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School of Psychology

**Mindfulness meditation as used by clinical psychologists in cognitive therapy: An existential-phenomenological analysis of how such practitioners describe their experiences with special reference to underpinning theory and professional issues**

by

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# Abstract

Clinical applications of mindfulness training (MT) in cognitive-behavioural therapies are becoming ever more widely adopted. A literature review was conducted that considered possible tensions and commonalities arising from the importation of an ancient meditative, spiritual practice into modernist scientific, psychotherapeutic technology. Efficacy evidence for key therapeutic approaches in the field was reviewed and critically evaluated, together with basic research into the effects of meditation on neurological and immune functioning. Evaluation was informed by two closely linked perspectives: selected aspects of historical Buddhist teachings relevant to MT; and contemporary debate centred around empirically-supported treatments (EST). The evidence showed encouraging early support for MT as a clinical intervention, although many key questions required further empirical investigation. The richly complex experiential nature of MT, and its inherently relational emphasis, risked being overlooked within a predominantly EST research agenda. The literature review argues for additional qualitative research that explores phenomenologically the contribution of MT to therapeutic change, and particularly how clinical psychologists who practice cognitive therapy are experiencing the use of mindfulness meditation. An empirical study using a descriptive phenomenological psychological methodology was then carried out. A small sample of clinical psychologists were interviewed in depth and the resulting transcripts analysed within the phenomenological perspective. A general psychological reduction was drawn up which captured the most common invariant themes arising across the participants. Conclusions for the clinical practice of mindfulness were drawn, and tensions highlighted between the spiritual and the secular, and between personal authority and published evidence.

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# A literature review exploring the compatibility of mindfulness training with cognitive-behavioural therapies

by

**David Mussell**

Dissertation for the Doctorate in Clinical Psychology
Literature Review

Statement regarding submission to the chosen journal

**The Journal of Cognitive Psychotherapy: An International Quarterly** is devoted to the advancement of the clinical practice and theory of cognitive psychotherapy in its widest sense. This scholarly journal seeks to merge theory, research, and practice and to develop new techniques by an examination of the clinical implications of theoretical development and research findings. To this end the journal will publish empirical research studies, case studies, theoretical articles, literature reviews on clinical topics, and articles specifying the clinical implications of topical research.

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## Abstract

Clinical applications of mindfulness training (MT) in cognitive-behavioural therapies are becoming ever more widely adopted. This paper considers possible tensions and commonalities arising from the importation of an ancient meditative, spiritual practice into modernist scientific, psychotherapeutic technology. Efficacy evidence for key therapeutic approaches in the field is reviewed and critically evaluated, together with basic research into the effects of meditation on neurological and immune functioning. Evaluation is informed by two closely linked perspectives: selected aspects of historical Buddhist teachings relevant to MT; and contemporary debate centred around empirically-supported treatments (EST). The evidence shows encouraging early support for MT as a clinical intervention, although many key questions require further empirical investigation. The richly complex experiential nature of MT, and its inherently relational emphasis, risk being overlooked within a predominantly EST research agenda. This paper argues for additional qualitative research that explores phenomenologically the contribution of MT to therapeutic change.

## Introduction

Over the last ten to fifteen years, forms of mindfulness training (MT) have become increasingly interesting to clinical psychologists as therapeutic interventions (Baer, 2006). Derived from Eastern spiritual traditions, most notably Buddhism (Kabat-Zinn, 1991; Linehan, 1993a), mindfulness involves paying attention in a deliberate way, in order to more fully experience the present moment, without judgement or striving. MT techniques in psychotherapy, including formal meditation practice, aim to help patients 'stay with' aspects of their daily living that have typically felt highly aversive or painful, so developing a different relationship over time between personal experience and its meaning. Verbal definitions of mindfulness can appear to make it a deceptively simple construct, whereas trying to understand it and work with it in practice can be complex and personally challenging. There remains a lack of consensus over a clear empirical definition of mindfulness (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006). Some form of practical training is usually required however, together with a conceptual, intellectual model that can be transmitted through language, which are jointly integrated through the effort of personal experiential practice.

The focus for the literature reviewed in this paper has been the therapeutic uses of mindfulness training in clinical psychology, with a particular emphasis on cognitive and behavioural approaches to psychotherapy. Much of the research focus in recent years on mindfulness has been driven by workers in this field (Baer, 2006), and much of the efficacy research in terms of empirically supported treatments (EST) supports the clinical uses of such therapies (Roth & Fonagy, 2004; Task Force,

1995). Search terms employed for this study included: *mindfulness; vipassana; insight meditation; stress reduction; mind/body.* The following databases were searched: Psychinfo; Medline; Cochrane Library. In addition, the reference sections of recently completed dissertations and related book chapters were also searched for relevant articles and papers. The paper seeks to review the better known applications of mindfulness in cognitive-behavioural therapies, and will therefore address both the ways in which each approach uses MT clinically, and the supporting evidence for the efficacy of the mindfulness-based interventions. Given the relatively undeveloped status of ESTs for mindfulness interventions however, this review does in addition explore the underlying basic research in terms of neurophysiology and immune functioning.

Although cognitive-behavioural approaches to psychotherapy are establishing a solid evidence-base for the use of mindfulness interventions, other psychotherapy traditions have also drawn on mindfulness meditation, although these will not be addressed in the current paper. For psychodynamic therapy see Epstein, 1995 and Molino, 1998. In humanist therapies, approaches such as Core Process Psychotherapy have been established (Donington, 1994). Other practitioners of mindfulness in psychotherapy have written of its potential as an integrative factor, with the power to bring together disparate approaches to therapy over the common ground of the therapeutic relationship (Martin, 1997). In psychology more broadly, some researchers have investigated other applied uses of mindfulness, such as Langer's work in education (Langer, 1994; Langer & Moldoveanu, 2000), which is also outside the scope of this review.

Examined firstly will be the better known cognitive-behavioural approaches to therapy that use MT therapeutically. These are mindfulness-based cognitive therapy (MBCT – Segal, Williams, & Teasdale, 2002), dialectical behaviour therapy (DBT – Linehan, 1993a; 1993b), and acceptance and commitment therapy (ACT – Hayes, Strosahl, & Wilson, 1999). Mindfulness-based stress reduction (MBSR – Kabat-Zinn, 1991) is reviewed initially as it has been so influential on the development of mindfulness used in cognitive-behavioural therapies (Linehan, 1993a; Segal et al, 2002). A brief examination of how each approach understands and clinically utilises mindfulness is given, followed by a review of the efficacy literature for using mindfulness. The state of the evidence for these four therapeutic approaches is then offered, before reviewing basic research into the physiological impact of MTs. Other researchers have also developed specific disorder-related interventions that combine mindfulness principles with cognitive therapy (CT). Baer (2006) reviews a number of such approaches, demonstrating an applicability across the life-span, and to a broad range of mental and physical health problems. Other uses of mindfulness in the context of CT include the work of Chadwick (2006; Chadwick, Newman-Taylor, & Abba, 2005) into mindfulness for psychosis, and Marlatt's work into relapse-prevention in addictions (2002; Witkiewitz, Marlatt, & Walker, 2005). Space does not permit inclusion of these approaches in the current paper.

It will be seen from the material in Part I of this review that Buddhism and Buddhist meditation practices are most widely credited as sources for MT techniques, although it should also be acknowledged that many other religious traditions offer contemplative or meditation techniques similar to mindfulness. For

example, Sufism in Islam, Kabbalah in Judaism, and some forms of Christianity; although it is fair to say that Buddhism has probably the most extensive literature and history of developing mindfulness in terms of a psychological understanding (Walsh & Shapiro, 2006). For this reason therefore, Part II examines in some detail the philosophical underpinnings of Buddhist-derived mindfulness, comparing and contrasting these to the philosophical underpinnings for cognitive-behavioural therapy. A traditional model of CT is presented as a baseline for comparison, rather than later developments in the field, such as schema-focused therapy or MBCT, for example. From this comparison, the compatibility of mindfulness and its methods of training are examined in relation to CT, and conclusions drawn as to the validity of the existing positivist shaped evidence-base. A question is raised about the role for personal authority in selecting a clinical intervention derived from individual experience as well as published empirical evidence, and to what extent this particular influence may be at work in the choice of clinical psychologists using mindfulness therapeutically, when the current state of the evidence-base is promising but not well-established. The need for further phenomenological research into this very process in clinical psychologists is recommended, in order to broaden the research base and find ways in which to include experiential aspects of using mindfulness in everyday clinical work in applied psychology.

## Part I – Exploring current cognitive-behavioural approaches that use MT clinically and reviewing the evidence for their effectiveness

### *MBSR*

The programme was developed as a 'behavioural medicine' intervention for people suffering the emotional distress of chronic pain and incurable disease, who had previously found little relief in other medical interventions (Kabat-Zinn, 1982, 1991). MBSR is an eight-week group teaching protocol that uses various meditation techniques and gentle yoga exercises to train people in ways of living mindfully. The programme includes a day-long silent retreat in the sixth week, designed to deepen and extend an individual's experiences of being mindful. In line with Buddhist teachings, Kabat-Zinn (1994) views the mind as a 'sense-organ', where internal experience can be known more fully through the mind's capacity for awareness – "mindfulness means paying attention in a particular way: on purpose, in the present moment, and non-judgmentally. This kind of attention nurtures greater awareness, clarity and acceptance of present-moment reality" (p.4).

Although clearly grounded in Kabat-Zinn's personal commitment and experience of Buddhist insight meditation, the principles and teaching of MBSR are available to all, aiming to address healing at the intersection of mind and body through meditation practices that combine aspects of tranquility and insight (Olendzki, 2000). MBSR participants are encouraged to cultivate a curiosity about their lives and to approach experience with a fresh view, bringing mindfulness into the activities of everyday life – to enhance a participant's ability to make adaptive decisions about difficult and problematic situations, as well as increasing the

enjoyment of pleasant moments. Mindful acceptance is not seen as being passive or helpless. There are always choices to be made and actions to undertake - but done mindfully, these are more likely to promote greater satisfaction and efficacy for the individual and those in the surrounding world. "Real meditation is living your life as if it really mattered and that, in a sense, is the most therapeutic thing I can think of", (Kabat-Zinn, 2005a).

*MBCT*

Closely modelled on MBSR, MBCT was developed to specifically address the prevention of relapse in depression (Segal et al., 2002). MBCT works with smaller groups than MBSR, comprising formal training in mindfulness meditation, combined with didactic psycho-education informed by the theory of Interacting Cognitive Subsystems (Teasdale & Barnard, 1993). This suggests that previously depressed people are far more likely to experience globally negative and self-critical feelings in response to the ordinary sad moods that are part of everyday life, thus triggering further depressive episodes which are then maintained through a ruminative thinking style. The yoga exercises and one-day retreat of MBSR are not part of the MBCT protocol. CT strategies are used in MBCT to emphasise 'distancing' or 'decentering', and not to challenge or dispute the contents of troubling thoughts. In this way, the relationship between an individual and their thoughts becomes of primary importance in MBCT.

Mindfulness is used to promote the close observance of experience in a spirit of non-judgmental acceptance, whilst such intentional focus on moment-to-moment experience serves also to reduce rumination. Thus a distinction is drawn in MBCT

between "doing" mode and "being" mode - between searching for solutions ("doing" mode), and the non-judgmental acceptance of current experience without trying to change that experience ("being" mode). Mindfulness helps one develop the ability to observe inner experience without it necessarily being seen as representing real aspects of the self or surrounding world. An exercise specific to MBCT is the "3-minute breathing space", practised regularly throughout the programme in order to promote adaptive choice in response to automatic negative thinking – it is likened to opening a door that reveals a number of corridors down which one could choose to walk. Participants are encouraged also to formally practise mindfulness daily, and to integrate mindfulness into their everyday lives.

*DBT*

Developed as a therapeutic system to help women of working age diagnosed with borderline personality disorder (BPD), DBT is a multi-faceted programme involving group skills training sessions and one-to-one therapy, in both of which mindfulness plays a fundamental role (Linehan, 1993a; 1993b). The nature of human experience in DBT is seen as a 'process', and clients are taught skills in behavioural analysis and emotion regulation as well as mindfulness. The practising of these skills in daily life by clients is supported through concurrent one-to-one therapy, and a programme would normally run for at least a year. Within DBT, "core" mindfulness skills involve training one's attention and developing "wisdom". In a dialectical framework the nature of mind is represented by two opposing poles of emotion and reason, where "wise mind" reconciles the two – balancing knowledge of facts with intuition; head with heart. Wisdom in DBT is seen as a universal human ability, and one that can be cultivated.

Mindfulness in DBT is taught far less formally than MBSR or MBCT, so that there are many shorter exercises based in concrete examples of everyday life. The elements of mindfulness are integrally bound up with the other DBT core components of interpersonal effectiveness, emotional regulation and distress tolerance, and the idea of "wise mind" acts as a unifying principle throughout. Acting *effectively* means doing what works or using skilful means to act in a manner both respectful and protective of oneself, as well as others where possible. DBT ultimately sees pain as an unavoidable part of life, so that distress tolerance skills are taught early to facilitate a patient's ability to stay with painful feelings, where no better action can yet be taken. These choices are likely to be better in terms of survival than ones previously made by patients (Linehan, 1993a).

*ACT*

ACT (pronounced as one word) is a general approach to psychotherapy intended for a wide range of problems and disorders, either on a one-to-one basis (Hayes et al., 1999), or as a group protocol (Bach, Gaudiano, Pankey, Herbert, & Hayes, 2006). Grounded in radical behaviourism, its proponents are 'spiritual' successors to Skinner, having embraced clinical applications of phenomenology and humanism along the way. Underlying ACT is the philosophy of "functional contextualism" (Hayes et al., 1999, p.18), which identifies the different ways that individuals experience themselves as being key determinants of the context within which any life is lived. Through the processes of human language, the ways in which private experiences of cognitive and emotional events are felt can become rigidly associated with a person's sense of self, so that an individual then becomes

closely identified with the content of such events (Hayes, Barnes-Holmes, & Roche, 2001). Where this process of identification is an aversive one, "experiential avoidance" may result in various unhelpful and distressing behavioural outcomes (Hayes et al., 1999, p.58).

ACT suggests that an increased awareness of how the process of human language functions in this regard, enables people to distance themselves from such painful over-identification, and provides increased scope for future behavioural change. This "psychological flexibility" (Hayes, Luoma, Bond, Masuda, & Lillis, 2006, p.7) is attained in ACT through the integration of several key therapeutic components, each facilitated by the practice of mindfulness exercises and metaphors, rather than formally taught meditation. The general aim is to cultivate awareness of internal experiences as transient and insubstantial, and to promote a sense of safety and compassion for oneself from which to commit to making behavioural changes, which in turn lead to specific actions for overcoming obstacles, facilitating overall progress to a more meaningful life for the client.

*Evidence for the efficacy of MBSR*

Evidence for MBSR was reviewed in a recent meta-analysis (Grossman, Niemann, Schmidt, & Walach, 2004), which reported that only one RCT has so far been published which deals with the outcome for patients in a health care setting (Speca, Carslon, Goodey, & Angen, 2000). Ten studies were identified that met the criteria for controlled studies, and of these only seven were randomized, and only five involved clinical interventions with patients, the other studies using analogue samples. Of the five patient studies, only three met the criteria for RCTs, and two of

these have not been published. In keeping with the origins of MBSR, the studies involving patients were focused on populations showing physical health problems with psychological distress such as heart disease, cancer, fibromyalgia and chronic pain. Significant differences between mindfulness meditation and control groups were found on mental health and physical health variables with the following effect sizes: for the controlled studies involving patients $d = 0.56$ in terms of mental health outcomes (total $N = 236$); and $d = 0.53$ in terms of physical health across all seven controlled studies (total $N = 203$). For a further eighteen observational studies without control groups, significant differences in pre and post measures of mental health variables were found: $d = 0.50$ (total $N = 894$). Nine of these studies also measured physical health variables, and a significant pre-post difference was also found: d = 0.42 (total $N = 566$). Grossman et al. (2004) concluded that clinical MBSR interventions showed considerable promise in terms of enhancing general features of everyday coping with distress and disability, as well as under more severe stress and disorder, showing improvements across a range of measures of physical and mental well-being. It is difficult to draw much support for the efficacy of mindfulness training from these studies however, as the methodological rigour is variable, only one RCT being published so far, so that conclusions are underpowered and lack reliability. Data is also lacking in terms of the possible effects of positive predisposition to the benefits of meditation, as well as the potential confound of therapist effects. There appear to be no studies that address the relationships within MBSR between theoretical explanations and specific components of the overall treatment package.

There are also two other recent reviews of evidence for MBSR (Bishop, 2002; Baer, 2003). Bishop suggested that the evidence-base for MBSR is flawed methodologically and also criticized the "paucity of controlled studies" (p.72), citing Speca et al., (2000) as the only published RCT. Bishop (2002) recommended increased rigour in study designs such that both "inactive" and "active" control groups are used in future trials, to control for improvements in outcome being due to the possible effects of "nonspecific factors, such as therapists' attention, social support, and positive expectancy" (p.72). Bishop also recommended that mindfulness be better validated as a construct, so that its specific mechanisms of action can be appropriately identified as drivers of change in MBSR. He concludes that the preliminary evidence is encouraging, although very limited in terms of the disorders and illnesses MBSR should be used with, and calls for the approach to be subjected to serious scientific enquiry in order to establish an empirical base that can guide clinical practice. Baer (2003) concluded that MBSR is a promising intervention clinically with the potential to bring "participants with mild to moderate psychological distress into or close to the normal range" (p.137). Baer also criticized the research-base for its lack of rigorous controlled studies and the inability to compare MBSR with other specific psychological approaches, as well as underpowered studies and poor evaluation of treatment integrity. Many studies have been conducted by the programme originators, and substantial research is required in the future to explore the possible mechanisms of change and the effects of mindfulness training on a broader range of outcomes. In Baer's opinion, MBSR may meet the criteria for a "probably efficacious" treatment under the rules established by the American Psychological Association (APA) Division 12 Task Force (1995).

One study has specifically addressed mindfulness meditation in MBSR from the perspective of immune function and neuroelectrical activity (Davidson et al., 2003). In a lateralised EEG study, they examined the effects of meditation training modeled on the MBSR programme in a community sample, being delivered in the context of a 'workplace well-being' initiative. A group of 25 meditators was compared to a non-meditating control group, and antibody titers were measured in response to an influenza vaccination administered at the end of the meditation programme. Meditators showed a significantly greater increase in titers compared to controls during the 4-8 weeks after vaccination. Also compared to controls at the end of the training period and at follow-up 4 months later, meditators showed a significant increase in anterior left-sided brain activity in response to induced negative affect. There was also a significant correlation noted between those meditators with the largest brain-activation asymmetry and the largest increases in antibody titers. Over the course of the training period, meditators showed significant within-group increases in left-sided anterior electrical brain activity in response to induced negative affect, as well as decreased trait anxiety. During the period from the end of training to follow-up four months later, meditators showed significant within-group increases in left-sided anterior electrical brain activity for both baseline rates and in response to induced negative affect, and significant decreases in trait negative affect. This is encouraging evidence for mindfulness training in terms of reduced anxiety – both state and trait – as well as enhanced positive affect, suggested by the increased left-sided anterior brain function, and suggests a possible link between MT, brain activation asymmetry and immune functioning. However, the researchers note that electrical activity is a crude measure of brain function, and the study provides no data relevant to possible mediating mechanisms.

*Evidence for the efficacy of MBCT*

Two published RCTs (Teasdale et al., 2000; Ma & Teasdale, 2004) address the clinical efficacy of MBCT in terms of preventing depressive relapse. Both were carried out by the programme developers, and used a treatment-as-usual (TAU) control. In Teasdale et al. (2000), the key finding was that MBCT reduced the rate of recurrence of major depressive episodes (during the 52 weeks following the end of the programme) by 39% in those people who had experienced three or more episodes in the five years preceding the trial ($p < .01$), yielding an effect size of $h = 0.53$. These figures reflect the intent-to-treat sample ($N = 76$). For the per-protocol sample ($N = 63$), the corresponding results were a 44% drop in recurrence rate of people with three or more previous episodes of major depression ($p < .005$), yielding an effect size of $h = 0.59$. For people with two or less prior episodes, there was no significant reduction in future relapse rates.

Ma and Teasdale (2004) replicated the above RCT on one site only with participants who had experienced three or more previous episodes any time prior to the trial – not just in the preceding five years. Comparisons were made for age of onset of first depressive episode, severity of most recent episode, and rates of recurrence in the 52 weeks following the end of the programme. Comparisons were also made on measures of adversity of early childhood experience between three groups: one comprising participants with two previous episodes or less of depression; one comprising participants with three episodes or more, and a matched control group of never-depressed people. Those people having experienced three episodes or

more prior to MBCT, showed a significant reduction of 54% ($p$ = .002) in their rate of recurrent depression – 36% of MBCT group experiencing relapse compared to 78% of TAU group, yielding an effect size of $h$ = 0.88. Other factors characteristic of this group were that the reduction in depressive episodes was associated with those episodes not triggered by significant life events, and that this group scored significantly higher on measures of parental abuse and indifference compared to the two-episodes or less group. In this latter group, most relapses were associated with significant life-events, and in a sub-group comprising people experiencing four or more episodes prior to treatment, there was a 38% relapse rate in MBCT group compared to 100% relapse in TAU group. It appears then, that the mediators for the beneficial effects of MBCT have something to do with internal psychological processes, and early childhood experience. MBCT may be viewed as "probably efficacious" under the EST criteria of the APA (Task Force, 1995), and could be recommended for people having experienced three or more major depressive episodes, following a reportedly adverse childhood, and where the first episode occurred relatively early in life. The empirical support for MBCT is, however, subject to the same criticisms as MBSR above in terms of specific mediating processes and confounding therapist effects, so that further research is required to address these issues.

*Evidence for the efficacy of DBT*

A fair amount of published data exists in support of DBT, although the conclusions drawn from it in terms of clinical guidance appear somewhat ambiguous. On the basis of five published RCTs (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan et al., 1999; Koons et al., 2001; Linehan et al., 2002; Verheul et al.,

2003), all of which relate to community clinical samples, DBT would appear to meet the APA Division 12 Task Force criteria for "probably efficacious" (Chambless & Hollon, 1998). However, in the USA, the American Psychiatric Association (2001), warned that it was difficult on the present evidence to be sure that the beneficial effects of DBT arose from its specific ingredients. In the UK, a Cochrane Review of psychological therapies for people with BPD (Binks et al., 2006) concluded that, "DBT seemed to be helpful on a wide range of outcomes ... but the small size of included studies limits confidence in their results" (p.2).

The five RCTs listed above, and a further recent RCT (Linehan et al, 2006), provide support for DBT as an effective treatment for chronically parasuicidal adult women with BPD. It was seen to reduce self-injurious and suicidal behaviours, limit psychiatric admissions and minimize therapy drop-out. DBT also appears to enhance interpersonal functioning and social adjustment in this clinical population (Linehan, Tutek, Heard, & Armstrong, 1994), and treatment gains are typically maintained up to a year later (Linehan, Heard, & Armstrong, 1993; van den Bosch, Koeter, Stijnen, Verheul, & van den Brink, 2005). In one RCT, just the validation and acceptance strategies from DBT were combined with 12-step facilitation as a treatment comparison for the standard DBT package (Linehan et al., 2002). This showed a 100% retention rate for the comparison group, whereas the DBT group had a 64% retention rate. This may go some way to supporting the efficacy of this specific aspect of DBT in establishing therapeutic alliance with BPD patients. Linehan et al. (2006) showed strong indications that DBT has a specific psychotherapeutic efficacy over and above community psychotherapy, when matched for many of the common factors often overlooked in efficacy research (Wampold, 2001). Key aspects of DBT

appear to focus on addressing issues of stress and burn-out within the therapeutic team and assertive efforts in keeping patients actively engaged in the programme. There is some indication also that only a reasonable adherence to manualised procedures is still enough to effect positive outcomes (Koons et al., 2001).

The DBT evidence-base shows limitations however, in the comparatively small sample numbers assessed (typically around 20 in DBT groups), as well as a lack of certainty about which particular aspects of the package may be specifically effective and how these aspects may function. The literature reviewed also suggests that DBT does not improve psychopathology in terms of depression or hopelessness, or enhance overall life satisfaction, so that further treatments are indicated to address these issues once DBT has helped patients to more adaptively manage risk-behaviours (Verheul et al., 2003). Larger-scale studies of DBT in comparison to standardized treatments may be useful (Verheul et al.) and these may also allow examination of component aspects of DBT that are necessary and sufficient for an efficacious outcome (Linehan et al., 2006). Further studies in countries outside the USA would be useful, especially in terms of naturalistic clinic settings, and performed by teams other than the treatment developers. Evidence in support of specific DBT components that mediate outcome through identifiable and measurable processes is also required. Linehan et al. (2006) provide a methodologically robust RCT, which addresses many criticisms of the EST decision rules voiced by Wampold (2001), although the possible confound of individual therapist effects was not addressed in this study or in any previous RCT. A range of other non-randomised observational studies and non-published RCTs have also been reviewed (Koerner & Linehan, 2000) which show support for DBT as a treatment for clinical

populations other than women of working age with BPD. For example, these include applications for eating disorders (Telch, Agras, & Linehan, 2001) and forensic settings (McCann & Ball, 2000; Trupin, Stewart, Beach, & Boesky, 2002). As suggested by Verheul et al. (2003), DBT may not be just a treatment for BPD, so much as a therapeutic approach generally applicable to "patients with severe, life-threatening impulse-control disorders" (p.139).

*Evidence for the efficacy of ACT*

ACT has a rapidly growing evidence-base across a wide-range of clinical problems that cover different geographical locations, ethnicities and socio-economic status. A meta-analysis of ACT outcome data (Hayes et al., 2006) presents seventeen RCTs, eleven of which compare ACT with another well-specified treatment deliberately applied to the target problem. For these eleven studies, a weighted-average effect size (Cohen's d) is reported at $d = 0.48$ ($N = 456$) for post-intervention between-condition outcomes, with $d = 0.63$ ($N = 404$) at follow-up ranging from 8-52 weeks post-intervention. The largest studies concern Type II diabetes ($N = 78$), psychosis ($N = 70$), and smoking cessation ($N = 62$). Across all seventeen studies an average weighted effect size is reported of $d = 0.66$ ($N = 704$) for between-conditions outcomes at post-intervention, and $d = 0.66$ ($N = 580$) at follow-up – a weighted average of 19.2 weeks.

The earliest RCT was published in 1986 (Zettle & Hayes), with a gap of around twenty years until the first of the current RCTs was published in 2000 (Bond & Bunce). ACT developers have in this time been establishing a basic research programme linking underlying philosophical principles with a theoretically coherent

model of psychopathology and treatment (Hayes et al., 2006). Critical of cognitive therapies for not adequately making links between basic science and clinical intervention, ACT researchers have paid specific attention to mediational evidence for therapeutic outcome, as well as overall efficacy. Many studies in ACT include mediational analyses and are reviewed in detail in Hayes et al. (2006), who conclude that the mediational evidence is initially encouraging, although subject to important limitations. Some of the measures used lack the support of published psychometric data. Many of the measures rely on self-report and have high face validity, as well as being applied often after outcomes have already started to significantly improve. The increased use of behavioural measures and observer ratings of hypothesized process variables is therefore strongly recommended. It is also the case that many aspects of the ACT model remain untested in terms of mediating processes (Hayes et al., 2006). However, the existing data is supportive and relatively consistent, and is a very positive aspect of the emerging evidence-base for ACT, as together with the programme of basic research into putative components of the model, it provides a solid, scientifically valid basis for ACT as a therapeutic technology.

The ACT outcome data shows it is working across a wide range of clinical problems – from psychosis (Bach & Hayes, 2002; Gaudiano & Herbert, 2006) to the everyday stress of people in the workplace (Bond & Bunce, 2000). Many of the studies are carried out by groups other than the original treatment developers, and there are a great many papers reflecting case-studies and within-group pre-post measures in clinical areas such as chronic pain (McCracken, Vowles & Eccleston, 2004; 2005), and obsessive-compulsive disorder (Twohig, Hayes & Masuda, 2006), for example. The evidence overall can be regarded as highly promising, and may be

nearing the status of a formally recommended EST in the areas of smoking cessation, psychosis, and pain management (Hayes et al., 2006). The evidence-base can be criticized for trialled interventions that are short in duration and somewhat limited in scope, as well a lack of studies so far that address the criticisms of Wampold (2001) and the interpersonal processes of therapy (Norcross, 2002). There is a need perhaps to extend the coverage of RCTs, as well as increase the number of naturalistic observational studies into everyday clinical effectiveness.

*Criticisms of the efficacy research-base*

The quality and scope of the supporting evidence for the treatment packages as reviewed above, shows early promise for mindfulness and acceptance approaches to therapy from within the cognitive-behavioural tradition. For some packages delivered with clearly defined clinical populations, the evidence has achieved "probably efficacious" status in terms of EST criteria. Both the scale and clinical relevance of the efficacy evidence continues to grow, and efforts are being made to show theoretical links between basic science, therapeutic technique and positive outcome. There is however, little specific support so far for the effectiveness of MT as a therapeutically beneficial intervention. The packages reviewed are all complex psycho-social treatments, involving many different technical elements drawn from different theoretical bases within the cognitive-behavioural tradition. Even within the training of mindfulness skills, there exists substantial variation, although the meaning and spirit of mindfulness as a concept seems fundamentally to inform each of the approaches at a contextual level. Dismantling studies and mediational analyses of efficacy and effectiveness trials are growing in number, although the future need for this type of research is highlighted as an urgent priority by many

researchers in the field, as is the need for more effectiveness studies addressing the naturalistic clinical demands of most everyday practitioners.

It is also widely acknowledged that the direction and emphasis of efficacy research is closely allied to the principles of ESTs (Wampold, 2001; Norcross, 2002), as set out by the APA Division 12 Task Force (Chambless & Hollon, 1998). Even within the EST framework however, some of these criticisms are being addressed by researchers as possible methodological confounds (e.g. Linehan et al., 2006). Beutler (2004) points to the need for a more balanced approach to empirical outcome research, where techniques and therapeutic relational factors are equally considered, as well as the specific interactions between them. Given the relative weakness of the efficacy literature in support of MT as a therapeutic technique, and the ongoing debate around the meaning of mindfulness as a psychological construct (Baer et al., 2006), research into the neurological and physiological correlates of MT is reviewed below.

*Basic research into the physiological impact of MT*

In terms of studies specifically addressing the impact of MT on human biology, there are very few. Most of the literature in this field examines the effects of meditation more generally on both psycho-immunology and neurological functioning. In the former category, there is evidence suggesting a positive correlation between meditation and markers of enhanced immune functioning, including natural killer cell counts (Kimura et al., 2005), growth hormone activity (Lee, Kim, & Ryu, 2005), and lymphocyte concentrations (Solberg, Halvorsin, & Holen, 2000). It should be noted that none of these studies address the possible

experimental confounds of participant biological pre-disposition, or self-selection into the various meditative practices.

In a wide-ranging and thorough review of neuro-electric and imaging studies of meditation over the last 30 years or so, Cahn and Polich (2006) comment on EEG studies, ERP studies and other brain-imaging studies. They concluded that there existed considerable discrepancies amongst published results due to a lack of standardized research designs, the variety of meditation practices studied, and a lack of technical expertise in the earliest studies, as well as wide variations in the experience and competence of meditators studied. Overall, EEG studies tended to show power increases in theta and alpha bands of electrical brain activity, together with an overall slowing of frequency, in response to meditation practice. Later findings have shown increased power coherence and gamma band effects. ERP studies have suggested that meditation generally increases attentional resources, as well as promoting increased speed and efficiency of stimulus processing. Brain imaging studies have started to show consistent localized effects of meditation practice, specifically in the frontal and prefrontal cortical areas, which indexes increased attentional demands, as well as alterations in experiencing of the self and feelings of love.

Exploring the links between neurophysiological findings and clinical effects, Cahn and Polich (2006) point to the following likely outcomes of meditation training generally. Improvements in attentional control were noted, especially in relation to MT and sustained concentration, as well as links between MT and the functional plasticity of the central nervous system with regard to stress and anxiety. They also

noted some initial support for an association between meditation and enhanced feelings of well-being, with psychometric measures of mindfulness suggesting it is increased following meditation. However, they caution that it is difficult, based on current neuroimaging research, to support a connection between metacognitive awareness and therapeutic improvement. They also caution that a wide range of meditative practices have been studied, of which MT is only one, although there is considerable overlap across the various practices. Cahn and Polich (2006) see it as likely that each meditative practice will result in different psychological and psychobiological effects, as influenced by each person's individual variability. In conclusion, they recommend that further research will require comparison of neuro-phenomenological reporting of individual experience with various meditative states and other induced altered states – as well as longitudinal studies to establish trait effects that reflect possible neural alterations underlying shifts in the locus of self-experience and the development of stable, unchanging awareness.

Basic research into the physiological correlates of meditation generally, whilst showing encouraging trends in support of clinical experience, remains at an early stage. Support specifically for MT appears to be lagging considerably behind its application in therapeutic technologies, although the initial indications are encouraging, and show some support for the putative mechanisms of therapeutic change in 'third wave' cognitive-behavioural therapies.

## Part II – The origins of mindfulness training in Buddhism and the origins of cognitive therapy

### *Relevant Buddhist perspectives on mindfulness*

As a religious and philosophical system, varieties of Buddhism have been followed for some 2,500 years across many countries (Wallace & Shapiro, 2006). Many different schools of Buddhism have arisen over time from cultures very different to Western ones. The following obstacle to understanding can exist in Western expositions of Buddhist principles and practices: that contemporary Western thinking is read back into original Buddhist ideas and teachings (Keown, 1996) – especially where such an exposition is based on a solely intellectual enquiry without any corresponding experiential understanding. The following highly selective account is drawn from the texts of three contemporary writers on Buddhism in the West (Batchelor, 1994, 1997; Keown, 1996, 2000; Nhat Hanh, 1998), and reflect two main traditions of Buddhism: Theravada and Zen, since these have most influenced the methods of MT seen in "third-wave therapies" (Hayes, 2004, p.660).

Mindfulness meditation as a set of Buddhist practices, is grounded in the ancient Vedic religious traditions of Northern India, pre-dating the Buddha by several thousand years (Hamilton, 2001). Arising from a mainly agrarian and feudal culture, a typically Buddhist view of ontology is pluralistic, and privileges subjective validation by the individual based on experiential rather than intellectual knowledge. Within an Indian worldview generally, it is the personal effort to see reality – or the nature of things as they really are – that facilitates one's release from the eternal round of birth, death and rebirth in the earthly realm – so that Indian philosophy has a fundamentally soteriological imperative, integrating both intellectual analysis and lived experience (Hamilton, 2001). A Buddhist perspective on this is presented through the teachings of emptiness and interconnectedness (Keown, 1996) – all

things are inherently without a fixed essence and at the same time, all things are interconnected. This promotes an understanding of material existence as a process of being, which is co-constructed in every moment in the interactions between an individual and the world around, including other people – and where the conditions of existence in this moment are shaped by the those in the moment just passed, and which in turn shape those in the moment to come. Mind and body, thought and spirit, form parts of a cohesive whole, where actions in this world are what require attention, not ideas of the mystical or metaphysical. The primary question for understanding the nature of reality in Buddhism may be framed as "how is this", rather than the "what is this" formulation of positivism and CT.

A fundamental *Dharma* doctrine is that of *dukka*, conveying that sense of things being never quite satisfying enough. People often want more than they already have, or want to be rid of some painful and aversive experience. The activity of clinging to pleasure or rejecting pain is motivated by the human desire for a sense of permanence in a world which is inevitably impermanent in all of its aspects. The multifarious ways in which people create a sense of permanence are mediated through social and cultural practices, although the underlying neurological processes are seen as universal: an existential truth about lived experience as an embodied human being. The Buddha taught that physical sensations or cognitions are not seen in themselves as inherently painful or pleasurable – what makes them so is how people respond to sensation. Severe and chronic pain for example, may lead someone to feel they are failing in terms of their personal expectations of health, so that being free of pain becomes closely identified with that person's sense of value in society. Such habits of identification with the content of experience – bodily

sensations, perceptions, feelings, thoughts – are an example of clinging and as such lead to *dukka*. Many Buddhists understand cognitions as sensations arising from the physical activity of the brain – the mind being the 'sense-organ' of consciousness in this context. As smell is the product in the brain of the olfactory organ – the nose – so thoughts, images and memories are the products in the brain of the consciousness organ – the mind. This has parallels with Western ideas of metacognition for example (Teasdale, 1999; Wells, 2005), and with how the self is constructed – see for example, the "contextualised self" in ACT (Hayes et al., 1999, p.188).

Mindfulness (*sati*) is seen as a means of cultivating wisdom, which in this context means the gradual peeling away of layers of ignorance about the processes that foster clinging to a false sense of permanence – the idea of self as 'fixed'. Many methods of Buddhist meditation commence with a sense of stillness or calm (*samatha*), before moving onto specific techniques designed to foster insight (*vipassana*) and 'loving-kindness' (*metta*) for oneself and others. Most mindfulness meditation uses a point of concentrative focus as a means to notice when one's attention has wandered, and to establish a sense of tranquility in beginning meditators from which to tackle forms of insight meditation. *Vipassana* techniques promote insight into the relationships between physical embodiment and cognitive constructions of the self, including also the relationship between thoughts and the thinker, and thus contribute to the growth of wisdom. Within the therapeutic approaches outlined above, 'mindfulness' tends to encompass all aspects of these meditative techniques.

Additionally, the idea of *metta* is often assumed as part of 'mindfulness'

without discrete definition or use of specific techniques. Often confused in Western therapies with 'compassion' (*karuna*), 'loving-kindness' (*metta*) is understood by many Buddhists as a feeling state, whereas 'compassion' would require formation of intent to act for the positive benefit of oneself or others. In practice, these aspects of meditative process are closely integrated, so that the act of bringing one's attention back to observing the breath without evaluating the original diverting process as good or bad, would be an act of compassion for oneself, and by extension for others in the world. In Western psychology, ideas of compassion are recognized as part of 'mindfulness', although rarely engaged with explicitly. Neff (2003) and Gilbert (2005) are notable exceptions perhaps. In Buddhist-inspired teachings, stillness, insight and compassion can be seen as indivisible parts of the process of meditation, which is practised in order that wisdom grows as part of one's everyday living. The collective Pali term for "meditation" practices is *bavana*, better translated perhaps as development or cultivation. These formal practices are seen therefore, as training for bringing this quality of awareness to every living moment of existence, in order to cultivate wisdom.

In one of the earliest written Buddhist teachings (c. 100 BCE) – the *Satipattana Sutta*, or the "Four Foundations of Mindfulness" – the Buddha is reputed to have set out the core skills for establishing a personal mindfulness practice. These exhort practitioners to train their awareness in the following ways. Firstly to develop a sense of being in one's body, through 'scanning' one's body parts in a deliberate way and seeing more clearly the constituent elements that make up the body's physical structure. Secondly, to focus attention on recognizing and identifying sensations without judgment, to view them as leaves flowing down a river. Thirdly,

to develop awareness of mental formations, or the activity of one's mind in giving rise to emotional states. Practitioners are encouraged to find within themselves the roots of such mental formations arising in consciousness – conveying the sense that all people have the potential for wholesome and unwholesome emotional states, and that a personal responsibility exists over which ones receive continued cultivation. Fourthly, to develop one's awareness of phenomenological activity – or the subjective nature of one's internal experience – in the sense that consciousness must always take an object (Giorgi, 1997; Moran, 2002). One is not conscious unless being conscious of something, so it can be seen that one's attention is necessarily selective and that the objects of one's consciousness are shaped in a highly individualized and subjective manner. Within Western psychology, mindfulness can become either a catch-all term for the aspects discussed above, or is used to describe just one facet of the experience (Baer et al., 2006). Either way, such descriptions risk losing the non-dual nature of the richly layered experience that is mindfulness.

*The traditional model of CT and its subsequent developments*

Grounded in a positivist framework of natural science, CT draws on an ontology of the objectively verifiable – analogues of human experience that can be reliably observed from a third-party perspective, and validated through experimental testing of theoretically derived hypotheses (Pilgrim & Treacher, 1992). Such methods engage with the material world, privileging empirical evidence, universal laws of cause and effect, and the use of reason as the compass for human progress – all being the legacy of the European Enlightenment (Hollinger, 1994). Other cultural inheritances from this project, exacerbated by modernist pressures of complex technological living, have been the ever-increasing emphasis on selfhood and

individuality, the separation of reason from religion, and the promulgation of mind as an idea distinct from the experience of the body, especially in relation to notions of healing and medicine. Over the last three-hundred years or so, separate specialisms in human intellectual endeavour have grown ever more discrete and fragmented, as secular knowledge has attained ascendancy over theology and the importance of personal salvation and spiritual concerns has diminished accordingly (Smith, 1998). Duality and the division of experience into separately identifiable categories is emphasized rather than the non-dual nature of Indian philosophies and Buddhism (Hamilton, 2001).

The traditional CT model assumes that emotion and behaviour are mediated by the meaning a person places on preceding events, whether these be external or inner private experiences (Beck, 1976). Such meaning, represented to oneself and others through thought, is influenced by prevailing moods and prior actions. CT usually holds that interpretative processes of meaning occur rapidly and just outside a person's conscious awareness (Teasdale, 1993), so people can often believe that their feelings are driven directly by events. CT suggests also that schemas are laid down through early childhood interactions, and shape pervasive personality patterns throughout life. What drives psychopathology in a CT formulation is the coincidence of stressful life factors activating negative and irrational schema, so that distorted cognitions consequently arise which produce emotional distress, which in turn continues to activate unrealistic schema in a vicious cycle (Neenan & Dryden, 2000).

CT is an active, time-limited and structured approach that utilizes a variety of

cognitive and behavioural strategies in order to challenge thoughts and beliefs. These aim to facilitate highly specific learning experiences for each patient: monitor negative, automatic thoughts; recognize connections between cognition, affect and behaviour; examine evidence for and against distorted automatic thoughts; substitute more reality-oriented interpretations for biased ones; identify and alter predisposing dysfunctional beliefs (Neenan & Dryden, 2000). Key to the delivery of CT is "collaborative empiricism" (Beck, Rush, Shaw, & Emery, 1979, p.6). This describes the basic conditions for facilitating the therapeutic alliance in CT, which aim to actively engage the client in the therapy and in the process of empirical investigation. More cognitively informed interventions tend to examine the validity of existing beliefs, whereas more behaviourally informed interventions tend to focus on the teaching of specific cognitive skills (Hollon & Beck, 1994).

Cognitive therapists who criticize the traditional CT model, do so on a number of fronts. One is that the model is not theoretically grounded in a cohesive scientific theory of cognition supported by basic research (Teasdale, 1993; Salkovskis, 1996). Such commentators see CT more as an integrated system of well-defined therapeutic techniques and procedures derived from positive clinical experience, where the informing model of cognitive psychological functioning is simply heuristic. Another criticism is that CT has inherited from the first wave of behaviour therapy a commitment to establishing evidence of relative therapeutic efficacy compared to other forms of psychotherapy (Wampold, 2001; Norcross, 2002), which tends to reinforce the importance in CT of specific technical ingredients. This has meant that basic research into cognitive processes underlying therapeutic assumptions of change have typically developed in a fragmented and

piecemeal fashion. Specific hypotheses about mooted change mechanisms in CT are difficult to validate experimentally, when they are linked to narrow definitions of specific psychopathology without an integrated functional theory (Salkovskis, 1996). This situation has resulted in a number of speculative cognitive models of psychological processing (Teasdale & Barnard, 1993; Wells & Matthews, 1996; Power & Dalgleish, 1997). Each of these models addresses another major criticism of the CT model – its assumption of single-level cognitive processing, readily accessible to conscious awareness (Teasdale, 1993; Wells, 2000). Multi-level cognitive models deal in various ways with the role of metacognitive processing, and the ways in which emotion and learning may be linked, for example (Teasdale, 1993). Beck (1996) himself has in more recent years endorsed the prima facie validity of such models in cognitive therapy. Some practitioners have championed the primacy of emotion in CT (Greenberg & Safran, 1989), whilst others have developed traditional CT to increase its existential and spiritual scope (Mahoney, 2003), and to widen its applicability to complex clinical presentations (Young, Klosko, & Weishaar, 2003). So it can be seen that CT has developed from its original model in various different ways, commonly around the need to better acknowledge the roles of meaning, metacognitive processing, and emotion in personal change.

*Comparing the Buddhist origins of MT and the traditional model of CT*

A number of tensions can be identified between the Buddhist roots of MT and the traditional CT model, both at a philosophical and cultural level, and at the level of theory and practice. These are summarized in the table below.

Table 1

*Key points in comparing the Buddhist origins of mindfulness training (MT) and the traditional model of cognitive therapy (CT)*

| Topic | Buddhist origins of MT | Traditional CT model |
|---|---|---|
| Ontology | | |
| *Differences* | Constructed & impermanent | Objectively verifiable & certain |
| | Relativistic & multiple | Positivist & universal |
| | Expansive & inter-connected | Reductionist & mechanistic |
| | Non-dualism always emphasised | Dualism most often emphasised |
| Epistemology & Authority | | |
| *Differences* | Subjectively validated | Empirically validated |
| | Personal experience privileged | Intellectual knowledge privileged |
| | Conduct & opinions of trusted others valued | Published scientific evidence valued |
| *Similarities* | Observation, supported by trusted others | |
| Mind | | |
| *Differences* | Sense organ for consciousness | Information processor |
| | Holistically integrated with body | Usually viewed as separate from body |
| | Language unable to fully represent experience (ineffability) | Language analogous with experience & easily accessible |
| | Metacognitive processing recognised | Single level processing only recognised |
| *Similarities* | Cognitions arise from biological substrate of embodiment, & in turn can also influence physiology | |
| | Changing behaviour can lead to consequent changes in emotion, cognition & physiology | |
| Phenomenology | | |
| *Differences* | Essential means of enquiring into one's personal experience of being human | Seen as simply a process of representing inner experience using words |
| | Communication between people occurs at levels beyond speech & | Communication between people seen as essentially verbal |

| | | |
|---|---|---|
| | verbal relations | |
| *Similarities* | Personal meaning is mediated through interpretation of experience | |
| | Human beings are able to act in order to change, within limits of "situated freedom" | |
| Self | | |
| *Differences* | Constantly constructed in moment & seen as impermanent, with different aspects of self-experience clearly delineated | Enduring & fixed with less clear delineations of different aspects of self-experience |
| | Process of self-awareness amenable to positive enhancement through deliberate reflection | Self amenable to positive enhancement through skills development or reality testing |
| Purpose | | |
| *Differences* | Non-theistic faith-based spiritual system | Science-based psychotherapeutic technology |
| | Life-long soteriological endeavour to attain cessation of suffering through enhanced existential awareness | Time-limited therapeutic interventions to facilitate relief of psychological & emotional distress through change in personal meaning |
| | Practised for benefit of oneself & others | Practised for benefit of others |
| *Similarities* | To diminish suffering & bring about lasting beneficial changes | |
| Psychopathology | | |
| *Differences* | Suffering arises from grasping pleasant or rejecting aversive experience in attempts to attain fixed sense of self | Suffering arises from beliefs at odds with inner expectations of self, so that experience is inappropriately evaluated |
| | Assumption of destructive normality | Assumption of destructive abnormality |
| *Similarities* | Suffering arises from ways that people interpret experience | |
| Psychotherapy | | |
| *Differences* | Shared experiential process in moment combined with techniques important | Technical procedures important |
| | Highly validating of client experience | Client validation less emphasised |

| | |
|---|---|
| Changing understanding about context of experiencing facilitates personal change | Changing content of beliefs generates changes in emotional experience & behaviour |
| *Aspects emphasised in CT but not in Buddhism* | |
| Increasing positively valenced activities in order to reduce negatively valenced activities | |
| *Aspects emphasised in Buddhism but not in CT* | |
| Emphasises interconnectedness of all beings so that sense of collective identity cultivated to subsume that of an individual "self" | |
| Karma as system for understanding consequences of one's individual actions for oneself & collectively in this world | |

What emerges most strongly from this table of comparisons is the inherent nature of non-duality in human existence as emphasised in Buddhist teachings, mindfulness practices having correspondingly arisen precisely to facilitate people's ongoing exploration of this non-duality in a number of highly effective ways. Two other points of relevance should be considered at this juncture. One is that the nature of language may in itself be a limiting framework for the adequate representation of felt human experience in its entirety (Batchelor, 1997). This constraining nature of language, and by implication thought, may be reflected in the human desire for certainty, and the narrow focus of conscious attention allowed by the brain at any one time. The natural tendency for human beings then, is a low tolerance for uncertainty and a need to concentrate on only a few things in detail. From this flows the second point – that Buddhist teachings present a view of reality in which the individual components of experience and their relationships with each other, as well as the context within which these occur, are what need to be seen – but that paradoxically, humans find this immensely difficult to envision, even with the benefit of experiential knowing. As a purely intellectual endeavour, most Buddhists would

suggest it to be impossible (Batchelor, 1997).

In light of this last point, the current focus in the scientific investigation of mindfulness used clinically can be criticized for being almost exclusively objectivist and reductionist. It seems unlikely, given the nature of mindfulness as an experiential process and the limits of human language highlighted above, that the fullest scientific understanding of mindfulness will be gained using only the methods of natural science. Such methods have proved of great value to psychology and will continue to be so. However, since such methods predominate in the field of CT, it can be argued that mindfulness cannot be fully integrated without some additional scientific means of exploring its experiential nature. The most appropriate means to scientifically acquire this additional knowledge of mindfulness from a Western perspective may well be those of phenomenological psychology (Romanyshyn & Whalen, 1989). The underlying philosophical principles of phenomenology closely mirror those of Buddhism as presented in the above table, especially in terms of the non-duality of human experience (Kvale & Grenness, 1975). Such initiatives are also supported by other psychologists calling for first-person accounts of experience in neurological research into meditation (Cahn & Polich, 2006; Mind & Life Institute, 2007).

Further issues of practical concern, in terms of using MT in the framework of CT, arise from the nature of the therapeutic relationship and its contribution to outcome, as opposed to the significance of specific therapeutic techniques and their effect on outcome (Wampold, 2001). The different tensions that arise are really reflections of this core conflict expressed at varying levels of abstraction. At one

level, it can be argued that the importation of MT into traditional CT changes so irrevocably the traditional CT model, that it ceases to apply. MT works at multiple levels of cognitive functioning and is concerned with the inherent nature of self and the nature of internal relationships that ensue from identification of different 'selves' with private experience. MT is derived from a broad spiritual tradition, so that it inherently carries with it an articulated concern for transpersonal issues, compassion and life values. The process of teaching mindfulness skills is arguably an inherently relational one, whether in the guise of formal meditation or not, requiring a deep engagement on behalf of the teacher with the nature of mindfulness in the context of their own being. Learning mindfulness skills initially pre-supposes a level of trust and confidence in the teacher, so that beginning experiences can be meaningfully shared and an individually appropriate intellectual framework provided to facilitate further experiential learning (Batchelor, 1994). Authority for the legitimacy of any *Dharma* process in Buddhism is seen as deriving from the results yielded when views and beliefs are put into action, counterbalanced for bias and misunderstanding by comparing these actions against the experience of people who are identified as 'wise' (*the Kalama Sutta*).

De Silva (1984) expresses an alternative view regarding the potential for integration between Buddhism and cognitive behavioural therapies, pointing out that therapeutic research of Buddhist-derived interventions tends to focus mostly on meditation. This serves to overshadow, in his view, the many strategies in Buddhist teaching that are specifically aimed at first-level behaviour change – strategies that do not necessarily make recourse to "insight or inner factors" (de Silva, 1986, p.226). Many such Buddhist strategies are listed and explored by de Silva (1984) in terms of

their close resemblance to behavioural and cognitive therapy techniques. These strategies can help clients to achieve therapeutically remedial change in currently damaging behaviours (e.g. alcohol abuse), perhaps laying the ground for work with meditative techniques of mindfulness to develop a prophylactic awareness of more covert inner processes. Such a view would be highly consistent with ACT and DBT technologies, both of which are grounded in radical behaviourism. Mindfulness in contemporary "third wave" therapies tends to serve both functions simultaneously – as a tool for facilitating specific behavioural change techniques, as well as cultivating an increased awareness of inner processing.

De Silva (1993) also posits the view that historically within Buddhism, much attention was paid to the well-being of lay-people – as much as to those seeking *nibbana* through a stricter religious observance of long-term behaviour change. A long tradition exists of lay-people seeking guidance, counselling and support from Buddhist 'clerics' for help with specific life-problems. Often, the advice forthcoming was aimed at direct behaviour-change for those specific problems, to assist in the increased well-being of individual and diminish suffering. Thus, de Silva (1984) concludes that techniques drawn from Buddhist teaching, including mindfulness practices, should fit well in the framework of psychological therapy – fitting particularly well with cognitive and behavioural approaches. He further stresses the need for empirical and experiential verification of Buddhist-inspired clinical techniques, drawing on the *Kalama Sutta* to evidence the corresponding Buddhist commitment to asking the question, "does this work?" (de Silva, 1984, p.675).

In terms of CT, the evidence-base for therapeutic efficacy is predicated on a positivist medical model, in common with all ESTs, which privileges the relationship between specific technical ingredients and outcomes (Wampold, 2001). Aspects of the therapeutic relationship are mentioned in CBT clinical trials, but are rarely deliberately explored, even though their contribution to the variability of outcome might significantly outweigh that of specific techniques (Wampold, p.209). It is also unlikely to be required in CT that therapists engage at a deeply personal level with a specific technique of treatment, or be prepared also to share something of their own experiences with clients (Kabat-Zinn, 2005b). In each of the 'third-wave' therapies examined earlier, clinicians are expected to have established a meaningful experiential grasp of mindfulness practice before using it therapeutically. This applies as much to the didactic teaching of mindfulness as a skill, as it does to the ability to 'be with' a client in-session, showing a fuller awareness of the relational aspects of therapy. Awareness in this context relates to present-moment experiences of the therapist and the relationship between therapist and client, as well as facilitating as open an expression as possible of the client's experience. In the analysis of therapy as process, the interaction between specific treatment techniques and the person of the therapist is seen as critical to outcome (Beutler, 2004), the foundation for this interaction being the therapist's belief in the rationale for any given treatment (Wampold, 2001). This kind of contextual understanding of psychotherapy can be seen as consistent with a mindfulness-based approach and its Buddhist underpinnings, rather more so than the positivist and rationalistic framework of CT. The aspects of therapy that tend to be emphasized and privileged in 'third wave' therapies are those relating to: broadly spiritual issues and life-values; acceptance of human experience as 'normally destructive', so that therapist and

client are seen as sharing a common fallibility; and validating therapeutic relationships where issues of rupture and repair are deliberately sought out and addressed.

It is likely to be the case, of course, that many effective practitioners of CT already incorporate those relational aspects of psychotherapy outlined by Wampold (2001) as most influential on outcome. It is unlikely to be the case however, that the empirical evidence-base for CT reflects these aspects of therapy, so that the issue of authority becomes one of particular concern. In the end, it is perhaps not so much the difference between CT and MT that matters, so much as the explicit emphasis that each places on its preferred parts of the therapeutic project, and the practical conclusions that naturally ensue.

## Conclusion

MT emerges from the literature reviewed in this paper as an exciting and potentially useful therapeutic intervention in the framework of cognitive-behavioural treatment, although currently with limited empirical evidence in support of its clinical benefits. Greater clarification is demanded in operational definitions of mindfulness as a psychological construct, and in its psychometric measurement (Bishop, 2002; Baer et al., 2006). As far as the 'third wave' therapies explored here, there is a need to investigate more fully the putative mechanisms of change specifically associated with mindfulness training, and the circumstances in which it is most likely to be therapeutically effective. However, it is also possible that in reducing the concept of mindfulness to the sum of its parts, its real usefulness as a

synergistic clinical process may be lost. Both the predominant nature of EST criteria in terms of efficacy research, and the positivist epistemology of the cognitive-behavioral tradition generally, may work together in producing such a sub-optimal outcome.

It can be seen from the nature of MT as a Buddhist spiritual practice, that it functions also in an experiential and relational context, influencing the person of the therapist, the person of the client and the interaction between these two. Its value may equally well reside in the moment-to-moment experience of its use and how that is sensed, felt and understood by all participants. There exists also a question of authority in choosing MT as a specific therapeutic intervention, where this is done against the background of the limited empirical support reported in this paper. What processes are at work in everyday clinical situations for cognitive therapists who use mindfulness in individual treatment and group protocols, and what are the experiences of such practitioners? In the UK at least, there is concern that few practising clinical psychologists have the resources to formally evaluate and publish details of practical interventions (Thomas, Turpin, & Meyer, 2002), although MT interventions grow increasingly popular. There is at least the possibility therefore, that important aspects of the experience of everyday practising clinicians using MT are not being fed back into the empirical research base, and that a great deal of the richness of this experience is not being captured by the prevailing research methodologies. Perhaps it would be wise to figuratively step back for a moment, and to engage qualitatively with this phenomenon; to check out some of the assumptions that prevail in the current empirical literature on MT in cognitive-behavioural therapies.

In terms of specific qualitative methodologies that would be appropriate for the task, the author of this paper suggests a descriptive phenomenological approach initially (e.g. Giorgi & Giorgi, 2003). This would allow for the holistic, structural nature of the phenomenon to be analysed and described in a relatively open and reflexive manner, so that presuppositions and assumptions on behalf of the researchers could to some extent be identified and declared. "In mindfulness meditation, everything that happens within the experiencing of one's various states of mind is embraced as one seamless whole, as different aspects of one's personhood and lived experience", (Kabat-Zinn, 2005b, p.435). Having drawn the lesson of mindfulness meditation from dharma-practice, it may be wise to apply it also in terms of how clinical psychology constructs its view of a phenomenon so multi-faceted, multi-layered and richly complex.

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# Mindfulness meditation as used by clinical psychologists in cognitive therapy: An existential-phenomenological analysis of how such practitioners describe their experiences with special reference to underpinning theory and professional issues

by

**David Mussell**

Dissertation for the Doctorate in Clinical Psychology
Empirical Paper

Statement regarding submission to the chosen journal

**Journal of Phenomenological Psychology** publishes articles that advance the discipline of psychology from a phenomenological perspective as understood by scholars who work within the Continental sense of phenomenology. Within that tradition, however, phenomenology is understood in the broadest possible sense and it is not meant to convey the thought of any one individual. The journal especially publishes "breakthrough" articles and the reporting of research findings that contain the broadest possible significance for the field of phenomenological psychology.

All submissions must be double spaced and fully justified. Each submission should include a 100-200 word abstract in block paragraph form. The beginning of each new paragraph should be announced by an additional space between it and the previous paragraph, rather than the traditional indentation of one tab. New sections should be announced with bolded flush-left headings, and subsection headings should be italicized and flush-left. References and footnotes should follow APA Guidelines.

## Abstract

This paper details a descriptive phenomenological psychological study of clinical psychologists who use mindfulness meditation in cognitive therapy, with special reference to underpinning theory and professional issues. A small sample of clinical psychologists were interviewed in depth and the resulting transcripts analysed within the phenomenological perspective. A general psychological reduction is reported which captures the most common invariant themes arising across the participants and gives some sense of the overall structural connections between these themes. The description aims to capture the subjective qualities associated with using mindfulness clinically that are necessarily overlooked in already published positivist empirical research. Conclusions for the clinical practice of mindfulness are drawn, and emerging tensions are highlighted between the spiritual and the secular, and between personal authority and published evidence.

## Introduction

Within clinical psychology, the therapeutic use of mindfulness has increased greatly over the last few years, especially in Western developed countries. The cognitive and behavioural traditions have been especially active in expanding the research base supporting mindfulness as a clinical application. Many different therapeutic approaches have been reported which combine mindfulness in some way with cognitive-behavioural therapies – see Baer (2006) for an indicative review. Much of this research reflects the current drive to establish specific psychological therapies as empirically-supported treatments (EST: Chambless & Hollon, 1998), and is therefore largely efficacy-based. Other strands in this evidence-base have focused on defining mindfulness operationally as a psychometric construct and developing appropriate tools for measuring aspects of this construct. A limited number of studies have explored mindfulness as a putative mechanism of change within the various therapeutic systems. The current state of the evidence generally finds that mindfulness used clinically in cognitive-behavioural therapies can be of considerable potential benefit to patients, across a variety of clinical settings and presentations of distress. Criticisms voiced however, call for many more component analyses and mediational studies, as well as improved operational definitions and psychometric instruments for measuring mindfulness. Effectiveness studies are also required in far greater numbers, to help assess how well 'manualised' therapies with specific research populations will translate to the everyday clinical needs of jobbing psychologists (Mussell, 2007).

Research in this field can be criticised also for being largely directed and shaped by the needs of an EST agenda. Some therefore argue that, as in much other efficacy

research, too little attention is given to common therapeutic factors, or the variance in outcome effectiveness arising from differences between individual therapists (Wampold, 2001; Norcross, 2002). In addition, the evidence so far published overwhelmingly favours positivist empirical methodologies. Mindfulness is also used therapeutically in clinical approaches that are clearly not identified with cognitive therapies (CT), and others outside the field of CT have described mindfulness as a "proposed common factor in psychotherapy" (Martin, 1997, p.291). Given the deeply reflective and experiential nature of mindfulness, as informed by its Buddhist origins, the existing evidence-base may be seen as offering a potentially biased scientific understanding of the phenomenon that is the clinical use of mindfulness. Baer, Smith, Hopkins, Krietemeyer, & Toney (2006) point to the complexity and richness of mindfulness as a human experience, and its multi-faceted nature when it comes to scoping experimental research. In addition to arriving at a widely accepted psychological construct of mindfulness, there are also a number of different ways in which one may be trained in being mindful. Mindfulness meditation is one approach commonly used by cognitive-behavioural practitioners to guide their clients in the practice of mindfulness, and the techniques involved are credited most frequently to methods of Buddhist insight meditation. However, many approaches to meditation may assist people in cultivating mindfulness, and most world religions besides Buddhism have mystical traditions with similarities to mindfulness practice (Walsh & Shapiro, 2006).

So, whilst it is clear that mindfulness can be investigated as an objectified construct in the context of positivist science and that such an approach offers psychologists and the wider community something of great value, it is also clear that other very

important aspects in the clinical use of mindfulness have not been empirically addressed. These include describing the experiential qualities of mindfulness in clinical use, as well as perhaps the spiritual aspects of the practice given the foundations from which it has arisen, and the ways in which personal experience and published evidence are reconciled in those practitioners that have chosen to use mindfulness with their clients. What was the process of their decision-making that persuaded them of the legitimacy of mindfulness as a clinical approach in the light of the under-developed evidence-base alluded to above? What is it that these professionals understand as mindfulness, and in what ways are they affected by its clinical practice as private individuals, as well as public psychologists? These are the research questions addressed in this study, as the popularity of mindfulness in cognitive therapy circles grows apace, and more clinicians are drawn towards using it with clients.

A phenomenological research methodology was chosen as the most appropriate to explore such questions, since they engage deeply with the subjective processing by individual psychologists of objectified scientific artefacts in their attempts to make such research workable in everyday clinical settings – the 'craft' of applied psychology (Barnard, 2004). The phenomenon identified for investigation in this study, therefore, was the use of mindfulness meditation by clinical psychologists in the broad context of a cognitively informed therapeutic framework, with particular reference to underpinning theory and professional issues. To this end a small number of clinical psychologists were asked to describe their experiences in depth, and the resulting transcripts were analysed using methods shaped by Descriptive Phenomenological Psychology (DPP – Giorgi, 1971a, 1971b, 1975, 1997; Giorgi &

Giorgi, 2003). What should emerge from such an analysis is a highly focused narrative description of the essential qualities found to be common across all participants, and which highlights important differences between them. In addition, the description should also address the way in which such common essences and differences are uniquely structured to make up the phenomenon and thus distinguish it from other similar phenomena. This is the particular value of phenomenological methods, in that a richly nuanced account of human experience is produced that adds to the wider research agenda in a way that is simply not possible with positivist methods. In terms of mindfulness meditation used clinically, this is especially timely and welcome for the reasons already set out.

## Method

### *Design*

In conducting this qualitative study and its writing-up, empirical rigour and quality of process have been key concerns throughout. Elliott, Fischer, and Rennie (1999) set out criteria against which to judge the quality of phenomenological analysis in psychology research, which has guided the writing-up of this paper. In keeping with the first criterion – "owning one's perspective" – parts of this report are written in the first person to better situate this research in terms of my own relationship to it as author. This has a further advantage, in that this radical shift in style for an academic research paper serves as a reminder of the different scientific assumptions underpinning this work, compared to a more traditional objectivist approach.

When considering in detail the method described below, the process of phenomenological analysis may appear somewhat opaque to those without first-hand experience of its use. The crux of the method for me as researcher has been the opportunity to dwell in the moment of communication, so that the focus of one's analysis rests on the edges between perceiving something and reflecting on the act of that perception – where subject and object are part of the same process of experiencing. This is to look for what is given precisely and to encounter it freshly, describing it exactly as 'intuited' – sensed before meaning is attributed to it. Phenomenologists refer to this act as 'reduction' (Giorgi & Giorgi, 2003), which involves the 'bracketing' of one's existing, culturally and historically bound assumptions about the world, in order to generate new and fresh perspectives on meaning. As Chamberlain, Camic, and Yardley (2004) point out, this represents a virtually impossible task, and one that requires intensive personal reflection throughout the research process, and the involved support of a supervisor. The best one can aim for is to get as close as possible to the fresh interpretation of meaning, and trust this will provide something original and thought-provoking to the wider research community.

DPP represents an attempt to derive psychological research methods from the phenomenological teachings of Continental philosophers, Husserl and Merleau-Ponty – where such methods provide alternatives to the duality imposed on the investigation of human experience by mainstream positivist, experimental approaches to psychology (Romanyshyn & Whalen, 1989). Two key principles from DPP have shaped the methods employed in this study. First, phenomenological psychology clearly identifies itself as an empirical *human* science, in antithesis to the

methods of *natural* science. Thus, of paramount interest to the researcher is the interplay between the processes and content of conscious experiencing, as reported by an individual. A number of such accounts related to a tightly bounded aspect of human experiencing – the phenomenon of mindfulness meditation used clinically by psychologists in this study – are then analysed to generate some essential qualities of that experience which will have a wider applicability beyond the original sample. Second, there is no set method that can be applied rigidly to investigations within a DPP framework. Rather, a collection of core principles has been elucidated as to method, and the exact procedure for each study emerges as a product of that specific research process (Wertz, 2005). The particular steps followed in this study are detailed under "Procedure" and "Analysis" below.

*Participants*

Eight clinical psychologists participated in the study, all located in Southern England. Two types of participant were purposively sampled: those who identified themselves as currently practising CT, or who had significant prior training and work experience in this orientation; and those who specifically rejected CT as an orientation. All participants were required to have some extended experience of using mindfulness clinically in publicly-funded psychotherapy, either in mental or physical health settings. Two non-CT practitioners were deliberately selected in order to provide a form of cross-referencing for the cognitive-behavioural focus of the study. This is a form of good practice in phenomenological research as recommended by Wertz (1983), that aims to facilitate a more thorough and rigorous analysis, and strengthen the quality of findings.

Seven of the participants were highly experienced and senior practitioners, aged between 40 and 55. The eighth had qualified three years prior to the study, and was aged below thirty. All participants were white Westerners, and five were women. Five were employed as consultant psychologists with managerial responsibilities in addition to their clinical duties. One participant headed their own research programme and one participant was originally a non-UK resident having trained abroad as a psychologist. Of the eight participants, six worked in mental health services, with four specialising in personality disorders and one in psychosis, whilst the remaining two participants worked in physical health with people suffering from life-limiting illness. In terms of therapeutic orientation, four participants were active current practitioners of CT, across a range of different approaches in this field. Two participants had significant prior experience and training in CT, having sought further subsequent specialist training in Gestalt or narrative approaches, although they both continued to provide cognitive-behavioural therapy to clients where appropriate or specifically requested. Two participants had rejected CT as a therapeutic orientation, practising from either a constructivist, narrative approach or from a body-psychotherapy approach underpinned by specialist training in Core Process Psychotherapy – a specifically Buddhist informed Western therapeutic orientation (Donnington, 1994). All participants worked with mindfulness, either in groups or on an individual basis with clients.

*Ethics*

Approval was received by the School of Psychology Ethics Committee of Southampton University (see Appendix I), and copies of relevant documentation are attached (Appendix II). LREC approval was not required since participants were

recruited outside of the National Health Service, interviews were held in the participants' own time, and no identifying clinical data was required as part of the research. Protecting the anonymity of each participant was a key consideration, with confidentiality and security of data being assured at all stages of the research process. To assist participants in feeling comfortable with the significant level of personal self-disclosure required, a copy of the interview transcript was sent to each participant shortly following the interview.

*Procedure*

A vital first step in this study was to explore my own assumptions about personal meditation practice and the published literature, and to 'bracket' these as far as possible, so I could engage in a deliberate and intentional way with the experiences of participants in the study. To help achieve this I undertook an extended literature review of the evidence-base for cognitive-behavioural uses of mindfulness, and how these were shaped by underlying Buddhist teachings and practices (Mussell, 2007).

DPP methodology requires that researchers explicitly reflect on their personal engagement with the subject matter and the participants involved, in order to consciously make accessible the ongoing subjective nature of the researcher's interaction with these things (Wertz, 2005). To assist in making this process of reflection more transparent to the reader, I situate myself as researcher in the following terms. I am a white, male Westerner, raised in a protestant Christian environment, having approached this study as a mature entrant to UK post-graduate training in clinical psychology, with an already established insight-meditation practice and an academic grounding in Buddhist teachings from within the

Theravadin tradition. I have previously used some aspects of mindfulness in my own clinical work with clients from a cognitive-behavioural orientation, and have participated in my own transpersonal therapy. The research question had significant resonance for me as a trainee clinical psychologist therefore, and for the relationship between my personal spiritual practice and my professional stance as a reflective scientist-practitioner. To assist in the ongoing reflexive processing of engagement between research and researcher, I maintained two journals throughout the whole study period. One included notes about the process of research itself and the demands made by the phenomenological method, comprising twenty-three separate entries made over a period of thirteen months (see Appendix III for illustrative examples). The other journal included notes about meanings as they emerged in the analysis of transcriptions and the reductions performed, and comprised thirteen separate entries over a period of eleven months (see Appendix IV for illustrative examples).

A semi-structured interview schedule (copy at Appendix V) was prepared to help guide the interview process, which aimed to encourage an in-depth conversation about what participants had actually done – thus attaining 'concrete' data compatible with a phenomenological approach. Participants were also encouraged however, to develop themes and describe their own processes of thinking, to foster reflexivity about their practice – especially about the interface between aspects of the professional and personal. Participants were reassured during the interviews as to confidentiality and anonymity, as some were isolated practitioners of mindfulness, and concerns were sometimes expressed about being identified. I maintained an awareness also of the possible power differentials between myself as a trainee and

participants as very experienced, and mostly senior psychologists. Would they respect me enough to participate honestly and openly – how much should I share about my own experience as a meditator and a student of Buddhism? In order to facilitate the sharing of open and detailed descriptions about the ways in which participants used mindfulness, I found giving an indication that I had some experiential grasp of what they described was helpful. Either because it was reassuring, or because it made it plain that the participant needed to explain further. There was a sense during every interview, that participants were voicing some new and fresh connections to them in their accounts of personal and clinical practice. As someone having only a fraction of the clinical experience of the participants, I made efforts to conduct the interviews with a sensitivity and respect for the personal vulnerabilities and doubts that were shared by them. This was especially the case for the two participants not practising within a cognitive therapy orientation, where my knowledge was even less. All conversations were recorded and then transcribed verbatim by myself, in a way that captured some sense of the conversational dynamics (O'Connell & Kowal, 1995), although not in the level of detail associated with discourse analysis, for example (see extract at Appendix VI). Each participant's interview was transcribed before proceeding with the next one, so that key emerging themes could be addressed as data collection progressed, and to allow for improvements to my interview style and competence (Kvale, 2003).

*Analysis* (see Appendix VII for flow-chart)

Having transcribed the interviews, each account was read through several times to get a sense of its gestalt and to enter further into the 'life-world' of a particular participant. In Husserl's method of enquiry, the aim is to get back to the things

themselves as given to consciousness, before the process of 'sense-making' intuits meaning to 'things'. The process of generating meaning is grounded in the 'life-world' of the individual – the cultural, social and material context of one's life, as well as one's personal internalised history of learning (Polkinghorne, 1989). Working through the transcript again, every time a shift in meaning was discerned a mark was made in the text, so that separate 'meaning-units' were identified. These were then placed in a table, together with my intervening questions and talk as interviewer (see extract at Appendix VIII). Some meaning-units were a single sentence, whilst some were several sentences long. I considered each unit separately, in order to reduce it to an essential meaning related to the psychological objective of the study. This involved holding the unit of meaning in mind, re-expressing it in language appropriate to the broad discipline of psychology, and then 'turning' that description in one's mind to examine it from as many aspects as possible until the most likely invariant essence of each unit, according to my view, was arrived at. Some sources in DPP refer to this act as "free imaginative variation" (FIV – Wertz, 2005), and it represents another form of 'reduction', the aim being to get as close as possible to a simple description of a meaning unit's essential quality that is both sufficient and necessary to distinguish it from other aspects of the phenomenon.

The judgement of quality and validity of this process lies as much in the repeated experience of reducing meaning-units, as much as in the product arrived at, since this is what starts to shape one's understanding of the structure of the phenomenon as well as its essential components. At this stage, and at all others, support from my supervisor was sought to ensure that the process of 'reduction' was adequately phenomenological and as a form of cross-referencing in terms of specific analytical

decisions. This helped to provide some sense of triangulation by involving an informed third-party perspective, providing additional assurance as to the reliability and validity of the methodology (Willig, 2001), and therefore its eventual outcome.

The resulting first reductions of meaning-units were then read again in relation to the whole transcript and amended or revised accordingly. For each reduction of a meaning-unit, a core theme was then identified, again making use of FIV. Once this themed analysis was completed, all the themes (numbering from 60 – 100 for each participant) were cut up and placed on a large table, so they could be arranged into groups of core themes. Between twelve and nineteen core themes emerged for each participant (see Appendix IX for an illustrative extract). Having listed these core themes, the original whole account was again re-read to ensure that what had emerged remained grounded in the context of each individual's account. When the lists of core themes for each participant had been completed, totalling around a hundred, these were also cut up individually, placed on a table and arranged into groups of superordinate themes across all participants, again employing FIV (see Appendix X). The analysis of themes was carried out in this way to assist in reducing complex and lengthy accounts to manageable common meanings. From this grouping of superordinate themes, the narrative reduction was written in language appropriate to the purpose of the research, checking back to individual transcripts and words used by participants to ensure that the final analysis remained grounded in the data. This narrative reduction is detailed in the results section of this paper, in two sections: one – a general psychological reduction of core themes emerging from the research that describes common essential qualities and key differences of the phenomenon, as well as its unique sense of overall structure,

explored through two core themes of spirituality and science; two – a separate description of the essential qualities that emerged in relation to mindfulness and forms of mindfulness training.

**Findings**

The narrative account that follows is a general psychological reduction, the purpose of which is to present some sense of what was described by participants in their experiences of using mindfulness clinically, and what emerged as essential in that experience across all participants. By way of illustration, selected extracts from the transcripts of participants are included, which assist in grounding these conclusions in the data (Elliott et al., 1999). Separate components of the phenomenon are described, together with relationships between them as they contribute to the overall structure of the phenomenon. Implications for these findings in terms of how they relate to the use of mindfulness in cognitive behavioural therapies, and associated professional issues for clinical psychology, are addressed in the "Discussion" section.

The following core themes have emerged from the analysis, and are jointly explored in the general reduction: correlates of mindfulness and cognitive therapy; therapeutic interaction; and issues of professional development. The overarching theme within which all of the above are subsumed can best be captured by the words spiritual and secular. This theme will be used to explore the structure of the phenomenon and the ways in which each of the component aspects is reflected in it. Following this, the essential qualities of mindfulness and mindfulness training are given.

*General psychological reduction highlighting core components and structure of phenomenon*

Those practitioners closely aligned with CT as a preferred orientation found several aspects of it compatible with mindfulness-based practices, although voicing similar criticisms of CT as those with a primary allegiance to other orientations. Aspects which were felt to be compatible included: ideas of metacognitive awareness and working with personal meaning; distancing oneself from overly close identification with one's thoughts through inner observation; the '3-minute breathing space' from MBCT.

> *So people come to the realisation that what's distressing me, what's really distressing me and grinding me down, is not this transient image or thought or even voice that comes to my mind, it's this relationship that I have with it – and if I were able to relate differently, that level of distress would not be there. I mean that is a fundamental meaning-shift – it's insight – to me it's metacognitive insight.* (P4-69).

Aspects of CT identified as less than compatible with a mindfulness-based approach included: ongoing thought recording and challenging; assumptions of 'destructive abnormality' in understanding psychopathology; manualising of therapeutic approaches without due regard for individual variations in the person of the therapist.

> *...I did know that cognitive therapy works when it works. Somehow, it's about what we do with thoughts and images and memories and so on. I wasn't convinced that what we were doing with them through verbal challenging – was what was producing the beneficial effect ... I wasn't convinced wholly that we were changing underlying dysfunctional assumptions. And the whole – the murky*

*concept of deep beliefs, core schemas – the kind of – the "magic". You know, it's hard to get to close to it and to know if it really is there.* (P1-11)

Whilst the manualised approaches of cognitive-behavioural therapies were valued by some participants as providing methodological rigour and consistency in approach, others found this aspect of CT overly prescriptive. Concerns were expressed by all participants about the 'branding' of mindfulness-based practices by particular named therapies. There was a sense expressed that mindfulness transcended any therapeutic approach that used it. Concerns were expressed about inadequate training of some CBT practitioners, particularly with regard to the quality of therapeutic engagement and the lack of emphasis on therapists' own self-exploration. It was felt this may translate in a clinical setting as a lack of validation for a client's experiences, and a lack of readiness in therapists to engage with the deep personal practice required to use mindfulness. All the participants described ways in which the clinical use of mindfulness had changed their therapeutic practice. Those working from a CT orientation talked about having changed their understanding of CT as a result of using mindfulness in their therapy, especially in terms of increasing their awareness of responses as therapist in a session and working with these as part of the therapeutic relationship.

... *it's about self-disclosure to a degree, about how you're feeling and the thoughts that you have and you might talk about things that you're doing in your private life as well, potentially. As long as it's sort of informing your clinical work really – in terms of helping people to move on. And actually that was quite liberating in a way, not to have to sort of – boundaries that – up to that point I'd*

*been much more boundaried about things like that - I didn't do self-disclosure really...* (P5-36/37).

The clinical use of mindfulness was preceded in all cases by first-hand experience of having practised mindfulness in one's personal life. For some this took the form of extended meditation practice over many years, whilst for others it involved only the briefest involvement in mindfulness as an idea derived from therapeutic practice. However, each participant described having experienced mindfulness as useful and helpful, sometimes profoundly so, in their own life. From this sense of it having helped them as individuals, each participant described wanting to offer the potential of this benefit to clients. Those participants with an established practice over several years felt better able to deal with enquires arising from the teaching of mindfulness meditation to clients, than those participants having engaged personally with mindfulness more recently.

*... yeah, I don't really think I've sat down and thought theoretically how – why mindfulness might be a therapeutically useful tool in relation to the other things I had done, really – it was more the fact that I just found it so helpful and transformative myself, and ... there didn't seem any way that I could offer this to clients, but it sometimes made me feel that I wasn't offering them things that I felt were really helpful ... (P2-19)*

The need for ongoing support and appropriate supervision was raised by all participants. This was sometimes an issue of training and developing appropriate skills in the transmission of mindfulness-based practice, or for less experienced

practitioners, a way of checking that one's enthusiasm for mindfulness was not running ahead of one's ability to safely use it in therapy.

All participants believed in the value of an expanding empirical evidence base for the clinical uses of mindfulness in the NHS, although some concerns were expressed at the same time about evidencing mindfulness practice. It was felt that less scope may exist in the current EST climate for personal innovation by clinicians, and that there was a greater need for more effectiveness research. A further difficulty arising was the issue of measuring mindfulness as a psychological construct and the extent to which this was possible or desirable.

> *So I think, I think it's too easy for us to say it's a complex or impossible to measure concept, let's just not try ... I think there's an opposite danger that psychology will throw away our way of doing things, say in CBT for example. I think it's important to say if we believe there's a mechanism here that is helping people stay well, helping people let go of depression, I think it's important to engage with the question of how can we measure that.* (P4-98).

A sense of sharing with the client a common sense of being human emerged strongly across the accounts, which was rooted in a recognition of the value of acceptance. What arises in consciousness is a result of an ongoing and ever-changing process, and concentrating on being present in the moment can provide an unexpected sense of stillness or calmness.

*But I mean, what I was thinking about was, um – there's a kind of paradox around change really ... um, once you're prepared to actually be who you are then paradoxically change is possible. And so I think that, um – what I get interested in is people changing their relationship to their internal process – not actually necessarily having to change the thought or the feeling or whatever, so when I'm talking about acceptance, I mean there is change going on, but it's changing a relationship ... that first ever being able to step back and say, so this is just an internal event, it's the equivalent of an itchy nose or a – that seems pretty important to me.* (P3-31/32).

The witnessing by the therapist of the client's struggle, and also of the earliest realisations that clients may have a choice about relating to their private experiencing, seemed to be highly validating to clients and also strongly reinforcing for therapists.

Some participants taught mindfulness as formal meditation practice in groups, whereas others used the ideas of mindfulness in individual therapy, with the client practising meditation techniques between sessions. One non-CT practitioner neither taught meditation skills, nor talked explicitly about mindfulness during individual sessions. Working within a highly integrated mindfulness approach, the skills and stance of mindfulness were modelled to the client in the specific context of that client's experience. This approach was avowedly non-dualistic and emphasised the embodied nature of human existence.

*It's not – I wouldn't call it meditation practice as in you know, Buddhist-based meditation practice where there's an object upon which you rest attention in*

*order to still the mind ... it's helping you to become – to establish witness and then become that which you're witnessing as well so that the two are not seen as separate. So once they've run through their bodies and described the sensations in their bodies, and I usually do that on many different levels – usually overt, physical stuff like heavy or tingly or whatever, there will also be emotional senses or imaginal like, er, my legs feel, um, kind of like a piece of glass and I'll get them to explore that a bit more so that, is that just – like the coldness of glass or see-through is it – so they're getting a strong sense of being kind of here and now whilst sitting with me and then where they're at with their level of arousal as well.* (P7-13/18/19)

This idea of 'tailoring' mindfulness was a common theme across all participants. However mindfulness informed their clinical thinking, and in whichever way they sought to deliver this to clients, each participant had a rationale for why mindfulness was likely to be useful therapeutically.

What encouraged each participant to persevere in their early clinical uses of mindfulness was that each had experience of their own beginnings in mindfulness where a trusted other was of significant assistance and support. Whether this had been a colleague, a supervisor, or a meditation teacher, each participant had been guided initially in some way by a trusted and respected other. In using mindfulness clinically, this role of the trusted other falls to the therapist, whether facilitating a group or working one-to-one, and can be flattering. Each participant interviewed described in some way this particular relational aspect of mindfulness training, and each treated it as a serious responsibility, and as a potential threat to the integrity of therapy.

*But in terms of the mindfulness component it's been incredibly helpful to kind of to be on study programmes, to go to meditation centres, to talk about my difficulties because my difficulties are my client's difficulties. In seven years my observations are that their struggles are the same as my struggles with mindfulness – not with mindfulness but with our experience. So I think that's really important yeah .... So I think what's important is going to somebody who has experience and wisdom in the area you need it.* (P4-93/94).

Working clinically with mindfulness in an environment shaped by the need for empirically supported treatments throws into sharp relief the tensions arising from the spiritual and the scientific. This sense of conflict arose repeatedly in the different ways that participants described their fears and hopes for mindfulness as a therapeutic resource - not just for clients, but also as a resource for therapists themselves.

*um – I was always interested in going on a retreat ...I would be more likely to do it now than then and really embark on it and risk it – 'cos I think it felt quite – maybe a bit too full on to be finding out about. Um – and again if I was going to do a retreat that would be the sort of thing I would aim for – just silence on the whole – um – and just to imagine what that would be like and the risk is that – is that suddenly when you've just got your thoughts and they're – sort of having that social interaction and suddenly your mind might feel overwhelming. That's my fear, I guess.* (P5-45/50).

*... noticing things more I think and being more fully in touch with whatever the experience is and being more aware of not getting caught with judgement of it – staying with the experience whatever it is. I think that's helped enormously, being so – although my formal practice is variable – enormously – it's that – I s'pose in – it's more about that for us – that Jon Kabat-Zinn take in some of his stuff of being aware of, of, of yourself in any activity and are you fully there?* (P6-23).

In a dialectical process however, all participants also found ways in which their experiences of embodied mindfulness were able to inform their intellectual understandings of the tensions between spirituality and science, so that mindfulness was able to perform too an integrative function.

*... but I think there is a way that this can be taught in an entirely secular context and be just as helpful – and I was talking to somebody at this party I was at about this – about well, she was saying, but Buddhism has a much higher aim, which is enlightenment, and I said yeah, but how many people do you know who've got enlightened through practising meditation? You know, most of us actually do it to cope with life better, to be happier, more steady with difficulties – and, you know, that's what people get from the groups.* (P2-27).

*And I knew I was floundering and struggling – but I was able to sort of pin it down to that kind of basic Buddhist practice – of being, noticing, observing, watching, not trying to change things. So the relationship is changing, we didn't*

*have to search for evidence to refute – we didn't have to do those things. But what would happen if we could just be with what is?* (P1-14).

Spirituality was described in various ways by different participants, its common defining features emerging as a sense of embodied experience in the here-and-now of everyday living viewed as a process of being, rather than as a description of feelings that have previously been. "Being with" was a frequent term used to describe the experience of therapist as mindfulness practitioner, as well as the quality of presence with a client, and of the quality of awareness hoped for in clients themselves who are practising mindfulness. The words "being with" were often imbued with a sense of mysticism – a wondering out loud perhaps about how this process felt for another human being, when it held so much significance of meaning for the participants themselves.

*And that's, that's where I find mindfulness, coming back into the moment and not projecting into futures, I find mindfulness, um, practice helps me. That I will just you know, in the wee small hours of the morning when I just kind of make sure my* [spouse] *is still there, is still breathing, and if I can feel the terror rising then I think, eugh, come on, and come back into the joy of just appreciating* [spouse's] *warmth next to me, um – or stroking the cat on the settee or like I did yesterday, looking at the fabulous clouds scudding across the sky, they were just magic, absolutely magical and feeling cold you know – so it's a way of kind of bringing my – not ... I pay passing reference to the terror, but recognising that the terror is not about now, it's about the future – and that there will be time to have the*

*terror when the time is terrifying, and I don't need to, I don't need to add to it.* (P8-37).

This also intimated a common dilemma expressed by each participant, which was how to make best use therapeutically of something so deeply a part of how one makes sense of one's own being in the world. This dilemma presented itself in various guises: is one overstepping the bounds of a client's expectations regarding any particular therapeutic undertaking; is one too ready to share one's own experiences with a client when sensing a resonance of beingness in therapy; is one perhaps trying to encourage a client into taking on as their own the personal beliefs of the therapist?

*I don't feel it's my place to be encouraging them to you know, emit loving kindness to all living beings. I don't feel that would be an appropriate thing for me to do – I'm not sure I could exactly say to you why. But it wouldn't feel like it was within the parameters of what that person has kind of committed to working on with me, and it would feel like I was moving into things that were perhaps more about my personal beliefs rather than my professional practice.* (P4-59/60).

In turn, this awareness of the permeability between therapist and client gave rise to concerns about the role of empirical evidence in the practice of clinical psychology. Each participant expressed concerns about the extent to which published evidence gave a legitimacy and validity to their clinical work with mindfulness, and to what extent such evidence imposed limitations on individual innovation and personal

creativity in therapy. A pragmatic resolution was voiced by all, in which the limits of the published evidence were acknowledged as being too general to reflect the specific nature of individual therapeutic encounters. Evidence was valued as essential for the field to develop, and also to provide an empirical justification for the continued use of mindfulness within a publicly funded health service.

*So I think that kind of, we can get caught up in ideas of science and evidence-base, and yes we have to know what we're doing, we can't just go around – um – willy-nilly behaving with people and doing unto people because it seems like a nice idea today – I think we have to be consistent, we have to know about the literature. We have, as best we can, to know about the evidence-base, but we also have to be aware that it's pretty poor, a lot of the research just hasn't been done so we can't know what we can't know, and that there is an element of not being attached to our outcome that's really – I mean, it's quite scary, it's hard – but it seems to me that that's the – I mean I've ... I have a general hope that I can be of some help to people alongside them in their time of whatever it is, but I don't know that – no – so I hope I'm working from a position of duty-of-care, professional responsibility and compassion – and with some expertise and some knowledge of the literature. But who knows, who knows? Again, you know, you can look at literature generally and kind of ask clients what they think's made – what they think makes a difference to them and it's somebody to listen or whatever, and we come up with all sorts of high-flown ideas and theory ...* (P8-29/30)

Fears were expressed also regarding the secularisation of mindfulness by the scientific community in psychology, so that it risked becoming another objectified intellectual construct and a therapeutic technique. All participants described the value and importance of having engaged with mindfulness practice in their own lives over some time, and that this seemed necessary in order to be able to use mindfulness effectively with clients – they doubted that mindfulness would have such a meaningful impact on clients were it to be used as a therapeutic technique without this aspect of personal engagement by the therapist.

> *And kind of, just getting in my body that I really do believe in these things, and they're lived experiences of my clients – they're not something I'm applying out of a book. And I spent a long time in my life doing things that way, and always feeling this sense of a hole somewhere, you know, like a hollowness that wasn't – and noticing that sometimes there was something that happened where clients got better, but kind of having this sneaky but strong suspicion that it was having nothing to do with that stuff I was getting out of the books. So kind of scratching my head the whole time and feeling really confused. So it's been good to talk about it and get that, yeah, it's ... to really get that I – for me it really needs to be – what's working for me is through my own sensitivity – through my own mindfulness practice – is essential. And then moving from there out to the client, and having – yeah – just knocked around a lot with trying different things out with clients and checking what worked for this client and what didn't for that client, and it's a bit different with each client. But then I'm in a much better place about mindfulness of my own process – mindful of that. So our*

*conversation for me pulls out a belief in my own – yeah – in my own work on myself and with myself.* (P7-73/74)

*... in the same way as there are lots around who do CBT and what they've had is a an afternoon's training – um, saying that you do mindfulness – I mean, y'know – I've had, I s'pose it's now maybe seven or eight years of mindfulness and I still see myself as a real beginner and, I worry that there are people who, with really good intentions, are teaching clients mindfulness, or to meditate – um, but in very kind of, um, judgmental and prescriptive ways and ways that actually aren't anything about what would be useful really. So that worries me.* (P3-62).

Whilst an interest in the Buddhist roots of mindfulness was important to some participants, and five described Buddhism as a personal spiritual practice, all participants believed that mindfulness could be used in a solely secular framework and that it was compatible with other religious traditions. Participants all made clear distinctions between religious observances and spirituality. There was another dilemma that emerged – that having a personal Buddhist practice may encourage the transmission of such personal beliefs to a client when their experience of mindfulness resonated strongly with the participants' own.

*Um ... well, I mean I guess what I've, I've always said – er, I mean I feel in a slightly difficult position particularly now because I am Buddhist and I don't want to be pushing - I'm not pushing my religion. I mean, what I've said is that – they're techniques that have basically been nicked or borrowed from Buddhism and that they're taught in a completely secular, non-religious way – and that*

*although some people use mindfulness as part of a kind of spiritual path, um, plenty people don't and they, they just use it as a life-skill – um – and I also know that there are meditative – um – um – aspects to all religions including Christianity ...* (P3-16).

The sense of spirituality described by participants was clustered around aspects of non-duality, or at least recognising and exploring instances in their lives where duality created the most difficulties and was previously difficult to notice. This included for example, weakening attachment to the idea of a controlling and directing self existing independently within one, and cultivating an awareness of embodiment, so reducing the sense of separateness between private and public worlds. This in turn leads to shifts in personal meaning, and a growing familiarisation with the sense of insight into one's experiencing, so that troublesome processes of separation become clearer in a greater range of testing and stressful circumstances. This speaks to a further element, which is the sense of connection between self, others and the world.

*The essential qualities of mindfulness and mindfulness training*

The overarching theme that emerged from the analysis as intimated above, was that of non-duality as a core essence of mindfulness practice. Firstly, mindfulness is both a state and an activity – something that can be experienced in the moment without reflection: 'just being'. It is also the act of reflecting on what arises: 'being with'. Both of these aspects seem to occur indivisibly when practising mindfulness, and have within them the potential for cultivating greater compassion and insight. Although these latter qualities may not necessarily be part of mindfulness when first

practised, they seem to grow from its continued use and are grounded in a further essential quality of mindfulness – acceptance. This involves just noticing what arises in consciousness without becoming trapped in making evaluations of it. Inevitably evaluations take place, and conscious attention drifts away to other things, so that noticing this has happened, and being aware of having noticed, are at the core of mindfulness. This can be understood as acceptance in progress – the sense that 'this is what happens' – not only to oneself but also to others. Accepting 'this is so', and practising this process of awareness through mindfulness, can allow one to feel greater compassion for one's own difficulties and distress, seeing the process from which they arise as a universal human given. As the act of deliberate conscious attention to one's experience continues – mindfulness practice – so an understanding can be developed of how one habitually makes sense of the world from within one's own situation. Such understanding can be called 'insight' – an increased recognition and an expanded model of how the inner world of the individual interacts with the outer world of things and people. The learning that can arise from the repeated application of mindfulness involving compassion and insight, opens the way for an individual to experience relief from anguish and distress so that a new pattern of relating to experience emerges and can be identified as change.

*... to say it's just a set of skills it's like – if you could help someone get to the point where they can be with themselves in the face of things that they have felt great shame about for example – um – and be compassionate towards themselves, to be able to stay present in the face of those memories or whatever it is and find compassion – I mean you can say that's a skill and you don't have to talk about anything spiritual, but I'm not sure the word skill really does the full*

*kind of, um – y'know, justice to what they manage to do really, um – I mean I think, I think it can be quite a profound process without it being anything to do with religion or spirituality really.* (P3-20).

Mindfulness is then: an intentional act of noticing fully in the present moment one's experience of being in the world, without judgment. This is at the core of mindfulness, and provides a ground from which other aspects of being in the world may be beneficially cultivated. These include compassion for oneself and others, insight into the process of being, and how one makes meaning of experience. These can in turn lead to beneficial change for an individual and relief from anguish and distress.

A distinction emerged amongst participants as to what constituted mindfulness training. Some participants taught techniques of guided mindfulness meditation in small groups, encouraging reflective enquiry after a period of meditation. Others worked with individual clients using guided meditation techniques in-session, whilst others made use of short mindfulness-based exercises in-session that were not formal meditation practices. Two approaches were identified therefore as to the training of clients in using mindfulness: one is by formally taught mindfulness-based meditation practices; the other is by mindfulness-based experiential modelling. What is common across these two approaches is that some form of transmission of mindfulness practices takes place through social interaction, with a therapist providing some sort of example as a trusted and respected other. An intersubjective quality of trust and respect emerges strongly from the interviews as a critical element for the effective transmission of mindfulness-based practices. It seems that the

common meeting point for client and therapist in this endeavour arises from the therapist's own personal experiential encounter with mindfulness, and an open recognition of the common humanity shared between client and therapist.

> *I'm not coming into work basing what I do with people on a spiritual practice of mindfulness – embedded in Buddhism. I do come into work being very mindfully aware of my own struggle in life and just what it, what is the struggle of just being alive and being human, which y'know I'm aware of all the time, and I kind of feel an affinity I think, with people when we just strip away everything else, and just talk about our experience, my mind's the same. Our feelings are the same, our thoughts are the same – our experiences may be different usually in some big ways – I think my own practice in trying to be aware and be present and my own practice in sitting and observing the breath – I bring that into work all the time. And I'm quite happy to talk about that if it seems relevant – if people actually want to know.* (P1-54).

Mindfulness used clinically can perform a powerful integrative function in a number of different ways, centred on its core essence of "getting it". This refers to the sense expressed by all participants of seeing what mindfulness is about – of seeing for oneself in the context of one's private and unique personal experience how duality works in human consciousness. Put another way, having the experience that it is possible to be aware of objects presenting themselves to consciousness, whether these be external objects or internally generated ones, and to notice how these are processed internally to produce meaning. Putting this into words inevitably sounds clumsy, since it is an aspect of experiencing that defies verbal description. An

instance of the "felt sense" perhaps, as described by Gendlin (1997, p.67). Each participant described a sense of this "getting it" in their own mindfulness practice, and pointed to it also as an essential experience for clients practising mindfulness. The emerging sense from the descriptions was of something fleeting and in the moment – that it was neither good nor bad, just a recognition of how the process of awareness and meaning-making were linked at the point where object and subject come together. What seems to emerge from mindfulness practice is a series of "getting it" moments, each of which are contextually different and unique, but when identified together as a noticed ongoing process of being, provide the ground for beneficial change. Given the universal nature of this essential kernel of mindful experiencing, it appears that practitioners of mindfulness are able to come together over this aspect of it, almost regardless of therapeutic orientation or underlying theory of psychology.

In the context of using mindfulness clinically, the experiential nature of these "getting it" moments requires that the therapist has already a thorough grasp of what this is about in the context of their own being. Therapists also need to have explored this experience in depth through conversation, in order to have corresponding conversations with their clients about their experiences of mindfulness. It is only through taking the recognition of these moments of "getting it", and working with them therapeutically in some way that mindfulness can be integrated into a specific treatment approach. What the clinical use of mindfulness provides is a framework for making these acceptance-based aspects of experience explicitly part of the therapy in different ways, and in bringing the quality of the therapeutic interaction to the centre of clinical practice.

## Discussion

This study set out to explore in depth the rich experience of clinical psychologists using mindfulness training techniques in their practice of cognitive therapies, and to describe this phenomenon with reference to underlying theory and professional issues. The current evidence-base can be criticised for its bias in favour of an EST agenda and its predominantly objectivist epistemology (Mussell, 2007). Therefore, a phenomenological methodology was chosen in order to specifically address the experiences of everyday practitioners in the field, and to engage explicitly with the lived, experiential nature of therapeutic mindfulness practice amongst clinical psychologists.

Mindfulness can be used in cognitive therapies as a means of relieving distress and to find greater acceptance for one's pain and doubt, or it can be pursued outside therapy as a system of transpersonal spiritual discovery. Some therapists used it this way in their own lives, being careful to monitor the boundary between this and its use in therapy. All therapists using mindfulness clinically were persuaded initially by a beneficial experience of it in their own lives, and had been subsequently encouraged by published evidence, and the example of trusted and respected others. A meaningful and committed engagement with mindfulness practice was required of a therapist before seeking to use it with clients, and an open and authentic sharing of the therapist's experience with mindfulness helped to provide validation and encouragement for clients. Mindfulness practices in clinical work brought the quality and nature of interaction between therapist and client to centre-stage, and through promoting non-judgmental acceptance were able to initiate the cultivation of insight and compassion. Finally, change for clients took place within mindfulness-

based therapy approaches, although this was likely to occur as a result of first 'being with' experience, so that change was not the primary focus of mindfulness-based clinical work in cognitive behavioural approaches to therapy.

Describing the essential meanings emerging from this study identified, above all, the importance of personal awareness by clinicians of the processes taking place when using mindfulness in the professional context of therapeutic interventions. This was reflected in the following core themes: specific tensions and compatibilities arising from the use of mindfulness in a cognitive behavioural framework; issues associated with the person of the therapist and therapeutic interaction; issues associated with the particular professional responsibilities of clinical psychologists as scientist-practitioners.

*Clinical Implications and suggested future research*

For clinical psychologists new to mindfulness, personal involvement in mindfulness meditation prior to its use clinically emerged as very important. This practice should engage deeply with the context of one's personal self-development, preferably supported and guided by a trusted and experienced teacher, where conversations about what is experienced take place. Most practitioners saw this as a necessary precursor to using mindfulness in clinical work, although approaches such as DBT (Linehan, 1993), would suggest that experience of mindfulness can be acquired as one is training in therapy. DBT for example, explicitly makes mindfulness a part of its therapy team support meetings, whereas other approaches do not. Very little published evidence currently exists to guide one in deciding how much and what

type of prior experience is required. The two participants in this study with the least experience of personal mindfulness practice expressed the most doubts, concerns and uncertainty about their clinical uses of mindfulness. These included issues of how best to authentically deal with specific questions arising from clients as to the practices being taught, as well as issues of theoretical integration with their existing frameworks of knowledge, and not least about feelings of vulnerability and self-disclosure when focusing on the inter-subjective nature of moment-to-moment engagement with clients. In terms of research directions, further work is required to explore the adequacy of supervision processes and effective means of training in mindfulness approaches for psychologists and other professions who routinely deliver cognitive therapies. Of particular interest would be the greater potential emphasis on therapeutic interaction and self-exploration by the therapist, both of which arguably tend to receive limited attention in traditional CT training programmes.

By highlighting such 'common factors' in cognitive behavioural therapies, and stressing particularly the need for ongoing reflexive awareness of the process of therapeutic interaction, the clinical uses of mindfulness can act perhaps as an integrative agent in bringing closer together practitioners of disparate therapeutic orientations. As a way of promoting greater cross-disciplinary integration in my own work for example, I have initiated with other like-minded clinicians a mindfulness working-group to explore applications with children and young people. This group involves practising different forms of mindfulness meditation and exercises, and sharing personal experience of this within the group. Phenomenological ideas of analysing 'languaged' experience have proved very useful in more quickly exploring

deeper shared meanings emerging across different disciplines and therapeutic orientations. Mindfulness work and a commitment to transpersonal awareness in a broadly spiritual sense, can serve to facilitate also integration between mindfulness and trans-diagnostic approaches to psychopathology within a CT framework (Harvey, Watkins, Mansell, & Shafran, 2004), and there are opportunities here for research into precisely where acceptance, mindfulness and trans-diagnostic theories coalesce. In addition, the inherent part played in mindfulness by compassion should be noted, and recent research into "loving kindness" may benefit from joint consideration with mindfulness as facets of one richly complex meditative approach grounded in Buddhist teachings (Neff, 2003; Corcoran, 2007).

*Strengths and limitations of study*

The strengths of the phenomenological method adopted in this study were the frank and deeply reflective subjective accounts of experience as described by participants. This allowed the research to engage with the complexity of the actual practices of everyday clinical psychologists, thus producing valuable practice-based evidence that serves to illuminate gaps in the existing literature.

The extent to which the findings can be extrapolated are limited by the nature of the study, although the aim was to describe common experiences across a group that shared highly focused common characteristics. Therefore, it is assumed that the findings will resonate with readers' own experiences beyond that of the eight participants involved. In terms of the participants, they were all, apart from one, senior clinical psychologists and experienced therapists. The majority identified their personal spiritual practice as Buddhist-informed, and the majority had personal

meditation practices extending over several years prior to their first uses of mindfulness in a clinical setting. It is also possible that the characteristics of these participants share something in common that predisposed their beneficial engagement with meditative practices, and it should be noted also that each one volunteered to take part in this study. Knowing when enough analysis had been carried out was eased by the involvement of the research supervisor, who provided some essential triangulation in terms of quality and validity. Although the method followed proved to be extremely involving in terms of time and commitment to the sheer depth of reflection demanded in order to make sense of the considerable data collected, a more robust protocol for verification may have been achieved through the involvement of a co-researcher for example, or revisiting participants to share emerging findings.

*Conclusion*

From a broader perspective, the implications for future research into applied uses of mindfulness, are shaped by a need to occupy two epistemological spaces at the same time. Positivist empirical research in psychology overall has proved to be of immense benefit – its methods are well established and widely accepted; its findings can be easily disseminated and readily understood by many. Difficulties arise however, when adopting these methods for researching the specialist field of applied psychological therapies, in that much of what interests clinical psychologists is the subjective experience of clients and therapists and the interaction between these two. With its explicit focus on the inter-subjective nature of therapeutic engagement, mindfulness can perhaps help to bridge the gap between reductionist, abstract theories of psychopathology and the need to contextually enact these during therapy

with a client. Phenomenological research methods provide an opportunity to add to the shared scientific knowledge of these processes, through an extended focus on the ways in which meaning emerges from the praxis between theory and application – a focus on the processes through which duality is generated. Making sense of the world, and the clinical psychologist's engagement with it, should not be a process just of identifying and delineating objects. There is a need always to explore the 'how' of knowing as well as the 'what' of knowledge.

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## List of Appendices

APPENDIX I

# Webmail :: Dissertation: Ethics Application

**Date:** Thu, 22 Dec 2005 10:58:14 -0000
**From:** "Smith K.M." <K.M.Smith@soton.ac.uk>
**To:** dpm203@soton.ac.uk
**Cc:** l.rankin@soton.ac.uk
**Subject:** Ethics Application

Dear David

Re: Mindfulness meditation as used by clinical psychologists in cognitive therapy: An existential-phenomenological analysis of how such practitioners describe their experiences with special reference to underpinning theory and professional issues

The above titled application was approved by the School of Psychology Ethics Committee on 21 December 2005.

Should you require any further information, please do not hesitate in contacting me. Please quote reference CLIN/03/98.

Best wishes,

Kathryn

Miss Kathryn Smith
Secretary to the Ethics Committee
School of Psychology
University of Southampton
Highfield
Southampton SO17 1BJ
Tel: 023 8059 3995 Fax: 023 8059 2606
Email: kms@soton.ac.uk

Request for participation in a qualitative research study -

**Mindfulness meditation as used by clinical psychologists in cognitive therapy: An existential-phenomenological analysis of how such practitioners describe their experiences with special reference to underpinning theory and professional issues.**

Dear Colleague,

I am Xxxxx Xxxxxx, a final-year trainee clinical psychologist at Southampton University carrying out research for my doctoral dissertation. As a clinical psychologist who is likely to have used mindfulness meditation in the context of cognitive therapy, or who continues to use it, I am inviting you to participate in this qualitative study. My interest is in exploring the experience of practitioners, through the gathering of in-depth descriptions by interview lasting up to 90 minutes. I will be inviting you to reflect on your experience of deciding to first use mindfulness meditation clinically, your experience of its actual clinical use, as well as your experience of the professional issues involved in its use. Some reflection on your personal involvement with mindfulness practice and how your clinical and personal experiences have interacted will also be invited.

The interviews will be digitally audio-recorded, transcribed, and then analysed by myself using a Psychological Phenomenological framework to identify the most invariant common themes emerging across all the interviews conducted. The aim of this research is to help in expanding the research base in the clinical use of mindfulness and to highlight novel directions for future research in this area. I may contact you again to arrange another interview, within three months of the first interview, in order to further explore general themes that have emerged from the analysis at that stage. This second interview could last up to 60 minutes and would also be digitally recorded and transcribed. All recordings will be destroyed once the analysis is completed. Shortly following an interview, you will receive a copy of the interview transcript with a request to provide any further reflection or feedback in writing, that you may wish to contribute. Personal information will not be released to or viewed by anyone other than researchers involved in this project, and the results of this study will not include your name or any other identifying characteristics. I may decide to use specific quotations from interview transcripts, or written feedback, in the final writing-up of the research. Where this is the case, you would be approached again for your consent to the use of any such quotations. You would, of course, be free to discontinue your participation in the study at any time, if you so wished.

A wide definition of cognitive therapy is being set for the purposes of this study, so that any psychotherapeutic activity which predominantly involves a focus on the subjective misinterpretation of cognitions arising from physical sensations, memories, images, emotions, or behaviours, would be included. This would encompass any variant of cognitive-behaviour therapy or rational-emotive behaviour therapy (DBT, ACT, MBCT), anxiety management, or schema therapy, for example. It would include both individual therapy and group protocols where the practitioner is using mindfulness meditation in some way, having previously received some formal instruction in these techniques.

If you are interested in participating, please e-mail me at xxxxxx@xxxx.xx.xx, or telephone xxxxxxxxxx and leave a message if you have no access to e-mail. I would be grateful if you could respond to this communication as soon as possible, as I would like to arrange for initial interviews to take place during January 2006. I will contact you as quickly as I can once I have heard from you, in order to arrange a suitable time and place to meet locally. I will travel to see you. Please do not hesitate to contact me if you have any questions about the research, or about your appropriateness to participate.

Thank you for taking the time to read this.

Yours faithfully,
Xxxxx Xxxxxxx

Mindfulness meditation as used by clinical psychologists in cognitive therapy: An existential-phenomenological analysis of how such practitioners describe their experiences with special reference to underpinning theory and professional issues.

## Consent Form for Research Participants

**Information sheet**

I am Xxxx Xxxxx, a trainee clinical psychologist at Southampton University carrying out research for my doctoral dissertation. I am requesting your participation in a qualitative study regarding the therapeutic uses, by chartered clinical psychologists, of mindfulness meditation in cognitive therapy. This will involve an initial in-depth interview lasting some 90 minutes, which will be digitally audio-recorded and subsequently transcribed. You will be asked to describe your experiences of having used mindfulness meditation clinically within the context of cognitive therapy, either with groups or during individual session work. You will be invited to reflect on the process of deciding to first use mindfulness meditation clinically, your experience of its actual clinical use, as well as your experience of the professional issues involved in its use. Some reflection on your personal involvement with mindfulness practice and how your clinical and personal experiences have interacted will also be invited. Following the interview, I will send you a copy of the transcript and ask for any written reflections or commentary you may wish to further contribute. Within three months from the date of this consent form, I may contact you again to arrange a further interview, for which specific consent will be sought at that time. Personal information will not be released to or viewed by anyone other than researchers involved in this project. Results of this study will not include your name or any other identifying characteristics.

Your participation is voluntary and you may withdraw your participation at any time. If you have any questions please ask them now, or contact me, Xxxxx Xxxxxx, at xxxxxxxx@xxxx.xx.xx or telephone xxx xxxxxx and leave a message.

Signature Date

Name Xxxxxx Xxxxxx

---

*Statement of Consent*

I _____ have read the above informed consent form.

*[participants name]*

I understand that I may withdraw my consent and discontinue participation at any time without penalty or loss of benefit to myself. I understand that data collected as part of this research project will be treated confidentially, and that published results of this research project will maintain my confidentially. In signing this consent letter, I am not waiving my legal claims, rights, or remedies. A copy of this consent letter will be offered to me.

**(Circle Yes or No)**

| | | |
|---|---|---|
| I give consent to participate in the above study | Yes | No |
| I give consent to be digitally audio-recorded | Yes | No |
| I understand that all recordings will be destroyed after analysis | Yes | No |

Signature Date

**Name of participant**

I understand that if I have questions about my rights as a participant in this research, or if I eel that I have been placed at risk, I can contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ. *Phone: (023) 8059 3995.*

# Mindfulness meditation as used by clinical psychologists in cognitive therapy: An existential-phenomenological analysis of how such practitioners describe their experiences with special reference to underpinning theory and professional issues.

## *Debriefing Statement*

The aim of this research was to gather in-depth descriptions given by clinical psychologists of their experiences of using mindfulness meditation clinically in the context of cognitive therapy. It is expected that common themes within the area of study will emerge by analysing these descriptions using a Psychological Phenomenological framework. Your data will help inform our understanding of the theoretical compatibility of cognitive therapy and mindfulness meditation, as well as highlight some of the professional issues involved. This will help in expanding the research base and informing novel future research directions. Once again, results of this study will not include your name or any other identifying characteristics. You will shortly receive a copy of the interview transcript, and be invited to provide additional reflection or feedback in writing should you wish to do so. The research did not use deception. You may have a copy of this debriefing statement if you wish, as well as a summary of the research findings once the project is completed.

If you have any further questions, please contact me, Xxxxx Xxxxx, at xxxxx@xxxxx.xx.xx or telephone xxxx xxxxxxxx and leave a message.

**(Circle Yes or No)**

| | | |
|---|---|---|
| I would like a copy of this debriefing statement | Yes | No |
| I would like a summary of the research findings once the project is completed | Yes | No |

Thank you for your participation in this research.

Signature Date

Name of participant

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ. *Phone: (023) 8059 3995.*

## Reflexive Journal – 23/3/06 ①

### PI Analysis - First Reduction

- Almost complete
- finding it hard to be sure if achieving appropriate stance iro "reduction" - have feeling that just summarising participant's own words!
- Should I have clearer picture of 'boundaries for my reductive stance?
  i.e. relevant to framework of clinical psychology
  therapeutically informed
  theoretically linked to CT
  professional / personal interface
- Also not sure that have asked appropriate questions (or at least framed them in right way during i/v)
  i.e. unsure I have actually got participant to describe in detailed everyday terms their experience of using mindfulness meditation
  - seems that often describing opinion about mindfulness & CBT, rather than doing it / using it.
- But then I asked part. to reflect on theoretical underpinnings & professional issues, so maybe need to carry on & see what emerges in total. Some of the stuff in i/v will be more useful than other stuff.
- Also using focused meditation to help with free imaginative variation & reduction

RJ 1/4/08 ② - Note-taking on methodology (Fischer, 1990).

- How possible is it to "bracket" pre-existing personal knowledge of phenomenon under investigation?
(quote Merleau-Ponty (1945/1962 p. xv – p. 3).
- By asking Ps questions, already informed by own beliefs & shaping 'data given by Ps in particular ways.
- Because description uses language not really poss to surpass horizon of meaning constituted by culturally & historically bound perspectives.

→ need to be explicit about what steps taken to "bracket" how far this progressed what limitations were experienced, & how affected research process.

- Lit review could be seen as part of this process of reflection & is important to do this first & to document reflective analysis during its ~~creation~~ construction.

RJ 29/1/07 - Themes for P3 (P3-28)

- Reflections on methodology = 2 :
  - 1 is that as compare themes across diff participants in quick succession, similarities in meaning seem to be emerging even though each participant using quite diverse languaging

e.g. P7, P8 & P3
(A) Experiential validation vs verbal ack (C)
(C) "Faulty" thinking/wrong vs validatin/respect (A)
(C) Focused on outcomes vs being with (A)
Change vs acceptance
CT vs Mindfulness

→ change/acceptance emerging as dialectic or constant tension

  - Other is that need to list themes by participant & group/categorise within participant
  - Then list categories → themes for all participants & group/categorise again
  - Allocate each participant theme to superordinate category & check back to initial meaning-units to see all captured.
  - Then write individual reduction for ea participant
  - Then write overall reduction.

Res Mem - 1/4/06 - Notes on methodology (Giorgi, 1975)

- My study is of psychologists going about their everyday business of using mindfulness meditation in psychological therapy - so it is about the everyday experience of clinical psychologists (not people in general).
- Aim of ~~the~~ study is to set aside investigations in laboratory controlled or closed-system questionnaire settings & see how mindfulness meditation operates in everyday life of therapy use ~~s~~ by psychologists
- Important to examine experience of clinical psychologists ~~as~~ to inform in propaedeutical way what is meant by shared understanding within this group of therapeutic practitioners.

Research memo - 12/12/06
P4 Analysis - Reading the whole

page 5: P4 musing on spirituality in therapy & its appropriateness or otherwise

→ makes really important point about therapy which is to be clear about what client is coming for & not to transcend this without permission

→ Can bring in own experience of thpst when talking about process of mindfulness but seeking to explore 'spiritual' issues ~~also~~ may be more about personal beliefs of thpst rather than practising professionally.

Research memo - 18/2/07 (1)
Themes for P7 (P7-19)

- Looking at 'feeling into room' & using with client imaginal/emotional resources for exploring internalised aspects & present moment experience

→ P7 uses "modelling" of mindfulness as primary means of transmission?
  - guides client through awareness of bodily sensation linking with emotion & arousal by getting client to describe in imaginal language what notice in body
  - not naming for client necessarily

→ So not "this is mindfulness & how we do it" but more meeting w client in present moment & engaging directly w experience & remaining aware at many different levels of what is present - theirs, client & in room (what happening w client but outside of their awareness).

**Mindfulness meditation as used by clinical psychologists in cognitive therapy: An existential-phenomenological analysis of how such practitioners describe their experiences with special reference to underpinning theory and professional issues.**

## *Guiding framework for semi-structured interviews*

**Describe to me the first time that you used mindfulness meditation (MM) in your clinical practice:**

- How used/with whom?
- How used after this first time/with whom?
- Training for clinical use of MM?
- What has worked really well?
- What found difficult?

**Tell me about how you first decided to use it in clinically:**

- What found persuasive?
- Doubts/concerns/risks?
- Prior personal involvement with MM?
- Thoughts/feelings about evaluating usefulness of MM?

**How do you feel that using MM clinically has affected you:**

- Theoretical understanding of cognitive therapy/MM?
- Differences in therapeutic approach generally before/after MM clinical use?
- Professional development incl. supervision?
- Personal development?
- Aspects of spirituality?

DM: So it sounds like mindfulness as, er, an approach – a way of being with one's experience – can sit quite independently of CBT or a cognitive therapy approach ... and there must be many people who can practise cognitive therapy without ...

P1: ... introducing mindfulness? ... yeah, that's right.

DM: ... but I get the sense that for you those two would be quite hard er that it would be hard for you to do cognitive therapy without ... using that idea of mindfulness or at least having it as part of the way that you – think of the work yourself or think of the way that your experiences and – I think, no, I'm just guessing, but ... I mean, I wonder if, y'know ... so I'm just trying to pin down how ...

P1: ... no, no ... it's a good question ...

DM: ... how you put those two together for yourself?

P1: Yeah. Um ... I slip in and out of them very - easily. // Occasionally, I still get patients who are very uncomplicated – they slip through the net ... [*shared laughter*] ... and I end up seeing them – and – y'know, as you're talking and formulating you can see how standard CBT is just going to – run. And it does – and ... there's no particular reason? – er - to interfere with that by complicating it, by introducing other concepts. But more often than not I'm working with people for whom – bits of the CBT package may be helpful but some other bits of it won't run really //

(34)

(35) // But I think also for me – I'm forever questioning what the hell it is I do. Um, it's not just about personal self-doubt, it's more of a kind of an intellectual – curiosity – really. Um ... I can read the theory of why this is supposed to be happening, but – I don't buy the CBT explanation for why CBT works. I don't believe personally any more that challenging negative automatic thoughts is an essential part of an effective – therapy.

DM: Can we just sort of explore that a little bit more? ... was that... you said you didn't believe that any more. I mean, can you remember that actually being a belief that you had? It seemed like it was a really important, essential part of what you did as a cognitive therapist.

P1: Yeah – I was – yeah ... and I would get bogged down with people not getting it – um, they'd find different ways of approaching it, and getting people to accept the, the tedium of writing down negative automatic thoughts. And then taking them on to thought-challenging and so on. And, of course, that behaviour would be rewarded – and reinforced, by people "getting it" – seemingly - and starting to challenge thoughts and starting to make some progress. So the idea, oh yes it was important to do that – that's an important part of the process – and I don't know that I believe that now // I think – there's something else going on there. I ... it is about noticing, it is about stepping back – 'cos one way of stepping back from thoughts and feelings is to distance from them by writing them down. Moving them out there. Then you can look at them – and you make some re-appraisal if you like. Um ... but that may not be essential, it may just be the, the behavioural change – the behavioural experiments ... or just accepting exposure – or just getting them doing things and being more active – and being, being present with activity. So I'm open to all sorts of possibilities there. //

(36)

(37) // So there's the bog-standard mechanistic CBT – this leads to this leads to this and then – voila – you get this outcome. Don't really buy that – don't believe that – haven't believed that for a long time. Um ... I think had I not had anywhere else to go I would have – I don't know – I think I'd have moved away from CBT and – maybe trained in another therapy. A very different therapy – probably something disastrous, psychodynamic psychotherapy //..

DM: ...yes ... although ... *[shared laughter]* ... interestingly, schema therapy involves a lot of object-relations stuff, doesn't it? So I guess it kind of came in by the back door?

P1: It did, yeah, it did ... yeah ...

DM: But, I mean actually – a sort of slightly different question – but I wonder, did that shift your thinking as well ... or ..

P1: ... what, the schema, the shema-focused therapy?

DM: Well – yeah. 'Cos it sounds like, if I've understood it, y'know, what you've discovered was that were limits for the people that you could help with this sort of standard approach to CBT and that - you were

searching for something … else - to do what? Yeah, that's - maybe that's the question I'm asking – what, what did you feel as the inadequacy with that approach for the people for whom it wasn't working – what felt like – what did you feel you needed more of, or to do something different?

(38)

P1: Well, some, some of the difficulties people had were just so fundamental – people who were saying they couldn't catch their thoughts. Or they weren't noticing any particular negative automatic thoughts – or they were noticing too many and didn't know which ones were worth writing down. And there's always a fairly lame construction – well, just notice the most upsetting ones and this kind of idea. But always wondering – y'know, why is this about?

(39)

Um … So there was a lot of that// And then of course - the other side is, people who do write them down, have caught them, who have challenged them – show no emotional change. Um … or no real belief change. Er … and those are the more complex presentations – your query personality disorder, whatever. Having almost what felt like a kind of wilful … difficulty with challenging negative automatic thoughts about themselves or others … it's just like ... almost … I just bloody well won't! *[laughing]*

DM: I just won't do it! *[laughing]*

(40)

P1: I'm just not going to shift my beliefs! *[laughing]* So, er … yeah. I think some of that had obviously a big part to play in – sort of, y'know – diminishing returns really – kind of, put in all that work, and for – quite a lot of people it's not really … doing the business// Schema-focused therapy I have - y'know, I think it's interesting stuff – I find it very interesting from a formulation point of view … I, I think it borrows in terms of its change methods very heavily from traditional CBT.

(41)

There is some experiential stuff and there is some visual-imagery stuff and so on and so forth, but … so, I think it's – I'm not, I'm not wildly convinced by schema-focused therapy as a bog – as a therapy in its own right for bringing about change and we still lack the evidence for it from that point of view. Um// Dialectical Behaviour Therapy … a bit like schema therapy in that it's a pot-pourri … of – methods and approaches. I did sit down boringly and try and tot up all – all the number of different interventions – the components within DBT – and it came – I gave up over 350, 360 different elements of DBT … I mean, thinking what, what is it that works here? Y'know, and, um … I don't know how you factor-analyse all that lot. But the, there's self-harm diaries … and doing what works … interpersonal effectiveness scales … mindfulness scales … y'know, it just goes on – which bit of this is bringing about beneficial change for people? I don't know. I really don't know//

(42)

DM: Is it possible to know, though, from any therapy that you do, what creates …

P1: Only - I guess, only if you are able to do a dismantling study … and actually play around with what are thought to be, be the key ingredients … add them and take them away and see what happens … there are huge researches to be done there … but, um … I think, y'know// my own experience of, of individual DBT and running a group – DBT group – of doing mindfulness in a group … um … taught me that, er - well … taught me lots of things one thing it taught me is how very, very difficult it was to get people with severe, er, emotional dysregulation problems to acquire mindfulness in a group setting. Um … and also then individually how difficult it was to get people to really commit to practising mindfulness in their daily lives, er ..//

(43)

DM. Because, I mean again correct me if I'm wrong, but in DBT it's just sort of an essential component of the whole approach?

P1: (44) //It is. But the amount of, the amount of, er, mindfulness practice that's required of people isn't stipulated anywhere within DBT. It isn't, y'know, oh well, there must be a commitment to practise half an hour a day, or whatever … so, some people – and, y'know, I, er … there's nothing surprising about it – some people get into the practice and then quickly realise it's just another way of, y'know – not being present. So they don't actually practise mindfulness – they practise some form of relaxation – which leads into dissociation, and y'know, report doing lots of it. And others who can barely sit still and be present for more than a few moments without feeling quite – anxious// So, er … but I think – I think there's a kind of meta-message that's getting across, and it's y'know, as we were talking about earlier, it's this idea of, of distancing – of stepping back … and looking at how things are in very real ways – as real as you can make it really. Um … and being with what is. The way things really are, which is a huge challenge for all of us//

(45)

DM: Yeah. I was just thinking – I was reading David Smail the other day – and he was talking about, y'know, the limits of effectiveness of therapy, as he does … and, and he was talking about the freedom of people to change, and that, y'know, often, if you're, y'know, if you're fortunate you might get very intelligent, able

P1: (57) // … I'm in the third wave. And I … but I still remember how to do second wave. And, um … sometimes, as I was saying, there are people who – just are so … y'know, the work we're doing is so productive within that, we don't need to go any further really. And – and that's great. Um … but I, I think if – if you listen to my tapes of me doing that, I think there are ideas creeping in that are not strictly CBT. You know – a much heavier emphasis on defusion.

DM: And I guess that's unavoidable in any kind of therapeutic approach that, your practice will evolve inevitably and –

P1: - God – hope so! –

DM: - and does it, y'know, is it important that it remains within, or under, an identifiable kind of, an umbrella … of approaches …?

P1: (58) // Hmm … it might be important. You see, that's the thing – it might just be important. I think there is evidence – um … that I don't like to think about too much really… but I know it's there in the literature saying that, y'know, the more you adhere to a manualised approach, and the less of you there is in it … the more effective you are as a therapist. Um, which is a bit of a bummer really … [*shared laughter*] … but I think that evidence is there y'know. And, um … it's been done – in fact, that evidence has been generated within CBT, saying that, y'know, you get people to do CBT for depression, panic whatever … the more you bring in yourself and your ideas, your way of doing it, the less effective you're going to be // Um … but, I reconcile it all with the fact that, y'know, in the Health Service these days psychologists are not working with, that many people for whom those manualised approaches would be helpful // Um, begs the question who is working with them, and I guess the reality in [names local area] as I know it is that there aren't many people getting the therapy they need. Um, unless they happen to be in secondary care – and even then it's scarce, but in primary care there is almost nothing … apart from practice counselling, and Graduate Mental Health Workers – that's it. (59)

DM: Ok. Um … so, in terms of the way that you've used mindfulness, and the way that it's kind of shaped and influenced the work that you do with clients, how does kind of, receiving supervision for your practice fit in with that – is it – have you found it necessary that you worked with someone who supervises you that also has a mindfulness practice, or not – or … what's your experience of that?

P1: (60) // Yeah. Well … um … yeah, the person I have my monthly supervision with is also interested in these ideas, so that's been really helpful and also going to ACT monthly supervision is helpful, keeps the ideas alive … erm, yeah – absolutely, um – but it's about interest really – what it – tends to be less about how do you think we could go with this from a mindful perspective, but more about, more about reporting – how it is really. Er //.

DM: Can you say a bit more about that?

P1: Yeah. Um, what it feels like to be there. In a, in a session …

DM: As a therapist what - it feels like to be in a particular situation with a client?

P1: (61) // Yeah … because, I – it's a bit like being the concept of the internal supervisor.

Well – that's a very interesting concept. Because, part of it is about being aware of what you're doing. Um … and sometimes the internal supervisor's kind of there in the background and you need to remember to bring it forward again. And my internal supervisor will then want to know, why on earth are you asking these questions – what is it I am paying attention to here – what am I getting drawn into here – what am I reacting to here – you know, what is going on – so, that kind of on-line, real-time, mindfulness – you know … awareness – But then in supervision, kind of reporting that, and then – but then, also talking about the - practical aspects of the work I'm doing with somebody and getting them to – maybe consider things more mindfully … be more aware of … um … yeah … yeah //

DM: And in terms of … meditation – mindfulness meditation … is that something that you feel it's important to practise yourself with other people, or you have a personal practice, or … you had a practice in the past, but now it feels like it's been more integrated into everyday work? Or - I'm just wondering how that … works out?

P1: // I think it's – I think it is important to have personal experience of mindfulness practice. I think it's, um … (62) I think it's essential actually, if you're going to use these ideas – and have some real sense of what they

P2: Yes… yes … I mean, I'm not sure in a way that they link either, because they're still not – they're not the same as, say acceptance-based work, because you're still trying to change things but, um … yeah, I don't really think I've sat down and thought theoretically how - why mindfulness might be a therapeutically useful tool in relation to the other things I had done, really – it was more the fact that I just found it so helpful and transformative myself, and … I had always slightly struggled with the fact that I found – y'know, even before I did mindfulness – I always found meditation and dharma-practice very helpful, but it felt like, well it's irrelevant to clinical work because, you know, you can't start teaching people Buddhism – I think I was practising in a more religious context … and there didn't seem any way that I could offer this to clients, but it sometimes made me feel that I wasn't offering them things that I felt were really helpful.

DM: … it's like you've kind of got this thing which you know – you sort of feel is really useful …

P2: … yeah, but it's not in the therapeutic tool-box so I can only – and, y'know, I always felt that a lot of this, um, cognitive therapy work particularly was very close to dharma – very much about how we create our worlds – the same with narrative approaches, solution-focused approaches. This idea that we, in a sense our thoughts or our mental states or the stories we tell ourselves, have a huge influence on our experience and on our emotions. So there was always that strong overlap – um, but that was more, um … that wasn't so much about a particular technique, that was more about the general philosophy, so … it just felt like this might be a way that I could really bring those two sides of my life together – if it was helpful, and er, possibly the reason I then went off and did quite a lot of training before I tried it out, as it were, was because I still felt slightly like, y'know, am I doing this to please me or am I doing it because it will be useful for people?

DM: So there was that kind of sense of conflict there, or uncertainty about …?

P2: Yeah, a little bit, yeah … um, y'know years and years ago I'd met some born-again Christians that were psychologists, and um, really felt they wanted to convert their clients to Jesus because they thought that would be more helpful, and I don't really want to become a "born-again Buddhist" [*shared laughter*] … and I did have a supervisor for a while who was a little bit suspicious of, you know this is from Buddhism and you can't go teaching that to people – um – I mean I actually think that mindfulness-based work is incredibly secular, and one of the things that John Kabat-Zinn and other people have really managed to do is distil the essence of what's effective and separate it from any kind of religious context, but it takes a while to really get your head around that I think, for me.

DM: So, if they've separated it from some of its religious background, has that also taken away some of its spiritual nature – is there a difference between the spiritual kind of nature of mindfulness work and the religious context of Buddhism?

P2: Um … I'm not sure – I mean, certainly that's something that I think some Buddhist teachers are a bit suspicious of – this kind of "dharma-lite" – um … I'm not sure that it is – I'm not really sure Buddhism was ever meant to be a religion – you know, the Buddha just taught some basic ways of dealing with suffering – overcoming suffering – um, though non-grasping and mindfulness and awareness – and then it became a world-religion, so now it's got lots of bells and smells and chanting and all the things religions have … um, I think it's probably – er, I'm not entirely sure about this – but I think there is a way that this can be taught in an entirely secular context and be just as helpful – and I was talking to somebody at lunchtime - at this party I was at about this – about well, she was saying, but Buddhism has a much higher aim, which is enlightenment, and I said yeah, but how many people do you know who've got enlightened through practising meditation? You know, most of us actually do it to cope with life better, to be happier, more steady with difficulties – and, you know, that's what people get from the groups – and, and – my sense is that the combination of mindfulness meditation and some very basic cognitive therapy tools is a very strong, very powerful combination and that some people who've been meditating for years could actually really benefit from some of the more cognitive aspects actually, which you wouldn't necessarily learn, but –

DM: That sounds very interesting … would you care to say a bit more about which cognitive therapy aspects …

P2: Well, yeah, we – in the programme there's a little bit about monitoring thoughts that underlie depressed and anxious feelings and how to modify them, um – there's also some –.

DM: … sorry, can I just stop you there. So, the modifying bit, how does that work in the context of …

P2: ... um, I'm just trying to think actually – I should have the book with me, um ... it's more about really seeing that thoughts are not the truth – that's the key thing, it's about noticing thoughts and noticing if they are the kind of thoughts that might tip you into very negative mood – anxiety, depression – and seeing if they can just be observed as they're just thoughts but not facts – they're not true. Um, even y'know, some of the ones - there's a phrase in the book "thoughts aren't facts – even the ones that say they are" – even like really compelling self-views – there's also quite a strong emphasis in the whole course on not judging yourself, not giving yourself a hard time for not being able to do the practices, et cetera – which I think also challenges a lot of habitual, um, tendencies that people often have in their thinking ...um ... so, just that sort of emphasis on catching thoughts and – um, can't quite ... there's various bits of self-monitoring that you do, but it's mostly monitoring pleasant and unpleasant events and again that includes looking at what thoughts were going through your mind at the time and what thoughts are going through your mind now as you write this down, until sometimes people realise that something at the time they thought was a catastrophe, as they write it down later they think, well actually it all worked out in the end, it wasn't such a big deal – um, and also monitoring pleasant events tends to make people more aware of tiny little things that give them pleasure that they might easily miss. Um, so just all those things that help people to pay attention a bit more to their thoughts and their feelings - and are more implicit if, if you learn mindfulness on vipassana retreats – those things aren't homed in on quite so, um, so deliberately if you like ...um, so I think that's what I mean really. I mean in the Mindfulness-Based Cognitive Therapy as it's practised for people who've been depressed there's more emphasis on, on working with negative thoughts, um ... the other thing that's included in that, that whole course is what they call the three-minute breathing-space ... which most, is what most people in the group find in, some ways, the most helpful thing - and again you could meditate for years and never come across that - and you might ...

DM: ... refresh my memory ...?

P2: Um – basically the three-minute breathing space they encourage people to do – first, first you just practise doing it three or four - two - I think three times a day – and then you start to apply it under stress – and it's basically just acknowledging whatever's going on in the body and mind – then coming back to the breath, gathering your attention on the breath and then expanding out again to the body and the area just around the body, so that if there is some painful emotion or physical tension – it's – by the end of the three-minute breathing space it's got a slightly bigger perspective around it really ... so, say you've got some anxiety you just acknowledge what's going on, come back to the breath and then broaden out again. And it's kind of a way of stopping and having a – well literally a breathing-space – um, so people have used it – one of my clients said that she'd used it before a meeting where she knew – she was chairing the meeting – she knew that there would be quite a difficult meeting – and so everybody else thought she was just shuffling her papers and getting ready, y'know, but actually she was, she was just going through this little process ... and, er, it's a really nice bridge I think from formal meditation practice to everyday life, which isn't a standard Buddhist teaching at all – they made it up ...

DM: Yes, ok ...so that is very practical – it brings it into the realm of people's everyday living and it is, y'know, a useful tool that they can do something with – I think it's almost like exposure work – y'know it's that sense of – staying with the feeling ...

P2: Yeah – it's interesting – I mean in some ways possibly from a theoretical point of view some of what we're doing is maybe closer to exposure as an – certainly techniques that are based on distraction and, um ... yeah. I mean the cognitive therapy part of MBCT, even I think as it's practised for people with depression, is not that big – it's, it's probably a bit of a misnomer Mindfulness-Based Cognitive Therapy

DM: Yes – it, it leaves out more than it includes ...

P2: ... it makes it very socially acceptable, y'know ...it's, it's.

DM: ... yeah, I mean you know, Teasdale's very clear about that – he certainly sets it out very clearly and says which bits ...

P2: ... and how they developed it ...

DM: Yes - and it is all about the decentring and specifically not about challenging reality ...

P2: And they certainly started by just tagging a little bit of mindfulness onto CBT and found that that wasn't really very effective, so ... um ...yeah.

um – and I guess inevitably that will happen eventually, but it become a bit like cognitive therapy – you don't have to have done a postgraduate year's course, but more and more people now do, um .../

DM: I was just thinking about that – about how cognitive therapy first started and then – I was just reading some research the other day about, y'know, if you used CBT in a manualised approach often the results are "better" than if you change bits and bring yourself into it but, y'know, I don't know who it's – which clinical group is it "better" with – y'know, and all those things which are research-based evidence about effectiveness are so tightly bound it's very hard to turn that into something that you can use every day – you have to rely on making decisions in the moment and with different people I think ...

P2: ... and clinical trials are so often based on a very hand-picked group of subjects who fit the criteria of your trial – y'know, ordinary clinical work's not really like that ./.

DM: ... yeah, I think so 'cos MBCT says about it works well with people who've had at least three episodes but not so well with people who've had less ...

P2: Yeah. Yeah. They are currently, as you probably know, Willem Kuyken is doing a study to try and replicate that in an ordinary clinical setting. Um ... so, where were we?

DM: We got there by - we were – I was asking you to think about how other professionals outside of psychology but associated with your work, kind of knew what you were doing, and then we looked at other sorts of therapists more generally coming to mindfulness as a result of each therapeutic ...

P2: I mean one of the things that's, that's kind of relevant is, in the States because MBSR started in general medicine and a lot of people who worked with Kabat-Zinn worked in pain management or heart-disease or whatever, a lot of the programmes in the States are in acute medical settings. In this country the main influences have been John Teasdale's work and Mindfulness-Based Cognitive Therapy and also DBT which is quite big in America as well but – so in this country mindfulness-based therapy work is more known about I think in mental-health services. So there's a bit of a transatlantic difference there I think. Perhaps both in the States, but here it's very much mental health/ so what I find is that nobody's heard of it at [*names local general hospital*] basically – I mean my manager has – psychologists have, but – so, um ... I mean, for example, I had a leaflet advertising the group and I had to go to a hospital committee to test whether it was readable or not and it was very clear from their comments that they had never heard of this and they thought it was really weird and so – I had to fairly politely say that, y'know, the fact that they didn't know about this shouldn't really be affecting their comments on the leaflet and I couldn't write a – I mean one of the comments was I shouldn't use jargon terms like mindfulness – so I said well, it would be like trying to describe CBT without mentioning the word cognitive. And I was quite surprised in a way – I shouldn't have been, but I thought God! you know, poor things, why would they know about it – so I think it's still pretty fringe in Health Psychology, maybe more than in mental health. And of course John Teasdale's work has done a great deal for it to become credible.//

DM: Yeah – yeah ... I think, y'know, because it's fully within the realm of cognitive therapy ...

P2: Yeah – and because he's so respected. People've been reading papers by him on depression for years ...

DM: ... yeah - even if you can't really work out what ICS is all about some of the time ...ok ... so, we're doing well.

P2: Are we?

DM: I just wondered whether we might change tack altogether and one of the areas that I am interested in as well is how these things go along in terms of supervision ... and what's your experience, your feeling about the importance of being supervised in this work and how important it is to be supervised by someone who may have a background or experience of doing this type of work as well. I mean I don't how that has worked out for you?

P2: Well, it's not been that straightforward obviously – because it's so new. What we have here is a local kind of peer group which myself, a friend and a colleague set up, er – and we meet every six weeks or two months or so and, um, there's just a handful of us who have been doing mindfulness-based groups of one kind or another – most of them in mental health. So that's a place where we take issues that arise, like y'know, my whole question about changing the format of the group or how to work on the enquiry – various problems that have come up/ Um – it hasn't entirely worked – um – and that's because as soon as you do something like this what happens is that people who've got an interest want to come and, y'know,

that – each time you go round your iterative spiral, it's still mindfulness but at different levels ... so it's that sense in which it's completely interwoven – an experiential as well as an intellectual concept that you can explain to someone in words. So I guess that's just part of what I'm trying to reflect in my research by asking practitioners about their experiences, is just to – to find out exactly how people are responding to that and how as a practitioner you work with that interface, when it's something which is so deeply part of your own personal experience at the same time. I guess it's that - the issue that I'm interested in is that aspect of the interface, and I suppose if I'm hearing you then, if you're – for many therapists when they're doing therapy well, that sense is with you anyway.

P4: (81) That's how I experience it yeah. If for example, one were a devout Christian or a Jew or a Muslim, I'm sure there would be a lot of occasions in therapy where what somebody was saying would connect with the kind of personal belief. So I feel everybody in their own ways is ... I think we're always having to kind of monitor our reactions, yeah.

DM: So I guess that actually ties me into another aspect of what I'm asking participants, is how we get on with people who are coming to this new, for the first time perhaps. And, you know, there's a suggestion in the literature that you need to have established a mindfulness practice of your own before you can use it clinically perhaps. And how that – and how you feel about that as someone who's very experienced and might be training other people professionally to use mindfulness?

P4: (82) Yeah, I mean – I think what I can sort of share with colleagues, is I do have, probably relative to other people, I have a lot of experience of introducing mindfulness [redacted]. And we've adapted in lots of ways how that's done and I feel very happy to talk to people about that (83) I think in terms of, um ... other people then choosing to kind of run mindfulness programmes – I mean it's, there's the beginnings (84) of a good industry already, you know, about – I have this huge thing about you know, nobody owns anything we've talked about today, nobody owns it (85) But clearly there are packages for delivering mindfulness alongside other things and I guess if somebody's gone down that route and they've kind of met whatever criteria those people have for running MBCT or MBSR or DBT, it's got nothing to do with (86) me really If people wanted to work with me then I would certainly, and have done – yeah, if we can get practical, I mean there was a woman did a Master's on mindfulness. She was really keen to run a group for people with early intervention mindfulness, so she took up the practice and she would probably have been meditating daily for a year and she came to one of the groups we ran here teaching people, and I supervised her throughout and that felt ok. But that was also something about her – she was at that point somebody who had many years work experience, family, she was just a kind of very rounded human being really, (87) took a lot of responsibility for herself So yeah, I certainly wouldn't ... I don't see how somebody could do that – I think if somebody doesn't really have solid experience themselves, I do not see how they could introduce someone to mindfulness, because ... I don't think they would introduce it in a way that did justice to it, I don't see how they would cope with difficulties that people encountered (88) I think mindfulness is a really interesting thing – it's like, at one level people say it's so simple, what I'm doing is to sit, close my eyes and become aware of what's happening, but I think the reality is that it's also very, very complex. I think it's a deeply complex thing and I've spent a lot of time thinking about it and practising it and I still find it challenging, I find it conceptually slippery – I kind of think I've got a handle on it and then it's gone again. So I think one's really got to engage with that process for a bit before introducing people to it yeah (89) And I will reflect on this interface with Buddhism because I do feel that it's not something I've really articulated. The interesting thing is I feel comfortable in my practice when I'm working with clients, yeah, it isn't – I'm not running up against a problem. So I think that in work with clients it's ok, but what I think I haven't done is kind of articulated - probably all those implicit decisions that take place about what I bring in and what I don't – I don't for a moment think that's right and it's what somebody else should be doing, but I guess it feels right for me because I'm not – I'm not tripping over things, I'm not tying myself in knots, I'm not feeling gagged – all the kinds of things that might be happening with clients if there was an issue and they're not

DM: Yeah. And for you as a practitioner have you been able to find sort of supervision for yourself from other people and how important has that been ... how important do you feel is it you get supervision from someone who has an experience with mindfulness themselves?

P4: (90) That's really interesting – I don't think I get supervision (91) .. but I – I learned mindfulness – I learned meditation, I mean I think that even for me is quite important – it's a meditation – I learned meditation at meditation centres, and at different times I spent four years kind of doing what you would call formal study (92) of kind of meditation and Buddhist psychology, and Buddhism – so what feels important to me is that I am connected with people – meditation teachers. I wouldn't ever talk – I've never talked to one as far as I can (93) remember now about a case But in terms of the mindfulness component it's been incredibly helpful to kind of to be on study programmes, to go to meditation centres, to talk about my difficulties because my

difficulties are my client's difficulties. In seven years my observations are that their struggles are the same as my struggles with mindfulness – not with mindfulness but with our experience// So I think that's really important yeah, and I almost feel – it probably does touch on your question about this kind of interface of Buddhism and psychology – you know, I don't feel I – if you want to understand about compassion I wouldn't come to me personally. I think there's people who've written about it and practised it and thought about it a lot more deeply. So I think what's important is going to somebody who has experience and wisdom in the area you need it, and if it's the meditation I don't think it needs to be a supervision sort of thing, yeah. A sitting group, meditation centres - served me very well// (94)

(95) // Just one other thing – I don't particularly have an answer on this – I mean my thinking changes, but I think one other issue that feels really important to sit with is you know – people put it in – I've often heard it expressed in Buddhist terms – is mindfulness Dharma-lite? Is it lacking things? And my experience is that – no it's not, it's all there. If you really understand the invitation with mindfulness it's all there// but to me it's a question of do we have to draw it all out and make it all explicit – like the compassion for example for all living beings. It's kind of implicit in there if we're accepting all experience, we're not judging ourselves, we're not judging others, we all suffer and we don't want to. I don't feel it's my job to be drawing all these things out, but they're kind of clearly in there// But I have a lot of – you know in my work generally, I have a lot of confidence in clients really, you know that they can, they can take things forward if they want to and in their own way really – around the edges – I very much stick to distress, working with people to alleviate distress to promote emotional well-being. Yeah, that's probably quite important to say – I don't know if I've quite expressed it – that's the, I guess that's the thing I come back to that probably helps to define my kind of scope// (96)

DM: Great, that's really helpful. I'm only looking doubtful because I thought my question had kind of escaped for a minute, um ... ok, it was when you were talking about the other aspects of mindfulness being implicit within it and then from within the sort of psychology field if you like there seems to be a great effort to kind of try and identify it as a construct – a psychological construct which can be measured. How useful is it to actually measure something called mindfulness or are we just measuring some aspect or some production of mindfulness?

P4: (97a) // Yeah. I personally think it's very important to engage with this question of how do we measure mindfulness// You know, it's quite interesting as an academic clinical psychologist to look at the, to look at the impact mindfulness interventions that have been published have had. And what's clear is there's some kind of zeitgeist – there's some real energy for what mindfulness brings that means that really its take-up has exceeded the evidence-base I think. So, for example, if you look at the key early studies they were not measuring mindfulness, so one can find that relapse rate in people who have had experiences of depression is significantly lower, but there's no demonstration that that's anything to do with mindfulness – because they haven't even measured mindfulness// So I think, I think it's too easy for us to say it's a complex or impossible to measure concept, let's just not try. I think – it's almost a bit like I was saying earlier, we can – I think there's a danger that people will start to be almost promoting Buddhism through their practice, I think there's an opposite danger that psychology will throw away our way of doing things, say in CBT for example. I think it's important to say if we believe there's a mechanism here that is helping people stay well, helping people let go of depression, I think it's important to engage with the question of how can we measure that// What we've done in our work for example is, um, tried to just be very specific on the measurement question and say we're not in any way trying to measure this vast kind of concept of mindfulness meditation – what we're interested in measuring is specific aspects of somebody's relationship, say, with [redacted] so .... To what degree is somebody able to [redacted] without reacting – to what degree is somebody able to experience an image and really turn towards it. To what degree is somebody able to not ruminate [redacted] not spend ten or fifteen minutes working out how that fits in with their overall belief system. Are they able to just experience the kind of sense that [redacted] – are they ever able to experience that and note it and let it be// I think at that level it's quite possible to begin to think about how to measure mindfulness and we're kind of underway with that, but I'm not for a moment am I thinking that that is tapping into all aspects of mindfulness or even from a psychological point of view I'm not thinking that it does that narrow bit really well, but I think it's good to start// I think it's good to remember that we are employed – you know, we are paid by the taxpayers, we have a responsibility I think to try and reflect and monitor and evaluate the work that we do – any work that we do// But it's fundamentally very exciting – very exciting to have, you know – I guess that's something else I haven't said actually is that what's really nice is that – if it were the case that – I don't how this could be the case, but imagine it were the case that someone was telling you that you just cannot ever use mindfulness meditation at work – some body has decided somewhere that it's a religious practice, you can't do it in the NHS. It would be very frustrating to feel that something that one knows can be helpful and conceptually ties in can't be used. So to me we're in the really good position of working with the integration and that feels really good.//

(97b) (98) (99) (100) (101) (102)

DM: Yeah, great.

P4: 'Cos I guess most people probably go through that – it's right back to your question about when you first start using it, probably most of us think, well – 'cos when I first starting using it I wasn't aware of Kabat-Zinn, and, um, MBCT had not been published, so it wasn't like I could go somewhere and be … you know, sort of … I didn't have an evidence-base or something I could go to, but it just felt like it was the right thing to do, yeah. *[laughs]* I do go back then to it's really important to try and evaluate it, because it might have been the wrong thing to do//

DM: So an allied question to that I guess is – as we start to wrap up maybe – is something I've asked all the people that I've seen is – in your reading of the literature and understanding of the evidence, and you may have alluded to this already, but is there anything you feel is missing from the literature, anything you feel is important and that somehow we've overlooked so far?

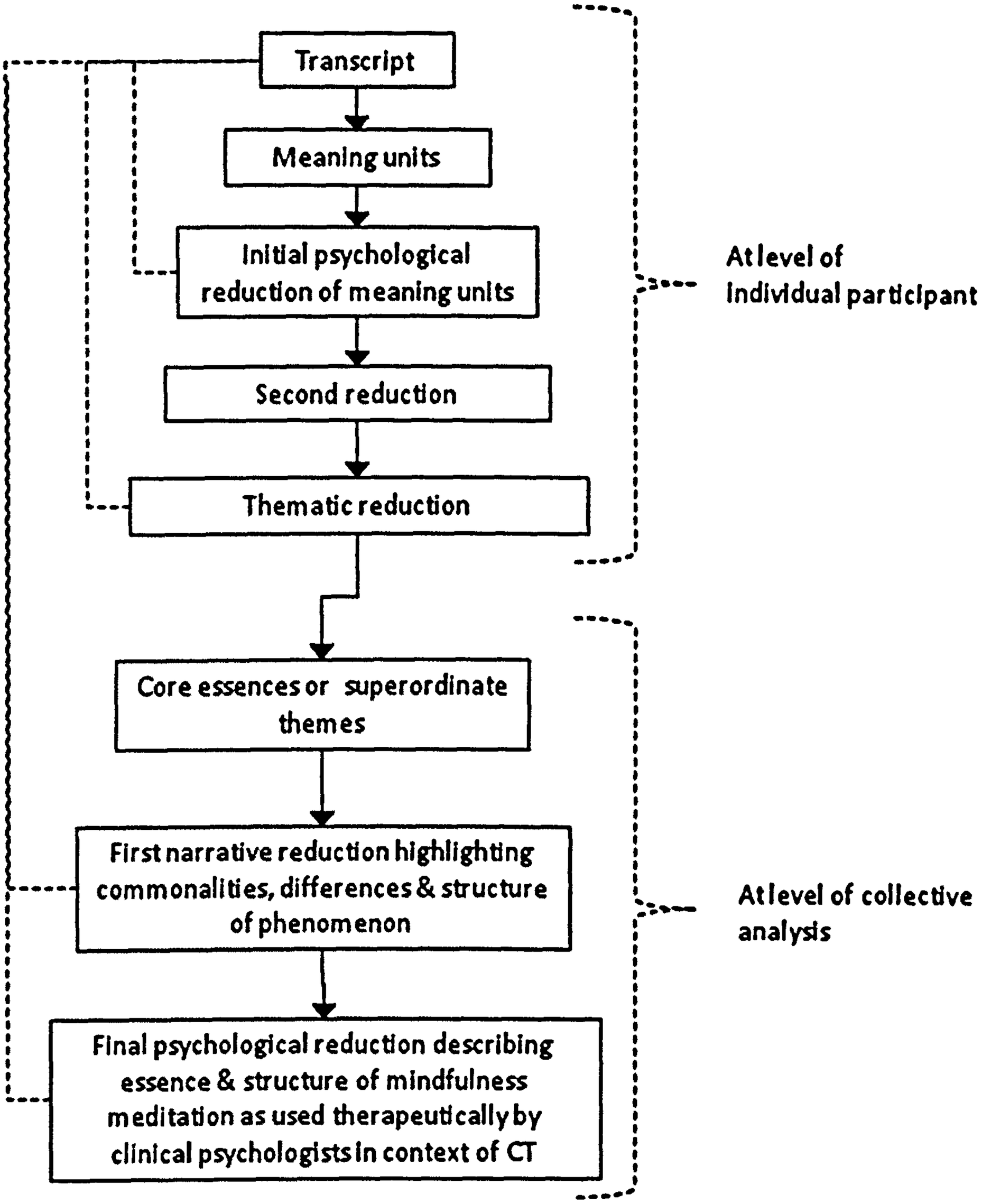
P4: Well – I think what your research taps into one area which is that I think there needs to be more exploration of the interface between mindfulness and Buddhism. I'm quite struck that where some people are very open – that they are Buddhist, that they may go to meditation centres, some people in the mindfulness field, others are almost quite reserved about that. So I think that is one really important area – it's something I will reflect on after today// And I think – I do feel that the integration question is still ongoing. I think just sitting the two beside each other is not integration – cognitive therapy and mindfulness// And I think the other key issues that I've alluded to – like the, the common focus on meaning, like the mechanism of change – not assuming that mindfulness is the active ingredient, not assuming that it works in the way we believe it works, not assuming that we can measure it but at least trying. I kind of feel like those issues are there and not throwing away - what is valuable in cognitive therapy and in the kind of scientist-practitioner approach// I think it doesn't have to mean narrow or mechanistic or reductionistic – it just means a commitment to, just as we ask our clients to, a commitment to articulating our own assumptions and reflecting on them and examining them. Yeah//

DM: Excellent. Thank-you very much.

P4: You're welcome.

*End of interview*

## Flow chart showing process of analysis



| No. | Meaning-unit | Reduction 1 | Themes emerging |
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| DM | So it sounds like mindfulness as, er, an approach – a way of being with one's experience – can sit quite independently of CBT or a cognitive therapy approach … and there must be many people who can practise cognitive therapy without … | | |
| P1 | … introducing mindfulness? … yeah, that's right. | | |
| DM | … but I get the sense that for you those two would be quite hard – er – that it would be hard for you to do cognitive therapy without … using that idea of mindfulness or at least having it as part of the way that you – think of the work yourself or think of the way that your experiences and – I think, no, I'm just guessing, but … I mean, I wonder if, y'know … so I'm just trying to pin down how … | | |
| P1 | … no, no … it's a good question … | | |
| DM | … how you put those two together for yourself? | | CBT can be effective with less complex patients<br><br>Some parts of CBT not effective with more complex problems |
| P1-34 | Occasionally, I still get patients who are very uncomplicated – they slip through the net … [*shared laughter*] … and I end up seeing them – and – y'know, as you're talking and formulating you can see how standard CBT is just going to – run. And it does – and … there's no particular reason? – to interfere with that by complicating it, by introducing other concepts. But more often than not I'm working with people for whom – bits of the CBT package may be helpful but some other bits of it won't run really. | P1 sees CBT as something helpful for patients with less complex problems, although sees very few such patients. For patients with complex problems, some parts of CBT are not effective. | |
| P1-35 | But I think also for me – I'm forever questioning what the hell it is I do. It's not just about personal self-doubt, it's more of a kind of an intellectual – curiosity – really … I can read the theory of why this is supposed to be happening, but – I don't buy the CBT explanation for why CBT works. I don't believe personally any more that challenging negative automatic thoughts is an essential part of an effective – therapy. | P1 wants to understand what is effective in his therapy, although no longer convinced by the explanation for why CBT is supposed to work. P1 is no longer convinced that writing down "negative automatic thoughts" and then challenging those is an essential part of effective cognitive therapy. | Writing down "NATs" & challenging them is not an effective therapeutic approach<br><br>Need to know what is effective in any therapy providing however |
| DM | Can we just sort of explore that a little bit more? … was that… you said you didn't believe that any more. I mean, can you remember that actually being a belief that you had? It seemed like it was a really important, essential part of what you did as a cognitive therapist. | | |
| | I would get bogged down with people not getting it – they'd find different ways of approaching it, and getting people to accept the, the tedium of writing down negative automatic thoughts. And then taking them on to thought-challenging and so on. And, of course, that behaviour would be rewarded – and reinforced, by | | |

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| | people "getting it" – seemingly - and starting to challenge thoughts and starting to make some progress. So the idea, oh yes it was important to do that – that's an important part of the process – and I don't know that I believe that now. | | |
| P1-36 | I think – there's something else going on there. I … it is about noticing, it is about stepping back – 'cos one way of stepping back from thoughts and feelings is to distance from them by writing them down. Moving them out there. Then you can look at them – and you make some re-appraisal if you like. But that may not be essential, it may just be the, the behavioural change – the behavioural experiments … or just accepting exposure – or just getting them doing things and being more active – and being, being present with activity. So I'm open to all sorts of possibilities there. | P1 reflects on possibilities for change in CBT, including behavioural activation, decentring of thoughts, and exposure, and remains open to many alternatives. | Many possibilities for therapeutic change in CBT exist |
| P1-37 | So there's the bog-standard mechanistic CBT – this leads to this leads to this and then – voila – you get this outcome. Don't really buy that – don't believe that – haven't believed that for a long time. I think had I not had anywhere else to go I would have – I don't know – I think I'd have moved away from CBT and – maybe trained in another therapy. A very different therapy – probably something disastrous, psychodynamic psychotherapy … | P1 not convinced by linear sequence model of CBT and could have chosen to pursue a different therapeutic approach instead. | Linear sequence model in CBT no longer convincing |
| DM | …yes … although … *[shared laughter]* … interestingly, schema therapy involves a lot of object-relations stuff, doesn't it? So I guess it kind of came in by the back door? | | |
| P1 | It did, yeah, it did … yeah … | | |
| DM | But, I mean actually – a sort of slightly different question – but I wonder, did that shift your thinking as well … or … | | |
| P1 | … what, the schema, the schema-focused therapy? | | |
| DM | Well – yeah. 'Cos it sounds like, if I've understood it, y'know, what you've discovered was that there were limits for the people that you could help with this sort of standard approach to CBT and that - you were searching for something … else - to do what? Yeah, that's - maybe that's the question I'm asking – what, what did you feel as the inadequacy with that approach for the people for whom it wasn't working – what felt like – what did you feel you needed more of, or to do something different? | | People often find it hard to write down thoughts |
| P1-38 | Well, some, some of the difficulties people had were just so fundamental – people who were saying they couldn't catch their thoughts. Or they weren't noticing any particular negative automatic thoughts – or they were noticing too many and didn't know which ones were worth writing down. And there's always a fairly lame construction – well, just notice the most upsetting ones and this kind of idea. | Patients often found it hard to write down thoughts as required by CBT, and P1 questioned the reasons for them having to do it. | |

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| | But always wondering – y'know, why is this about? So there was a lot of that. | | |
| P1-39 | And then of course - the other side is, people who do write them down, have caught them, who have challenged them – show no emotional change. Or no real belief change … and those are the more complex presentations – your query personality disorder, whatever. Having almost what felt like a kind of wilful … difficulty with challenging negative automatic thoughts about themselves or others … it's just like ... almost … I just bloody well won't! *[laughing]*. I'm just not going to shift my beliefs! *[laughing]* | Patients that appear to follow the CBT model still show no change emotionally or in their beliefs, as though deliberately refusing to change. | Can follow CBT model with patient & show no changes emotionally or in beliefs |
| DM | I just won't do it! *[laughing]* | | |
| P1 | I'm just not going to shift my beliefs! *[laughing]* So, er … yeah. | | |
| P1-40 | I think some of that had obviously a big part to play in – sort of, y'know – diminishing returns really – kind of, put in all that work, and for – quite a lot of people it's not really … doing the business | P1's work with CBT felt like the benefits got less the more work involved in getting patients to do it. | Harder one works with patient to get them to do CBT, less likely it is to be effective |
| P1-41 | Schema-focused therapy I have - y'know, I think it's interesting stuff – I find it very interesting from a formulation point of view … I, I think it borrows in terms of its change methods very heavily from traditional CBT. There is some experiential stuff and there is some visual-imagery stuff and so on and so forth, but … so, I think it's – I'm not, I'm not wildly convinced by schema-focused therapy as a bog – as a therapy in its own right for bringing about change and we still lack the evidence for it from that point of view. | Schema-focused therapy was an aid to formulation, involving some experiential aspects in its work, although its change mechanisms still drew heavily on CBT as well as lacking evidence for its efficacy. | Schema-focused therapy included experiential aspects in its formulation approach – but relies still on CBT mechanisms for eliciting change |
| P1-42 | Dialectical Behaviour Therapy … a bit like schema therapy in that it's a pot-pourri … of – methods and approaches. I did sit down boringly and try and tot up all – all the number of different interventions – the components within DBT – and it came – I gave up over 350, 360 different elements of DBT … I mean, thinking what, what is it that works here? Y'know, and … I don't know how you factor-analyse all that lot. But the, there's self-harm diaries … and doing what works … interpersonal effectiveness scales … mindfulness scales … y'know, it just goes on – which bit of this is bringing about beneficial change for people? I don't know. I really don't know. | DBT involves a variety of over 350 separate change strategies, so difficult to know what works for the benefit of patients. | Difficult to know what is effective in delivery of DBT as potentially so many mechanisms of change |
| DM | Is it possible to know, though, from any therapy that you do, what creates … | | |

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| P1 | Only - I guess, only if you are able to do a dismantling study … and actually play around with what are thought to be, be the key ingredients … add them and take them away and see what happens … there are huge researches to be done there … but, um … I think, y'know … | | |
| P1-43 | … my own experience of, of individual DBT and running a group – DBT group – of doing mindfulness in a group … taught me that - well … taught me lots of things. One thing it taught me is how very, very difficult it was to get people with severe, emotional dysregulation problems to acquire mindfulness in a group setting … and also then individually how difficult it was to get people to really commit to practising mindfulness in their daily lives, er… | Teaching mindfulness in a DBT group to patients who experience severe emotional dysregulation is very challenging and participants find it hard to maintain practice outside the group. | Teaching mindfulness in DBT group can be very challenging & participants find it hard to maintain practice outside group |
| DM | Because, I mean again correct me if I'm wrong, but in DBT it's just sort of an essential component of the whole approach? | | Mindfulness can be used by some participants in DBT as a form of dissociation |
| P1-44 | But the amount of, the amount of, mindfulness practice that's required of people isn't stipulated anywhere within DBT. It isn't, y'know, oh well, there must be a commitment to practise half an hour a day, or whatever … so, some people – and, y'know, I … there's nothing surprising about it – some people get into the practice and then quickly realise it's just another way of, y'know – not being present. So they don't actually practise mindfulness – they practise some form of relaxation – which leads into dissociation, and y'know, report doing lots of it. And others who can barely sit still and be present for more than a few moments without feeling quite – anxious. | Some patients practise relaxation in DBT instead of mindfulness and use it was way of dissociating, whereas others feel very anxious. | |
| P1-45 | So … but I think – I think there's a kind of meta-message that's getting across, and it's y'know, as we were talking about earlier, it's this idea of, of distancing – of stepping back … and looking at how things are in very real ways – as real as you can make it really … and being with what is. The way things really are, which is a huge challenge for all of us. | Common meaning across various approaches which is "to be with what is" and create distance. | Common approaches across mindfulness-based work are to be with what is & to create distance between what is experienced & who experiences |
| DM | Yeah. I was just thinking – I was reading David Smail the other day – and he was talking about, y'know, the limits of effectiveness of therapy, as he does … and, and he was talking about the freedom of people to change, and that, y'know, often, if you're, y'know, if you're fortunate you might get very intelligent, able | | |
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| P1-57 | … I'm in the third wave. And I … but I still remember how to do second wave. And … sometimes, as I was saying, there are people who – just are so … y'know, the work we're doing is so productive within that, we don't need to go any further really. And – and that's great … but I, I think if – if you listen to my tapes of me doing that, I think there are ideas creeping in that are not strictly CBT. You know – a much heavier emphasis on defusion. | P1 still does traditional CBT if seems to suit a particular client and unnecessary then to use other ideas, although non-traditional CBT constituents still present, most notably the use of "defusion" from ACT. | |
| DM | And I guess that's unavoidable in any kind of therapeutic approach – that, your practice will evolve – inevitably and – | | Manualised approaches to therapy can be more effective than allowing too much of one's own thinking & personality to be involved |
| P1 | - God – hope so! – | | |
| DM | - and does it, y'know, is it important that it remains within, or under, an identifiable kind of, an umbrella … of approaches …? | | |
| P1-58 | Hmm … it might be important. You see, that's the thing – it might just be important. I think there is evidence – um … that I don't like to think about too much really… but I know it's there in the literature saying that, y'know, the more you adhere to a manualised approach, and the less of you there is in it … the more effective you are as a therapist. Um, which is a bit of a bummer really … [*shared laughter*] … but I think that evidence is there y'know. And, um … it's been done – in fact, that evidence has been generated within CBT, saying that, y'know, you get people to do CBT for depression, panic whatever … the more you bring in yourself and your ideas, your way of doing it, the less effective you're going to be. | It is possible that therapy can be more effective if one sticks closely to a manualised approach, rather than allowing too much of one's own thinking and personality to become involved. | |
| P1-59 | But, I reconcile it all with the fact that, y'know, in the Health Service these days psychologists are not working with, that many people for whom those manualised approaches would be helpful. | Psychologists in the NHS most often work with patients having more complex problems, so the research supporting effectiveness of manualised approaches is less relevant. | Efficacy research based on manualised approaches is less relevant to NHS work as see patients with more complex problems than research trials |
| P1 | Um, begs the question who is working with them, and I guess the reality in [names local area] as I know it is that there aren't many people getting the therapy they need. Um, unless they happen to be in secondary care – and even then it's scarce, but in primary care there is almost nothing … apart from practice counselling, and Graduate Mental Health Workers – that's it. | | |

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| DM | Ok. Um … so, in terms of the way that you've used mindfulness, and the way that it's kind of shaped and influenced the work that you do with clients, how does kind of, receiving supervision for your practice fit in with that – is it – have you found it necessary that you worked with someone who supervises you that also has a mindfulness practice, or not – or … what's your experience of that? | | Personal supervision with someone who shares ideas of mindfulness<br><br>Group supervision in ACT that is more experiential |
| P1-60 | Yeah. Well … um … yeah, the person I have my monthly supervision with is also interested in these ideas, so that's been really helpful and also going to ACT monthly supervision is helpful, keeps the ideas alive … erm, yeah – absolutely, um – but it's about interest really – what it – tends to be less about how do you think we could go with this from a mindful perspective, but more about, more about reporting – how it is really. Er … | P1 receives personal supervision from someone with a shared interest in ideas about mindfulness and attends ACT peer supervision where the emphasis is on sharing the experience of working in an ACT therapeutic framework. | |
| DM | Can you say a bit more about that? | | Aspect of mindful practice is "internal supervisor" – moment-to-moment checking in on aspects of in-session activity & responding<br><br>Informs what is shard also in peer supervision |
| P1 | Yeah. Um, what it feels like to be there. In a, in a session … | | |
| DM | As a therapist what - it feels like to be in a particular situation with a client? | | |
| P1-61 | Yeah … because, I – it's a bit like being the concept of the internal supervisor. Well – that's a very interesting concept. Because, part of it is about being aware of what you're doing. Um … and sometimes the internal supervisor's kind of there in the background and you need to remember to bring it forward again. And my internal supervisor will then want to know, why on earth are you asking these questions – what is it I am paying attention to here – what am I getting drawn into here – what am I reacting to here – you know, what is going on – so, that kind of on-line, real-time, mindfulness – you know … awareness – But then in supervision, kind of reporting that, and then – but then, also talking about the - practical aspects of the work I'm doing with somebody and getting them to – maybe consider things more mindfully … be more aware of … um … yeah … yeah … | For P1, providing therapy within a framework of mindfulness is like having an "internal supervisor", where P1 is asking himself pertinent questions of his practice in the moment-to-moment working with a patient. This is a form of mindful awareness in itself and informs what is shared during group peer supervision, where such reflections on practice are discussed together with more practical aspects of working mindfully with patients. | |
| DM | And in terms of … meditation – mindfulness meditation … is that something that you feel it's important to practise yourself with other people, or you have a personal practice, or … you had a practice in the past, but now it feels like it's been more integrated into everyday work? Or - I'm just wondering how that … works out? | | To work effectively with mindfulness in clinical setting, therapist needs to have own personal mindfulness practice |
| P1-62 | I think it's – I think it is important to have personal experience of mindfulness practice. I think it's, um … I think it's essential actually, if you're going to use | To make effective use of mindfulness ideas with a patient, it is necessary for a therapist to | |

| No. | Meaning-unit | Reduction 1 | Themes emerging |
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| | | | SFBT & narrative retain goal of changing – so different from acceptance-based approaches like mindfulness<br><br>Not consciously explored theoretical links between approaches<br><br>Decision to use mindfulness clinically informed by P2's personal transformative experience of it in own life<br><br>Conflict experienced between using something from personal Buddhist spiritual life in professional work |
| P2-19 | Yes... yes ... I mean, I'm not sure in a way that they link either, because they're still not – they're not the same as, say acceptance-based work, because you're still trying to change things but, um ... yeah, I don't really think I've sat down and thought theoretically how - why mindfulness might be a therapeutically useful tool in relation to the other things I had done, really – it was more the fact that I just found it so helpful and transformative myself, and ... I had always slightly struggled with the fact that I found – y'know, even before I did mindfulness – I always found meditation and dharma-practice very helpful, but it felt like, well it's irrelevant to clinical work because, you know, you can't start teaching people Buddhism – I think I was practising in a more religious context ... and there didn't seem any way that I could offer this to clients, but it sometimes made me feel that I wasn't offering them things that I felt were really helpful ... | P2 sees SFBT and narrative therapies as different from "acceptance-based" work as former retain the aim of changing things, although P2 has not deliberately stopped to consider the theoretical linkages between them. P2's decision to work with mindfulness based in own experience of finding it personally transformative, although had previously felt uncertain about using meditation work in professional life, since it had arisen in a Buddhist religious context in P2's personal life, and that was a conflict for P2. | |
| DM | ... it's like you've kind of got this thing which you know – you sort of feel is really useful ... | | |
| P2-20 | ... yeah, but it's not in the therapeutic tool-box so I can only – and, y'know, I always felt that a lot of this, um, cognitive therapy work particularly was very close to dharma – very much about how we create our worlds – the same with narrative approaches, solution-focused approaches. This idea that we, in a sense our thoughts or our mental states or the stories we tell ourselves, have a huge influence on our experience and on our emotions. So there was always that strong overlap - | P2 had felt for a long time that cognitive therapy shared much in common with dharma teaching, as well as SFBT and narrative therapies, since all centre on how our cognitive interpretations shape experience and emotion. | Commonalities between dharma teaching & CT, narrative & SFBT – all centre on how cognitive interpretations shape experience |
| P2-21 | um, but that was more, um ... that wasn't so much about a particular technique, that was more about the general philosophy, so ... it just felt like this might be a way that I could really bring those two sides of my life together – if it was helpful, | P2 saw these links more as a guiding philosophy that allowed the bringing together in a helpful way of personal and professional aspects of P2's life. | Bringing together various strands of theory & philosophy important to P2 in integrating personal & professional practice around mindfulness |
| P2-22 | and er, possibly the reason I then went off and did quite a lot of training before I tried it out, as it were, was because I still felt slightly like, y'know, am I doing this to please me or am I doing it because it will be useful for people? | In order to explore the sense of dilemma between using mindfulness as a helpful intervention for others, or to satisfy P2's own desires, P2 pursued a lot of further training before trying out mindfulness clinically. | To help resolve sense of dilemma that acting on personal zeal, rather than professional authority, P2 undertook more training before using mindfulness clinically |
| DM | So there was that kind of sense of conflict there, or uncertainty about ...? | | Wants to avoid proselytising for Buddhism |

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| P2-23 | Yeah, a little bit, yeah … um, y'know years and years ago I'd met some born-again Christians that were psychologists, and um, really felt they wanted to convert their clients to Jesus because they thought that would be more helpful, and I don't really want to become a "born-again Buddhist" [*shared laughter*] … and I did have a supervisor for a while who was a little bit suspicious of, you know this is from Buddhism and you can't go teaching that to people – | P2 remembers meeting psychologists in the past who were "born-again" Christians and feeling they wanted to convert patients to Jesus. P2 wants to avoid any similar zealousness in advocating mindfulness and becoming a "born-again" Buddhist, especially when supervisors are not familiar with approach. | or evangelical zeal<br><br>Aim not to convert patients to Buddhism, but to help them clinically<br><br>Also need to keep management & supervisors on board when unfamiliar with mindfulness |
| P2-24 | um – I mean I actually think that mindfulness-based work is incredibly secular, and one of the things that Jon Kabat-Zinn and other people have really managed to do is distil the essence of what's effective and separate it from any kind of religious context, but it takes a while to really get your head around that I think, for me. | P2 sees mindfulness-based work as decontextualised from its religious Buddhist background, and that it works well outside this framework – although it took P2 some time to personally process this kind of separation. | Mindfulness can be very effective used independently of Buddhist context<br><br>Took some time for P2 to personally process this separation |
| DM | So, if they've separated it from some of its religious background, has that also taken away some of its spiritual nature – is there a difference between the spiritual kind of nature of mindfulness work and the religious context of Buddhism? | | Some teachers of Buddhism see mindfulness as an abridged version of the dharma |
| P2-25 | Um … I'm not sure – I mean, certainly that's something that I think some Buddhist teachers are a bit suspicious of – this kind of "dharma-lite" – um … I'm not sure that it is – | P2 aware that some teachers of Buddhism see mindfulness-based therapeutic work as an abridged version of dharma. | |
| P2-26 | I'm not really sure Buddhism was ever meant to be a religion – you know, the Buddha just taught some basic ways of dealing with suffering – overcoming suffering – um, though non-grasping and mindfulness and awareness – and then it became a world-religion, so now it's got lots of bells and smells and chanting and all the things religions have … um, I think it's probably – | P2 views Buddhism as originally a practical system for reducing suffering in one's life, through non-grasping & mindful awareness, and that it became a world religion later. | Buddhism originally a practical system for reducing suffering in one's life through non-grasping & mindful awareness – became religion later |
| P2-27 | er, I'm not entirely sure about this – but I think there is a way that this can be taught in an entirely secular context and be just as helpful – and I was talking to somebody at lunchtime - at this party I was at about this – about well, she was saying, but Buddhism has a much higher aim, which is enlightenment, and I said yeah, but how many people do you know who've got enlightened through practising meditation? You know, most of us actually do it to cope with life better, to be happier, more steady with difficulties – and, you know, that's what people get from the groups – | Mindfulness can be taught in secular context divorced from its Buddhist spiritual framework, and still be of practical help to people in coping better with life's difficulties. Although Buddhism may have enlightenment as an aim, very few people achieve this in West through practising meditation – it just helps them cope better, and that is what mindfulness groups offer too. | Can teach mindfulness in secular context independently of Buddhist spiritual framework, & is practically helpful to people in coping better with life's difficulties<br><br>Even if enlightenment is aim of Buddhism, very few meditation practitioners if West achieve more than coping better with life's difficulties |

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| P2-28 | and, and – my sense is that the combination of mindfulness meditation and some very basic cognitive therapy tools is a very strong, very powerful combination and that some people who've been meditating for years could actually really benefit from some of the more cognitive aspects actually, which you wouldn't necessarily learn, but – | P2 believes that some people with an established Buddhist meditation practice could benefit from some CT techniques, and that mindfulness meditation combined with basic CT is very powerful. | Some Western meditation practitioners could benefit from CT techniques<br><br>Combination of mindfulness & CT potentially very powerful |
| DM | That sounds very interesting … would you care to say a bit more about which cognitive therapy aspects … | | Bangor teach monitoring of underlying thoughts & their modification as part of mindfulness |
| P2-29 | Well, yeah, we – in the programme there's a little bit about monitoring thoughts that underlie depressed and anxious feelings and how to modify them, um – there's also some … | Bangor mindfulness programme includes aspects of monitoring thoughts underlying anxiety & depression and how to modify these. | |
| DM | … sorry, can I just stop you there. So, the modifying bit, how does that work in the context of … | | Thought modification here is about learning to identify the habitually most troubling ones in terms of anxiety or depression - & observing their nature to reduce the extent to which those thoughts appear to be objectively true to the client |
| P2-30 | … um, I'm just trying to think actually – I should have the book with me, um … it's more about really seeing that thoughts are not the truth – that's the key thing, it's about noticing thoughts and noticing if they are the kind of thoughts that might tip you into very negative mood – anxiety, depression – and seeing if they can just be observed as they're just thoughts but not facts – they're not true. Um, even y'know, some of the ones - there's a phrase in the book "thoughts aren't facts – even the ones that say they are" – even like really compelling self-views – there's also quite a strong emphasis in the whole course on not judging yourself, not giving yourself a hard time for not being able to do the practices, et cetera – which I think also challenges a lot of habitual, um, tendencies that people often have in their thinking …um … so, just that sort of emphasis on catching thoughts and – um, can't quite … | P2 expands on thought modification, explaining that this involves not seeing thoughts as true in any absolute sense, but rather about observing the nature of thoughts, especially those that seem particularly convincing in terms of habitually evaluative self-description. | |
| P2-31 | there's various bits of self-monitoring that you do, but it's mostly monitoring pleasant and unpleasant events and again that includes looking at what thoughts were going through your mind at the time and what thoughts are going through your mind now as you write this down, until sometimes people realise that something at the time they thought was a catastrophe, as they write it down later they think, well actually it all worked out in the end, it wasn't such a big deal – um, and also monitoring pleasant events tends to make people more aware of tiny little things that give them pleasure that they might easily miss. | Monitoring centres around recalling previous pleasant and unpleasant events, together with the kinds of thoughts that went with those experiences at the time and what thoughts occur about the events as record in writing. Recording pleasant events also brings into awareness very tiny moments of pleasure that people might have otherwise discounted. | Monitoring uses a written record of thoughts associated with pleasant & unpleasant events, so can bring to mind examples of troubling thoughts<br><br>Also helps people to recognise that have moments of pleasure as well as pain |

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| P2-32 | Um, so just all those things that help people to pay attention a bit more to their thoughts and their feelings - and are more implicit if, if you learn mindfulness on vipassana retreats – those things aren't homed in on quite so, um, so deliberately if you like …um, so I think that's what I mean really. I mean in the Mindfulness-Based Cognitive Therapy as it's practised for people who've been depressed there's more emphasis on, on working with negative thoughts, um … | P2 feels that in vipassana retreats, the cognitive aspects outlined above are not explicitly identified as such, although are inherently part of the mindfulness approach. | Such cognitive aspects of mindfulness not made explicit in vipassana training – although inherently part of mindfulness |
| P2-33a | the other thing that's included in that, that whole course is what they call the three-minute breathing-space … which most, is what most people in the group find in, some ways, the most helpful thing - and again you could meditate for years and never come across that - and you might … | P2 finds that most group participants respond to the "3-minute" breathing space as being the most helpful mindfulness component taught, which is not something found in traditionally taught meditation. | Many participants find "3-minute" breathing space most helpful component – not a traditional Buddhist teaching |
| DM | … refresh my memory …? | | Breathing space: recognise arising of aversive experience – stop & focus on breath, expanding out to body awareness incl space around<br><br>Distances one from immediate negative interpretation of experience & close identification with it |
| P2-33b | Um – basically the three-minute breathing space they encourage people to do – first, first you just practise doing it three or four - two - I think three times a day – and then you start to apply it under stress – and it's basically just acknowledging whatever's going on in the body and mind – then coming back to the breath, gathering your attention on the breath and then expanding out again to the body and the area just around the body, so that if there is some painful emotion or physical tension – it's – by the end of the three-minute breathing space it's got a slightly bigger perspective around it really … | In face of some aversive inner experience, one can acknowledge what is happening and bring attention to focus on the breath, before expanding attention to rest of body and space surrounding it, which helps to distance one from the immediate involvement with negative interpretations of that experience. | |
| P2-34 | so, say you've got some anxiety you just acknowledge what's going on, come back to the breath and then broaden out again. And it's kind of a way of stopping and having a – well literally a breathing-space – um, so people have used it – one of my clients said that she'd used it before a meeting where she knew – she was chairing the meeting – she knew that there would be quite a difficult meeting – and so everybody else thought she was just shuffling her papers and getting ready, y'know, but actually she was, she was just going through this little process … and, er, it's a really nice bridge I think from formal meditation practice to everyday life, which isn't a standard Buddhist teaching at all – they made it up … | P2 finds breathing-space a useful link between formal meditation practice and using mindfulness in everyday living, and identifies this technique as one created by proponents of MBCT – not a Buddhist technique at all. | Breathing-space is critical link between formal meditation practice & applying mindfulness in everyday living<br><br>Created by originators of MBCT – not Buddhist technique |
| DM | Yes, ok …so that is very practical – it brings it into the realm of people's everyday living and it is, y'know, a useful tool that they can do something with – I think it's almost like exposure work – y'know it's that sense of – staying with the feeling … | | |

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| P2-35 | Yeah – it's interesting – I mean in some ways possibly from a theoretical point of view some of what we're doing is maybe closer to exposure as an – certainly techniques that are based on distraction and, um … yeah ... I mean the cognitive therapy part of MBCT, even I think as it's practised for people with depression, is not that big – it's, it's probably a bit of a misnomer Mindfulness-Based Cognitive Therapy. | Mindfulness-based work has some similarity with exposure techniques, although has less in common with cognitive therapy. | Mindfulness-based work has more in common with exposure than cognitive therapy |
| DM | Yes – it, it leaves out more than it includes … | | Use of cognitive therapy in MBCT may be there to help gain recognition from psychological establishment |
| P2-36 | … it makes it very socially acceptable, y'know …it's, it's … | The name mindfulness-based cognitive therapy may be a device to gain wider acceptance from psychological establishment. | |
| DM | … yeah, I mean you know, Teasdale's very clear about that – he certainly sets it out very clearly and says which bits … | | |
| P2 | … and how they developed it … | | |
| DM | Yes - and it is all about the decentring and specifically not about challenging reality … | | Adding mindfulness to CBT did not originally work well |
| P2-37 | And they certainly started by just tagging a little bit of mindfulness onto CBT and found that that wasn't really very effective, so … um …yeah. | Teasdale's team originally started from CBT and added mindfulness to it, finding that this did not work very well. | |

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| P2-50 | um – and I guess inevitably that will happen eventually, but it become a bit like cognitive therapy – you don't have to have done a postgraduate year's course, but more and more people now do, um … | | |
| DM | I was just thinking about that – about how cognitive therapy first started and then – I was just reading some research the other day about, y'know, if you used CBT in a manualised approach often the results are "better" than if you change bits and bring yourself into it but, y'know, I don't know who it's – which clinical group is it "better" with – y'know, and all those things which are research-based evidence about effectiveness are so tightly bound it's very hard to turn that into something that you can use every day – you have to rely on making decisions in the moment and with different people I think … | | Clinical trials do not match demands of everyday clinical work |
| P2-51 | … and clinical trials are so often based on a very hand-picked group of subjects who fit the criteria of your trial – y'know, ordinary clinical work's not really like that … | P2 reflects again on how clinical trials do not match criteria of everyday clinical work. | |
| DM | … yeah, I think so 'cos MBCT says about it works well with people who've had at least three episodes but not so well with people who've had less … | | |
| P2 | Yeah. Yeah. They are currently, as you probably know, Willem Kuyken is doing a study to try and replicate that in an ordinary clinical setting. Um … so, where were we? | | |
| DM | We got there by - we were – I was asking you to think about how other professionals outside of psychology but associated with your work, kind of knew what you were doing, and then we looked at other sorts of therapists more generally coming to mindfulness as a result of each therapeutic … | | Focus in UK for mindfulness in mental-health work |
| P2-52 | I mean one of the things that's, that's kind of relevant is, in the States because MBSR started in general medicine and a lot of people who worked with Kabat-Zinn worked in pain management or heart-disease or whatever, a lot of the programmes in the States are in acute medical settings. In this country the main influences have been John Teasdale's work and Mindfulness-Based Cognitive Therapy and also DBT which is quite big in America as well but – so in this country mindfulness-based therapy work is more known about I think in mental-health services. So there's a bit of a transatlantic difference there I think. Perhaps both in the States, but here it's very much mental health | P2 feels that a difference between UK and USA in that focus here is on mindfulness in mental-health work, whereas in states known equally well in physical health and mental health settings. | In USA equally well known in physical & mental health |

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| P2-53 | so what I find is that nobody's heard of it at [*names local general hospital*] basically – I mean my manager has – psychologists have, but – so, um … I mean, for example, I had a leaflet advertising the group and I had to go to a hospital committee to test whether it was readable or not and it was very clear from their comments that they had never heard of this and they thought it was really weird and so – I had to fairly politely say that, y'know, the fact that they didn't know about this shouldn't really be affecting their comments on the leaflet and I couldn't write a – I mean one of the comments was I shouldn't use jargon terms like mindfulness – so I said well, it would be like trying to describe CBT without mentioning the word cognitive. And I was quite surprised in a way – I shouldn't have been, but I thought God! you know, poor things, why would they know about it – so I think it's still pretty fringe in Health Psychology, maybe more than in mental health. And of course John Teasdale's work has done a great deal for it to become credible. | In practical terms, P2 finds that generalist hospital staff are unlikely to have heard of mindfulness as a health intervention, so that it can appear untried and a bit alternative, requiring greater efforts in education, although Teasdale has done much in the UK to enhance the credibility of mindfulness-based work. | Generalist hospital staff in UK unlikely to have heard of mindfulness as an approach<br><br>Most mental-health professionals will have heard of it<br><br>Teasdale done much to enhance credibility of mindfulness |
| DM | Yeah – yeah … I think, y'know, because it's fully within the realm of cognitive therapy … | | |
| P2 | Yeah – and because he's so respected. People've been reading papers by him on depression for years … | | |
| DM | … yeah - even if you can't really work out what ICS is all about some of the time …ok … so, we're doing well. | | |
| P2 | Are we? | | |
| DM | I just wondered whether we might change tack altogether and one of the areas that I am interested in as well is how these things go along in terms of supervision … and what's your experience, your feeling about the importance of being supervised in this work and how important it is to be supervised by someone who may have a background or experience of doing this type of work as well. I mean I don't how that has worked out for you? | | Supervision in peer group<br><br>Discuss practical issues of teaching mindfulness & experiential concerns that arise in group work |
| P2-54 | Well, it's not been that straightforward obviously – because it's so new. What we have here is a local kind of peer group which myself, a friend and a colleague set up, er – and we meet every six weeks or two months or so and, um, there's just a handful of us who have been doing mindfulness-based groups of one kind or another – most of them in mental health. So that's a place where we take issues that arise, like y'know, my whole question about changing the format of the group or how to work on the enquiry – various problems that have come up. | P2 participates in a local peer supervision group that specifically addresses issues of using mindfulness clinically, particularly in group protocols, and meets regularly every couple of months. Issues such as changing aspects of group content and working with enquiry are what get discussed. | |
| P2-55 | Um – it hasn't entirely worked – um – and that's because as soon as you do something like this what happens is that people who've got an interest want to come and, y'know, | P2 has experienced difficulties in peer supervision group with people wanting to join who are interested, and maybe have some meditation experience, but who are not actually delivering any group work, so that purpose and focus of group can become blurred – as well as people wanting to learn. | Peer group supervision for mindfulness can be overwhelmed with practitioners who have interest in mindfulness, although not actively using it clinically |

| No. | Meaning-unit | Reduction 1 | Themes emerging |
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| DM | that – each time you go round your iterative spiral, it's still mindfulness but at different levels … so it's that sense in which it's completely interwoven – an experiential as well as an intellectual concept that you can explain to someone in words. So I guess that's just part of what I'm trying to reflect in my research by asking practitioners about their experiences, is just to – to find out exactly how people are responding to that and how as a practitioner you work with that interface, when it's something which is so deeply part of your own personal experience at the same time. I guess it's that - the issue that I'm interested in is that aspect of the interface, and I suppose if I'm hearing you then, if you're – for many therapists when they're doing therapy well, that sense is with you anyway. | | |
| P4-81 | That's how I experience it yeah. If for example, one were a devout Christian or a Jew or a Muslim, I'm sure there would be a lot of occasions in therapy where what somebody was saying would connect with the kind of personal belief. So I feel everybody in their own ways is … I think we're always having to kind of monitor our reactions, yeah. | Therapists are likely to feel a deep sense of connection between the positive aspects of therapy when it is going well, and their own personal and spiritual beliefs. This requires ongoing awareness by the therapist. | |
| DM | So I guess that actually ties me into another aspect of what I'm asking participants, is how we get on with people who are coming to this new, for the first time perhaps. And, you know, there's a suggestion in the literature that you need to have established a mindfulness practice of your own before you can use it clinically perhaps. And how that – and how you feel about that as someone who's very experienced and might be training other people professionally to use mindfulness? | | Length & breadth of experience in using mindfulness clinically allows teaching of approach to other clinicians |
| P4-82 | Yeah, I mean – I think what I can sort of share with colleagues, is I do have, probably relative to other people, I have a lot of experience of introducing mindfulness And we've adapted in lots of ways how that's done and I feel very happy to talk to people about that. | Compared to other people, P4 feels experienced in bringing mindfulness for the first time to people with psychosis, and has faced many different challenges in doing this. | |
| P4-83 | I think in terms of, um … other people then choosing to kind of run mindfulness programmes – I mean it's, there's the beginnings of a good industry already, you know, about – | P4 suspicious about other people exploiting commercial benefits of mindfulness in psychotherapy. | Beware others exploiting commercial benefits of mindfulness in therapy |
| P4-84 | I have this huge thing about you know, nobody owns anything we've talked about today, nobody owns it. | P4 feels strongly that mindfulness in psychotherapy cannot be "owned" by any individual. | No one individual can own mindfulness in psychotherapy |
| P4-85 | But clearly there are packages for delivering mindfulness alongside other things and I guess if somebody's gone down that route and they've kind of met whatever criteria those people have for running MBCT or MBSR or DBT, it's got nothing to do with me really. | P4 recognises that other practitioners may be comfortable in adhering to minimum criteria for using mindfulness clinically as expounded by specific therapeutic approaches. | Some other approaches have minimum criteria for establishing mindfulness practice, before allowing new practitioners to use it |

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| P4-86 | If people wanted to work with me then I would certainly, and have done – yeah, if we can get practical, I mean there was a woman did a Master's on mindfulness. She was really keen to run a group for people with early intervention mindfulness, so she took up the practice and she would probably have been meditating daily for a year and she came to one of the groups we ran here teaching people, and I supervised her throughout and that felt ok. But that was also something about her – she was at that point somebody who had many years work experience, family, she was just a kind of very rounded human being really, took a lot of responsibility for herself. | In P4's experience, the successful clinical use of mindfulness requires of the therapist a certain amount of personal maturity acquired through a broad range of life challenges, and a disciplined commitment to personal mindfulness practice over many months. | Clinical use of mindfulness requires some maturity of life experience in clinician & disciplined commitment to personal mindfulness practice over many months |
| P4-87 | So yeah, I certainly wouldn't … I don't see how somebody could do that – I think if somebody doesn't really have solid experience themselves, I do not see how they could introduce someone to mindfulness, because … I don't think they would introduce it in a way that did justice to it, I don't see how they would cope with difficulties that people encountered. | P4 cannot see how a therapist without significant personal experience of mindfulness practice could introduce somebody else clinically to its use, since therapist would be unprepared for dealing with the challenges likely to arise in clients. | Unlikely to work successfully with mindfulness without having an established personal practice – especially in dealing with likely challenges faced by clients |
| P4-88 | I think mindfulness is a really interesting thing – it's like, at one level people say it's so simple, what I'm doing is to sit, close my eyes and become aware of what's happening, but I think the reality is that it's also very, very complex. I think it's a deeply complex thing and I've spent a lot of time thinking about it and practising it and I still find it challenging, I find it conceptually slippery – I kind of think I've got a handle on it and then it's gone again. So I think one's really got to engage with that process for a bit before introducing people to it yeah. | Mindfulness as an intellectual construct and an experiential process is both straightforward and very complex. One needs to have personally engaged with its perplexing and paradoxical nature before using it clinically with others. | Mindfulness is both straightforward & complex – as intellectual construct & experientially<br><br>Need personal engagement with its perplexing & paradoxical nature before using it clinically |
| P4-89 | And I will reflect on this interface with Buddhism because I do feel that it's not something I've really articulated. The interesting thing is I feel comfortable in my practice when I'm working with clients, yeah, it isn't – I'm not running up against a problem. So I think that in work with clients it's ok, but what I think I haven't done is kind of articulated - probably all those implicit decisions that take place about what I bring in and what I don't – I don't for a moment think that's right and it's what somebody else should be doing, but I guess it feels right for me because I'm not – I'm not tripping over things, I'm not tying myself in knots, I'm not feeling gagged – all the kinds of things that might be happening with clients if there was an issue and they're not. | P4 feels that as a therapist, the Buddhist aspects of mindfulness are not causing a problem, although has not deliberately reflected on the process of which aspects feel legitimate for P4 to use professionally and which ones do not. P4 feels has struck a balance that works well for P4, but each therapist must find own balance [*between personal beliefs and professional practice*]. | Each therapist must find own balance between personal & spiritual beliefs & professional practice |
| DM | Yeah. And for you as a practitioner have you been able to find sort of supervision for yourself from other people and how important has that been … how important do you feel is it you get supervision from someone who has an experience with mindfulness themselves? | | |

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| P4-90 | That's really interesting – I don't think I get supervision … | | |
| P4-91 | … but I – I learned mindfulness – I learned meditation, I mean I think that even for me is quite important – it's a meditation – I learned meditation at meditation centres, and at different times I spent four years kind of doing what you would call formal study of kind of meditation and Buddhist psychology, and Buddhism – | P4 learned meditation, rather than mindfulness as such, at different meditation centres over four years and studied aspects of Buddhist teaching and psychology. | Meditation practised & learned over number of years<br><br>Studied Buddhist psychology & other teachings too |
| P4-92 | so what feels important to me is that I am connected with people – meditation teachers. I wouldn't ever talk – I've never talked to one as far as I can remember now about a case. | P4 feels "connected" with meditation teachers, although has never discussed a clinical case with any teacher. | Personal connection with meditation teachers – would not discuss case material with a teacher |
| P4-93 | But in terms of the mindfulness component it's been incredibly helpful to kind of to be on study programmes, to go to meditation centres, to talk about my difficulties because my difficulties are my client's difficulties. In seven years my observations are that their struggles are the same as my struggles with mindfulness – not with mindfulness but with our experience. | P4 draws much support clinically from personal learning and study of meditation, as feels challenges encountered by P4 are same challenges encountered by clients in terms of struggling to relate mindfully with one's experience. | Struggling with mindfulness presents same challenges for clients as does for therapist, so can draw support for this from personal study & practise of meditation |
| P4-94 | So I think that's really important yeah, and I almost feel – it probably does touch on your question about this kind of interface of Buddhism and psychology – you know, I don't feel I – if you want to understand about compassion I wouldn't come to me personally. I think there's people who've written about it and practised it and thought about it a lot more deeply. So I think what's important is going to somebody who has experience and wisdom in the area you need it, and if it's the meditation I don't think it needs to be a supervision sort of thing, yeah. A sitting group, meditation centres - served me very well. | P4 feels that not personally an expert in compassion as it relates to mindfulness meditation, and that each therapist needs to find appropriate expertise for their stage of personal learning, naming qualities required in a prospective teacher as "experience" and "wisdom". It is not necessary to receive clinical supervision in mindfulness practice itself. | Look for "experience" & "wisdom" in meditation teachers or other areas of personal development as need to find them<br><br>Direct clinical supervision in mindfulness practice not necessary |
| P4-95 | Just one other thing – I don't particularly have an answer on this – I mean my thinking changes, but I think one other issue that feels really important to sit with is you know – people put it in – I've often heard it expressed in Buddhist terms – is mindfulness Dharma-lite? Is it lacking things? And my experience is that – no it's not, it's all there. If you really understand the invitation with mindfulness it's all there, but to me it's a question of do we have to draw it all out and make it all explicit – like the compassion for example for all living beings. It's kind of implicit in there if we're accepting all experience, we're not judging ourselves, we're not judging others, we all suffer and we don't want to. I don't feel it's my job to be drawing all these things out, but they're kind of clearly in there. | P4 does not see the clinical use of MM as an attenuated form of Buddhism if the therapist using it fully understands "the invitation with mindfulness". All aspects of Buddhist teaching are present in MM, although it is not necessary to make them explicit – they are inherently part of the teaching of MM. | All aspects of Buddhist teaching inherently present in mindfulness, although no need to make these explicit<br><br>Should understand something of the nature of "invitation" however, when offering mindfulness to clients |

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| P4-96 | But I have a lot of – you know in my work generally, I have a lot of confidence in clients really, you know that they can, they can take things forward if they want to and in their own way really – around the edges – I very much stick to distress, working with people to alleviate distress to promote emotional well-being. Yeah, that's probably quite important to say – I don't know if I've quite expressed it – that's the, I guess that's the thing I come back to that probably helps to define my kind of scope. | P4 believes critical in therapy to stick to helping people relieve distress and promote emotional well-being, and believes in clients' ability to pursue further for themselves those things in life that feel useful to them. | Critical to stay with relieving distress & promoting well-being in therapy – clients can pursue further those things they find useful outside therapy |
| DM | Great, that's really helpful. I'm only looking doubtful because I thought my question had kind of escaped for a minute, um … ok, it was when you were talking about the other aspects of mindfulness being implicit within it and then from within the sort of psychology field if you like there seems to be a great effort to kind of try and identify it as a construct – a psychological construct which can be measured. How useful is it to actually measure something called mindfulness or are we just measuring some aspect or some production of mindfulness? | | Measuring mindfulness important |
| P4-97a | Yeah. I personally think it's very important to engage with this question of how do we measure mindfulness. | P4 believes very important to measure mindfulness. | |
| P4-97b | You know, it's quite interesting as an academic clinical psychologist to look at the, to look at the impact mindfulness interventions that have been published have had. And what's clear is there's some kind of zeitgeist – there's some real energy for what mindfulness brings that means that really its take-up has exceeded the evidence-base I think. So, for example, if you look at the key early studies they were not measuring mindfulness, so one can find that relapse rate in people who have had experiences of depression is significantly lower, but there's no demonstration that that's anything to do with mindfulness – because they haven't even measured mindfulness. | Early efficacy studies of mindfulness meditation used clinically have not measured mindfulness, so that P4 feels therapeutic uses of mindfulness have got ahead of the empirical data. | Therapeutic uses of mindfulness ahead of data as not measuring efficacy of mindfulness directly |
| P4-98 | So I think, I think it's too easy for us to say it's a complex or impossible to measure concept, let's just not try. I think – it's almost a bit like I was saying earlier, we can – I think there's a danger that people will start to be almost promoting Buddhism through their practice, I think there's an opposite danger that psychology will throw away our way of doing things, say in CBT for example. I think it's important to say if we believe there's a mechanism here that is helping people stay well, helping people let go of depression, I think it's important to engage with the question of how can we measure that. | An empirical requirement exists to try and identify likely effective mechanisms at work in mindfulness interventions, and also to try to measure the operation of those mechanisms, otherwise prevailing CBT approaches may jettison clinical uses of MM. This is as much of a danger as introducing Buddhism through the clinical use of MM, in lieu of CT. | Without empirical evidence of mechanisms of change in mindfulness, CT may jettison mindfulness<br><br>This danger as great as that of introducing Buddhism through use of mindfulness |

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| P4-99 | What we've done in our work for example is, um, tried to just be very specific on the measurement question and say we're not in any way trying to measure this vast kind of concept of mindfulness meditation – what we're interested in measuring is specific aspects of somebody's relationship, say, with – so .... To what degree is somebody able to without reacting – to what degree is somebody able to experience an image and really turn towards it. To what degree is somebody able to not ruminate , not spend ten or fifteen minutes working out how that fits in with their overall belief system. Are they able to just experience the kind of sense that – are they ever able to experience that and note it and let it be. | In P4's work not attempting to measure whole of MM, just its expression in terms of a relation with one specific aspect of troubling inner experience, and to what extent a client is just able to be with that experience and not be involved in reacting to it. | Try to measure mindfulness in its relation to just one aspect of troubling inner experience, & how far client able to be with that experience & not involved in reacting to it |
| P4-100 | I think at that level it's quite possible to begin to think about how to measure mindfulness and we're kind of underway with that, but I'm not for a moment am I thinking that that is tapping into all aspects of mindfulness or even from a psychological point of view I'm not thinking that it does that narrow bit really well, but I think it's good to start, | P4 sees this as a starting point for how to measure psychologically a highly specific aspect of mindfulness, and requires much greater refinement in the future. Is not setting out to measure all aspects of mindfulness. | Need to refine what attempt to measure in mindfulness – not all of its aspects at once |
| P4-101 | I think it's good to remember that we are employed – you know, we are paid by the taxpayers, we have a responsibility I think to try and reflect and monitor and evaluate the work that we do – any work that we do. | As P4's practice is publicly funded, feels has a duty to continuously evaluate and assess any therapeutic work done. | Duty to continuously evaluate clinical work as publicly funded |
| P4-102 | But it's fundamentally very exciting – very exciting to have, you know – I guess that's something else I haven't said actually is that what's really nice is that – if it were the case that – I don't how this could be the case, but imagine it were the case that someone was telling you that you just cannot ever use mindfulness meditation at work – some body has decided somewhere that it's a religious practice, you can't do it in the NHS. It would be very frustrating to feel that something that one knows can be helpful and conceptually ties in can't be used. So to me we're in the really good position of working with the integration and that feels really good. | P4 feels that MM can be highly beneficial clinically and would not want the NHS to decide that cannot deliver it therapeutically because deemed as religious practice for example, so that empirical investigation is critical to its continued clinical practice. | Empirical investigation of mindfulness critical to its continued availability in NHS<br><br>May be prevented from using it if seen as just a religious practice |
| DM | Yeah, great. | | |
| P4-103 | 'Cos I guess most people probably go through that – it's right back to your question about when you first start using it, probably most of us think, well – 'cos when I first starting using it I wasn't aware of Kabat-Zinn, and, um, MBCT had not been published, so it wasn't like I could go somewhere and be ... you know, sort of ... I didn't have an evidence-base or something I could go to, but it just felt like it was the right thing to do, yeah. [*laughs*] | When P4 started using MM clinically, just felt like it would be clinically helpful, and had no published evidence-base to draw upon, so starting doing it anyway. P4 suspects most clinical practitioners of MM have felt similar dilemma in the past. | Started using MM because of personal conviction it would be helpful, & had no evidence when started<br><br>Similar tensions for other clinicians using mindfulness in past |

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| P4-104 | [*laughs*] I do go back then to it's really important to try and evaluate it, because it might have been the wrong thing to do. | P4 reinforces the need to have empirically evaluated the clinical use of MM in circumstances where no evidence-base existed. | Even more crucial to establish empirical basis for using mindfulness therefore |
| DM | So an allied question to that I guess is – as we start to wrap up maybe – is something I've asked all the people that I've seen is – in your reading of the literature and understanding of the evidence, and you may have alluded to this already, but is there anything you feel is missing from the literature, anything you feel is important and that somehow we've overlooked so far? | | Need for further exploration of interface in therapists between mindfulness & personal belief based in Buddhism<br><br>How far may therapists share these with client |
| P4-105 | Well – I think what your research taps into one area which is that I think there needs to be more exploration of the interface between mindfulness and Buddhism. I'm quite struck that where some people are very open – that they are Buddhist, that they may go to meditation centres, some people in the mindfulness field, others are almost quite reserved about that. So I think that is one really important area – it's something I will reflect on after today. | P4 feels there needs to be more exploration of how mindfulness and Buddhism inter-relate in terms of therapists' personal practice and beliefs, and to what extent therapists may share such experiences with clients. | |
| P4-106 | And I think – I do feel that the integration question is still ongoing. I think just sitting the two beside each other is not integration – cognitive therapy and mindfulness. | P4 feels there needs to be further investigation into how CT and MM can be more fully integrated, rather than being delivered in parallel. | Further exploration of how to integrate CT & MM, rather than run them as 2 parallel systems |
| P4-107 | And I think the other key issues that I've alluded to – like the, the common focus on meaning, like the mechanism of change – not assuming that mindfulness is the active ingredient, not assuming that it works in the way we believe it works, not assuming that we can measure it but at least trying. I kind of feel like those issues are there and not throwing away - what is valuable in cognitive therapy and in the kind of scientist-practitioner approach. | P4 also reinforces the commonalities between CT and MM – personal meaning and mechanism of change - and the need to continuously question assumptions that mindfulness is what effects change, or that people know how it works and that is can be measured. P4 reiterates the importance of keeping what is effective from CT and the scientist-practitioner model. | Personal meaning & mechanisms of change are common to CT & MM - & must continue to question how these are working<br><br>Keep what is effective from both & work in scientist-practitioner model |
| P4-108 | I think it doesn't have to mean narrow or mechanistic or reductionistic – it just means a commitment to, just as we ask our clients to, a commitment to articulating our own assumptions and reflecting on them and examining them. Yeah. | The value of CT and the scientist-practitioner approach is in clearly expressing underlying assumptions and investigating these in a rigorous and open way. | Express underlying assumptions & investigate these in rigorous & open way |
| DM | Excellent. Thank-you very much. | | |
| P4 | You're welcome. | | |
| **END OF INTERVIEW** | | | |

<u>CBT felt to be ineffective in some cases, in light of growing complexity of problems presenting clinically, so that CBT not always effective and some techniques not always very productive (P1-01)</u>

- Harder one works with patient to get them to do CBT, less likely it is to be effective (P1-40)
- Committed to CBT, but aware that not appropriate for every patient – even in schema-focused mode (P1-08)
- Can follow CBT model with patient & show no changes emotionally or in beliefs (P1-39)
- P1 experienced doubts about therapeutic effectiveness of key parts of CBT model (P1-11)
- Some parts of CBT not effective with more complex problems (P1-34b)
- CBT can be effective with less complex patients (P1-34a)
- Many possibilities for therapeutic change in CBT exist (P1-36)
- Writing down "NATs" & challenging them is not an effective therapeutic approach (P1-35a)
- People often find it hard to write down thoughts (P1-38)
- Linear sequence model in CBT no longer convincing (P1-37)
- CBT-relaxation not always effective with pain patients (P1-01)
- Reflecting on causes & nature of suffering resonates very quickly with clients compared to traditional CBT model – can relate easily to everyday experiences (P1-56b)
- Schema-focused therapy included experiential aspects in its formulation approach – but relies still on CBT mechanisms for eliciting change (P1-41)

<u>Being with experience rather than avoiding it (P1-02)</u>

- P1 invited patient to try ways of staying with inner experience that found very hard until then (P1-13)
- Being with painful experience allows shift from previously avoidant & self-damaging responses, & this is beneficial to patients (P1-32)
- "Being with" experience is not part of CBT or relaxation (P1-33)
- Sense of not being to able to sit with herself emerged between patient & P1 ((P1-09)
- Being present (P1-03b)
- Despite unpredictability of complex patient, benefits accrued over year of working on how things are in present (P1-15)
- Role of experiential-avoidance in emotional distress and mental health disorders, also needs further exploration (P1-66)
- Forms of avoidance seemed particularly relevant (P1-12b)
- Develop awareness of how mind works & its capacity for evaluation (P1-20)

<u>Relationship between thoughts & thinker is key, and relevant to commonalities and differences between mindfulness used clinically & CT, as mindfulness increases awareness of inner experience & the distance between it & the observing self – a metacognitive shift – whereas CT puts emphasis on engaging directly with thoughts themselves (P1-03)</u>

- CT & mindfulness are different in that CT engages directly with thoughts, whereas mindfulness involves seeing process of thinking & evaluation (P1-21)
- This involves an exploration of personal meaning (P1-18b)
- CT is compatible with mindfulness as increases awareness of internal experiences whilst increasing distance between it of observer & questions process of evaluating that experience in the moment (P1-18a)
- Relationship between thinker & thoughts is key thing to address in therapy – tailored to individual needs of patient (P1-24)
- Therapy started to feature conversations about ways clients related internally to cognitive & physiological experience (P1-12a)
- Metacognitive shift is what makes CT a protective intervention, & this is present also in mindfulness(P1-22)
- Common approaches across mindfulness-based work are to be with what is & to create distance between what is experienced & who experiences (P1-45)
- Shift from idea of being controlled by external events to seeing what part people play in their own suffering – very powerful realisation (almost palpable) & key moment in therapy (P1-56c)
- Your mind is not your friend – find concrete examples in patient's experience (P1-28)

Importance of personal experience of mindfulness practice in therapist's own life (P1-04)

- To work effectively with mindfulness in clinical setting, therapist needs to have own personal mindfulness practice (P1-62)
- Mindfulness practice can encompass present awareness of everyday activities, formal sitting meditation, as well as short periods of mindful reflection during working day (P1-63a)
- Fluctuations in levels of mindfulness practice result in fluctuating levels of stress (P1-63b)
- Formal mindfulness retreats have been beneficial (P1-64)
- Maintained fluctuating personal practice ever since (P1-02b)
- Early meditation experiences (TM) & became aware of mindfulness through work colleague (P1-02a)

Importance of supervision, both as shared with others and as an inner awareness developed through mindfulness practice (P1-05)

- Personal supervision with someone who shares ideas of mindfulness (P1-60a)
- Aspect of mindful practice is "internal supervisor" – moment-to-moment checking in on aspects of in-session activity & responding (P1-61a)
- Informs what is shard also in peer supervision (P1-61b)

DBT corroborated personal approach to using mindfulness clinically – but some concerns about DBT itself (P1-06)

- Used mindfulness clinically before hearing of DBT (P1-06)
- DBT emerged & corroborated P1's approach, so felt encouraged by this (P1-16)
- Difficult to know what is effective in delivery of DBT as potentially so many mechanisms of change (P1-42)
- Mindfulness can be used by some participants in DBT as a form of dissociation (P1-44)
- Teaching mindfulness in DBT group can be very challenging & participants find it hard to maintain practice outside group (P1-43)

Nature of mind as machine that processes information & that verbalises experience internally – which leads to suffering & need for "defusion" strategies (due to overly-close identification with activities of mind) (P1-07)

- Mind as highly capable machine that can generate fear & danger (P1-07)
- Mind can be usefully explained using mechanical metaphors (P1-29)
- Verbal world that people inhabit is oppressive, & attempting to control painful experience by not accepting it as it is leads to suffering (P1-46a)
- Easily caught up in what mind produces (P1-27)
- Defusion is key therapeutic strategy – identify less closely with thoughts & feelings (P1-30)
- Even when uses traditional CBT for some clients, defusion still present (P1-57)

Working with patients using mindfulness requires sensitivity to their individual needs & pace of understanding – putting things in their language & using simple metaphors for mind-process – as informed by repeated clinical experience (P1-08)

- *Influences on practice of personal experience & principles for self-disclosure (P1-08a)*
  - P1 drew on personal experience of Buddhism & personal practice of meditation to build on idea of observing experience without striving to change it (P1-14)
  - Will share aspects of personal meditation experience if patients interested in that process for themselves (P1-54c)
  - Personal experience of meditation allows P1 to use sense of shared struggle in therapy (P1-54b)

- *Experience of speculative trial with 1 patient encouraged further clinical use before any real published research evidence available (P1-08b)*
  - Therapeutic relationship was sound (P1-04b)
  - Work with this patient informed work with other patients (P1-10)
  - After extended work with 1 patient unsure what to try next (P1-04a)
  - Mindfulness worked well with this patient, so encouraged to try approach with other patients (P1-05)
  - Meditation seemed to fit some patients better than others (P1-03a)

- *Repeated experience of using mindfulness clinically has taught P1 some key approaches in therapy (P1-08c)*
  - Try ideas in tentative & sensitive way & develop those that patient picks up on (P1-25)
  - Mindfulness work involves developing set of shared ideas, & quickly finding concrete examples of them from patient's own experience (P1-31)
  - Alienate clients if seek to use mindfulness out of mistaken belief that must be helpful to them because found it personally useful in own life (P1-55)
  - P1 meets with clients as one human with another on basis of existential equality – predicated on acceptance that all people share universal processes for experiencing life (P1-54a)
  - Suffering unique to each person according to their history (P1-46b)
  - Everyone has inner resources to help heal themselves – although cannot write over personal history (P1-46c)
  - Work with what feels right for each patient session by session (P1-26)

<u>Buddhist concepts very informative as underpinning framework – other religious traditions share similar ideas (P1-09)</u>

- Mind interpreting personal experience is ancient idea & present in Buddhism, Greek philosophy & Christianity – as well as CBT (P1-19)
- Compassion in Buddhist sense is missing from mindfulness literature (P1-67)
- Working with compassion & mindfulness together produces therapeutic change (P1-68)
- Buddhist concept of suffering as universal to lived experience of being human is key influence (P1-56a)
- Karma is a key concept for effective therapy – as necessary for patients to accept that what they choose to do with own experience affects their level of suffering (P1-51a)
- This must be addressed in therapy (P1-51b)
- Many patients already aware of some Buddhist ideas before entering therapy (P1-53)
- Buddhism is helpful framework in personal living – although reincarnation difficult to believe in (P1-50)
- Mindfulness can be used in a non-religious way (P1-49)

<u>ACT ideas also very influential (P1-10)</u>

- Communicating ACT ideas to clients can be difficult (P1-47)
- Exposure-related aspects of ACT require further exploration (P1-65)
- Group supervision in ACT that is more experiential (P1-60b)

<u>Research evidence regarding clinical uses of mindfulness difficult to apply to everyday therapy work as mostly efficacy-based (P1-11)</u>

- Mindfulness spreading across psychological mainstream over last 10 years (P1-17)
- Efficacy research based on manualised approaches is less relevant to NHS work as see patients with more complex problems than research trials (P1-59)
- Need to know what is effective in any therapy providing however (P1-35b)
- Little evidence currently for helping actively depressed people with mindfulness (P1-23)
- Manualised approaches to therapy can be more effective than allowing too much of one's own thinking & personality to be involved (P1-58)

## P4 Analysis of Grouped Themes

**Appendix IX (b)**

Profound personal experience of mindfulness in own life encouraged its use clinically and developed into group protocol from there (P4-01)

- Meditation practised & learned over number of years (P4-91a)
- Established & frequent personal meditation practice before using mindfulness therapeutically with others (P4-01)
- Personal experience of meditation showed clearly this inner conflict between cognitions & sensations (P4-17a)
- An altered relationship between them developed through meditation practice (P4-17b)
- First used with an individual as a potentially helpful but untried intervention (P4-04)
- Therapeutically rewarding, although not consistently helpful (P4-05a)
- Original motivation was to help relieve distress arising from people's inner psychotic experiences (P4-03a)
- CT as commonly understood not consistent with own experience (P4-23a)
- Grounded in clear explanatory framework for working with psychosis, tried to integrate MM into therapeutic practice (P4-38)
- Stressed untried nature of idea when started using in groups (P4-05b)

Applied to psychosis providing simple rationale and starting meditation by using awareness of bodily sensation to teach acceptance of experience as it is (P4-02)

- Distress arising from psychosis can either be responded to by avoidance, or by fighting experiences because fear being overwhelmed (P4-07)
- Short introduction to MM with new clients & check out worries (P4-09a)
- Introduction incl. brief conceptual explanation & outline of process involved (P4-09b)
- Explain that will be guided in becoming more aware of what "experiencing in bodies, breathing & minds" (P4-09c)
- Move smartly into practice & reassure that "just sitting" (P4-09d)
- Start meditation training by bringing focus to bodies & where contact external surfaces (P4-10a)
- Never used full bodyscan (P4-10b)
- Maintain deliberate engagement with bodily sensations, & find place of comfort from which to notice breathing (P4-12a)
- Just noticing – not changing – just accepting what is (P4-12b)
- Emphasise everyday shifting of attention in mind & accepting this as universal experience (P4-13)
- MM middle-way between 2 extremes of getting caught up in experiences, or pushing them away (P4-08)
- Literature cautious about use of mindfulness in psychosis – not borne out in P4's approach & experience (P4-14)

Empirical measurement, clearer definition & evaluation of mindfulness important to justify its continued clinical use in NHS, and as part of CT approach (P4-03)

- Measuring mindfulness important (P4-97a)
- Started using MM because of personal conviction it would be helpful, & had no evidence when started (P4-103a)
- Similar tensions for other clinicians using mindfulness in past (P4-103b)
- Even more crucial to establish empirical basis for using mindfulness therefore (P4-104)
- Empirical investigation of mindfulness critical to its continued availability in NHS (P4-102a)
- Without empirical evidence of mechanisms of change in mindfulness, CT may jettison mindfulness (P4-98a)
- Therapeutic uses of mindfulness ahead of data as not measuring efficacy of mindfulness directly (P4-97b)
- Try to measure mindfulness in its relation to just one aspect of troubling inner experience, & how far client able to be with that experience & not involved in reacting to it (P4-99)
- Express underlying assumptions & investigate these in rigorous & open way (P4-108)
- Need to refine what attempt to measure in mindfulness – not all of its aspects at once (P4-100)
- Keep what is effective from both & work in scientist-practitioner model (P4-107b)
- Duty to continuously evaluate clinical work as publicly funded (P4-101)

- May be prevented from using it if seen as just a religious practice (P4-102b)
- Increasing popularity of clinical MM good thing as range of ways in which to experience mindfulness in therapeutically useful formats (P4-48)

<u>Change in personal meaning is key to both CT & mindfulness practice, derived from an increased awareness of relationship between inner fears and distress – risk losing this focus if CT moves on to next fashionable thing (P4-04)</u>

- Not clear to many that MM involves changing one's personal meaning (P4-64)
- Change in meaning also key in P4's view (P4-68)
- Experiential exploration by therapist & client equally important, where put meaning at centre of work, informed by Rogerian acceptance, mindfulness & Buddhist teaching (P4-31)
- Personal knowledge of how reactions to inner experience drive distress, combined with realisation of how powerful are one's reactions to most feared inner experiences, are at heart of what mindfulness training can achieve in changing meaning (P4-76)
- Meaning is key to working with CT – consistent with Rogerian approach (P4-44)
- People working with meaning in CT rarely focus on automatic thoughts (P4-45)
- Wary of losing work with meaning in mindfulness as popularity increases (P4-49)
- "Working with meaning" will be cast aside (P4-28)
- Chasing the latest fashion in therapy circles risks losing the importance of working with meaning as look for next new thing (P4-51)

<u>Mindfulness is common process for both therapist & client, so that therapists can be reinforced for sharing own experience – should allow client to develop at own experiential pace & in own context (P4-05)</u>

- Mindfulness can be universal leveller & highly respectful of people's experience, whatever it is (P4-73)
- Mindfulness meditation is potentially useful personal resource, brought to others through shared mutual experience, not teaching (P4-02)
- Should understand something of the nature of "invitation" however, when offering mindfulness to clients (P4-95b)
- New ideas introduced into clinical work s/b grounded in client's personal context of understanding (P4-06)
- Being able to mindfully see 3x the way in which troubling experience captures one's attention & responses, is enough to facilitate awareness that distress arises from reaction to experience & control people try to exert over experiences (P4-75)
- Client feedback persuasively supports view that deeply troubling inner experience can be seen without reaction for short periods of time - & that people can positively about themselves in these moments (P5-77)

<u>Clinical use of mindfulness requires some therapist maturity & commitment to personal mindfulness practice, opening door for qualitatively different therapeutic interaction with client as drawing on something deeply meaningful for therapist also (P4-06)</u>

- Clinical use of mindfulness requires some maturity of life experience in clinician & disciplined commitment to personal mindfulness practice over many months (P4-86)
- Need personal engagement with its perplexing & paradoxical nature before using it clinically (P4-88b)
- Qualitatively different interaction with client when using something derived from personal experience compared to something derived from academic source (P4-21)
- Struggling with mindfulness presents same challenges for clients as does for therapist, so can draw support for this from personal study & practise of meditation (P4-93)
- Coherence with own conscious awareness of living when deciding what to use when in helping someone therapeutically (P4-20)
- Important to share personal experience with client of meditation (P4-62)
- Personal expressions of deeply individualised inner experiences & attempts at controlling these, often illustrate the power of such processes to clients when express then verbally - & rewarding for therapist when this happens (P4-79)

Essential to have personal practice of mindfulness in order to work clinically, although no single therapeutic approach owns mindfulness, and cannot rigidly specify minimum practical experience with mindfulness before able to use it clinically (P4-07)

- Unlikely to work successfully with mindfulness without having an established personal practice – especially in dealing with likely challenges faced by clients (P4-87)
- Length & breadth of experience in using mindfulness clinically allows teaching of approach to other clinicians (P4-82)
- Process of mindfulness training is critical in allowing self-acceptance & personal awareness to meld together – so that group protocol & sharing of mindfulness experiences are crucial parts of process (P4-78)
- Some other approaches have minimum criteria for establishing mindfulness practice, before allowing new practitioners to use it (P4-85)
- No one individual can own mindfulness in psychotherapy (P4-84)
- Beware others exploiting commercial benefits of mindfulness in therapy (P4-83)

Shared sense of humanity critical to successful therapy, together with an understanding limits of what seeking to achieve with client in therapy (P4-08)

- Clinical training in psychology teaches that people with psychosis different (P4-25b)
- Lack of preconceived ideas about therapy & Rogerian acceptance key early determinants of way do therapy (P4-24)
- Common sense of humanity in meeting with client as therapist (P4-25a)
- Therapy for P4 about helping relieve deeply troubling & painful experience, not spiritual guidance (P4-54)
- Critical to stay with relieving distress & promoting well-being in therapy – clients can pursue further those things they find useful outside therapy (P4-96)
- Understanding deeply ways people engage with troubling sensations key to effective therapy - & mindfulness facilitates this (P4-27)

Potential tensions in combining CT with mindfulness derived from assumptions of individual practitioners (P4-09)

- Annoying when CT presented too simply (P4-42)
- Simplistic views of CT challenged by use of MM (P4-43)
- Clinicians can engage with either MM or CT as techniques, without attending to experience of doing either (P4-18)
- If understand CT wrongly then likely to show conflict in languaging of MM (P4-41)
- Most tension between CT & MM arises from behaviourally oriented CT'ists (P4-46b)
- More behaviourally oriented CTists can demonstrate epiphany when get MM (P4-46a)
- Further exploration of how to integrate CT & MM, rather than run them as 2 parallel systems (P4-106)
- Alarming when practitioners use conflicting terminology to talk about CT & MM (P4-40)
- This danger as great as that of introducing Buddhism through use of mindfulness (P4-98b)

CT and mindfulness also inherently compatible where sharing focus on changes in personal meaning through therapy and arising of metacognitive insight into distress as product of connections between cognitive events (P4-10)

- MM & psychological therapy share 2 common aims: alleviating distress & promoting well-being through recognising that suffering arises from person's inner relationship with sensations (P4-16)
- CT & MM 2 different ways of changing meaning (P4-50)
- Possible to engage with MM & CT in more responsive & reflective way – to ask questions of one's experience in relation to client's & explore coherence (P4-19)
- Both MM & CT can be deeply empathic, warm & understanding - & both can equally be the opposite, depending on person of therapist (P4-47)
- Personal meaning & mechanisms of change are common to CT & MM - & must continue to question how these are working (P4-107a)
- CT & MM to fully complement each other theoretically - & practically with regard to client & therapist experience (P4-39)
- CT & mindfulness cohesively integrated, or work together as 2 systems in parallel (P4-37)
- CT & MM both foster such metacognitive insight (P4-70)

- Metacognitive insight is key to change – as awareness of how distress arises from ways understand & connect with cognitive events is what helps – not belief that cognitive events directly drive distress (P4-69)
- Teaching meditation not enough by itself (P4-29)

<u>Exploring interface between Buddhism & clinical use of mindfulness very important, although clinical mindfulness not necessarily in itself a Buddhist undertaking (P4-11)</u>

- Relationship between mindfulness & Buddhism very important – especially in current terms (P4-30)
- Studied Buddhist psychology & other teachings too (P4-91b)
- Self & evaluation both key ideas in Buddhism & meditation literature (P4-67)
- Looking deeply into arising of distress & dis-satisfaction have much in common for Buddhism & therapy (P4-34)
- All aspects of Buddhist teaching inherently present in mindfulness, although no need to make these explicit (P4-95a)
- Need for further exploration of interface in therapists between mindfulness & personal belief based in Buddhism (P4-105a)
- Religious aspects of Buddhism not appealing (P4-33)
- Clients don't come looking for Buddhism when consider therapy (P4-35)
- How far may therapists share these with client (P4-105b)

<u>Tensions between Buddhism & clinical mindfulness & how therapist manages own beliefs about living in connection with client's exploration into meaning & personal experience (P4-12)</u>

- Relationship between Buddhist teachings & clinical use of mindfulness are in tension & flux (p4-32)
- Tensions between Buddhism & therapy operate at personal, emotional levels in therapist (P4-36)
- Need to manage tension in therapy between encouraging & facilitating client's deep personal enquiry into own process of living - & staying aware of potential for therapist's own beliefs about living to be offered to client (P4-63)
- At times of positive growth for client in therapy, tempting for therapist to feel deep connection between these moments & their personal, spiritual beliefs – be aware of this (P4-80)
- Can move beyond reasonable expectations of client if follow therapist's own agenda (P4-55)
- Discomfort arises from personal beliefs of therapist impinging on scope of therapeutic work as agreed with client (P4-60)
- Objectively identifying self with labels of what one does in world can be misleading (P4-22)

<u>Wider framework of working with spirituality in therapy leads to tensions between role as therapist & personal beliefs of client and therapist, especially in respect of clinically exploring 'compassion' from Buddhist perspective (P4-13)</u>

- Ways of working with people's experience in spiritual framework is worrying (P4-52)
- Spiritual life of clients is important to them without doubt, but challenges exist in how to work this as therapist (P4-56)
- Spiritual experience is valid in therapy, as long as clear about purpose of specific therapy & client's expectations about it (P4-53)
- Each therapist must find own balance between personal & spiritual beliefs & professional practice (P4-89)
- Compassion as facet of spirituality – how to introduce this in client work (P4-57)
- Compassion inherently part of mindfulness & therapy more widely (P4-58)
- Specifically working with clients to generate "loving kindness" feels inappropriate – unsure why (P4-59)

<u>Mindfulness involves 'being with' one's experience as acceptance & seeing how this can generate or relieve distress – latter is metacognitive insight (P4-14)</u>

- Mindfulness is both straightforward & complex – as intellectual construct & experientially (P4-88a)
- What noticed is "raw sensation" & how these "constantly change" (P4-11)
- MM operates at 2 levels of awareness – a process of experiencing sensations; an opportunity for discovering something about the way the first process functions in generating & relieving distress (P4-15a)

- Latter aspect of awareness is "metacognitive insight" (P4-15b)
- Metacognitive insight available to all people potentially (P4-71)
- Insight & mindfulness meditation are same thing (P4-66a)
- Both allow cultivation of seeing more clearly one's engagement with sensation & suffering, & relationship between these two (P4-66b)
- Acceptance of such experiences is basis of therapeutic helping (P4-03b)
- Acceptance in mindfulness very close to Rogerian acceptance – client being with experience & therapist validating that experience (P4-26)
- Acceptance alters that common understanding (P4-23b)
- Observing mindfully automatically involves being caught up to some extent in responding (P4-74)
- Everybody can increase their awareness of present moment (P4-72)
- Can focus on striving in meditation practice at expense of the purpose that meditation serves (P4-65)

<u>Supervision in mindfulness clinically not necessary – can pursue as part of own personal development without discussing case material (P4-15)</u>

- Direct clinical supervision in mindfulness practice not necessary (P4-94b)
- Look for "experience" & "wisdom" in meditation teachers or other areas of personal development as need to find them (P4-94a)
- Personal connection with meditation teachers – would not discuss case material with a teacher (P4-92)

## Superordinate Themes – Analysis of Participants' Themes <u>Appendix X</u>

**NB** *For the purposes of illustrating the procedure followed during analysis, the following themes show only those contributions from participants 1 and 4. Therefore, some themes show contributions from only 1 participant, and some show no contributions from either.*

1 <u>Spiritual versus secular</u>

- Buddhist concepts very informative as underpinning framework – other religious traditions share similar ideas (P1-09)
- Potential tensions in combining CT with mindfulness derived from assumptions of individual practitioners (P4-09)
- Exploring interface between Buddhism & clinical use of mindfulness very important, although clinical mindfulness not necessarily in itself a Buddhist undertaking (P4-11)
- Tensions between Buddhism & clinical mindfulness & how therapist manages own beliefs about living in connection with client's exploration into meaning & personal experience (P4-12)
- Wider framework of working with spirituality in therapy leads to tensions between role as therapist & personal beliefs of client and therapist, especially in respect of clinically exploring 'compassion' from Buddhist perspective (P4-13)

2 <u>Issues associated with empirical evidence: some way to go to reliably establish effectiveness for mindfulness as clinical intervention in NHS</u>

- Research evidence regarding clinical uses of mindfulness difficult to apply to everyday therapy work as mostly efficacy-based (P1-11)
- Empirical measurement, clearer definition & evaluation of mindfulness important to justify its continued clinical use in NHS, and as part of CT approach (P4-03)

3 <u>Some techniques & underpinning ideas from CT combine well with mindfulness – although when mindfulness is used within a strict CT framework, it is required to name mindfulness and identify it as a technique together with an intellectual rationale for why it may be useful to client</u>

- Relationship between thoughts & thinker is key, and relevant to commonalities and differences between mindfulness used clinically & CT, as mindfulness increases awareness of inner experience & the distance between it & the observing self – a metacognitive shift – whereas CT puts emphasis on engaging directly with thoughts themselves (P1-03)
- Change in personal meaning is key to both CT & mindfulness practice, derived from an increased awareness of relationship between inner fears and distress – risk losing this focus if CT moves on to next fashionable thing (P4-04)
- CT and mindfulness also inherently compatible where sharing focus on changes in personal meaning through therapy and arising of metacognitive insight into distress as product of connections between cognitive events (P4-10)

4 <u>Participants described disparate range of therapeutic influences beyond those of CT when recalling what persuaded them to initially use mindfulness therapeutically – even when they used it in context of CT</u>

- CBT felt to be ineffective in some cases, in light of growing complexity of problems presenting clinically, so that CBT not always effective and some techniques not always very productive (P1-01)
- DBT corroborated personal approach to using mindfulness clinically – but some concerns about DBT itself (P1-06)
- Nature of mind as machine that processes information & that verbalises experience internally – which leads to suffering & need for "defusion" strategies (due to overly-close identification with activities of mind) (P1-07)
- ACT ideas also very influential (P1-10)

5 <u>Used in groups where formally teaching mindfulness, require an intellectual rationale to inform client why mindfulness relevant & appropriate approach to their particular problems, at this time</u>

- Applied to psychosis providing simple rationale and starting meditation by using awareness of bodily sensation to teach acceptance of experience as it is (P4-02)

6 All participants reported a deeply significant experiential engagement with mindfulness in personal lives as highly influential in their decision to start using it clinically with clients

- Importance of personal experience of mindfulness practice in therapist's own life (P1-04)
- *Influences on practice of personal experience & principles for self-disclosure (P1-08a)*
- *Repeated experience of using mindfulness clinically has taught P1 some key approaches in therapy (P1-08c)*
- Clinical use of mindfulness requires some therapist maturity & commitment to personal mindfulness practice, opening door for qualitatively different therapeutic interaction with client as drawing on something deeply meaningful for therapist also (P4-06)
- Essential to have personal practice of mindfulness in order to work clinically, although no single therapeutic approach owns mindfulness, and cannot rigidly specify minimum practical experience with mindfulness before able to use it clinically (P4-07)

7 Core aspect of using mindfulness clinically for all participants was a sense that underpinned by an assumption of "destructive normality" – so that naturally promoted more authentic human to human interaction & that client's distress reflects universal human processes

- Working with patients using mindfulness requires sensitivity to their individual needs & pace of understanding – putting things in their language & using simple metaphors for mind-process – as informed by repeated clinical experience (P1-08)
- Mindfulness is common process for both therapist & client, so that therapists can be reinforced for sharing own experience – should allow client to develop at own experiential pace & in own context (P4-05)
- Shared sense of humanity critical to successful therapy, together with an understanding limits of what seeking to achieve with client in therapy (P4-08)

8 Wider dissemination of mindfulness training techniques in NHS therapies requires commitment to appropriate training & clinical supervision – although resources limited

9 For every participant, positive subjective feedback from earliest clients with whom mindfulness was used encouraged its continued clinical use

- *Experience of speculative trial with 1 patient encouraged further clinical use before any real published research evidence available (P1-08b)*
- Profound personal experience of mindfulness in own life encouraged its use clinically and developed into group protocol from there (P4-01)

10 "Being with" key to mindfulness as a therapeutic undertaking – sense of 'getting it' helps develop compassion & insight

- Being with experience rather than avoiding it (P1-02)
- Mindfulness involves 'being with' one's experience as acceptance & seeing how this can generate or relieve distress – latter is metacognitive insight (P4-14)

11 Metta & compassion not widely addressed in literature & confusion as to its relevance clinically, although acknowledged as implicitly key part of what makes mindfulness effective

12 Issues around supervision

- Importance of supervision, both as shared with others and as an inner awareness developed through mindfulness practice (P1-05)
- Supervision in mindfulness clinically not necessary – can pursue as part of own personal development without discussing case material (P4-15)