comparison allowed him to link the curiosity

of the scientist to the wonder of religious feelings, and to suggest that the unifying line is in the healing capacity that curiosity may bring.

The split of mindfulness between a technique and a belief was evident in the accounts of all the participants. Most of them started as scientists/evidence-based practitioners and moved over the years to the realms of beliefs and values. Charlotte talked about her worry that MBCT is devoid of spirituality or connection to Buddhism, and is used as a technique only.

Extract 21:
*Charlotte: People are seeing it as a technique. And I think that is extremely worrying.*

*Interviewer: A tool*

*Charlotte: um. And more worrying because of the MBCT. Because it is another CBT technique that we can add to our repertoire. And there is no notion of the fact that there needs to be some personal resonance about what it is. And that is why I think the downside comes in, because it has been stripped from its Buddhist roots. That is now being able to be used at (unclear) a technique rather than something that holds a personal value that you can then use as part of who you are as a therapist. And try and transmit that. ...we need to see people in a more …complete whole.*

*Charlotte, lines 1042-1064*

Linking neatly to Kabat-Zinn's (1990) vision of 'wholeness', the above account argued for seeing people as a '*complete whole'*. Charlotte talked about the interventions (MBCT) as being *'only a technique*, *bare of its spiritual roots'*. As such, this tool holds little spiritual value. Charlotte seemed to be critical of MBCT as she saw its "*down side*". This is in contrast to Marcus' account. Marcus argued that for a strategic purpose

MBCT had removed its Buddhist religious connotations[21]. Hence, for Charlotte the split between technique and value is a worry while for Marcus it is a necessary 'skilful means' to attract clients (Kabat-Zinn, 2011). Nevertheless, she does not view mindfulness as a religion. There is a continuum to be noticed: from tool through value to a belief and a religious belief. Despite sounding quite strong about the need to retain a sense of value within MBIs practice, Charlotte does not cross the line into religious belief. Her version of 'what is mindfulness' represents a middle ground between tool and spirituality**.**

Similarly, Marcus talked about the integration of body and thought in MBCT:

Extract 22:

*"Putting some flesh on the bone, saying: what does it actually mean for integrated 21st century psychological theory of the mind. And what do we know about the way in which minds work, how cognitions and emotions interact with bodily sensations, and so on. And how does all that work. How does it go together".* *Marcus, lines 129-135*

Marcus tied body and mind and argued that it is modern science's task to explore *"how does it go together".* Clearly, in the account above there is no separation. The expression 'flesh on the bone' means to give substance (OED, 2006). This suggested that he viewed his integrating approach as a more advanced and 'full' version of explanation of the human condition.

Equally wrestling with the clash of therapy versus healing, some participants talked about the "wholeness" aspect of the mindfulness processes, to treat the client in an integrating, unifying way. They reported

[21] Nevertheless, the distance between these two participants is not large. They both agree about the value and belief system, which underpins MBIs, but they chose to take separate paths as they had different goals. Marcus worked with MBCT and wished to bring it to the NHS and the masses; Charlotte worked privately, and did not aim to educate such large audiences.

to have been doing ‘therapy’ but have aspired to do ‘healing’. Nick talked about ‘a sense of healing’ from making whole:

Extract 23:
*“When you are doing mindfulness, it is very, very clear, that it is not, that it is not, it is very, it is very, more like a...I mean, this is not a very NHS word, but it is almost like there is a sense of ...healing as a word seems to fit more than the word therapy…….. a lot of service users people are actually ...rather do...find it quite a meaningful word, giving them a different spiritual holistic traditions, sort of...yes... apart from wanting as it were...and a sense of healing comes from making whole, well, this is what mindfulness is interested in doing”.*

*Nick, lines 1198-1215*

Nick’s account illustrated the opposing difference between therapy and the healing process. This difference became further defined against the background of the NHS. This framework confines the clinician to use professional secular language and the account depicted how this made Nick uncomfortable, as it changed the meaning of his work. In line with the opening of this sub-theme, the construct of ‘wholeness’ is emphasized once again. This demonstrated the overall propensity for integration to which the participants aspired.

### 3.4.2 Linking between personal practice and professional work

This sub-theme added to the overall premise of the super-ordinate theme, since it yet again depicted the idea of integration of two domains that get portrayed as separate in Western culture. In this sub-theme, the areas are personal versus professional life. In contrast to this, the participants talked about a coherent and integrating sense of self that ‘practiced what she preached’.

The accounts that demonstrated this were: first, “you cannot teach what you do not practice beforehand”; second, “personal practice for work is within the context of the therapeutic relationship” and “the TR does not grow out of vacuum but from personal practice” was the last and third account.

Tabitha asserted that the psychologists need to practice mindfulness in their private life in order to be able to teach it in their professional life:

Extract 24:
*“...In my opinion: if you do not do it in your private life ...if you do not really experience it from first-hand experience, it is not something that you are just going to learn and then you are going to teach your clients. It just does not work that way”. Tabitha, lines 483-488*

Tabitha asserted that one needs to embody the qualities of mindfulness, and teaching without practice simply will not work. She highlighted the experience that needs to be felt and has to actually take place.[22] The account above implied that one could not superficially learn how to be mindful and immediately transfer that to the client. Yet from the perspective of the TR, Charlotte talked about the importance of the psychologist’s self-practicing of mindfulness for the therapeutic relationship. She believed that mindfulness is key to the therapist’s quality of work:

Extract 25:
*“The more mindful you are as an individual, the more mindful you would be as a therapist. And the more mindful you are as a therapist, the better therapist you are going to be because what happens in the therapy room is…really when things start happening. Charlotte, lines 1427- 1436*

[22] *When reading this I reflected: is there anything at all, which one can learn and immediately teach? Nevertheless, the above account, despite contradicting it, suggested that there are some fields in which such incongruence can take place.*

Charlotte drew on the TR to explain the importance of the psychologist's capacity to be mindful. The word 'happening' has positive connotations. She is using it instead of the word 'activity'. On reflection, Charlotte may have alluded to a state where things are *becoming* a happening, since in the account there is integrity between the individual self-parts and the professional self-parts of the psychologist. Similarly, Nick depicted further reiteration of the importance of personal practice. He talked about relating, which grew out of the personal practice of the clinician:

Extract 26:
*"But there is this whole sense of how you are (? Unclear) (48:17) as a therapist in the session as well, and I think in some ways that is even more fundamental to using mindfulness as a the therapeutic technique, it would not be ...work, unless the therapist was actually practicing mindfulness themselves, it would not, it is not something that can happen as sort of ...in a sort of vacuum, it has to happen...so I think that is the sort of...I think that is the ground of the work, is the quality of ...aaa....connection, I think that is the biggest achievement there is".*

*Nick, lines 787-799*

Nick highlighted the importance of '*how you are'*, i.e., the being of the psychologist, rather than the 'technique' part of the therapy. The use of the word 'vacuum' is interesting and suggested that without genuine self-practice in private life there is an absence of matter, an empty space. Additionally he used the word 'ground', that suggested something basic that serves as a foundation. Hence, as in Charlotte's account above, practicing meditation in private life is the foundation to the existence of the connection[23].

### 3.4.3 Summary

The psychologists recognised that the nature of mindfulness is a much more holistic endeavour than to be just a tool, technique or a body-awareness device. What seem to be dichotomies of contrasts or opposing

[23] Please note that a third sub-theme named 'just being' had to be omitted, see Appendix 19.

differences such as body versus mind, and treatment/therapy versus healing, can be integrated into a more complete holistic view, despite some constraints that the secular professional environment and Western culture around the psychologists might impose upon them. These constraints did indeed result at times in some internal conflict, which the participants voiced. However, they outlined how vital integration is, highlighting the multifaceted dimensions of MBIs, and illustrated how only through looking at themselves holistically, as a person practicing mindfulness in their personal lives, would they then model these qualities and bring them into their work.

In summary, this theme showed how some apparent contradictions kept appearing. These dichotomies were manifestations of the psychologists' Western way of thinking. However, practicing mindfulness directed them towards integrative holistic paths, where a 'middle way', which unites oppositions, is sought. The contrasting pairs of spirituality versus science and belief versus technique were made sense of. The participants managed to contain them both and did not buy into Cartesian dichotomies. Lastly, by unifying personal and professional endeavours in their lives the psychologists advocated that the TR benefited from their practice of meditation as individuals in their private lives.

In the first super-ordinate theme it was demonstrated that working with MBIs had an impact on the TR, the relationship with the self and group relating. Yet, it was not idealised as a 'miracle' enhancer of the relationship, since practicing mindfulness in some group situations did not allow for the TR to have space to flourish. A balanced view of the "middle path" evaluating MBIs strengths and challenges in regards to the TR was struck. Simultaneously, the importance of the TR, and the accounts depicting the quality of the TR, highlighted the relevance of the research to counselling psychology as this professional discipline places the TR as one of its main principles. Similarly, in this second super-ordinate theme a 'middle path' exploring the struggles, contradictions and challenges to an integrative view had been highlighted. Counselling psychology advocates

an integrative perspective combining various theoretical modalities and epistemological positions, such as science and belief (Woolf, Dryden & Strawbridge, 2003). Therefore the relevance of the research to counselling psychology was demonstrated.

## 3.5 Theme three: the process of mindfulness

This super ordinate theme consists of two sub themes: first, 'becoming' and second, 'accepting challenges'. This super-ordinate theme captured how the psychologists went through the process of teaching and doing MBIs. Firstly, the psychologists emphasised the dimension of 'becoming' rather than having arrived at a fixed end-result. The idea of becoming something rather than having become or being is perhaps a common theme in many areas of life. This moving perspective might at times deny what the person has become.

Second, the participants discussed the challenges that they faced while treading the paths of mindfulness teaching, and elaborated on how mindfulness is not a solution to all problems but rather a way of managing problems better, through contact with the self and awareness of others. Working within the NHS presented them with challenges and limitations that they accepted and strived to work with.

### 3.5.1 Becoming

This sub-theme illustrates the feeling that working with mindfulness is a journey, without an end point. The 'way' is emphasized rather than the 'arrival'. The word "becoming" is a manifestation of this sentiment. Becoming is 'the process of coming to be something or of passing into a state' (OED, 2006). Additionally any change from the lower level of potentiality to the higher level of actuality is how the construct is defined in the philosophy of Aristotle (OED, 2013). Mostly, it indicates the process of change. Hence, the participants allude to how practicing mindfulness is a

moving, shifting action, reflecting to the ebb and flow of life itself that is never a constant.

Tabitha talked about how becoming more finely tuned to subtle energies in the body helped her to be more present in the therapy room:

Extract 27:
"*Also, it was helpful with my own practice, of course, as a clinician and now as a therapist – becoming more aware, you know, as I did more and more practice, and particularly as I got more into the internal styles of martial arts, you know, it is very much about subtle energies in the body, really becoming quite fine-tuned to that, and I definitely noticed as I increased my Thai Chi practice what I noticed in myself in the room, exponentially just…boo…and it was like…wow".*

*Tabitha, lines 945-955*

Tabitha's account illustrated how practicing mindfulness, through martial arts and in particular through the body, changed her capacity to be aware and notice herself during the therapeutic interaction. The use of the word 'exponentially' to signify that her awareness increased to a very large amount is striking, especially as it is accompanied with the words 'boo' and 'wow', both heartfelt expressions of amazement. When I listened to the interview again I noticed that it was pronounced with great pleasure too. This pleasurable effect is further illustrated in the extract from Nick's account. He talked about becoming open to an 'innate source' of well-being as a result of sustained meditation practice:

Extract 28:
*"Nick: It takes determination to actually get a meditation practice going, or to sustain that, so there is a bit of a paradox, that umm...for me, I kind of have more a sense of ...how I do see it more in terms of becoming open to something, as it were".*

*Interviewer: and what is that something?*

*Nick: ummm...I think there is some kind of sense, an innate...innate source of wellbeing.* *Nick, lines 319-327*

This extract demonstrated the paradoxical situation in which the psychologist is caught: finding it difficult to sustain the practice despite awareness that the process facilitates wellbeing. The change from 'potentiality' to 'actuality' is highlighted here with the expression '*becoming open'*. This referred to unlocking internal blocked states, which allow free exploration. Nick also talked about how becoming mindful resolved the (seeming) contradiction between change and acceptance:

Extract 29:
*"It comes from Larry Rosenberg, an American mindfulness trainer who says: 'If you want to get from A to B, ummm...really be A'. I thought that kind of resolves this split between change and acceptance that somehow, if you actually become mindful, then some kind of change happens without...without striving or a more problem solving basis".*
*Nick, lines 407-415*

As highlighted in the extract above, change being perceived as the opposite of acceptance is the subject of many questions from novice mindfulness meditators. However, using the expression 'becoming mindful' indicated that even for Nick, who has been a practitioner for the last 30 years, there are still some questions in the process. However, he answers his own wondering by stating that change does happen, when one goes through the process of becoming.

While Nick expressed a way to amalgamate change and acceptance (change is what happens while one accepts being in a particular place) the following extract amalgamated practicing psychology and Buddhism. Dermot talked about how he encountered a parallel process between becoming a psychologist and becoming more familiar with Buddhism and

meditation. In contrast to Cleo, for him these were two processes that seem to go hand in hand.

Extract 30:
*"I was thinking about becoming a psychologist, and at the same time I was starting aaa….kind of meditation practicing, Buddhism with my partner…we have developed it together, so I did a couple of retreats, ummm…and then had a fairly established mindfulness practice, we were doing quite a lot of other things around exploring Buddhism, aaa….and it kind of felt like becoming a psychologist would be a step into the right livelihood, really.* *Dermot, lines 124-135*

In the extract above, the word 'becoming' is connected both to becoming a psychologist and to starting to have an established practice of mindful-meditation. This is interesting, as it encompasses both facets of the psychologist's life under the unifying umbrella of 'becoming': the private and the work domain. Both areas are described as a process of change from a potentiality to an actuality. The parallel between the two reflected how complementary both domains were for Dermot. Additionally, the extract also alluded that both phenomena are lifelong journeys, as one never ceases to learn as a practitioner of psychology or mindfulness.

In summary, this sub-section of the 'becoming' illustrated one aspect of the passage to mindfulness, which focused on the process, and being, on the way towards an ideal state of awareness. It captured the 'exponential' growth of noticing the therapeutic self, the amalgamation of change and acceptance, and the parallel process of becoming a psychologist and a mindful-practitioner (For a further sub-theme that complemented the above and suggested how the passage was conveyed via space analogies, see Appendix 17).

### 3.5.2 Accepting challenges

In light of the participants' conflicts around the apparent contradictions within mindfulness, (for example: 'just sit with it' versus 'let go'; 'observe and notice' versus 'be non-judgmental'; 'just do it' versus 'be mindful') this sub-theme embodies the psychologists' needs to make sense of the challenges of mindfulness meditation, and to act to resolve the personal dilemmas as outlined above.

Charlotte illustrated the difficulties in 'being mindful' in the extract below. She commenced by talking about how hard it is to 'just sit' and meditate. Moreover, finding the time for meditation is arduous too.

Extract 31:
*"You can give time to yourself by just meditating, sitting quietly, but I think the 'metta' one can be quite difficult for people. I think both are difficult, and hard for a lot of people to negotiate around this. People tell me: 'I do not have five minutes'!. And I say to them, I get round to saying – perhaps in nicer words: that is nonsense".*

*Charlotte, lines 1154-1161*

This demonstrated again the paradox between how *'quite difficult'*[24] it is for clients to '*simply sit',* despite mindfulness being talked about as something which becomes effortless (Kabat-Zinn, 2012). Yet it is imperative that the clients are told right from the start that the cultivation of mindfulness may be a very hard task and that finding the time is essential. This issue of 'finding time' is typical of our hectic Western modern lives, where people multitask and rush.

The challenges of meditation are echoed also via Marcus' account regarding the 'complaints' of the clients, who find it hard to meditate (complaints about meditation are necessary for insight, Marcus, lines 316-314); however, he subverted these into a benefit. Like grist to the mill, complaints are like corn that is brought to a mill to be ground into flour.

[24] In addition to mindfulness meditation, Charlotte referred to the 'metta' meditation, which is a love and kindness wishing meditation to one self and others.

Extract 32:

*“And then the question is how can you use the complaints as grist for the mill, and for that you have got to have your own experience, I believe, having seen many-many teachers (15:29) trying to teach it without much experience, and I can see how they are not picking up the cues that the participants give them, if they could pick them up they could make that into something which is a good aa...aa…a very helpful and insightful move forward”.* *Marcus, lines 312-324*

The above extract highlights the challenge of sitting in meditation. The difficulties that arise from having to stay with ‘whatever comes up’ is a ‘blessing in disguise’, as it can be used to elevate insight by an experienced teacher. This demonstrated an alternative view to handling difficulties in mindfulness practice.

However, mindfulness is not the answer for all client groups. Nick provided an example of how a client may not be appropriate for mindfulness work, due to the work being in conflict with the client’s religious beliefs. This is similar to the narcissistic client of Matt who was not suitable for self-reflective work.

Extract 33:

*Nick: “There are some people who feel that mindfulness is not in accord with their own spiritual or religious beliefs.*

*Interviewer: OK. You have encountered such people?*

*Nick: I particularly...staff...yes. And people from aaa...African Christian, certain African Christian communities. The pastor would tell them aaa...aaa...if you ...do not accept voices or do not, do not, do not meditate, because it allows the devil in, …… ...people do not want to go against what their pastor claims. And aaa...it is one thing going into a whole...what is the word? Going into a whole discussion about how effective is it to*

*block out stuff... but also it can feel a bit like perhaps it might not be helpful to, to do that. So, so just kind of being mindful basically around how, how congruent is mindfulness within people's spiritual belief systems...ummm....ummmm*

*Nick, lines 1368-1392*

The point Nick is making is that mindfulness can seem to be incongruent with the client's belief system, or the client's 'other' teachers. Therefore, in such cases, perhaps using a different avenue of therapy may be suitable.

### 3.5.3 Summary

Overall, this theme has highlighted how the psychologists are practicing MBIs. It has shown that they reflect on it as a process of becoming, rather than getting to a point of 'achieving' something for life, like an accreditation that need not be maintained. Additionally, locating things in space as an analogy to explain mindfulness was described (see 'space' sub-theme in Appendix 17). Again this is an analogy that is very common yet revealing important things such as: "We are all in the same boat". The difference with mindfulness is that if the psychologist meditates together, she is participating in a shared experience with her client in a way that does not occur in other forms of therapy. In a normal therapy session by engaging in a task of work the psychologist's energy levels are depleting, but if she is meditating, engaging in the process with the client, then the psychologist may also leave the room enhanced. Spaciousness of the body has highlighted becoming more aware of the body. Like clearing out the clutter of a house and realising that there is more space than you thought there was. Maybe mindfulness helps people experience the full house of their body rather than one cluttered room in which they were living.

Lastly, challenges faced by the psychologists in the context of working with MBIs were discussed. It had shown that the participants struggled with issues such as remembering to be mindful, finding the time to

practice, complaints about mindfulness practice from the clients were challenging for the psychologists, and mindfulness was not suitable for all clients, nor was it a tool with which to 'solve the whole of the world's problems' as sometimes it gets marketed[25].

# CHAPTER FOUR – DISCUSSION

## 4.1 Overview

This chapter discusses the analysis of this study, in relation to the research question regarding the experiences encountered by psychologists who work with Mindfulness Based Interventions (MBIs) in

[25] For reflective notes Chapter three see Appendix 5 B.

the context of the TR. This is an important topic for counselling psychology due to the amalgamation of the following facts. First, there is a large body of research that shows that MBIs are effective in terms of positive therapeutic outcome (Kabat-Zinn, 2013). Second, there is another significant body of research that shows that the largest predictor of positive outcome/effective therapy is the TR/TA (Lambert & Barley, 1994). Third, research has demonstrated that the outcome is mostly determined by the quality of the relationship (rather than by the intervention) (Lambert & Barley, 2001). And last, for counselling psychology as a discipline, the TR stands at the core of the profession (Woolfe et al, 2003). Therefore, it seemed highly relevant for counselling psychology to explore psychologists' experiences of working with MBIs in the TR context.

Through my research, I am trying to alert counselling psychologists to the relationship between MBIs and positive outcome, while emphasising the importance of incorporating MBIs into training and practice. Despite the fact that I have not looked directly at MBIs and outcome, this research might allow some tentative suggestions to be made about where to go next regarding the TR (see section 4.7). Furthermore, as the discussion will highlight, these results question the foundations of certain therapeutic models that advocate a more separate and detached position (Baldwin, 2013).

The results will be discussed in the light of the pre-existing research and literature outlined in Chapter One. Smith et al. (2009) asserted that research interviews and analyses will lead the researcher to explore new areas. Therefore, new literature will be covered when applicable. A critical evaluation of this study and implications for existing theory and practice will be provided. Areas for potential future research are outlined throughout this chapter.

Semi-structured interviews were conducted with seven psychologists. Relating to the main research question, the following areas were explored:

1. How and what does the TR feel like when working with MBIs?
2. What is the experience of working with MBIs like?
3. What are the benefits/difficulties of working with MBIs?

Interpretative Phenomenological Analysis (IPA) was utilized to analyse the psychologists' accounts, and three super-ordinate themes were identified (see Table 3: 54). Put together, these three super-ordinate themes suggested an overall account of what it is like to be a psychologist working with MBIs. The following chapter will discuss the findings while answering the three questions outlined above through Rogers' (1961) core conditions for the TR, since the participants used those constructs to describe their experience (e.g. extract 1,2,3).

### 4.1.1 The research argument / take away message

The research presented here has demonstrated that when working with MBIs in the context of TR, the psychologists have a good strong connection with their clients: the bond from the Working Alliance (WA; Bordin, 1979). This finding was corroborated by Wang (2006), Wexler (2006), Nanda (2005) and Rothaupt & Morgan (2007). This research has found that Rogers' (1961) core conditions of the TR (i.e. the unconditional positive regard, empathic understanding and genuineness) were talked about by participants as being enhanced.

However, there were other voices that expressed ambivalence to the centrality of the TR in the work of MBIs (extracts 7,8). A few issues were raised: first, it was questioned whether it is possible to create a one-to-one relationship in its classic form when work was done in a group. Second, the issue of disclosure was raised in the context of the psychologists meditating with their clients. For some psychologists this was not comfortable, therefore it problematised the TR. The dynamic of equality between the client and psychologist was challenging for some psychologists. The overall narrative provided a balanced account: on the

one hand there was an elevation of the relationship (Rogers, 1961; Bordin 1979); on the other, it was not an unproblematic way of working.

### 4.1.2 Novel elements of the research

This research presents both the advantages and challenges of working with MBIs. In the existing literature around mindfulness and the TR, mindfulness is often portrayed as an enhancer of the TR or as a facilitative-mechanism for the enrichment of the therapeutic process (Nanda, 2005). Unlike the above studies, this research arguably provides a more balanced view of the phenomenon. Additionally, it provides evidence to an area that has been theorised by various authors but has not been subjected to an evidence-based analysis (e.g., Hick & Bien, 2010). Those authors are drawing on their own personal experiences of practicing MBIs rather than conducting a systematic analysis.

This research is original in various ways. First, the sample group has not been studied previously. Second, its finding of a 'balanced' message of ambivalence is unique. Third, this research contributes to counselling psychology awareness that working with MBIs facilitates conditions of strong bond and enhances Rogers' (1961) core conditions. Last, it contributes to the awareness of the psychologists' relationship with themselves. The message of the research can be contextualised in the 'middle path' Buddhist philosophy (Kulananda, 2003). In essence, the research argued that MBIs were not problem-free therapies but were a useful approach that enhanced the TR. This could be of benefit to counselling psychology since the profession emphasizes the TR at its core.

## 4.2 The TR's qualities when working with MBIs

From the analysis it was clear that the process of working with MBIs influenced and created a strong sense of bond or connection. The bond is a crucial and necessary part of the Working Alliance (WA) (Bordin, 1979).

In addition, the very same qualities that Rogers identified as sufficient and necessary for personality change such as acceptance, care, empathy, genuineness and authenticity were noted too (Lambert, 1986; Rogers, 2007). Last, a sense of equality in the relationship was described. The participants also discussed different kinds of relationships that mindful-meditation helped to evoke with oneself, within a group, or between two or more people. They described a sense of transcendence to a shared consciousness and expanded the relationship beyond the particularity of the TR to include a distinct transcendental dimension. The construct of mindfulness can be defined in various ways (Kabat-Zinn, 2012), therefore the plurality of its interpretations might influence and explicate the above results.

### 4.2.1 MBI's enhanced 'bond-connectedness'[26]

The finding that working with MBIs led to participants feeling connected to their client as "two humans" (Tabitha, 1) aligns with Buber's notion of the 'I-Thou' relationship (Buber, 1970) and Clarkson's fourth classification of the TR: the person-to-person relationship (1990). Furthermore, authors such as Surrey (2005) and Nanda (2005) suggested that connection is the object of mindfulness. This was corroborated in this research. Shapiro & Schwartz (1999) construed connection as the middle part of a feedback loop process that maintains stability and adaptability to change. They asserted that mindfulness (as defined by Kabat-Zinn, 1990) cultivates awareness of the movement towards connection, informed by the intention to return to connection again and again. The participant Tabitha felt she connected in a genuine way, and in a reverse power dynamic, as the client became her teacher. This highlighted how, while practicing MBIs, not only the relationship is genuine, it can even have an opposite role formation from the traditional powerful-expert-psychologist versus helpless-client.

[26] Part of the Working Alliance (Bordin, 1979).

Kabat-Zinn (1990), Brown & Ryan (2003) and Brown, Ryan & Creswell (2007) have all argued that mindfulness promotes connection and closeness in relationships, and that mindfulness was positively related to, or predictive of, a felt-sense of relatedness and interpersonal closeness. Similarly, Chrisman, Christopher & Lichtenstein (2009) have asserted that by developing a capacity for connectedness, mindfulness practices have the potential to heal the splits of a dualistically divided world and foster the kind of ethics of care and compassion that enhances the TR. Kabat-Zinn (2011) asserted that mindfulness brings intrinsic interconnectedness as beings, and so the possibility of greater compassion towards others and towards the self is created. Additionally, Green (2010) suggested that deep connectedness of human beings is not only beneficial to the client and to the TR but also sustains the therapist. This is aligned with the findings of this research, where strong connection was reported by participants. (e.g., Tabitha asserted: "*we had connected*", 1). She felt deeply connected and the benefit to her as a psychologist was expressed as a feeling of learning from her client.

### 4.2.2 Transpersonal connection

The quality of the connection/TR while working with MBIs was described by some of the participants as transcendental. Transcendental psychology is defined by Lajoie & Shapiro (1992: 80) as concerned with "the self, interpersonal encounter and mystical phenomena". In contrast, Mace (2008) defined 'transpersonal' to be those aspects of our mind that are not dedicated to pursuing individual needs/interests. Clarkson (2003: 187) defined transpersonal relationship to be "the spiritual dimension of the healing relationship". The transpersonal and transcendental are two similar concepts that have a shared construction of spiritual dimension and sacralisation of everyday life (Lajoie & Shapiro, 1992).

The analysis chapter illustrated how the participants perceived that at times something beyond and above a usual TR took place. The participants felt that both clients and psychologists were able to grow

beyond the boundaries of the ego, and a feeling of shared experiences, shared struggle of existence, shared quality of space ("numinous") and a sense of the psychologist-client similarities were noted (Matt, line 11; Marcus, lines 637-645; Tabitha, 12; Dermot, 9). This is reminiscent of Fulton (2005) who postulated that when the ego and the ego boundaries are somewhat eroded, the psychologist could have a sense of shared existence, similarity and connection. Likewise, Clarkson (1990) has postulated that the transpersonal relationship is characterized by intimacy and emptying of the ego. She asserted that into the 'emptied out' space, something 'numinous' (spiritual) could be created, in the 'between' of the relationship. The numinous quality of life was mentioned in this research too (e.g., Marcus, lines 637-645). Clarkson (1990) talked about the way the therapist's unconsciousness communicates with the client's unconsciousness, an idea borrowed from Jung (1969). This unconscious communication seemed to be what those participants who felt the transcendental element have reported. For example "mindfulness transcends all of that... it might come out in the relationship" (Tabitha, 12).

The participants talked about the fact that "we are all essentially similar to each other" (Dermot, 9; Matt, 11). Being engaged with the transpersonal side of the TR made them aware of being like their clients. Similarly, Fulton (2010) discussed the illusionary aspect of separateness, which surfaces through working with MBIs in the transcendental elements of the TR.

### 4.2.3 Connection with the self

The participants' accounts indicated that psychologists who meditated by themselves strengthened their relationship with themselves – "*I need to bring myself to …saying: 'Life feels pretty crap at the moment but just keep perspective, it is OK, you can get through this' (*Charlotte, lines: 954-6). However, many training programmes have no focus on the

development of 'the self' of the therapist, this is an area that gets neglected (Baldwin 2000). It is suggested that future research should examine the important issues of training programmes developing the therapist's sense of self and increase self-awareness during the training.

### 4.2.4 MBIs enhanced acceptance/care, empathy and genuineness/authenticity in the TR

The participants suggested that while working with MBIs, the TR included and enhanced all the known Rogerian (Rogers, 2007; Steffen, 2013) conditions of the TR: acceptance, and non-possessive care; empathic understanding; and genuineness/authenticity. These will be evidenced below.

#### Acceptance, self-acceptance and self-care

As seen in the results chapter, acceptance of feelings of fear (Tabitha, 2) and compassion (defined as unconditional positive regard with patience and understanding; Peled, 2010) are qualities that emerge within the TR while using MBIs. This is demonstrated when use of MBI by Tabitha helped her to accept her client's imminent death. That allowed her to transcend beyond her fear of death, and to feel happy to explore these issues with her client. In this way she embraced an existential approach, and with empathy, or deep awareness of the suffering of the client, she embodied compassion.

#### Self-acceptance

Practicing mindful-meditation enhanced self-acceptance: "It is OK being me" (Tabitha, 13). Tabitha found a way to remain authentic to her own energy levels, yet to fulfil the role of a clinical psychologist in a way that reassured her supervisors of her professionalism. While mindfulness is gaining popularity as an intervention for clients, there is simultaneously a growth in the idea that clinicians may want to adopt mindfulness practices

in their own lives (Welwood, 2002). Kabat-Zinn (2003) referred to this when he asserted that instructors cannot authentically teach mindfulness to others unless they have incorporated mindfulness into their own lives. Lum (2002) suggested that therapists could not be fully congruent and connect with their clients unless they are consistently aware of and accepting of their own processes. Similarly, the participants purported that practicing mindful-meditation made them accept themselves and care for themselves (see for example extracts 14, 15).

## Self-care

Part of unconditional positive regard is care (Rogers, 1961). The participants described elevated self-care too (e.g. extract 14). This was also highlighted by Aggs & Bambling (2009) and Shapiro & Carlson (2009). The analysis shows that some participants found meditation to be a time to focus "simply on me and bring some kind of stability" (Charlotte, 14). The participants postulated that stability that resulted from meditating by themselves could shield them from burnout. May & O'donovan (2007) emphasized the advantages of the mindful therapist and demonstrated decreased burnout and work satisfaction among mental health professionals. Cohen-Katz et al. (2005) found similar association between mindfulness and burnout in nurses and healthcare professionals. One might tentatively suggest that these studies give the results further validity.

## Balance as self-care outcome

The results illustrated that psychologists meditating by themselves promoted balance. Participants clarified that meditation helped them not to be reactive, but to be able to contain the different components of their lives. "We are not all laughing or glowing, or terrible and dreadful or awful… mindfulness helps us to stay with the different parts" (Charlotte, lines 653-656). Similarly, Rothaup & Morgan (2007: 48) reported parallel

findings. Self-care and balance between external demands and internal needs was achieved. Likewise, Satir et al.'s (1991) model of the development of the therapist's self highlighted that self-care is necessary to promote balance. Vredenburgh, Carlozzi & Stein (1999) postulated that the psychologist's self-care protects against burnout and adds to an internal perception of balance. This research and the above-mentioned studies emphasise the need to incorporate mindful-meditation in the training of counselling psychologists as burnout is a serious issue for the profession (Woolfe et al., 2003). Further research should examine the issue of training programmes developing the therapist's sense of self and self-care in order to avoid practitioners' burnout.

Another experience of 'attunement' (awareness & responsiveness) was demonstrated by the participants (e.g., Dermot, lines 1360-1368). The participants also reported, like Roger's assertions, that self-attunement was needed so that attunement to the client could take place (Nick, lines 927-933). Bruce et al. (2010) defined attunement as a process of bi-directional communication in which one person focuses on the internal world of the other, and the recipient feels understood and connected. They further postulated that mindfulness is a means of self-attunement that increases one's ability to attune to others. This interpersonal attunement ultimately helps clients achieve greater self-attunement that, in turn, fosters greater well-being and better interpersonal relationships. The construct of attunement was accounted for in this research as a phenomenon that takes place as part of intrapersonal and interpersonal processes. This seems to be important as it might lead to wellbeing and resonates with 'being more present' (e.g., Nanda, 2005).

## Empathic understanding

Rogers' (1961: 284) definition of empathy is the ability "to sense the patient's private world as if it were your own, but without losing the 'as if' quality". It describes empathy as a conscious cognitive process. Safran & Segal (2004: 85) postulated that: "Empathy involves the therapist's

disciplined stance in trying to walk in the patients' shoes so as to understand the subtleties of their phenomenological world". Indeed, the ability to empathise was demonstrated in the analogy described by Tabitha (line 1903). The process of meditating with the client was portrayed as "walking the walk…both (client and psychologist) walking alongside".

In the case of the psychologist Tabitha (13), self-empathy was the mediating factor that allowed her to accept herself. Tabitha was able to accept her tendency to have high energy and feel empathy towards this tendency that provoked comment from her supervisors. Germer, Siegel & Fulton (2005), Kabat-Zinn (2011), and Shapiro & Izett (2010) emphasized the importance of empathy or 'affectionate attention' towards the self. This emphasis highlights the centrality of the construct, in particular to counselling psychology that places value on this concept (Woolfe et al., 2003). Fulton (2005) and Shapiro & Izett (2010) posited that psychologists often encourage clients to 'go easy' on themselves. They wondered whether this generosity could extend towards the self. They emphasized the danger of burnout without empathy towards oneself.

Germer et al. (2005: 337) asserted that empathy towards oneself is a central part of mindfulness practice. The object of meditation becomes the self and the muscle of non-judgement: empathy is strengthened. Moreover, "compassion that emerges from self-empathy is better prepared for holding another in its care". Likewise, Nanda (2005) noted that experiencing empathy was an outcome of the therapists meditating by themselves. In summary, MBIs consistently have been theorised to promote empathy (Fulton, 2005; Shapiro & Izett, 2010), and research utilizing a variety of methods is now accumulating to support this premise which the present research corroborates. Aiken (2006) found that therapists who were experienced meditators believed that it helped develop empathy towards clients. Similarly, Wang (2007) found that

therapists who were experienced meditators scored higher on measures of self-report empathy than therapists who did not meditate. These results are in line with the present research findings but extend to the current population of psychologists.

## Genuineness and authenticity

Finally, Rogers' third condition that concerns genuineness/authenticity was noted by the participants who discussed feeling that "honesty (in MBIs) helps to build the relationship" (e.g., Cleo, lines 1394-5; 1387) as a result of working with MBIs. The authenticity/genuineness that were felt were dominant aspects of the participants' experiences. Such findings advance our knowledge of the benefits of working with MBIs since genuineness is a highly important part of the TR, and because this research illustrated that the facilitative conditions for a positive TR exist when working with MBIs. As argued in Chapter One, mindfulness-meditation has a lot in common with existentialism. One of the main themes of existentialism is authenticity in people's personal lives and society (Flynn, 2006). Sartre argued that existentialism is a humanistic philosophy (Sartre, 2003). For existentialists, becoming authentic was part of the project of becoming an individual (Flynn, 2006). Hence, the authenticity that was observed in the TR can be seen as part of much-desired social ethics, and this cultivation might have implications for transformation. For example, the experiencing of a psychologist working with MBIs and expressing authentic positions can model the clients for a way of being that facilitates healing since it eliminates gaps between true and false selves (Winnicott, 1960).

## Ambivalence regarding the role of the TR while working with MBIs

This research demonstrated accounts of elevated connection, acceptance of self and client, care for clients and self-care that led to internal balance, empathy, genuineness and attunement in the psychologists. However, some participants minimized the importance of the relationship within BMIs in the group context, or seemed to have embodied less than complete

respectful equality with their clients. For example, Cleo discussed a hierarchy of the 'healthy' therapists versus the 'ill' patients. By doing so, a power differential was highlighted. Kabat-Zinn (2013) echoed Marcus' reflection (extract 8) regarding the group element of mindfulness courses. He asserted that in the early days of MBSR, a teacher had interviewed each participant of the course, and that single meeting has contained some elements of the TR. However, due to the high demand for the courses, it was felt unnecessary and the group sharing replaced the one-to-one relationship. Nevertheless, Kabat-Zinn postulated that the TR is incredibly powerful, since mindfulness is about the relationship with the teacher/psychologist. This research highlighted that there were variations in experiences. The implications for the use of MBIs are the following: both in one-to-one and group work, the majority of the accounts indicated that MBIs created facilitative conditions for strong bond/TR. However, in some instances, in a group setting, the relationship between the psychologist and the client might be less pivotal for the healing process and create some challenges for the psychologist. These challenges might include the need to find time and space to maintain the one-to-one attention to the individual client.

This section has highlighted the potential of mindfulness in fostering an effective TR. Chapter one demonstrated that the TR is central for effective interventions, (e.g., Lambert, DeJulio & Stein, 1978). Many studies have concluded that the TR is more important for therapy outcome than specialized therapy techniques. Therefore, if one treats MBIs as technique 'only', then it is plausible for this argument to also be true for MBIs. However, in the following section it will be argued that MBIs are neither a technique nor a belief but an integral sum of both.

## 4.3 The experience of working with MBIs

The following discussion will address the overall lived experience for the participants' work with MBIs. While some assume that sharing a meditative space with the client brings equality, an eradication of the power

imbalance, and see such a relationship as a positive enhancer of the TR, others feel uncomfortable with this removal from the more traditional psychodynamic 'blank slate' stance.

### 4.3.1 Power dynamics of equality

Reflecting on the essence of working with MBIs, participants reported that the TR's power dynamic changes when working with MBIs. The results of this research showed that the disclosure of the meditation experience gave rise to a sense of similarity/equality between client and psychologist. However, some psychologists responded with feelings of ambivalence regarding this TR dynamic; they did not favour the equality of the relationship (e.g. Charlotte 6) and decided that it was inappropriate to meditate with the clients due to this power dynamic. Those who asserted that the power dynamic felt different experienced the therapy as a joint endeavour, collaborative, and as helpful to the quality (or equality) of the relationship. Some of them said that "Being in the same boat, doing the same thing changes the dynamic" (Nick, lines 1152-1154) and discussed how they treated the clients in a welcoming and inviting manner, rather than with the 'blank slate' of the traditional therapist.

This is in line with the WA (Bordin, 1979) and CBT (Safran & Segal, 2004) models of the TR that emphasised collaborative work. The findings indicated the complexity of the TR's dynamic. This ambivalence marked an overall narrative of cautious 'balance'; mindful-meditation had a positive impact on the TR but also challenged/was not suitable for all psychologists. Therefore, the implication for some counselling psychologists who tilt towards psychoanalytic methods is that they might need to consider the equality dynamic and ponder whether this suits their way of working.

## Therapeutic boundaries

Relaxation of the therapeutic boundaries is caused by disclosure. Therapeutic boundaries were suggested as "a complex and controversial

area of practice. Boundary violations remain occupational hazards for psychotherapists of all disciplines, with the risk of boundary fluidity" (Bridges, 1999: 292). However, other theorists (e.g. Levin & Friedman, 2000) dismiss traditional boundaries as limiting techniques that fade mutuality and empathy (Bridges, 1999). The participants reported both advantages and disadvantages to disclosing their own experiences of meditation in the post-meditation discussion. The therapeutic community, despite moving away from Freud's 'blank screen persona', is still divided regarding issues of self-disclosure (Lemma, 2003). It is important to consider whether the client's reactions to the disclosure hinder or take forward the therapy (Piercy & Bao, 2013). The majority of the participants in this research valued the equality in the TR and did not problematise the dynamic. It is critical to remember that difficult memories can come up during meditation. When an individual meditates, they are on their own inside their heads in silence. Therefore, in MBI work, the reactions to the disclosure could be pivotal to the process. The patient's transference and attachment to the therapist may not optimally occur without some disclosure that reveals the therapist's humanity (Levine & Friedman, 2000). However, for two of the participants post-meditation disclosure was an issue because they believed that disclosure would hinder the client from reflecting on their own issues.

The dialogue in the post-meditation discussion was construed by Kabat-Zinn (1990) to be a 'dialogic' space where people feel safe to open their hearts without judgment. In line with the majority of the participants, Kabat-Zinn referred to the open quality of the post-meditation discussion in a positive manner. Lysack (2010) who practices family mindfulness therapy[27] asserted that forming dialogic relationships entails the shift from subject-object (*I-it*) relationship to subject-subject (*I-Thou*) relationship (Buber, 1970). "The dialogic quality of 'I-Thou' relationships is a critical and

[27] Family Mindfulness therapy focuses on the patterns of connection between people in networks of relationships. It relies on 'dialogic' approach that allows multiplicity of perspectives, and fosters alternative explanations of human experience. Dialogic approach in family therapy is a form of co-meditation practice (Lysack, 2010: 144).

essential perspective that informs the therapeutic interactions in MBIs" (Lysack, 2010: 144).

The notion of a "real" relationship is implicit in the MBIs approach where the therapist is a participant in shared activity of meditation, and whose own personal psychology shapes the unfolding therapeutic process. This research has started to explore this and has found contradicting accounts. This ongoing preoccupation of self-disclosure would benefit from being a future avenue of research within MBIs.

### 4.3.2 More awareness as a therapist

The participants asserted that in working with MBIs they have become more aware as therapists. The participants emphasised that they practiced mindful-meditation in their private lives in order to be able to model mindfulness to their clients, thus become more aware as therapists of their client's issues. "*I need to feel that I attune to myself before I can achieve it with a client*" (Nick, 15, lines 927-930). The findings clearly resonate with Nanda (2005) and Rothaupt & Morgan (2007), who suggested that their participants practiced mindful-meditation in order to be able to listen to self, and by listening to their own suffering they were able to connect and empathise with their clients suffering.

The participants' concept of having to attune to themselves in order to attune to the clients clearly resonates with the ideas of Grepmair et al. (2007: 337) who named it the 'use of the therapist as an instrument'. They asserted that promoting the use of the therapist as an instrument has long been neglected in favour of therapeutic techniques. Grepmair et al.'s study suggested that direct promotion of mindfulness could positively affect the therapeutic outcome. This was corroborated in this research by some participants who reported that when they practiced meditation by themselves, it helped them to be aware of the client's issues (e.g., Marcus, line 1215).

### 4.3.3 Integrating dichotomies

The participants discussed mindfulness as an integrating construct and that it facilitates a working environment that sees the client as a whole. "We make every effort to apprehend their intrinsic wholeness rather than see them as patients with various problems, diagnoses and ailments" (Kabat-Zinn, 2011: 292). This is an example of the tendency of MBIs to integrate dichotomizing aspects of experience and find a balanced, middle path of operation, where the psychologist/teacher makes every effort to see each participant as a whole human being. The emphasis is on non-duality. The results of this research revealed dichotomies between spirituality and science; technique and belief; body and mind; and healing and treatment.

The results indicated that the participants, in the researcher's interpretation, did not wish to subscribe to those dichotomies because they saw the client as a whole entity, and the only reason to use one of two constructs was that at times it was strategically helpful. This in Buddhism is called 'skilful means'[28]. Kabat-Zinn (2011: 290) has suggested

*"mindfulness is an umbrella term that meant to carry multiple meanings simultaneously, not in the sense of finessing or confounding real differences, but as 'skilful means' for bringing the streams of science and Buddhism together"*.

Therefore, mindfulness as a philosophy of living does enhance the integration of dichotomizing epistemological positions. However, depending on the moment's needs, different aspects of a construct might be highlighted. In this research it was found that the psychologists were grappling with those dichotomies, yet the Buddhist framework that

[28]Skillful (Kulananda, 2003: 41) is a term that Buddhism uses to determine the quality of an action. Rather than good or bad, Buddhism talks about actions being 'skillful' or 'unskillful' and these are determined by the quality of the mental states that give rise to them.

underlined MBIs pushed for non-dualism, and might have nurtured their tendency to integrate.

An example worth examining is the dichotomy of 'science' versus 'belief' that was expressed in the participants' accounts (see Chapter Three, theme two).

Kabat-Zinn (2011) divorced mindful-meditation and MBSR from any spiritual or religious connotations because he did not want clients to be put off by the perception of mindfulness as an alternative new age method. Kabat-Zinn did this for a pragmatic purpose namely to encourage clients to attend the MBSR course. The participants voiced similar preoccupations regarding what aspect of mindfulness to highlight and in what circumstances. The participants highlighted an ability to integrate dichotomising constructs since mindfulness invited such integration. However, simultaneously, when and if useful, they utilised only one of the two in order to facilitate MBIs work.

Working with mindfulness cultivates emphasis on non-duality or integrative aspects, and leads to seeing the whole of the client. The integrative framework of counselling psychology "is in favour of an holistic approach to the person coming for help" (Gilbert & Shmukler, 2003: 448).
Hence, this common link of integration tendency adds to the argument that counselling psychology has shared commonalities with MBIs and would therefore benefit from a natural incorporation of MBIs onto its training courses.

### 4.3.4 Linking between personal and professional lives

Another phenomenon that described what it is like to work with MBI was the existence of a link between the participants' personal and professional lives. The participants discussed consistency of meditation practice in both domains. They noted that a coherent and integrating sense of self got construed through the continuity of practice. Furthermore, on a reflective

note, through the researcher's interpretative eyes, this sense of integrity and embodiment of a 'way of being' is one of the benefits of working with MBIs. Kabat-Zinn (2011: 286) referred to this merger as the attempt "to bring my dharma[29] practice together with my work life into one unified whole". The participants construed this flow between domains as a significant benefit for themselves, as a person and as a professional. These results align with Bruce et al. (2010), May & O'Donovan (2007) and Fulton (2003) who discussed the benefits for health professionals to have continuity between the different parts of their lives, so they do not contradict in dissonance, and the practitioner can stay aligned to him/herself. Overall, the importance of the psychologists having first-hand experience of practicing mindfulness is particularly pronounced in relation to the task of imparting mindfulness to clients. This was asserted by several authors (e.g., Crane & Elias, 2006) and is in alignment with the findings of the current study.

## 4.4 The benefits and difficulties of working with MBIs in the context of the TR

### 4.4.1 Becoming

The participants asserted that working with mindfulness is an endless journey in which the 'way' was emphasized rather than the 'arrival'. The 'state' of becoming mindful was a unified position without a split between acceptance and change (Nick, 29). Moreover, it was stated that change happens when one goes through the process of becoming mindful. This statement emphasised the need to be in a process in order to cultivate the ability to change. In this research, participants articulated how what was important was not whether you achieved a state of full awareness, but that you were engaged in the process of trying to change, and the movement itself is what created a sense of positive development.

This movement also incorporated the sense of temporality: being in the process of becoming mindful, the nature of mindfulness is always

[29] The Dharma is a complex Sanskrit word, that can mean law, way or truth. (Kulananda, 2003).

changing. Being mindful was perceived as a state, rather than a trait. Likewise, it was seen as an ideal, more than an achievable reality. The participants described how, just as one is forever developing as a psychologist, the journey of becoming mindful is one that is continually evolving.

### 4.4.2 Group issues: both an advantage and a challenge

Working with MBIs in the context of the TR presents many benefits that at times co-exist with challenges. For instance, the group setting of MBI courses was perceived as a positive element that facilitated intimacy but also as a challenge to the 'classic' one-to-one TR. The group renders the one-to-one 'classic' TR difficult to achieve due to the multiplicity of people and events, yet it has a supportive quality and positive social pressure. Fulton (2003) argues that the social pressure keeps the psychologist and participants bound together, taking refuge in the group. Furthermore, practicing meditation in isolation can be hard when the individual does not belong to a community of meditators and lacks the support of the group (Fulton, 2003). Meditation was developed in the East where adherence to communal ("Sangha") ways of living is frequent (Kulamanda, 2003). Some participants acknowledged that in the West, people find that they are required to practice mindful-meditation alone, hence the group setting of MBIs courses can be beneficial. Moreover, an important argument was that during the post-meditation discussion, sharing one's experiences was valuable and could not take place in isolation. Hence the participants discussed the group as an essential and necessary requisite for the sustainability of MBIs work.

#### Group dynamics: horizontal and vertical relationships

Researchers of group therapy have long emphasised the importance of the group dynamic to the outcome of group-based interventions (Yalom & Leszez, 2005). In this research, when working in a group, the relationship

was described as ‘hosts to guests’ (Marcus, 16): the teacher/psychologist prepared refreshments for the clients. Burlingame, Fuhriman & Johnson (2002) have outlined the ways in which the group can influence therapy’s outcome. Group cohesion influences the outcome and is the manifestation of two primary relationships: the influence of group members on each other (horizontal relationship); and the influence of members of the group on the group leader and vice versa (vertical relationship). The current research findings fit with the above classification, and reveal influences in the horizontal and vertical relationships.

Most participants’ accounts perceived sharing and being part of a group as an empowering experience for clients. The TR was played out mostly horizontally between members of the group rather than vertically with the psychologist/teacher. Furthermore, one participant’s account (Marcus, lines 1256-1259) of the leader-group relationship echoed how different this encounter was from the ‘classic TR’ and fundamentally challenged the need for meetings solely on a one-to-one basis. However, this is not to say that when the psychologists worked in group settings, the TR was made redundant. Rather, the TR shifted to a horizontal relationship (client-to-client) from the classic vertical relationship (client-to-psychologist).

MBSR proponents have emphasised the importance of the group in fostering mindful interactions between participants (Kabat-Zinn, 1990). MBSR teachers flexibly use group dynamics to deepen the group’s mindfulness. Thus, vertical relationships of client-teacher/psychologist interactions are very likely to occur (Kabat-Zinn, 1990). The implication of this statement for this research is that the TR exists in both horizontal and vertical forms. Likewise, Imel et al. (2008) concluded that MBSR does not appear simply to be an individual intervention delivered in a group setting, but rather its effects occur at both the individual and group level. Relating in a group is an important treatment variable worthy of further investigation

since it is possible that some of the positive outcome of MBIs that is attributed to mindful-meditation is actually due to the group dynamic.

Overall, the findings regarding the TR in a group context indicate ambivalence towards the centrality of the TR's role in working with MBIs. One participant questioned whether the 'classic' TR (as in one-to-one) is indeed pivotal to the process of MBIs in group context, and whether it exists at all in any significant way. The rest of the participants did not voice such doubts. It is possible to make sense of these contradicting voices by recalling the significance of the horizontal relationships. The discordant participant did not say that the TR did not exist; he just emphasised the horizontal TR (Clarkson's person-to-person relationship; 2003) as the relationship that held the group. Kabat-Zinn (2013) agrees that the group provides a community that empowers the clients and circumnavigates the one-to-one relationship of the therapist-client. However, this does not eliminate the need for TR in its 'classic' form of psychologist-client. Further research could investigate which TR is most effective: horizontal or vertical.

The implications for counselling psychologists working with MBIs could be to pay attention to the group/individual setting when considering how to practice. Working in a group is an economical solution and could be an efficient way of addressing psychological issues (Gilbert & Shmukler, 2003). Counselling psychologists could facilitate such work and thus assume leadership roles. In summary, the group setting is both an advantage (helps to meditate, acts as a refuge) and a challenge (to the creation of the 'classic' one-to-one TR). More research into the group aspect of MBIs could look further at what actually happens in the different TRs in groups, and to the therapists' style of relating (Gilbert & Shmukler, 2003).

### 4.4.3 Benefits and challenges to the psychologists

The participants expressed many ways in which mindfulness can assist psychologists including: a positive impact on acceptance and empathy; better relationships with themselves; better self-care; and providing a model for clients illustrating the importance of accepting themselves. These positive findings were reported also by other authors (Nanda, 2005; May & Donovan, 2007; Rothaup & Morgan, 2007).

Kabat-Zinn (1990) proposed that mindfulness influences one's experience of wellbeing through being attuned (aware and responsive). Self-awareness has been acknowledged by therapists as fundamentally important to their wellbeing and to the continued commitment to their work (Coster & Schwebel, 1997). MBIs teach the psychologists how to open and accept intense affect. The process of learning to tolerate one's own pain grants the psychologist the ability to tolerate the affect of her/his clients (Schure et al, 2008). Other benefits for the therapist include the cultivation of empathy and compassion. But empathy for the suffering of the client will also be tempered by the broader view of equanimity that stems from recognizing the genuine limitation of the psychologist's ability to change somebody, unless they want to change themselves (Fulton, 2003).

Siegel (2009) argued that the process of mindfulness uses the same neural circuitry as being empathetic, to attune to the minds of others and to create relationships. He also noted the similarities between this type of self-relationship (e.g., when the psychologist meditates and is attuned to herself) and a secure attachment between parent and child (when the parent is attuned to the child) (Bowlby, 1988). Thus, mindfulness can be thought of as a form of secure attachment with oneself. The participants suggested that one of the challenges facing psychologists was the issue of managing disclosure boundaries (since they perceived some disclosure to be part of the post-meditation discussion). This issue needs to be negotiated with awareness. Not all psychologists are comfortable to make

the disclosure that is perceived to be required when meditating with clients[30].

### 4.4.4 Mindfulness in conflict with religious belief

Due to the Buddhist roots of MBIs, or the perceptions around the principles of practice that are involved in MBIs at times, mindfulness can contradict the belief system of the client. In order not to develop a conflict, the psychologist may choose to avoid working with MBIs in an explicit way. Despite attempts to divorce MBIs from spiritual or religious connotations, working with MBIs can still be incongruent with the client's own spiritual belief system. It is interesting to note that the psychologists in this study did not report MBIs being in contradiction to their own beliefs, despite some of them having other non-Buddhist spiritual affiliations.

## 4.5 Summary of findings

The main research question was 'what are the experiences of psychologists working with MBIs in the context of the TR?'. 1 The method utilised to explore this was Interpretative Phenomenological Analysis (IPA). The complex 'answer' is that it depends upon the environmental setting. One has to separate the one-to-one MBI work and the group MBI work.

In the case of the one-to-one setting, the findings suggest that the TR gets enhanced, as long as the therapist is not threatened from the change in the power dynamic due to the sharing of meditation and some disclosure in the post meditation discussion. As stated by Davis & Hayes (2011: 211) "therapists' mindfulness seems to aid their ability to cultivate and sustain successful relationship with their clients". In this research the participants

[30] Disclosure is not explicitly a formal requirement of the therapist by the MBIs cited but the individual participants offer it. The participants raised the issue of disclosure, rather then it being a formal requisite of the approach.

conveyed similar stance: “The therapist's mindfulness is key to the quality of the relationship” (Charlotte, 1427-1433).

In the case of the group, the TR between the psychologist/teacher and the group member may not have the space to evolve due to the busy nature of the crowded course, but the peer support and sense of empowerment may replace that, resulting in a different pivotal horizontal relationship formed client-to-client.

The implications are that a group setting can still contain pivotal and nourishing relationships, from the person-to-person classification perspective (Clarkson, 2003), despite the challenge to the ‘classic’ TR between psychologist/teacher and the client.

Additionally, the various effects on the psychologist’s relationship with her/himself, such as self-care, self-acceptance, self-attunement and self-awareness, are an important finding, which resonates through all of the participants’ narratives. It is also something the researcher has experienced on a first-hand basis. All this is pivotal for psychologists’ therapeutic work because the quality of the TR is a predictor of a positive therapeutic outcome. The implications for counselling psychology are that utilising MBIs and practicing mindful-meditation in their private lives may facilitate the TR, and generate a positive outcome.

## 4.6 Evaluation of the research from a reflective stance

The research explored the psychologists’ lived experience of the TR while working with MBIs. Although IPA is not designed to generalise, some people continue to problematise it in this way. It is not a problem I see, however, it is worth mentioning that the findings of IPA studies cannot be generalized without great care due to the use of small samples.

Nevertheless, this research offers an exploration into a neglected aspect of MBIs work. This in-depth study has provided evidence for the need to

create greater awareness in psychologists of the benefits and challenges of working with MBIs. The detailed material that was gathered was in line with current counselling psychology's models of research (Willig, 2001).

The reasons the participants agreed to participate would have an impact on the accounts and analysis. First, the participants said that they wished to assist me as they had once been in a similar situation as trainees. They also commented that they enjoyed reflecting on their MBI work. Second, the participants were keen to elevate awareness of their MBIs work with current and future psychologists as they were passionate about it. Hence it can be argued that this is a 'biased' group. However, the epistemological framework of this research asserted that there is no 'objective' stance in human sciences; thus this group can be considered acceptable for the research (Willig, 2001).

*Following from that, it is pivotal to consider my position regarding this study. I care deeply about the research topic, as I practice mindful-meditation and work with MBCT, MBSR and DBT. Throughout the research process, issues of personal interest might have been made explicit. Such a position might have leaked out through verbal and non-verbal actions during the interviews, by probing or ignoring certain directions of conversation. I attempted to address these issues through a reflective diary (see excerpt in appendices), noting areas of interest explicitly in the hope of maintaining a more neutral stance in subsequent interviews. From the diary, I noticed my passion for the subject matter, and this awareness informed the way further interactions with the participants and the material was conducted. I then aimed to adopt a more neutral position. I achieved this by being aware of my body language and mindful of the way I phrased my questions.*

*Upon reflection of the findings, I wondered about the 'double hermeneutic' level of interpretation that may have taken place in listening and interpreting the participants' accounts. Was it me who wished to hear positive stories that made the participants disclose such narratives? Did I*

*listen to the transcripts and analyse them through positively skewed glasses?*

The choice of IPA was extremely useful to the research as the interviews and analysis benefited from the detailed guides of Smith et al. (2009). Additionally, IPA and mindfulness share many similarities in their philosophical framework so the fit between the research and the underlying theoretical assumptions of the method added to the coherence of the study (Yardley, 2000). However, the choice to use IPA also had an effect on what could be analysed. For example, using discourse analysis could have led to exploration of power relationships in depth. It could have also allowed me to look at the constructed nature of mindfulness, which is not 'one' thing but a process or a practice. Discourse analysis, enabling focus on the negotiations of meaning within social context (Nielsen, 2007), is a recommended path for future research.

The methodology of the study could have been improved via a pilot study to develop the interview schedule further. The decision to cover four different MBIs brought an array of issues that needed to be taken into account, such as the particular commonalities and differences between them. The similarities between the four approaches were significant enough not to break the homogeneity required by an IPA study. However, while many of the experiences were not exclusive to the specific MBI discussed, often the participants got sidelined with a specific story related to a particular protocol of work. Overall, however, these multi-faceted accounts illustrated that MBIs are not fundamentally different from each other. Nevertheless a future avenue for research could be looking at the TR in the context of only one specific MBI. For example, examining only DBT that is practiced in group and individual sessions could add specific understanding to the change in the dynamic of the TR in both modalities.

I recognise that the interview schedule employed has had some effect on the accounts given, as well as the themes analysed. However, every effort was made not to use leading questions, and to stay flexible around the

interview schedule. Additionally, the participants were invited to make further comments towards the end of the interview to allow new emerging topics.

The researcher drew on Smith et al.'s (2009) guidelines when evaluating the quality, validity and reliability of the study. Additionally, Yardley (2000) outlines the following four principles for quality: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. Many of the steps ensuring quality and reliability have been previously highlighted (see chapter two, section 2.7). Measures of prevalence of the themes were given in the analysis chapter in which the researcher engaged in the 'double hermeneutic' principle. Throughout the analysis and discussion chapters, the researcher highlighted how the study has produced information that adds to the existing literature. Most importantly this chapter has provided a first time investigation into the experiences of psychologists working with MBIs within the specific context of the TR. Smith's six guidelines for quality and validity (2011) were addressed. First, clear focus on the TR was provided; second, the research had strong data; third, the research was rigorous; fourth, elaboration on each theme was demonstrated; fifth, different levels of interpretation, and not just description, were utilised; and sixth, the analysis pointed to both convergence and divergence patterns of similarities regarding enhanced relationships, as well as differences in the types of the relationships and the qualities of these relationships.

## 4.7 Suggestions for future research

It seems that more qualitative research exploring the psychologist's experience is needed to further substantiate the current study. For example, the dynamic in the group setting could be explored further, as it was only a minority of participants who addressed the differences between one-to-one and group work in depth.

Mechanisms that affect change in the client, such as the TR, are known to contribute to successful therapy outcome. Future research is needed to better understand the benefits of mindfulness meditations and MBIs. Future research could include investigating realistic ways in which mindfulness practices and/or formal mindfulness meditation could be integrated into trainee's practice and clinical supervision. Future research questions could include "does practicing formal mindfulness-meditation as a group help in establishing group cohesion, self-care, relational skills or Rogerian common factors that contribute to successful therapy?"
Given the limited research thus far on empathy, more research is needed on how MBIs affect those constructs. This would be useful for counselling psychology because empathy is a central construct within Roger's (1961) TR, and the TR is a prominent part of the discipline's ethos and practice.

This study, as well as that of Shapiro & Carlson (2009), suggested that mindfulness could also serve as a means of self-care to help fight burnout rates. More research is needed in the future on how the practice of MBIs may facilitate trainee's development and how the psychologist's own practice could help to prevent burnout. Burnout is an important issue for counselling psychology because the psychologists are exposed to a high volume of clinical hours, and consequently may lose their empathic capacities. In order to avoid clinicians leaving the profession, it would be advised to address the issue of burnout (May & O'Donovan, 2007).

## 4.8 Clinical Implications

Psychologists working with MBIs need to know that: first, the TR includes strong bonds and connections, and at times for some psychologists using MBIs leads to a sense of transcendence. Second, two separate therapeutic settings were identified - group and one-to-one. The TR was talked about as if it were to be enhanced in both situations, and included: acceptance, care, authenticity & genuineness, attunement and empathy.

However, in the group setup the TR may take place in a client-to-client horizontal context rather than with the psychologist. Third, meditating with the client and the disclosure in the post-meditation discussion leads to change in the power dynamics, and to a sense of equalness or at least of being less hierarchical. At times it brings up issues of boundaries that the psychologists need to be aware of. Fourth, the analysis indicated that the relationship of the psychologists with themselves was enhanced, and included acceptance, care, and attunement. The self-care led to them feeling more balanced within their lives, and some of them suggested that it seem to shield them from burnout (e.g. Marcus and Charlotte). Last, the fact that they practiced mindful-meditation in their private lives as well as at work made them feel congruence, a sense of continuity and integrity between the two domains.

The clinical implications of working with one-to-one as opposed to a group are that in a one-to-one there is more emphasis on the 'classic' TR, but when working with MBIs, the right balance has to be struck between the manualized technicalities that need to be handled such as checking homework, setting up new homework, meditation and between listening time when the TR can be built. In contrast, in a group situation there is often more time for the session to take place, but the attention of the psychologist/teacher is thinly divided between all the members of the group. The supportive power of the group and the relationship between members can be, and need to be, cultivated and observed by the psychologist, but she/he does not need to strive to have the same TR as in the one-to-one situation, as the horizontal relationships replace it.

In regards to the efficacy of the work, the participants reported that the interventions were effective and this was achieved partly via the cultivation of the strong bond, rich TR and meditating in their private lives. The implications are that counselling psychologists might want to explore practicing mindful-meditation in their private lives, and working with MBIs in order to have a positive relationship with their clients.

Given that current research provides empirical support for the perceived benefits of mindfulness meditation as evidenced by the psychologists' accounts, further research is needed on effective and practical means of teaching therapists mindfulness meditation practices. The development of formal training as well as theoretical literature and practical exercises might be needed.

Extending this further, psychologists need to recognize the complexities of working with MBIs in the following areas. First, the need to integrate between the private and professional arenas of the psychologists' lives in order to have congruence and continuity between the two domains carries with it advantages such as equanimity and self-care. However, it also entails challenges in remembering to practice and the daily consistency of practice.

Second, the need for a certain amount of self-disclosure requires careful thought, and may not suit all psychologists. Some may feel that it strips them of their professional status. This raises issues of power and professional boundaries and potential re-evaluation of clinical models.

## 4.9 Conclusion

The current surge of research on mindfulness appears to hold promise for a potential transformation in ways to facilitate psychologists' work with MBIs and the development of trainees to incorporate mindful-meditation into their self-development and professional development.

This research supports the findings of the majority of the previous literature highlighted in this thesis. It demonstrated the positive impact of working with MBIs on the TR, despite some issues of ambivalence that need to be acknowledged. Therefore, the need to familiarise counselling psychologists and trainee counselling psychologists to the possibility of working with MBIs is important. This could involve standardized training in

NHS trusts, use of MBIs in supervision groups, and in qualification programmes.

The novel aspect of this research lies within the portrayal of three different kinds of relationships, each consisting of different qualities and adding different benefits to the wellbeing of psychologists and clients. The one-to-one TR; client-to-client relationship within group setups; and the relationship with the self.

The qualities of the TR that were identified in this research as being enhanced by the practice of MBI are a combination of qualities found in previous research together with some novel qualities. In addition to the qualities that have been identified previously which are the bond-connection, acceptance and empathy (Aiken, 2006) this research identified some novel qualities which are authenticity and genuineness, attunement, care for the client and care for the self.

A substantial body of research confirms that the quality of the TR is the largest predictor of positive therapeutic outcome (Lambert & Barley, 2001). This research demonstrated that according to the participants, MBIs had a positive effect on the TR. Therefore this research combined with the body of research on the effect of the TR on positive outcomes, implied that in the majority of cases, MBIs would lead to positive outcome. Future research that could be helpful to the field of counselling psychology would be to investigate whether a relationship exists between mindfulness in psychologists and positive client outcome.

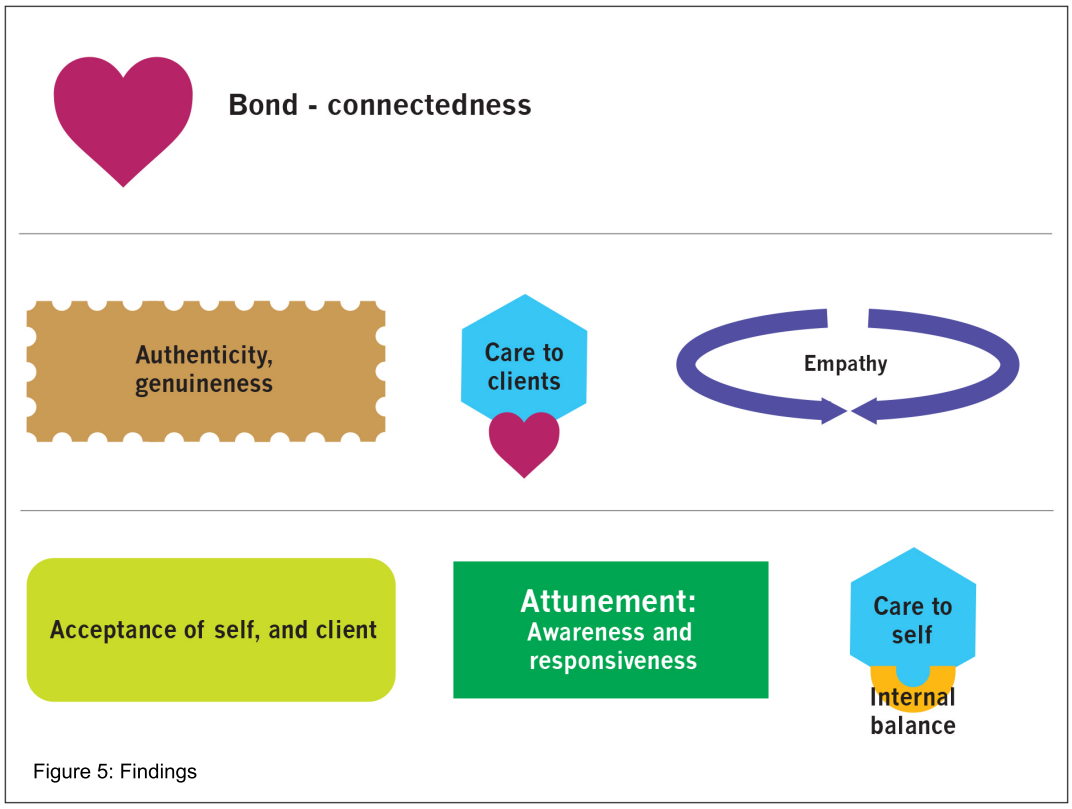


Figure 5: Findings

Figure 5 helps to see at a glance the outcome of the analysis and compare it to previous research (see Figure 3: 37).

*"The whole spirit of mindfulness is one of non-striving, in a way, just being with experience, and I think it is for quite a lot of people there is a sense of ...it takes determination to actually get a meditation practice going, or to sustain that, so there is a bit of a paradox, that emm...for me, I kind of have more a sense of ...how I do see it more in terms of becoming open to something, as it were.… Emm...I think there is some kind of sense, an innate...innate source of well being.… wholeness being and...yes...so, there is a sense of confidence which almost comes with that as it were, so it is about confidence that that is enough as it were".*

*(Nick, lines 316-332)*

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# APPENDICES

## Appendix 1: Mindfulness in Buddhism

Mindfulness is the English translation of the Pali word sati. Since Mindfulness may play a role in creating an effective TR, its origin and place within a Buddhist context will be outlined.

Mindfulness is an aspect of a number of ancient spiritual traditions and lies at the heart of Buddhist psychology. Buddhist psychology shares with western psychology the goal of alleviating suffering. However, unlike the latter, which explores phenomena from objective third person observations, Buddhist psychology is a highly disciplined, systematic, first-person approach (Germer, Siegel & Fulton, 2005). The name 'Buddha' means the one who is awake. The Buddha taught about the four noble truths (four basic ideas). First, the human condition involves suffering. Second, the conflict between how things are and how we desire them causes this suffering. Third, suffering can be reduced or even eliminated by changing our attitude towards unpleasant experience. And fourth, there are eight general strategies ('The eight fold path') to bring suffering to an end. Buddhist psychology is primarily a practical way to know, shape and free the mind (Nyanaponika, 1965). Mindfulness is the core practice of Buddhist psychology, including the Buddha's original teachings and later writings of the Abhidharma. These may be considered the theoretical basis for Mindfulness (Bhikkhu Bodhi, 2000).

It was while employing Buddhist psychology, and in particular Mindfulness, that people began to explore the nuances of perceptual experience using methods that modern science might recognise as empirical, experimental and repeatable – despite being entirely introspective.

## Appendix 2: Description of the four MBI interventions

Mindfulness Based Stress Reduction (MBSR). Jon Kabat-Zinn (1990) pioneered the integration of traditional Buddhist mindfulness meditation into a psycho-educational eight-session programme: MBSR. Kabat-Zinn's intention was to inform the lives of patients who suffer from chronic pain, terminal illnesses, back pain, and a variety of other conditions, including primary mental health. Kabat-Zinn's plan was to disconnect the association of mindfulness with ancient traditions and create an accessible secular mainstream programme. It is a group-based programme, which caters for up to 30 participants, and that integrates psychological understanding and models of stress from mind-body medicine with explorations of the challenges of modern living (Crane, 2009). The programme involves intensive training in mindfulness meditation, and teaching which enables participants to apply the learning into daily life. It entails weekly two-and-a-half-hour sessions, one full day intensive session, and extensive homework practice (Kabat-Zinn, 2001). The sessions are experiential, with direct practice of techniques and post meditation discussion of difficulties. In each session, mindful-meditation exercises are practiced focusing attention on internal and external phenomena (e.g., the breath, sound, material object and physical sensations), developing awareness of the arising of thoughts and emotions without becoming captivated into their content, and practicing mindfulness in everyday activity such as walking and eating. Hatha yoga is utilised to encourage awareness of the body. MBSR is different from other types of meditation (such as chanting or sitting meditation) because it includes various practices that cultivate awareness of the body and mind in a multifaceted manner.

MBSR has been the subject of a number of studies, which have all broadly supported the programme's effectiveness with a range of populations (e.g., Baer, 2003). As it was originally designed for use with medical patients suffering from chronic pain, this was one of the first clinical applications that was evaluated (see review and critique of this literature in section 1.1.4).

Mindfulness Based Cognitive Therapy (MBCT). Teasdale, Segal & Williams, (1995) developed MBCT in order to help participants with a history of recurrent depression to avoid relapse after recovery (Mace, 2008). It is based on the same principles and basic techniques as the MBSR course and uses many of the same exercises. It uses the formal as well as informal mindfulness techniques, such as formal sitting and walking meditation, and mindfulness of everyday tasks being encouraged. However, it combines these with features of cognitive behavioural therapy (CBT; Beck, 1970,1976). As with MBSR, the programme is delivered in a group setting and has a general focus on teaching skills, however, it is usually delivered to a group who all have a history of depression, rather than the varied groups usually used in the MBSR programme. The didactic element of the

course therefore focuses primarily on depression, rather than on stress, as in MBSR. It is designed to train recovered participants in skills which will have some protective factor preventing future depressive relapse (Mace, 2008). It uses the MBSR emphasis on viewing thoughts and sensations as mental events worthy of observation, rather than indisputable facts. MBCT has similarities with CBT in this respect, as CBT aims to give a greater awareness to thoughts and feelings and an ability to distinguish thoughts from facts. However, in contrast to CBT it does not aim to change thought content or teach labelling of thoughts as helpful or as positive or negative (Hawton et al., 2002). Further cognitive exercises are taught alongside the techniques taken from MBSR, incorporating discussion of automatic thoughts. Additionally, MBCT introduces the A-B-C model of CBT. This model examines how an event (A) leads to an interpretation (B) that might consequentially lead to low mood (C). It highlights the interpretative stance of the client, which might aggravate his/her depressive state (Hawton et al., 2002). MBCT also explicitly teaches awareness of warning marks of looming depression and identification of escalating depressive patterns of thought.

Since MBCT is taught to those recovering from depression, it can therefore be taught in the absence of current depressive symptomatology or diagnosis. One significant technique in MBCT, which is not present in the MBSR programme, is the three-minute ‘breathing space' exercise. Efficacy evidence and critique of the research will be presented in the section 1.1.4.

Dialectical Behavioural Therapy (DBT). Linehan (1993) created DBT as a treatment programme originally developed for treating those with borderline personality disorder (BPD), although more recently it has been adapted for use with other populations, such as those with binge-eating disorder (Teich, Agras & Linehan, 2001). The Oxford English Dictionary (2006) offers a number of definitions of dialectic, one of which is a construct where ‘paradoxes merge to form a higher certainty’. It is this sense of the integration of opposing ideas that is meant in DBT. In the context of the programme, the central dialectic is the integration of acceptance and change. It uses a range of techniques from cognitive therapy and integrates mindfulness practice as a way of facilitating acceptance and change. DBT includes four modules of abilities or skills of which core mindfulness is just one. It differs from the use of mindfulness in MBSR and MBCT in a number of important ways, the most significant of which is the teaching style.

Linehan & Schmidt (1995) suggested that those with BPD may not be willing or able to tolerate lengthy formal meditation practice, and DBT therefore teaches mindfulness through a variety of short, informal techniques.

Since mindfulness is only one of many tools in DBT, unlike the above-mentioned interventions, it does not demand that therapists have regular, formal meditation practice of their own, but it does require that they engage in, and are familiar with, the mindfulness exercises that are taught. This is highly relevant to this research, as it goes against Kabat-Zinn's (2011) and Segal, Teasdale & Williams' (2002) assumptions that psychologists' meditation practice in their personal lives makes a difference to their MBIs practice. In contrast, in DBT, the impact of treating mindfulness as a mere technique might influence the quality of mindfulness as embodied by the psychologists and consequently the interaction with their clients.

The format of DBT is very different from MBSR and MBCT, comprising of both group and individual therapy meetings, each delivered weekly, and contact with therapists between sessions is allowed if required. It is also a much longer-term treatment programme than either MBSR or MBCT. DBT usually requires an initial commitment of one year.

So far we have noted MBSR, MBCT and DBT – all interventions of group work level although each can be conducted on a one to one level too. Lastly, Acceptance and Commitment Therapy (ACT), a one-to-one mindfulness therapy, will be examined.

Acceptance and Commitment Therapy (ACT) (Hayes, Strosahl & Wilson, 1999) is an individual therapeutic approach which can be used with a wide range of clinical problems and populations. It includes both behaviour change processes, as in cognitive therapy, and mindfulness and acceptance processes which are designed to facilitate the necessary behavioural changes. One of the central concepts of ACT is experiential avoidance, which is seen as key in many psychopathologies. Experiential avoidance refers to the tendency to try and avoid negative internal phenomena, such as thoughts and emotions, and taking actions in order to avoid or eliminate such experiences. This has a theoretical basis in laboratory findings which show the attempt to avoid thoughts and emotions makes them more likely to be experienced (e. g. Gross, 2002). Mindfulness is used to help participants disengage from experiential avoidance.

As with the other therapies previously discussed, ACT uses mindfulness to encourage noticing and observing whatever the present experience is without judgement or avoidance. ACT resembles DBT in the use it makes of short, informal mindfulness tasks rather than longer, formal meditation exercises (Mace, 2008). Unlike the other therapies described above, ACT also seeks to help clients explicitly identify and examine their own values and goals. Baer & Krietemeyer (2006) postulated that mindfulness skills are not practised merely for their own sake, but rather to enable the possibility of a meaningful life for the client.

**APPENDIX 2B: DEFINITIONS OF THE PSYCHOTHERAPEUTIC RELATIONSHIP (PTR)** (Clarkson, 2003).

According to Clarkson (2003) there are five facets to the PTR. These are defined below:

**(1) The Working Alliance (WA)**

The WA is the part of client-psychotherapist relationship that enables the client and therapist to work together even when either or both of them do not want to (Clarkson, 2003). Bordin (1979) differentiated between goals, bonds and tasks. Further common factors are the significance of the early stages of therapy (Luborsky, 1976) and the patient's ability to form a meaningful relationship with the therapist (Strupp & Hadley, 1979).

**(2) The transference-counter transference relationship**

The transference/countertransference relationship is the experience of 'distortion' (Freud's word) of the working alliance by wishes and fears and experiences from the past transference (carried over) onto or into the therapeutic relationship. It is the unfinished business from the past interfering with our here and now relationship.

**(3) The developmental relationship**

The reparative developmentally needed relationship is the intentional provision by the psychotherapist of a corrective, reparative, or replenishing relationship or action where the original parenting (or previous experience) was deficient, abusive or overprotective.

**(4) The person-to-person relationship**

The person to person relationship is the dialogic relationship, or core relationship. It concern the authentic humanness shared by client and therapist. It has also been referred to as the 'real' dimension of the therapeutic relationship.

**(5) The transpersonal relationship**

The transpersonal relationship is the timeless facet of the psychotherapeutic relationship, which is impossible to describe, but refers to the spiritual, mysterious or currently inexplicable dimension of the healing relationship.

## APPENDIX 3: PERSONAL REFLECTIONS

(CHAPTER 1)

*Whilst considering a topic on which to write my doctorate, I was faced with the inevitable challenge of trying to find something that would be engaging enough for me to sustain such a large piece of work spanning effectively nearly three years, that would be interesting enough for someone else to want to read it, and that had relevance for counselling psychology. I struck upon the idea of investigating some aspects of mindfulness since I attended an MBCT course a couple of years earlier, and found it most helpful personally, as well as a door opener to a whole world of constructs and ways of being with one self.*

*In my consideration of this particular area of research, I came to realise how my intra-psychic relationship is important and defines the way I relate in the world.*
*Being mindful (or the opposite of it) lay at the very edge of my awareness, lurking as something I had not really acknowledged as being that significant. On reflection, I now realise how my attitude of judgement, my short attention span, and my lack of awareness to some internal interpretative processes pervades my everyday life, and its subtle influences permeate all domains of my life.*

*I suppose that I have always just accepted my critical/negative feelings towards myself as par for the course. To me, they are "normal" despite periods of higher or lesser intensity. I realised that I was indeed one of the many people in our society who have, to some degree or other, a normative discontent regarding their self concept (Williams, 2002). During the course of a lifetime, major transformations will occur to a person's' life including failures and traumas and periods of high anxiety or low mood. In such periods, (such as high anxiety period) many people report as not being aware of the attitude in which they attend to themselves or of the interpretations they put upon events in their lives (Williams, 2002).*

*I am a woman who has been exposed to periods of high anxiety and low mood. I have also been through a significant trauma in my early thirties involving a loss of a child. Despite not experiencing periods of clinical depression nor panic attacks, I do spend a considerable amount of time ruminating on how my life may have been different should the traumatic event not have happened.*

*For this reason, I became interested in the shift in which I attended to myself when I went through the MBCT course, and the following changes which came from regular mindfulness walk, yoga practice and meditations. This led me to wonder whether other psychologists notice these changes too, and whether this has an impact upon them and*

*their relationship with their clients. I decided to choose a group of practitioners who have been using mindfulness meditation for more than two years because of my own experience: it took time for me to embody the ideas of the MBCT course and embed them into many areas of my life. In addition, it also seems to me that newcomers into the practice will not have as rich an experience to share with me. There has been much recent media attention to 'mindfulness' usage by therapists and the caring professions. Additionally, mindfulness became increasingly popular and 'fashionable' within the psychologically related professions, and became part of the courses of clinical and counselling psychology albeit a small one. I therefore felt that this group of participants, psychologists who have been using mindfulness in their private lives, might be a relevant group to investigate, as well as holding a personal interest for me, as they are both 'same' and 'other'. My starting point at the beginning of the research process was that I assumed that the participants would have suffered at some point in their lives from negative self-attitudes and emotional pain/trauma. Additionally, I assumed that since mindfulness meditation seem to have a relaxation effect, and cultivate less rumination and more detachment (Mace, 2008), the practice would be helpful for the individual to have better relationship with herself, better ability to concentrate, and therefore also have better relationship with others, being able to concentrate and stay with the challenges in the present moment, such as her clients.*

*When I reflected on the origin of my assumptions, I realised that I expected to find that being mindful affects the therapeutic relationship in a positive way. The general notion in our society is that being mindful through meditating cultivates empathy (Shapiro & Izett, In Hick & Bien, 2010; 161). Additionally "meditation practice allows for significant transformation in one's relationship to self and other" (Shapiro & Izett, In Hick & Bien, 2010; 172). However, this may or may not have a positive impact on the therapeutic relationship. For example, detachment is a construct which mindful-meditation is cultivating. However, is this contradictory to the kind of relationship that the therapeutic relationship is hoping to evoke?*

*When I reflected on my assumptions, I realised that the literature on mindfulness tends to focus on the positives of meditation, and that "there is a broad consensus that decreasing attachment to internal feelings (also discussed as affect regulation) is central for the therapeutic relationship" (Hick & Bien, 2010; 232).*

*However, in order that I might, as far as possible, engage with the participants' accounts in a fresh and open manner (Finlay, 2008), I needed to put aside (bracket) these assumptions and be aware of them. In this spirit, other sections describing ongoing aspects of the reflexive process will be found throughout the report. This is so that the reader may develop an understanding of the processes that have contributed to the study. I hope that this will provide insights into how subjective and inter-subjective factors*

*have influenced the research, thus increasing its integrity and trustworthiness (Maso, 2003).*

## APPENDIX 4: Further reasons for utilising IPA over other research methods

Furthermore, discourse analysis (DA) emphasises the action-orientation of the discussion while IPA emphasises the content and meaning (Smith et al., 2009). DA sees people's lives as a linguistic construction. This does not marry with the epistemological assumptions that this researcher holds: life has other aspects outside language. Therefore IPA was chosen

## APPENDIX 5: PERSONAL REFLECTIONS

**CHAPTER TWO, METHODOLOGY.**

***Reflections regarding conceptual elements***

*Since reflexive thought and 'gaze directed inwardly' is part of a qualitative IPA research process, in order for the researcher to understand and be aware of his/her own preoccupations and perceptions around the research, numerous such personal reports will be embedded intermediately throughout the following sections. To distinguish these they will be presented in italics, and the first person will be utilised (Willig, 2008: 64). These reflections will allow me to inspect the research process further, as they will provide a context for comprehending my own biases, assumptions, understandings and feelings towards the research topics.*

*During my year as a clinical assistant psychologist, I encountered a Buddhist clinical psychologist who worked with ACT and MBCT, and who recommended to me to attend the local Buddhist centre for a MBCT. Over the last three years, I have worked utilising MBSR, MBCT and DBT in various NHS placements. Group work and individual sessions were attended by individuals who were diagnosed with personality disorder (PD), borderline personality disorder (BPD), anxiety and depression. The clients were from diverse ethnic and cultural backgrounds and different age groups. The MBSR group work was conducted with two other colleagues who were cognitive therapists. I initiated using MBIs due to my personal conviction of the benefits that can be elicited, and asked approval in cases where the formulation provided justification for such work. Consultants who were not specialists in MBIs provided supervision.*

*Throughout the doctoral course, and prior to that as a research assistant, I studied and used a range of epistemological approaches, encouraging me to question assumptions and 'taken for granted' beliefs. I found the positivist perspective helpful in some types of research; however, it was not a methodology that enabled the kind of in-depth accounting that I was interested in. Within positivism, participants are objectified in order to prove some commonalities and verify/objectify a hypothesis, ignoring the fact that human beings are not physical objects. It asserts that participants can be understood without the context of meaning. Within my epistemological stance, knowledge and meaning are derived from experiences, which prioritise the individual's subjective meaning. Thus, located in the epistemological continuum, I chose the position of an interpretative (or hermeneutic) phenomenology (descriptive) paradigm. Via my clinical work experiences, I realised how my beliefs and assumptions confounded my listening and understanding. I acknowledge that I can never fully understand the phenomena experienced by my client, as it first transforms itself through his/her interpretative world, and then also through my own. This realisation was vital to my clinical work, but also to this research. Therefore, reflective notes were recorded to raise awareness of my own subjectivity, which could potentially skew the research.*

*I am aware that an IPA research has to be relatively homogenous in terms of the phenomenon under investigation (not just the sample of participants). I have chosen four different mindfulness interventions, as there is not sufficient research on the TR context of MBIs to separate the interventions, and my aim in the research was to develop the understanding of this relatively novel area. By exploring the experience of only one particular MBI, the research would be inviting a comparison, which does not fit the aim.*

*I am mindful that my experiences working with clients and colleagues using MBIs will have inevitably shaped my research, contributed to my personal and professional wonderings and contributed to the choice of questions used in the interviews with participants.*

***Reflections regarding participants:***

*A prospective lack of homogeneity due to not using tight criteria regarding the psychologists' ages, ethnicity or professional qualification (clinical or counselling) was an issue of which I was mindful. Initially, I tried to obtain participants who were counselling psychologists only. Nonetheless, after discussions with my supervisors, I decided that the restriction, which caused pragmatic problems in the recruitment, could be dropped since the aim of the research was to develop a new understanding in this scarcely researched area.*

***Reflections regarding recruitment:***

*I felt concerned and anxious at the lack of response in the initial stages via the BPS website, and the NHS trusts list. Initially, my decision was to restrict the research to counselling psychologists but this narrowed the potential sample. After much discussion with my two supervisors, I reached the conclusion that the differences between counselling and clinical psychologists are not as significant as they may have been in the past. Both professions hold to the ethos of evidence based research and practice. Similarly, both hold the TR to be pivotal to a successful therapeutic outcome. Steffen (2013: 64) postulated that "an increasing number of counselling psychologists now work in services in which they are taking up roles that hardly differ from their clinical psychologists colleagues". Consequently, I took the decision to approach the psychologists directly, based on colleagues' recommendations. I was reassured by the response of the individual psychologists. I was able to recruit a range of highly trained participants, with in-depth, recent experience and knowledge of working with MBIs. I am aware that the recruitment method may have biased the creation of the sampling, but purposive sample acknowledges that the researcher set out to recruit only the people who share the specific experience investigated. It is not really possible to garner a random sample or a representative sample (Langdridge, 2007: 58).*

***Reflections regarding sample:***

*I was concerned at my initial difficulty in recruiting only counselling psychologists, and anxious that the clinical psychologists might not share the same professional ethos, which places so much importance on the TR. However, the clinical psychologists in my sample did provide rich data. On reflection, I became aware that my anxiety, passions and enthusiasm for the topic might influence the interview process, and reminded myself not to forcefully place the participants in a position where they are inclined to provide a particular account rather than their own true experience.*

***Reflections regarding research interviews***

*The first interview felt somewhat like a pilot. It was somewhat scattered and unfocused. I did not feel on top of the conversation, and the participant seemed to wish to talk about his history as a psychologist, in a way that I was not sure was connected to my questions. However, I did not interrupt, as I wanted to provide a space for him to talk freely. Furthermore, I was anxious about the personal experiences that he shared. I realised that he was exploring his experiences in the context of the interview, and noted his own reflexivity as well as mine. As the interviews progressed, I was pleased with the openness revealed. The psychologists all noted that they were pleased to have the opportunity to share their experiences, and despite some similarities, no interview was like another. I sensed that the decision to use semi-structured interviews was appropriate. Since all of*

*the participants were experienced psychologists, and they were aware of me being a trainee, I felt that there was a teacher – student dynamic, which mirrored often the topic of the research: the meditation teacher/guide – client relationship. I reflected on the transference that took place, where I may have projected a sense of admiration or idealisation upon the participants. I wondered how aware they were of their own counter transference. With one participant in particular who provided an emotional narrative, my identification with her experience was conflated with my own life experience. We were both highly emotional. Later on, I reflected on this and wondered how she had perceived the interview. In a later meeting at a conference, the participant and I discussed the interview and she did not disclose any negative emotional consequence to the interview.*

***Reflections regarding data analysis***

*Listening to the tapes enabled me to understand the tone of the participant, and thus understand better how important or meaningful this was for the participant, especially when they got emotionally expressive. In stage two I finally felt that all the work of the previous months was starting to yield some results. However, it was a slow and laborious process. I was aware of my assumptions, and tried to put them aside, and not to look for evidence of these in the transcripts. Initially, I found it hard to discard information, I noted this in my reflective diary, and knew that I may have to revisit some emerging themes. Copying the emerging themes onto colourful sticky notes was helpful, since I am dyslexic, and thus it was paramount for me to work consistently and in an organised manner. Colours register strongly in my synesthetic/dyslexic brain, hence writing the emerging themes by hand, and colour coding them was very helpful. At stage three, I found that some themes seemed repetitive and needed merging; yet I still could not see the overall pattern. Towards the fourth stage, since I am a visual learner, the easiest way to make the connections between themes and across participants (each participant had his/her own colour of sticky notes) was to turn my attention to the 'whole' picture and visually spread the long lines of A5 papers on three connected tables. Thus, pictorially and conceptually based decisions were configured, labelled and reconfigured.*

***Reflections regarding validity and quality***

*At an early point of the analysis, I was concerned whether I used my own voice to make sense of the participants' accounts since I stayed close to their reports. In later stages, I added my own interpretative point of view. However, my own interpretative stance came to light in the synthesis that I conducted and in the overall narrative that I was able to communicate as the essence of the research (see Chapter 3).*

***Reflection regarding validity and quality***

*Since I am a new IPA researcher, I was anxious to provide the right level of rigour required. Therefore I attended an IPA group bi-monthly, lectures in conferences, and utilised a variety of literature to develop my knowledge.*

## APPENDIX 5: REFLECTIVE NOTES, CHAPTER THREE

***For accepting challenges sub-theme***

*The reflection on mindfulness not being the 'solution to all the world's problems', made me think about how much mindfulness is or is not connected to spiritual goals. Solving the world's problems seems to me to be a classic spiritual aspiration. However, mindfulness may be a form of mind/brain training to increase focused attention and cognitive efficiency at a given task, which may not be solving any problems beyond being a better tennis player, for example.*

***For the 'becoming' sub-theme***

*Dermot compared becoming a psychologist with becoming a practitioner of mindfulness. Both are about becoming. A psychologist has a point where you have become when you are awarded a certificate and a title. Being a mindfulness teacher is becoming that way too. This part also made me think about practice in terms of: if you do not practise a skill, do you lose it? So do we become a certain level of psychologist or mindfulness practitioner and then we have to practice to maintain it? For ourselves, not just for the formal external processes of accreditation?*

## APPENDIX 6A: Recruitment for Mindfulness research 15 11 2011

From: "shani ram" <shaniram@yahoo.com>
To: [redacted]

Dear Sir/Madam. [redacted]

For: Head of psychology department, [redacted] NHS trust, [redacted].

I am trainee counselling psychologist (year 3) at the
University of East London. I am conducting a doctorate research
about how using mindfulness meditation interventions may impact on the therapeutic relationship.
I wonder whether you will be willing to hang the attached poster in your department, or and circulate this email to counselling psychologists within the department who work using Mindfulness Based Interventions?
I used to work as an assistant clinical psychologist in the [redacted], and I
practice meditation as well as do group work with MBCT at [redacted].

I will be grateful for your support and cooperation.

With warm blessings

Shani Ram du Sautoy.

P.S. please see below the advertisement to the DCoP.

- - - - -

'The Impact of Mindfulness on the therapeutic relationship: Counselling psychologists' experiences' of using mindful meditation interventions.

I am a Trainee Counselling Psychologist at the University of East London, conducting professional doctorate research under this title. I aim to recruit participants who are counselling psychologists, (including integrative, person-centred, CBT, psychodynamic theoretical backgrounds).
You will be asked to describe your clinical experiences of working with mindfulness meditation interventions (MBCT, MBSR, ACT and DBT). And the way mindfulness affected your professional and / or personal development. In addition I will be interested in how working with mindfulness intervention impacted (or not) the therapeutic relationship. The main inclusion criterion is to have practised mindfulness interventions for more than two years. My supervisors are Dr. Pippa Dell and Professor Rachel Tribe (p.a.dell@uel.ac.uk), and my project has been ethically approved by the University of East London. If you're interested in participating, please contact me via email at shaniram@yahoo.co.uk.

## Appendix 6B: RECRUITMENT SECOND STAGE

**Recruitment for Mindfulness research directly to psychologists** 15 12 11
From: "shani ram" <shaniram@yahoo.com>
To: k;lkds;lfkldsk;fds;lkfds;lf

Dear Ms. Iliopoulou

Neil Johanessen has kindly given me your name and email
as I am trainee counselling psychologist (year 3) at the
University of East London. I am conducting my doctorate research
about how using mindfulness meditation interventions is experienced by psychologists in the context of the therapeutic relationship.
I wonder whether you will be willing to see me for 1 - 1.5 hours to discuss your experiences?

I used to work as an assistant clinical psychologist in the south Team, and I practice meditation as well as do group work with MBCT at NELFT.

I will be grateful for your insight and sharing of experiences.

With warm blessings

Shani Ram du Sautoy.

P.S. please see below the advertisement to the DCoP.
I am interviewing clinical psychologists as well as counselling psychologists.
- - - - -
'Counselling psychologists' experiences' of using mindful meditation interventions in the context of the therapeutic relationship.
I am a Trainee Counselling Psychologist at the University of East London, conducting professional doctorate research under this title. I aim to recruit participants who are counselling psychologists, (including integrative, person-centred, CBT, psychodynamic theoretical backgrounds).
You will be asked to describe your clinical experiences of working with mindfulness meditation interventions (MBCT, MBSR, ACT and DBT). And the way mindfulness affected your professional and / or personal development. In addition I will be interested in how working with mindfulness intervention impacted (or not) the therapeutic relationship. The main inclusion criterion is to have practised mindfulness interventions for more than two years. My supervisors are Dr. Pippa Dell and Professor Rachel Tribe (p.a.dell@uel.ac.uk), and my project has been ethically approved by the University of East London. If you're interested in participating, please contact me via email at shaniram@yahoo.co.uk.

**APPENDIX 7: INFORMATION SHEET** 31 05 12

**University of East London**
Water Lane, Stratford, London, E15 4LZ

**Consent to Participate in a Research Study**
The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study.

**University Research Ethics Committee**
If you have any queries regarding the conduct of the programme in which you are being asked to participate, please contact the Secretary of the University Research Ethics Committee, Ms Caroline Lake, Admissions and Ethics Officer, Graduate School, University of East London, Docklands Campus, London E16 2RD (Tel 020 8223 2976,

**The Principal Investigator**
Shani Ram du Sautoy

Supervisor: Dr. Pippa Dell & Prof. Rachel Tribe

School of Psychology
University of East London
Water Lane, Stratford
London E15 4LZ
Tel. [redacted]
Email: u0430874@uel.ac.uk

**Project Title:**

Psychologists' experiences of using Mindful Meditation Interventions in the context of the Therapeutic Relationship.

**Project Description**
The objective of this interpretative qualitative study is to explore the participant's experiences of using Mindfulness Meditation Interventions (MMI) in the context of the Therapeutic Relationship (TR) which they have established with their clients. It also aims to systematically map these experiences.
The study will investigate the connection between MMI and the TR by exploring the participants' experiences of the impact of teaching and practicing MMI.

**What is the purpose of this study?**

The study is being undertaken for educational purposes, as part of PHD degree.

**Who has reviewed the data?**

This study has been reviewed by the UEL ethics committee which has granted it ethical clearance and by the east London Research Ethics proportionate Review Sub Committee.

**How will this study be conducted?**

Interviews of 1 – 1.5 hours of one to one will be conducted, and recorded. You can choose to stop the interview or redraw your participation at any time during or after the interview. The interviews will be transcribed and analysed by the researcher but the information will be animalised and confidential.

**Confidentiality of the Data**

Your data will be kept on a password-protected computer in a secure office in the School of Psychology. Only the Researcher and examiners will have access to your data. All data will be destroyed or deleted upon completion and write-up of the research.

**Disclaimer**

Your participation in this research is voluntary. You are free to withdraw without disadvantage to yourself and without obligation to give a reason. Should you wish to withdraw from the research, please contact the Researcher.

## APPENDIX 8: POSTER

Are you a counselling/clinical psychologist working with

Mindful Meditation Interventions

(for at least two years?)

Would you be interested in participating in a study about:

Psychologists experiences of using mindful

Meditation Interventions and its impact on the

Therapeutic Relationship

The aim of this interpretative qualitative study is to explore

The participant's experiences of using mindful meditation interventions in the context of the therapeutic relationship. It aims to systematically map these experiences, and explore the impact of teaching and practicing mindfulness with clients.

If you can help please contact:

Shani Ram du Sautoy, Supervisor: Dr. Pippa Dell

School of psychology, University of East London

Water lane, Stratford, London E15 4LZ

Tel: 07852 112519 E: shaniram@yahoo.com

## APPENDIX 9: Demographics & Semi Structured Interview Schedule.

05 12 11

Age ____ Gender: Male/ Female,

Place of work: _____,

Ethnicity_____,

Educational qualifications_____,

Profession: _____,

Spiritual affiliation or religion (if any) _____.

Length of time working with Mindful Meditation Interventions (MMI)
_____

Length of time practicing Mindfulness Meditation in private life (if at all)
_____

## APPENDIX 10: ETHICAL APPROVAL FROM UEL.

**From:** "Amanda Roberts" <A.D.L.Roberts@uel.ac.uk>
**Date:** 20 September 2011 17:13:01 BST
**To:** "Shani Ram du Sautoy" <shaniram@yahoo.com>
**Cc:** "Pippa Dell" <P.A.Dell@uel.ac.uk>, "Rachel Tribe" <Tribe@UEL-Exchange.uel.ac.uk>

**Subject: RE: Shani Ram du Sautoy Ethics**

Hi Shani,

As acting chair of the ethics committee, I give full ethical approval for your study.

If you could send me a signed copy that would be great- and I will fill out an official approval form for you once I receive that.

Good luck with your thesis!

Best wishes,

Amanda

**********
**Dr Amanda D.L. Roberts**
Senior Lecturer in Psychology,
School of Psychology,
University of East London, Stratford Campus,
Water Lane, Stratford, London. E15 4LZ, UK.
Tel: +44 (0)20-8223-4580 (direct);
+44 (0)20-8223-4966 (secretarial office);
Fax: +44 (0)20-8223-4937.
email: *a.d.l.roberts@uel.ac.uk*
**********

** Note: After having done over six months of NHS Research Ethics Committee ethical form and submitted it, the NHs has changed its rules and postulated that psychologists do not need ethical documentation to be interviewed, hence the application was made redundant. However, the researcher have learnt from the experience of filling an lengthy application about such process.*

**APPENDIX 11: INFORMED CONSENT**

CONSENT FORM

Psychologists' experiences of using Mindful Meditation Interventions and their impact on the Therapeutic Relationship.

UNIVERSITY OF EAST LONDON

Consent to Participate in an Experimental Programme Involving the Use of Human Participants

I have the read the information leaflet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what it being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to me what will happen once the experimental programme has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me.

Having given this consent I understand that I have the right to withdraw from the programme at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)
……

Participant's Signature
……..

Researcher's Name (BLOCK CAPITALS)
……..

Researcher's Signature
……

Date: ……

Participant Reference number: ____

**APPENDIX 12: Schedule of semi structured interview** 02 07 12

1. **Therapeutic relationship** – Link between your own mindful-meditation on the quality of the TR if at all?, Does (if at all) and how working with MBIs affects the TR between yourself and the client, can you provide examples. How do you experience MBIs in terms of its usefulness to the clients? Is this connected to the TR?

2. **professional experiences (past)** – what was the journey that brought you to work with MBIs?

3. **personal experiences** – **past** – How long have you been a meditator, what is it like for you to meditate? Do you experience difficulties in your practice and if so what are they?

4. **personal experiences** – **present** – what is the impact of practicing meditation on your life at present? If any… Do you strive to be mindful and if so what are the benefits?

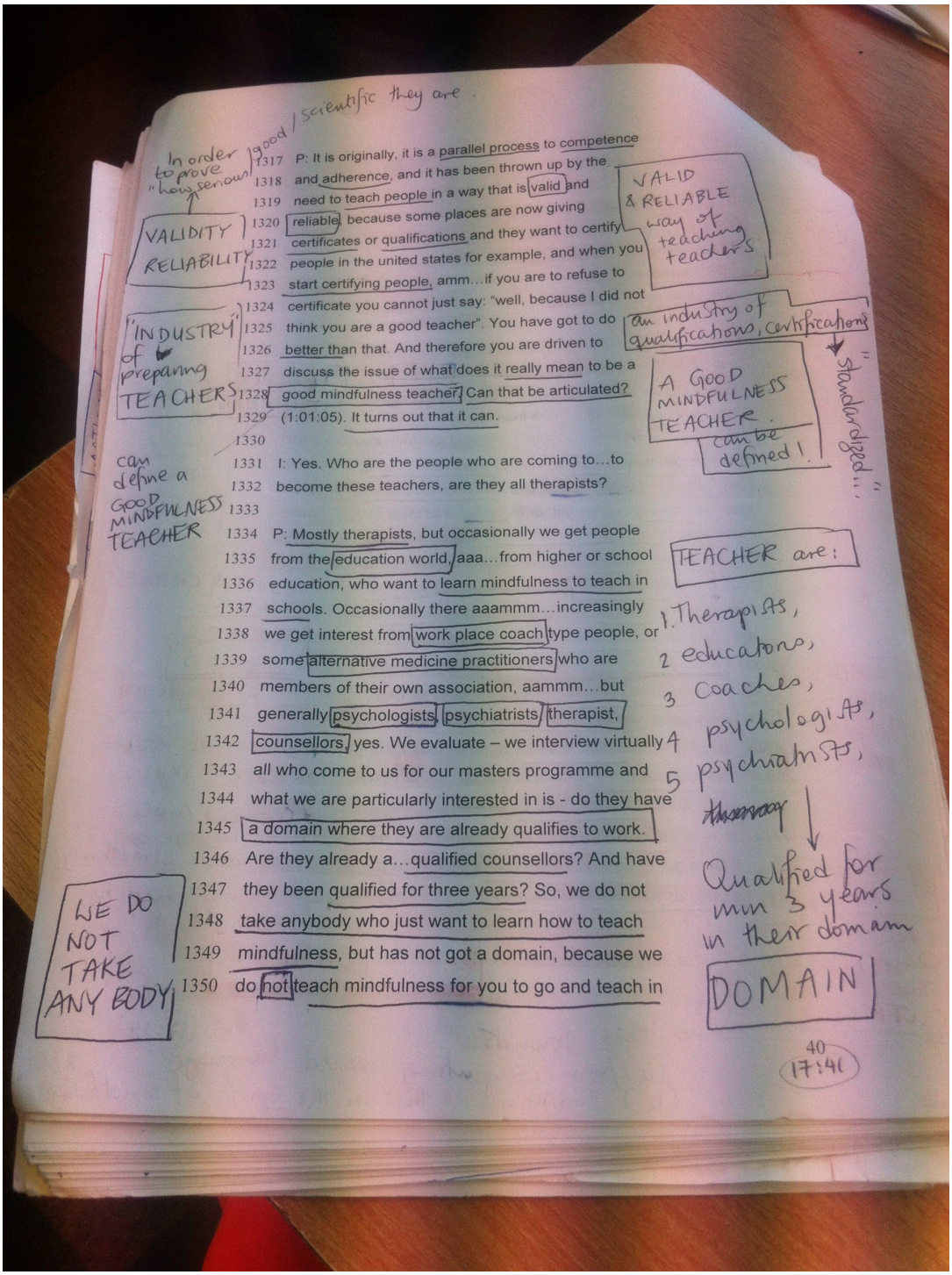
5. **professional MBI experience – present** – What is your experience of working with MBIs with your clients? How is it different or similar to the rest of your work with clients? What is your experience of meditating with clients in terms of the impact of meditation on the client if any, on yourself, if any?, what does working with MBIs mean for you?

6. **Benefits/ difficulties of working with MBIs,** Did you experience some resistance if so, how did you overcome it? If you did encounter resistance, did you frame it in terms of the TR?

7. **Other clinicians** and environment of practice

## APPENDIX 13: Two example for working through a transcript

.

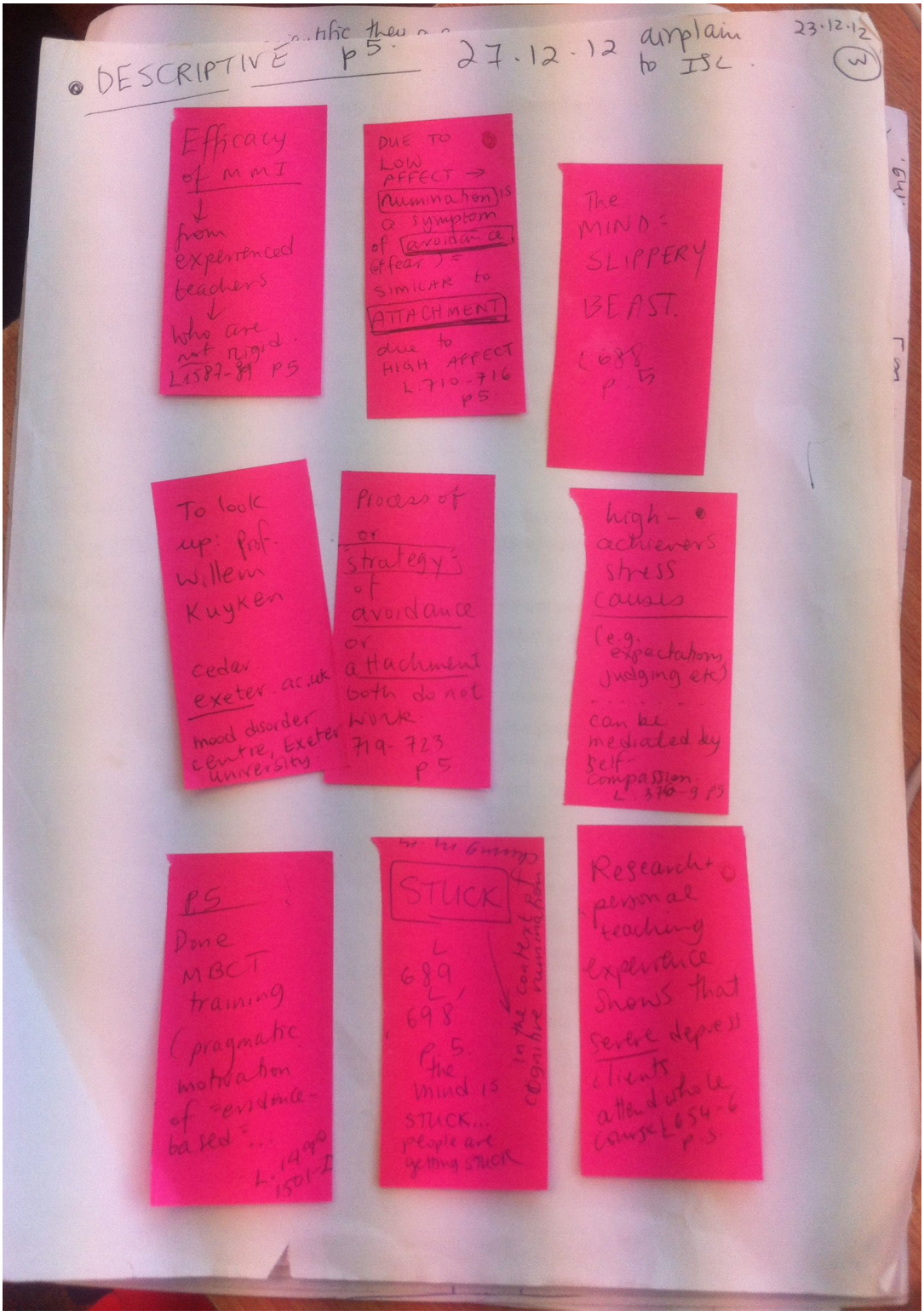



1317 P: It is originally, it is a parallel process to competence
1318 and adherence, and it has been thrown up by the
1319 need to teach people in a way that is valid and
1320 reliable, because some places are now giving
1321 certificates or qualifications and they want to certify
1322 people in the united states for example, and when you
1323 start certifying people, amm…if you are to refuse to
1324 certificate you cannot just say: "well, because I did not
1325 think you are a good teacher". You have got to do
1326 better than that. And therefore you are driven to
1327 discuss the issue of what does it really mean to be a
1328 good mindfulness teacher? Can that be articulated?
1329 (1:01:05). It turns out that it can.
1330
1331 I: Yes. Who are the people who are coming to…to
1332 become these teachers, are they all therapists?
1333
1334 P: Mostly therapists, but occasionally we get people
1335 from the education world, aaa…from higher or school
1336 education, who want to learn mindfulness to teach in
1337 schools. Occasionally there aaammm…increasingly
1338 we get interest from work place coach type people, or
1339 some alternative medicine practitioners who are
1340 members of their own association, aammm…but
1341 generally psychologists, psychiatrists, therapist,
1342 counsellors, yes. We evaluate – we interview virtually
1343 all who come to us for our masters programme and
1344 what we are particularly interested in is - do they have
1345 a domain where they are already qualifies to work.
1346 Are they already a…qualified counsellors? And have
1347 they been qualified for three years? So, we do not
1348 take anybody who just want to learn how to teach
1349 mindfulness, but has not got a domain, because we
1350 do not teach mindfulness for you to go and teach in

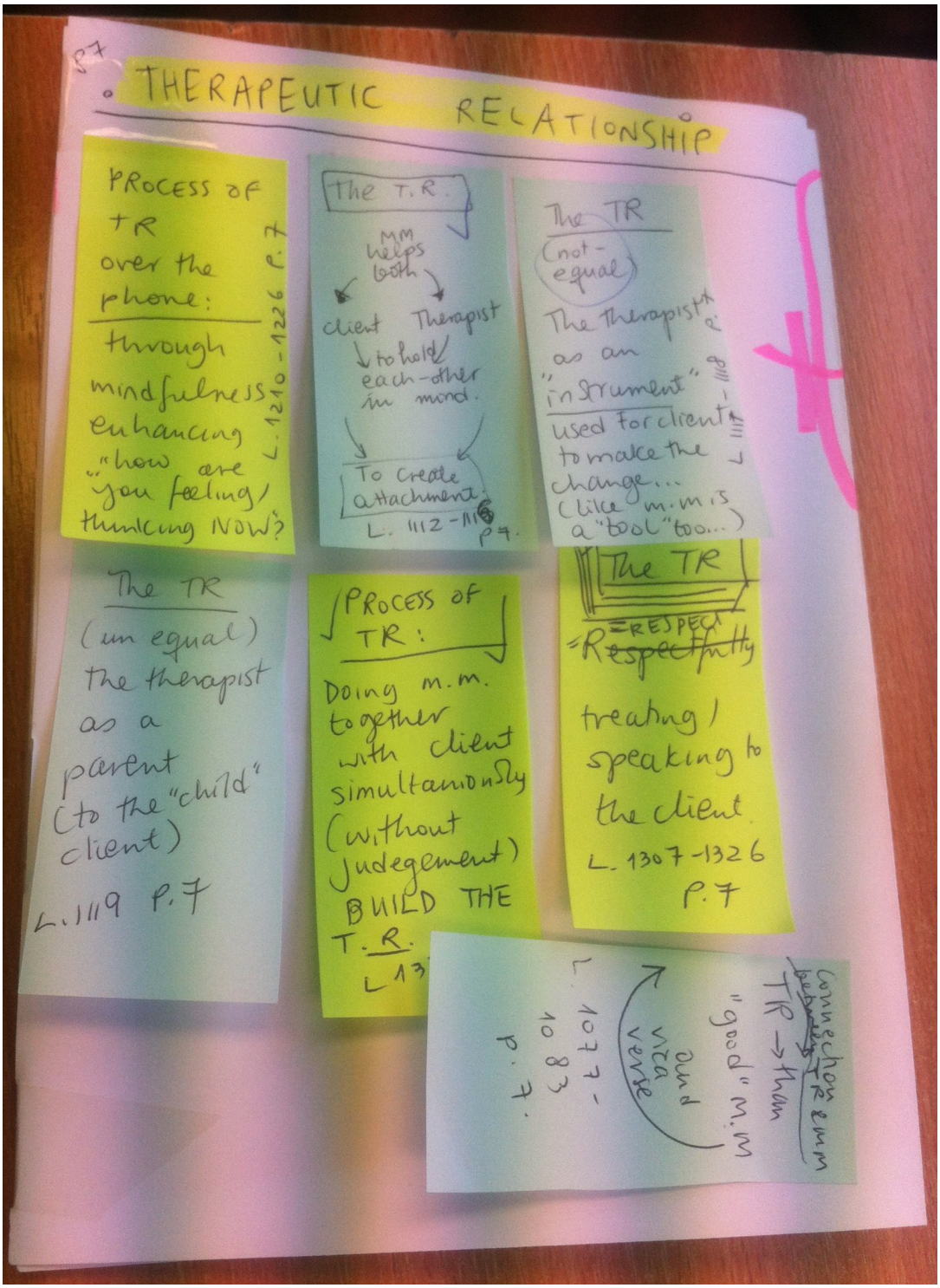
## Example two: working through a transcript

**APPENDIX 14: An example of Analysis Stage 2**

'Descriptive' division of emerging themes (rather than Content or Linguistic)



## APPENDIX 15: An example of Analysis Stage 3: themes finding.


P7
THERAPEUTIC RELATIONSHIP
PROCESS OF TR over the phone:
through mindfulness enhancing "how are you feeling/ thinking NOW?
L. 1210 - 1226 P. 7
The T.R.
MM helps both
client Therapist
to hold each-other in mind.
To create attachment
L. 1112 - 1116 P. 7
The TR
(not-equal)
The Therapist as an "instrument"
used for client to make the change...
(like m.m. is a "tool" too...)
The TR
(un equal)
the therapist as a parent (to the "child" client)
L. 1119 P. 7
PROCESS OF TR:
Doing m.m. together with client simultaniously (without judgement)
BUILD THE T.R.
L 13
The TR
=RESPECT
=Respectfully
treating / speaking to the client
L. 1307 - 1326
P. 7
Connection TR & m.m
TR → than "good" M.M
and vica verse
L. 1077 - 1083
P. 7

## APPENDIX 16: Super Ordinate Themes: Stage 4

Taken: 28 01 2013, 15:34 PM
(On left corner in orange: hand written table of super ordinate and ordinate themes)

Photo of table at library

## APPENDIX 17: Two discarded sub themes

For lack of space, these two sub-themes could not get into the body of the work, but are nevertheless interesting enough to be incorporated into the Appendices

### 3.4 THEME TWO: INTEGRATION

### SUB-THEME: 'JUST' BEING

Despite variations in individual references of context, the word 'just' crept into every single part of the participants' accounts. Its appearance is so frequent and so striking that it presented the researcher with the need to explore this phenomenon. OED explained 'just' (adverb) as: 'merely; only', and 'simply; certainly'. It can also be an intensifier. Why would the participants pepper their accounts with so much of this tiny word? The assumption behind stating 'simply' do this or 'only' do that was emerging, and will be explicated with the analysis of the following extracts. Various different 'just' s were noted. First, "just do it", secondly, "just being" and thirdly "just sit with it".

Matt used to lead a co-counselling community of clinicians who met regularly to meditate and provide therapy for each other. In this account he used the word 'just' to describe his conflict between counselling and meditation.

Extract 22:

*And I have got a passion for integration. ummm…you know, trying to integrate co-counselling with meditation. (55:28) That was two very important personal growth modalities, and I <u>just,</u> you know, from the outset, I could not quite work out how one which was about identifying repressed feelings and then becoming identified with them, and then expressing them, you know, a loud growth, and then on the other hand – you know, from the Buddhist perspective…you know, <u>just simply being</u> with feelings, and you know, neither expressing them nor repressing them…<u>just</u> this kind of middle way of knowing them and being with them and making room for them. And you know they were two different ways somehow, and I…I got very fascinated about how to make sense of them. I was integrating them.*

*Matt L 1042 – 1061.*

In the extract above Matt recounted how '*just simply being'* with one's feelings, belittling words, is in contrast to 'expressing' them, the latter being what counselling would advocate. The word 'just' appeared three times. In the latter two of these occasions it is in contrast to the content of the discourse. For example when Matt contrasted counselling with meditation he stated: "*I could not quite work how*" (to integrate them, line 1048) as despite his passion for integration they seem paradoxical. It is as if <u>because</u> it is not simple to be with feelings, and it is very hard to find a middle balanced way, that he

needed to minimize the enormity of the task. Matt compared what seem two contradicting modalities: counselling and Buddhism. This illustrated how difficult the task of reconciling '*expression of repressed feelings'* with '*being with feelings without reactivity'* is. If this 'just' reflected a conflict, the following reflects a sense of urgency regarding meditation, which is in contrast to the spirit of mindfulness.

**2'Just' do it**

For Clio and Charlotte the famous Nike advert 'just do it'[31] resonated in the discourse. There is an act of simplifying in the sequence as described below:

*"With people who do mindfulness we do it together, you need to put the books down and everything, and you just do it and then you feed back: what was that for you?*

*Clio: lines 1382 – 1386*

Cleo does not provide any further description of the meditation process; it is the middle 'filling' part of the 'sandwich'. This process happens somewhere between putting the books down and the post-meditation discussion. The process happens but it has a feeling of being something that one *'just'* need to jump into. Alternatively, it can be seen as a production line, like a metronome where one phase follows the other, but there is no emphasis on the meditation part, one goes through it like a machine. Hence, the use of the word 'just' conceals the difficulty that the clients of Cleo may experience, especially since they are DBT clients, diagnosed with personality disorder. Adding 'just' before the meditation part seems to diminish the difficulty, and also to contract the effort required in self-regulation during the meditation period.

**3 Just sit …Just everything…**

In the face of a challenge, the word 'just' is yet again utilised to negate, contradict, or help 'fight' the difficulty.

In a dialogue with a client, Tabitha further illustrated an attempt to simplify a potentially difficult task:

Extract 24

*"That happened in the bi polar group, somebody that was really distressed, and I just…I just kind of …I did just sit with it, but my mind was like….brrr….go , go, I should be doing something …what is going to happen, she is going to kill herself when she goes…wa-wa-wa…and she came back, and she just said: you know, that was the most helpful saying that I have ever experienced"…*

[31] 'Just Do It' is a highly recognized trademark of the shoe company Nike, and one of the core components of Nike's brand. The slogan was coined in 1988 at an ad agency meeting. The founder of advertising agency Wieden+Kennedy.

*Tabitha: lines: 1096 – 1104*

In a mirroring act, the psychologist sounded as hectic and anxious as the client, finding it really hard to 'just sit with' her concerns. The 'just' is a contradiction to the difficulty Tabitha had in refraining from being reactive. Tabitha's mind was racing, her speech was fast, she repeated the word 'go', used 'brrrrr', and repeated the word 'just' 4 times in the short extract. In this case, the word 'just' is the complete opposite from how complex the processes being described were, both to the client and the psychologist. They may be used as a defence mechanism, to hide the challenging nature of the situation, in a denial manner (de la Silva, 2009). Overall, the word 'just' is used as a verbal tool which signifies the contradiction in terms. However, it is not the word itself that the reader is invited to notice, but rather the fact that so many contradictions need to be integrated.

**THEME THREE: THE PROCESS OF MINDFULNESS**

**SUB-THEME: SPACE ANALOGY**

This sub-theme encapsulated the psychologists' accounts that were grounded in analogies of space. When reading the interviews I was struck by how often the descriptions utilised synonyms of distances, areas, and locations. I wondered whether it indicated a need to locate in concrete three-dimensional terms the phenomenon of mindfulness, and whether doing that was an expression of some anxiety, due to the illusiveness of the experience of practicing mindfulness. Additionally, it may be an appropriate metaphor that attempted to concretise the abstract process of mindfulness. Since concentration comes and goes from moment to moment, there is a need to 'capture' the focused mind, before it slips away yet again.

This sub theme contains the following accounts: "being in the same boat", "make time space": and "navigate that space: body mindfulness as a space".

Nick's account captured the overall notion that the process of mindfulness encapsulates '*being in the same space'* (same boat) as the client and subsequently has an impact on the power dynamics which become more equal as a result.

Extract 37:
*"…. if I guide some people with their breathing I would always be with my breathing as well, ummm....so...I suppose there is a sense of almost like being in the same boat as the client, when you do it, because you are actually both doing the same thing".*
Nick L 1149 – 1154

Nick highlighted the idea of being in a similar situation as the client. Furthermore, a boat is a vessel for transport by water, constructed to provide resilience by excluding water, shaped to give stability and movement. This reflected the shared difficulties[32] that both psychologist and client are facing together; hence this analogy emphasised the togetherness and equalness of the partakers in the passage.

Similarly, Marcus talked about the need to teach mindfulness by modelling, since what is being asked of the client (*to navigate a space*) is the 'tall order' of staying and being without reactiveness.

Extract 38:

*"That…that…and that is the reason why I think that within mindfulness it has got to be…ummm…based on your own experience of mindfulness, in order that you know the space in which you are asking people to navigate. (11:13) Which is seeing clearly their own patterns of reactions without actually doing anything about them. Marcus L227 - 233*

Once again, a sense of being on the same area as the client was demonstrated. Marcus advocated the need for self-practice of meditation for the clinician, so that they share '*the same space'* as the client. The word 'navigation' alluded to an unknown territory, a process of accurately ascertaining one's position. It is often used in connection with the control of the course of a ship. This connection further demonstrated the resemblance between Nick and Marcus' metaphors.

In contrast to the accounts above, Dermot brought the body as a space to his account. He referred to the body as an '*OK space'*, referencing his own experience of sexual abuse as a child, which allowed him to recognise a similar experience with his 11 year old female client:

Extract 39:

*"But the fact that I am sensing that, and I have recognized it, and I umm…able to sit with it, might well be enough for her to kind of feel like this is an OK space. To be in. Is this making any sense?*

*Dermot L 2314 – 2317*

It is not clear whether Dermot was talking about the room as an OK space, or the violated body of the abused child, but in other parts of his interview he talked about the body as a space:

[32] Intriguingly, Nick mentioned the breath. The analogy often accompanying it is an anchor, which is another object from the world of water and sea.

Extract 40:

*"You would look at mindfulness as everything that you did, you would call the whole thing mindfulness. Cause I think that does fit well with creating a more effective spaciousness inside you, to monitor what you do as you are doing it. And that, I think that would include a sense of what is happening in your body".* *Dermot L 904 – 910*

Dermot connected the body with space once again, and defined mindfulness as a process in which '*effective spaciousness'* is created internally. Hence inside the body of the meditator more space is generated. It seems as if in this account the body space is not necessarily a physiological element. As one's sense of awareness expands so does one's capacity to contain it within the body. It is again a metaphor to indicate the message that if one practices mindfulness, one develops more scope to deal with stress and other issues.

In summary, the space analogy was demonstrated being in the same domain as the client; the need to navigate as an experienced knower of mindfulness in order to facilitate the client, and the way expansion of awareness created a sense of body-based spaciousness. All of these suggested that the process of mindfulness is located within the body and is concretised via real or imagined space to reflect equalness between teacher and client. The following sub-section will attempt to explore the challenging aspects of mindfulness processes since the participants provided a balanced account of the process, and did not refrain from highlighting the difficulties.

## APPENDIX 18 Notes reflections from research diary –
**Bracketing about interview 1, Matt 17 01 12**

*I have made this interview a little while ago,*
*Mostly I remember that he was terribly nice, and that it went on and on and on.*
*Sometimes he digressed dramatically, especially into his co-counselling stories, and I did not really understand often what he was talking about but was rather worried about asking too many clarification questions.*
*He is such a nice person that I felt uncomfortable to stop him and say "look, this co-counselling business is not really relevant", but maybe it was? Because it is like the process of doing mindfulness with the client?*

*I drove far away to see him, and he gave me a lot of his time. It is a very long interview. An hour and a half at least. He did tell me some very personal things: like his psychotic episode. Something his voice is very…skimming the surface, wondering, he is not an intellectual, he is a more a 'lived experience' kind of person. He says this himself.*

*We laughed a lot in the interview, what was that about?*

*I am worried that I was too enthusiastic about mindfulness and that made him somehow position himself in a super positive manner too?*

*Perhaps I need to be more neutral in my next interview. Not to come across as a 'groupie' of the subject, so the interviewees can be honest and show their concerns with the intervention too?*

**APPENDIX 19: CD containing interview's transcripts and excel file of themes data.**