A PORTFOLIO OF STUDY, PRACTICE AND RESEARCH

Research Title: The experience of Mindfulness in Western Therapeutic encounters; Practitioner's Perspective

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Submitted to fulfil the requirements for the degree

Doctor of Psychology (DPsych)

City University, London

Department of Psychology

July 2009

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TEXT CUT OFF IN THE ORIGINAL

God grant me the serenity
to accept the things I cannot change;
courage to change the things I can;
and wisdom to know the difference.

Living one day at a time;
enjoying one moment at a time;
accepting hardships as the pathway to peace;
taking, as He did, this sinful world
as it is, not as I would have it;
trusting that He will make all things right
if I surrender to his Will;
that I may be reasonably happy in this life
and supremely happy with Him
forever in the next.
Amen.

Reinhold Niebuhur (1892-1971)

The Guest House

"This being human is a guest house.
Every morning a new arrival.
A joy, a depression, a meanness,
Some momentary awareness comes
As an unexpected visitor.
Welcome and entertain them all!
Even if they're a crowd of sorrows,
Who violently sweep your house
Empty of its furniture,
Still, treat each guest honourably.

He may be clearing you out
For some new Delight.
The dark thought, the shame, the malice,
Meet them at the door laughing,
And invite them in,
Be grateful for whoever comes,
Because each has been sent
As guide from beyond."

Rumi (1207-1273).

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Acknowledgments

There are a number of people I would like to thank for their support and help in completing this portfolio. I would like to thank my supervisor, Dr Malcolm Cross who was provided so many helpful comments and suggestions. My field supervisor Dr Ann Colborn who has offered so much of her time, experience and compassion, and was so patient with many occasions of excitement and distress during this whole process. Thanks also to her husband and my friend Glenn who has no doubt suffered behind the scenes, as well as keeping an eye out for so many interesting articles. I would like to thank my work colleagues who had to put up with my sullenness on occasions, but were always ready with encouraging and supportive comments. In particular Sue, our secretary who now knows more about Mindfulness whether she liked it not.

Special thanks in particular to hoses who helped throughout the process, Bruce, Steve, Adrian, Dave, Nikko, Jannik, Eddie, Bisi, John 'Numberwang', Dominic, and Pushkin.

Special thanks to my wonderful partner Jo who has stood alongside me throughout all of this, has always been available and responsive and put so many plans on hold whilst waiting for this to be finished. Thank you for knowing how important it is to me.

Particular thanks to the participants, Steve, Sally, Alison, Duncan, Christina, Edward, Polly and all the clients who have allowed me to share in their processes and continue to develop professionally and personally.

This research and portfolio is dedicated to my mother without whose encouragement I would never have been able to be part of this career I love, and for always telling me that dyslexics find their own way there in the end.

Declaration

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Hamilton Fairfax

Abstract

Background: Mindfulness has become increasingly popular in recent psychotherapeutic literature that strongly indicates its use for the treatment of a variety of psychiatric disorders. It has been incorporated into cognitive behaviour based models such as Mindfulness-Based Cognitive Behavioural Therapy (MBCBT), and Dialectical Behavioural Therapy (DBT), as well as specific model of treatment for chronic pain, Mindfulness Based Stress Reduction (MBSR). These models in particular have attracted a significant amount of outcome research that consistently suggests that they are of benefit to specific clinical populations. MBCBT and DBT are recognised as evidence based treatments of choice by organisations such as the National Institute for Clinical Excellence (NICE) in the United Kingdom. Clinically, it is something that I have some limited awareness (during DBT training, and through awareness clinical literature), and have been interested in finding out more about it. Despite these findings however, there is no established definition of mindfulness, no consensus of what it does, and no shared understanding in literature of what it means to be Mindful. Furthermore, Mindfulness originated in Buddhism around 2, 500 years ago and is therefore closely related to this discipline and Eastern culture in general. These are issues that have also received little attention in the research. Mindfulness therefore finds itself in a relatively unusual position in terms of therapeutic research, generally being accepted as a beneficial and helpful practice, but with no clear understanding of what it really is, or how it works. This research attempts to explore these questions further by presenting the perspectives of psychological practitioners who routinely use Mindfulness in their therapeutic practice. Working back perhaps from the outcome literature, this research attempts to capture the participant's experience of Mindfulness therapeutically, what they feel it is, how they experience it in their clinical work with clients, and what it means to them personally, professionally and culturally.

Method/ Analysis: Given that the research is based on capturing individual, phenomenological processes, qualitative methods were seen as the most appropriate methodology. As the research involves exploring the each participant's perspective with the aim of providing general themes between accounts, Interpretative Phenomenological Analysis (IPA) was chosen. IPA also recognises the role of the researcher and their potential biases, e.g. a therapist with some basic awareness of Mindfulness, as a feature within the research methodology. Recruitment letters were sent to Community Mental Teams (CMHTs), Psychology, Psychotherapy and Psychiatry Departments, and local University throughout a specific region in the United Kingdom (Devon). Participants were required to be currently working as therapists who described themselves as using Mindfulness within their clinical practice. Five from an initial response of nine participants were interviewed. Reasons for attrition included, moving job, moving area,

and pregnancy resulting in change of life circumstances. The participants were three women and two men aged between their late thirties to late fifties. Professional backgrounds included Social Work Occupational Therapy, and Core Process psychotherapy, and all worked within NHS settings, and some private work. Interviews were transcribed and subject to a thematic analysis using IPA that produced three master themes. Cohen's Kappa was used to test for inter-rater reliability.

Results/ Conclusion: Three master themes were identified; the Culture and Context of Mindfulness, The subjective Experience of Mindfulness and Being a Mindfulness Practitioner. These were explored in terms a concept called 'Being-With'. 'Being-With' explored the results in terms of literature concerning core therapeutic conditions, therapeutic process, and the presence of the therapist. It was concluded that this term described the interpersonal and process based nature of Mindfulness, as well as capturing the participant's perspective that Mindfulness was not a technique but a therapeutic attitude or way of being based on ongoing personal and experiential practice. The findings are critiqued and suggestions for further research discussed.

SECTION A - PREFACE

Preface

1.1 Overview

One of the central themes of this portfolio is the exploration of important human activities that are often outside of the usual interest of published psychological research, both at a wider level of culture, and the more individual therapeutic process. This is explored through the presented research into the practitioner's experience of Mindfulness, the professional component, which examines my process with two clients, and the critical literature review, which examines the role of spirituality in psychological research. An underlying question concerns how insights from cultural, social and religious belief systems are understood and applied in western cultures. This portfolio examines therapist's current interest in the application of Mindfulness as well as exploring the impact of asymmetrical differences in therapeutic process.

My interest in these issues has in many ways paralleled both my personal and career development. Before I studied Counselling Psychology, I completed a degree in Theology and Philosophy. This was based on an early interest in spirituality and religious history, particularly Christianity, which increasingly led to an interest in philosophy of religion and philosophy in general. My main attraction to these disciplines was that they both seemed to be interested in people, how they functioned, and how this could be improved. It was during the first degree that I was exposed to Psychology through

specific theology and philosophy modules. I had also begun to work with people through volunteer activities such as university counselling services and Nightline. Following the completion of the degree I pursed further training in counselling, and Counselling Psychology, as well as increasing my therapeutic experience. Throughout this time I also maintained an interest in spirituality and how it is understood in the clinical literature. My current religious position would be best described as 'interested agnostic' and I do not actively subscribe to any particular denomination or system of religious belief.

1.2 Research

The research component explores how Mindfulness is experienced in the therapeutic process by Western practitioners. I was interested in Mindfulness for two reasons. Firstly it is an area that attracted a significant amount of research and clinical interest. Secondly, I was exposed to Mindfulness during training in Dialectical Behaviour Theory (DBT) some years ago, and found it to an interesting concept, both personally and therapeutically. Mindfulness has a long history in Buddhism, but since the late 1970's and particularly in the 1990's, it has been increasingly incorporated into psychotherapeutic theory and practice. However, unusually, this was in the context of there being no clear definition of Mindfulness, what it did, and how one practiced it. Mostly the literature described it as technique, but even then there was no established protocol or description. The Mindfulness literature had consistently found positive outcomes, even suggesting it to be evidenced based for recurrent depression, but there

was no clear foundation to explain what these outcomes may be based upon. In many ways this seemed to 'bottom up', with the majority of research based on the outcomes and the minority investigating the process behind it. Therefore, research into the process and nature of a 'Mindful therapist' and what it meant to be one, was missing from the literature.

I explored the rationale and process of Mindfulness by conducting interviews with five therapists who described using Mindfulness in their work with clients. The interviews were transcribed and analysed using Interpretative Phenomenological Analysis (IPA). Three master themes were identified and explored in terms of the relationship to existing process research.

1.3 Professional Component

In this section two case studies, Edward and Polly, are presented. Both highlight the need to understanding the phenomenological reality of clients in the individual therapeutic process, and in Edwards case in particular, the wider health care system. Edward is client with neurological problems, but also profound emotional difficulties, and I present our therapeutic process, reflecting on the theoretical and interpersonal issues, as well as detailing the nature of our work. Polly is client diagnosed with a long standing Eating Disorder and in this case study I reflect upon both of our issues of unacknowledged personal bias and assumptions towards the diagnosis, and how this was worked through

during the process. These case studies are included here for two main reasons. Firstly they acknowledge the struggle in balancing diagnostic led interventions (for example the established literature relating to neuropsychological theories and specific eating disorder techniques), with a phenomenological appreciation of the client. I feel this may be an experience familiar to many Counselling Psychologists, especially those working within organisations informed by the medical model such as the NHS. Secondly, the inclusion of these case studies has been invaluable to me as a personal learning experience. I believe the formal process of reflection has helped to emphasise the value of constantly reviewing my own personal biases and assumptions in order to develop further as a therapist.

1.4 Critical Literature Review

In the final section of the portfolio the issue of how spirituality has been understood in the psychotherapeutic literature is critically investigated. Earlier research into the subject often treated spirituality and religion as similar concepts. However within the last forty years this has become more acknowledged by the research and studies have begun to investigate each phenomenon separately. This study aims to review the literature since that time to consider the findings relevant to psychological distress and the psychotherapeutic process. It is hoped that any findings may help to bring greater clarity to understanding the present role of spirituality and religion in psychotherapy.

1.5 Summary and Conclusion

It is hoped that this portfolio will promote a greater general understanding of both the process and experience Mindfulness, and the consideration of phenomenological nature of individuals in therapeutic processes. It is hope that this will add to the existing literature and promote further questions for future research.

In order to encourage this further I intend to share the findings within the psychotherapy professions, in particular Counselling Psychology, through publications and conferences. I hope this portfolio represents a helpful and considered response to the experience shared by the participants involved in this work, and whose presence was invaluable

SECTION B- RESEARCH

The experience of Mindfulness in western Therapeutic encounters; Practitioner's perspectives

CHAPTER 1: INTRODUCTION

1.1 Background

"Buddhism will come to the West as a Psychology" (Chogyam Trungpa, 1974, p.6).

The purpose of this research is to explore therapist's experiences of Mindfulness in Western therapeutic encounters. Therefore the aim of this chapter is to provide both a clear context and the necessary background for the reader to gain an appreciation of the relationship between Eastern Thought and Western psychotherapy. This will be achieved by providing a brief overview of the historical development, a description of salient Buddhist philosophical tenets, and identifying the most significant applications of Mindfulness to Western psychotherapy and clinical interventions.

It is not possible to provide a definitive definition of Mindfulness, and as suggested later, this is one of the major obstacles to research in Mindfulness. Indeed this uncertainty is a motivator for the current investigation. However, several theories have attempted to clarify this further. A clearly articulated definition is suggested by Bishop et al. (2004) who proposed a two component operational definition of Mindfulness. The first part relates to individual's ability regulate attention and maintain it on immediate experience. *Self-regulation* therefore involves, sustained attention, returning attention if the mind

wanders, and bare awareness of thoughts, feelings, and sensations. The second component involves the individual's orientation to experience with curiosity and acceptance regardless of the perceptive benefits or costs of the event. *Orientation* is described as flexible, non-judgemental attention to the present moment. Although a widely acknowledged definition (Hayes and Feldman, 2004), it has been criticised as being too limited; Shapiro et al. (2006) argue that it does not include qualities they identify with 'intention' (see Section 1.82 for further discussion of this theory).

Fromm (2002) has distinguished between two applications of meditation in psychotherapy. The first is the autogenic techniques (e.g. muscle relaxation, progressive relaxation techniques) taught with the intention of helping the client to relax. The second Fromm (2002) describes is to "achieve a higher degree of non-attachment, of non greed, and non illusion...put simply to reach a higher level of being" (p.50). Mindfulness is associated with this latter category. This however is only one part of Mindfulness as it can also involve; "a quality of consciousness characterised by heightened clarity and awareness of present experiences and functioning" (Chatzisarantis and Hagger, 2007, p.58) and, "paying attention in a particular way: on purpose, in the present moment, and is non-judgemental" (Bondolfi, 2005, p. 45).

It is important here to note that there are various forms of mediation in the Buddhist practical cannon, including Transcendental Meditation (TM), and different cultural types of Buddhism, e.g. Tibetan, Chinese, Indian. An extensive review of these is beyond the current remit. Mindfulness in this context is understood as an insight practice from the Theravada tradition of Buddhism as this is the most commonly applied in the West. From

the outset therefore, it is important to note the ambiguous nature of Mindfulness, especially when considering how individual practitioners apply and experience it in therapeutic interventions.

1.2 The Development of Eastern Thought in the West

At a lecture at Harvard University given by Dharmapala, a Theravada Buddhist, in 1901, William James is said to have noted, "This is the psychology everybody will be studying twenty-five years from now", (Fields, 1992, p.134). However it is only within the last thirty years that Buddhism and Eastern philosophy has become a significant area of interest in Western psychological thought and practice. One reasons for this was initially scholars were more occupied with studying the language and culture of Buddhism, than it's psychology. Despite James' initial interest there were not enough good quality translations available. An exception to this however was Rhys Davids (1900) who published an early translation of the first book of the Adhidamma (the Dhamma Sangani), titled 'Buddhist Manual of Psychological Ethics'. In this Rhys Davids described a psychological nature of Buddhism, stating; "Buddhism, from quite an early age, set itself to analyse and classify mental processes" (Rhys Davids, 1900, p. xvii). However, Katz (1983) has also suggested that the development and dominance of Behaviouralism and it's rejection of introspectionism in favour of observable behavioural change, further delayed psychological engagement with Buddhist philosophy.

In the 1950's wider interest grew in Buddhist application to Western society, particularly in America. Orientalists, scholars, exiled Buddhist teachers and philosophers also began to popularise Buddhism and Eastern thought (e.g. Kornfield, 1993, Nhat Hanh, 1998). Although not a psychologist, Alan Watts' (1961) work on the conceptual integration of Buddhism and psychotherapy helped to re-stimulate interest in its application to influence science, medicine and psychotherapy. As Watts (1975) describes, "The main resemblance between these Eastern ways of life and Western psychotherapy is in the concern of both with bringing about changes of consciousness, changes in our ways of feeling our own existence and relation to human society", (p.4). Around this time Humanistic Theories (e.g. Maslow, 1954, Rogers, 1961) were developing, and although not directly influenced by Buddhist philosophy, they explored more phenomenological and introspective techniques of psychotherapeutic intervention. As it developed, Humanism was seen by many as a reaction to the more objectifying theories of behaviouralism and psychoanalysis, and it's emphasis on individual meaning and self actualisation arguably had much more in common with Buddhist theory than mainstream psychotherapeutic theory of that time.

Paralleling these academic and sociological developments, there has also been an increase in the popularity of Western esoteric traditions, popularised by New Ageism, but also includes, renewed interest in Paganism, the Kabbalah, Gnosticism and mystical traditions of the Sufis. A central concept in Western esoteric religious experience is Gnosis, or a direct and immediate knowing. There is also the belief that it is possible to have 'contact' or direct experience with the Higher Being. Gnostic belief describes a

quality of experiential knowledge, and practices are concerned with individuals having to go further into themselves and their lived experience. As opposed to exoteric spirituality and religion, esoteric traditions are concerned with transcendence, mainly of oneself. Western esoteric traditions are relatively new, originating within the last two hundred years as a result of a loss of faith in dominant creeds, the development of science, and globalisation providing contact with other cultures. However it is within the last thirty years that it these traditions, and spirituality in general, has become a more accepted area of academic discussion; e.g. Balvatsky's Theosophical Society developed to spread eastern ideas. A more extensive review of these traditions is provided by Smoley and Kinney (1999).

Recognition of the growing relationship between Eastern and Western thought has to led the establishment various multi-perspective and inter cultural-conferences. The most recognised of these is perhaps 'Mind and Life' which has been convened every two years since 1987 by the Dali Lama to facilitate discussions between Buddhists and Western scientists (for further details see Varela, 1997, Zajonc and Houshmand, 2004).

It is clear from the above that Buddhist thought has been a growing influence in Western and psychological and philosophical thought. Initially this appears to have to have been an academically driven process, but, as will be suggested later, Buddhist techniques in particular Mindfulness, has a significant presence in psychological literature. The following section therefore provides a brief description of the underlying philosophy of Buddhism. It should be noted that this is presented for informative purposes and in no

way should be considered an extensive description. Rather, it is intended that this section presents the reader with a better understanding of the theoretical context of Mindfulness.

It should also be noted that the author is not a Buddhist or has any formalised training in Buddhism and therefore the following is based on personal selections of what is considered relevant to the current investigation. Recommended descriptions can be found in Humphreys (1975), Brazier (2003) and through the Buddhist Society, London.

1.3 Buddhist Theory

The earliest Buddhist writings are found in the Tipitaka, the third part of which, the Abhidamma, has been of the main interest to Western scholars and is the major source that describes Buddhist psychological states. Bodhi (2000) observes, "The primary concern of the Abhidamma is to understand the nature of experience, and thus the reality on which it focuses is conscious reality...the philosophical enterprise of the Abhidamma shades off into a phenomenological psychology." (p.3). Of note however is Guenther (1957), who argued that much of Buddhist psychological study has only involved the Abhidharma tradition. The core of Buddhist psychological theory concerns the Four Noble Truths which gives an understanding of difficulties in life and how we respond to them. A brief explanation of each of these is provided below.

The first Noble Truth concerns 'Dukka' which is commonly translated as suffering. However it has a wider description; the Buddha defined dukkha as, "Suffering, as a noble truth, is this: Birth is suffering, aging is suffering, sickness is suffering, death is suffering, sorrow and lamentation, pain, grief and despair are suffering; association with the loathed is suffering, dissociation from the loved is suffering, not to have what one wants is suffering – in short, suffering is the five categories of clinging objects" (Nanamoli, 1993, p.32). Dukka therefore describes a sense of existential affliction, the inevitable consequences of life and our reaction to them. Rigid attachment, or in Buddhist terms 'grasping', to one's perspective or belief of 'how things should be' results in a habitual and unprocessed way of life and leads to distress.

The Second Noble Truth, Dukkha Samudaya, can be described as, "the thirst for sense - pleasure, for being and non-being" (Samyutta Nikaya 56.11.6, in Brazier, 2003, p.11). This involves considering how individuals respond, both physically and emotionally to dukka. The common response, Buddhism argues, is distracting or avoiding uncomfortable feelings, however the individual is instead encouraged to cultivate a feeling of stillness and acceptance. Developing and reinforcing one's identity, as a method of creating an illusion of safety, is also a response to dukka.

Dukka Nirodha, or 'cessation', the Third Noble Truth, describes the capacity to let go of whatever is occupying the individual's desire and maintaining the suffering. Suffering can occur when, if the feelings arise, the individual 'grasps' or becomes attached and in

the process creates more feelings, thereby creating further distress. Cessation involves identifying and containing cravings as they arise and disconnecting oneself from them.

The Fourth Noble Truth, Marga, or 'the path' is a description of the spiritual process of the Dharma Wheel. This involves the Eightfold Path which are eight steps to create a complete cycle; right seeing, right thinking, right speaking, right action, right ethics, right effort, right mindfulness that leads to Samadhi, 'true vision'. It is important to note that 'Right' from the original translation also includes the quality of being 'wholehearted'.

An important concept in understanding the psychological process involved in dukka are the 'The five Skandhas' or 'The five aggregates of grasping'. This starts with Rupa, or objects that have influence of the individual due their perceived importance. Instantly following this is Vedana, 'Knowledge, reaction', which also includes attraction, aversion and confusion. It is a bodily reaction and can also be described as a 'gut feeling'. Following from Vedana is Samjna, 'knowledge that comes from a thing'. This describes the stimulation of associations and memories; often it can be the point when the individual becomes attached to the process. During Samjna the person slips into their conditioning, are on 'automatic pilot' acting habitually. Habitual patterns lead to Samskara, 'mental formations', which includes ruminative patterns and familiar ways of acting. The outcome of the five skandahs is Vijana, 'consciousness', which Brazier (2003) describes, "it is the mind that places you at the centre of your life story and construes everything else as indicators of yourself." (Brazier, 2003, p. 92). Attachment to an object therefore can result in a complete experiential enmeshment that results in the

development of an inauthentic self-construction. It is also important to understand that conditioning in Buddhist terms is broader than Western definitions, describing the states of mind that occur in response to the conditions the mind is exposed to as well as where one's attention is placed.

The Buddhist epistemological stance, therefore, known as the 'Three Signs of Being', is identified below:

- All samaskras (mental formations) are impermanent
- All samaskras (mental formations) are affliction
- All dharmas (true reality) are non-self

The main way to implement, and 'live' this perspective is through meditation, specifically insight-based meditation such as Mindfulness. Mindfulness involves practices such as eating, walking, the body scan and most commonly breathing, all with the intention 'to see things as they really are' (Telles, Mohapatra-Raja and Naveen, 2005).

The shared interest in human development between Buddhism and Western psychotherapy cannot be over stated; "In Buddhism, therefore, psychology is not a peripheral interest. It is, rather, embedded in its most important techniques", (Brazier, 2003, p. ix). Moreover Buddhism provides theoretical constructs that go beyond a metaphysical spiritual purpose and are akin to psychotherapeutic notions of formulations

and interventions. Koans, for example are spiritual questions that do not have straightforward answers, the purpose of which is not an intellectual process but to reach an experiential awareness, of what it means for the individual to exist at that moment. It is therefore understandable why Buddhism has a close association with developments in Western psychotherapy.

The following section briefly explores this relationship, before presenting a description of the most widely used models. Due to the remit of the current investigation, this is not a comprehensive description and is provided for illustrative purposes. The research referred to is based on applications of Mindfulness, which is both the most recognised aspect of Buddhism applied to psychotherapy and the subject of this investigation.

1.4 Buddhism and Psychotherapy

Buddhism has had more of an impact on psychotherapy than any other part of psychology, with meditation, in particular Mindfulness, being the most applied and researched intervention (Epstein, 1995). However early psychotherapeutic perspectives were less than encouraging. Commenting on the Freudian perspective, Cooper (1999) notes that Freud maintained that Asian mediation practices resulted in a regression to an 'oceanic' infantile self centred state when the individual does not yet feel an 'I' that is distinct from others, and should, therefore, be regarded as pathological. Freud further argued that religion in general was the result of repressed libido.

It is interesting that one of the causes of the spilt between Freud and Jung centred on understanding the mystical. The most well known of early writers of Eastern thought in psychology, Jung wrote four major essays on Buddhism and several introductions to related texts, as well as participating in discussions and lecturers with established Zen Buddhists. Jung placed emphasis on the Eastern tradition of intuition and spiritualism and saw this as a balance to Western intellectualism. The development of the collective unconscious for example, was based on similarities between ancient myths and cultural beliefs. Jung became interested in Eastern meditation through the translation of the Tibetan Book of the Dead (Barbo Thodol) by his friend Evans-Wetz, apparently carrying it everywhere with him and regularly using it for inspiration. However Jung was concerned about the use of meditation, conceiving it as a short cut to the subconscious which may be too overwhelming for the standard Western psyche to bear. A major criticism of Jungian theory however, is that he and most other theorists at the time did not know any Asian languages and had to rely on a small number of often poorly translated texts that often misrepresented Buddhism itself.

Inspired by the influence of Jung and the cultural integrations outlined previously, psychoanalysis developed a softer stance towards the East. In 1957, Suzuki and Fromm convened a conference entitled 'Zen Buddhism and Psychoanalysis'. Fromm et al. (1960) later argued that psychoanalysis represented a solution to a 'Western spiritual crisis in the twentieth century'. Following from this, he argued, as treatment of psychological 'symptoms' improved, the goal of psychoanalysis would be to treat the 'suffering' of

self-alienation and existential crisis. Rubin (1996) has noted that there are similarities between Zen practices and later psychodynamic interventions, in particular refined attentiveness and increased ability to connect and relate to the client.

Buddhist theory also appears to have some, perhaps understated influence, on the development of other schools of psychotherapy, as well as being seen as a tool of reconciliation between these different theories. Brazier (2003) notes; "At the same time it (Buddhism) offers detailed analysis of the psychodynamics of conditioning, thus bridging...the division Western psychology has erected between...psychodynamic and...cognitive behavioural schools. (p. xiii).

Within the last twenty years especially, the influence of Buddhism has become more acknowledged, with several therapeutic models explicitly developed around Mindfulness. The following section provides a brief description of the main models. Again, this is for illustrative purposes and for a greater exploration of the historical development of Mindfulness see Dryden and Still (2006).

1.5 Main Models of Mindfulness

1.51 The 'Third Wave' of Cognitive Therapies

Within the last fifteen years, Mindfulness has been integrated into a number of therapeutic models, but perhaps none more systematically that what has been referred to

as the 'Third Wave' in CBT (Hayes, Strosahl and Wilson, 1999). Hayes (2004) summarised the third wave as:

"...the third wave of behavioural and cognitive therapy is particularly sensitive to the context and functions of psychological phenomena, not just their form, and thus tends to emphasize contextual and experiential change strategies in addition to more direct and didactic ones. These treatments tend to seek the construction of broad, flexible and effective repertoires over an eliminative approach to narrowly defined problems, and to emphasize the relevance of the issues they examine for clinicians as well as clients. The third wave reformulates and synthesizes previous generations of behavioural and cognitive therapy and carries them forward into questions, issues, and domains previously addressed primarily by other traditions," (p. 658).

To briefly place this in the wider historical context, the first development (or 'wave') was Behavioural Therapy (BT) in the 1940's, which premised therapeutic success on purely empirical behavioural changes (Skinner, 1953). The second wave was Cognitive Behavioural Therapy (CBT) during the late 1960's, which introduced the effect of thinking, or cognition, on emotions and behaviour (Beck, 1972). The third wave therapies, which also includes, Cognitive Behavioural Analysis System of Psychotherapy (CBASP), Functional Analytic Psychotherapy (FAP), and Integrative Behavioural Couple Therapy (IBCT), have come to greater prominence, particularly in the case of the mindfulness based therapies and have attracted a growing evidence base (Ost, 2008).

As will be explored later, the main theoretical difference between CBT and third wave CBT is related to control and emotional avoidance (Zettle and Hayes, 1987), in particular the suggestion that the process of trying to control thoughts or feeling results in greater distress. Third wave theorists suggest that traditional CBT practitioners need to concentrate as much on process of thinking as the content of thoughts themselves. This, it is suggested, is accomplished by reacting to thoughts in new, different, or more contextual (e.g. seeing the thought more as consequence of a particular environment and to responded to or endured as such), ways as opposed to a purely intellectual debate concerning the rationality of thoughts. Empirical support for the third wave has been suggested by anomalies in the literature that whilst finding positive outcomes for CBT, find a lack of support for the hypothesized mechanisms of change (Dobson and Khatri, 2000, Burns and Spangler, 2001). For example, studies of component analysis have generally failed to find support for the importance of direct cognitive change strategies (Gortner, Gollan, Dobson, and Jacobson, 1998, Morgenstern and Longabaugh, 2000).

The following section presents the main models in the third wave, in particular their use of Mindfulness. These are provided for information purposes and should not be considered comprehensive descriptions.

1.52 Mindfulness Based Stress Reduction (MBSR)

The first main model based on Mindfulness in the psychotherapy context, this is an eight-week programme designed by John Kabat-Zinn, described in detail in his influential text

'Full Catastrophe Living', (1990). Sessions last around two hours, are usually group based, and consist of guided Mindfulness practice; such as breathing, sitting and bare awareness (ie open to experiences and not judging it). It was developed originally for the treatment of chronic pain, but has also been applied to clients with anxiety problems, depression and significant problems with stress. The main aim of the intervention is to practice Mindfulness in order to develop moment-to-moment awareness. This enables the client to take control and to 'own' all psychical sensations and experiences of that moment. From this perceptive the client is encouraged to have a new relationship with whatever arises in that moment no matter how distressing or painful, "This is the essence of full catastrophe living" (Kabat-Zinn, 1990, p.11)

In describing how MBSR may help the client, Astin (1997) argues that the practices helps to bring awareness to the patterns of the mind, encouraging the development of the 'capacity to mindfully disengage' from distressing or anxious mood, and negative thoughts. Kabat-Zinn, Chapman and Salmon (1997) further suggest that MBSR teaches the client to how to learn to 'stay in touch' with the present moment, by not ruminating about the past or being overwhelmed with anxiety related to an ac uncertain future. Mackenzie, Carlson, Munoz and Speca (2007) in a study of client's perceptions of the benefits MBSR found the following themes, opening to change, self-control, shared experience, personal growth and spirituality.

In considering possible underlying process involved in MBSR two areas of intentional control have been postulated; Focused Attention (FA) and Open Monitoring (OM), (Lutz et al., 2008), FA describes the ability to maintain selective attention on a chosen object, e.g. being aware of a item from moment to moment (Kabat-Zinn, 1982). OM involves attentive, non-judgmental awareness of whatever is occurring in the present moment, without focusing on any particular object. OM in MBSR is related to the process of observation without response, distraction or judgment. Extending this further, Grant and Rainville (2009) have suggested that FA and OM may have different effects on sensory and emotional perception of pain.

MBSR has been the most researched model in Mindfulness, and a meta analysis of MBSR suggests that it can be of benefit to a broad range of clients with clinical and non-clinical problems (Grossman et al., 2004). In particular it has shown to be effective with chronic pain and health conditions (Saki, 1999, Ockene, Sorensen, Kabat-Zinn, Ockene, and Donnelly, 1988), including, multiple sclerosis (Mills and Allen, 2000), psoriasis (Kabat-Zinn et al., 1998) and fibromyalgia (Kaplan, Goldenberg, and Galvin-Nadeau, 1993). MBSR also has been shown to be effective with anxiety (Kabat-Zinn et al., 1992), eating disorder (Kristeller and Hellett, 1999), quality of life, (Reibel, Greenson, Brainard and Rosenzweig, 2001), carers of children with chronic illness (Minor et al., 2006) and medical students' practice (Ockene et al., 1990),

Research has also suggested that MBSR has long-term effectiveness (Carlson, Ursuliak, Goodey, Angen and Speca, 2001, Miller, Fletcher and Kabat-Zinn, 1995). Further details

can be found in reviews by Grossman, Niemann, Schmidt and Walach (2004) and Salmon et al. (2004).

1.53 Mindfulness based Cognitive Therapy (MBCT)

Influenced by MBSR and Cognitive Behaviour Therapy (CBT), Segal, Williams and Teasdale (2002) developed a group therapy that emphasises skills training through mediation practice. MBCT is usually consists of around eight to ten, two hour weekly group sessions teaching guided mediation based upon paying attention to the present moment without evaluating, judging or being emotionally involved in whatever arises. Assignments are given after each session which normal involve home practice of the techniques. Unlike standard cognitive therapies, MBCT does not require the client to challenge thought patterns but to observe and respond differently to them. MBCT involves accepting thoughts and feelings without judgment rather than trying to push them out of consciousness, with a goal of correcting cognitive distortions (Fulton, Germer and Siegel, 2005). Relaxation or happiness are not the aims of MBCT, but rather a "freedom from the tendency to get drawn into automatic reactions to thoughts, feelings, and events", (Segal, Teasdale and Williams, 2002, p.122).

Research has suggested the compatibility of CBT and Mindfulness (e.g. Hayes, Follette and Linehan, 2004, Hamilton, Kitzman and Guyotte, 2006, Huss and Baer, 2007, Lau, M. and McMain, 2005). There is also good empirical evidence that MBCT is effective in

reducing instances of relapsing depression (Ramel, Goldin, Carmona and McQuaid, 2004). A multi-centre RCT indicated that MBCT helped clients who had suffered the most number of previous episodes of depression. It had no effect on those who had only two episodes in the past, however it substantially reduced the risk of relapse in those who had three or more previous episodes of depression (from 66 per cent to 37 per cent), sometimes for twenty years or more. Participants reported being able to develop a different ('decentred') relationship to their experience, so that their depression-inducing thoughts could be viewed from a wider perspective as they were occurring (Teasdale et al., 2000a and Williams et al. 2000). The findings were replicated by Teasdale et al., 2000b.

As a consequence of the research, the UK National Institute of Clinical Excellence (NICE) Guideline for the treatment of depression (2005), has recommend MBCT as a treatment of choice for long term a resistant depression on the basis of research that indicates it helps to considerably reduce the chances of depression returning.

MBCT has also found to be effective for reducing the symptoms of chronic fatigue syndrome (Surawy et al., 2004), treatment-resistant depression, (Kenny and Williams, 2007; Eisendrath, et al., 2008), reducing anxiety and distress in suicidal patients with a history of Bipolar Disorder (Williams et al., 2008) and Generalised Anxiety Disorder (Evans et al., 2008). MCBT has also begun to establish a cross-cultural research base (Lee et al., 2007).

Unlike other psychotherapeutic models of Mindfulness, MBCT has placed as much emphasis on investigating possible mechanisms of change as outcomes of the intervention. This has led to an accumulation of research examining the Differential Activation Hypothesis (DAH) suggested by the originators of MBCT, Teasdale, Moore, Hayhurst, Pope, Williams, and Segal, (2002). This is explored in greater detail in section 1.81.

1.54 Dialectical Behaviour Therapy (DBT)

Created by Linehan (1993), DBT is a biosocial theory of personality functioning in which borderline personality disorder is seen as a biological disorder of emotional regulation. It includes Cognitive Behavioural Therapy, Mindfulness, and Dialectical theory and emphasises the interrelated nature of human functioning and reality. It also looks for a synthesis to replace rigid and dichotomous ways of responding by the individual in order to help encourage change. DBT asserts that an individual has borderline personality disorder as a consequence of growing up in an 'Invalidating Environment', or a particular set of harmful and contradictory biological and social circumstances. Linehan (1993) describes such an individual as 'emotionally vulnerable' whose autonomic nervous system becomes conditioned to react excessively to relatively low levels of stress, and takes longer than normal to return to baseline once the stress is removed. This results in a difficulty in moderating emotion. Principle therapeutic strategies in DBT are 'validation' and 'problem solving'. Change is presented in the dialectical context of interventions that

validate the client's behaviour and emotion as understandable consequences of their invalidating environment, balanced with learning effective ways to respond to challenges.

There are four primary modes of treatment in DBT :

1. Individual therapy
2. Group skills training
3. Telephone contact
4. Therapist consultation

DBT is a highly structured intervention and is designed around four stages, with each stage consisting of a number of goals. Progress is linear and the client must be in control of each behavioural stage identified before proceeding to the next stage (Linehan, 1993, Palmer, 2002). A brief description of each stage is presented below;

Pre-treatment	*assessment, commitment and orientation to therapy*
Stage 1	*suicidal behaviours, therapy interfering behaviours, behaviours that interfere with the quality of life, developing the necessary skills to resolve these problems*
Stage 2	*post-traumatic stress related problems*
Stage 3	*self-esteem and individually determined goals.*

Individual intervention in DBT is also very structured with clients and therapists negotiating a series of agenda items each session (e.g. decreasing suicidal behaviour, challenging therapy interfering behaviours, decreasing behaviours that interfere with quality of life) before client's individual issues can be addressed.

Mindfulness in DBT has been suggested as an important ingredient in the process of change (e.g. Lynch and Bronner, 2006, Dimidjian, and Linehan, 2003). It is seen as a core skill, along with interpersonal effectivenesss, emotional regulation and distress tolerance, and is taught as the first component in the weekly skills group. Therapists also encourage mindfulness during the individual sessions (Linehan, 2002) and model an attitude of acceptance towards the clients and life events (McKay, Wood, and Brantley, 2007).

Based on the Zen Buddhist concept of radical acceptance, Mindfulness is understood as another way to validate the essential 'wisdom' of the client, DBT presents Mindfulness as the interaction of three 'mind states' ie, wise mind, logical mind, and emotional mind (Linehan, 1993). Emotional mind describes decisions that are made when acting from a purely emotional state, also called 'hot' state of being. Logical mind is the state whereby the individual responds from rational and concrete activities, and referred as a 'cool' state. Wise mind is the balanced response between the other two states, bringing awareness of feelings and thoughts providing the opportunity to respond to events in a way that is genuine and least harmful to the self.

Mindfulness skills are taught through skills of 'what' and 'how' (Linehan, 1993). The first 'what' skill, *observation*, teaches the client to notice thoughts, feelings, events, and

behaviours without response with the purpose of finding out more about what is happening. *Describing* the experience promotes the understanding that feelings and thoughts are not facts, and allows the possibility for a more involved relationship with the event and self-control. *Participate* without self-consciousness, the final 'what' skill, teaches clients to be fully present in each the moment of their lives.

The first 'how' skill is *non-judgment* or seeing something as neither good nor bad but to look to the consequences of events. The second skill of *one-mindfully* is a method of practice to control attention to one activity without being distracted by an anxiety or thought. *Doing what works*, is the final "how" skill and describes the ability to complete the directives of a particular goal without being distracted by what seems to right or fair.

An advantage of the clear structure of DBT is that it is amenable to empirical investigation (Lynch, Rosenthal and. Smoski, 2008). In a comprehensive evaluation of the possible mechanisms of change in DBT, Lynch et al. (2006) identified the central process of reducing the tendency for ineffective action associated with dysregulated emotions. They further identified the key DBT structural interventions of mindfulness, which are validation, targeting, chain analysis, and dialectics, and concluded that change was related to helping the patient to engage in functional, life-enhancing behaviour, even when intense emotions are present.

In addition to borderline personality disorder, DBT has been found to be effective with parasuicidal clients (Linehan and Heard, 1991), substance abuse (Linehan et al., 1999, Linehan, 2002), depression in older adults (Lynch, Morse, Mendelson and Robins, 2003) and eating disorders (Wiser, and Telch, 1999, Safer, Telch, and Agras, 2001, Telch,

Agras, and Linehan, 2001). It has also received a number of RCT's and longitudinal studies demonstrating effective outcomes (Clarkin, Levy, Lenzenweger, and Kernberg, 2004, Van den Bosch, 2005, Soler et al., 2005, Verheul et al., 2003, Bohus et al., 2003 Scheel, 2000).

1.55 Acceptance and Commitment Therapy (ACT)

Hayes, Stroshal, and Wilson (2003) proposed ACT as a therapy designed to relieve human suffering by encouraging clients to live a "vital and valued life" (Freeman et al., 2006, p.1). It differs from Cognitive Behavioural Therapy (CBT) as it encourages individuals to notice, accept and embrace their distressing thoughts or memories as opposed to changing them. ACT encourages the individual to access what is termed 'the self as context', or the observing part of the self that is unencumbered by thoughts feelings or judgments. Through this process ACT aims to increase awareness of personal needs, and develop psychological flexibility and vitality to client's lives (Hayes and Wilson, 1994).

Psychological distress is formulated as the result of experiential avoidance, which gives rise to cognitive entanglement that results in a state of fragility in which the individual feels incapable of making behavioural changes (Hayes, 2002). This is commonly represented in the ACT literature (Hayes and Smith, 2005) by two acronyms, FEAR and the alternative ACT:

Fusion with thoughts

Evaluation of experience

Avoidance of experience

Reason providing for behaviour

Accept reaction

Choose a valued direction

Take action

Based on Relational Frame Theory (RFT), ACT highlights the role of language in the development and maintenance of psychological distress by encouraging clients to be in conflict with their inner experiences. Clients are helped to recontexulaise their, thoughts, feelings, physical sensations, memories, though acceptance of these events without judgment. ACT further requires that these experiences are fully explored to provide greater detail about the individual's personal values, and then the client chooses to commit to the corresponding behavioural change based on these insights. The main techniques of ACT include metaphors (which to illustrate qualities of acceptance), use of paradoxes, experiential exercises, Mindfulness and other forms of meditation. Mindfulness is described as helping the individual become aware of the restrictive impact of language, but is seen as one of many different ways of establishing change (Hayes and

Wilson, 1994). However ACT defines Mindfulness specifically in terms of three of it's six core principles categories (Harris, 2008);

- **Defusion**, or the ability to 'let go of' and establish personal distance from distressing thoughts, feelings or events.
- **Acceptance**, incorporating difficult experiences within oneself and allowing them to exist without resistance or judgement, seeing 'suffering' as a normal process of existence
- **Contact**, being fully involved in the present moment with curiosity, interest and receptiveness.

It is suggested that these are component parts of an individual's psyche, which is ineffable, but referred to in ACT as the 'observing self' (Harris, 2008).

ACT has begun to accumulate both a theoretical and outcome research base, (e.g. Strosahl, Hayes, Bergan, Romano, 1998). Hayes, Luoma, Bond, Masuda and Lillis (2006) reviewed more than thirty randomised control trials, although the vast majority of these were small numbers and compared to controls on waiting lists. A study comparing ACT to CBT (Lappalainen et al., 2007) found a good effect size but the results were limited by the small cohort who were psychology trainees, and therefore demand characteristics and allegiance effects could not be controlled. Research into ACT has been applied to the a wide range of therapeutic activities including, survivors of sexual abuse (Wilson et al., 1996), difficulties with mood (Hayes, 2006), psychosis (Gaudiano

and Herbert, 2006), OCD and phobia (Twohis, Hayes and Masuda, 2006), couples therapy (Jacobson and Christensen, 1996) and social work interventions (Dewane, 2008).

1.56 Other Specific Models of Mindfulness

Several specific models have also been developed, but as they attracted little attention in the literature they are included here for informative purposes. They include Mindfulness-Based-Emotional Intelligence Training (MBEIT), Cognitive Emotional Behaviour Training (MBET), Mindfulness-Based Cognitive Therapy for Children (MBCT-C), Mindfulness-Based Art Therapy (MBAT), Mindfulness-Based Reality Therapy (MBRT), Mindfulness-Based Eating Awareness Therapy (MB-EAT) and Mindfulness-Based Relationship Enactment Therapy (MBRET).

Mindfulness has also been integrated into the Positive Psychology movement (Seligman, 1997, Seligman and Csikszentmihalyi, 2000, Seligman, 2002).

1.6 Clinical Applications of Mindfulness

The following section presents examples from the research literature indicating clinical areas in which mindfulness has been applied. This is provided to give an indication of its relevance to psychotherapeutic intervention.

One of the largest areas of research is health and physiology; this may be due in part to the development of Mindfulness-Based Stress Reduction (MBSR). This includes different forms of cancer (Brown and Ryan, 2003, Smith et al., 2005, Smith, Richardson, Hoffman and Pilkington, 2005, Monti et al., 2006), management of diabetes (Gregg at al., 2007), chronic fatigue (Surawy, Roberts and Silver, 2005) and traumatic brain injury (Bedard et al., 2005). Mindfulness has also been associated with lasting reduction in distressing symptoms in clients with chronic physical and psychological pain, increased quality of life and well being (Majumdar et al., 2002), and chronic pain and heart disease (Shigaki, Glass and Schopp, 2006). However the research in the above areas has not been extensively replicated and there has been a lack of longitudinal studies.

Positive physiological changes related to Mindfulness include slow alpha and fast theta EEG power in the frontal areas of the brain which is associated with serotonergic activity (Takahashi, et al. 2005), resting prefrontal alpha-asymmetry on EEG in clients with suicidal thoughts, which suggests balanced affect related brain functioning (Barnhofer et al., 2007). Mindfulness mediation has also been associated with shifts in cardiac sympathovagal balance, reduced sympathetic tone and increases in white vagal tone (Telles, Mohapatra-Raja and Naveen, 2005), and positive changes in hypothalamic pituitary adrenal axis functioning (HPA) in clients (Carlson, Speca, Patel and Goody, 2004). Relative to other forms of relaxation, Mindfulness body scan meditation was associated with decrease in cardiac pre-ejection period and decrease in diastolic blood pressure (Ditto, Eclache and Goldman, 2006). The consistent findings in physiological

and neurological changes as a result of Mindfulness has led to suggestions of greater collaboration between scientific medicine and Mindfulness based psychotherapy (Ryback, 2006).

Applications of Mindfulness to specific psychological difficulties include;

a) Trauma based intervention (Berceli and Napoli, 2006) b) Post Traumatic Stress (Batten, Orsillo and Walser, 2005), c) Anxiety (Vujanovic et al., 2007), d) Social phobia (Bogels, Sijbers and Voncken, 2006) e) Eating disorders (Baer, Fischer and Huss, 2005), f) Body image (Stewart, 2004), g) OCD, (Fairfax, 2008), h) Borderline personality disorder (McQuillian et al., 2005), i) Preventing suicidal behaviour (Williams et al., 2006), j) Psychosis (Chadwick, Taylor and Abba, 2005), k) Aggressive behaviour in severely mentally ill clients (Singh et al., 2007). All highlight the usefulness of Mindfulness with these clinical populations. Again, more longitudinal and replication studies are needed for each clinical presentation.

Mindfulness has also been associated with increases in positive mood states (Jain et al., 2007), reducing negative and dysthmic moods (Broderick, 2005), and psychological mindedness, which facilitates empathy, self consciousness and awareness of self and other (Beitel et al., 2005). Mindfulness based attention predicted ahedonic depressive symptoms and negative predictions of health (Zvolensky et al., 2006). Jain et al. (2007) found that Mindfulness may be unique in being able to reduce distractive thoughts, rumination and behaviour and associated distress.

It has also been integrated into treatment across life stage development including; anxious children (Semple, Reid and Miller, 2005), caregivers of children with chronic illness (Minor et al., 2006) and older adults (Smith, 2004, Lynch and Bronner, 2006, Smith et al., 2007). Mindfulness has been applied to martial and relationship therapies, (Carson, Carson, Gil and Baucom, 2004, Burpee and Langer, 2005) and has associated with greater sexual response and higher sexual satisfaction (Brotto and Heinman, 2007).

Mindfulness has been used to help addictions (Hoppes, 2006). For example, the use of Mindfulness was related to decreased use of substance and alcohol misuse and increased positive social behaviour in prisoners (Bowen et al., 2006). However, the study by Alterman et al., 2004 also examining the use of Mindfulness in addictions found no significant improvements.

Specific assessment tools for Mindfulness have been developed; Frieburg Mindfulness Inventory (FMI) (Bucheld and Walach, 2006), Toronto Mindfulness Scale (Lau et al., 2006), Kentucky Inventory of Mindfulness Skills (Baer 2006), Langer Mindfulness Scale (Langer, 1997), and the Mindful Attention Awareness Scale (MAAS) (Brown and Ryan, 2003). However none of these have been used routinely.

1.7 Summary of Clinical Applications and Research

With regards to the research in general, despite positive findings, there are some significant concerns. By far the biggest criticism has concerned the differing

methodologies and lack of methodological rigour (e.g. Grossman et al., 2004, Smith, Richardson, Hoffman and Pilkington, 2005, Shigaki, Glass and Schopp, 2006), and good quality empirical research (Grossman, Niemann, Schmidt and Walach, 2004, Allen, Blashki and Gullone, 2006). Despite the wide range of studies suggesting the positive effects, these are usually single examples and due to issues of consistency, Bishop (2002) concluded, "The available evidence does not support a strong endorsement of this approach at present", (p. 71). These findings have further implicated an underlying difficulty that there is no clear operational construct when discussing Mindfulness, and have strongly suggested the need for qualitative research (Proulx, 2003).

1.8 Underlying Psychological Mechanisms of Mindfulness

The above sections have detailed substantial empirical investigations into the outcomes and applications of Mindfulness. However, as alluded to particularly in Section 1.7, there has also been a significant literature examining the possible underlying mechanisms that may explain the effectiveness of the practice. The main theories will be briefly explored below.

1.81 Differential Activation Hypothesis (DAH)

This was proposed by Teasdale, Moore, Hayhurst, Pope, Williams, and Segal, (2002) to explain the contribution of Mindfulness to MBCT and further supported by Sheppard and

Teasdale (1996) and Lau, Segal, and Williams (2004). They suggested a three-stage 'spiral' in depression beginning with transient negative moods (TNM) that promoted negative thought patterns, which in turn led to full diagnostic depressive episodes. The DAH suggests that through Mindfulness, clients learn to become aware and identify TNM thereby providing the opportunity to interrupt the process and respond differently. Teasdale et al. (2002) have described these components of Mindfulness as *defusing* and *decentring* to prevent the spiral and alter the course of potential relapse. This involves promoting awareness of thought processes and disengagement from ruminating by understanding thoughts as events to which the individual does not have to identify him/herself with. Therefore the target of the DAH is not the content of the thoughts, but the relationship of the individual to the process of thinking. Mindfulness shifts the metacognitions from personal negative self-evaluating, to seeing thoughts as impersonal from a decentered perspective.

Hayes, Strosahl, and Wilson's (1999) and Hayes et al. (2004) describe a similar process of cognitive defusion in ACT, in which the emphasis is on changing one's relationship to thought rather than attempting to alter the content of thought itself.

1.82 Intention, Attention and Attitude (IAA)

The IAA was suggested by Shapiro, Carlson, Astin and Freedman, (2006) to address perceived limitations of the DAH, particularly to provide an account of whether and how mindfulness affects change and transformation.

Based on Kabat-Zinn (1994) definition of mindfulness as 'paying attention in a particular way: on purpose, in the present moment, and non-judgmentally' (p.4). Shapiro, Carlson, Astin and Freedman (2005) suggested three axioms of mindfulness; *intention* (I), *attention* (A), *attitude* (A). However these axioms are not distinct and separate, but rather intertwined components of a single, simultaneous cyclical process identified as Mindfulness.

Intention is at the heart of mindfulness meditation embodying qualities of self-exploration and self-regulation for both the patient and the therapist. Without intention, mindfulness could become aimless. Attention describes moment-to-moment observation of the individual's experience. Attention is common to most therapeutic practices. Shapiro, Carlson, Astin and Freedman (2005) defined attitude as the qualities the individual brings to mindfulness meditation. They further describe attitude as a compassionate, warm and 'openhearted activity' as opposed to a rational clinical exercise. These 'heart qualities' are identified as crucial components of attitude as without it judgment, striving, attachment and non-acceptance may define the practice. Such an approach may well have consequences contrary to the intentions of the practice.

1.83 Repercieving in IAA

Shapiro et al. (2005) suggested that IAA leads to a significant shift in perspective termed 'repercieving'. This quality of repercieving first describes the individual's ability to consider themselves as not identified (decentred or detached) with the contents of

consciousness and then to actively stand back and witness the unfolding nature of their existence. Although a similar position to other therapeutic models, this fundamental shift, or reperception they argue, can only be guaranteed through the application of the IAA. As Goleman suggests, "The first realization in 'meditation' is that the phenomena contemplated are distinct from the mind contemplating them" (1980, p. 146).

They are careful to underline the fact that research into mindfulness is 'still in its infancy and requires great sensitivity and a range of theoretical and methodological' approaches 'to illuminate the richness and complexity of this phenomenon' (p. 376).

Repercieving is not the same as disconnection but allows a deeper experience without clinging or attachment as, Kabat-Zinn (2003) describes, "a deep, penetrative nonconceptual seeing into the nature of mind and world" (p. 46). This is the experience of what is as opposed to a description of, or story about what it is. Repercieving is not indifference, but "allows one to experience greater richness, texture, and depth, moment by moment" (Shapirio et al., 2006, p. 342), or a quality of 'intimate detachment'.

It is also described as developmental process in which what was previously 'subject' becomes 'object', identified as key to development and growth across the lifespan in the increasing capacity for objectivity about the individual's internal experience (Kegan, 1982). Hayes et al. (1999) describe a similar process in ACT as a shift from 'self as content' (the awareness of being in observation) to 'self as context' (agent of observation).

Shapiro et al. (2006) further suggest that Repercieving may lead to four further mechanisms that in turn contribute to the positive outcomes produced by mindfulness practice. These are:

1. Self-regulation and self-management behavior (Brown & Ryan, 2003)
2. Emotional, cognitive and behavioral flexibility, (Brown & Ryan, 2003; Ryan and Deci, 2000)
3. Values clarification (Borkovec 2002)
4. Exposure (Barlow and Craske, 2000)

A detailed description of these is outside the remit of the current investigation however it is important to note that Shapiro et al. (2006) maintain that these further mechanisms are contingent on the IAA. They further acknowledge that these are largely untested concepts without significant support from research although examples from the literature are provided for the reader's interest.

1.83 Summary of Underlying Psychological Mechanisms of Mindfulness

Although providing a detailed theory of the possible mechanism of Mindfulness, Shapiro et al. (2005) acknowledges that the IAA together with the DAH, are still largely conceptual. There is a limited but growing evidence base, although the proponents of particular theories and their contributors undertake much of this research. As Shapiro et al. (2005) describe, "The investigation of mindfulness is still in its infancy and requires

great sensitivity and a range of theoretical and methodological glasses to illuminate the richness and complexity of this phenomenon" (Shapiro et al., 2005, p. 384). A further difficulty with these approaches is that they rely on isolating and testing specific variables within the therapeutic encounter. As has been previously suggested in process research, the complexities in the context of such a relationship often precludes accurate quantitative scientific enquiry (Scott-Gordon, 2000, McLeod, 1990, Greenburg, 1986, Orlinsky and Howard, 1986).

There have also been criticisms of the cognitive mechanisms involved in the process of anxiety. Wells (1999), for example, proposed the Self-Regulatory Executive Function Model (S-REF) which suggested that the internal self directed use of attention suggested by DAH increases negative appraisals related to self-focused attention, threat monitoring, ruminative processing, and activation of dysfunctional beliefs. Wells (1990) described these four processes as 'dysfunctional metacognitions' and there has been some empirical research suggesting an association with psychosis, generalized anxiety disorder, obsessive-compulsive symptoms, hypochondrias, and PTSD (Myers & Wells, 2005). In opposition to the cognitive theories of Mindfulness therefore, models such as the S-REF suggests strategies of external attentional monitoring.

Further criticism has extended this, centering on the validity of the whole process of attempting to isolate and investigate mechanism of Mindfulness. Grossman (2005) for example has argued that; "Embracing a more circumscribed conception of mindfulness that easily fits, as just one more technique, into the armamentarium of behavioral and

psychotherapeutic interventions neither does justice to the original idea nor represents the scientific investigations and literature on mindfulness interventions to this point", (p.2).

In summary it appears that despite strong theoretical and empirical research, it is not currently possible to definitively isolate a particular process to explain the effect of Mindfulness. However, as the most widely researched concepts, DAH, IAA and Repercieving offer both valuable insights and important exploratory structure in examining the therapeutic process of Mindfulness.

1.9 Aims of Research

In terms of volume of research, it is reasonable to state that Mindfulness has had a significant impact on Western psychotherapeutic interventions. It has been applied to a multitude of psychological difficulties and contexts, and been incorporated into a number of specific treatment models. However, despite this popularity, it is not clear exactly what it is, or how one knows when one is Mindful. The tradition from which it comes, Buddhism, is based on phenomenological experienced 'truths', arrived at through experiential practices. As suggested above, the current empirical research can tell us something about the outcome of Mindfulness, but is less certain about the process behind it. The need for qualitative research to explore this in greater detail has previously been acknowledged. We are not really sure what to expect from being Mindful, how it would

be used clinically, whether it is a just technique or can only be part of a broader philosophical intervention, or how it contributes to the therapeutic process.

It is gaps such as these, that this research hopes to explore, based on how Mindfulness is experienced by the therapists who use it in their everyday practice. It is hoped to be able to describe something of their lived experience as Mindfulness practitioners and therapists. I am also interested in the participant's descriptions of their therapeutic process, how Mindfulness feels and is experienced, how Mindfulness has influenced them as a therapist working with clients, and what they have to say about the value of Mindfulness as a therapeutic intervention. In general, most therapeutic practitioners have undertaken an extensive period of training in one or several therapeutic interventions, and specific models, such as Cognitive Analytical Therapy (CAT), insist that clinicians experience the approach themselves as part of the training. This is because it assists with the learning process and develops experiential familiarity with the model. I am also interested therefore, in whether such considerations are relevant to the participant's experience of training in Mindfulness. This research is interested in the experience of Mindfulness by the therapists, and therefore primarily designed to explore these interpersonal therapeutic process issues as opposed to support particular outcomes or hypothesised mechanisms of how Mindfulness may work.

CHAPTER 2: METHODOLOGY

2.1 Research Questions

The purpose of this research was to explore Western clinician's experience of Mindfulness within the therapeutic process. Participant's accounts could help to increase understanding of the experience and impact of Mindfulness on clinical practice as well as commenting on its meaningfulness that may make it feel more assessable to the wider clinical community.

In order to address these research questions the following methodology was chosen:

a. Qualitative methods; where the aim of the research was to explore therapist's experience, and therefore methodology that captures experiential data was seen as most appropriate.

b. Exploratory methodology; the research was deigned to describe and present therapists experience and not to test a specific hypothesis.

c. Cross sectional; the data was gathered through single extensive interviews with each participant. This further included retrospective data as I also asked about the origin and development of their interest in Mindfulness.

In presenting this research I acknowledge that my interpretation is inevitability informed by my personal experience, perceptions, therapeutic training and clinical experience. I acknowledge also that the participants are all practicing therapists working within the NHS and to some extent their experience will be informed by the context of their working environment and individual therapeutic trainings. However, in order to maintain an open minded approach I kept a Reflexive Journal. This enabled me to note and reflect on how my perceptions and experiences could be influencing the research. It also provided the opportunity to explore and develop thoughts as they arose during the process. I also found the use of supervision to be of enormous help throughout the research. An example of the reflective journal can be found in Appendix A.

2.2 Method

The research explored the personal meanings of the participants reflecting upon their experience as opposed to testing a set of hypothesis, and therefore a qualitative methodology was selected to gather and analysis the data (Smith, 1996). As the research was experientially based, data collection needed to be flexible and opened ended to allow participant's generated meanings and experience to emerge as freely as possible (Willig, 2001). A semi-structured interview was used and is discussed in section 2.6 below.

Methods of analysis considered were Grounded Theory, Discursive Psychology and Interpretative Phenomenological Analysis (IPA). Grounded Theory did not seem appropriate as it can argued that it is more relevant to social processes and is descriptive rather than explanatory (Willig, 2001). Discursive Methods, through their emphasis on language and its relationship to social construction can be criticised as being too subjectively interpretive. The method for the analysis of data chosen was Interpretative Phenomenological Analysis (IPA), (Smith, Jarman, and Osborn, 1999). IPA is a method of exploring the participant's thoughts, feelings, beliefs and experience of the given phenomena being investigated, allowing the researcher to gain an 'insiders perspective' into the subject. Furthermore, IPA acknowledges that the researcher's interpretations of the participant's accounts will inevitably be influenced by both the researcher's perspective and background as well as by the interaction between researcher and participant. This is acknowledged in IPA as a necessary part of the sense making process in exploring another person's experience (Willig, 2001). Therefore IPA is a valid and appropriate methodology to investigate Western therapist's perspective of the use of Mindfulness in the therapeutic process.

2.3 Theoretical Underpinnings of the Method

This research is influenced by Phenomenological theory (Moustakas, 1994, Giorgi, 1995) and symbolic internationalism (Denzin, 1995). Phenomenological psychological research methods place the emphasis on the individual's perspective, description and experience of an event, through an inductive process, and it this in which the researcher engages.

This is in contrast to the positivist tradition in which there is an attempt to develop an objective evaluation of phenomena through the testing of hypothesis (Smith, 1995). Symbolic interactionism maintains that an individual's motives and understanding of their actions organises their interpersonal and interactional experiences. It is these meanings that are of principle importance and can only occur as a consequence of social interactions (Smith, 1995).

2.4 Data Collection Method

An interview schedule was developed to elicit the areas of interest previously outlined. This was constructed through the process of discussions with my supervisor to broadly cover participant's early interest in Mindfulness, their understanding of what Mindfulness is, its impact of the therapeutic process and their clinical practice, and their view of client response. These were chosen on the basis of the research question, the therapist perspectives of mindfulness in western therapeutic encounters, and therefore aimed to elicit free expression of data related to this subject. Therefore it was important that their interest in Mindfulness and their application and experience of it therapeutically was captured.

In keeping with Smith, Jarman and Osborn (1999) description of IPA data collection, the interview schedule was flexible in design and not structured. A copy of the interview schedule can be found in Appendix B. The interview schedule was used as a guide to the areas of research interest but used flexibly to facilitate the participant's full account of

their experiences. Following the IPA methodology process, the interview schedule was designed to include 'prompts' as opposed to 'questions'.

A dilemma encountered in constructing the interview schedule was acknowledging the context of the research question, specifically relating to the title (western therapeutic encounters), and how this may bias the participant's responses. This aspect of culture therefore, was an important characteristic of both the research question and the sample, and needed to be acknowledged, but I was cautious of not wanting to influence their responses when mentioning culture. Furthermore it was important also to allow each participant to interpret their phenomenological understanding of culture from their own experiences. One of my prompts was to be curious about their interpretation of all aspects of the research question, which acknowledged the issues of culture.

Permission for the study to take place was granted by the local NHS ethics committee, following the completion of an ethics form and the scrutiny of the research proposal by the ethics board (Appendix C).

2.5 Recruitment Procedure

Subsequent to ethical approval, letters were sent to Psychology and Psychotherapy departments, Community Mental Health Teams and local universities throughout the region, to recruit participants. Participants selected were practicing therapists, from any

professional discipline that worked in adult mental health settings and who used Mindfulness in their therapeutic practice. The letters stated the aims of the research, a description of the methodology and use of the research.

This form of purposive sampling, e.g. the principle of selections "is the researchers judgement as to the typology of interest" (Robson, 1993, p.141) was carried out, as the purpose of the study was not to generalise the findings to all therapists who use Mindfulness therapeutically but to enable the in-depth exploration of this selected group of therapists.

2.6 Procedure

Therapists who practiced Mindfulness within the county were identified and invited to participate by letter (Appendix D). They were also sent an information sheet (Appendix E) that explained the purpose of the research, why it was being conducted, its application and the methodology. Participant involvement, the transcription of a taped interview, was described. The information sheet further detailed the ethical considerations identifying confidentiality, participant's right to withdraw at any time in the research process, and also time limit to respond to the request. The author's contact details were provided and participants were invited to confirm their involvement either by sending back a reply slip or through electronic mail. Telephone and email details were also provided should participants have further questions concerning the research.

Before beginning the research interview all participants completed a consent form (Appendix F) that confirmed that they were aware of details contained on the information sheet and their right to withdraw. Participants were interviewed individually at a time and location of their convenience. This included the Psychology Department, a Research and Development Department interview suite attached to a Hospital, and a Community Mental Health Team. Interviews lasted between one and one and a half hours and were audio taped. Questions during the interview were open ended designed to elicit individual accounts and meaning. In general, questioning developed within a process of electing and probing (Flowers et al., 1997).

Time restraints of the research meant that it was not possible to transcribe and analyse each interview sequentially. However brief notes were kept following each interview to maintain active awareness of the developing themes and ideas. These notes and ideas were also addressed in the research supervision process. In terms of this process the first two interviews were conducted within a day of each of other, there was more than a month gap between the second and third interviews with the fourth occurring within a week of the third. The final interview occurred within a month. During the initial gap the first scripts (Steve and Duncan) were transcribed and analysis began sequentially (starting with Steve). Given time constraints related to organising the interviews, the latter interviews were transcribed after initial analysis of the first scripts occurred. All scripts however were transcribed within three months of the first interview. This is consistent with the methodological realities described by the IPA process (Smith, Jarman and Osborn, 1999, Smith, 1995).

Following each interview, time was set aside for de-briefing, allowing the participants to discuss the experience and any other matters relating to the interview. All the participants requested debriefing, which lasted between twenty to thirty minutes. The de-briefing process was not audio taped. Participants were also given the option of a follow up meeting should there be further issues or comments that they wanted to raise. None of the participants requested a further meeting.

2.7 Participants

Eight invitations were sent and six participants responded. One participant was unable to continue for personal reasons, and two participants did not respond to the invitation letter. Therefore five agreed to participate. Research evidence indicates that IPA can be conducted on a single participant (Eatough and Smith, 2006). The number of participants in this research was discussed further with both of my supervisors and formed a part of a wider debate at an annual research presentation held at City University, London. Therefore it was concluded that this was an adequate number by my supervisors and was consistent with research guidelines (Turpin et al., 1997). In accordance with ethical guidelines, participants were self-selected and fully aware that their participation was voluntary and they could withdraw at any point in the process. Those who did not respond were not followed up.

2.8 Qualitative Analysis

Interpretive Phenomenological Analysis (IPA) acknowledges the integral nature of the researcher's own process in interpretation and understanding participant's individual accounts. In this context the analysis is influenced by my training as a Counselling Psychologist and inevitably my interpretations will be influenced by this perspective. I also received some exposure to Mindfulness through specific training in Dialectical Behaviour Therapy (DBT), and have attended brief courses on Mindfulness and spirituality. During the course of the research I have been developing my own practice by attending a weekly one hour Mindfulness session with two other individuals. Counselling Psychology encourages the holding in mind of different psychological and psychotherapeutic theories when attempting to understand a given phenomena or client experience. The central ethos of Counselling Psychology is phenomenological (Woolfe, Dryden and Strawbridge, 2003) and therefore the importance of understanding an individual's experienced reality in their current context is central to the discipline. Theories of particular interest are Existential theory in psychotherapy (Spinelli, 1996), process research (Kahn, 1997), Spirituality and Transpersonal theory (Wilber, 2000). These theories therefore may have had an impact on my interaction with participants during the interviews and my interpretation of the data.

Analysis was conducted in accordance with guidelines suggested by Smith, Jarman, and Osborn (1999). Each transcript was read and number of times to become familiar with the

individual account. Following this, notes were made in the margin to capture emerging thoughts, comments, early interpretations and codes (for an example see Appendix G).

Consistent with the idiographic ethos of IPA (Smith, 2004) a detailed analysis of the fist script was conducted before moving on to the new interview. Following this, emerging themes were listed and analysed in detail to identify connections and establish master themes. At each stage the transcripts were continuously checked to make sure that the connections identified still closely related to the participant's account. The codes for each transcript were then compared and contrasted with each other and connections between them recorded, sorted and further refined into larger categories and finally main superordinate themes were identified. Parts of this process were carried out independently by the author and also in supervision, and findings compared for similarity.

To maintain open minded approach to theoretical models, an extensive literature research was carried out following the analysis (Robson, 1993, Smith, 1995, Willig, 2001) to expand on the literature already referred to in the introduction. This is consistent with the interrogative process in IPA (Smith, 2004). A data base search (PsycINFO, Medline, AMED and Cochrane Library) was also conducted using a combination of themes and key words such as 'Mindfulness', 'therapeutic process', 'core conditions', 'Eastern beliefs' and 'psychotherapy and mediation' and 'culture and psychotherapy'. This produced an extensive amount of literature and another sorting process based on the research question and the integration of the results, together with the current literature

and theoretical ideas was carried out. Following this I returned again to the original transcripts to check for further sub themes in light of the expanded literature search.

2.81 Inter Rater Reliability

To check validity and reliability, triangulation was used by taking segments from the transcriptions that were independently analysed by the author and research supervisor (Dr Ann Colborn). The research supervisor was given section from two different interviews and asked to analyses each script in terms of the IPA models. The researcher analysed corresponding sections and both recorded emerging themes and ideas. These were then compared to ensure that sufficient similarity of concepts was occurring. Overall there was a good level of inter-rater agreement (roughly approximated to above 80%). This process provided the opportunity to discuss areas of disagreement and differences within supervision. Initial validity was further added by asking a trainee Clinical Psychologist also undertaking her own IPA research to analyse the same extracts of a transcript. Her analysis was then compared to the previous data and found a similar approximated level of convergence.

At the end of the analysis themes were subjected to a further test of reliability. A Clinical Psychologist with postgraduate experience in qualitative methodology agreed to independently analyse the themes suggested by the researcher. The independent rater was known to the researcher but did not work in the same clinical area or locality and was not associated with the research in any way. They

had an awareness of Mindfulness in psychology but did not have a personal practice and did not use it therapeutically. The independent rater was given 62 quotes randomly selected from all of the interviews. This number was selected as it was felt by the researcher and supervisors to be valid representation of the data set. Themes were placed in front of the independent rater and they were given the quotes in a random order, which had been written on cards and asked to ascribe quotes to themes they thought appropriate. Following this process the data was recorded and compared with the researcher's allocation. Cohen's Kappa was used to calculate the level of agreement between observers (Cohen, 1960). This test was chosen as it is a valid and widely used test of inter rater reliability providing an indication of agreement between raters (perfect agreement described as 1.0). There has been some debate concerning the interpretation of Kappa (Landis and Koch, 1977, Byrt, Bishop and Carlin, 1993, Lantz and Nebenzahl, 1996). However the following well supported formula (Altman, 1991, Sim and Wright, 2005) was used:

- ***Poor agreement*** Less than 0.20
- ***Fair agreement*** 0.20 to 0.40
- ***Moderate agreement*** 0.40 to 0.60
- ***Good agreement*** 0.60 to 0.80
- ***Very good agreement*** 0.80 to 1.00

The results are presented by Table 1 below

Table 1: Inter-rater Reliability Using Cohen's Kappa Co-efficient

Theme	Kappa	Interpretation
Theme 1	0.68	Good Agreement
Theme 2	0.7	Good Agreement
Theme 3	0.81	Very Good Agreement

Theme 1, The Culture and Context of Mindfulness, a Cohen's Kappa of 0.68 was calculated for agreement between the two raters for the quotes. According to above formula this falls in the Good Range of reliability. The percentage of disagreement concerned the sub themes of 'Research' and 'Measuring Outcome' which appeared to overlap in terms of meaning and were collapsed into to one sub theme called 'Research and Outcome'.

Theme 2, The Subjective Experience of Mindfulness, a Cohen's Kappa of 0.7 was obtained for agreement between the raters indicated by the formula as Good Agreement. The variance related to sub themes of 'Noticing' and 'Awakening' which again appeared to be overlapping concepts and merged into a central sub theme 'Noticing'.

Theme 3, Being a Mindfulness Practitioner, a Kappa of 0.81 was calculated for agreement between raters indicating Very Good Agreement. The small percentage of variance was in the identification of a sub theme 'Client Qualities' which as a result of further discussion between the two raters was felt to be unsupportable and omitted from the theme.

CHAPTER 3: ANALYSIS

The Analysis section will be structured as follows. A brief description outlining the five participants will detail their background in Mindfulness provided both for informative purposes and to help provide a context for each participant. The themes are presented, followed by a table that gives an example of the coding process. Each theme is then described in turn with extensive quotes from the transcriptions. The section is concluded with a summary and points for discussion.

3.1 Description of Participants

As noted in the Methodology the participants were given the option of anonymity but all of them declined this and are referred to by their first name only.

3.11 Steve

Steve is a British white male in his late 30's and works as a Social Worker in adult mental health as part of Community Mental Health Team in the NHS for approximately ten years. He has recently qualified as a Family Therapist. He is trained in Dialectical Behaviour Therapy (DBT), which was his first exposure to the formalised therapeutic use of Mindfulness. However his interest in Mindfulness has developed since a childhood interest in spirituality. Prior to starting Social Work training he completed a theology

degree, and retains a strong interest in comparative religion and spirituality. He has practiced his own personal Mindfulness since late adolescence, and although has been part of formal Buddhist and meditation groups in the past, he does not describe himself as a Buddhist and has not been part of a formal group for more than ten years. Steve has regular personal practice and attends a weekly meditation group although this is secular and is not led by any conventional practise or discipline.

Steve's only formal psychotherapeutic training in Mindfulness is DBT, he was a member of a DBT service for a year, and was involved in teaching Mindfulness in the skills group as well as using in individual session. He works with Adult Mental Health clients in a secondary care service and offers Mindfulness on an individual basis only. This is usually part of an integrated approach to clients with diagnosis of Personality Disorders and severe mental health needs. In describing his practice further, Steve explained that mostly he presented Mindfulness as an in vivo intervention, which he practices with the client in session. This can involve homework, whereby the client is asked to practice specific techniques and discuss them the following session, which is usually weekly. Therapeutic practice is only a limited part of Steve's role but he would consider Mindfulness with all the clients as part of a care package. In describing this further, Steve reported that his use of Mindfulness ranges from a brief discussion to specific practice of techniques, and would describe most of the interventions as somewhere in between the two, which is often a two to three session introduction combined with practice and discussion. When discussing the practice, Steve relates Mindfulness to his application to immediate difficulties in the context of the current presentation to mental health services.

3.12 Christina

Christina is a white Canadian female in her early 50's who has been living in Britain for approximately thirty years. Christina works as a private therapist and also part time as a Psychological Therapist within an Obstetrics, Gynaecological and Sexual Health Service in the NHS. She is trained as a Core Process Therapist. Christina has a life long interest in religion and spirituality, and has a long established mediation and Mindfulness practice. She is involved in teaching and training events at several Buddhist informed organisations.

Christina does not have any formal psychotherapeutic practice in Mindfulness, although meditation practices are a recognised part of Core Process Psychotherapy. However she did express a strong interest in MBSR, which she had pursed informally through attending conferences and familiarity with the literature. In describing her practise she reports to offer Mindfulness as both a discreet intervention and as part of an integrated intervention. In keeping with her training she mainly practices from an integrated perspective and is particularly interested in how it can involve somatic and body process in therapeutic practice. Christina finds it harder to offer this in her role in the NHS largely due to nature of referrals, which are specific requests for anti natal and abortion support. However she has offered Mindfulness in this context, particular when the client is very distressed or anxious, mostly through in vivo body techniques (e.g. awareness of breath and body scan).

Whilst not describing herself fully as a Buddhist, Christina explained that she finds its philosophy, in particular Theravada, highly compatible with her psychotherapeutic training. One example of this was the Buddhist emphasis on acceptance of distress as an immediate reality and how there were a variety of ways, cognitive and somatically to address change. Christina left the country during the course of the research write up but up to that point was an active member of a Buddhist Theravada group local to where she lived. She met regularly with this group, organised and attended lectures.

3.13 Sally

Sally is a white British female in her mid 40's and works as Primary Care Therapist in the NHS based at GP surgeries, seeing clients with Depression and Anxiety. She runs a MBCT based group. Sally is trained as an Occupational Therapist and has worked in this role for around twenty years on Psychiatric Wards and a Community Mental Health Team. She has a long interest in Buddhism and mediation practices since her late adolescence and is a trained Yoga teacher.

Sally was formally trained in MBCT four years ago, but also had attended various short courses in MBCT and MBSR prior to that time. She co-facilitates eight session groups for clients in Primary Care services with depression, run explicitly on MBCT protocol (see section 1.53 for further details). Although this group is Sally's only current application of Mindfulness, in previous posts she taught Mindfulness to a variety of client

groups and health care settings including inpatient wards. In discussing this further Sally described a model of intervention that was influenced by MBSR, involving significant taught practise to increase client's awareness of the present. She reported favourable outcomes and had run a general Mindfulness influenced groups for any clients referred to Adult Mental Services for a number of years in her role as an OT. The groups were brief (up to eight sessions) and again based on MBSR.

Sally did not describe herself as a Buddhist and was not a regular member of a Buddhist community. However she attends courses and d meetings at various local and national venues and had in the past pursued her interest by visiting temples in the East. She has a regular personal practice but not a member of a regular group practice.

3.14 Duncan

Duncan is a white British male in his early 40's and works as a Clinical Psychologist in adult mental health settings in the NHS. He also works at the Psychology Department at a local University. He has been a trained psychologist for approximately twenty years, and runs Mindfulness groups for a variety of patient groups and health professionals. Duncan has had an interest in spirituality since childhood but developed a more ritualised Mindful practice shortly after qualifying. He also teaches Mindfulness courses and runs retreats.

Duncan has been trained in MBSR, and although not trained in other models of Mindfulness based psychotherapy, has extensive academic and clinical knowledge of

their practice. He has attended conferences and short courses in MBCT, DBT and ACT. In using Mindfulness therapeutically Duncan describes a practice that is similar to MBSR in its aim to increase awareness of the present moment, although he does not fully identify himself as an MBSR practitioner. He offers Mindfulness usually on a brief (around ten sessions) group based intervention to clients, health professionals and organisations.

Duncan does not describe himself formally as a Buddhist but is involved with and regularly attends events at a Buddhist community near to where he lives. Mindfulness was not part of his training in Clinical Psychology, but he pursued this more intensively after qualifying and the application of Mindfulness has been a theme in his practice ever since.

3.15 Alison

Alison is a white British female in her early 40's and works as a Primary Care Therapist in the NHS based at GP surgeries, seeing clients with Depression; she also runs a Mindfulness based group. Alison is also a trained Occupational Therapist and worked in this role for more than five years on Psychiatric Wards and several Community Mental Health Teams. She has been interested in mediation and Yoga for most of her life, but has only been introduced to formal therapeutic practice of Mindfulness through Mindfulness-Based Cognitive Behavioural Therapy (MBCT) in the last three years. She is also involved with research into Mindfulness at a local university.

Part of Alison's role is to run MBCT groups within the Primary Care for clients diagnosed with relapsing non-severe depression. This is currently part of a long-term study by a local university which is part of an RCT and therefore subject to rigorous inclusion and treatment criteria. Alison's group has been designed to complement the most recent protocols in MCBT (see section 1.53 for further details). Alison has been trained in MCBT and has attended courses in ACT although does not currently offer ACT individually or as part of a group. Alison has also completed extended MBCT training at the Oxford Cognitive Therapies Centre. Her current clinical work is group based MBCT related to the research trial. Her therapeutic training and formal interest in Mindfulness coincided with a change of work role three years ago. Alison is also involved in lecturing at the university associated with the trial, providing experiential training in MBCT, and is part of a development to establish a postgraduate course in this model.

Alison does not describe herself as a Buddhist and is not a member of a formal Buddhist community but has a personal practice and attends groups for MBCT practitioners held throughout the year. She attends events held as retreats locally but has no formal commitment.

3.16 Summary of Participants

All of the participants therefore expressed an early interest in Eastern theories and practices that predated specific therapeutic or mental health training. Participants

described a developmental process that started with personal interest and practice, then preceded to involvement and training in mental health. Their decision to apply Mindfulness in their practice was based on the sense of sharing what they had found personally useful in their lives and wanted to express this experientially with their clients. Most of the participants felt that the structure of Mindfulness was one of the main reasons for their initial and continued interest. Participants described valuing its accessibility, 'portability' and practicality were valued, referring to how Mindfulness practice does not need specialised environments or equipment.

None of the participants currently work together; attend a regular retreat, mediation group or community. It is possible that participants have attended similar meetings at the same times although this was not disclosed, and some (Steve, Alison and Sally) know of each other, although do not have direct professional or personal relationships and do not meet to discuss or practice Mindfulness. Alison and Sally have run MBCT groups together in the past but no longer do so, and are involved in groups with different client presentations.

3.2 IPA Analysis

After substantive analysis as described in the Methodology, the following themes were identified:

a. The Culture and Context of Mindfulness

b. The Subjective Experience of Mindfulness

c. Being a Mindfulness Practitioner

Table 2 below provides an example of how superordinate themes were identified. Due to restrictions of space a table is not provided for each theme.

Verbatim quotations from the participants are recorded throughout the Analysis. The quotes are in italics and serve to illustrate the ideas and concepts being described. Participant quotes are identified with the first names detailed above. Where certain words, phrases, repetitions or hesitations were recorded in the original transcript, these have been omitted from the script and indicated in the text by the use of the syntax '...' These alterations were made to the accounts more succinct and easier to read.

Text	Initial Code	Code	Category	Theme
I mean my god these people all live in monasteries, they don't have anything to do with society, they often live in grave yards and cover their heads with ashes (Steve)	Differences in culture with apllyong Mindfulness	Being aware of differences and contextual implications (from East to West)	Challenge of applying Mindfulness to the West	The Culture and Context of Mindfulness
We can't become more Eastern because we are Western, so adapting our behaviour to incorparate some things of another culture that might be useful I think, rather than trying to make us more Eastern – or not (Sally)	Cultural context of Mindfulness	Mindfulness as a role of filling an existential gap in Western culture		
Its about getting rid of the pathological bits of people...it's about giving people space to make decisions from their own point of view about where they are going in their lives and I kind of accompany them in that (Duncan)	Challenge of moving away from diagnosis towards acceptance of stuckness	Medical model vs. Mindfulness as a psychological intervention	Mindfulness in Western Mental Health Practice	
I think there is, um. I am sure there's some feeling about Mindfulness being gobble-de-gook (Alison)	Reluctance to discuss Mindfulness practice with other clinicans	Challenge of other professional's misconceptions about Mindfulness		

Table 2: Example of the development of the theme: 'The Culture and Context of Mindfulness' from original text extracts.

3.3 Theme 1: The Culture and Context of Mindfulness

This theme incorporates eight sub-themes described below.

3.31 Eastern Beliefs about Mental Health

All of the participants spoke about differences between Western and Eastern societies, and the importance of recognising this when considering Mindfulness therapeutically. Participants drew attention to the fundamental difference in relationship to mood and distress between the two cultures. In the East, for example, sadness and states that could be described as negative moods are accepted and not necessarily seen as something to be made better; instead they might simply be understood as 'shifting moods', or an experience that needs to be responded to without judgement. Some of the participants described psychological problems and the Western perspective of mental health as a lack of 'contentment'. This sense of discontentment was identified by individual's expectations that things should be perfect, giving attention to the past, holding on to things that won't change, leading to bitterness, resentment and, rumination.

Drawing upon this further Christina described her practice in the NHS;

"Yes, I suppose although I think that does affect symptoms, you know, um, but then of course you see to a large extent my work I am not working with symptoms within the NHS, I am working with life processes, um decision making...as a society we are not very skilled at supporting people through those process" (Christina).

The quote below illustrates Sally's understanding of how emotional distress is understood within the framework encouraged by her practice. She identifies a sense of giving the individual permission to be upset as opposed to changing their moods, and how this is reflected by a general sense of acceptance in the wider community.

"We are not discontent because we know how to be sad, you know...so we are sad...but to say actually yes, you know something's wrong I'm going to be sad, I'm going to weep and wail, you know if everybody did that here they'd have them committed...So its, its just a different cultural thing...there is more awareness how people are and there is more caring within families and things, looking, looking after people and accepting that people aren't perfect." (Sally).

Many of the participants acknowledged that there might be fundamental differences between East and West in terms of understanding mental health. Whilst they did not feel either position was exclusive of each other, it was felt it was important to have an awareness of both stances. Duncan illustrates this below;

"So I think you've, we have to hold on to that these two things may have profoundly different goals. One is embracing life and functioning within it, the other is you know, really about renouncing the material world and those are two different concepts. Um, I am not saying that that there isn't an overlap but I think we have to become aware of that" (Duncan).

3.32 Body-Mind

An important cultural difference noted by all of the participants was the emphasis placed by Eastern insight traditions, on full awareness and integration of mental and physical experience. This was referred to as 'Body-Mind', a single term to express the interrelation between the two. Mindfulness practice often involved incorporating the body and bringing awareness of physicality as well as thoughts; body and mind. Western culture was seen as separating the mental from physiological to treat them differently whereas Mindfulness was seen as bringing them together.

"this is the bodymind you know with no hyphen, no space, so if one enters into mental states...then I think one balances those states with an awareness of the body – like in Buddhism especially, you have the whole thing about body scans you know." (Steve).

"you know, our medicine looks at either mental health or physical health...mindfulness and stuff it brings it together, there's a completion." (Sally).

Both Steve and Sally emphasise the importance of the body-mind process and how this can be used therapeutically.

3.33 Mindful Community

Many of the participants suggest the importance of applying Mindfulness with an understanding of its theoretical and sociological context.[1] It highlights an important difference that in the East personal Mindful practice is accepted at a wider cultural level, and that there are sociological systems in a Buddhist or Buddhist informed culture that can promote and acknowledge its practice. Participants described that in the West there is a need for a reference point, cultural context and a sense of being part of a community to maintain and develop their ongoing practice.

"We might have the practice but we need a community as well to hold that together and if we don't then I think it's in danger of being lop sided." (Steve).

"It's not just a lonely thing...in fact good practice needs to be with others who, you know actually do it. We're not too good in the West at doing that, like its some indulgence or middle class thing to go on a retreat, but talking about with others is part of the whole thing." (Alison).

[1] In Eastern cultures this is was best described in terms of the 'Three Treasures'. These refer to i) the figure of the Buddha, ii) the teaching of the Buddha, and iii) the community of the Buddha. All three are required for successful Mindfulness practice.

Alison and Steve argue Mindfulness is not a disembodied solitary pursuit, but a practice that also needs be supported by contact with others who share a personal experience of Mindfulness and have some understanding of its culture of origin.

3.34 Mindfulness in Western Mental Health Practice

The participants are not attempting to make the West more East, or indeed the East more West. They also pointed out that good Mindful practice in East standards may not be transferable, or even desirable in the West.

Steve highlights this point when referring to Eastern cultures:

"I mean my god these people all live in monasteries, they don't have anything to do with society, they often live in graveyards and cover their heads with ashes." (Steve)

Participants identified cultural practicalities of particular importance to the West such as routines and time management that are counter to a pure Mindful approach. There are clear differences in culture also that have ramifications for psychotherapeutic interventions. In the West for example, change may be premised on embracing life and improving functioning within it, whereas in the East it could be concerned with renouncing the material world. In contrast to this, the therapists describe an approach that it is more about finding a balance through cultural understanding and integration. There

may well be cultural overlaps but therapists felt part of their role also involved awareness of any client difficulties and the contextual implications for each individual.

Sally illustrates this point when she says:

"we can't be more Eastern because we are Western so adapting our behaviour to incorporate some things of another culture that might be more useful I think rather than trying to make us more Eastern – or not. (Sally).

The participants also commented on the cultural context of Mindfulness and its relevance to Western therapy. Some suggested that modern Western societies are now experiencing a gap that was formally filled by priests and now by counsellors. Duncan describes it in terms of the *"Western Cultural Project"*, that psychotherapy in the West is an *"attempt to fill an intrinsic existential lack"*.

Mindfulness, therefore, in this capacity is counter intuitive as it encourages acceptance and relationship with what is missing. Within this sub theme, the participants commented on the challenge of applying an Eastern philosophy to Western culture and how it also may bridge a gap that has traditionally been filled by religious and spiritual beliefs. Christina describes this below:

"Its, I think its an interesting question because counselling becomes more important as fewer people have a clear place to take their spiritual um anxiety. I am not the first

person to question the role of counsellors and as to some extent replacement for good priests and spiritual community people" (Christina).

Many of the participants described difficulties integrating their practice within traditional Western mental health services. Some felt that the process of diagnosis and treatment could lead to a sense of 'stuckness', futility and discontentment that Mindfulness intends to challenge. This is seen to be true of both the client and the wider system.

"I've been very resistant to the kind of normalising, pathologising kind of elements of Clinical Psychology and aspects of therapy. Its about sort of getting rid of pathological bits of people, so I don't really, I've never really been keen on that kind of way of working and I mean um for me a lot of therapy work is about giving people space to... make decisions themselves from their own point of view about where they are going in their lives." (Duncan).

Concerns and experience of other professional's disapproval or suspicion has led to some participants not discussing their practice in detail. Many identified some sense of hostility from other practitioners. Steve for example describes feeling that he is seen as a, *"new age, strange effeminate therapist" or even slightly "KuKu".*

Alison further comments on this prejudice:

"I think there is um I am sure there's some feelings about Mindfulness being gobble-de-gook." (Alison).

However Steve, like some of the other participants also describe a more ambiguous relationship with colleagues who, though are somewhat dismissive about Mindfulness, acknowledge that they are working well with difficult clients; *"They know I see some very difficult people...and still refer them"*. A reason suggested for this is that others are unclear about the difference between Mindfulness and other forms of meditation, and therefore may rely on social stereotypes. Some participants described a sense of professional apathy and disinterest towards Mindfulness, Duncan recalled an experience at a conference when Mindfulness was described as *"the latest fad"*.

3.35 Research and Outcome

The participants expressed some ambivalence about research into Mindfulness and it's current clinical popularity. Whilst welcoming interest by researchers, as Duncan for example pointed out, it brought advantages in terms of funding and permission for clinical practice, they were also concerned about how it was being investigated. In particular, the tendency for Western empirical research to concentrate on outcomes as opposed to processes was highlighted.

Christina highlights this further:

"It isn't just a technique and I think its used as just a technique you, you're taking this tiny part of something that's hugely powerful, you know, you might a benefit from that but I just think you're wasting time...and it doesn't work and then whole things trashed." (Christina).

Alison comments on how she believes Mindfulness may respond to the rigours of research:

"Um, I it's great in some ways that its flavour of the month but flavours of the month go out and that's a shame um I think the great thing about being flavour of the month, is more research is happening and more will be found out about it um. I would kind of think it's here to stay, myself, Buddhism seems to have been a survivor (laughs)." (Alison).

Behind this fear was the feeling that Mindfulness is something that's lived in and not just worn occasionally. Meaning perhaps that interest only in it's potential results, or attempts to define it as thing to be applied, only captures a small part of Mindfulness and could miss the point. The participants were not describing an aesthetic, mysterious process, requiring highly specialised training, it was more a sense that to fully understand it and be authentic, one had to live it.

Formal clinical measures of Mindfulness, although not rejected by the participants, were treated with caution. Mostly this reservation related to the use and definition of terms.

Sally for example, argued that wellness should be individually understood and it was more a phenomenological concept than an objectively defined state.

"I don't know how you can measure it... because, you know, what is wellness for a start? My wellness might be different from your wellness. Most certainly would." (Sally)

Concern was also expressed about formal measurement setting certain limits to the world of experience and that the phenomenological becomes secondary to the demonstrable. Christina highlights this point:

"there's a great danger in limiting the world to what can be measured and therefore a lot that's valuable is rejected, not because it's not valuable but because its not easy to compartmentalise or measure." (Christina).

Participants questioned the applicability of clinical measures as Mindfulness was not seen not a cure or an outcome in the clinical sense. They argued it can be a prevention to psychological distress but this is a by product, it is not about 'becoming better' in the traditional Western sense. One of Duncan's clients explained when completing routine outcome measures;

"I don't think this form is going to reflect what Mindfulness has meant to me. I'm not sure you're going to see my score change but that doesn't really mean anything about how valuable I found, Mindfullness', and to me that hits the nail on the head." (Duncan).

Here Duncan describes Mindfulness as a process rather than an outcome, with the emphasis on the experiential nature of the practice rather than the drive to achieve an endpoint.

3.36 Manualisation

All of the participants were concerned that in the process of making Mindfulness more digestible to the Western pallet it could become a ritualised practice without meaning; without the 'spirit' of Mindfulness.

"I think if it becomes too complicated that's what worries me, um the psychologists, excuse me, take hold of things (laughs) and other mental health professionals take hold of things, try to make it into something very complex and special and like that ownership of it." (Sally).

Sally argues that Western descriptions therefore may attempt to fit Mindfulness into the language of mental health outcome measurements and miss a crucial essence in the translation. This is exemplified by Duncan's description of the difference between what he refers to as *"science and scientism"* in Western cultures. The latter concept confers acceptability of a phenomenon such as Mindfulness only if it can be operationalised. In this sense technical language and description become synonymous with the only valid form of discourse, and things outside of this arena become less valuable.

"it's not open to dissection in the same way that...the use of certain psychological models would be, where you could test these with parity to the model." (Steve).

Duncan expands this point by emphasising the simplicity of Mindfulness and the risk of making it too complex and processed.

"the way I have learnt Mindfulness meditation is that it doesn't come with too much theoretical baggage and that is partly about simply a naïve noticing...I think it would be a real shame if Mindfulness is kind of put through the usual mangle that everything is put through to make it palatable...we will really lose something in the process – and in the case of Mindfulness it's a big risk to take." (Duncan).

The participants felt that attempts therefore to manualise it could lead to misrepresentation as Mindfulness was seen as far more a way of being and not just a set of operations.

"Oh there's this thing that's powerful - and they're trying to grab on to it as a technique without recognising what really makes it powerful and therefore my fear is that it is going to be flavour of the month and then it won't work because the wrong people have been done and then it will be rejected and then they'll go 'oh we tried that and it didn't work'..." (Christina).

Here Christina highlights the concern that by reducing Mindfulness to a technique or set of techniques it's authenticity will be lost and risks the practice being rejected as a whole.

Therefore although most of the therapists used formal quantitative outcome measures, they all expressed a preference for client's self report and qualitative measures. Experiences in which they were interested included the choices clients made and changes in their responses, what they felt was important or helpful about the process, if life felt more spacious, and ability to prioritise more clearly. Steve described the experience of being Mindful as, "*Small steps not necessarily earth shaking things.*"

3.4 Theme 2: The Subjective Experience of Mindfulness

Five sub themes are outlined that describe the participant's personal experiences of being Mindful.

3.41 Noticing

A main quality of being mindful identified by the therapists was 'noticing'. This was described in terms of being interested in one's own mind, just noticing when the mind is all over the place without responding or judging the process. Noticing is also a more finely tuned quality of observation, which encourages the observer to be more immersed

in the details of the process. It is not about necessarily stopping to allow one to positively reframe a situation but just being fully present, experiencing that moment fully.

Duncan and Alison both describe the experience of 'noticing':

"You are sitting there, there's not much happening, you're not having great cosmic insights, nothing much is happening and its kind of just OK, that's OK. (laughs)." (Duncan).

"a real view of the ability to kind of step back, reflect, and have a witness to one's process as a valuable life skill." (Alison).

They describe noticing as not about feeling better; instead it involves being in the world and having to confront the totality of what's happening at that moment. Change, though welcomed, is a consequence, or interesting outcome only, not the purpose in itself. Sally explained this concept as:

"because people start noticing, and when we start noticing we notice our relationship with other people, we notice what's going on and, you know, that can open a few doors that are best kept closed in some ways because it involves other people... We tell people right from the start, this is great this Mindfulness stuff and hopefully you will learn loads from it but don't be surprised if other people aren't so keen on your um awareness." (Sally).

Noticing for Duncan is similar to *"cultivating an inner reflecting team"*. Drawing an analogy to Family Therapy practice, this describes developing the ordinary sense of noticing, with the detailed awareness as if others were watching, of how one is sitting or feeling and reflecting on this internally. This quality of noticing was described as a challenge to normal Western nine-to-five routines as it encourages a posture about non attached observation. Duncan described that when noticing, one is simply curious and non judgemental as judgement and interpretation are seen as an attachment that takes the individual away from the present moment:

"what you're doing is you're becoming more aware of that anxiety that's often for many of us bubbling away and you're slowing down enough to see it, and that's OK you don't have to push that anxiety away, you don't have to do anything with that but if you can just stick with that a little bit and just notice it then um then that's Mindfulness practice." (Duncan).

"Something at home came up and I started to worry a little bit and I just thought, oh yeah there seems to be some anxiety around this particular event, so I just thought yeah it's good to notice that and then carry on with the rest of it and I didn't have to carry it will be all the time, because what's the point?" (Sally).

These quotes highlight the complexities of 'noticing' when considering using a Mindful perspective.

Some of the participants described having assumptions before they became involved in Mindfulness. One of the participants for example felt that it would not be for them as they thought of themselves as 'not a sit still person'. They identified further preconceptions that Mindfulness meditation could be a passive, transcendental, or relaxation orientated practice. In describing the awareness of these assumptions, the therapists used terms of *'awakening'* and *'waking up'*, describing Mindfulness as a formal practice of active noticing, an ability that is innate in all individuals. Mindfulness is not seen as a distant process of enlightenment for the select few, but a possibility for everyone.

"so people kind of find that they are throughout the day just tuning in differently to their experience, not all the time but they have just little moments when they drop into it...People see that as um being a lot more positive, privileged in their experience." (Alison).

Here Alison describes the active, rather than passive process of practicing Mindfulness that it involves a conscious decision to tune into and relate to themselves differently.

3.42 Acceptance

Following on from noticing, the participants describe the possibility of acceptance. Acceptance appears to be a core component identified by the participants, which is described as a non-judgemental response when one perceives themselves to fail or things

are not going well. It is not about distraction, avoidance, reframing, having a *"dull mind"* (Sally), or automatic response. Instead, through the process of noticing in a fully present way, and then accepting the entirety of the experience of what one notices without judgement, there is the possibility of having a relationship with the problem.

"We go over and over things as if somehow it's going to be different, the eighteenth time around. Well it isn't that's the way it was and that's the way it was and that's the way I felt about it at the time when that happened...its about um cultivating another, different relationship with all those difficulties and emotions." (Sally).

Here Sally suggests that Acceptance also means a fundamental commitment to accept that the world and existence is impermanent and ever changing. The participants emphasise that in doing this one is less likely to become stuck through attachment to the past or through attempts of re-experiencing a particular feeling, and looks instead to experience the moment in a fully present and undistracted way.

In the quotes below, Sally and Duncan describe how learning acceptance through Mindfulness has helped them live in the present with less judgement and attachment about the past and future.

"if we go into Mindfulness practice expecting to feel more comfortable then we may be setting ourselves up for failure because...Mindfulness isn't about achieving comfort. Its not about smoothing everything out...to me a definite danger of Mindfulness, is that we

can subtly use it to actually numb out even further but we just do it with more panache (laughs)." (Duncan).

"Actually when you look and you think well I've a ton weight in there no wonder it's heavy I can either choose to give this to someone else to carry or I can strengthen myself so that I can carry it or I can choose not to carry it all the time. So that's, that I how I sort of feel about it". (Sally).

"You are sitting there, there's not much happening, you're not having great cosmic insight. Nothing much is happening and its kind of just OK, that's OK (laughs)" (Duncan).

3.43 Stillness and Space

The concepts of stillness and spaciousness are referred to by most of the participants. These seem to refer the ability to notice a space within the self that is not occluded by physical tension, emotional distress or feelings of stuckness. Strong feeling, physical pain or distress take the person away from this sense of space by diverting attention away from simply observing and experiencing. The participants argue that Mindfulness, by encouraging full participation in the present moment reduces distress, and helps the individual to regain inner stillness. It is from this place that the participants describe being able to respond to what's happening appropriately.

"for me again it is connecting with that, that stillness, that place where for a fleeting second we can touch it, and know that it's OK...it's about not trying to change it, that's really important." (Alison).

Here Alison comments on the importance of noticing and accepting a given moment of stillness and not just trying to judge, change or define this moment. Duncan comments further that in acknowledging a space or a moment it can be built on or changed as a result of simply noticing it:

"for me a lot of therapy work is about giving people space to be and also space to kind of see what's there in their experience and then feel that they can make decisions themselves from their own point of view about where they are going in their lives and I kind of accompany them in that." (Duncan).

Some of the participants felt that conventional western rationalism, through the importance it places on strict linear time boundaries, is contrary to this sense of spaciousness.

"Well, I guess um what Mindfulness at it's core seems to promote is a greater sense of mental spaciousness...it's trying to move away from um a very kind of full mental state to a relatively empty one so that one can observe what's arising, one can become aware of the self, and the body and that um maybe things feel slowed down you know so that when emotions arise perhaps one's response is more considered (laughs)" (Duncan.

"I think there are profound levels of stillness and emptiness and there's that, you know its just that little millisecond more is a mindful practice, you know, its becoming that much more aware" (Steve).

In the above quotes Duncan and Steve describe the purpose of generating 'space' to gain a better insight and choice into the experience of being-in-the-world.

3.44 Response and Intention

Noticing and acceptance encourages the therapists to relate differently to whatever is happening in their experience. When that experience may be distressing, the participants use terms like *"sitting with" (Alison), "leaning into"(Duncan), "not holding onto" (Christina)* and a process of *"touching and letting go" (Steve).* They describe a participatory dynamic in relation to distress, in that Mindfulness enables a sense of 'interested detachment' from the emotion. They do not talk about rejecting, dismissing or challenging a difficulty, instead it is a position of benign curiosity. Duncan describes this process of touching and experiencing an emotion in detached way, but also with the stance of an *'interested observer'*:

"So then there is that touching element so if something yucky comes up there is still that aagh anxiety. Just touching that, you know, letting it go aah you know depressions, you know aaah yuck you know its OK just there." (Duncan).

Below Sally identifies the component of intention behind Mindfulness practice. This describes a quality of choice to be fully engaged in the practice as opposed to a sense of 'going through the motions':

"It's about intention, you know your intention to be Mindful and noticing when we are not being Mindful and then just doing it and I don't think for years, because some people have been, you know, doing meditation things for years and years and still haven't quite grasped it...but other people may be, you know, have always been doing it but didn't even know they were doing it." (Sally).

It was strongly expressed by all the participants that practicing Mindfulness was not to feel comfortable, resolve a difficulty or be distracted from the experience, irrespective of it's content. Mindfulness is not premised on enhancement of mood or feelings of enjoyment. Duncan describes that this experience of Mindfulness can be like, *"one long series of insults and disappointments"*. Again this observation emphasises the process of being Mindful rather than expecting a positive outcome.

"It's about slowing down, becoming self aware in a way that's not overwhelmed by our emotions or unhelpful thoughts." (Steve)

As a consequence the participants described that being Mindful involved not having expectations, but rather being investigatory and curious towards experience. Some therapists further described the need to be rooted in the moment enabling a detachment toward thoughts and feelings as they arise and seeing them as part of a *"cyclical process" (Christina).* All of the participants felt it was vital that a sense of compassion and good humour was adopted towards oneself and one's experience. Self compassion was also related to a sense of self awareness, of both thought and physical processes, but in a way that is not overly introverted. Mindfulness was described as a process of observation, therefore more an experience of opening out, not retreating within.

"I don't have to respond, I don't have to try and grit my teeth through it, I can almost let go of it, disengage with it, you know it's very powerful." (Steve)

Here Steve highlights how his experience of Mindfulness can help him to detach from emotion and also learn from it as a curious observer.

Sally and Alison describe the intention to be Mindful and responses in clients using the practice:

"...they are flying off the handle for instance so much, that they're even been pausing to think about situations. Um I think people notice a kind of slowing down and making

changes in themselves...People in just subtle ways just start thinking a little bit Mindfully" (Alison).

"it could be that people suddenly realise their job is rubbish and it's not helping them so they must jack in a job, relationships or whatever. It's very powerful." (Sally).

3.5 Theme 3: Being a Mindfulness Practitioner

Participants described different components of being a Mindful practitioner and these described using are identified by five sub themes.

3.51 Training

Training was seen as vital by all the participants. However, when discussing training in Mindfulness a level of caution was raised. All the participants were keen to express that training should not be seen as a linear process in the traditional sense. For example it wasn't about learning a particular model for a set period of time. Nor was it about fulfilling certain criteria that one could 'pass' to become a Mindfulness therapist. In fact some of the participants expressed concern that Mindfulness training could become systematised in the conventional ways. One didn't have to be a guru, instead one attempts to live Mindfully, congruent and accepting of the difficulties and successes of doing so in their lives. In discussing this quality of training further, they described the importance of

being authentic through an attitude of *'intending to Mindful'(Duncan)*. This can be understood as the intention to embody the principles of noticing, accepting and non judging through continued experiential practice.

Duncan comments on his own training:

"it was particularly encouraged to be non goal orientated, to be respectfully curious about your experience and to bring a lot of kind of warmth and humour and interest to what was arising." (Duncan).

This also referred to the trainers, as just because someone is seen as a clinical expert does not necessarily mean that they have a good Mindfulness practice. Here Steve illustrates this point:

"highly qualified psychologists etc...doesn't necessarily mean that they are highly experienced meditators or Mindfulness practitioners...in fact they may be, you know, relative innocents in it." (Steve).

Most of the participants however, also felt that together with this quality of experiential training, to have a better understand of Mindfulness, individuals may also need to have some understanding of the Buddhist philosophy underlying Mindfulness. In particular, concepts such as the universe is ever changing, self compassion in the context of

accepting that *"things arise and decrease" (Steve)* in an endless process, and the true nature of observation without response were suggested by the participants.

Alison highlights the importance of self directed learning:

"if people go off and do more reading like that, there's meditation and they're going to come across Buddhism." (Alison).

Whilst none of the participants describe themselves as Buddhists or feel that clients have to be, they all felt that some understanding and discussion of its principles was essential to authentic practice.

3.52 Personal Practice

Closely related to this idea of training was the importance placed on regular personal practice. Personal practice was closely associated by the participants with therapeutic concepts of being congruent, authentic, honest and real. None of the therapists felt it would be genuine to use Mindfulness with a client if they themselves had not regular experience of many of the struggles that may be involved.

"Mindfulness has a huge role in, in my own Mindfulness practice, informing how I knew life and change and pain, you know those things are hugely influenced by my Mindfulness practice and have implications for my clients." (Steve).

Several participants drew attention to the need for them to be grounded in the practice, so that they could respond effectively to whatever the client may experience as strange or disturbing; Steve referred to this as, *"Fear and uncertainty of transpersonal states"*. For example although calmness and space may occur as a result of Mindfulness, extreme states of anxiety and isolation have also been reported. It was seen as vital therefore for the therapists to have some understanding of such experiences or sense of being prepared, as Duncan described, Mindfulness is not *"a one shot deal."* The participants argued that personal practice therefore, also has important ramifications for the process, as therapists are modelling the whole experience of Mindful practice with the clients. Without continued experience of Mindfulness they thought it could be easy for therapists to become uncertain and display this to the individual they are working with.

Christina comments of the necessity for personal practice:

"I thought it was fascinating that in John Teasdale's work he said that when they tried to do it without having the meditation themselves it didn't work and I really believe that's true because not only does the practitioner need an understanding and experience of it but they have to be able to bring it to the work." (Christina).

Participants further drew attention to the need for both clients and therapists to have a whole commitment to Mindfulness in their lives, in the sense that is was something they had experienced, struggled with and continued to use in their daily lives.

"I think the same with being a parent, it means huge amounts of hours and I can't fit it in, and that's, you know, an ongoing thing as well that's hard to put that in if you're not sure what's at the end (laughs) hung on in there for the kids. Kind of that it's right to do this but I am not sure why at time...Because without the practice, I don't think it would, wouldn't necessarily work." (Alison).

Here Alison describes both the usefulness of Mindfulness in their personal life and also the struggle to prioritise and practice it alongside daily family pressures. Below Duncan explains how personal practice has affected him:

"I've been practising Mindfulness all these years and I still am completely worked up about x, y and z, nothing's changed – you know, but I just think you know in a sense we are all in it together, it's a very very strong cultural narrative and that really a big step is just to notice and then have a lot of compassion and good humour about, because just practising Mindfulness isn't going to be a kind of ticket, hasn't been for me, to just kind of gaily walk away from all that and not be informed by it." (Duncan).

Sally describes the importance of authentic engagement in personal practice as opposed to purely a skill learning process:

"he was as a counsellor, just wanted to come on the course for patients to learn it so he could take it away and give it to his patients. Well it doesn't work like that, you know, it's

a deeper thing and in that deepness I don't think it's anything, you know, that should be shrouded in mystery and you have to have gone on so many retreats and, you know, do all this stuff either, somewhere in the middle where it just needs to be done honestly." (Sally).

3.53 Teaching

'Teaching' clients about Mindfulness was often expressed by many of the participants. This was described as not as a didactic process but more guided investigation, perhaps similar to the developmental process of parents instructing their children and allowing them to purse their own ideas in life.

"So the practice doesn't have a goal um but as therapists I have a label that I teach people something I guess, teach them to the best of my ability." (Alison).

Here Alison highlights the sense, reported by other participants, that that Western conceptions of teaching did not sit comfortably with her role a Mindfulness therapist.

Duncan, below, describes how the need for critical appraisal of Mindfulness and it's teaching in application to therapy.

"I don't class myself as a Buddhist but um of the things that I, that was very interesting that the Buddha is alleged to have said is 'don't believe anything because it's passed on

to you- test everything, be a light unto yourself'. Which is you know, I think is a, good, a good grounds for therapy" (Duncan).

Therefore there is the need for some degree of experience. Steve and Sally describe how 'expertise' comes from practice as opposed to it being taught on a course.

"It needs um commitment and training to the whole process rather than someone who has done, you know, a one week course in Newton Abbot." (Steve)

"I think it is really important that the person who is teaching somebody else to be Mindful has some concept of what it is themselves because how do you know whether they are doing it or not...It's like people just used to put a leotard on and sit cross legged and say they were doing yoga, and that wasn't it - they just happened to be sitting cross legged in a leotard. Big Deal" (Sally).

3.54 Collaboration and Self-Disclosure

With such an emphasis on experiential practice and modelling, Mindfulness was described by many of the therapists a *"joint practice"*. This was seen as challenging the therapeutic power imbalance and empowering the client by allowing them to see that the therapists can struggle in life as much as other people. To this end some of the therapists preferred to describe confronting difficulties psychotherapeutically by using terms such

as 'workability' as this created an environment away from concepts such as treating or solving, and encouraged the idea of a joint endeavour between the client and the therapist.

Christina explores the process of collaborating with the client:

"I come in and tell the client about my stuff and my issues but you know we are both working at bringing as much awareness as we can to this process that is going on." (Christina).

The use of self-disclosure was described by all the participants as an important part of the practice. For example they all often began the therapeutic process in a similar fashion, explaining that Mindfulness was a way of managing dissatisfaction with life, that it is not abnormal to be dissatisfied, and that this was true of all people including the therapist. Although they were clear about not wanting to overload the client with therapist's problems, self disclosure was not only seen as part of being collaborative, but also an authentic way to model the process. Many of the participants highlighted the need for the therapists to be seen as human and fully present, and some contrasted it with other therapeutic models such as psychoanalysis, seeing it as having an *"abstinate kind of background" (Steve).*

"So I had to bring me into the room not just stick to an agenda and for whatever I am doing." (Alison).

"Mindfulness is...centred on our experience here and now rather than any specific attainment of mystical state, is much more of a centering...aware of our own processes." (Steve)

"I sometimes share what I'm noticing about myself with the client, like noticing a tension, an 'eergh' feeling in my body and they offer tell me back how they are" (Duncan).

Alison, Steve and Duncan highlight the importance of their presence within the therapeutic process, and the need for attention to be placed on the present moment.

Awareness of the client's process was seen as a crucial part of Mindfulness practice. Some of the therapists described Mindfulness as being on a continuum for both the therapist and client, and it is a process that can be *'dipped in and out of' (Sally).* Others described it more as a process of developed observation, noticing their responses in relationship with the client. In discussing this further, some of the participants felt that this was not the same as the process of transference. They described it as being more "involved" than transference, as attention was being placed to whole aspects of the person, such as physical sensation or posture, and that it was a process of simply noticing and being aware without attachment to any theory. The response encouraged in both the therapist and the client, was described more in terms of curiosity, and not explanation or interpretation. Christina and Sally comment on this point:

"I don't think someone's either being Mindful or not Mindful, I think it's more a degree...its not whether someone is or isn't, its how much and how can you keep that, and share this process with the client. I mean noticing and observing what's going on between us" (Christina).

"...then I think there's a much broader energetic, subtle, connection and influence, both ways and from the outside world that happens, that's, that is just more complex. You know, what am I feeling? And you might even do a little, kind of looking through, how actually do I recognise that, oh that's connected with my history" (Sally).

3.55 Therapeutic Stance

All of the participants stated that Mindfulness underpinned, or was the foundation to their therapeutic stance. Duncan for example, explained how the practice of Mindfulness related to his philosophical viewpoint, as it was not concerned with concepts of normalising or pathologising the individual that he felt typified other psychotherapeutic models.

Christina further describes how Mindfulness contributes to her therapeutic position:

"I'm always working Mindfully – because I'm always applying attention...you're not just paying attention to your client, you're paying attention to what process is going on in

you. So that attention and that experience is in the room every time I am with a client." (Christina).

Christina also mentioned this, in terms of Mindfulness being adaptable to any therapeutic model:

"it underpins it...what I think I'm always trying to encourage in anybody I work with whether they're short term or long term is the observing, the part that that can notice rather...being completely caught up in whatever emotion they are feeling or whatever crisis they're in." (Christina).

The participants described how Mindfulness allowed them to draw on a sense of spaciousness between themselves and the client and not be attached to preconceived therapeutic goals. It helped them to remain more client centred in their practice, to stay with the immediacy of the process and not be distracted by mutual attempts to avoid distress. Part of the therapeutic stance involved accepting uncertainty in the process for both the client and the therapist. Some of the participants felt such a level of acceptance helped to establish a new way or *"third space" (Duncan)* in the process, in which positions of *'not having to ward off' (Sally)* or be *'controlled by sensation or emotion' (Christina)* could be experienced. In this way the participants describe how the therapist and the client are encouraged to 'make friends' with uncertainty as opposed to seeing it as thing to avoid or fill. Acceptance of uncertainty also related to an open acknowledgement that the therapist, like the client, was not perfect and was not expected

to be all knowing. In this way the collaborative, joint exploratory nature of the process was ingrained in the therapeutic position.

Commenting on the therapeutic stance further, many of the participants described that it was as much an emotional and interpersonal position as an intellectual one.

"...one of the most important things we both have out of the work is that it becomes an enquiry that they will use um whenever. Yes, yes a real view of the ability to kind of step back, reflect, and have a witness to one's process as a valuable life skill" (Sally).

The participants argue for the practice to be authentic it has to have some personal qualities and involvement from the therapists. Christina for example referred to it as a *"heartfelt process"*, which described the importance of the therapist accepting their vulnerability by being affected by the client's process and not be detached and remote from their distress.

"because to me it's a very heartfelt process, it's not about thought and intellect, although that has a place, it's also about heart and vulnerability and a willingness to be touched and affected by who we work with." (Christina).

None of the participants saw Mindfulness as a *"quick and fast"* technique *(Duncan)*. It was not about reducing symptoms or reaching a particular goal. They argued that it involves challenging the therapeutic power imbalance and doesn't simply identify the

client as the one with the problem. All of the participants questioned any conception of Mindfulness as a technique, describing it more as a *"method of enquiry" (Christina),* an *"everyday life skill" (Steve),* an *"attitude" (Steve, Sally),* or a *"way of being" (Duncan, Sally, Alison, Steve).*

Sally and Christina highlight the point of Mindfulness being more than a technique to be learned:

"people are always looking for what's quick in a class and it isn't, it isn't quick and fast and it does demand something of the therapist." (Christina).

"It's not about thought and intellect, although that has a place, it's also about heart and vulnerability and a willingness to be touched an effect by who we work with and if we try and stand back and then be clinicians, I don't know if it would work" (Sally).

3.6 Summary

The three themes provide a detailed account of the process of Mindfulness described by the participants. Before commenting on how this will be developed further, it is important to note the context in which the data was obtained. Primarily it must be recognised that the participants are all practising Mindfulness therapists, and therefore they all believe in the validity and benefit of the approach. Although the aim of the research is to gain a

greater understanding of Mindfulness from the practitioner's experience, the Analysis and Discussion should be read with this in mind. The purpose of this research is not to validate Mindfulness, which arguably may be the implicit intention of the participants, but to obtain a greater understanding of the process and experience of Mindfulness from the practitioner's experience.

The Discussion therefore identifies several theoretical implications from the themes and explores this further with reference to the relevant literature. In particular, issues of therapeutic process, core therapeutic conditions and the clinical presence of the therapists will be examined. The cultural perspective will also be explored in considering how Mindfulness may become a more intelligible concept to Western practitioners.

CHAPTER 4: DISCUSSION

4.1 Introduction

The purpose of this research was to understand more about the role of Mindfulness, an Eastern tradition, in the Western therapeutic process from the perspective from those who use it. A review of the current literature established an evidence base largely supporting the effective outcome of Mindfulness in a variety of client groups and therapeutic settings, but revealed comparatively less focus on understanding the *process* of Mindfulness and how these outcomes were achieved. The literature also revealed that although three standardised models have been established that incorporate Mindfulness (MCBT, MBSR and DBT see Introduction), the vast majority of research was based on either single case examples or more personalised uses of Mindfulness. Therefore I wanted to know more about how Mindfulness related to the therapeutic process, why the participants felt it was helpful and establish what it meant to be a Mindfulness practitioner. Given the phenomenological perspective, a qualitative method was selected and I interviewed five Mindfulness practitioners and their experiences were analysed using IPA to produce three master themes. These were;

1. The Culture and Context of Mindfulness
2. The Subjective Experience of Mindfulness

3. Being a Mindfulness Practitioner

In exploring these further I have identified a central concept, which I have termed 'being-with'. Being-with refers to both the shared experience between client and therapist of the therapeutic process (described by the participants use of terms like 'sitting with', 'moving away from' or 'touching'), joint Mindful practice (e.g. Noticing, Non Judging, Awakening or Accepting), and also to the interactional process between the therapist and client. Illustrating this, the participants all described the intervention as collaborative, and noted the necessity for personal Mindful practice and self disclosure as part of the (being-with) process. Understanding Mindfulness using the concept of being-with I will further argue, helps to facilitate the emphasis placed on therapeutic conditions (such as honesty and authenticity). It also identifies the role of the therapist, described by the participants as an active and fully present contributor to the process. Being-with will initially be explored in terms of the research through the concepts of core conditions and the therapeutic relationship. I will then present the practitioner component by considering the literature on therapist presence, personhood and clinical wisdom.

The conclusion will critically consider the value of this concept in being able to present an accessible understanding of Mindfulness to the interested clinican. This will necessarily acknowledge difficulties with this position such as cultural implications and how these concepts may be applied to Western health care systems.

4.2 'Being-With'- The Therapeutic Relationship and Core Conditions

As indicated by the Analysis there is a strong relationship between the practice Mindfulness and therapeutic conditions (see sections 3.35, 3.41, 3.42. 3.43. 3.54. 3.35). It is necessary therefore to consider the literature relating to this aspect of the therapeutic process to further explore the potential role of Mindfulness. In particular this will highlight the experiential and phenomenological nature of the therapeutic relationship. As Childs (2007) suggests, "Clinical interest in Mindfulness has hoped to make more salient and to differentiate a relation to experience which is familiar, has consistent qualities but is not well described within psychology" (p.374).

4.21 Therapeutic Process

In general between two thirds to four fifths of clients benefit from psychotherapeutic interventions, irrespective of therapeutic orientation or model (e.g. Smith and Glass, 1977, Smith, Glass and Miller, 1980, Smith, 1982, Hunt, 1993, Miller et al. 1997). In particular the quality of therapeutic relationship, common to all therapeutic practice has been highlighted as crucial (e.g. Luborsky et al., 1988, Garfield and Bergin, 1994, Beutler, Macado and Neufeld, 1994). Historically, psychoanalytic and psychodynamic practitioners have argued that the relationship and therapeutic frame in general has to be carefully controlled and the therapist needs to be a remote and absent presence (Langs,

1975, Gregson and Lane, 2000). Criticisms to this position suggest that distant, anonymous therapists can suffocate the client (Coltart, 1992), are too controlling (Loma, 1987), feel critical and invalidating (Trerniet, 1993, Wachtel, 1986), and that it can result in client non compliance or suffering (Strupp, 1973, Meissner, 1996).

Arguments from Humanistic and Existential therapies and even within psychoanalysis (Intersubjective Psychoanalysis, Lane and Storch, 1986) have suggested ways in which therapists can be less distant towards clients. This has included increasing the therapist's direct emotional engagement with the client, representing, genuineness, authenticity, self-disclosure, respect and the promotion of trust and safety in the therapeutic relationship. An implication of these theories is that psychological change does not just come from new insight in the classic Freudian model, but also from the experience of the relationship (Ehrenberg, 1984). The client's present reality and how this is expressed and experienced therefore becomes of central therapeutic relevance. Hazler and Barwick (2001) in a comparative review of therapeutic environments suggest therapist involvement, trust and immediacy are common across psychotherapeutic theories. This has ramifications for the clinician in the sense, as Purton (2002) describes, "the procedures of the other schools of therapy will only be effective insofar as they facilitate the client's being in touch with his or her own experiencing" (p.9).

Research into the experiential outcomes of Mindfulness has indicated particular client themes of openness to change, self control, shared experience, self-awareness, personal growth, and spirituality (Walach et al., 2006, Mackenzie et al., 2007). As described by

the participants (Theme 2) Mindfulness is understood as a present moment focused, client centred, phenomenological method of enquiry and discovery. It can therefore be seen as an effective way of relating to, and 'being-with', the individual experience.

4.22 Core Conditions

Similarities in the literature relate to the centrality placed by Rogers' (1959) on the therapeutic relationship and the core conditions of therapy: unconditional positive regard, empathy, and congruence. Carkhuff (1984) integrated client-centred and behavioural theories, and suggested further conditions of respect, specificity, genuineness, self-disclosure, confrontation, immediacy, and concreteness. In describing key components of a positive therapeutic alliance, Erikson (1950) identified 'Basic Trust', (general optimism and hope), 'Secondary Trust', (remaining open to parental or other influences and ideas), 'Autonomy', (allowing the client to take responsibility), 'Initiative', (confidence in the individual's interpretations) and 'Industry', (confidence to believe in individual's responses and plans). Respect and belief for the client's innate ability to solve their own difficulties is further seen as integral to productive therapeutic relationships. Interestingly Freud (1920) also associated trust with belief in individual autonomy. Humanistic and Existential practitioners have also described trust and autonomy as core conditions associating it with unconditional positive regard and respect (Brazier, 1996), as have Cognitive Behavioural Therapists (e.g. Beck, 1979).

There is strong empirical evidence therefore, that such core conditions are seen by many practitioners from different therapeutic orientations as the central ingredients to a successful and beneficial therapeutic relationship. There also is significant argument that highlights the importance of therapist's characteristics and presence in both the establishment of core conditions and therapeutic effect (Baldwin and Satir, 1987, Lambert, 1989, Holdstock, 1993, Stevens, 1996, Erwin, 1997, Frank, 1998). Acknowledgement of the therapist as participator therefore is a shared interest of Mindfulness and psychotherapy research. A full exploration of conceptions of 'the self as therapist' exceeds the remit of the present investigation but for examples of relevant theories see Casdan (1988), Van Deursen-Smith (1998), Andrews (1991), Howe (1993), Mann (1994), Wetherell and Maybin (1996).

These core conditions are perhaps reflected in the participant's descriptions particularly in Theme Two (The Subjective Experience of Mindfulness) and Theme Three (Being a Mindfulness Practitioner). It could be argued, and will be explored later, that one of the main contributions of Mindfulness is that by design it promotes core therapeutic conditions by providing an environment that co-creates and sustains this kind of therapeutic relationship.

As previously indicated, however, the language of Mindfulness is perhaps more similar to poetry and literature than to clear scientific descriptions, and therefore it does not lend itself to a single operational definition (Brown and Ryan, 2004, Bishop et al., 2004). A number of the participants (e.g. Duncan) highlight this difference. It will be suggested

that this reflects the nature of Mindfulness as a process and not a simply technique, (as explored in Theme 1) and therefore understanding 'how to be Mindful' is similar to understanding 'how to appreciate art'. Although one can describe 'unconditional positive regard' for example, and how this may be achieved, it is quite another thing to experience it. This phenomenological perspective in Mindfulness therefore is the essence of 'being-with' and must be the starting point when considering its relationship to the core conditions.

4. 23 Choice, Autonomy and Immediacy

Mindfulness practice is described as proving access to the client's innate ability to choose and have freedom by being based in their phenomenological experience as it occurs and is not restricted by past precedents (3.43, 3.44). Childs (2007) characterises this position of Mindfulness as a sense of asking 'Why not?' as opposed to 'Why?' Existential theories further argue that therapeutic environments are ones that consistently show faith in the client's ability to make good choices for themselves and others (Van Durzen, 1997). Throughout the analysis participants make reference to how Mindfulness creates a condition whereby this level of self-fulfilment can be expressed (e.g. 3.41). The participants constantly refer to client empowerment and having faith in the client's ability to resolve their issues (e.g. 3.44). Mindfulness is seen as helpful way of un-cluttering thoughts or feelings that block this process of self-empowerment.

Similar perhaps to humanistic concepts of developing unconditional positive regard, autonomy and self-acceptance Kabat-Zinn (1991) suggests that Mindfulness can be understood in terms of seven 'attitudinal' foundations. These are Acceptance, Patience, Trusts of One's Intuition, Non Judging, Non Striving, Letting go (not grasping or pushing away), and Beginner's Mind (seeing everything as if for the first time). The latter foundation in particular encourages the client to be congruent in the here-and-now and not with past modes of being.

4.24 Self Actualisation

Rogers (1961) and Humanist theorists (e.g. May 1960) argued that all humans have an innate tendency towards self actualisation and it was the therapist's responsibility to help enable the client to reach their potential. It was very much a practice of 'doing with' not 'doing to'. Existential theories (see Cooper, 2007) also argue that individuals are continually seeking growth and self actualising experiences in the world and it is this potential that therapists attempt to free from the constraints placed on by the self and others. Considering the Mindful position as described the by participants, it is not separation of the Mindful self that embodies qualities of compassion or awareness, but an identification that this already occurs within the self. One does not become Mindful, one is Mindful, or 'wakes up' (3.41) to their innate Mindfulness (Kabat-Zinn, 1991, Childs, 2007). Similarly to the Humanistic position therefore, Mindfulness encourages the client to be in touch with 'hidden' qualities as opposed to be trained in new ways of being. Mindfulness is relearning not new learning (3.53). However Mindfulness is not simply a

Freudian way of making the unconscious more conscious, it is about active individual movement and growth in the present (Cortright, 2007); or noticing, accepting and informed response (Theme 2). The sense of self actualisation may be a more helpful way for the Western practitioner to understand the Buddhist concept of Enlightenment.

4. 25 'Being-With' – The Presence and Personhood of the Therapist

The results of the analysis, in particular Theme 3 (Being a Mindfulness Practitioner), provides an account of the role of Mindful Therapist. It is clear that this is seen as close, collaborative and open, and that the therapist's position is very much participant and observer, sharing their own process, as opposed to the more classical role of observer-interpreter (3.54). The therapeutic encounter in Mindfulness therefore is clearly a 'two-person process', more familiar with guided self discovery of the Humanistic and Existential frameworks than the abstinence suggested by traditional psychoanalysis (3.55). This further sense of 'Being-With' calls for the Mindfulness practitioner to be more emotionally available to the client, vulnerable, comfortable with self disclosure, and more able to stay in the moment and not necessarily rely on a particular therapeutic 'script' (e.g. feedback from homework and goal setting). Research that has considered differences between Mindfulness practitioners[2] therapists and other therapists has found they have more self consciousness, enhanced self awareness, reduced stress, less negative emotions, reduced anxiety, and increased positive feelings and self compassion (Brown and Ryan, 2003, Shapiro et al., 2007). Mindfulness was also correlated with positive

[2] Predominately in training

emotional states and control of behaviour (Brown and Ryan, 2003) and has been related to increased client success during the therapeutic process and the outcome (Grepmair et al., 2006).

Interestingly, in comparison to research on therapeutic technique and results, the therapist's presence throughout the process is relatively ignored. A key feature of Mindfulness is that both therapist and client presence, and the experience of this, are crucial conditions. This draws attention to the moment-by-moment process of therapy and the immediacy of the therapist in response to the revelation of the client's unfolding story. This process is given little attention by many therapeutic models, but one of importance to therapists themselves (Smail, 1978). As Hazler (2001b) comments; "Therapists are not automatically graced with productive therapeutic environments. No matter how advanced their training. No amount of knowledge or experience dictates all the human factors clients and therapists bring to a given session. Conscious planning and preparation of an environment is the starting place, but the ability to recognise and adapt to changing situations is essential follow up" (p.6).

4.26 Therapeutic Relationship

One of the most basic components of the therapeutic encounter is the relationship, not just providing a containing or holding environment for the client (Winnicott, 1965) but one that equally considers the therapists. It is interesting that many theories (e.g. DBT,

psychoanalysis) are cautious of therapists becoming 'too involved' with the client's distress, or to discourage client's requests for more intimacy of contact. Such requests can be pathologised as 'dependant' or 'manipulative'. However interventions such as Narrative Therapy (Monk et al., 1997) argue that by being fully immersed in the client's story helps to understand how they respond and conceive the world and establish an agreed frame of reference between the client and therapist. However, unlike novels, client's narratives do not have a clear process to follow and it takes patience by the therapist to sit with the process. Narrative Therapy also recognises that as a result of the intimate and unique nature of the narrative, therapists have to be aware of the pace of the process (Kottler, 1991).

Fisher (1990) points out that one of the main reasons clients come into therapy is because of a lack of intimacy in their relationships, and suggests that intimacy should be recognised a legitimate therapeutic concern. Fisher (1990) suggests that therapist's self-disclosure and sharing experience is crucial in the process of the client really 'feeling' a relationship. Smoley and Kinney (1999) further argue that without this sense of feeling in the relationship there can be no genuine and authentic connection and without which there is no significant change. As Jung is cited as remarking to clients, "So you're in the soup too!" (Jung in Bennet, 1982, p.32).

4.27 Two-Person Process

Considering the importance of relationship, therapeutic practice can be understood as a two-person process which perhaps acknowledges that being-with necessarily means the active involvement of the therapist. This is not a unique statement in psychotherapy theory, (Bion, 1962, Ehrenberg, 1984), as discussed briefly below, but a stance that seems integral to Mindfulness practice (see sections 3.54, 3.55).

It is of note that in identifying a 'two-person process', the main models (MBCT, MBSR, ACT) of Mindfulness are largely provided on a group bias. Whilst some of the participants offer group therapy (two exclusively), they also comment on it's use individually. Although DBT offers Mindfulness as part of the group training, it also understood as a central component in initial therapy with clients, and within the model therapists are expected to practise and discuss the client's use and experience of Mindfulness on a weekly basis (Linehan, 1993a). There is also a relevant, growing body of research that has examined the application of Mindfulness in individual interventions (Crane and Elais, 2006, Kelly and Kahn, 1994) including CBT (Walsh, 2005). Given the results of the analysis derived from participants experience of group and individual therapy, in particular their descriptions of the process, there is notable overlap between these two therapeutic mediums suggesting once again the importance of individual phenomenological exploration in Mindfulness.

Jung's (1963) theory of the collective unconscious suggested an interconnectivty of a shared heritage of predispositions and qualities, expressed by the individual through experience. Jung referred to therapy as a 'dialectical process' and therapeutic relationship as 'dialectical mutual', acknowledging the dual responsibilities of both parties to make sense of the issues.[3]. In this sense he described the therapist as a 'wounded healer', who is able to identify their wounded qualities in the client and that conversely the client sees the healing and coping nature of the therapist. To Jung, the therapist was the instrument of therapy that drew on his or her own distress to help with the healing process. Interestingly, Jung also maintained that for this process to happen, training and personal therapy was essential. This was also suggested by the participants (see section 3.52).

From a dynamic perspective Neo-Kleinians (Schafer, 1994, Spillius, 1994) also acknowledge dual roles in the therapeutic process. Therapists are seen as 'receivers' and 'projectors' of non verbal communication. This has been described as the process of the therapist's projection of bare attention, non-judgement and non-attached awareness of the present. Barwick (2001) has drawn a parallel between this position and Mindfulness, noting; "It is the introjected condition of meditative Mindfulness that may offer hope of true psychic change" (p.31). Considering the interpersonal quality of relationships, Buber (1970) suggested that what he described as the 'I-Thou relationship' is critically different from the 'I-It relationship', as it provides the essential environment for growth and change to occur. Therapeutically, the former process ('I-Thou') acknowledges and promotes equality, whereas 'I-It' emphasises the therapist as a role more than an

[3] It is interesting to note that one of the main popular therapeutic models that incorporates Mindfulness is DBT, which is based on the theory of Dialectics

individual. Perls (1976), from the experiential encounter perspective, described the therapeutic relationship as one in which the boundaries of the internal world connect with the external environment and argued that change occurs when these boundaries are explored through the relationship between two people.

There is significant cross model debate therefore, that advocates for an active, immediate and intimate role for the therapists. As Hazler (2001c) suggests, "The question...is not whether there is contact, but will there be enough to allow troublesome therapeutic boundaries to be approached successfully?" (p. 81).

4.28 Qualities of the Mindfulness Therapist

Personal practice was described as a vital and ongoing necessity by the participants, linking it with authenticity, competency, mastery and greater chance of client success (see section 3.52). Personal practice has been also identified as the main way to understand Mindfulness (Allen, Blashki and Gullone, 2006, Rothwell, 2006). Bein (1962) argued that as a holistic therapy practitioners should not only have a personal practice but also have developed a sense of spiritual awareness. Other therapeutic models such as Cognitive Analytic Therapy (CAT) and Transactional Analysis (TA) require that therapists experience personal treatment in the model as part their training, but there is no insistence that this should continue when qualified (Connor, 1994, Le Shan, 1996).

Psychodynamic practitioners often continue with model specific personal therapy but this is not the same quality of ongoing practice described by the participants (see section 3.51, 3.52). Personal Mindfulness practice is not about achieving a goal such as feeling better or becoming a more skilful practitioner therapeutic, it is concerned with just experiencing, and it is this kind of engagement that authenticity is achieved. Therapeutic skill in this sense is more a consequence than the aim (see section 3.35. 3.36). It is less about being 'done-to' and more 'doing-alongside', or simply 'doing' (Miller, 2002). Mindfulness is a more global practice than improving psychological health. As indicated by the participants it is perhaps better understood as a way of being or an attitude than a psychotherapeutic model (3.55). Such a rigid application of 'techniques' also contradicts any phenomenological perspective into the therapeutic process. As Wosket (1999) has commented, "My belief is that many counsellors could become more effective if they sometimes directed their attention away from models and processes taught to them, and more towards acknowledging their own unique helping attributes" (p.3).

4.29 Presence

The emphasis on 'being-with' also requires the therapist to be an involved participant in the process, and their clinical presence and personhood becomes an important ingredient (see sections 3.36, 3.54, 3.55). The necessity for such a quality of clinical presence is relatively overlooked in the literature, (Miller, 2002) though is central to arguments by Wosket (1999), Childs (2007), Cortright (2007) and Kahn (1997). Put simply, clinician's

presence can be described as "Presence requires practice and empathises a personal experience. You have to be there". (Childs, 2007, p.369). As noted above, presence therefore encapsulates the need in Mindfulness for a therapist to have personal practice, personal understanding through experience, self-disclosure and immediacy (see sections 3.36, 3.54). Commenting on the a review of the relationship of different orientations to the therapeutic process, Hazler and Barwick (2001) concluded, "therapists bring all their training and professionalism to the encounter with clients, but it is their 'personhood' and the human relationship they can offer that provides the most unique aspects of this therapeutic environment", (p. 95).

Presence therefore describes therapists who embody their practice, being aware of it to some level in all aspects of their life, and not one who wears it only at certain times or on certain occasions. As Brazier (1996) argues, "What matters, after all, is not whether one adheres to the best list of principles so much as whether those principles are harmoniously integrated in one's way of being with another person and being with the world at large", (Brazier, 1996, p.5), (see sections 3.41, 3.54). On occasion this can require the therapist to priorities presence above theory in the service of the therapeutic process, "Although no therapist can do without a typology, at a certain moment the therapist throws away as much of his typology as he can, and accepts the unforeseeable happening in which the unique person of the patient stands before the unique person of the therapist" (Freidman, 1992, p.17).

4.210 Self disclosure

As discussed earlier, therapist's self disclosure opposes the detachment advocated by the classical psychotherapeutic position, and in so doing raises important issues of empowerment that are central to humanistic, existential and egalitarian process. Again, this is a perspective that has a long, if occasionally ignored, history; "The doctor must emerge from his anonymity and give an account of himself, just as he expects patients to do", (Jung in Barwick, 2001, p.21).

Similar to the Mindful position, Prouty (1994) argued that positive contact requires both client and therapist to be aware of the immediate interaction and space between each other on a moment-to-moment situation. One way of achieving this is through the mutual sharing of feelings, thoughts and bodily reactions as they occur, and being in the here-and-now (Kohut, 1971, Prouty, 1994, Gendlin, 1996), (see sections 3.32, 3.54). Self disclosure based on the experience of the process can be seen as a vital ingredient in building a positive relationship, "Therefore it is not so important whether the counsellor interprets or reflects, but rather whether the counsellor offers symbolisation that articulates those aspects of the client's experience that represents potential for further development" (Timulak and Lietaer, 2001, p.71).

Appropriate self-disclosure therefore, is based on the accurate expression of the therapist's experience of being-with the client. More than just a therapeutic technique, self-disclosure contributes to the establishment of therapeutic environment premised

solely on the experience of the client. As Hazler (2001) agues, "It is the therapist's willingness and capacity to experience unique world visions of another that makes it possible to create an environment designed to focus on the perceived world of the client, the phenomenological world" (p.73).

4.211 Clinical Wisdom

In Japanese literature Mindfulness is represented by interactive figures representing the heart and the mind. (Santorelli, 1999). Shapiro and Schwartz (2000) have also suggested that a more accurate translation would be heart-mindfulness and have argued for the identification of 'heart qualities' (Shapiro & Schwartz, in preparation). They suggested that such qualities can be identified with bringing concepts of kindness, curiosity, compassion, pertinence, and openness to awareness, particularly when one's experience of an event is in contrast to their wishes or expectations. They further argued that the absence of heart qualities could result in a punitive and judgmental practice. A similar quality has been proposed by Bishop et al. (2004) who defined curiosity, acceptance and non-striving as *orientation to experience*. Although some theorists (e.g. Cortright, 2007) discuss different but overlapping components of Mindfulness and Heartfulness, many more note the importance of being 'heartfelt', or developing an 'open heart presence' (e.g. Kabat-Zinn, 1991). This quality of Heartfulness highlights the importance of therapist's presence and practical experience to understand the practice in relation to being with the client. It is not therefore about obtaining a theoretical understanding of experience, but more a cultivation of 'enrichment' for the therapist and client (Stern, 2004). As Kabat-Zinn (1995) described, "It is simply a practical way to be more in touch

with the fullness of your being through a systematic process of self-observation, self-inquiry, and mindful action. There is nothing cold, analytical, or unfeeling about it. The overall tenor of Mindfulness is gentle, appreciative, and nurturing. Another way to think of it would be 'heartfulness' (p.142). It calls for the therapists to have an explicitly personal engagement in the therapeutic process, with a more sophisticated use of theoretical ideas informing, as opposed to directing the process (3.35). Recalling the theories of mechanism discussed earlier (see section 1.8), this arguably adds support to theories of IAA (section 1.82) and Repreciving (section 1.83).

This component of heartfulness also relates to research that has identified the concept of 'Clinical Wisdom' (Shapiro et al., 1989, Lomas, 1991, Kline, 1992). This term describes the accumulated skill and experience that allows therapists to be more flexible in their interactions with clients, to validate their in-the-moment feelings, and use this to direct interventions. Clinical wisdom has been seen as more important determinates of outcome than technique or specific theory (Feltham, 1997, Patterson and Hidore, 1997, Childs, 2007). Echoing the research into therapeutic process, as discussed previously, Wosket (1999) further noted that, "the most clinically effective therapists are in many respects equivalent and that equivalence derives more from factors such as clinical wisdom and the enlightened use of the self than from the utilisation of techniques and systematic treatment procedures" (p.19).[4] Clinical Wisdom therefore recognises the value of the

[4] Interestingly, drawing on the anthropological and cultural context, Wessler and Wesler (1997) argued that important figures of guidance in primitive and modern societies have been priests, shaman, sages, elders, and counsellors who relied on such this accumulation of experience and wisdom.

individual humanity of the therapists, not as a static and mechanical entity, but as a developing and phenomenological wise being. (sections 3.34, 3.51, 3.52)

In keeping with the existential position, inherent in clinical wisdom is the recognition for the therapist not to be perfect, and that there is no 'ideal situation' (section 3.51). A sentiment also voiced by Transactional Analysis (Berne,1961, Van Stewart and Jones, 1987). It also I feel, recognises the developmental, experiential and integrative expertise of therapists who over time become less bound to a particular theory or set of theories, and practice something more personally meaningful. As Kottler (1986) notes, "the first decade of our professional life is spent imitating the master clinicians before we ever consider what we really believe in our hearts" (Kottler, 1986, p.15). It is not abandoning one's training but instead choosing to be led and informed by it when appropriate, as Karausa (1999) has argued, "the surviving clinician...does not need theory to buttress his being" (p.132). This is the essence of theory-guided-practice and similar to what Wosket (1999) describes as 'healthy unorthodoxy' and Mearns and Cooper (2005) identification of 'relational depth'.

Following from this it can be argued that the kind of psychotherapeutic variables evidence based practice seeks to identify, cannot be divorced from the situational context created by each unique therapeutic dyad with any significant meaning (Butler and Strupp, 1986, Beutler and Consoli, 1993). Wosket (1999), for example, identified a therapist's stance as either 'experience-near' (personal, vulnerable, exposing, phenomenological) or 'experience-distant' (remote and descriptive, theoretical as opposed to personal). By

investigating the outcome favoured by a RCT, one misses the individual variables that may contribute as much to change. This could be the therapist's presence as much as the application of a given technique. Strupp (1986) described the difficulties of a technique only perspective, "it is largely meaningless to examine the surgeon's scalpel to discover why a particular operation was successful, but one may learn a great deal by focusing on the manner in which the surgeon...employs it" (p.125).

4.212 Summary of 'Being-With' from the Mindful Perspective

Mindfulness therefore is very much about encouraging the individual to 'be-with' the full breadth of their experience at a given moment in time. Recalling the theory of Buddhism outlined earlier, it permits the person to experience an emotion or an event without having to embody it (sections 3.41, 3.42, 3.44). Buddhism is not the only culture that suggests one can experience a feeling and not 'be' it. In Gallic Irish an individual describes themselves as 'having a sadness come over me' as opposed to the formalised 'I am sad'. One's self or 'am-ness' therefore is not conditional on a particular emotional state. Instead one can just be a participant-observer. However, inherent in Mindfulness is also a sense of compassion, described not only by self-soothing but also good humour and good natured resilience (Gilbert, 2005), (3.44). Non-judgment is not just about ending self criticism but points as well to an existential acceptance of the givens of life; the acceptance that sometimes 'that's just how things are'. Bad things can and do happen but it serves no purpose being overly attached to them. This is not to reject grief, anger or

appropriate emotional response, instead the Mindful position notices and accepts, giving the individual psychological space to experience them and continue with their life (section 3.42).

Being-With also acknowledges the presence and contribution of the therapist as a participatory human being. The therapeutic process is a co-constructed space and attention to the therapist's expressed humanity, through the use of self-disclosure and shared narrative is a vital consideration. Being-with also permits the therapist to sit alongside the client informed by their clinical and personal wisdom and not just the boundaries of the model. In this way the process is unique and client defined, and not an attempt to fit their experience purely into a favoured therapeutic model. In this way, through the insistence of being present moment focused, personally vulnerable and accepting of the client's expression, Mindfulness encourages the core conditions to be a primary consideration in the process (sections 3.35, 3.51).

In a dialectical tension, 'being-with' invites the therapist to find a synthesis between the thesis of 'model-bound' and the antithesis of 'model-less', but one based on the autonomy and present reality of the individual client and the shared reflexive process of how it feels to be with that person at that time. Understanding it in this way sees Mindfulness as more than just a method to obtain or maintain this stance. Instead, as the participants argue (Theme 3: Being a Mindfulness Practitioner) it is a way of being, and attitude that underlies all components of their therapeutic processes.

Recalling the theories of mechanisms discussed earlier (section 1.8), this arguably adds support in particular to the theories of IAA (section 1.82), Repreicving (section 1.83) and the indetification of Focused Attention (FA) and Open Monitoring (OM) in MBSR These concepts describe the imporance of therapeutic process in Mindfulness, caputring also the 'heartful' through the shared experience of 'heart qualities'. The axioms of the IAA and quality of Repercieving further supports being-with in the recognition of the two person process that invites the clinically wise therapists to be an involved, present, active and genuine particpants in the process.

4.3 Reflective Process

As recommended by IPA I kept a Reflexive Journal throughout the process of the research (see Appendix for an example of journal entries). This has been of central value, not just to the research process, but also to help inform the supervision process and an account of my wider clinical development. I often reflected back on the journal and used entries as free space to a contemplate issues stimulated by undertaking the research that were of more general salience to my practice and professional identity. Sometimes these were quite basic reminders. For example following my second research interview, I was struck by my feelings concerning the relationship. Although I had conducted qualitative research in the past I had not considered enough the issues of role and power. I have been working for more than nine years in the NHS in multi disciplinary teams. Relationships with other professionals although varied, are within a certain context. Even discussions

about other's practice are informal, and still contained within the NHS environments of service provision, clinical responsibility, care planning and risk. People simply do not have the time, or perhaps it is not seen as a valuable use of time by the organisation, to reflect on their practice with others. The research question therefore premised on understanding therapist's experience is in stark contrast to this climate, for both the participants and myself. With hindsight I think there are ways in which this can be seen in the interviews. For example in some interviews we initially seemed to follow an 'assessment script' (starting with a history, present situation etc), when beginning to explore their experiences. This may have influenced discussions concerning the role of Mindfulness in Western practice, as perhaps both of us had become aware of this on some level as the interview progressed. It is interesting to note looking back at the interviews that this occurred with both female and male participants regardless of professional training, but was perhaps more obvious in interviews with more long term practitioners. A minority of practitioners had some private practice but all were in involved in the NHS. It would be interesting to see if similar experiences would be expressed by practitioners with no NHS experiences or who are involved in organisations with a different value base.

One of the most significant reflections was the development of my understanding of Mindfulness throughout the research. I started with an interest, some indirect training through DBT, and a limited awareness through its raised clinical profile. If thoroughly questioned at the beginning, as reflected through my journal, I would have concluded that it was a skill or a technique that appeared to be helpful but I was uncertain of its shape

and form and therefore perhaps a bit suspicious. This suspicion I feel is related to an underlying sense of inadequacy of needing to be able to master something in a clear and full way. Interestingly, considering the nature of Mindfulness, such a feeling of mastery, if ever really attained, has often proved to be unfulfilling. I had joined a small Mindfulness group during the course of the research which met on a weekly basis. It was set up as a secular group practicing bare Mindfulness for two twenty minute sitting. In some ways this may be seen as a bias in my objectivity towards Mindfulness, but in many ways felt like a companion on my experiential journey, synchronous to the research process. It gave me no 'answers', was not led or guided by any individual or specific method, and often characterised by uncertainty. Through both processes I increasingly became aware that Mindfulness was not such simply categorised phenomena, and made me consider how I understood other theoretic models or psychological theories, and how I understood myself as a therapist. For example what exactly was my role in the relationships, how am I understood and how do I understand myself? For sometime I have suspected that a therapist is more an informed companion on a particular journey with the client, than a detached expert. Through the process of the research, interviewing the participants, analysing their material, and researching its implications, this position has been further solidified. Not however without some discomfort. Having to abandon the idea of somehow embodying 'cure' in the medical model perspective was almost as uncomfortable as having to admit that part of me had cling to this identity. I hadn't realised how this perspective had grown within me, although on reflection it is endemic in the NHS. In an interesting parallel to Mindfulness, letting this go and exploring the space that is left has been enormously freeing and has increased my therapeutic depth

greatly. It also helped me develop a clinical service with a colleague offering a group to clients often diagnosed as having untreatable personality disorders. It is this personal and clinical maturity that I feel reflects the process of Mindfulness. This describes a way of relating and disposition from which Mindfulness is perhaps the most visible component. This put me back in touch with my initial training and the basic counselling relational qualities, which include warmth, genuineness, empathy, presence, compassion, being interested in the other, non judgement.

Reflecting upon this further I am surprised by how non evangelical the participants were in their interviews. There was no attempt to sell Mindfulness to me, in stark contrast to the DBT training where our processes were evaluated in compassion to their fidelity to the established position of Marsha Linehan. Instead participants spoke of their experiences, only inviting me and others to 'try it and see' with appropriate guidance. I didn't feel pressurised or influenced to support a particular view, and there was not a great sense of antagonism expressed towards practices they disapproved of (e.g. how Mindfulness was researched in West). Instead they spoke of concern and a need for more mutually informed discourse. I am of course affected and influenced by the accounts of the participants, but I don't feel I have become a champion or destroyer of a particular therapeutic position. As the section below indicates there is much that I am still unsure about. Thinking about the experiential process has helped to clarify some of the original 'how to's' and 'how do you know when' questions I initially had, but there is a still an elusive quality to the practice.

There has been a synchronous quality to this research from the outset. The IPA methodology, rooted in phenomenological, individual understanding has felt similar to my experience of Mindfulness. The frustrating, often confusing, occasionally maddening, but coupled with moments of exhilaration, derived from the process of IPA, has much in common with Mindfulness. Both seemed to be about cultivating a detached, meta space of observation, resisting the constant appeals of emotion or thought, to arrive at a more grounded and evolved understanding of a process at that moment. It seems obvious to think it now, but it was not something I had prepared myself for, and despite listening to, and reading about the experiences of other's IPA processes, one can't know 'it' until one is doing it. I have felt immersed in so many varied contexts.

I'm not sure what the participants will think of the research, the analysis and the conclusions, but I hope they will feel it is an honest account of their experiences, which has been given much thought, and attention. I hope also it captures some part of their position and adds to their clinical and theoretical discussions. It has been a huge voyage of discovery, leading me to not just consider, but to really in engage in all the implications. I didn't expect to have to think so much about phenomena of therapeutic practice, clinical wisdom, the core conditions and the whole cultural debate, for which I still remain unsure, when I first started to be interested in a technique I'd heard about called Mindfulness.

4. 4 Critical Evaluation

This section presents critical limitations of the research identified as three themes, Methodological, Cultural and Conceptual.

4.41 Methodological Limitations

This research does not represent every therapist who practices Mindfulness but a homogeneous group of participants who identified themselves as practitioners who used Mindfulness in their practice. Furthermore the research cannot account for practitioners who either did not (or felt they did not) meet these criteria or those who did not respond to request for interview. Recruitment methods for participants described in the Methodology would also have restricted access to participants. In particular participants who did not work in the NHS or NHS related organisations were excluded. This may present a further bias when considering participant's experiences. Therefore it would recommended that similar research be conducted in different clinical contexts and countries in the East and West to investigate differences

Participants also had long but varying levels of experiences of Mindfulness therapeutically. Further research could involve larger numbers of participants with more matched clinical experiences. It may be helpful to conduct interventions with two groups of newly experienced and significantly experienced Mindfulness therapists and compare any difference. There has been no attempt to control for differing professional trainings

and it is unknown if this is a significant variable. Further research could also match Mindfulness practitioners with specific mental health training or therapeutic training to see whether, for example, CBT practitioners are more inclined to adopt Mindfulness interventions, as opposed to Psychodynamic orientated practitioners.

Participants were also all white, English speaking, mostly from a British background and living within a similar geographical area (the South West of Britain). Therefore other ethnic groups may construct their experiences from a different cultural perspective and as suggested above, research investigating such cultural explanations would be recommended. Furthermore, this research is based on a UK based sample of therapists and practitioners from other Western countries may have different experiences.

Another limitation of the research was that participants were all self selected and fully informed about the purposes and uses of the research prior to interview. There could therefore be bias in a sample that only includes those that wish to participate. For example, participants could tailor responses in an effort to be helpful or they may be interested in promoting personal perspectives. As the interviews lasted more than an hour and were phenomenological in nature, it would however be difficult for participants to maintain an overly guarded approach.

Further qualitative studies could be conducted to investigate both the specific and general concepts of the analysis. IPA studies of different groups of analysis may find notable similarities or differences. It would be of interest to compare findings with therapist's

experience of mindfulness. However, as a methodology, IPA can be criticised in that as a phenomenological based method its powers of generalisation are limited and highly specific to a particular time and location. IPA further prioritises the validity of the representational nature of language and therefore may only be capturing abstractions as opposed to the reality of the phenomena under question.

Considering the use of descriptive language and also the various cultural implications of translation, Discourse Analysis would be recommended to further analyse these and other transcripts. Longitudinal qualitative studies could also explore the effect of Mindfulness practice on mental health and well being over defined time periods.

Quantitative research, perhaps through questionnaire-based analysis, could compare the themes suggested by the Analysis with other Mindfulness practitioners to see if there is significant agreement. This may further enhance the external validity of the study. This could be conducted within the UK and different cultures again to see if there is a significant level of agreement.

The theoretical concepts in this research have only been briefly explored and more detailed investigation is recommended. In particular, overlaps with Existentialism would be of interest.

Finally, the results of the Analysis suggest that anthropological, cross cultures, and theological research could add significant information to the wider understanding of the

Mindful position. In particular ethnographic research in cultures of origin could yield more detailed data regarding the personal and community practice of Mindfulness.

4.42 Cultural Limitations

It has to be noted that although an important area to be considered, there is no attempt to present a detailed account of the effects of cultural variables on the individual therapeutic process as it exceeds the more generic lens of the current investigation. Relevant reviews however are provided by Ruiz (1998), Bland and Kraft (1998).

Although the concepts of 'being-with' may be a helpful way to express the practitioners' experiences of Mindfulness, there are several reservations concerning their use that must be considered. Initially, one must acknowledge the difficulties encountered by translation, both verbally and sociologically, and the issues of cultural relativity. Taking a dialectical position towards 'East versus West' it would be unrealistic to reconcile this debate by adopting the antithesis and make the West more East or vice versa; a criticism again voiced by the participants (Theme1: The Culture and Context of Mindfulness). As Jung (1929) suggested, "It is lamentable indeed why the European is false to himself and imitates the East or 'affects' it in any way. He would have so much greater possibilities if he would remain true to himself and develop out of his own nature all the East has brought forth from it's inner being in the course of the centuries", (Jung, 1929, in Smoley and Kinney, 1999, p. xvii).

In emphasising the Eastern origins of the practice therefore, practitioners have to give serious attention to the question, 'can one culture ever be really understood by another?' Language is perhaps the most visible example of possible communication differences, but it is also cultural bound in the sense that the concepts language describes can only ever be fully understood within the unconscious, non verbal and developmental process of that culture. An example of this is would be the many Post Modern sociological and anthropological critiques. Indeed the process of translating Eastern concepts may lead to confusion especially when there are not equivalent Western terms. It would erroneous therefore to reference Eastern thought as a guarantee of authenticity of practice. The description of Eastern thought itself furthermore being a meta construct that describes many different forms of practice and theories. Examples of visiting eastern Masters have indicated that often they do not recognise what a Western practitioner may describe as Mindfulness, mediation or yoga (Epstein, 1995, Brazier, 2003).

Smoley and Kinney (1999) suggest, "In the civilisations of Asia, esoteric teachings have seemed more or less at home. Disciplines such as Yoga and meditation are widely known and have been widely practiced. This has not been the case in the West. Esoteric schools have often surfaced for a generation or two...and vanished, often enough they are deliberately destroyed or suppressed" (Smoley and Kinney, 1999, p. xx). One interpretation could be that this represents an aggressive and controlling nature of the West. Another could be that this just may represent how Western culture develops. Put simply, the structures of the East may be respected, but we simply don't want them. As the Analysis indicates, the participants are keen to refute suggestions to make the West

more Eastern. This underlying dynamic however, may be saying something more generic about the cultural appetite of the West. Maybe it is like an irrepressible child, hungry for new experiences and reluctant to settle on one, whilst in the East a child is more content to savour a specific flavour without fantasising about the next course. Perhaps neither position is necessarily wrong, but fundamentally they are just built differently. Recalling the Noble Truths and the experiences of Mindfulness described, they could therefore be an irreconcilable clash of cultural mindsets.

A full discussion of the effects of integrating Eastern and western Theories exceeds the remit of the present research. It does however pose questions concerning how we understand scientific truth and perhaps leads to a consideration of the New Physics movement and the theories of Quantum physics.

4.43 Conceptual Limitations

How, for example, does one establish themselves a practitioner without a governing body or set of standards to ensure safe practice? Is it just enough to state that one is operating from a Mindful position? In terms of training, although it is seen as essential and ongoing, it is not structured and there are no guidelines that stipulate attainment of essential requirements, progression, supervision standards or examination. There is no way therefore of quantifying a therapist's knowledge and therefore no way of establishing a criteria for quality of practice or indeed protection of the public. One implication of this could be to describe the Mindful position as one of style, preference or personality.

However, evidence-based research (e.g. NICE, 2004) would suggest this kind of experience is not needed for many clients referred to services. Two thirds of these initial referrals are to brief, technique based, Primary Care services. Similar to objections made against psychodynamic and model specific therapists (Smail, 1978, Mason, 1992) practitioners may also have to respond to charges that their practice is more related to personally indulgence and less to client need.

This relates to further considerations regarding how Mindfulness is practiced within Western healthcare systems. If one accepts the concerns participants raised regarding the appropriateness of Western research methods, it is hard to know how Mindfulness can be incorporated within organisations such as the NHS without fulfilling the evidential rigour expected of other treatments. If Mindfulness is to be understood as a complementary practice it would be needed to be understood within this culture and its access to health care systems would be significantly reduced.[5]

4.5 Conclusion

Mindfulness to the participants involved in this research appears to have represented a way to integrate and contain secular theoretical and philosophical beliefs into their everyday personal and professional lives and is seen very much as the glue behind their therapeutic processes. Mindfulness is in essence simple to describe, one notices, observes

[5] An example would be the rejection of Hypnotherapy by NHS and Insurance companies as a legitimate form of treatment, although there are accreditation boards and established training courses in Hypnotherapy.

and accepts. In experience however, it is totally different. This divide between description and experience is perhaps at the heart of this research and underlies every theme and theory described. Putting aside the complex arguments of existentialism or personal construct theory one is left with the reality of their being-in-the-world. It's not very comfortable and it's not necessarily particularly satisfactory. It won't be met with fanfares or an ecstatic sense of enlightenment. In a position similar to suggestions from therapeutic process based theories (Skovalt and Ronnestad, 1992, McLeod, 1993, Fear and Woolfe, 1996), the therapist's role is to sit alongside the client sharing uncertainty, accepting unknowingness, and finding a way to work together.

It is this quality that this research highlights, and unique in the current literature identified by the concept of 'being-with'. It places the emphasis firmly on the reality of the therapeutic process, makes space for the existential clinical wisdom of the therapist, and gives permission for their identity and feelings to be an expressed presence in the room. The therapeutic process is not confined by external structures; instead it is defined by the meeting of two human beings, limited only by the restrictions they impose themselves.

In many ways Mindfulness exposes emphasis placed on rationality by the West. The premise of Logical Positivism, the dominant philosophy in science, and arguably the prevailing cultural ontology, is based on what can be seen and proved logically. Writers such as Tungpa (2005) have noted Buddhism was not conceived with Western psychiatric diagnosis in mind, and although Mindfulness may be useful in treating anxiety and other psychological disorders, it is a practice that has a wider cultural context within a tradition

which is used for different purposes such as liberation from a continuing cycle of suffering and rebirth (Epstein 1995). Enlightenment in this sense is not about attaining Western states of euphoria or omnipotence; instead it is more about really knowing 'what's on the end of one's fork', being in a moment, irrespective of where one has come from or where one thinks they should be going. Existence is a process and Mindful acceptance lets one sit alongside it synchronously not like a prisoner or subject. Mindfulness, like existentialism, highlights how one can choose their dukka, dis-ease, or distress. It identifies attachment, grasping and avoidance as common themes to therapeutic processes, without constructing complex typologies of diagnosis or standards of normality. Instead of distress encourages responses of compassion and good humour.

The Mindful perspective is counter cultural in this sense that it is not 'either or' and is not simply a technique. It suggests a way of being that is not restricted to formalised cultural practices, religious beliefs, or reliance on a logical positive cognitive based truth. It highlights an important and overdue concern for the West, questioning the conception of existence as 'I think therefore I am' and suggesting instead 'I am therefore I think'. It is the 'am-ness' that is of interest to the client and therapist alike, in a dyadic two person collaboration, and a not simply about reduction of symptoms that defines and comprises the therapeutic encounter. Therapy, therefore, in the Mindful perspective is only ever about the process.

Echoing the Tibetan concept of Mahamudra, the term for something that is beyond expression, the ancient teacher Tilopa noted, "Mahamudra is like a mind that clings to naught. Thus practicing, in time you will reach Buddhahood" (in Chuang, 1974, p.32).

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SECTION C – PROFESSIONAL COMPONENT

'EDWARD': Case Study
'POLLY': Case Study

CASE STUDY 1: 'EDWARD'

1.1 Client Background

Edward is a 53-year-old white, married man who was employed as an Occupational Assessor. He has adult children from his first marriage. His second wife has physical problems related to a back injury and requires support from social services. He suffered a sub-arachnoid haemorrhage secondary to an aneurysm of the pericallosal artery in 2005 with resulting cognitive difficulties. Although there had been improvement in these complaints,Edward continued to have emotional difficulties particularly with expressing his anger. This had resulted in a diagnosis of Episodic Dyscontrol Syndrome, and following concern from his wife after an outburst at home, Edward had been admitted to the inpatient ward.

Edward was referred for a psychotherapeutic intervention by the Neuropsychologist to focus on issues of anger and expression of emotion. A further cognitive assessment had placed Edward within the normal range in terms of his age and intellectual abilities, indicating a good recovery from the brain haemorrhage. It was the suspicion of the Neuropsychologist that there may be more functional elements to his current complaints. A referral was then made to myself to assess and tailor an intervention to address his psychological needs.

1.2 Presenting Issues and Assessment

At the time of the referral Edward had spent three months on a voluntary admission to a psychiatric ward following his wife's concerns about her safety. He was engaged in several ward based Occupational Therapy programmes and had completed the majority of a cognitive rehabilitation programme established by the Neuropsychologist. Furthermore, there had been no reports of any major incidents whilst on the ward or significant aggressive outbursts.

Before I even met with Edward, I was surprised by the concern, with the exception of the Neuropsychologist, expressed by other professionals. There was a clear message from the ward for me to ensure I was in a safe environment and took the appropriate safety measures. I recall feeling quite anxious as I checked the alarm in my pocket before our appointment.

Edward is a large man, well groomed, with a presence of some authority. His posture was straight and confident and he appeared to be reacting to meeting another mental health professional well within in his stride. I felt intimidated as he deliberately refused the chair positioned in front of him and selected another, and then carefully searched through the folders he brought with him and selected one with my name clearly written on the front. I later reflected how the staff on the ward would have reacted to this behaviour.

I explained the boundaries, and held firm for an expected attack. Edward questioned my neurological knowledge, 'I'm not a neurologist or Neuropsychologist', I explained, 'but have some training in treatment of neurological conditions'. I continued by explaining about the association between mind and body and how psychotherapeutic interventions could help, and realised too late that he knew that already. He was just testing me out. That seemed to be satisfactory for him though and there were no more tests. I asked about his feelings and he told me how he was thinking. I asked again and he broke down in tears.

In the remainder of the time we covered much ground. His self-esteem, battered by the illness, had only reinforced messages from his childhood by his parents. He had always felt a failure, personalising every mistake or event that was negative, and the events over the past year seemed to prove it. We spoke about his current environment, his sense of loss and grief, and what he wanted to change. I suggested the goal of leaving the ward and he expressed relief to hear it. From there we briefly looked at long term goals, e.g. leaving the ward feeling safe, and short term goals of building confidence and control of emotions. Edward left expressing hopefulness and I promised to send material for him to read for the next session. I had forgotten about the alarm and removing it from my pocket remembered thinking that I had not just met a man with uncontrollable anger, but an upset individual desperate to regain control of his life.

1.3 Choice of Intervention

This was influenced by several factors. Initially there were time boundaries, as the intervention would last until discharge. I would therefore have to be sensitive to the to the possible intensive nature of a therapeutic model. Secondly, there were clear psychosocial issues, which both contributed to, and influenced the therapeutic issues. Thirdly interventions would have be informed by his neuropsychological difficulties (Lishman, 2001). Finally there were systemic issues that had to be considered.

I felt an Integrative perspective would be the most appropriate approach, (Hollanders, 2003). In terms of his negative thoughts and issues with confidence and control I felt a Cognitive Behavioural framework would be most effective, (e.g. Gilbert, 2000) It had a tenable structure that I felt would appeal to him and one that would be able to be generalised on the ward environment. However from the initial meeting it was clear that there were longstanding underlying negative thoughts. They could be understood in a schema-focused approach, or, I felt, more appropriately psychodynamically. The association with parental introjects, the importance of control and power and issues with self seemed more reflective of this kind of approach. There were also clear issues of grief and loss, that while they could be understood in Cognitive Behavioural terms, seemed to be significant in themselves, again well informed by a psychodynamic understanding, (e.g. Burton and Davey, 2003). Furthermore there appeared to be wider systemic issues that could be understood in this perspective. His identity on the ward and the response to him was important, especially considering the length of time he had been admitted

without any incident or suggestions of improvement in his behaviour. There were also the issues of power dynamics within his relationships with others.

Ethically I was cautious of not beginning a possibly long term, intensive treatment that may also have de-stabilising factors on his physiological condition, and the balance between offering what was felt to be the most effective treatment.

Through the process of supervision I explored my formulation and I suggested a two stage treatment model, shared with Edward, in which we focused on immediate goals of control of impulse, whilst at the same time being aware of underlying issues that might be contributing. Secondly, we were to be mindful of systemic issues and how this could be managed. I further informed myself about the literature on Brief Integrative practice and brief psychodynamic interventions (Hollanders, 2003, Clarkson, 1995).

1.4 Formulation

I remembered thinking who was assessing who? On reflection I felt I acknowledged something of the issues of power, control and powerlessness that I felt were central to the formulation. This is man who less than eight months ago suffered an unexpected illness that took away control of his body and mind as suddenly as it occurred. An important man, successful in analytical understandings of business, who had for a period of time lost control of his movement, speech, and emotions. Now, with his wife unwell and apparently fearful of him, and admitted to a ward, he had lost his family and home.

I felt also that from the beginning of the intervention, control and power in the therapeutic relationship were going to be crucial issues, and I would need to monitor them carefully. From the outset therefore I had to establish clear, genuine, respectful, boundaries and be unafraid. In understanding the later attribute I refer to 'risking' suggestions and interventions. If I were to be too much 'expert', the process would likely to become a duel, too little authority and I risked a befriending role. A further issue to consider was my relationship with the ward staff. With his permission, I liased with staff after our sessions. This proved to be difficult with changing staff shift patterns, and so I was unable to identify a consistent staff member responsible for his care.

1.5 Summary of Sessions

I have mostly presented a session by session account, as given the nature of the intervention, I feel this best represents the content, process, and context issues.

1.51 Session One

Edward arrived promptly, again refusing the two most obviously arranged chairs. This forced me to adjust the positioning of my chair and in so doing I was conscious of feelings of power and a sense of threat. However I was unsure if this was a just a personal feeling. I felt the need to comment but was also aware that the chair he chose ensured that a low table was between us. Maybe he felt threat as well. I thought of the Feminist

psychodynamic theory (Ussher,1991) and had an image of two male animals sizing each other up. I acknowledged his choice of chair and that it differed from the week before. He seemed to shift uncomfortably. I continued by explaining that it was okay for him to sit where he felt comfortable but given that I am deaf in my right ear it was easier if he were on a certain side. There was no acknowledgement apart from nodding his head but I felt a sense of relief from him, and he did not object to me moving the table to one side. Edward explained that he had read the material I sent, finding the Cognitive Behavioural information the most useful, (I also sent a basic manual on stress). He described how he had begun to relate to the model on the ward. As he spoke about an incident with a member of staff I was conscious of the huge number of negative self-statements and the amount of personal responsibility he took. I was aware as he spoke, of an explosive emotion, but it did not seem like anger, more a great sadness. Feminist theory (Ussher, 1991) occurred to me again, how do men show their distress?

I wanted to ask him about his feelings but it felt better to approach this in the 'first stage' way. I applied the situation to the Cognitive Behavioural model, and he calmed quickly demonstrating an understanding by making suggestions. Remembering my need to be unafraid I asked about similar past situations. He paused and then became tearful, returning again to the list of negative self-beliefs. This time however he directly related it to childhood dynamics and his belief that his role was to make everyone else feel better. We began to explore this considering his wife's illness and Edward described feelings of guilt.

I suggested Edward keep daily diary records to monitor the negative automatic thoughts and also suggested he allow time to reflect on the insights he had made in the session.

1.52 Session Two

Edward chose the same chair and was keen to review the diary sheets. He had made good use of the model and been able to develop awareness into the negative thoughts that were underlying his feelings and behaviour. He had found that he was enjoying O.T woodwork sessions more and although had felt angry, had been more optimistic about controlling his emotions. I pointed out that there had been no aggressive incidents but he still seemed to see himself as potentially explosive. I wondered where the messages were coming from. As we increased the cognitive techniques, it became apparent that there were some situations in which he was misreading emotions in others. I wondered about the impact of his injury and Edward revealed that the Neuropsychologist was intending to assess his facial and emotional recognition abilities. In supervision I discussed this further and my feeling that perhaps this resulted from automatic negative beliefs as opposed to a brain injury.

1.53 Session Three

The Neuropsychologist was unwell and given the situation had asked if I would complete the assessments, (see Appendix I for a list of neuropsychological tests used). In the past I have been concerned about interrupting the therapeutic process with formal assessments

as I felt this introduced another form of power dynamic into the process. However through familiarity with the assessments and their potential contribution, I understood them as further therapeutic tools to be incorporated into the collaborative process. Although there were often clear rules for the interaction during assessment, discussion with the client about the experience was often extremely productive. Using assessments this way is not unique but I feel it is something that Counselling Psychology, with the emphasis on understanding the process of interaction, can increase and develop.

Edward became distressed during one of the psychometric assessments based on his belief that he was performing badly, and later we were able to explore this further.

No apparent facial or emotional recognition difficulties were suggested by the assessments, indicating that there was no significant right hemisphere or corpus callosum damage. Interestingly, a qualitative interpretation of the results revealed a consistent misconstruing of the emotions surprise and fear. Such a finding could be related to the area of his aneurysm and perhaps suggested an idiosyncratic residual difficulty. Controlling for this possibility however, fitted well within assumption testing and use of relaxation already incorporated in his treatment. Edward was also encouraged by the results, expressing hope in the sense that he could do something to control his behaviour.

1.54 Session Four

Meeting with Edward now felt more relaxed and I did not have a strong feeling of any power imbalance. He started the session with a negative appraisal but quickly identified this with feelings of guilt relating to not being able to support his wife who had undergone a minor surgical procedure. We normalised some of this feeling but explored it further in terms of understanding guilt and his relationship to this emotion. Almost instantly he spoke of anger and his role with the family as he was growing up, a role of being there for others and seen as weak if he expressed his emotion.

During the interactions between us there was more humour, often irreverent, and I felt this reflected his growing comfort with the process. I introduced Mindfulness, (Kabat-Zinn, 1990), as a technique to complement the thought challenging, and also to help with the reflective process to develop insight into the origins of some of his feelings. We practised a brief exercise, and I felt it added to the collaborative nature of the process.

1.55 Session Five to Seven

Edward was finding the Cognitive Behavioural techniques beneficial and was able to identify his own success, increasing his self-confidence. In this sense the 'stage one' goals were being addressed. He was also finding identification with parental introjects and their effects an easier process, and at one point remarked, "Everytime I feel better about myself it's a poke in the eye to my father". Although we had been aware of the systemic

issues, it felt that these should be more of a focus, especially considering the treatment goal of discharge and the difficultly in engaging ward staff to be involved with the psychological intervention. This necessarily involved organising a formal review, and in the first instance contacting other mental health professionals. Given his inpatient admission, I had believed that this would be an easier process than the organisation involved with community clients. However an initial attempt proved unsuccessful, and offers for informal meetings were not responded to. Dynamically it felt that there was sense of distancing from the client and I was reminded of the climate that surrounded his initial referral.

The final sessions with Edward were dominated by a sudden decision to discharge him from the ward. It was a difficult time for both Edward and myself, and my role therapeutically primarily became supportive. Although there had always been an awareness of time limits, not being part of the discharge plan imposed unplanned restrictions. As a consequence the 'Stage Two' psychodynamically orientated awareness was not as carefully addressed, as necessarily, here-and-now issues of loss, confidence building, and consolidation of skills became more pressing. In supervision, I argued that I finish the contract of work with Edward, but due to him living outside my clinical catchment area, it was not permitted. He was therefore referred to his local CMHT for further ongoing support. I ensured that a comprehensive report, detailing the psychological work completed and recommendations for further interventions, was sent to the Community Mental Health Team (CMHT), GP, with Edward's consent.

1.6 Evaluation

I was angry concerning the discharge and the lack of prior consultation and can only guess at what this was about. In part I feel that the continued pre-minence of the medical model in the ward environment contributed the method of discharge. Ethically it was an unhelpful and unthoughtful process and was not a planned holistic decision. I believe that his observed improvement helped to solve the initial mistake of his presence on an unsuitable psychiatric ward, and remove a seeming to be problematic individual. In some ways I feel that Edward's difficulty was that he was not properly 'mad', and in a sense to solve the cognitive dissonance from the ward staff he had been labelled with behavioural difficulties. It was more comfortable perhaps for the ward staff to understand him terms of a Personality Disorder than it was to acknowledge the messiness of his situation. I feel that there is an ethical question related to how someone is understood if their behaviour is seen as challenging and problems persist outside of the expected improvement.

However it was also a situation that forced me to be adaptive, being angry without focus was unproductive, considering also that there were very real needs for Edward. Acknowledging this in part helped to reinforce the strength of the therapeutic relationship, which had been shaken by the mixed communication around the discharge. It also provided a catalyst and Edward became motivated to show people he could cope. Personal contact with other professionals involved, together with supervision, was extremely helpful, as it gave me space to be annoyed with the situation but not to lose the focus of the intervention. Supervision in particular, I recognise on reflection, helped to

prevent me being potentially inducted into Edward's world view to the exclusion of other possible interpretations.

I feel that Edward's presentation illustrates the contribution of a Counselling Psychology perspective to clinical presentations perhaps primarily seen as medical, and reflects the complex relationship between physical and mental health problems. I feel it is a discipline that offers useful and varied ideas and in particular have found working with Neuropsychological issues to be a challenging but exciting area to practice. In discussing this role with colleagues they have been surprised that Neuropsychology would be an area that is compatible with Counselling Psychology. Personally I feel the breadth of theoretical and therapeutic knowledge demanded by Counselling Psychology, coupled with the focus on experiential and process issues, makes it an extremely portable discipline. I believe Counselling Psychology practice places emphasis on a holistic understanding of the individual to help gain an understanding of their frame of reference. I feel the rigorous attention paid to reflective practice and formulation, further complements this process. It is within this perspective that Neuropsychological concepts and assessments can be effectively incorporated and contributed to. For me Neuropsychology, which I had feared was quite a distant quantitative practice, has been a rich and dynamic process. I have learnt a great deal of theoretical information, which in turn has influenced my practice in general. I have also benefited from the experience of finding more creative ways to use theory and intervention, for example using Cognitive Behavioural Techniques for specific organic problems.

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CASE STUDY 2: 'POLLY'

2.1 Client Background

Polly is a thirty nine-year-old married white woman, who has two young children and works as an administrator at a school. She was referred by her GP following a re-occurrence in her symptoms of Bulimia Nervosa, which she has suffered from for more than twenty years. She received private treatment using a Cognitive Behavioural Intervention three years ago which proved to be successful in significantly reducing the incidences of bingeing and purging through vomiting, and resulting in weight gain. At the time of referral her weight is around seven and half stone and she is 5 foot 4 inches tall, and the incidences of bingeing have increased to three times a week.

2.2 Assessment

In terms of understanding this process as a whole it is important to acknowledge it's impact on me even before I met with Polly. When I received the referral my automatic response was to find a way of avoiding seeing her. This was based on my feelings of inadequacy and I had so far managed to avoid complex eating disorders presentations, which had strengthened my feeling that I would not able to deal with 'it'. I will discuss this later when considering my personal learning.

Polly had the pallor, skin, and pale eyes associated with long term malnutrition. However she was bright, articulate, co-operative, humorous, and extremely honest. As she explained how she had maintained the behavioural changes but was still bingeing and vomiting at least once a week, I began to forget about being afraid and more intrigued by what she saying. Behind the fixed smile and pleasant way she spoke about punishment, self-loathing and overwhelming guilt, I felt that there was an enormous sense of anger, and to an extent, fear.

During the initial assessment sessions she explained how she felt trapped by the need to be a perfect wife, mother, friend, daughter and work colleague. It was important for her to be in control and to be seen to be in control, but nothing seemed as important as the once a week ritual associated with bingeing when her husband was out of the house. She experienced relief followed by guilt, and then guilt about not being as guilty as she felt she should be. She seemed fed up with the continuous cycle of trying to be perfect, stuck in a seemingly unchangeable pattern, angry with why this was so important. As she explored the meaning of her behaviours it became apparent that at core there was a problem with identity, and I speculated frustration with only the 'failed me' expression of herself.

2.3 Formulation

Polly's complaints relate to Diagnostic and Statistical Manual- IV (DSM-IV) description of bulimia, and related issues of control, perfectionism and punishment. Her stated

therapeutic goal was to understand why she still had bulimia and challenge it. In terms of intervention I thought it was important to evaluate the helpful and unhelpful aspects of previous treatment. She responded well to behavioural interventions which helped to develop feelings of control over the condition, however I wondered how much she had incorporated these ideas in the pre-existing structures of control and punishment. For example, although incidences of bingeing had reduced, it had lost none of its significance, and indeed seemed to have taken on more importance as 'one big' treat as opposed to several smaller ones. She also appeared to have developed behavioural substitution techniques into punishing roles, for example going for a walk to get out of the house when feeling low had become a ritualised exercise schedule with a strong emphasis on burning calories and 'being good'. Polly had found Cognitive techniques unhelpful and the previous treatment had become primarily behavioural focused. I wondered if there was something in the emphasis on beliefs that she had found uncomfortable, especially at the level of schema.

Following the initial assessment sessions it was my suspicion that identify and self-concepts were core issues. I felt that the meaningfulness of bulimia needed to be understood before attempts were made to change the behaviour. I suspected that bulimia had become a potent but restrictive expression of herself in the world, and that she felt unable to communicate her frustration with this restriction. She appeared to be in a bind whereby she attempted to exist through a series of unattainable goals that justified her self beliefs about failure. These feelings were only expressed through methods (eg bingeing, exercise) that reinforced her sense of not being good enough.

2.4 Choice Of Intervention

In terms of intervention, I felt that the best approach would be from a perspective of Theoretical Integration, (Hollanders, 2003). Primarily this was an Existential Phenomenological Framework, (e.g. Spinelli, 2003), but also included broader humanistic concepts of self and immediacy, as well as a psychodynamic developmental perspective (e.g. Bateman and Holmes, 1995). I incorporated Mindfulness techniques from Dialectical Behavioural Therapy (Linehan, 1993), which were used as a method of experiencing self as separate but related to urge, thought and behaviour.

It also helped to find a way to tolerate the discomfort of 'being', independent of action. Cognitive Behavioural techniques were also employed, but in the context of exploring the meaningfulness of her behaviours and the impediments to expressions of self. The psychodynamic perspective complemented the existential understanding of the experience of self in relation to others, as well as providing a possible account of the genesis of her complaint. These techniques could also allow permission for the expression of emotion, current as well as past.

In proposing this intervention I acknowledge that there are ideological differences that could challenge this type of integration. For example, an existential phenomenologist could question the necessity of a psychodynamic interpretation, maintaining that the focus should be on the experience of the here and now reality as opposed to asserting the

impact of past relational influences to explain current meaning. However I felt this form of Integration would best understand the meaningfulness of bulimia and it's relationship to self-identity.

I acknowledge also that there is little attention paid to the physiological and biological aspects of her presentation. Weekly weight recording, structured eating plans were not part of the intervention and her only formalised medical contact was through the GP. In part this reflected her maintenance of success from the previous treatment, but more importantly reflected the shift of emphasis away from understanding her as just a set of symptoms, towards a curiosity about the meaningfulness of her behaviours in the context of self-concept.

2.5 Summary of the Sessions

I have presented the intervention by identifying 'stages' as opposed to providing an account of each session. I have chosen this format as I feel it better reflects the flow of the intervention as well as what I felt to be the key themes in the process.

2.51 Stage One

In the initial session Polly was primarily focused on her behaviour and the felt awfulness this reflected about her as a person. She oscillated between anger and guilt for her actions, finding respite when she was attempting to please others, but principally found

relief through bingeing and purging. I was very easily swept along with the hopelessness she felt, backed up by clear, seemingly logical statements such as, 'I have been doing this for so long it will never change' and, 'I must be a terrible person to be doing something I know is not rational'. The invitations for me to go along with her sense of 'badness' were attractively presented. Often this felt a cue for me to begin a cognitive exploration, but I had the strong sense that Polly would welcome this and I would quickly become chewed up in a debate between what is rational and what is irrational.

Resisting my immediate urge I fell back on my formulation, 'bulimia is a very important and useful behaviour for you, I think it is important that we find out why'. In the gap that followed, which I filled with concerns about calling bulimia useful, Polly stopped talking and shifted uncomfortably in her seat. She hadn't expected that. I suspected that she had intended to use the session as a space to outline and justify her self-prosecution, but my suggestion had railroaded her. Reflection on the there and then process, often shared, was going to be the principle guide in this therapeutic relationship. With hindsight I think this early shift away from a purely objective behavioural interpretation was crucial to the intervention.

The next several sessions were a struggle between Polly focusing on her behavioural failures and me steering away from purely this interpretation. The middle ground was reached by understanding more about the importance of bulimia to her on an emotional, functional, personal and existential perspective. From the third session I introduced Mindfulness as a way to challenge the urge to binge. Polly had a meditation practice, so

the concept was not unknown to her. I introduced it gradually in terms of 'urge delay', by asking Polly when feeling the urge to binge to accept it's presence but not to automatically act on it. Instead she was to focus on her breath, returning to the task every time her mind was directed by the binge. We agreed that she should try and do this for up to two minutes before she binged. Although on one level this appears to be a simplistic intervention, it was a method of introducing several fundamental processes:

1) Acceptance, a concept crucial to an existential framework, for through an acceptance of givens one can then be in a position to change or respond differently to them.
2) An identification of the self as separate from a given urge, feeling or thought.
3) A method of affecting control in a situation and establishing the possibility to choose to act differently.
4) De-automatising responses and increasing a sense of control to make cognitive challenges more accessible.
5) Creating the space for the expression of other aspects of self, such as emotion.

From these initial sessions I was struck by how hard Polly was desperate to work at what she initially felt was impossible to change. I reflected my sense of her courage but it appeared to be difficult for her to hear. On reflection I feel it was too early to do this, and she later revealed praise could feel burdensome for her, as it felt like another role in which she had to please other people.

2.52 **Stage Two**

During these sessions Polly's use of mindfulness enabled her to have some control over her urges and in so doing appeared to permit a focused exploration of her identity as understood through bulimia. I was surprised by how quickly Polly was able to employ mindfulness and generalise it to other aspects of her life. For example she was able to mindfully wash dishes, thereby resisting her normal tendency to use this time to negatively reflect on her performance during the day. Through the process of incorporating mindfulness with acceptance of state, Polly binged only once when her husband was away for a week, usually used as an opportunity to binge several times a day.

The next session marked an important change in the therapeutic process and I feel a brief account would be helpful.

Polly is softly spoken, always well dressed and often has a fixed smile that rarely slips even when describing seemingly distressing events. Everything about her radiates pleasant respectability. It was so convincing that it was probably very easy for people to look past the physical signs of malnutrition and focus on her smile and relaxed tone. However it became clear from the beginning of this session that she was afraid. She had again resisted the urge to binge for a week and had been using mindfulness to take more control in a variety of situations. The usual debate about the successes of her changes was brief, I remembered thinking that she gave in too easily. Instead Polly spoke about what

she was feeling, her fear about how she would cope when her husband was away. My instinctive need to respond with coping mechanisms almost occluded the recognition of the shift within her. Polly was talking about how she really felt and exposing herself to what she thought would be the inevitable criticism from others. The fear was not simply confined to her husband's absence but also, I felt, to the risk of showing herself in the therapeutic relationship. We explored this change in the context of the mindful dynamic between acceptance and change, but this session was significant for Polly experimenting with risking being seen by another. With hindsight I begin to recognise how difficult it must have been for her in the weeks between sessions.

In later sessions we discussed Polly's childhood experiences, a strict religious upbringing, repeated at boarding school that gave clear instructions for what women's roles were and how they should behave. A psychodynamic exploration of this revealed many introjects that informed her punishing self-schema and her sense of being in the world. The focus however was on the here-and-now, acceptance of the past, and acknowledgement of existence and change in the present.

2.53 Stage Three

As Polly allowed the non-bulimic expression of herself, the sessions became more focused on her core goals. Her bingeing pattern was sometimes erratic and occasionally I felt the sense of hopelessness she expressed. My process of Personal Therapy on an unrelated issue helped me to think again about the unconscious ways feelings can be

projected, and to disentangle myself from them. I began to suspect that not only was the bingeing a response to the difficulties of change, but that she could also be testing my response to 'set backs'.

Mindfulness became more than just an urge control technique but increasingly a method to distance herself from the bulimic self and it's associated cognitive and behavioural responses. Increasingly other ways of being were expressed, she told me when she was angry with me, accepted some praise, laughed more and spoke of doing the things she had always wanted to do in her life but felt too selfish to attempt. This was reflected in the process of therapy; her facial expression was less fixed when in the room with her, and it felt that she was not always presenting the well-behaved self. She stopped being at least ten minutes early for the appointments. The content became more focused on the process of interaction with others and myself. Regular supervision was essential, enabling me to check my own feelings about the process as well as think about the thoughts of another.

2.54 Stage Four

Our discussion of process enabled thoughts of ending to feel natural. We thought about closure, what it meant to Polly, and planned an end to the intervention. Polly was still bingeing but with far less regularity. However, I think now that removing bingeing completely was not the realistic goal of therapy. Perhaps, rather like the Grounded Theory in Qualitative Research, the appropriate goals emerged during assessment and

were expressed during the therapeutic process. Through an understanding of the meaningfulness of bulimia and relation to self, Polly was able to accept, rather than persecute herself, thereby allowing an existential choice to act differently. As a consequence, her previously gendered roles became less oppressive and with the time this freed up, she was able to begin to pursue the career and self focus she wanted without feeling guilty.

2.6 Evaluation

In many ways I see a parallel between the process of Polly's learning to understand her relation to bulimia, and my own. To question the importance of a behaviour and its meaningfulness on an individual basis before making interpretations must always be the basis of a respectful, empathetic therapeutic relationship (Kottler, 1993). Often such an understanding can be automatic, but for me fear and personal issues of inadequacy had distanced me from this integral position.

My difficulties with Eating Disorders started during my training when stark videos accompanied even more distressing case evidence and research findings about the 'anorexic' and the 'bulimic'. The emphasis on the efficacy of psychiatric inpatient admission, forced feeding and painful behavioural interventions upset my developing therapeutic sensitivities and I began to be afraid that this 'disorder' could make me feel so much fear and inadequacy. Through my experience of working in various clinical settings I became aware of a general sense of hopelessness with other practitioners

associated with this client group. Eating Disorders was often the preserve of a specialist worker or referral to a dedicated unit. It seemed a marginalised group, more permissible for me to avoid, but at the same time this increased my ignorance and fear. My 'sensitivities' had provided a paradoxical and stigmatising understanding of eating disorders, and though served to reinforce my ignorance, had also prevented me from communicating this to individuals until I was experienced enough to be able to acknowledge and confront these biases.

I benefited greatly from the process of supervision and the further specialist support of a female Clinical Psychologist who specialised in Women's Mental Health. Not only did this provide appropriate guidance, resources, (e.g. Cooper, 2000), and containment for working with the specifics of Eating Disorder, but also provided the opportunity to learn more about the experience of 'being' expressed by women suffering with similar conditions (Garner and Garfinkel, 1997). I benefited from thinking again about gender in the context of the therapeutic relationship, for example, many of her issues of control and role seemed heavily based on internalised patriarchal rules, therefore I needed to be aware of my presentation and how therapeutic interventions could be interpreted (Kagan and Tindall, 2003, Burck and Speed, 1995). I also found it useful to explore my role as a male therapist in supervision and how this may have impacted on the therapeutic relationship.

I was cautious about my use of Mindfulness, despite the research evidence and training I had received. I find the technique extremely difficult to use personally, and although

there had been some literature concerning its use with Eating Disorders (Linehan, 1993), this was not expansive. I questioned the appropriateness of using this as the primary technique, especially considering my lack of confidence concerning Eating Disorders. However, it's effect on the therapeutic process helped to instil confidence in both Polly and myself, increasing the sense of optimism throughout the therapy.

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SECTION D – CRITICAL LITERAUTRE REVIEW

How is spirituality and religion relevant to applied psychology today? A critical review of the last 40 years

1.1 Introduction

The question is based on a growing awareness, both in clinical practice and research, of the application of spirituality and religious based perspectives in psychotherapy (e.g. meditation, Mindfulness, Yoga). Spirituality for example, has been related to improvements in a variety of indicators of psychological well-being[6] (Elmer et al., 2003). I was interested in how these systems may relate to psychological practice, what implications there may be for clinical interventions, and what level of research informs these positions.

The aim therefore of the current investigation is to present some understanding of the above and account for the relevance of the subject in modern psychological practice. Initially I will provide a brief historical background, consider the difficulties in definition of the two concepts, and acknowledge their role in professional development in social sciences. Following this I will explore the effect on physical and mental health, and present Transpersonal Psychology, the main theoretical contributor in the area. I will conclude by considering the empirical difficulties, directions for future research, and a reflection of undertaking research into the subject.

A critical literature review as opposed to a systematic review seemed a more appropriate method to explore the question, as the quality of the available research was not conducive

[6] Physical health conditions, longevity, low suicides rates, better response to illness, lower divorce rates, more pro social and empathic behaviour, less likelihood to be involved in crime, and some evidence links it to anomalous activity in the temporal lobe.

to a systematic review, and the question parameters were broader than a specific systematic focus. I searched for relevant literature on two data bases, PsychLit and Questa, initially using 'religion and spirituality' as keywords, then narrowed the range by adding 'psychotherapy' to the search. At first I planned to review all the relevant literature but during the search process had to limit the search to a more viable time period due to the amount of material and it relevancy. Research before the 1970s was excluded because the quality of research was less robust in terms of being less empirically based. Since the 1970s there has been a growth in interest in this subject, and an increase in the application and evaluation of psychological theory in terms of treatment models. Studies that were not translated into English were excluded and therefore the review may not adequately reflect the views of other cultures. The search also involved following up important articles, indexes, theses, conference papers, books and studies indicated by the literature, and the contributions of the main authors generally acknowledged as experts in the area. This was identified through citation analysis of bibliographies and references. Although I have based the review on research since 1970, there are some occasional earlier references that have been included for the following reasons; a) for contextual and historical reasons, b) related to experts in the field, and, c) particular research of importance.

1.2 Historical Background

Horgan (1979) observed; "...in psychology, anyone...involved in or tries to talk in an analytic, careful way about religion is immediately branded a meathead, a mystic, an

intuitive, a touchy feely sort of moron" (Horgan, 1979, in Bergin, 1980, p. 99). Reasons for this implicate a motive within Western psychology to be seen as a valid *'scientific'* profession (Lehman and Witty, 1931). As the positivist scientific framework developed in the West, religion and spirituality was regarded with scepticism and academic psychology became more allied to this position in order to gain scientific validity (Post, 1993). Theoretically also it was influenced by Freudian perspectives of religious belief which are arguably the founding theories in psychotherapy (Shafranske and Gorsuch, 1984).

Despite the psychology of religion being a main area of study from the 1870's to 1930's, (Jones, 1994), the amount of research declined to the extent that Bergin (1983) argued it was an, "orphan in academia" (Brawer et al., 2002, p.204). Since the late 1970's there has been a gradual resurgence in research, mainly in America, due to the development of pastoral psychology and clergy interest in using psychological theory (Jones, 1994). The American Psychological Society added spirituality to the index in PsychLit in 1986, and in a 10 year review Helminack (1996) found 13, 030 related studies.

The increased interest in the psychology of religion can also be linked to the growth in multiculturalism, occasionally described as the 'fourth force in psychology'. Within this there has also been a particular interest in Eastern psychology over the last century in part due to globalization and the availability of well translated texts (Gilbert, 2005). Religion has correspondingly become more acceptable to discuss in psychology theory and practice. It is possibly also more relevant due to world events such as religious terrorism

(Shafranske and Malony, 1990). Growth in interest has also been related to outcome research into religious and spiritual informed interventions. Since 1950 there have been increasing numbers of studies showing a positive physiological and psychological effect of breathing, mindfulness, meditation and yoga (Davison et al., 2003). Theoretically there has been an increase in integration and the development of specific models (Linehan, 1993, Segal et al., 2002). This in itself has caused interesting debates within psychology, highlighting difficulties in merging the two systems. For example, language problems, semantic differences, and Eastern emphasis on the therapist's participation as opposed to a more removed provider of techniques (Gilbert, 2005, Young-Eisendrath and Mauramoto, 2002). Gilbert (2005) further argues that Western approaches are based on "doing or achieving" (Gilbert, 2005, p.3), which is in contrast to Eastern beliefs such as acceptance of suffering and abandoning self.

Similarities between religion and psychology have been suggested in that they both suggest theories and practices for understanding and developing the inner world (Jones, 1994), and are also important activities that structure experience, belief and behaviour (Luckoff et al., 1992). Jones (1994) suggests two ways in which religious belief can influence psychological theory; a 'critical-evaluative mode' in which scientific theories are evaluated for a match to the therapist's religious belief, and 'constructive mode', whereby religious beliefs contribute positively to psychological theory. Examples of this are meditation practice, transpersonal psychology, and Jungian theory. It has also been suggested that spiritual care is a responsibility of health professionals, but has been

difficult to apply due to lack of a conceptual framework (Dyson et al., 1997, Watson, 1985, Reed, 1992).

It is clear from this therefore, that not only is this is an area of contemporary relevance, but also one that that has a complex and controversial relationship within psychological study. The above research also indicates a key issue within the subject, namely the use of religion and spirituality interchangeably, a difficulty that was not fully acknowledged until the beginning of this century. Although this will be discussed later, the main purpose of this paper is to explore the contribution of both perspectives to psychological practice. Research in both religion and spirituality in this context is therefore relevant, but it is important to acknowledge that they are two different concepts under investigation.

1.3 Definitions of Religion and Spirituality

A fundamental difficulty for research in this area has been establishing clear definitions of religion and spirituality (Mack, 1994). In many cases the terms are used interchangeably (Helminiak, 1996, Burkhardt, 1989), yet they have been argued to be qualitatively different (Reed, 1987, Brown and Williams, 1993, Morberg, 1984, MacDonald, 2000). It can be asserted that religion is linked to formal institutions, whereas spirituality does not necessarily depend on an institution, although religion can often be the structure that helps the individual be in touch with the spiritual (Warner-Robins and Christiana, 1989). However some systems such as Tibetan and Zen Buddhism

are examples of non theistic spirituality (Trungpa, 1973). Furthermore some individuals would describe themselves as both religious and spiritual (Zinnbauer et al. 1997).

A panel to define spirituality and religious belief was commissioned by the National Institute of Healthcare Research (NIHR) (George et al., 1997). The NIHR defined spirituality as, "the feelings, thoughts, experiences and behaviours that arise from a search for the sacred", (George et al., 1997, p.21). The California State Psychology Association, (CSPA) Task Force on Spirituality and Psychotherapy, defined it as, "the courage to look within and to trust. What is seen and what is trusted appears to be a deep sense of belonging, of wholeness, of connectedness, and of openness to the infinite", (Shafranske and Gorsuch, 1984, p. 233). Religion however, it was argued, provides structure for individual's search, as George et al. (2000) further describe, "the distinctive character of religion is it's collective reinforcement and identity", (p. 104). However these definitions are difficult to operationalise in terms of clinical application and research. It could also be argued that spirituality is also experiential and interpersonal and its expression is influenced by a given individual's culture and environment (Elmer et al., 2003, Hay, 1989). Transpersonal Psychology (TP), (as explored in more detail in Section 1.9), sees it as a normal and natural part of human development that reflects the highest stages of development which can be encouraged through specific practices, beliefs and lifestyle, although problems can occur in the emergence and expression of spirituality.

It seems reasonable to conclude that although two clearly different concepts, there can be an important crossover between religion and spirituality A central component is the

"search for the sacred" (George et al., 2000, p. 104). Religion can be understood as a conceptualisation and possible framework to express spirituality. This is perhaps the difference between organised Religion ('R') and religion ('r') that describes cultural, systemic or personal practices that organise or structures spiritual expression. Spirituality also goes beyond religious concepts as it describes a non-theistic relationship with the essence of human nature (Burkhardt, 1989, Kim, McFarlane and McLane, 1984). Following from this it is necessary to consider how such important, socio-cultural concepts are addressed by psychological theory and practice. This would include an appreciation of a therapist's personal (cultural) and professional background. The influence of spirituality and religion on psychological training will first be discussed before considering the impact on theory and intervention.

1.4 Training and Professional Perspective

There has been a growth in academic courses in religion and spirituality in US medical schools (Thomas, 1999) and an increasing interest in religiously orientated psychology training (mostly in America). There has also been a growth in professional organisations and special journal issues related to religion, spirituality and psychotherapy (for a review of journals publishing reviews in religion and psychotherapy see Worthington and Kurusu, 1996, p.450 and Worthington, 1986). However this has not been clearly formalised and psychologists still do not receive as much training in religion as other forms of human diversity, such as gender or sexual orientation (Yarhouse and Fisher, 2002). Brawer et al. (2002) looked at religious and spiritual training in American Clinical

Psychology courses. Participants were directors of courses who responded to a questionnaire. Out of 51% response rate, 77% of participants reported some training through it was most likely to be discussed in clinical supervision. Most training occurred as part of another course, 13% offered a separate course but this varied in frequency. It is also an area that generated comparatively little student research interest. Criticisms of this study include nearly half of those surveyed did not respond, suggesting that it may not be an accurate picture. Also the sample is based on the reports of course directors who it could be argued are more likely to give a favourable presentation of their courses. Shafranske and Malony (1990) found that the therapist's personal religious belief and not their training were more likely to influence whether issues of religion and spirituality was involved in treatment.

Shafranske and Gorsuch (1984) surveyed 1400 psychologists in California and found that they were less religious than the general population, but not non religious or anti religious. Most thought that spirituality was both personally and clinically relevant, although none of the respondents had training in spiritual issues. However this was based on a 29% response rate of mainly male therapists. Also the research took place in a region of US noted for interest in spiritual theories and practices. They could therefore be specific regional as well as wider cultural bias. Shafranske (2000) found that despite 72% of American psychologists expressing a belief in God, (compared with 90% of the population), 50% did not feel it was important to ask clients about their religious background and 51% felt that religion was not important in daily life (compared with 11% of the general population). Shafranske and Malony (1990) in a study of 1000

psychologists in America using self report measures found that religion and spirituality were seen as important but they did not have appropriate training. However less than half responded and therefore it is difficult to make generalisations. Gender bias exists as respondents were predominately male (73%). The authors use of self report measures makes it hard to be objective and to control what kind of data is being gathered.

The studies highlighted here present a mixed picture, suggesting that although spirituality and religion is seen as important by the general public it is not recognised as such by training courses, and considered less relevant than other forms of human diversity. This would suggest that an important human phenomena is largely ignored by courses and that training may not adequately equip a psychologist to understand this part of a client's functioning. However, the vast majority of the research in this area is conducted in the United States and therefore particular to this culture. It would therefore be prudent to be cautious when interpreting these findings or attempting to generalise across cultures.

Before exploring the relationship between spirituality, religion with mental health it is necessary to first briefly discuss research findings concerning their role with physical health.

1.5 Relationship of Spirituality and Religion to Health

There has been significant research into the effect of spirituality and religion on physical health, though a detailed review of this exceeds the remit of the current investigation, (for

further reseach see; Kass et al., 1991a and 1991b, Elmer et al. 2003, Ellison and George, 1992, George et al., 2000, Idler, 1987, Ellison and Levin, 1998, Kark et al., 1996, Strawbridge et al., 1997, Goldbourt et al., 1993, Harris et al., 1995, Spiegel et al., 1989, Frankel and Hewitt, 1994, Kaczorowski, 1989).

In general, religion appears to have a positive effect on health, however there have been difficulties found when medical care has been in conflict with particular religious beliefs (e.g. blood transfusions), or ignored in favour of faith healing (Asser and Swan, 1998, Pargament, 1997). However these findings need to be interpreted with caution for the following reasons:

a) Methodologies vary across studies.
b) It is difficult to control for social and environmental influences.
c) Studies are predominately based in America and there is a lack of cross cultural data.
d) There is a lack of follow up studies.
e) The research makes limited attempts explain how religious beliefs contribute to any improvement.
f) No rigorous attempts are made to explore differences between religion and spirituality.

It is therefore difficult to identify a definite causal relationship between improvement in health and the level of religiousness and spirituality. However how they may influence client care and understanding in nursing and mental health is investigated below.

1.6 Spirituality-Influenced Care

There has been notable research into the importance of spirituality in general nursing care. This was based on client self-report and observations that spiritual care is often neglected in favour of physical, psychological and social need (Dyson et al., 1997, Sims, 1987, Carson, 1989). Spiritual need in this context has been defined as giving and receiving forgiveness from others and managing loss (Ross, 1994, Liehr, 1989), expressed through happiness and crying (Linholn and Eriksson, 1993), and physical needs (Oliver, 1990).

The intention of spiritual care is to increase spiritual well being which has been associated with increasing inner resources (Morberg, 1984). Two main components are 'meaning' and 'hope'. Meaning is seen as central to spirituality but is also personally defined (Frankel, 1959, Brown and Williams, 1993) and is associated with finding a sense of peace and a way to deal with stress (Kobassa, 1979, Burnard, 1986). Hope was seen as a spiritual need in particular with terminally ill patients (Notowny, 1989, Herth, 1989, Ross, 1994). It was described variously as an 'energy' between the individual and their environment (Owen, 1989), empathy (Hinds, 1988), and a sense of possibilities and power beyond the present circumstances (Francis, 1986). Acknowledging and

comprehensively assessing the uniqueness of the individual's beliefs is associated with developing meaning and hope (Clark et al., 1991). Another component is relatedness and connectedness with others, self and a higher power (Hungermann et al., 1985, Conrad, 1985, Morrison, 1990, Oldnall, 1986). However the research has been affected again by the lack of clarity between spirituality and religion. Stoll (1979) for example felt that the individual's relationship with God is the highest value in a person's life, although a spiritual relationship could be associated with an object, motive or other personally defined belief (Oldnall, 1996).

All of the above studies are based on subjective observation and case studies, therefore do not have objective empirical evidence. The vast majority were based on clients who were terminally ill (e.g. Notowny, 1989, Herth, 1989) and it is hard to claim that concepts such as hope are related to spirituality, fear of death or other motives that may be related to having a terminal disease. Almost all of the research is based on American clients and therefore may not be representative of other cultures. One study was based on terminally ill Hindu cancer sufferers (Francis, 1986), but like Christian clients, both religions involve a belief in higher power and life after death. There is no clear definition of spirituality and therefore it is unclear whether the research is testing the right concept, and not a different component such as self actualisation.

1.7 Relationship of Spirituality and Religion Mental Health and Psychotherapy

Research has indicated that spiritual experiences occur in up to 30% of the population (Levin et al., 1987, Ring, 1985, Thomas and Copper, 1978). However these findings are limited to American participants. Kass et al. (1991) found that clients from a clinical population reported spiritual experiences following relaxation and psychotherapy, expressed a greater purpose in life, increased feelings of satisfaction and improvement in health. However participant's levels of pre-morbid religiosity are not described. In a study of American psychiatric patients, Targ (1999) found the majority reported themselves as religious or having spiritual beliefs. Shafranske and Malony (1990) found that 60% of clients used religious language to describe their experiences.

Developmental theorists suggest a transcendent dimension occurs when an individual questions themselves and their meaning in the wider context of life (Levinson, 1986). Other theorists have also suggested a spiritual dimension (Allport, 1970, Jung, 1958, Frankel, 1959, May, 1953). Diagnosis of terminal illness such as AIDS can lead to a spiritual crisis, defined as questions of purpose and meaning (Helminak, 1995, Carson et al. 1990). Goldfarb et al. (1996) found that clients with substance abuse placed importance on spirituality. However Goldfarb et al's study was based on an American sample, and it can be argued that these treatment programmes can be religious in structure (e.g. Buxton et al. 1987).

Religious belief has been related to reducing anxiety, depression and substance abuse (Koenig, 1997, Gorsuch, 1993, Worthington and Kurusu, 1996, Koenig et al., 1993 Spika and Werme, 1971, Allport and Ross, 1967 Kahoe 1974), with public religious participation being a strong predictor of mental health. Religion has also been associated with recovery from mental illness (Koenig et al., 1998). However if illness or distress is seen as a punishment from a higher power the individual is thought to be more likely to have increased mental health problems (Worthington and Kurusu, 1996). However it is not clear from these studies how much is due to other possibilities such as treatment or medication. Much of the research is from the same authors and the results could reflect a particular view of spirituality and religion that may not be generalisable. Also some of the research is conducted on non clinical populations and therefore may not be fully representative.

Martin and Nichols (1962) identified 12 studies from the 1950's that suggested religious belief was associated with emotional distress, prejudice, rigid personality and lack of intelligence. They replicated the studies using the same sample group of university students and found no correlation and argued that the initial finding was due to chance. Wilson and Miller (1968) found a positive correlation between anxiety and religious belief on the Minnesota Multiphasic Personality Inventory (MMPI), although these are results from a small sample and cannot be generalisable. However Bohrnstedt et al. (1968) found no correlation from a much larger population. Bergin's (1983) meta analysis of 30 studies found a negative outcome associated with religious belief in 23% of the studies but a positive correlation in 47% of studies. However this was based on a

small data set, and it is hard to generalise and compare across different outcome measures and methodologies. Worthington and Kurusu (1996), found an association between the prevalence of mental health problems and extremely religious people. However negative or non-significant correlations to positive or negative effects of religion and mental health has been also been found (Bergin, 1983, 1985, 1991, Frenz and Carey, 1989, Kroll and Sheenan, 1989, Larson et al., 1989, 1997).

Before considering the contribution to psychological theory it is necessary to review and summarise the main findings so far:

a) Spirituality and religion are different concepts although there can be overlap in terms of their expression and practice. However research predominantly uses them interchangeably.
b) Both have been associated with mental and physical health improvements although no specific mechanism has been suggested.
c) There is a predominance of western based research and a lack of cross cultural studies.
d) Spirituality and religion are seen as important activities by the general population but are largely neglected as a teaching component on psychotherapy training courses.

1.8 Main Theories Contributing to Psychotherapeutic Intervention

An exhaustive discussion of the main psychology theorists exceeds the remit of the present investigation. Instead I will briefly outline Transpersonal Psychology (TP), the most recognised academic discipline investigating spirituality and psychology. TP is an established division of the British Psychological Society and publishes an internationally peer reviewed journal, *The Journal of Transpersonal Psychology.* Other theories have acknowledged the relevance of religion and spirituality, Including Contemplative Psychology (May, 1982), Existential theories (Kirkegaard, 1967) , 'We-Psychology' (in Benner, 1988), analytical depth psychology (Jung, 1933, 1958). There is also evidence that humanistic theory recognised similar issues, Rogers (1961) suggested, "There is some kind of transcendent organising influence in the universe which operates in man as well," (p.102). However Transpersonal Psychology represents the most comprehensive perspective in which to explore the relationship between spirituality and psychotherapy.

1.9 Transpersonal Psychology

Transpersonal Psychology (TP) was established in the late 1960's, with the main objective to explore the relationship between consciousness and spirituality to physical and mental health (Elmer et al, 2003, Walsh and Vaughan, 1980). For a comprehensive explanation see Grof, 1976, 1985, 1989, Faber, 1989, Wilber, 2000, Valle, 1989, Lajoie and Shapiro,1992.

In common with humanistic theory, TP based on exploring positive function as opposed to looking at pathology and deficiency. Health is defined not just in terms of the absence of pathology but the "presence of growth orientedness and movement toward well-being and self realization" (Elmer et al., 2003, p.160). TP does not exclude other perspectives on health but attempts to expand on them. It recognises that spiritual experiences can occur negatively, such as psychotic experiences (Lukoff et al., 1992, Lukoff, 1985, Wilber et al., 1986), but attempts to understand these in the wider social-cultural context. (Hutchings, 2002, Maslow, 1968). Lukoff (1985) helped to establish a non disorder based category for religious experience in the Diagnostic Statistical Manual-IV (DSM-IV). For this reason it has been argued that TP is the most comprehensive and inclusive context to view the individual (Friedman and MacDonald, 2002).

Spirituality and states of consciousness are seen as developmental stages and as the individual moves towards transcendent states and non ordinary consciousness they have to be incorporated into the individual's development as a part of a universal whole (Valle, 1989). This is a different perspective from Western psychology's emphasis on the state of the human being, or their states of functioning, as the centre of study. TP also places importance on findings from paranormal experiences and near death experiences that can lead to positive changes in a person's life (Ring, 1984, Greyson and Stevenson, 1980). It argues that a world view open to life beyond physical death can enhance general well being (Koenig, 1990, McLenon, 1994, Kennedy and Kanthamani, 1995).

There are a variety of theories within TP, including; Structural-Hierarchal Perspective (e.g. Wilber, 1983), Spiral-Dynamic (e.g. Washburn, 2003, Jung, 1963), Participatory (e.g. Ferrer, 2002), Feminist (Wright, 1995), and Ecological (e.g. Fox, 1990). An exploration of these is outside the remit of the present investigation. However of brief note here is the contribution of Wilber (1983, 1986, 1997, 2000). Although a bio-chemist and bio physicist with no clinical or academic experiences in the social sciences, Wilber is the most prolific contributor to TP, developing four main theories stages (Wilber 1-4) culminating in the All Quadrant, all Level Theory (AQAL) which has been adapted into a therapeutic approach (Holden, 2004).

However, within this key therapeutic model there has been conflict between transpersonal psychologists who reject scientific approaches and psychologists who reject transpersonal theories (Sliff et al., 1999). Matthews (1999) agued that spirituality is in fundamental conflict with the existential approaches, and Steele (1998) suggested that TP is not compatible with constructive theory as it claims there is an 'absolute' and definitive reality. Humanistic theories have argued that human beings are not able to be reduced to spiritual, material or supernatural beings (Davidson, 2000). Mental health professionals can see transpersonal experiences as pathological (Friedman and MacDonald, 2002), and Ellis (1989) criticized TP as a whole as 'magical thinking'

1.10 Influences on psychotherapeutic intervention

1.101 Clinical Assessment

The process of assessment in a clinical setting has received perhaps the most substantial attention in the research. In part this was based on an acknowledgment of psychological difficulties related to spirituality, e.g. diagnosis of religious or spiritual problem (DSM IV, American Psychiatric Association (APA),1994). These can include depersonalization, anxiety, agitation, narcissism, restlessness, and psychotic experiences (Wilber, 1986, Epstein and Lieff, 1986, Grof and Grof, 1989). Equally there have been suggestions that spiritual interventions can increase difficulties. Meditation for example, has been related to reinforcing and increasing existing pathology (Epstein, 1986). This led to suggestions that spirituality, and understanding it's meaning to the individual should be explored in the assessment process (Benner, 1989, Hunt et al., 2002). Interestingly, the main theorist such as Wilber (1986)[7], has not suggested tools for objective methods of assessment.

Grof and Grof (1989) however, are major contributors who have developed an assessment procedure. They identified a 'spiritual crisis' occurring when some individuals are unable to integrate spiritual development in their lives resulting in problems with increased levels of distress which have interfered with wellbeing. They cited the following as potential risks; near death experiences, shamanic crisis, past life experiences, UFO encounters, psychic opening, possession states, awakening of the

[7] Wilber's developmental model identified the pre egoic stage with psychosis, borderline personality disorder and narcissistic personality disorder.

Kundalini (a spiritual energy believed by Hindu to be at the base of the spine), and communication with spirit guides. Grof and Grof (1990) suggested a comprehensive assessment conceiving 'spiritual emergency' as the level of functioning before and during the crisis. This involves standard medical and psychological assessments to identify conventional pathology, and the therapist's judgement to decide whether the experience is a spiritual emergency. However the authors have not developed standardised tools to assess the quality of the experience or emergency.

MacDonald et al. (1995) reviewed popular psychological assessments and found that most did not have any spiritual or transpersonal measures and those transpersonal responses were seen as pathological, usually psychotic. Freidman and MacDonald (2002) reviewed 100 transpersonal and spiritual tests and found that most were used in basic research studies, and due to a lack of norms and empirical research, none were able to be used clinically. However they suggested two measures that may be effective, which included the Expressions of Spirituality Inventory, ESI, (MacDonald, 2002) [8], and the Self-Expressiveness Level Form, SELF, (Friedman, 1983). Chief amongst the criticisms of these tests is that they are not empirically tested and the two tools they recommend to guide further investigation are the author's own.

[8] The ESI is based on a factor analysis of different tests of spirituality and identifies five scales of spiritually. However it is not empirically tested, does not offer diagnostic interpretations, and is not related to any specific theoretical concept. Furthermore the factor analysis is based on selected research findings the author has previously acknowledged to be invalid and untested. The SELF is based upon the transpersonal concept of self expansiveness describing the fluidity of an individual's identity, and plots the self on dimensions of space and time. An example of positive functioning is identified with the 'middle self', when the self concept is expanded beyond the personal but still connected to the person as an individual. The SELF also claims to have some empirical support, however this relates to two studies conducted by the authors (Friedman, 1983 and MacDonald, 2000). Other criticisms of the tool are that it is based on a non empirical and loosely defined concept, and there is no diagnostic interpretation. It is also a complex tool, which may account for its lack of use in wider research projects.

Freidman and MacDonald (1997, 2002,) have suggested a multimodal and multidimensional assessment. They define the transpersonal assessment as collaboration of the therapist's and client's understanding to suggest an expanded view of the client's overall functioning, as well identifying areas of difficulty. Assessment should not exclude conventional assessment, but use explicit transpersonal measures, based on a view of positive health (not based on deficits in functioning). They also suggest 'methodological pluralism' by using non-conventional tools such as the tarot. However no robust data exists and they do not suggest how conventional and non-conventional assessments would be cross validated. It could be argued that practices such as the tarot are not designed as assessment tools in the Western conventional understanding and therefore invalid for this purpose.

Following from the above discussion the following general difficulties can be identified:

a) Difficulty identifying what constitutes authentic spiritual health.
b) Spiritual experiences are by definition beyond normal scales and therefore immeasurable (Matthews, 1999).
c) Quantitative assessments limit the expression of the subjective experience (Hodge, 2001).
d) Most transpersonal measures are based on informal data gathering methodologies such as interviews or questionnaires only (Koenig and Pritchard, 1998).
e) There are no empirically validated transpersonal assessment tools.

f) No single method of assessment has been adopted or widely used, limiting both the opportunities for research and the possibility of establishing objective definitions.

1.102 Clinical Intervention

Psychotherapeutic interventions in TP are mostly modifications to existing treatments or the use of spiritual practices in addition to mainstream interventions such as mediation and visualisation (e.g. Assagioli, 1965). An intervention is transpersonal if it is primarily premised on considering spirituality and informed by the TP perspective. This approach, similar to integrative and eclectic theories, can be criticised on grounds of consistency, rigour, reliability and genralisability (for a more in depth discussion see Hollanders, 2004). There are a variety of specific techniques, but none of these have attracted significant research or widespread clinical use. Examples of these are prayer, (Worthington and Kurusu, 1996, Turner and Clancy, 1986), 'Spiriting', (Burkhardt, 1989), and the Transitional Technique Method, (Bergin, 1991).

Meditation and body orientated approaches have greater empirical research base, however common difficulties with most of this research include no clear differentiation between the types of intervention, (e.g. transcendental mediation verses Mindfulness meditation), no long term follow up results, and participants are often non clinical or mediation practitioners. For more comprehensive overviews of these approaches see

Frager, 1989, Valle, 1989, Shapiro and Walsh, 2003, Lowen, 1975, Orme-Johnson and Haynes, 1981, Haimeral and Valentine, 2001.

1.11 Conclusion

Several clear conclusions can be drawn following the review of literature. The first relates to problems with the empirical research listed below.

1.12 Empirical Research Difficulties

a) Disagreement concerning the definition of spirituality and lack of agreement with what constitutes spiritual practice (George et al., 2000, Bergin, 1991, Worthington and Kurusu, 1996). The National Institute on Aging (NIAG) (1997), for example, reviewed over 200 measurements of spirituality and religion and found that most were single items, had limited psychometric qualities, and were mostly unreliable and invalid. Less than 10% of the measures included direct mention of spirituality.

b) The majority of research before 2000 was based on religion and not spirituality and therefore omits a number of people who call themselves spiritual but not religious (George et al., 2000). Interestingly this group are disproportionately high in levels of socio economic achievement (Zinneauer et al., 1997).

c) Most theoretical research is conceptual and does not involve real clients (Worthington et al.,1996, Mack, 1994).

d) There is a divergence in existing assessment tools with no clear valid measure (MacDonald and Friedman, 2002).

e) The nature of spirituality and health relationship varies as a function of the methodology in different studies (Elmer et al. 2003, Gartner, 1996).

f) When significant results are found, the effect sizes are small, (Bergin, 1991, Worthington and Kurusu, 1996).

g) Quantitative methods are seen by some transpersonal psychologists as compartmentalising individual experience (MacDonald and Freedman, 2002).

h) The relationship between health and spirituality varies depending on the type of functioning studied, e.g. social behaviour or pathology.

i) The vast majority of research has methodological problems, such as single case study or limited scale designs that limit their application and generalisability. [9]Elmer et al. (2003) suggest, "Despite the wide-spread optimism that views spirituality as strongly related to health outcomes, the jury is not yet in" (p. 163).

j) There are problems between culturally sensitive (CST) and empirically supported (EST) therapies as many CST do not have good empirical support and many EST are not valid across the various cultures in the United States (Draguns, 2004, Hall, 2001). The majority of research in EST has taken place in United States and English speaking countries, and so cultural variations have not be recognised

[9] Research between 1984 to 1992 based on Worthington and Kurusu (1996) definition of religious research, out of 29 studies the methodologies of 15 were correlation questionnaires, 5 Survey research, 3 Factorial Design, 2 Between Subjects, and one study only in Repeated Measure, Meta analysis, ANCOVA and interview.

(Rehm, 2002). There is a lack of research into how the main therapeutic interventions are practiced around the world and how the interventions are effected by different cultures. There is also a high failure rate in engagement of clients in North and West Africa who have Western interventions imposed on them (Draguns, 2004)

k) There is a bias towards American based Judaic Christian values in the research. Larson et al. (1989) found that in the studies they reviewed, Jews and Protestants were over represented, and in some studies patients clearly held a Christian view of spirituality (Brown and Williams, 1993).

Although the difference between spirituality and religion is beginning to be recognised, most research and theory have used these concepts interchangeably, therefore reducing the potency of findings. Post modern and multicultural developments within psychology have helped to highlight this, although cross cultural research is still limited. Both spirituality and religion can sometimes be acknowledged by therapists as important but are often excluded from the process in favour of more 'real' therapeutic issues. Despite the establishment of Transpersonal Psychology in the 1950's there are as yet no established therapeutic procedures or techniques in widespread use.

Although the research is flawed, there is still a consistent finding that what is understood by religion and spirituality appears to have a variety of positive effects. It is however hard to see how to investigate this further using traditional methods. Wright (1999) for

example, has suggested that human behaviour needs to be understood within a 'bio-psycho-social-spiritual' model, arguing for a broadening of the current paradigm. Echoing Kuhn's (1970) post positivistic philosophy of science, O'Donohue (1989) argued for the existence of 'metaphysical sentences' or un-testable beliefs embedded in culture and integral to all sciences.[10] In accepting this one has to again consider Kuhn's (1970) assertion that all data is theory laden, sorted and processed instinctively by our senses; all seeing is 'seeing as'. Science therefore becomes less removed, understood as a cultural and human phenomena progressing through refining theories not the accumulating of facts. Gilbert (2005) argues as the West explores Eastern beliefs they will eventually be redefined through developing culturally constructed perspectives. This however does not call for a complete rejection of traditional concepts. Barbour's (1990) concept of Critical Realism suggests that there are limits on which pre-existing conceptions can impose a structure of reality. Although biased, the selection and collection of data shapes and develops our knowledge further. Following from this, further research implications can be suggested, in particular considering methodologies that both address the phenomenological nature of the subject but are also valid methods of data collection and evaluation. Qualitative methods would seem to be the most appropriate way to begin the process and inform more quantitative process (Braybrooke, 1987, Burkhardt, 1989). Such explorations could address four main areas:

a) Measure and describe the subjective nature of spirituality (Burkhardt, 1989, Mack, 1994),

[10] An example of this is Heisnburg's Uncertainty Principle. Spiritual truths could perhaps be seen as analogous to a metaphysical sentence, which would certainly be congruent with TP's understanding of the Perennial Philosophy.

b) Investigate how psychologists approach meaning, faith, spirituality, morality and religious development and how they interpret these phenomenon (Shafranske and Gorsuch, 1984, London, 1986),

c) Investigate what constitutes spiritual experience and the validity of spiritual and transpersonal theory and test the effectiveness of specific interventions (Worthington and Kurusu, 1996, Elmer et al., 2003, George et al., 2000),

d) Provide accounts of culturally distinctive therapy in multicultural societies (Worthington et al., 1996 Richards et al. 1989). Draguns (2004) describes, "studies may be conducted of both clients and therapists across cultures and ethnicities in order to establish the culture's impact upon their attitudes toward various aspects of therapy intervention...the experiences, events, and interventions considered by clients and/or therapists will be crucial for therapy to produce beneficial effects. These issues could be explored prospectively and retrospectively" (p. 384).

Undertaking this investigation and attempting to understand the relevance of religion and spirituality to psychology has felt similar to the quest for the Holy Grail. As a well known metaphoric symbol, the Grail can symbolise a quest for an elusive truth that ultimately by its nature is intangible, leaving the searcher to consider the motives for the quest and reflect on what has been learnt from the process. As the above investigation indicates, although religion and spirituality have form, ultimately there appears to be something so relative and individual about their experience, they allude conventional description and measurement. There have been attempts to quantify these concepts, to find a physical

chalice in terms of the analogy. However the pursuit of this has only led to the realisation that it requires a cultural, social, individual, experiential and possible metaphysical understanding in addition to the empirical. Similar to any other form of human difference and expression, sensory, physically or culturally, spirituality and religious belief clearly has a place in both psychotherapeutic process and academic psychology. Although its relevance may be determined by the client, therapist or researcher in any given process, it is also clear that it is an area of human activity that is under represented. In part this omission seems to a consequence of Western cultural empiricalism, and standards of what constitutes the 'believable'. However, the increase of cultural globalisation could well lead to a fundamental paradigm shift, resulting in a reconsideration of what is 'real' and how this is understood.

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Appendix A

Example of Reflexive Journal

Excepts from Reflexive Journal

July 2006

It was strange interviewing someone I knew, although I don't think it affected the quality of the interview. There were some environmental difficulties, it took some time to set up the tape reorder and recording levels. Also the interview took place in an attic on a very hot day and we had a break half way through to hydrate. The interviewee had been very helpful allocating time in the day that was convenient to us both, but there was some pressure with time due to appointments he had to attend at a certain time.

I felt slightly insecure during the interview, although I put this down to being the first interview; I think also it was due to the interview style, which was an organic process, only marginally informed by a prompt sheet of questioning. On reflection also I think there was something about the quality of the interaction that I was unsure about, should I be leading more? Do I agree or not show too much of my feeling? How much do I explore certain areas and how much do I try not to contaminate the process? The more I became aware of these feelings the more I was aware of the tape reorder, how I might sound, whether I was asking the right questions, and how long was the interview going to be and was it good enough? On reflection I perhaps feel that this related to the anxiety of interviews and conducting research. I had discussed this with Ann in supervision and it was helpful to draw on these conversations, and remind myself that this is the active part of the methodology and sitting with the discomfort is part of process and what will ultimately make it an original research **is there a parallel in this to Mindfulness?.**

Although it's too early to think and themes the interview has influenced me to think more about **supervision** for practitioners and the necessity **for group experience and process.** Also he discussed the nature and expression of self and introduced a difference between clinical practitioner and Mindfulness practitioner. In his experience Mindfulness is experienced differently and in different intensities by other people.

May 2007

The process of doing analysing the interviews has been an extremely productive and difficult one. I am continually aware that there are 'no shortcuts' in the sense that IPA is a complete and involving process , it doesn't shut off and there is no way to compartmentalise it. It lives on its own and I share my existence with it. With other kinds of academic undertakings it is easier to make space and set goals that feel containable, such as 'I'll do an essay by this time, spending this amount of allocated time to it'. I have accepted that this is not the process with IPA, it is expressed in different ways and it's very unsettling for me, as I feel I don't have my usual ways of containing it.

September 2007

I have been avoiding the difficulties with the research and relying on previous ways of making sure things are done. This was because of discomfort and external worries, but talking with Ann has helped to be far more flexible, something I find very difficult personally, and let it emerge. I have been trying to control a process, which is interesting, and therapeutic, and about controlling anxiety and fear. Once I accepted it I am able to be effective and relate to the research authentically. The relationship between IPA and Mindfulness is certainly to do with it emerging and really acknowledging the individual's perspective as important. I understand that more at the moment, it feels real, and helps give me confidence for the research, yes it is an academically rigorous process but it is also one that gives permission for the individual to be okay, it does not have to be a removed and impersonal process but more real and grounded in authentic experience. I feel more comfortable understanding the research in this way as this is what I feel my clinical practise is about, applying various theories and psychotherapeutic models to be relevant to a particular individual at a given time.

December 2007

This makes me think of some many relationships between Mindfulness, IPA and Counselling Psychology in description. They are all about the experienced phenomenological, the immediate 'how it is experienced', the reality as opposed to the conceived, assumed or thought about. There really feels no other way to research Mindfulness, but is personally and professional challenging. However this feels such a positive consequence as well as destabilising and frightening. At the moment I can think that this is what I started the course for, it wasn't just about doing research and qualifications but it is a clinical experience and I feel that it has been clinically enhancing in a way I have not experienced for some time. I am applying what I am learning to everyday practice form the rigors of the critical literature review to the individual phenomenological experience with clients. I feel that this has been the right time for me to do this research in my development as whereas I used to think of qualifications that have to be obtained to be seen as good enough, this is more than just that, I feel I am only now mature enough to take the most out of this opportunity and grow personally and professionally. If I were to reflect too much on what I have just described I could imagine myself cringe, and be clichéd, but at the same time I know this is actually how I feel and accepting that gives me confidence to take this process forward. I am improving as a professional in the sense that I feel more able to accept and sit with my anxiety and concentrate on the client need. I have also been more involved in organisational development and actually spoken out about something I have often found very hard to do. I still can but I realise it's about allowing myself to have an expression and through this I can relate through experience to client difficulties and be more authentic with the feeling that struggles can be overcome and successful.

Appendix B

Interview Prompts

Interview checklist

1. Can you tell me how you came to be interested in Mindfulness?
    - Why use Mindfulness therapeutically?
    - Is the choice influenced by particular client groups or therapeutic models?

2. What do you think Mindfulness is?
    - influence of culture, personal history?

3. Does Mindfulness effect the therapeutic process?

4. What is their experience of clients reactions to Mindfulness?

5. Has Mindfulness effected or changed their practice?

6. Anything else they would like to be asked?

Appendix C

Ethics Form

Devon Partnership NHS
NHS Trust

Research and Development Directorate
Wonford House Hospital
Dryden Road
EXETER EX2 5AF

Tel: 01392 403462/421
Fax: 01392 403445

Email: maria.sheppard@devonptnrs.nhs.uk
www.sword.nhs.uk

13 February 2006

Mr Hamilton R J Fairfax
Counselling Psychologist
Devon Partnership Trust
Clinical Psychology Department
Ladywell Unit
North Devon District Hospital
Barnstaple EX31 4JB

Dear Mr Fairfax

Re: Study R&D Code: DPT103 (LREC Code: 05/Q2102/122
The Experience of Mindfulness in Western Therapeutic Encounters: Practitioners' Perspectives

I have reviewed the Trust R&D file for your study and am happy to give approval on behalf of the Devon Partnership NHS Trust.

You are reminded that you must report to the R&D office any **adverse event or serious incident,** whether or not you feel it is serious, quoting the DPT study reference number. This requirement is in addition to informing the Chairman of the Local Research Ethics Committee. You are also required to submit to the R&D office a **final outcome report** on completion of your study, and to provide interim reports on progress as requested. Should **publications** arise, please ensure that the Devon Partnership NHS Trust is suitably acknowledged and please also send copies to the R&D office, Wonford House for inclusion in the study's R&D file.

I would also like to remind you of the responsibilities of anyone who conduct research within the NHS, which are:

1. Work must be carried out in line with the research governance framework, which details the responsibilities for everyone involved in research.
2. The Data Protection Act requires that you follow the eight principles of 'good information handling' as summarised in the guide for staff.
3. You must be aware of, and comply with Health and Safety standards in relation to your research

More information about these responsibilities is available from the R&D Office.

With best wishes for a successful study.

Yours sincerely

Dr Peter Aitken
Director of R&D

cc Dr T Jones – North and East Devon Research Ethics Committee

Appendix D

Invitation Letter to Potential Participants

Department of Clinical Psychology
Ladywell Unit
North Devon District Hospital
Barnstaple
EX31 4JB

01271 322442

30th May 2006

Dear

Re: Participation in Research into Mindfulness

I would like to invite you to be interviewed for the above research. Attached you will find information about the research, what it involves, and how you can help.

As you can see your participation will involve being interviewed about the role of Mindfulness in therapeutic processes. The interviews will be recorded for the purposes of transcription, and will last between an hour and hour and a half. Rooms are available in Barnstaple or Exeter, but I would be happy to meet you at a different venue if this were more convenient.

I am hoping to conduct the interviews between June, July and August and can negotiate a time of the day that fits with your requirements. There is a tear off slip at the bottom of this letter on which you can indicate your availability and preferred time. A self-addressed envelope has been included for you to return your response. Alternatively I can be contacted on the number above, by email (hamilton.fairfax@nhs.net), or mobile 07883025426.

The research has Ethical approval from both Devon Partnership Trust and London, City University, and I would be happy to answer any other questions about the research.

Thank you for your help. I look forward to meeting with you soon.

Yours sincerely,

Hamilton Fairfax
Chartered Counselling Psychologist

Name_____ Preferred Month (circle) June July August

Preferred time of day _____

Location?_____

Appendix E

Information Sheet for Participants

Participants Information Sheet (Approved Version)

Title of Research: The Experience of Mindfulness in Western Therapeutic Encounters: Practitioner's Perspective

You have been invited to take part in research that is interested in understanding the use of Mindfulness in the therapeutic context and your experience of the practice as Mindfulness therapist.

Who I am

My name is Hamilton Fairfax and I am Chartered Counselling Psychologist working in a Community Mental Health Team (CMHT) in North Devon, employed by Devon Partnership Trust. I am also undertaking doctoral research at City University, London. I have been interested in Mindfulness for several years and would like to know more about what it is and how it may relate to the therapeutic process.

Details of Participation

If you would like to take part in the research, please send your signed consent form along with your contact details using the enclosed stamped addressed envelope. I will then contact you to set up a time for us to meet for an interview, at a place and time

that is convenient to you. I have rooms available in Barnstaple and Exeter, but would be more than happy to meet with at your place of work if you would prefer. The interview will last no more than an hour and half and will be audio recorded. It will then be transcribed and studied along with recordings from other participants. During the interview I will ask you questions about your experiences as a Mindfulness practitioner, and you can tell me as little or as much as you would like. All the information you provide will be confidential, the only exceptions would be any reports of serious risk to yourselves or others.

Taking part in the research is entirely voluntary and you can withdraw from the study at any time in the process up until it's submission by May 2008.

Confidentiality and Ethical Information

The research has received ethical approval from Devon Partnership Trust Board of Ethics, and approved by City University London. I can supply you with both these contact details if you have any specific questions.

Your details will be kept anonymous through the use of a pseudonym, and the removal of any identifying material, and all information will be stored securely and kept in locked filing cabinet that can only be accessed by me. Any pseudonym used will be known only by me, and I will keep your contact details in a separate place from your transcription. The only other people who will have access to any of this information will be my research supervisors Dr Ann Colborn, Devon Partnership

Trust, and Dr Malcolm Cross, City University. Guidelines recommend that the information I collect will be kept for five years under secure conditions and will be destroyed after that time.

Academic Applications of the Research

My research findings will be written up and submitted to City University London as part of a research portfolio, and I would be more than happy to send you a copy if requested and you are free to give me any feedback, positive or negative. I also hope to present the findings at conferences for health professionals and to submit them to journals for publication in order to disseminate the information and raise professional interest in the subject.

If you have any further questions you can contact me by phone 01271 322442 (information can be left on a secure answer phone after 5.00pm) or by email hamilton.fairfax@nhs.net. You can of course contact me at anytime during the research.

Thank you for taking the time to read this information and considering becoming involved in the research.

Appendix F

Participant Consent Form

Consent Form

Research Title: The experience of using Mindfulness in western therapeutic encounters; a practitioners' perspective

Name of Researcher: Hamilton Fairfax

1. I confirm that I have read and fully understood the information sheet dated-------- (Version 2) for the above study and have had the opportunity to ask questions.

2. I am aware that my participation is entirely voluntary and I can withdrawal at any time without medical care or legal rights effected in any way.

3. I agree to take part in the above research.

----------	----------	----------
Name of participant (Printed)	**Date**	**Signature**
----------	----------	----------
Name of Researcher (Printed)	**Date**	**Signature**

Copies: Participant
Researcher

Appendix G

Transcript and Example of IPA Coding

HAMILTON FAIRFAX – INTERVIEWS

Interview 3 Duncan

Duncan OK um where do I start. Well I think it's probably best to start not in Mindfulness possibly with meditation er Buddhist meditation, if that OK. Um because that's where it started for me um in Scotland. I was working as a Clinical Psychologist in Dumfries in Galloway and there is a Tibetan Buddhist Monastery called Sami Ling which is up in that neck of the woods and um I got involved with um going to some things at that centre and I got an interest in Buddhism from years ago um and to cut a long story short I got, kind of introduced to meditation practice in the Tibetan tradition there and er I think at that point it was helpful for me because I was going through quite a lot of life changes, we were expecting our first child, I had just moved to Scotland and was fairly stressed so I think that was a motivator. Yeah.

HF Has the interest been longstanding

Duncan Yeah

HF Has it featured at all in your psychology training?

Duncan No. Er not in any direct sense at all, I mean we are going back now to the, I trained, sort of in the late 80s early 90s and there wasn't really much around in Clinical Psychology training, some interest in transpersonal psychology was around and my other interest at that time was Jungian Psychology and I guess there was elements of Jungian Psychology linked with it, yeah, but not really – there was no, certainly Mindfulness wasn't around at all in my training, I don't think it was on the horizon um in the late 80s.

HF Could you

Duncan Well, um I began my meditation practice and moved from well, started in meditation practice and I was working in a department in Scotland where the Head of Psychology was also interested in meditation and spirituality in general – so we used to have conversations about that. But it was pretty

much something that was in my personal life and not in my work life but since then I moved down to work in Sussex and er I think over a period of years confidence to bring Mindfulness into my work became stronger um although not necessarily in the sense of teaching people to practice Mindfulness but more in the sense of I was seeing overlaps between Buddhist Psychology and meditation and the kind of Psychology that I was interested in therapeutically. Um particularly systemic psychotherapy and social constructionist-type thinking.

HF What kind of overlaps?

Duncan Well, the way I was taught um meditation in a way, in my memory of it, was that it was particularly encouraged to be non-goal orientated, to be respectfully curious about your experience and to bring a lot of kind of warmth and humour and interest to what was arising and that was interesting, very similar to, really things I picked up about practice from Psychologist working within say, social constructionist or systemic ideas – partly because I think of the kind of people they were but they also encouraged me to work clinically in that kind of less goal orientated non-pathologising, reflective, sitting with what was there, noticing, being curious, being respectful, so I immediately saw some, some links and also I suppose on a more philosophical level in my dim way I could see some resonance between post modern philosophy and Buddhist philosophy around a self that doesn't exist as a thing but is a kind of, well in social constructionist terms it's a social construction and in Buddhist terms it's a construction too. So there is a resonance there. Yeah.

HF How does that how easy in practice ....

Duncan Yup, um well I think um both aspects. Those therapeutic ideas and the Buddhist Psychology has influenced my practice and it's sometimes too hard to define ways um because its had to tell which bit its come from. I mean I think for years I've been, I've been very resistant to kind of normalising, pathologising kind of elements of Clinical Psychology and aspects of therapy. Its about sort of getting rid of pathological bits of people, so I don't really, I've never really been keen on that kind of way of working and I mean um for me a lot of therapy work is about giving

people space to be and also space to kind of see what's there in their experience and then feel that they can make decisions themselves from their own point of view about where they are going in their lives and I kind of accompany them in that. Um so I think I can see elements of the sort of systemic social constructionist kind of stuff as well as community psychology I should say and, er and also Buddhist Psychology not in the formal sense I am not a scholar of Buddhism but more in the sense of things I picked up from reading and working with Buddhist teachers around er the value of giving people space, of not being too orientated in to how people should be and not too goal orientated generally and having a lot of, sort of, compassion towards the kind of idiosyncratic ways that we all manage in life. Sorry that's a very vague answer.

HF No that's

Duncan Feels a very vague answer.

HF Something about that subject is quite vague, its very hard to catch vagueness. My next question is thinking about Mindfulness, is it a technique, is it, what is it – how do you know when you are Mindful?

Duncan Well I wrote a paper a few years ago called "Not just another Technique" so I suppose I have to say it isn't a technique (laughs). Um or at least not just another technique I suppose yeah. Um I don't think Mindfulness is a technique except in a very loose sense that there are certain kinds of ways of sitting or postures and some very, like practice, sort of instructions that go with formally practising Mindfulness but I think Mindfulness in general is a way of being in the world more than a technique um depends really what one means by technique I suppose. Um yeah, depends what it means.

HF My with Mindfulness was several years ago and was very much skill based

Duncan Yes, yes

HF I found practice

Duncan Yeah, yeah

HF I suppose in those terms it very much - this is the store

Duncan Yes, Yes

HF How would that affect

Duncan Uh hah (sighs) Um well I, I appreciate that way of describing it, I huh I have, well for me personally the way I was introduced to Mindfulness was through particular Buddhist teachers who perhaps didn't really talk about it in that kind of way. There was a Tibetan teacher called Chungum Chungpram Rumashou. I remember I, he described Mindfulness or meditation as one long series of insults and disappointments (laughs) because he was very much emphasising Mindfulness as a way of being in the world where you just come face to face with your own sort of errrgh your own sort of day, moment by moment kind of experience which often is quite difficult but in a way its very simple as well, I mean, I think in one description he describes Mindfulness as being sitting like a discarded paper cup. So he had a certain choice of phrase which is, I very much related to, other people might not, but I think I had come across previously books on meditation which were more saying "this is a skill you can learn it will offer you these kind of benefits" and I actually found that off-putting because I thought – yeah well they will probably won't have those benefits for me and I will probably fail at it anyway – so what's the point. And Chungum Chungpram particularly used to say- "just do it, don't have expectations, just do it, just sit with yourself. See what's there, investigate for yourself, be your own, you know, be your own judge of that, but not having too many expectations, not too many ideas of what's going to happen or how it should be, should I be tranquil or not". He said you might not be, you might just be bored and he described a lot of Mindfulness being connected with boredom and he talked about the difference between what he called hot boredom and cool boredom and he said practising Mindfulness can help you move from being hot, hop from hot boredom to cool boredom is the way he described it.

HF What was that thinking

Duncan Well hot boredom is more that kind of completely agitated you know mind's running at 300

miles an hour and can't settle to anything, that kind of itching kind of boredom. Whereas cool boredom is more like a discarded paper cup. You are sitting there, there's not much happening, you're not having great cosmic insights, nothing much is happening and its kind of just OK, that's OK. (laughs)

HF That's interesting, listening to you talk about it like that, uncomfortable, kind of be there, that kind of state. Is that something that you've experienced with others?

Duncan Yes it is uncomfortable, it can definitely be uncomfortable and that is something else that he emphasised, that if we go into Mindfulness practice expecting to feel more comfortable then we may be setting ourselves up for failure because he particularly emphasised that Mindfulness isn't about achieving comfort. Its not about smoothing everything out neither is it the opposite but its kind of um I think he and a particular follower of his called Pen Bertroderum talk about Mindfulness as both offering a sense of relaxation space but also a sense of being more face to face with ones own intrinsic restlessness, agitation, discomfort with oneself, discomfort with states of mind that we find very aversive and we all use subtle and not so subtle ways of blocking out and we could, and can, use meditation Mindfulness to subtly block out unwelcome states of mind and that to me is a definite danger of Mindfulness, is that we can subtly use it to actually numb out even further but we just do it with more, more panache. (laughs)

HF That's me. Can you tell me more about that sort of dangerous side of things

Duncan Yeah, well I think I have noticed with myself that the practice of Mindfulness when you are you know, ones formally sitting and you know er in whatever context and um the way I was taught Mindfulness in terms of the practice was to sit and when thoughts come up is to say 'thinking' and then let them go. Which is just noticing the kind of way in which one can do that so I could be saying 'oh thinking, thinking', you know not being caught up with that but then something really unpleasant comes up and I just notice that element of 'aaaah thinking'. Its like almost before its there its like that 'thinking' and its like that subtle sense of pushing it away, just very

subtly a sense of just thoughts, nothing to do with me. You know, just thoughts – quick they've gone, they will be gone soon. There is that element of subtly pushing away particularly yeah unsettling, unpleasant, aversive, so it's - I think because for many of us when we come to sit and practice meditation Mindfulness we often have a very strong agenda about – this is going to chill me out, this is going to make me more relaxed, this is going to make me feel better - and if in the process of sitting we have unpleasant and aversive states of mind then immediately there is a slight element of um panic, or this isn't what I wanted, this isn't right so then one can use the technique to say 'ah thinking' and it's just like quick, you know, keep it away but that wasn't how I was taught meditation I was taught that it's about really, the way that Chungum Chungpram described is touching and letting go, touching and letting go. So then there is that touching element so if something yucky comes up there is still that aagh anxiety. Just touching that, you know, then letting it go aah you know depression, you know aaah yuck you know its ok just there.

HF Really see what's on the end of the fork

Duncan Yes, seeing what's on the end of the fork before you've let it go again, quick, you know and um developing a lot of compassion and good heartedness towards that and um I do think that, you know, that's there in the Mindfulness tradition. I mean a phrase of Jon Kabat-Zinn's that's always struck me is when he said that 'Mindfulness isn't relaxation spelt differently.' That's a phrase he used by which I understood him to mean is that ' you can practice Mindfulness and not be relaxed at all and you're not failing'. So you could be tense before you start, you can tense while you're doing a body scan and you can be tense afterwards but if you've been able to lean into that and notice then that's Mindfulness practice. Otherwise you might as well call it a relaxation exercise and then if you haven't relaxed at the end then it is clearly not working.

HF That's really interesting. How do you get that across to clients?

Dunan Its very difficult because there is a danger in going to one of two extremes, so either one can get very caught up in saying 'yes practice this and

you'll become calmer and more relaxed' so that's one extreme I've tried to avoid. There is another extreme that's possible which is to over emphasise the discomforting aspects so that in a way you almost put people off, I think unnecessarily, because um again that's only part of the equation because I think relaxation, a sense of space, and a sense of calmness and clarity can and does also come up with practising Mindfulness but it is not a one shot deal. Um so you know I think it's just been something I have tried to be very aware of in presenting Mindfulness to anybody and thinking about it myself to try and make space for both, that um you know if in week one people are saying – I remember once I was doing this with some staff and a member of staff was saying 'well I'm feeling more anxious doing this, so clearly I'm not doing this right'. So it's at those moments in a way it's important to kind of immediately address that and say 'that's absolutely fine, what you're doing is you're becoming more aware of that anxiety that's often for many of us bubbling away and you're slowing down enough to see it, and that's ok you don't have to push that anxiety away, you don't have to do anything with that but if you can just stick with that a little bit and just notice it then um then that's Mindfulness practice'.

HF Is it that um Mindfulness technical inform of all the time or actually produce to talk

Duncan Both I think. Um it informs my position um in as much as I am hopefully drawing on that sense of spaciousness and um not being attached too much to goal etc etc that we talked about earlier and then sometimes in the past um and now I would explicitly suggest it but I've done that less actually. I mean the Mindfulness work that I've done with clients in a formal sense has been, normally been, in the context of a group where people know what they're coming for, they've signed up to come to a Mindfulness Group and occasionally in the past I have been specifically referred someone who was interested in meditation. Its much rarer for me to actually raise it with someone who hasn't raised it themselves in individual therapeutic context. I am somewhat uncomfortable with doing that actually. Somewhat uncomfortable with doing that.

HF

Duncan Um mm well I suppose partly because I don't see it as simply a technique that people can just be offered and just go off and do. Um so the way I've worked therapeutically is I have never really introduced techniques to anybody of any kind so I am, therefore generally, don't go into kind of – it doesn't mean that I sort of sit there like an analyst saying nothing and being desperately sort of er I don't know esoteric. I am, you know, I am very happy to chat and be pragmatic and offer advice etc etc if necessary but I've never been very good at saying "why don't you try this technique at home", it just hasn't been, I mean I am, I would be hopeless as a CBT practitioner do you know what I mean, I'm just not, I just don't do that sort of thing so I suppose its partly just that, its not a habit of mine to say "why don't you go and keep a thought diary" or I just don't generally advise people in that kind of way. I might say "why don't you go, and go swimming more often" something very ordinary but so on that level I think haven't and also I suppose – because it is a subtle way of being, I think if it naturally arises as something to talk about with someone I just feel more comfortable that it's useful than if I suddenly kind of shoehorn it in to a conversation. And on the times I have tried it's normally not, not worked that well and – mind you I suspect its probably because of the half-hearted way I bring it in perhaps – but um but I think also it just shows me that I am not the kind of the person as a therapist I think who, who naturally works well with that sense of 'hey, why don't you try this technique?' I think it just doesn't fit with my style really very well, which is why maybe people think 'oh well, I am not really that interested so I'd rather not if you don't mind'. Um so I prefer a situation like a group where I know that people have come because they've got an interest or not necessarily because they're interested but because they've signed up to come 'to a Mindfulness Group so therefore I've got permission. Yeah.

HF This might be a really impossible question to ask, but process between two people the way you described yourself
is that something that, that you notice perhaps

Duncan Um, well I don't know because I mean there's many CBT practitioners who are also Mindfulness practitioners these days. Um I think that

way of being with people was there for me before I got interested in Mindfulness because it was kind of the way I had learnt to be as a therapist. I also, my own experience of having therapy, it was a way my therapist was with me um so I guess I took that cue. Um I suppose I was taught that a way of being a therapist is about being as human and as informal and as natural as possible whilst still maintaining to some kind of distinctive role as a therapist so you are not just becoming a mate who's having a chat with someone but on the other hand trying to keep as light as possible the notion that one is an expert applying theories or techniques to someone. I am much more of the idea that I a human being who has got a range of narratives and sort of practices that I have been trained into who can draw on those in the space with someone who is also drawing on their expertise, in their own life. Um and then seeing what we can work out between us.

HF Is Mindfulness about having ?

Duncan Um I am sure, I would hope it supported that, yeah. I mean I think um the analogy I would draw is that in systemic psychotherapy you often work with a reflecting team, you know, which is a group of individuals who will sit in another room or in the same room and if they are a nice reflecting team they will, they will feel like a supportive, empowering, compassionate presence in the room who can just help you see what you are doing as a therapist. So to me Mindfulness can be a bit like cultivating an inner reflecting team that's like 'ah you know this is what I'm doing today, just noticing how I'm sitting, or how I'm feeling' you know because I think Mindfulness encourages just that sort of ordinary sense of noticing, without necessarily having to do anything with that and I think in that way Mindfulness is a support to that position because unlike maybe an analyst perhaps who might notice a counter transference reaction and then would probably be already conceptually and analytically making sense of that and then using it through a lens of a theory, I think this is more about just, in more simple way, just noticing and maybe or maybe not doing anything with it very analytical. Because in a sense Mindfulness is quite simple minded I think, it is not very analytic and that's one of the things I like about it actually.

HF It seems interesting to me that one thing about association with people with transference especially . Is it, you know, like a theory, theory of observation?

Duncan Yes, if such a thing as pure observation is possible, I mean I guess you are always going to have your own narratives that you bring into your observation but I think may be it's just done with a lighter touch and with less emphasis on – I mean one of the issues I have with psycho-analysis is that it tends to apply theory in what to my mind, a very heavy handed way and in a way that often leaves very little room for manoeuvre, for either the therapist or the client sometimes. It's like, it's a little bit of a closed universe of discourse where either you fully sign up to it or you're kind of in the outer darkness, you know there's no in-between with psycho-analysis and I've always found that somewhat claustrophobic so I don't relate to that very well. I am sure there are analysts out there who hold to it and with a very skilful light touch which is good but, but you know it's a cliché to describe analysis in the way that I am but there is an element of truth I think to what I am saying, um but I think the way I have learnt Mindfulness meditation is that it does not come with too much theoretical baggage and is partly about simply a kind of naïve noticing which again was a little bit like some of the ways I was taught systemic therapy, although systemic therapy can get technical and obtuse and off putting to me but when it is done in ways that appeal to me then it was often just very much a sense of 'oh what did you notice?' I remember working with one supervisor who I would write reams of notes from my family therapy sessions and he would say 'why did you bother writing all that down, just say a bit about what you noticed'. And it was like put that down all the detail and just – what did you notice? And that a bit like meditation – oh what did you notice?

HF Partly again feel slightly uncomfortable with what's happening, insecurity.

Duncan Yeah

HF I think when you OK about mindful, reading a paper or something

Duncan Yeah, yeah I think there is um I think, you know, certainly Buddhist meditation is about

leaving security behind um in many ways, I mean I think in a way that's, that's almost the whole point of it. Its about groundlessness, about taking away the usual way in which we shore ourselves up. Um but um but not in a way that I think we have to rub our noses in that I don't think we have to kind of, well I haven't, you know I am by nature a fairly frightened person. I am not going to kind of jump into utterly groundless states of being and I will just freak out you know but I do think um it's taught me to have a sense of humour about trying to kind of say "Oh I know what I am doing" and of course there is a strong similarity with the trainings of therapists because I think that haunts all therapists, well if they want to recognise it or not as being haunted by that sense of "I don't know what I'm doing, I don't know what's going on and I don't know what to do next". And its like "pow" either, well, I mean I think different therapists do different things without either, they overlay it with having loads of techniques up their sleeves so they never have to feel that or they avoid feeling that or – and I think at best its about making friends with that, actually saying that's OK, that's actually what the job's about.

HF Feel better (laughs) There's something else in there as well .. about
Thinking about clients saying to you "I'm quite

Duncan Mmm yes, yes

HF And I suppose is there a danger
I mean psychotic or overly anxious is there a danger in that?

Duncan Erm, I think if one kind of pubbled, kind of, Buddhist philosophy about non-self at people in a way that was really in their face and got them to do loads of practice - *if one can get anyone* to do loads of practice - you know if they had such sort of unswerving devotion to you as a therapist they would go away and do loads of practice then yeah it could be but I mean that, that certainly would not be the way I would go about things,. I mean one of the debates I have had with colleagues when we have done Mindfulness Groups is the tradition in MBSR and MBCT, is asking people to go away and do 45 minutes a day, I have never done that. I have never said to anyone "I think you should go away and do 45 minutes" because I don't and I don't, I am really not comfortable with asking people to do what I can't do.

And also I just feel that it is probably too much for most people, so for me it's again very much, I think, a kind of hallmark for me is about having a light touch so it's about really helping people, just sow some seeds of Mindfulness in their lives and dip into it and just see what its like and not really kind of asking people to jump in and I would not really talk about no-self at all anyway. That might just naturally come up for some people and then it's about helping people feel OK with that. Its like one woman in a Group saying "Oh the other day I was just perhaps singing and I just suddenly felt completely alone in the Universe, I must have been doing something wrong", and we were saying "no, no those kinds of things can happen" but you know its just about – it's OK, you know, its just, kind of insight life, you don't have to freak out about freaking out about it, so its just, it's OK these things can come up. Um but I don't think there would be a danger for most people if anybody in asking someone to sit and work with their breath for 15 - 20 minutes a day without too much overlay of any kind of idea about what to expect from that. I think that's fairly grounding practice, but I guess it's partly just depends how one would present it and how people might take it that there's always a risk that someone might, it might just sort of um create um discomposure, but it's not been my experience to date.

HF So does that mean

Duncan Mm yeah

HF Had she

Duncan Giving her space just to talk about it but not really then going into it too much, but just kind of - ah yes well that's – making her feel that its OK, that its part of what can happen, neither going into it too much which might be uncomfortable for her and not, kind of, ignoring it um but I suppose because of the context of saying "these things can happen in Mindfulness" it becomes less – oh my lord that wasn't what was, I was told, would happen or it was very unexpected – um I think in a way there is not an awful lot one can do, either the person is going to be then thoroughly put off and I have worked with people who at the first sense of discomfort have just stopped practising because it is not what they wanted, you know, and I respect that. You know I wouldn't want it

to kind of say - no you've got to get over that – you know I think it's very much people just have to vote with their feet and decide either this is something that makes sense enough to me to, even when its not comfortable, just to carry on and for others it maybe isn't the right time, or isn't the right practice for them. Um isn't not like that I don't care one way of another but I just think, I think, I just trust that people will, will, will make sense of it in the way that they can, er as best they can. So if it's very anxiety provoking and they decide not to practice then so be it, you know, that's maybe, is what they need to do at the moment, I don't really have, I'm being vague here because I don't really have a strong view one way or another, It would depend I think.

HF

Duncan Yes, yes

HF I suppose were thinking about behaviours exposure that kind of structure pattern

Duncan hm hm

HF Would you be thinking about how we understand one
Certainly NHS
What your opinion in a nutshell of all those kind of things,

Duncan About whether it's evidence-based or whether it could be evidenced based

HF Yes, yes

Duncan Um well it's playing out in a particular way in the West um and I have to be careful not to be too negative about aspects of it because I wouldn't be earning a living partly from Mindfulness if it wasn't for people like John Teasdale taking it to people like the um place yo~~u~~ worked for, what is it called – the Cognitive Therapy Research place – and developing his theories in a very strict evidence-based scientific way, has led Mindfulness to have acceptability. So I have to take my hat off to John Teasdale and others for doing that, um because it has helped make Mindfulness socially acceptable in healthcare. I think my worry is that um in that process something of the spirit of Mindfulness can get lost and there is a

difference in my mind between science and scientism and I think there is a danger of a scientistic approach always these days in the world of therapy and healthcare and by scientism I mean things like, you know, Mindfulness is only OK if its operationalised and is - you hand out Mindfulness based questionnaires that assess peoples levels of Mindfulness and that Mindfulness is only talked about in certain ways as a kind of attentional control training, blah blah blah. That to me is scientism because what it's doing is using a certain kind of language and a certain kind of attitude as if it is the only way and the only right way and I think it will kill something of the sort of poetic unpindownable nature of, of what Mindfulness is pertaining to. That I think the Buddhist tradition, you know, has wonderful reserves of both a kind of abstract logic side but also the great kind of Masters and Mistresses of meditation who have written in ways that I think bring people into practice but aren't written in that kind of arid desiccated kind of way that's so beloved of modern healthcare and modern science, and er I think it would be a real shame if Mindfulness is kind of put through the usual mangle that everything is put through to make it palatable. That although a lot of people say – yeah well we need to do that – its really important to say -yeah and we will really lose something in the process - and in the case of Mindfulness it's a big risk to take.

HF Is there a way that

Duncan Um I think there are always ways of presenting things as valuable things to do I think it's partly who one needs to persuade. It's a contextual question really. Um and that for me is the whole issue about evidence, is this partly evidence for whom and in what context? And one kind of evidence is only useful for certain people in certain contexts so um so if I have to persuade a, some work colleagues, that Mindfulness might be a good thing to do then the evidence I need to draw on is going to be different than if I've got to persuade a funding body to give me money, you know, and I think its about horses for courses. I mean the research I am involved in at the moment was around simply interviewing participants in a Mindfulness Group, to just talk about their experience. There again, quite simple minded really – so what, you know, what was it like practising Mindfulness, being in a group, you know what came

up for you – that's kind of evidence for me. It's, it's again on a quite straight forward level and that's something that I'm involved with at the moment. And you can do different things with that and turn that into different kinds of evidence, but on a certain level that's the kind of evidence of simply asking people.

HF .... Student data. What kind of things did you, when

Dunan Um well a whole range of stuff um I think one of the main themes that's come up is about this idea of just noticing, that people saying how one of the impacts of Mindfulness is about how they became more aware of changing seasons or of, just things in day to day life, very ordinary things, a sense of just noticing but also that they, maybe, their sense of noticing things that were unpleasant as well as pleasant and that was linking back to this whole idea that Mindfulness is not just a pleasant thing it can also be challenging, difficult and unpleasant and I think that's been a theme um for a number of the participants, you know, er having to stick with, wanting to stick with Mindfulness even though they would often feel worse as a result of being more aware of yucky stuff going on for them, but actually well I'm grateful for seeing them, for a number of them is that they were able to kind of see beyond that discomfort to see that there was something about, I think how one participant described it as – just learning to stick with oneself while unpleasant states of mind are out – which I know is DBT, is like DBT really.

HF efficient outcomes

Duncan No, No.

HF

Duncan Exactly and a very good example of that is we, we because it's Trust policy, we had to give people Core forms at the beginning and end of the group and as one of the participants was filling in her Core form on the last week of the group she said "I don't think this form is going to reflect what Mindfulness has meant to me. I'm not sure you're going to see my score change but that doesn't really mean anything about how valuable I found, perhaps in Mindfulness" and to me that hits the nail on the

head because I was never intending it to be a symptom reduction course at all. So that isn't, that isn't my goal but if, if its about saying - yeah I do experience extreme states of anxiety but I have begun to feel that I can still hold my head up as a human being and feel on some fundamental level OK. And a very um defining moment for me was on the first meditation retreat I went on, more or less, the person leading the retreat at the very beginning, almost I think the very first thing he said, was - ladies and gentleman the first thing I want to say and its really important is that you are all without exception absolutely fine as you are right now – and there was almost a gasp of outrage around the room, how can we be? And I thought what a wonderfully subversive thing to say, particularly in our culture that we all without exception are absolutely fine as we are. And that's immediately pointing to the idea of Buddha nature or basic goodness in Buddhism which I think is a tremendously important aspect of Buddhist psychology and Mindfulness that is counter-cultural to the Western psyche which is around deep down I am fucked up and therapy unfortunately I think, often is as much part of the problem culturally as it is part of the solution in playing into that idea, because often is says – yeah and we can sort that out, come and see us – so it's the therapeutic industry contributing to that deep sense of lack and there has been some very interesting philosophical stuff written about – there's, there's a book that's quite hard to read called "A Buddhist History of the West" by a Western philosopher who's steeped in post modern philosophy who talked about the Western cultural project, if you like, being about filling an intrinsic existential sense of lack and that therapy, consumerism and Western philosophy are all desperately trying to fill that hole. Buddhist philosophy is about letting that hole breathe and I think that's what Mindfulness can be. So on a certain level it's very subversive.

HF Absolutely. I suppose, would you like to have gone through that process, about people battling culturism

Duncan Yeah

HF would want to have clients experience that

Duncan Absolutely, I, I, you know I think it's a real challenge, it's a real challenge for me on a daily

basis I've been practised for some years, like a colleague of mine, a friend of mine, who's a very experienced meditator says, you know its constantly a sense of swimming upstream, a sense of whole cultural neurosis that you can't just step out of, and I think its really important to see because, for if he feels kind of defeated, thinking you know – I've been practising Mindfulness all these years and I still am completely worked up about x, y and z, nothing's changed – you know, but I just think you know in a sense we are all in it together, it's a very very strong cultural narrative that really a big step is just to notice and then have a lot of compassion and good humour about, because just practising Mindfulness isn't going to be a kind of ticket, hasn't been for me, to just kind of gaily walk away from all that and not be informed by it.

HF sort of levels of

Duncan That's not the purpose for me, no the purpose for me is about giving some sense of basic goodness which then can kind of, in the best sense, haunt us in the nicest way. That we can, kind of, remember and can be there as a seed that can grow in its own place and some people have said to me that once you've planted that seed even if you wanted it to go it can't. In fact Chungum Chungpram himself used to say, you know, if you stop practising it's going to haunt you because once you've started it's got, it's got to, you know, and there is a traditional Tibetan saying, apparently, which used to say er – better not to start, if you start better to finish – about practising meditation, you know once you've started you cant go back really, even if you wanted to. Even if you want to say, 'right I don't want to be mindful now, I don't want to feel aware', it's been very difficult to stop that process.

HF Is this very much
How, how, is there, how that sort of balance with Mindfulness.

Duncan Um, well, its difficult, I mean like we were saying earlier, its about context and may need to adapt what one says for particular masters, at particular times and er you know when I was doing this research obviously I have to write, as I am sure you've had to, protocols and get things through ethics committees etc etc um but on the other hand I've

often found with managers in healthcare that they will respond to kind of a personal description of the value of things, and also sometimes quite informal descriptions. If I, if I were, you know, if in at a time when NHS wasn't in such a state financially I was to go along and say - look I've done this research which has been asking service users about their experience doing this practice and here's some really quite qualitative, narrative research, I think many of them would say – 'yeah that looks good'. I mean a good example of that is the Mental Health Foundation's work on service users description of what's helped them recover, you know the recovery work, it's very informal, qualitative, non-rigorous in the usual sense kind of research and yet it's been promoted by the Department of Health, by the Sainsbury Foundation etc etc. So it shows you that there are other ways of persuading that aren't necessarily about going down the hard science route and that's one of the things I've found is that, you know, there is a movement now around spirituality and healthcare which has got, you know, the Royal College of Psychiatry has got working groups on, NIMY locally have a spirituality group and there is the whole service user movement and that kind of research done there is not generally of the king of hard science end, its about asking people their experience. So I think that kind of thing also appeals to Commissioners. Saying that there's bugger all money for anything at the moment and the Mindfulness work I did in Plymouth had to stop for lack of funding so, you know, I am not doing a Mindfulness Group currently in Plymouth due to lack of funding, and I am not sure when another one will happen. Um but then again I've got another manager in Primary Care who's got, I've got, a good personal connection with and she's known about the work I've done and she is keen for a Mindfulness Group to start. So I think a lot of it is about those kind of personal connections and things can happen. So I, in a way I think it's only in certain situations that one has to really, as it were, go through hoops of writing things in very formal ways which might not always feel comfortable and if one has to do that then one has to do that and square that as best one can and the way I squared it I suppose was by doing a fairly qualitative, to some people probably flaky piece of work anyway, that I felt comfortable with. So I, you know, I described it as a process narrative, process study of a Mindfulness Group. I got that through um because, you know, there is a qualitative research kind of

tradition now, so er, you know, the whole IPA tradition etc. etc so I think things are easier in that sense than they used to be, you don't have to kind of completely turn it into this kind of hard science language.

HF Thinking about some checks
just thinking about that, how Mindfulness

Duncan Yep

HF Using that ....
Academically

Duncan Yes, yes, yep

HF How, how do you feel about?

Duncan Um mixed feelings. Um I think um again its inevitable so therefore not worth protesting about that um there will be kind of academic discourses around Mindfulness and I think on a certain level then that's absolutely fine and good and maybe, maybe useful um. I say that without much sense of conviction for myself but um but yeah, I suppose it just goes back to what we were saying earlier around what the dangers of – I suppose being interested in social constructionism, I'm interested in language and the impact of language in constructing, it doesn't just simply describe it actually constructs experience, so if we start constructing a different discourse about Mindfulness that's in a language of academic psychology, then it becomes something else in the process of using other words. You know if we talk about, you know if we say, we could describe Mindfulness as befriending our um well lets say, you could sit down and say to someone – what is Mindfulness, its about trusting your heart, that's one end of the spectrum or you could say – its intentional control training and its an exposure response prevention technique. They're both descriptions of Mindfulness but they both have quite strong impacts and they will both, as it were, open up a different landscape for the person who is introduced to it that way, for better or worse. Um so I think for me its just about keeping, keeping aware of how we are talking about this and one of the things that, I suppose I have trouble with scientism, it has a funny kind of religiosity to it, that its quite fundamentalist it will have no other prophets before it, you know its like, its only this way and everything else is subsumed to it and um I think

its ironic with Mindfulness, this is a hobby horse familiar to colleagues of mind because I've gone on about it, that I think in NBSR and NBCT trying to keep religion out which I think by and large I think people have said you know we don't want Buddhism too much, we don't want it to be too spiritual, its secular, etc etc that as Freud you know, great theory of Freud is - The Return of the Repressed - you really kick something out it will come back in a disguised form. And some of that religiosity is coming into it, whether its Jon Kabat-Zinn becoming a guru figure and everything he has said and done must be held to, which is something that gets my goat, you know – you have to have the raisin exercise because that's what Jon Kabat-Zinn did – week three of NBSR oh you have to do it this way because that's what Jon Kabat-Zinn did, its like – well just because Jon Kabat-Zinn did it, you know, he's not Jesus, you know, its like he was just someone tinkering with Buddhism and we can tinker with Jon Kabat-Zinn, you know, so long as we do it mindfully. Um so that kind of religiosity and then also the kind of religiosity of scientism which is around – this is only OK if we've operationalised it, and its only OK if we defined it in very sparse clear technical language and that's the only true highest kind of level discourse, description. That to me is a kind of religiosity that's a religion of a certain kind of positive science, that you know is, is um people hold to as kind of faith. Sorry I'm going off on a hobby horse there so..

HF That's a really good place to be (laughs)

Past service. Mindfulness based group – following point

Duncan Yeah, yup

HF its very sold to GPs as a, you know, ... On top of everything we've been saying whats the general response to that kind of thing..

Duncan Which aspect, the fact that you've got somebody who's very experienced and someone not, or the fact that its being sold as a skill for ..

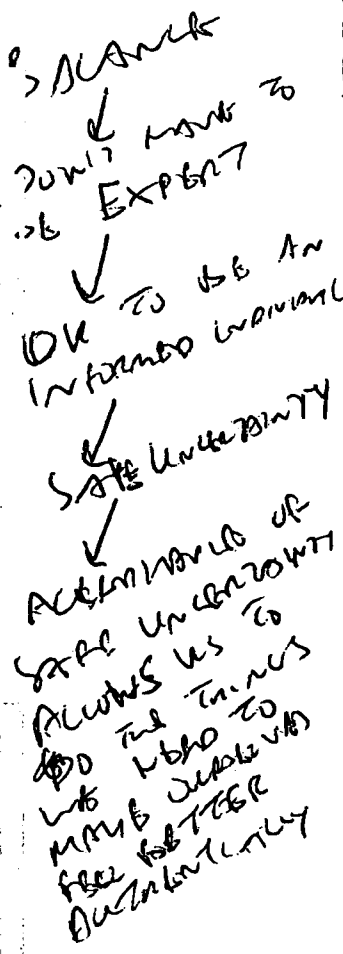
HF Both really

Duncan Yeah, it doesn't matter practice, I think that's always a, a very difficult one to talk about in

abstract because I think again there are different voices in the community, the Mindfulness community, you know again Jon Kabat-Zinn's very kind of – I think – a little bit too um extreme about that in that he says you know – you've got to have a rigorous and unwavering commitment to meditation in your daily life for years before you can go near – and I'm thinking goodness that's going to reduce the number of people we could offer this down to almost zero - ah you know just feels too much but then maybe that's because I can't manage that so maybe I shouldn't even be doing it myself, you know anything that's bye the bye. Um on the other hand, I hear of and come across people who've like done one weekend course and then start offering it willy-nilly, which may be - you're thinking well have you got much of a sense of this yet yourself. I think if you combine someone who's very experienced with someone very inexperienced then it may be a perfect combination. Um I think if you had two completely inexperienced people that might not be so helpful. Um

HF More dangerous ...

Duncan I think the main danger is that probably people would present it in too textbooky a kind of way. They could take the Jon Kabat-Zinn or John Teasdale, Mark Williams book and use it as a cook book and I guess that would be OK but in fact John Teasdale and Mark Williams themselves talk about what happened when they tried to do that, that it didn't work very well because they weren't practising it much themselves. So I think that would be main danger and I suppose also the danger that someone comes and says – "well I've been practising and X has happened to me", if they've not really practised that much themselves they are not going to have much of a sense of that. Um my worry with DBT sometimes is that its been presented by people who, I sometimes worry, it's a little bit kind of done-to, a sense of – you poor personality disorder people ought to practice this skill because it will be good for you. You know, and I've almost felt a bit uncomfortable with that and I was once a bit sharp with a DBT person running a workshop who said, oh you know these people who are um, they're basically um um aversive to strong negative emotional states, and I said – well who isn't for goodness sake, its all relative. I mean you know, show me someone who isn't, you know, yes they may be a slight or more extreme but if



we start saying - this group of people need it because they are averse to, you know.. well what about the rest of us. (laughs) Because, you know, like - physician heal thyself - I mean that's clearly an issue for anybody, and I just worry about that kind of them and us – these people need it but we don't. I don't like that but on the other hand I think there has been a tendency for people to get too het up about – oh well I can't offer this because I am not practising for an hour a day for years – I think, I think somehow we have to, there's a, there's a great systemic therapy paper about, by a guy called Barry Mason, who wrote a paper called "Towards the Position of Safe Uncertainty" which is a wonderful paper where he basically says you know, there's - if you draw a grid there is like safety in unsafety along one bit of the grid and the other is about uncertainty in certainty and he said so often we are trying to be in the safe certain bit of the grid but actually that's not possible, it's never possible as human beings in an uncertain world to be safely certain so, often that flips into unsafe certainty – so we think well we've filled in all the paperwork, we've done our risk assessments and therefore we are OK, as unsafe certainty. So he said what we really need to aspire to is safe uncertainty and I think that's relevant here. Its like – can we just think, have I got a feel for this enough to start offering it to people. I can check that out with myself, I might find a mentor I can check that out with and then I just have a go, and just trust that if I feel somewhere inside that I am ready to then I can have a go but I keep checking it out, with myself, with others and then to me then that's a safely uncertain approach. Rather than, what I'm really worried will happen, is that Bangor University will come out with some edict saying 'Only people who have done this course and practised this amount of time can offer NBSR in this accredited manualised form', I'm sure its going to happen.

HF You can see that

Duncan Yeah I um, I think it's very likely that's going to happen. I had some debates with the Bangor people when I did a week's course there because I think there is attention, and again I don't want to be too extreme about it because there is tension for them. People are coming to their courses sometimes with very little experience, sometimes maybe not necessarily safe practitioners, who knows, and so they hold to sometimes quite a kind of tough

line of 'You've got to do it this way and have this amount of experience', and I do see that but on another level it can sometimes feel a little bit like um it's a kind of rigid, you know the phrase that kept being used to me – it was - don't tinker with MBSR, you know, if you're going to do Mindfulness based then you've got to do the 8 week course and I was saying yes but Jon Kabat-Zinn tinkered with Buddhism to create MBSR and then John Teasdale tinkered with MBSR to create MBCT. If nobody tinkered then everything would be frozen and also I am not Jon Kabat-Zinn so I've got to do a group in a way that, and personally for example the raisin exercise does nothing for me. Just does nothing for me, so why do I have to do this, there's nothing sacred about raisins, but it is almost like the Holy Raisin now to me – so I assume you know about the raisin exercise.

HF I've listened raisin exercise in a group (laughs)
But as you it was really quite interesting

Duncan yeah,

HF We all at sat there thinking well what's this about, which is actually interesting you say that – that doing something mindful it must be

Duncan Exactly, and I think all that kind of thing, or I've heard people say - well if its week 3 you've got to be doing .. and the Mindfulness groups that I have done with a colleague luckily, she's been similarly minded, that we, we've had in the background our awareness of the MBSR and MBCT programmes but we have also then just brought our own local flavour to that and we haven't done things exactly in that programmed way and we have introduced other stuff or other readings or other bits or done it in a slightly different sequence or more than 8 weeks and you know I think that should be how it is but I, if I was going to say something else right, quite prejudiced. Um well I might as well say it, um I do think that its slightly a character set, this is an awful thing to say, but I, well I've started now so I'll finish, I think all the kind of tribes of therapy have their own strengths and weaknesses, their own like character set. I think the character set often of those of us interested in CBT is that sometimes we are quite attracted to relying on strict structures and form and we get a bit freaked out

if we haven't got a bit of a manual or a bit of structure and we also like it in clients, a bit of a structure, and we panic a bit if things feel a bit loose and I think because Cognitive Behavioural Therapy has particularly got attached to Mindfulness it's brought with it both the strengths of that, which is its pragmatism, its non-idealological, some things I like about cognitivism but it's also bought to me a weakness which is around a slightly anally retentive addiction to things have to be done in a particular kind of structured way and we've got to offer programmes and packs and that whole kind of CBT kind of, if you like, stylistic. It's almost like a stylistic, which you don't get in humanistic therapists or systemic therapists or other kinds, or Jungians if you like that, you know, they just don't have that style, they have other weak stylistics, like systemic therapists love using awful language that no-one understands you like second order cybernetic blah blah, which I think what the hell is all that about, you know, so there are other things that would be problematic but I think there is a particular problem with CBT as a kind of tribe that it does like things done in a particular way and because that's not my way of thinking, I kind of kick against that a bit.

HF Why do you think CBT is taken up from

Duncan Yeah,

HF

Duncan I think its um that's a hard one to answer because I think in a way it isn't necessarily CBT that has, it's more that, because CBT is so in the foreground that the ways in which CBT has taken it up are that much more visible, because CBT is much more visible. Existential psychotherapy is, hardly has a presence, but if, I mean one might say that it may be a higher percentage of the few existentialists there who are interested in Mindfulness, maybe a higher percentage than the CBT practitioners who are interested in Mindfulness. If you see what I mean, relative.

HF Yes, yes

Duncan but because it's got such a small profile it doesn't feel as if it is really the one owning Mindfulness, so I think it's partly just because CBT is

so big. On the other hand I think it's because some key figures in CBT like John Teasdale in particular got into it, so it's kind of almost happen-stance. Um I think also because CBT is naturally interested in thoughts and in the process which links with aspects of Buddhist psychology, um but on other levels it actually is almost a kind of contradiction for CBT to be interested in Mindfulness to me because CBT is, if it's about anything, it's about analytically disputing the functionality of the content of thinking processes. Mindfulness is not. Quite the opposite.

HF Sure

Duncan ..and I can't see how those two work together at all personally and that's why I feel other forms of therapy have got much more in common, because CBT is often very goal orientated, very hot to what's pathological and what isn't and what's functional and what's dysfunctional and Mindfulness isn't. So you get these, kind of, weird kind of hybrids of acceptance basis CBT now. But I think another thing that's happening with CBT is that it's kind of swallowing everything in its path really. You know everything in the end will be CBT, we will have brief interpretative um counter-transferential CBT, we will have family work, you know, family CBT. You know, I think it's partly a cultural process happening that CBT has grabbed the moment because of its style, it fits the times with its kind of – I have to say, its quite New Labour CBT to me, you know, if you look at New Labour language and CBT style I think they fit very well with each other and I don't just mean that as a criticism I think that cuts both ways.

HF Interest in favourite

Duncan Yes, but I think there is a stylistic that's around um that's again about pragmatism, packages, about clear unambiguous language, bullet points, things that everyone can understand, outcomes that people can sign up to, that's such a strong language - well I mean the University I work in and in healthcare as you know, I mean that's the language of the times you know, Knowledge and Skills Framework. Knowledge and Skills Framework is very CBT and its very New Labour. So that's a perfect example. (laughs)

HF I'm still around all these things.

Duncan Yes,

HF Now this is a problem
CBT Mindfulness based stress

Duncan yes

HF In a sense aspects. Well
I remember reading that tax therapy rather than
Core processes are done

Duncan Yep, Yep

HF I suppose part of me likes
Is it that sort of , is becoming CBT
evolving or is it as you say just a high profile

Duncan Well I think it has. CBT swallows everything in its path, fortunately it is also evolving um which is, which is good and in a way it is almost impossible to talk about CBT as if it was one thing now. I mean I meet some people who describe themselves as CBT, when they describe their practice they don't sound like the straw man of CBT I often set up, you know, and I found that years ago actually when I worked with CBT practitioners – yes I thought well you're really doing gentle humanistic, you know, slightly constructionist therapy, sounds great I've got no problem with that. Then I'd meet other CBT people and I think – I wouldn't touch this with the longest barge pole – so they were both calling themselves CBT practitioners, to me they seemed in different tribes, really in different tribes. I think at one end of cognitive therapy you've got people with interesting narrative, and um you know the kind of Ann Pedetski stuff, I'm not that familiar with, but its really much closer to narrative therapy. Um so that, if that's CBT I really have no particular, well I have some issues with it, but other kinds of CBT which is much more the kind of manualised, structured treatments for dysfunctional problems, you know, has never been my bag and that's still around and um I suppose its that bit of CBT taking Mindfulness that I am less keen on. If people with a kind of broad interest in the way people, in thinking processes and, and cognitivism and narrative get interested in Mindfulness then that, that's all to the good. Um although actually a tradition that I've always been interested in which is the sort of social realist tradition,

they have a bit of a problem with even social constructionist and, or any of the kind of, new wave of therapies that are interested in language and the way people make sense, and there is a writer called David Smale who has written a lot about this and he describes it in very withering terms as usual, as magical voluntarism, this idea that one simply has to re-language ones experience for our experience to change – as if by magic. And he is very, very down on that and there is a part of me that has some sympathy, you know, the way I've described it to myself is that you can't language your way out of everything, you know just telling a different story doesn't make the world different and I think in Buddhism there's been sometimes a tendency to see Buddhism as a sensitive cognitivist philosophy and I don't think it is necessarily, I mean I don't think Buddhism would say "you can simply meditate your way out of everything" you know on a certain level. Um yeah

DISCUSSION

DISCUSSION

HF Thinking about your position

Duncan Hm hm

HF do you find yourself having to defend the practice

Duncan Um no, not these days at all, really with anybody, um because it's the latest thing. I more have to actually defend against cynicism about it, somebody will say oh yeah it is the latest thing, it's the latest band wagon. I heard Craig Newns, if you know Craig Newns, he's a kind of very sort of leftie quite fun sort of Clinical Psychologist who writes, he's the Editor of Clinical Psychology which became Clinical Psychology Forum and he was at some community psychology conference where people were talking about Mindfulness he said "Oh you know that's just the latest fad" and I thought he was very cynical about it so I think I'd want to say "well look there is more to it than that, its not just simply a fad". So sometimes I feel like I have to kind of, particularly to non-CBT practitioners who say – oh that's just the latest CBT fad – to say well look I'm not a CBT practitioner and it isn't, I don't think it is a fad and, you know, look if you're an analyst or you're a family therapist you know there are ways of you seeing its relevance to you, don't just let CBT turn it into some technique, you know, don't, you know there is more to it than that but

CRITICISM MINDFULNESS

I haven't, there isn't any sort of sense of orthodoxy saying – this is a flaky thing any more – I think its gone beyond being seen as flaky by anybody. Um definitely, yes.

HF Its very hard in practical tests to
The other day
What's the way of sort of talking to them

Duncan Well, talking to them er so yeah it's about audience isn't it. Um well if I felt myself into that scenario I'd say well um – its about helping people become more aware of what's arising in their experience which could then give them more purchase on skilful ways of living with what's perhaps not likely to just kind of go away in terms of stressful, difficult, painful, chronic ways of reacting and dealing with the world, that become a sense of workability with that. The word 'workability' I find really helpful, that Mindfulness can help make our lives more workable and the reason I like workable is that it isn't the same as treatable, or solvable, workable to me means that we can somehow lean in to the difficulties of our life with a greater sense of being able to see them and to be able to have a sense of confidence that we can sit with them a little bit more, and in sitting with them a little bit more we are not just creating further problems for ourselves by constantly warding off and then being impulsive. Because again going right back to Buddhism that is the way we all deal with the world, is that we either ward things off or we run after them saying yes, yes, yes I want more now. So I think Mindfulness is just about creating a third space where we can just say yeah, I can just, even if it's only for a fraction of a second, I am neither ward off nor jump into this. Just go aah. I think that is in a sense a skill, in a sense.

HF That's a really interesting take on

Duncan Mm, yes – its not mine, I have to say I got that from again from I think, Chungum Chungpram – I think he used that word. I think that's where I got it from, and I always found it really helpful. Makes things workable. Yeah

HF Finally I want to ask you, you

Duncan Um, no I am aware that I have said sort of things that sometimes look quite a cliché kind of

way um it is quite complicated, I think Mindfulness sits in a very interesting meeting point between therapy and all the different kinds of therapies, the academic scientific community and spirituality and it kinds of sits in some kind of, like a venn, like those old circular venn diagrams, it sits right in the middle of those and so it kind of plays out in really interesting ways in relation to that and that's probably what makes it really fascinating. But at its heart go back to the beginning, you know it's, it's sitting like that glass of water, in the end its as simple as can be, I love that phrase that they use of sitting like a discarded paper cup. That, it's that level which I find it so powerful because that just cuts through everything, everything, (laughs) so you end up with nothing to say (laughs)

HF Brilliant

Appendix H

Neuropsychological Tests Completed by 'Edward'

Neuropsychological Assessments completed by 'Edward' in Case Study 1

Repeatable Battery of Neuropsychological Status (RBANS)
Randolph, C. (1989). San Antonio: The Psychological Corporation.

Hayling and Brixton Tests
Burgess, P. & Shallice, T. (1997).Bury St Edmunds: Thames Valley Test Company.

Kaplan Baycrest Neurocognitive Assessment (KBNA)
Leach, L., Kaplan, E., Rewilak, D., Richards, B., and Proulx, G. B. (2000). Oxford: Pearson Assessment

The Right Hemisphere Language Battery, 2nd Edition
Bryan, K. (1989). London: Wiley.

The Rey Auditory Verbal Learning Test (RAVLT)
Schmidt, M. (1987). Los Angeles: Western Psychological Services.