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Mindfulness in Traditional Psychotherapy: A Qualitative Study

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Mindfulness in Traditional Psychotherapy: A Qualitative Study

by

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MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
University of St. Thomas and St. Catherine University
St. Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of

Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

Abstract

Empirically tested research suggests the effectiveness and applicability of mindfulness interventions in psychotherapy to treat or provide supplemental treatment to a variety of mental health disorders, to improve the therapeutic alliance, and to promote self-care and use of self in clinicians. Despite the successes of mindfulness in the mental health community, only a select culture of clinicians utilize mindfulness techniques in their practice. In order to explore how mindfulness can impact the therapeutic process, a qualitative study was conducted. Seven clinicians who currently practice mindfulness and who utilize mindfulness-based and mindfulness-informed interventions in clinical practice were interviewed. The interviews explored the use of mindfulness in psychotherapy in four sub-topics: 1. How mindfulness can impact the clinician in terms of self-care and perceived therapeutic ability; 2. How mindfulness education/techniques can impact the client; 3. How relational mindfulness can affect the therapeutic relationship between clinician and client; and 4. The challenges and implications of using mindfulness in a therapeutic setting. Using grounded-theory to analyze the data, seven major themes were suggested in the findings. The themes consisted of the following: self-care; affect regulation in the clinician and the client; populations with sub themes of anxiety, trauma, and psychosis; client and clinician relationship/connection; language; access; and culture. The findings imply that mindfulness is beneficial for clinician self-care and as an intervention for a variety of mental health populations by allowing for greater affect regulation. The findings also imply that mindfulness can positively impact the therapeutic relationship by allowing the therapist to remain grounded, present, and authentic in interactions with clients. However, the findings identified that language and cultural aspects may create barriers to the effectiveness of mindfulness. Despite the identified themes, the limited sample size did not allow for generalization of the findings. Further research should be directed towards the understanding of how mindfulness can impact the clinician, client, and therapeutic relationship in clinical education and practice.

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Mindfulness in Traditional Psychotherapy

Mental health has become a growing topic of interest in the last five decades after the passing of the Community Mental Health Act in 1963 (Joiner, 2013). The National Institute of Mental Health estimates that approximately one quarter of Americans aged 18 and older suffer from a mental health disorder (Mental disorders in America). The growing number of mental health diagnoses has increased the need for treatments and interventions for these disorders. Some treatment tactics have included the development of new interventions and the creation of medications to alleviate symptoms (Mojtabai & Olfson, 2011). Prescriptions for medications for mental health disorders are on the rise (Mojtabai & Olfson, 2011). Antidepressants, alone, have become the third most commonly prescribed class of medication in the United States over the past two decades (Mojtabai & Olfson, 2011). While medications can be very effective in some cases, they can also come with fairly significant side effects (Miller, Keefe, Stroup, Lieberman, Caroff, Davis, Rosenheck, McEvoy, Saltz, Riggio, Chakos & Swartz, 2008). In order to reduce medication consumption and treat mental health disorders more naturally, researchers have expanded their studies to encompass integrative therapies and interventions to alleviate these disorders (Elliot, Kennedy, Morgan, Anderson, & Morris, 2012). This research has been relatively successful and interventions involving physical movement, music, and animals, for example, have all shown effectiveness in treating many types of mental health disorders (Parshall, 2003; Elliot, et al., 2012; Halligan, 2013).

One integrative intervention that is becoming more popular in the mental health world is the use of mindfulness-informed, and mindfulness-based therapies. Mindfulness

is a practice rooted in Buddhist teachings and invites the practitioner to observe and understand the path to non-suffering through the practice of being mindful, or non-judgmentally being present in his or her experience (Kabat-Zinn, 2003). Promising research has shown mindfulness interventions to be effective in treating or providing a supplement to traditional treatment methods in mood, pathological-related, and personality-related disorders (Grepmaier, Mitterlehner, Loew, Bachler, Rother & Nickel, 2007; Didonna, 2009). Additionally, Turner (2009) proposed that mindfulness can assist the practitioner in developing attention, affect regulation, attunement, and empathy skills.

As the literature suggests, it is important to examine the benefits of mindfulness in mental health. Three of the benefits include the following: First, mindfulness allows the practitioner the potential to create a relationship or alliance with his or her client that is grounded and present (Falb & Pargament, 2012). Second, mindfulness can serve an educative function in which the therapist can invite the client to reduce suffering by non-judgmentally observing and freeing him or herself from attachment to experiences and outcomes (Didonna, 2009). Lastly, mindfulness can serve the clinician as an effective tool in self-care practices (Shapiro, Carlson, & Washington, 2009). The research suggesting the benefits of mindfulness posit that skills gained from mindfulness could be helpful not only for the client, but also for the mental health clinician (Turner, 2009)

The three benefits of mindfulness in the mental health profession suggested above relate not only to mental health clinicians, but to all professionals working in a helping profession. One profession often involved in working with clients with mental disorders is the social work profession. Currently, 60% of mental health professionals are clinically trained social workers (www.naswdc.org). In addition to working directly in the mental

health field, social workers also work with clients who suffer from mental health disorders in agency field settings. Mindfulness is particularly appropriate for social work in that, similar to mindfulness, one core-value of social work is to attempt to relieve suffering (Turner, 2009). This concept is observed in the multiple venues in which social workers work with clients to promote social justice within the confines of societal constructs. Exploring the ways the three benefits of mindfulness mentioned above can apply to those working in helping professions, especially social workers, may be useful in assisting their work with clients and in their self-care routine.

While mindfulness has become a topic of interest in mental health, the psychology on which mindfulness is built is vast and complex. Continued research is needed in order to gain a better understanding of how mindfulness can effectively be used in clinical practice. This study will explore the present uses of mindfulness as they relate to clinical practice. Additionally, this study will seek to qualitatively explore the current use of mindfulness in traditional psychotherapy to gain a better understanding on how this integrative intervention is being used to treat patients and to gain understanding on perceived challenges and implications of this practice.

Conceptual Framework

In order to discuss the use of mindfulness in clinical and social work practice, it is important to examine mindfulness through a conceptual framework related to these professions. Unfortunately, though mindfulness is a practice engrained in Eastern world history, it is not specifically related to any one conceptual framework within social work practice. Mindfulness, instead, can be more generally related to several social work frameworks including, but not limited to, strengths, humanism, and integrative

perspectives (Lee, Ng, Leung & Chan, 2009). Because mindfulness cannot be clearly connected to any one framework, mindfulness will be examined through two perspectives in this paper: 1. a more traditional social work theory, the strengths perspective; and 2. a newly proposed social work theory, the body-mind-spirit integrative framework (Miley, O'Melia, DuBois, 2011; Lee, 2009) .

The strengths perspective acknowledges that all people carry inherent power within themselves and encourages social workers to work with their clients to draw this power to the surface (Miley, et al., 2011). This practice requires the social worker to focus on the strengths of the client on micro, mezzo, and macro levels (Miley, et al., 2011). The strengths-perspective was created because of the often-negative circumstances that are attached to clients connected to social workers (Miley, et al., 2011). By using this perspective, the social worker can promote resiliency by challenging him or herself and subsequently, the client, to alter his or her paradigm to focus on the positive aspects, or the strengths of the situation (Miley, et al., 2011). Mindfulness also challenges the practitioner to invoke a paradigm shift by being present in an experience in a non-judgmental way to alleviate suffering. According to Didonna (2009), “The aim [of Buddhist psychology] is to free individuals from negative mental states by altering the perceptive and cognitive processes” (p. 4).

While the strengths-perspective will allow the researcher to examine mindfulness as a strength-based intervention, the strengths-perspective does not incorporate the spiritual aspect of mindfulness and therefore does not allow the researcher to examine mindfulness as it is rooted in Eastern Buddhist tradition (Lee, et al., 2009). The body-mind-spirit integrative framework builds upon the strengths-perspective and is a holistic

framework that expands the traditional social work bio-psycho-social perspective to also include spiritual and habitual aspects (Lee, et al., 2009).

The body-mind-spirit framework is derived from the basic knowledge of social work practice. Social workers view this framework to be oriented in the areas of social work justice and ethics (Lee, et al., 2009). In addition to having a social work foundation, this perspective utilizes eastern philosophies including Daoism, Buddhism, and theories of traditional Chinese medicine to inform and promote a holistic practice (Lee, et al., 2009). While this perspective emphasizes the importance of spirituality, it does not attach itself to a religious practice (Lee, et al., 2009). In this framework, spirituality is defined as a broad concept that encompasses and integrates “all aspects of the person in the process of searching for meaning and purpose” (Lee, et al., 2009, p. vii).

The application of this framework relies on the belief that the process of life is in constant evolution. According to Lee, et al., (2009) the focus of the body-mind-spirit perspective is on engaging “inner wisdom and environmental supports of clients in order to nurture resilience, empowerment, and transformation” (p. vii). It is in this way that the practitioner can fully understand the client by evaluating him or her through a “well-being” lens. This lens challenges the practitioner to view every aspect of a person’s life as connected (Lee, et al., 2009). This lens also assists the client in balancing and grounding him or herself in order to “maintain a sense of peace and personal integrity while facing life’s unfolding challenges” (Lee, et al., 2009, p. 197).

A combination of the strengths-perspective and the body-mind-spirit framework will allow the researcher to examine mindfulness under a strengths-based and spiritual lens (Lee, et al., 2009; Miley, et. al, 2011). The following literature review will explore

the dynamics of mindfulness as it is currently portrayed in psychology and clinical social work through the lenses of these two perspectives.

Review of Literature

The following review of literature explores mindfulness in mental health. This exploration will review the history and definition of mindfulness and will briefly look at how mindfulness has been used in psychotherapy. Finally, this literature review will seek to explore how mindfulness can be beneficial in traditional psychotherapy, to the clinician, to the client, and to their relationship.

History of mindfulness

Mindfulness is rooted in the 2,500-year-old core teachings of Buddhist psychology; however, meditation and mindfulness are thought to have begun as far back as 4,000 years with ancient eastern yogic practices (Didonna, 2009; Shapiro, et al., 2009). According to Didonna (2009), the definitional base of the English word “mindfulness” translates from the Pali word, “sati,” “meaning awareness, attention, and remembering” (p. 18). The core of mindfulness strives, in the words of Didonna (2009), “to eliminate needless suffering by cultivating insight into the workings of the mind and the nature of the material world” (p. 18). Mindfulness has often been referred to as “the heart” (p. 145) of Buddhist meditation and is an attribute of the core teachings of the Buddha (Kabat-Zinn, 2003). Kabat-Zinn (2003) portrayed the historical Buddha as “a man who became a well-known and regarded physician, a scientist-of-sorts, with no tools other than his own mind, body, and experience” (p. 145). This “learned way of being” as demonstrated by Buddha points to the idea that it is possible for each of us to gain insight into our “self”

and through experience and self-awareness have the potential to eliminate internal suffering (Kabat-Zinn, 2003, p. 145).

The history and principles of Buddhism are intricate and impossible to cover in the scope of this paper; however, the idea of eliminating suffering is a crucial element to the Buddhist teachings (Harris, 2009). Suffering was taught in the Buddhist psychology and is acknowledged in the four noble truths (Lopez, 2013). The four noble truths are: 1. The truth of suffering; 2. The truth of the cause of suffering; 3. The truth of the end of suffering; and 4. The truth of the path that leads to the end of suffering (Lopez, 2013). These truths are recognized by all branches of Buddhist practice and are considered the “middle way,” between abstinence and indulgence in the Buddhist psychology (Harris, 2009). The eightfold path, also recognized by most Buddhist followers, offers the way to enlightenment regarding these four truths. Mindfulness is part of the eightfold path and is designed to cultivate an awareness that can bring an internal understanding of the four noble truths. This understanding acknowledges there is suffering, but also that there is an internal path that can lead to the end of suffering. Mindfulness contributes to finding this path by enlightening the practitioner on how to eliminate attachment to worldly possessions, emotions, thoughts, and outcomes (Kabat-Zinn, 2003).

There are a number of ways to practice mindfulness; however, mindfulness is typically cultivated through intentional mental practices involving meditation (Didonna, 2009). Meditation is usually practiced in four formats, including: experiential mindfulness, formal meditation, movement meditation, and retreat practice (Didonna, 2009). Experiential mindfulness is an intention that involves reminding oneself to pay attention to what is happening in the moment (Didonna, 2009). Formal meditation is

setting aside time to sit alone and quietly with an internal focus. Movement meditation refers to practices such as yoga or qi gong that incorporate being mindful into kinesthetic activity. Finally, retreat practice is referred to by Didonna (2009) as a “vacation” (p. 23) dedicated entirely to cultivating mindfulness. Retreats typically involve extended periods of the aforementioned formal meditation practice. Regardless of the method, all meditation practice invites the practice of non-judgmentally experiencing feelings, thoughts, and emotions as they occur during the designated meditation time. Each format requires practice and dedication (Didonna, 2009). The goal of each of these forms of mindfulness meditation is to be aware of all experiences in our lives with acceptance, gratitude, compassion, and non-attachment thus, alleviating internal suffering (Didonna, 2009).

While mindfulness is derived from eastern Buddhist practices, the attributes of mindfulness are embedded in many religious and spiritual traditions and can be found in western culture in philosophical and psychological schools of thought (Kabat-Zinn, 2003; Shapiro, et al., 2009). Some of the literature discussed below will look more deeply at the implications of mindfulness and its relation to non-secular roots.

Mindfulness in psychotherapy

While mindfulness has been present in psychotherapeutic treatment approaches since the 1980's, interest in this subject has increased exponentially in the last ten years (Grepmaier, Mitterlehner, Loew, Bachler, Rother & Nickel, 2007; Didonna, 2009). Shapiro, et al. (2009) identified that attempting to write about and describe mindfulness in an “academic and conceptual way,” (p. 3) is, in many ways, against the very nature of the term. They note that the concept of being mindful and meditative is an internal and

experiential process. Despite this claim, the practice of mindfulness is, at its very root, a therapeutic process, and therefore must be studied and literally identified in order to create ethical uses in clinical practice (Turner, 2009).

As mindfulness has made its way into western therapeutic practices, the definition has been altered to identify a more unified academic definition (Shapiro, et al., 2009). For the purposes of this paper, we will use the operational definition of mindfulness as composed by Jon Kabat-Zinn (2003): “the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment to moment” (Kabat-Zinn, 2003, p. 145). According to Siegel, Germer, and Olendzki, (Didonna, 2009) mindfulness is a “deceptively simple way of relating to all experience that can reduce suffering and set the stage for positive personal transformation” (p. 17). This is because it allows the practitioner of mindfulness to respond to difficulties in life in an altered, mindful, and non-attached way (Didonna, 2009). It is for these reasons that mindfulness has become increasingly popular in traditional psychotherapy (Grepmaier, et al., 2007).

Mindfulness interventions in psychotherapy

As mindfulness has become more prevalent in the mental health world, clinicians have begun incorporating mindfulness tactics into their practice through mindfulness-based interventions and mindfulness-informed therapy (Shapiro, et al., 2009).

Mindfulness-informed therapies utilize elements of mindfulness within traditional work with clients (Shapiro, et al., 2009). Mindfulness-based therapies incorporate mindfulness into specific interventions (Didonna, 2009).

Some examples of mindfulness-based interventions include Mindfulness-Based Cognitive Therapy (MBCT), a therapy designed to prevent relapse of major depression (Coelho, Canter, & Ernst, 2013); Dialectical Behavior Therapy (DBT), a skill-based mindfulness therapy showing success in working with clients who have borderline personality disorder (Didonna, 2009 p.85); Mindfulness-Based Stress Reduction (MBSR), an intervention that has been used to treat anxiety and chronic pain (Didonna, 2009; Shapiro, et al., 2009); and Acceptance and Commitment Therapy (ACT) which explores the use of mindfulness, cognition and language to help a variety of mental disorders (Falb & Pargament, 2012; Shapiro, et al., 2009). Each of these mindfulness-based interventions has, thus far, shown to be promising in regards to their clinical effectiveness and is becoming a popular intervention in work with clients (Coelho, et al., 2013).

On the other hand, mindfulness-informed psychotherapy involves incorporating the knowledge of mindfulness more generally into the therapeutic setting (Shapiro, et al., 2009). The implications of this therapy are varied because mindfulness is applied in a less structured way (Shapiro, et al., 2009). Subsequently, the use of mindfulness in mindfulness-informed therapy can differ from clinician to clinician based on his or her knowledge and insight into the practice of mindfulness, the client's receptivity to using mindfulness, and the time the clinician is able to dedicate to teaching it. More research in this area would be helpful in order to understand how to effectively implement mindfulness-informed practices into work with clients in this way (Shapiro, et al., 2009).

While mindfulness has been found to be successful in psychotherapy, the use of mindfulness in psychotherapeutic care is often separated from its spiritual Buddhist roots.

This includes mindfulness-based interventions, which are typically separated from Buddhist roots (Falb & Pargament, 2009). Even mindfulness-informed therapies, which are typically utilized because of the basis of their spiritual origins, may be secular in nature depending on the knowledge embodied by the clinician using mindfulness techniques in clinical practice. Despite many suggested benefits of utilizing mindfulness in therapeutic interventions, the understanding of mindfulness as rooted in spiritualism can be a controversial topic based on the limited literature that examines whether or not mindfulness is therapeutically effective when used in a secular manner. Instead, many authors and studies on this topic regarding mindfulness psychotherapeutic interventions consider mindfulness and recognize its Eastern roots. Often, these authors also consider mindfulness a part of the western tradition and culture and a concept that can be effective when secular in nature (Didonna, 2009). Additionally, because the concept of mindfulness is inherent in many other spiritual traditions, mindfulness can be incorporated into therapeutic care through other spiritual relationships (Kabat-Zinn, 2003; Shapiro, et al., 2009). The religious application of mindfulness in Western tradition, in addition to secular use of mindfulness, further removes mindfulness from its Buddhist origins, however, increases the population with which clinicians can utilize mindfulness techniques.

Conversely, Rosenbaum (2009) suggests separating mindfulness from its traditional Buddhist foundation and psychology in psychotherapy runs the risk of being harmful to the client. Rosenbaum (2009) suggests that often, when mindfulness is used in psychotherapy, it is completely severed from its spiritualistic ties. While this is recognized by Rosenbaum (2009) as a possible way to avoid alienating clients who may

object to practicing a religion other than their own, Rosenbaum also points out that removing mindfulness from its original roots can lead to “emphasizing technique at the expense of relationship” (p. 208). By this, he means it becomes easier to “brand,” mindfulness as a particular skill that may be removed completely from the actual concept and goal of being mindful (p. 208). Rosenbaum (2009) urges clinicians who use mindfulness to be wary of their understanding of mindfulness before implementing it into their psychotherapeutic practice.

Mindfulness and the client

Mindfulness-based therapies have been created and suggested as effective in alleviating multiple physical and mental health symptoms in clients of all ages and cultural backgrounds (Didonna, 2009). One example of how mindfulness has been suggested to be helpful involves the use of Mindfulness-Based Cognitive Therapy (MBCT). In one study, MBCT was used in a randomized control group study focused on treating patients with depression. In this study, MBCT was found to be effective in preventing depression relapse/recurrence in recovered depressed patients with three or more previous episodes (Ma & Teasdale, 2007).

Similarly, in a meta-analysis, 39 participants were selected and pre and posttests which measured the effects of mindfulness on participants with a diagnosable psychological or physical/medical disorder ranging from depression to anxiety to chronic pain were analyzed (Hofmann, Sawyer, Witt, & Oh, 2010). The vast majority of these studies utilized MBSR and MBCT as interventions for these disorders (Hofmann, et al., 2010). The findings showed that mindfulness based-therapies improved anxiety and depression symptoms across a wide range of intensities even when the symptoms were

related to medical problems (Hofmann, et al., 2010). More research is needed, but evidence is pointing to positive effects of mindfulness-based therapies for mood and anxiety disorders.

While the majority of research in mindfulness has been focused around mood disorders, there are limited studies that have suggested that mindfulness is also effective in helping to treat psychotic disorders (Chien, Lee, & Phil, 2013). In a study completed in China, a controlled trial using a repeated-measures design studied the effects of mindfulness-based psycho-education program (MBPP) on Chinese patients with schizophrenia. This program was intended to increase patients' knowledge and insight into their illness and its symptoms and consisted of 12 bi-weekly, two-hour group sessions focused on teaching patients to become more aware, or "mindful," of their accurate and inaccurate reactions to the world (Chien, et al., 2013). Compared to the control group, the patients who participated in the MBPP showed significant improvements in many areas including illness insights, symptoms severity, functioning, and number and length of re-hospitalizations over the 18 months following the intervention (Chien, et al., 2013). Additionally, this study highlights the importance of tailoring mindfulness-based approaches to the culture of the disorder and environment of the client (Chien, et al., 2013). While this study suggested positive use of mindfulness with psychotic disorders, other research completed on this topic has been inconclusive or pointed to mindfulness as a negative intervention for psychosis (Didonna, 2009). This points to the need for further research on how interventions that utilize mindfulness affect people suffering from psychotic disorders (Didonna, 2009).

The benefits of mindfulness can be seen not only on a behavioral level, but also on a biological/neurological level (Didonna, 2009; Howells, Ives-Deliperi, Horn, & Stein, 2012). In a pilot study, participants with bipolar disorder underwent a variety of tests analyzed by electroencephalography (EEG)(Howells, et al., 2012). In a pre-test, post-test model, results showed increased activity in the right frontal cortex suggesting that MBCT may result in improved “attentional readiness, and attenuated activation of non-relevant information processing during attentional processes” (p. 1) in individuals with bipolar disorder (Howells, et al., 2012, p.1). This means participants were better able to focus on tasks regardless of their current emotional state. This is one of very few studies completed that suggest mindfulness is capable of changing brain functioning (Howells, et al., 2012). These studies support the assertion that incorporating mindfulness into already established treatment methods can add to the effectiveness of these interventions.

Mindfulness and the clinician

The growing research regarding efficacy of mindfulness-based interventions in psychotherapy suggests that mindfulness is an effective therapeutic technique for clinicians to use to help their clients (Chien, et al., 2013; Howells, et al., 2012). While less research has examined how mindfulness can be beneficial for clinicians themselves, existing research does suggest benefits for mindfulness practicing clinicians (Shapiro, et al., 2009). Just as research suggests that mindfulness may improve psychological well-being, mental, and physical health in clients of psychotherapy, so can it also improve these factors in the therapists who treat these clients (Shapiro, et al., 2009). Studies show mindfulness to be effective for clinicians in two ways: 1. Alleviating occupational

burnout/compassion fatigue; and 2. Allowing clinicians to work more efficiently with their clients.

Psychotherapy is a “helping profession,” and is an occupation that can cause many psychological stressors (Shapiro et al., 2009, p. 113; Shapiro, Brown, & Biegel, 2007). Research suggests that due to the nature of therapeutic work, therapists are at risk for developing psychological problems such as increased depression, emotional exhaustion, anxiety, social dissatisfaction, and job dissatisfaction (Shapiro, et al., 2007). Additionally, despite the research supporting these common stressors in this occupation, most academic and occupational settings do not offer self-care courses as a requirement within their curricula or training for therapists/clinicians (Shapiro, et al., 2007). The lack of self-care skills in clinicians may lead to “compassion fatigue,” (p. 105) higher rates of occupational burnout, and a lessened ability to work effectively with clients (Shapiro, et al., 2007, p. 105).

A study completed by Shapiro, et al. (2007) points to the efficacy of mindfulness as a self-care technique for therapists in training as it explores the effects of MBSR as an approach to self-care. Using a controlled pre-test, post-test design, the therapists in the MBSR program reported significant improvements in perceived stress, negative affect, state and trait anxiety, rumination, and self-compassion. Participants also reported higher levels of mindfulness following their training (Shapiro, et al., 2007). While this study was limited in scope, it does point to the possibility of mindfulness-based interventions as effective clinician self-care techniques and highlights the positive effects of this type of training as a built-in part of a therapist’s education (Shapiro, et al., 2007).

Less literature is available in regards to mindfulness and clinician efficacy in treating patients (Didonna, 2009). One study that supports clinicians using mindfulness to increase their ability to work with clients is a quantitative study conducted in Germany. In this study, a group of 124 inpatient participants were treated for 9 weeks by 18 psychotherapists. Half of the psychotherapists practiced meditation, while the other half did not. In a pre-test, post-test model, the participants receiving treatment from psychotherapists practicing meditation showed greater results in all categories of testing, including symptom reduction. The results suggested that promoting mindfulness in psychotherapists could positively influence the therapeutic course and treatment results in patients.

Mindfulness and the therapeutic relationship

Historically, the therapeutic alliance in psychotherapy has been regarded as an influential component in change and viewed as an important factor in therapeutic outcomes (Goldberg, Davis, & Hoyt, 2013). Furthermore, studies have shown mindfulness techniques to have a positive impact on clinicians in their ability to work with their clients in a “meaningful and mindful” way, thus strengthening the therapeutic alliance (Falb & Pargament, 2012, p. 352). This effect is demonstrated in a study by Rimes and Wingrove (2010). In a pre-test, post-test model, clinician trainees underwent MBCT training. The post-test results suggested the participants, themselves, experienced the effects of MBCT that they were learning to use with clients. The participants also reported significant benefits to their clinical work in regards to awareness relating to clients (Rimes & Wingrove, 2010). Similarly, Goldberg, et al., (2010) studied the effects of mindfulness on the therapeutic relationship where clinicians used MBSR in attempt to

help clients quit smoking. In this study, the clinicians all had a long-term history of personal mindfulness meditation practice (Goldberg, et al., 2010). Measurements were taken in the form of questionnaires examining demographics, smoking behavior, nicotine dependence, treatment compliance, psychological functioning, mindfulness, and working- alliance (Goldberg, et al., 2010). In this study, the alliance was not shown to predict smoking outcomes, however, the synergy of mindfulness-based treatment and the therapeutic alliance was effective in improving the learning and implementation of mindfulness in the treatment process (Goldberg, et al., 2010).

Relational mindfulness is a relatively new term identified as the focus of mindfulness as practiced in relationship to other people. The concept of relational mindfulness, or practicing mindfulness as it exists in all relationships, opposes the original definition and use of mindfulness, where practice is focused inward and on the self (Falb & Pargament, 2012). Currently, the literature exploring relational mindfulness is very limited, however, Falb and Pargament (2012) suggest that relational mindfulness is a potentially important mindfulness factor in the therapeutic alliance that needs to be more deeply explored. Gregory Kramer, a teacher of meditation and author of *Insight Dialogue*, has suggested a more specific technique on how to enhance relational mindfulness in practice (Kramer, n.d.). In his book, *Insight Dialogue*, Kramer lists a composition of six steps that explore how to create relational mindfulness within a session this process can also be extended to use with personal relationships (Kramer, n.d.). These six steps invite the clinician to: 1. pause; 2. relax; 3. open; 4. trust emergence; 5. listen deeply; and 6. speak the truth (Kramer, n.d.). More research on how

mindfulness can affect the therapeutic relationship, specifically in the area of relational mindfulness, is needed to further understand the benefits and implications of this work.

Research Question

The benefits and uses for mindfulness in psychotherapy appear to be applicable on several levels of treatment. While this may be, Didonna (2009) argues that mindfulness should not be expected to be a “cure-all,” for mental disorders on its own. Didonna (2009) suggests four steps for consideration before clinicians use mindfulness in their practice:

(1) careful consideration of the population being served, and the current understanding with respect to etiology and maintenance of the particular condition being treated, (2) determination of how mindfulness might be helpful with this population, making reference to the mechanisms of change research, (3) evaluation of whether mindfulness training can be integrated with other empirically supported interventions, and (4) inclusion of a rationale to patients for the mindfulness components. (p. 95)

The rationale behind the considerations listed above comes from the need for more research involving the use and efficacy of mindfulness in psychotherapy (Didonna, 2009). The available literature points to the effectiveness of mindfulness in multiple areas of clinical treatment, for example, efficacy in positive client outcomes, clinician self-care, and the therapeutic alliance. As stated above, the idea of using mindfulness in traditional psychotherapy is not a new concept; however, based on the literature, specific areas need more developed research regarding the use of mindfulness in psychotherapy. Additionally, mindfulness-informed therapy is only formally utilized by a select group of

practitioners in the psychotherapeutic culture. The exploration of how clinicians who use mindfulness practices themselves can affect the clients' therapeutic results is an area that remains relatively unresearched. Furthermore, the exploration of how relational mindfulness can improve the therapeutic alliance and client relationships with others is another realm of mindfulness that needs to be more thoroughly studied (Falb & Pargament, 2012).

This research paper will explore mindfulness by interviewing clinicians who actively practice and prescribe mindfulness techniques to their clients. This study will also explore the present uses of mindfulness as they relate to clinical practice. Finally, this study will seek to qualitatively explore the current use of mindfulness in traditional psychotherapy to gain a better understanding on how this integrative intervention is being used to treat patients and to gain understanding on perceived implications of this practice.

Methods

The literature suggests that there are several important considerations to keep in mind when integrating mindfulness into therapeutic practice. This indicates a need for a better understanding of first-hand perspectives on how mindfulness is currently being used in practice. In regards to qualitative research, Berg (2009) suggests, "quality is essential to the nature of things" (p.3). Consequently, this study is qualitative in nature in order to understand, from first-hand accounts, the quality and the nature of mindfulness as it is integrated into the psychotherapeutic world. The interview questions developed by the researcher explored the use of mindfulness in psychotherapy in four sub-topics: 1. How mindfulness can impact the clinician in terms of self-care and perceived therapeutic ability; 2. How mindfulness education/techniques can impact the client; 3. How relational

mindfulness can affect the therapeutic relationship between clinician and client; and 4. The challenges and implications of using mindfulness in a therapeutic setting.

Sample

The sample for this study included clinical professionals who utilize mindfulness-informed and mindfulness-based interventions in their psychotherapeutic practice. Seven professionals were interviewed. These professionals were selected as a non-probability sample through networking and online search efforts by the researcher. The interviewees range in years of experience in working with clients in the clinical setting and in their experience using mindfulness in personal and professional settings. While the demographic and experience levels varied widely among interviewees, the participants were selected based on their understanding of the roots of mindfulness and meditation as they relate to mindfulness-informed and mindfulness-based practices. In addition, participants were also chosen based on the notion that each had his or her own mindfulness practices. A broader and more diverse interviewee population allowed for insight into how the practice of mindfulness is being used over a wide range of demographics.

In attempt to ensure that participants would fit the sampling requirements, participants were reviewed and screened by the researcher. Screening consisted of researching the potential participant before the initial contact and at initial contact to ensure he or she could speak to mindfulness as it is rooted in history, and that he or she is currently utilizing mindfulness-informed and/or mindfulness-based interventions in his or her practice. Researching these participants was done online and also by gaining a better understanding of their mindfulness uses by consulting the person that referred them each

as a participant. At initial contact with the participant, the topic of the research was reiterated as was the importance that he or she have his or her own mindfulness/meditation practices. Additionally, in order to create uniformity among interviews, every effort was made to follow the outline of the interview questions.

Data Collection/Procedures

After receiving Institutional Review Board (IRB) approval and participant consent, the data for this study was collected in a semi-formal interview style (Berg, 2009). The interview consisted of a set of questions composed by the researcher. These questions began with exploring the demographics and the personal theoretical orientation of the clinician's practice. Also explored, was the interviewee's personal definition of mindfulness as it is used in his or her practice. Following these questions, the interviewer addressed the sub-topics of the research question stated above. This involved a series of questions including: 1. How does mindfulness impact you in terms of self-care?; 2. How does mindfulness impact you in terms of perceived therapeutic ability?; 3. How do mindfulness education/techniques impact the client in session?; 4. How do mindfulness education/techniques impact the client in life?; 5. How does mindfulness affect the therapeutic relationship between you and your clients?; and 6. What are the challenges and implications of using mindfulness in a therapeutic setting? (See appendix A for a full list of interview questions). Other supplemental questions regarding the sub-topics of the research questions were also developed. These additional questions addressed the nature and use of mindfulness in the clinical setting, client and clinician benefits, and the significance of mindfulness in the therapeutic relationship. The questions developed by the researcher were reviewed by peers in a classroom setting and by the researcher's

committee in order to improve their reliability, validity and applicability to this study and to the overall research question.

Of the seven interviews, four interviews took place in person, and three interviews were conducted over a corresponding e-mail interview format. In the e-mail interview, the participant was given a hard copy of the interview and responded to each question. Follow-up questions were conducted over e-mail. All in-person interviews were conducted in private office settings with no interruptions. The in-person interviews were recorded, transcribed and coded. The e-mail interviews were individually compiled each into their own document and coded in the same manner as the transcribed interviews. All recordings and transcriptions and documents were kept in a locked safe and/or password protected computer file and destroyed at the end of the project.

Data Analysis

Analysis of the transcription content, or content analysis, is the systematic way of examining and interpreting material in order to identify patterns, themes, and biases (Berg, 2009). In this case, the transcription material of the interview was analyzed using a process called open coding. This process involved examining the transcript line by line and identifying unified codes or themes. A code is a record of pattern in the data, and a theme is formed once three or more of the same code has been identified in the data. An inductive grounded theory method was utilized to find codes and themes and was used to code similarities and differences (Berg, 2009).

Researcher Biases

Bias should be a considered factor in all research. Being mindful of how bias can skew data collection and results is an important aspect of being a researcher. Based on the

nature of this paper, the biases of this researcher come in the favor of using mindfulness techniques in traditional therapy settings. This bias had the potential to lead the researcher to dismiss or spend less time on interview questions that pose mindfulness may not be helpful in the mental health world. Berg (2009) discusses the interviewer's role as having "bias effects," (p. 129) or "reactivity," (p. 129) to the interview process. As the title of this research suggests, this study refers to the exploration of mindfulness as it currently exists in traditional practice. This means, regardless of bias, the researcher hopes to gain a holistic and genuine perspective on this topic whether negative or positive. Because interviewees were also proponents for the work of mindfulness as a therapeutic intervention, it was important to emphasize and push for understanding all aspects of this work during the interviews.

While biases can affect the integrity of the interview, they can also affect the data analysis process. When coding the collected data, it was important to see the data as objectively as possible. Open-coding assisted non-objectivity by dismissing thoughts of true summarization until after the coding was completed. Grounded theory suggests documenting thoughts throughout coding and examining the nature of those thoughts after coding is completed (Berg, 2009). Both of these techniques were used in an attempt to diminish bias and to reflect on any possible biased notions. Finally, utilizing mindfulness to bring biases and judgments to my awareness during this process was helpful in encouraging objectivity.

Findings

Interviews were conducted and transcribed. Following the transcription process, coding was completed and themes were identified. Also, presented in Appendix B is a

compilation of mindfulness resources for both clinicians and clients as recommended by participants and found by the researcher. The findings section will first present a picture of the participants' backgrounds and will be followed by a presentation of the personal mindfulness definition of each participant. Finally, the seven major themes identified in this research will be presented. The themes consisted of self-care, affect regulation in the clinician and the client, populations with sub-themes of anxiety, trauma, and psychosis, the client and clinician relationship, language, access, and culture.

Participants

While most of the professionals contacted to participate in this study were interested in participating, time and scheduling restraints resulted in seven interviews for this study. While credentials and experience varied, the use of mindfulness in personal and professional settings was consistent. All participants currently work directly with clients in mental health clinics in the Midwest and currently participate in some form of personal mindfulness or meditation practice. While efforts were made to include a range of age, ethnicity, and gender in the interview sample, lack of diversity in the Midwest proved to be problematic in this task. The participants consisted of six female interviewees and one male interviewee. All participants were Caucasian.

Of the seven professionals interviewed for this study, two are currently licensed as clinical social workers (LCSW), three are licensed marriage and family therapists (LMFT), one holds a dual licensure as an LCSW and LMFT, one holds a dual licensure as an LMFT and Certified alcohol and drug Counselor (CADC), and one is currently licensed as professional counselor (LPC) and as clinical substance abuse counselor. Two

participants are registered yoga therapists (RYT). One participant works primarily with children, while the others work primarily with adults and adolescents.

Years practicing psychotherapy ranged from fifteen to twenty-seven years. Theoretical orientations of participants ranged from “eclectic,” to psychodynamic-focused, to systems perspective-oriented. Five of the seven participants are trained in eye movement desensitization regulation (EMDR). Three of the seven participants indicated they were trained in Dialectical Behavior Therapy (DBT). Experience utilizing mindfulness in psychotherapy varied from four to fifteen years. Personal mindfulness practice ranged from eight to twenty years. Five of the seven participants discussed studying mindfulness under someone, directly. One participant is a Buddhist layperson.

Definition.

All participants were asked to provide their personal definition of mindfulness as it is used in their direct and individual practice. All given definitions included the concept of awareness or being present in the moment. Four of the seven participants specifically included an environmental awareness in their definition. Three of the seven participants specifically articulated the importance of a nonjudgmental stance on awareness in their definition.

Participant one described mindfulness as:

... So, when I think of mindfulness I think of the concept of being present. So, depending on what context we use it in, I might say [mindfulness] is being mindfully aware of how you're presenting or being mindful about your emotional state, or being mindful about the situation or putting things into context. So I think mindfulness shows up in very different ways. You can be mindful emotionally, you

can be mindful mentally, you can be mindful physically, you can be mindful environmentally, but it really is just about being present and being aware.

(Participant one)

Similarly, participant two defines mindfulness as follows:

It's being present, the ability to be aware in the present moment. Not only of ones' surroundings, but of ones' internal experience (Participant Two)

Participant three described mindfulness as:

Awareness. I would describe mindfulness as being aware. And of being aware, being aware in a neutral way. So when I think of mindfulness I think about being aware of what I'm experiencing and also I think about mindfulness as not getting attached to what I'm experiencing so noticing it, seeing, labeling, but not judging it so that I can make a more clear decision on what to do. (Participant three)

Participant four's definition:

An awareness of the present moment with acceptance. (Participant four)

Participant five's definition:

Most simply put – mindfulness is awareness. (Participant five)

Participant six described mindfulness as:

Mindfulness is being present. Fully present to whatever is going on around you. Where we are, right here, right now. It is seeing the colors, hearing the sounds, smelling the smells and truly being present while alone or with another person.
(Participant six)

And finally, participant seven defined mindfulness as:

...the moment-to-moment awareness of thinking vs. riding thoughts and the awareness of the thought and then awareness of the judgment that often comes over a thought. Also, compassion. Creating understanding or allowing yourself to have understanding. And then also to look at something as if you've never seen it before. As if it's brand new. (Participant seven)

Self Care

All participants in the study discussed the use of mindfulness as a component to their self-care routine. Additionally, all participants indicated personal meditation/mindfulness practices of daily sitting meditation and/or breathing techniques as a part of their self-care routine. One participant utilized Qi Gong in mindfulness practice. Five of the seven participants stated that yoga was a regular part of their meditation/mindfulness practice. Participants indicated that mindfulness assisted them in staying grounded and enhanced their ability to be present, accepting, and non-judgmental with clients, co-workers, and in their every day lives.

The following quote exemplifies how one participant views mindfulness in her life and self-care practices.

...you know, it [mindfulness] does impact my self-care. Every morning I do some kind of meditation whether I read, meaning it may just be a reading, but it's a time to just sit and reflect and think... (Participant three)

Another participant emphasized how mindfulness assists her in adding a joyful component to self-care activities.

...most importantly – [mindfulness allows] finding joy through activities including horseback riding, family time, sitting meditation, yoga practice and Ayurveda teachings around food as medicine. (Participant five)

Affect Regulation

Mindfulness as a tool for affect regulation was the most integrated theme in the interviews and was discussed multiple times by each clinician. This theme was presented in terms of the clinician's and the client's ability to regulate affect in stressful settings. The theme is outlined in two subcategories: mindfulness and affect regulation in the clinician and mindfulness and affect regulation in the client.

Clinician. All participants indicated that mindfulness was a tool for affect regulation or reactivity in their lives. Mindfulness was used as tool for affect regulation by clinicians in sessions, in work settings with coworkers, and in their personal lives. In these settings, mindfulness allowed the practitioner to be aware of his or her experience to create calm and peace within the self. The following quote describes how mindfulness can assist a clinician in controlling his/her reactivity as it applies to countertransference and in general application.

I think that mindfulness can help you develop a greater awareness of your countertransference. You may be more attuned to reactivity in yourself and better able to identify what is occurring. Most importantly, however, I think that mindfulness can help a clinician become less reactive to their reflexive thoughts or feelings. (Participant six)

Another participant discussed how mindfulness can impact affect regulation after a session.

...also, at work I do little regulating mindfulness things just to calm myself down, especially if it's been a really hard session. That has helped me immensely.

(Participant three)

The following quote is an example of how a participant used mindfulness in her personal life to regulate her reactivity.

And just yesterday I was leaving the house and there was, I'll just be myself, there was crap everywhere. I have 4 kids there was stuff everywhere and [I] started to go "AHHHH!! OH MY GOSH!" And then I said [to myself], "right now you're going to work. You cannot address this right now and you're getting yourself all upset for something you cannot manage in this moment." And what I'm able to do is bring myself back pretty quick. (Participant seven)

Client. All interviewees also discussed how mindfulness affects the affect regulation of their clients in and out of session. Affect regulation was reported as being more easily controlled with mindfulness practice across many populations including children, adolescents, adults, and parents. Clients were able to achieve increased affect regulation by using several mindfulness techniques taught by the participants, including guided meditations, breathing techniques, mindfulness movement exercises, and by reading books with a mindfulness approach. Participants identified that these techniques allowed the client to pause and understand his or her role in a given situation before responding reactively.

I find that people who practice mindfulness have a greater ability to identify their internal thoughts/feelings, as well as the ability to accept those states with greater ease and flexibility in their behaviors. Rather than simply seeking to avoid

unpleasant thoughts/feelings, these patients can develop a confidence that he/she can respond more wisely to whatever is occurring. It truly helps people realize that they cannot only tolerate, but learn from intense and/or painful experience.

(Participant four)

Another participant identified mindfulness as a valuable tool to regulate emotions by connecting thought and physical experience.

[Mindfulness] Allows them to de-escalate, connects their thought experience with their physical experience, gives them some tools to manage life differently.

(Participant five)

Populations

Three interview questions directly addressed how clinicians used mindfulness with their clientele. Participants discussed populations of clients with which they would and would not use mindfulness. Most participants discussed feeling comfortable using mindfulness on all mental health populations. Participants that differed stated having challenges using mindfulness techniques specifically with Axis II disorders, and clients with psychosis. While several populations were mentioned as appropriate for mindfulness based and informed interventions, clients working through anxiety, trauma, and clients with psychosis were the clientele populations discussed most frequently.

Anxiety. Anxiety was mentioned at some point in the interview by five of the seven participants. Participants seemed to have mixed ideas on how to use mindfulness with anxiety. While all five participants reported using mindfulness with clients who suffer from anxiety, some participants stated that depending on the client, mindfulness, especially physical mindfulness exercises like deep breathing, could perpetuate and even

increase feelings of anxiety in clients. One participant discussed how, initially, mindfulness can cause anxiety in clients because it opens the client up to a different way of thinking. This same participant focused on preparing clients to be accepting of uncomfortable feelings. Other participants focused solely on how mindfulness techniques helped to alleviate anxiety. Of the five participants who discussed anxiety, two specifically mentioned using mindfulness in their personal lives to overcome anxiety. All five participants seemed to agree it was important to approach mindfulness carefully with clients in this population.

The following quote is an example of one participant's experience where a breathing mindfulness exercise made a client's anxiety worsen. This quote exemplifies findings that indicate the importance of introducing breathing techniques slowly to clients with anxiety.

Only one [client] that I can think of. Her anxiety was so high that trying to attempt following her breath only made her more anxious. We, she, did however, try other things and it seemed when she had an anxiety or panic attack if she held her breath it seemed to help. (Participant six)

The following quote is another example of how one participant has found breathing exercises to be dysregulating for clients with anxiety. This participant described her experience working with mindfulness to alleviate the anxiety in a client by having the client lie on the ground and place a heavy sandbag on his or her stomach and begin to notice how the sand bag feels and moves. This quote exemplifies the findings that indicated mindfulness can be helpful for this population of clients, but caution must be

taken in the introduction and implementation of mindfulness interventions with populations of clients who suffer from anxiety disorders.

People with anxiety need to learn how to exhale, but if you talk to them about their breathing, it tends to make their breathing worse. It just goes even more dysregulated. So using the sandbag, I can just, I don't have to talk about breathing I can just talk and tell them "just notice the way the sandbag and watch how it rises and falls and just notice what's that like and where you feel the movement" and if they're comfortable with that then I gradually start to slip in things like "notice how it falls when you exhale, let it fall as much as you can."
(Participant two)

Trauma. Another population mentioned four of seven times throughout the interviews was clientele with a history of trauma. Again, a general consensus among participants was that mindfulness is beneficial with this population, but to use caution when approaching trauma with mindfulness techniques. Participants who cautioned using mindfulness with clients suggested that it is possible that being mindful of emotions and having body awareness can activate and exaggerate retraumatization in clients. While many participants who mentioned trauma indicated that caution should be exercised when working with clients with past trauma, all participants suggested it could also be very helpful, and two participants specifically mentioned using mindfulness as a powerful grounding tool with clients working through trauma.

They're in a trauma state and so I think understanding the brain chemistry of mindfulness and understanding the brain chemistry of trauma is a really big thing because that validates them and they think that 'if I feel this I'm going to be done,

I can't handle this." And so I think minding the brain chemistry pieces of trauma and combining them with experiencing mindfulness and saying "ok you can experience this and still use that cut off and still walk out of here and be fine," I think that's where you're teaching them and I think that can be really, really empowering. That they can allow themselves to feel and still have control. And a lot of clients think they don't have that. (Participant one)

The next quote illustrates the importance of using caution especially when addressing the physical aspect of mindfulness. This quote also points to the importance of a good therapeutic relationship when using mindfulness on clients with a traumatic history.

Sometimes people who are trauma survivors, one has to be careful about the external part of it, in moving into their own experience it's easy to blunder, it's easy to stumble into something that it's not going to work for them to pay attention to and so it's more important to have a really good therapeutic relationship developed... ..you have to be more cautious and that same thing is true for teaching yoga to people who are trauma survivors. (Participant two)

Psychosis. Three clients discussed the use of mindfulness with clients who struggle with psychosis. All three participants stated they would not use mindfulness or meditation with these clients, however, later in the interview, two of the three participants stated that maybe there were some techniques that would be applicable to use with this population of clients. These techniques focused on keeping the client grounded and giving them the tools to focus on real versus delusional thoughts and perceptions.

Techniques that were not recommended for use were meditation exercises.

The following quote is an example of a client with whom the participants stated they would not use mindfulness.

I wouldn't be doing insight meditation with psychosis. So, I have a 19 year old with schizophrenia, and no, I don't do mindfulness with her. Not at all. I do reality testing and CBT and the medication piece, but not [mindfulness]. And I don't know how you would. (Participant three)

The next quote is an example of how the same participant readdressed the use of mindfulness with her client later in the interview.

Well, thinking about my 19 year old now, there are some mindfulness techniques that are effective. Because to be aware of your thinking pattern, like if you think someone's following you and they're out to get you, to be present enough to go "ok, oh this must be a delusion" vs. "this is real." I think it does take an element of mindfulness to do that. But I don't do any meditation stuff with her and I don't know how I would or if I should... (Participant three)

Relationship

Another theme, as discussed by four participants, was how mindfulness enhanced the relationship and the connection of the clinician and client. Participants stated that mindfulness has allowed them to be present with their clients and has increased the authenticity in their interactions with clients. Participants also stated that mindfulness has allowed them to be more grounded and to more empathically pace a session. The first quote shows an example of how mindfulness can create a sense of "realness" and compassion in the therapeutic relationship. The participant discusses how mindfulness allowed her to relate to clients in a group setting more genuinely.

...it's been interesting that the people in my anger management group have appreciated that realness because they don't feel judged then. Yeah, so there is also that relational piece, that I can learn their dance and dance it with them so they feel comfortable and I feel comfortable with it also. (Participant seven)

One participant discussed how personal practice of mindfulness can impact the focus and attunement of the clinician and, ultimately, the therapeutic alliance during the session.

Like many others, I believe that cultivating my own mindfulness practice helps me be more aware and present with my patients. I believe it helps me pay closer attention to the unfolding process unfolding, as well as more patient and compassionate with whatever is occurring. It also seems to help me stay more attuned with the actual experience in the room, rather than me being distracted or tied to my theories about a client vs. the client themselves in that moment.

(Participant four)

The next quote was made in reference to a research study a participant discussed regarding how a clinician's mindfulness practice, or lack thereof, can directly affect the client's success in using mindfulness/meditation. This participant also discussed how mindfulness allows the therapeutic alliance to be grounded and allows for less of the clinician's self or countertransference to be mixed in to the relationship. This quote also exemplifies the three participants that noted that the "grounded" feeling they experience as a result of being mindful in session can impact the client's ability to ground him/herself.

You can't communicate what you don't know in yourself. And, that was really, I um, that really got my attention. It may, not in the sense of "oh, I have to do

something,” but in the sense of “oh, this makes sense that my connection with clients is going to be much more grounded and much less, I can be much less mixed in there.” I mean I can be present, but my own stuff will be a lot less mixed in there...I also observe that, and I experience that with myself, when I’m with someone that is grounded and calm I tend to be grounded. So that’s the most fundamental thing that I try to do. (Participant two)

Language

All participants discussed the way they discuss the use of mindfulness to a client. Five of these participants indicated that it was important for them to be cautious in their introduction of mindfulness. Two indicated the way they introduced, or described mindfulness to a client was not an issue. Those who exercised caution did so for many reasons, but the main reasons seemed to be to neutralize resistance or to align with spiritual orientation.

...so I think it’s about you as a clinician being able to understand what truly happens with being mindful, and then you’re able to explain it in a way that fits the clientele. I mean, I don’t know who’s using “mindful” with every client. I use different words. It’s about how do you tap into that language so that they buy into whatever it is that you’re trying to help them with. (Participant 1)

The following quote acknowledges the two participants that do not identify language as an issue for them.

...I don’t stop, I don’t have any barriers, people might get defensive, because of their own belief system, but when they learn that mindfulness is used in all practices, that seems to end any issue. Now some people are going to not be at a

place of willingness, they're going to be willful and until they're at a place of willingness, they're going to be where they're at. (Participant seven)

Access

All but one participant indicated that there was limited access to mindfulness training in their baccalaureate and graduate education. Most participants indicated being introduced to mindfulness in some other way and seeking training afterwards on their own accord. Two participants specifically discussed the access to mindfulness training is now more accessible than it was when they were in school. One participant discussed how access to yoga training was not accessible while she was attempting to develop her practice. Though this participant eventually found training in a closer proximity, travel time of almost two hours was still required in order to access the desired yoga training.

The following quote exemplifies one of many responses that highlighted not having mindfulness or self-care training in formal schooling.

Other than focusing on countertransference and being encouraged to attend my own therapy, I didn't really receive much training on self-care techniques.

(Participant 4)

One participant expanded on the idea of access to mindfulness and discussed her experience with client access to mindfulness training as “elitist.” This participant discussed her experience with mindfulness as a concept where accessibility and exposure to mindfulness correlates with socioeconomic class. Her personal experience working with lower-income clients showed that mindfulness was highly effective for this population. However, she recognized not only was the education of mindfulness techniques not always readily accessible to her lower-income clients, the language of the

literature was often difficult to read, and/or her clients lacked the resources to access many of the mainstream avenues to learn about mindfulness.

The language gets, it gets elitist. So they [professionals] talk about having scents in the room [during mindfulness] but I'm working with a parent who lives in homeless shelter and so I struggle talking to them about this, this class is an elitist... ...And so what that does for working class people, people who are marginalized by society, they think that they can't have this [mindfulness training]. And that's simply not fair and the language [of mindfulness literature] is off-putting. They [working class citizens] think they don't have a place at the table and they do!... ...So it, I think that in some ways it [mindfulness] becomes an elitist movement... ...that is why I'm trying to bring bits of mindfulness to women who can't have the Hazleton experience. They go to L.E. Philips and there's nothing [on mindfulness] and it's so unfair. (Participant three)

Culture

The final theme addresses the thoughts of participants on mindfulness as it was intended by Eastern tradition versus Western use. All participants responded the beneficial aspects of incorporating mindfulness into one's life no matter the cultural implications. Two participants discussed a more neutral stance on this topic, while five participants identified Western culture being attached to "expectations," or "results" of mindfulness.

I do think that in the West, we have to be careful not to overlay our cultural aspects such as what will I get out of it (lower blood pressure, enlightenment.) We are very goal oriented. Doing for just doing is foreign

for us. We want to do things fast, have quick results, make it about ourselves. And we have to be careful about the marketing mentality of the term mindfulness.

(Participant 5)

Another participant echoed this idea and applied it to the Buddhist framework.

Compared to thousands of years of Buddhist practice, Western psychology's understanding and use of mindfulness is more narrow and limited in scope.

Additionally, the goals for mindfulness in mainstream psychology are different than in Buddhism. Mindfulness in therapy is designed to help people feel better and lead this life in a meaningful fashion. Mindfulness in Buddhism is designed with the goal of attaining enlightenment and less focused on this life. (Participant four)

The following quote acknowledges the opinions of two of the seven participants that view mindfulness more as a useful therapeutic tool that can be successful and viable in any culture.

...if you're using mindfulness it's mindfulness. And if you, in my understanding, look at mindfulness practitioners in Christianity, [they] are following the same steps as Buddhist practitioners. Whenever the ego gets involved, then you're going to have problems, and I think any entity, any religion, god, that [problems] can happen when you get into the place of rightness or wrongness. (Participant seven)

Discussion

The information gathered during the interviews was rich, but vast. The discussion will focus on connecting the findings to the literature as it applies to the four sub-

questions originally posed for this research: 1. How mindfulness can impact the clinician in terms of self-care and perceived therapeutic ability; 2. How mindfulness education/techniques can impact the client; 3. How relational mindfulness can affect the therapeutic relationship between clinician and client; and 4. The challenges and implications of using mindfulness in a therapeutic setting.

Mindfulness and the clinician

Self-care and affect regulation. The first theme, self-care, was explored based on the literature that pointed to mindfulness as a useful tool in improving psychological wellbeing as well as alleviating occupational burnout/compassion fatigue (Shapiro, et al., 2009; Turner 2009). All participants reported having personal mindfulness practices and reported mindfulness techniques assisting their ability to enhance their self-care. Additionally, the way each participant achieved mindfulness was unique, which points the possibility of tailoring mindfulness techniques to individuals on a personal preference basis.

While the importance of mindfulness in self-care practices is becoming more evident in helping professions, the focus on self-care in related graduate and undergraduate studies, is not. According to all but one participant, self-care was not formally taught in the classroom, and according to all participants, mindfulness was not formally taught in the classroom. Instead, participants indicated that mindfulness training was sought out individually after graduation and through personal discovery. In a career where burnout rates are substantial, the findings of this research support that mindfulness is a powerful self-care tool and that at least introducing mindfulness and self-care practices in undergraduate or graduate training to social work, and mental health

professionals, specifically, could be useful in alleviating compassion fatigue in this profession.

The second theme, affect regulation as it pertained to clinicians, was one not necessarily discussed in the literature, but was very apparent in the findings. Every participant discussed mindfulness as an affect regulation tool in some way. Participants identified mindfulness as a transferable concept that could be utilized not only at work or at home, but in any setting to evoke a more peaceful and accepting lifestyle. In this way, affect regulation was also connected to the self-care theme as it helped clinicians to approach life with less reaction and with greater acceptance.

Different participants applied mindfulness as a tool for affect regulation in various settings. In home life, participants discussed being able to use mindfulness when interacting with children and spouses/family members, especially in stressful or chaotic situations. When applying mindfulness to the psychotherapeutic work setting, participants discussed being able to maintain more controlled or appropriate reactions to coworkers and to clients. Affect regulation in the work setting supports the discussion by Shapiro, et al., (2007) which suggests mindfulness can allow clinicians to work more efficiently with their clients. Based on the literature and findings, having the ability to regulate affect gives the clinician the capacity to be empathic, yet maintain a balanced environment that lends itself to therapeutic healing. Maintaining balance in a profession where you are often working with clients who have unbalanced reactions was found to be a valuable tool. Additionally, the findings suggest that affect regulation in the clinician can directly impact affect regulation in the client in session, thus adding to the therapeutic application of mindfulness in this setting.

The theme of affect regulation fits well with the theme of self-care as several participants indicated that mindfulness allowed them to not only to better control or regulate strong feelings and emotions, but that this regulation helped them to stay grounded and have a more clear perspective on experiences. In session, this benefit of mindfulness was especially helpful for participants after working with clients with trauma or anxiety. In life, participants discussed mindfulness allowing them to add components of joy and compassion to daily activities. Again, while the literature did not specifically address clinician affect regulation, this theme and its connection to self-care does support the literature that discusses mindfulness as it is used in the Buddhist tradition to alleviate suffering (Didonna, 2009; Kabat-Zinn, 2003). The findings showed all participants were able to use mindfulness to better regulate and be non-judgmental of feelings and emotions. This allowed acceptance of the self and others and ultimately promoted less suffering.

The findings regarding how mindfulness can impact the clinician support mindfulness as a beneficial tool for the clinician to promote self-care and affect regulation in work and life settings. These findings support the research that suggested mindfulness can improve self-care and alleviate compassion fatigue among mental health professionals and that mindfulness can promote the path to less suffering as discussed by Buddhist teachings.

Mindfulness and the client

Affect regulation and populations. The second theme, affect regulation as it pertained to the client was a widely discussed topic among participants. Similarly to the way clinicians used mindfulness to regulate affect, participants reported that they

regularly used mindfulness techniques to help clients identify the cause of feelings and emotions. Once identified, mindfulness also could be used as a tool to regulate emotions by acknowledging and accepting them non-judgmentally. The participants discussed their clients reporting successful use of mindfulness for affect regulation in and out of session to improve daily functioning and relationships. In the findings, mindfulness as an affect regulator was used across age populations, and points to the use of mindfulness as a successful option in treatment of Axis I disorders as discussed in the literature. (Didonna, 2009; Ma & Teasdale, 2007; Hofmann, et al., 2010).

Additionally, the third theme discussed using mindfulness on multiple populations of clients. Among the more misunderstood applications for mindfulness included populations with anxiety and trauma. Again, participants indicated promising benefits for use of mindfulness with anxiety and trauma, however, approached the discussion with caution. Mindfulness as a grounding tool was discussed several times. Additionally, mindfulness could be used as a grounding tool for clients by asking them to be mindful of their current environment, their current physical state, their current mental state, or a combination of the three. Participants suggested using mindfulness as an environmental grounding application, as opposed to physical or mental application, may initially benefit this client population and prevent them from being overly aware which could result in perpetuating their anxiety or result in retraumatization. Considering mindfulness is used to alleviate suffering, the question arises: do the clients that have difficulty using mindfulness with anxiety and trauma have the ability to fully grasp what mindfulness is and how to effectively use it?

The findings support the literature that indicates mindfulness can assist in alleviating symptoms of depression and anxiety (Grepmaier, et al., 2007; Didonna, 2009). More research is needed in order to fully understand the effects of mindfulness on anxiety and trauma. Additionally, the posed question points to the need for more research to investigate how educating the client about mindfulness impacts his or her ability to effectively utilize it. Further research will be useful in order to have a better understanding on how mindfulness techniques can be used with these populations.

The literature and the findings regarding mindfulness and psychosis were inconclusive (Chien, et al, 2013; Didonna, 2009). As indicated in the literature, using mindfulness on clients experiencing psychosis is still misunderstood and research points to use of mindfulness with this population as being more harmful than helpful (Didonna, 2009). The findings supported this mixed stand in the literature as participants discussed remaining cautious on using mindfulness with this population of clients. One study, presented in the literature, suggested using educative mindfulness techniques assisted patients with schizophrenia (Chien, et al, 2013). Educating these patients on mindfulness allowed them the ability to be more grounded in reality. The findings in this research supported this literature, and two participants specifically discussed using mindfulness as a way to help clients with psychosis to separate reality from delusion. More research is needed in order to fully understand how, if at all, mindfulness can be effectively implemented into practice with clients suffering from psychosis.

Ultimately, as discussed in the literature and in the findings, mindfulness is a useful and effective tool for a variety of mental health populations. Mindfulness can be used in the session to ground and regulate a client, but a client can also use mindfulness

in life to better regulate emotions and consequently his or her affect. Mindfulness can also potentially be used with clients with psychosis to allow better insight into reality versus delusions. Continued research should focus on how mindfulness works specifically with mental health populations. Additionally, future research should seek to understand how the education of mindfulness to clients affects their ability to successfully implement mindfulness into their lives.

Mindfulness and the therapeutic relationship

The literature on mindfulness and the therapeutic relationship suggested mindfulness could be used by the therapist to work with clients in a “meaningful and mindful” way (Falb & Pargament, 2012, p. 352). In the fourth theme, the relationship, participants supported the literature and discussed the benefits of using mindfulness on the therapeutic alliance. Mindfulness was discussed being used by each participant as a way to ground the therapeutic relationship. Many participants stated using mindfulness allowed them to keep themselves out of the equation and therefore assisted with the identification of countertransference. Mindfulness, when used by the clinician, helped clients to remain focused as it assisted clinicians in recognizing traits that could get in the way of therapeutic intervention. Mindfulness also assisted in neutralizing judgment of clients and in making clinicians more relatable to clients.

In addition to assisting the client and clinician to develop a more meaningful therapeutic alliance, the literature suggested that clinicians who practice mindfulness have clients that are able to conceptualize and utilize mindfulness more effectively themselves (Rimes & Wingrove, 2010; Goldberg, et al., 2013) In one interview, a participant supported this literature by referencing a study in which clinicians were more

effective with the implementation of mindfulness with clients when having a personal practice. Understanding the dynamics behind this phenomenon will be important to future research in order to understand if it is the clinician's understanding that promotes successful use of mindfulness in clients, or if it is the therapeutic alliance cultivated by mindfulness that allows for clients to better grasp and utilize mindfulness in session and in life.

Of the clinicians participating, none had directly heard of the term "relational mindfulness," as it was defined in the literature, however, most participants stated that they used mindfulness as a way to understand the dynamics of the relationships with clients. As mindfulness becomes more prevalent in psychotherapy, research should focus on better defining the concept of relational mindfulness and understanding how it can be used in a psychotherapeutic setting.

Challenges

Language. The fifth theme, language, was discussed and identified as a barrier for most participants when describing the concept of mindfulness to clients. This theme indicates that some challenges remain in fully integrating mindfulness into psychotherapy and that, perhaps, there is some stigma tied to the word "mindfulness." Most participants indicated that in order to improve the acceptance and usability of mindfulness techniques, they needed to temper the language to ensure clients would not shut down to these ideas. Most often, this was a result of trying to be respectful of spiritual or religious affiliation. Many participants discussed the idea that a client's initial perception of mindfulness can lead to apprehension in utilizing mindfulness techniques. Many clients perceive

mindfulness as a religious practice as opposed to a practice that is independent of any specific religion.

These findings indicate the concept of mindfulness may not be fully understood by our culture. As a result, this misunderstanding may increase resistance to using mindfulness among clients. Therefore, the importance of introducing and educating the client on the concept of mindfulness is crucial, yet should be tailored to assuage the cause of the client's apprehension. The findings also imply that it may be beneficial for a clinician to orient him/herself with different religious cultures to better relate the idea of mindfulness to clients.

Access. The sixth theme, access, relates to the ability of clinicians and participants to become educated on the concept of mindfulness. As discussed in the findings section, all but one participant stated that mindfulness was not a part of their formal undergraduate or graduate training. Though studies suggest mindfulness offers promising results for both mental health professionals and clients, mindfulness education is not as accessible as other intervention trainings. While most participants completed their graduate programs ten or more years ago, and the education of mindfulness has grown in that amount of time, this theme points to the idea that mindfulness still requires a considerable level of acceptance before it becomes a regular aspect of psychotherapeutic care and training. The findings coincide with the literature that discussed mindfulness as a growing trend in psychotherapeutic care; however, the findings related to access also support the overall research findings that suggest there is a common misperception of mindfulness. The lack of understanding of mindfulness

demonstrates a need for greater access to education about mindfulness and its uses and implications in the therapeutic world.

Participants also discussed client access to mindfulness. Although mindfulness has been shown to be an effective therapeutic intervention for clients, many clients may only be introduced to the concept of mindfulness if they engage in mental health care or social services with a worker familiar with mindfulness practices. Included in the theme of access was the idea of potential limited access to mindfulness concepts based on socioeconomic status. With higher rates of mental illness among citizens with lower socioeconomic status in the United States combined with the benefits and success rates of mindfulness in working in mental health, clients of lower socioeconomic status would most likely greatly benefit from mindfulness practices (Hudson, 2005).

As presented throughout most of the literature and findings, mindfulness is becoming a buzzword in western culture, not only in psychotherapeutic care, but also in mainstream society (Grepmaier, et al., 2007; Didonna, 2009). Searching “mindfulness” on the internet opens the door to a variety of websites and venues to learn more about this concept, however, one first must be introduced to the fact that mindfulness is a “searchable” topic before being able to access these resources. As mindfulness becomes a growing phenomenon in western culture, more access may arise for all populations. Further examination of the demographic orientation of those currently accessing mindfulness practice may be helpful in learning how to reach populations who have limited access to mindfulness concepts.

Culture. Certainly, one could dedicate an entire study to the subject of how mindfulness is used in eastern culture versus how it is used in western culture. In this

study, culture was found to have a strong influence on the perceptions of mindfulness.

Overall, participants indicated the benefits of using mindfulness in its westernized format was more beneficial than not, however, participants noted the differences between eastern and western use of mindfulness.

As discussed by participants and corroborated by Buddhist psychology, the use of mindfulness in eastern culture and western culture varies slightly. As used in eastern culture, participants identified mindfulness as a way of life in which the practitioner looks to avoid passing judgment on or attempting to control a given situation. In essence, mindfulness is to be aware and accepting of one's current state of being. In western culture several participants described mindfulness as a "non-judgmental awareness," but noted it being difficult for Western practitioners, especially those in a therapeutic setting, to separate mindfulness practice from the western expectations of a derived benefit or goal. Participants concluded this mindset was most likely a result of fast-paced Western society in which one comes to therapy to "get results" or immediately "alleviate suffering." When introduced to mindfulness, it is easy for clients to 1. disagree with the use of mindfulness based on their religious affiliation, or 2. use mindfulness with the expectation that it will offer a result, or a cure for their mental health ailments. Participants indicated expectations may skew the way clients use mindfulness, and ultimately the way clients may benefit, or not benefit from utilizing mindfulness.

"Expectations," while in opposition to the eastern tradition of mindfulness practice, essentially become part of using mindfulness as a tool to provide therapy to mental health clients. Although many of the participants identified this as a derivation from true mindfulness, they recognized this westernized approach to mindfulness may be

the only practical way, as of now, to implement mindfulness into their practice and in particular, into Western culture. Questions that arise from these findings center on how expectations play a part in therapeutic practice: Is it bad that expectations come into play with mindfulness? Or, is this a positive translation of an eastern practice that is effective in working with clients in western culture? Further research in this area will be helpful in addressing these questions.

Implications

Several implications were found in this study for the use of mindfulness in psychotherapeutic care and research. The following section discusses how the findings suggest implications for further research, in social work/mental health education, and in mental health practice.

As presented throughout the discussion section, the findings highlight several areas where further research is needed. Those areas include continued research on the understanding of how mindfulness impacts certain populations of clients, in particular, clients who suffer from anxiety, trauma, and psychosis. Additionally, further research should seek to understand how the introduction of mindfulness to clients impacts their receptivity, and ultimately, their ability to use mindfulness in a therapeutic way. Finally, further research should focus on how the secularization of mindfulness from its Buddhist roots impacts the use of mindfulness in clinicians and clients.

This research study also suggested implications for education. The findings implied that mindfulness education was beneficial in self-care practices where mindfulness could help to alleviate helping profession burnout and compassion-fatigue. The findings also pointed to limited mindfulness and self-care training in undergraduate

and graduate studies. Despite the limited training, findings suggested additional focus on mindfulness would be useful in the education of mental health professionals.

Additionally, findings pointed to the benefit and importance of expanding the availability of mindfulness training to populations with lower socioeconomic status.

Finally, as discussed in the introduction and review of literature, the implicit goal of social work is to address suffering (Kang, 2011; Lopez, 2013). The literature suggests mindfulness is a beneficial approach for alleviating clinician compassion-fatigue and burnout, and for intervention with “suffering” clients. Returning to the four noble truths in Buddhist psychology invites a closer look at the idea of mindfulness and suffering and helps to better illustrate how mindfulness can be used as it pertains to the clinician, the client, and to psychotherapeutic practice.

The first truth, “the truth of suffering,” refers to the suffering of clients who come to counseling. It also addresses the clinician, who not only has his or her own personal suffering, but is exposed to, and must create a containing space for, the suffering of his or her client (Lopez, 2013). The research findings implied that mindfulness may provide mental health clinicians a better understanding of the concept of suffering within themselves and within their clients. This understanding and the use of mindfulness may be helpful in assisting clinicians in taking an empathic stance with themselves and clients while allowing them to stay grounded in emotion and affect.

The second and third truths, the truth of the cause of suffering and the truth of the end of suffering, refer to the understanding of how suffering comes to be and the understanding that it is possible for suffering to cease (Lopez, 2013). The research findings imply mindfulness may allow the mental health clinician and client better insight

into the cause of the client's suffering through non-judgmental awareness of the self. The findings also indicated the importance of clinician mindfulness practice to evoke a more authentic and grounded relationship and allow the client a better understanding of and better success using mindfulness in his or her therapeutic journey.

The fourth truth, the truth of the path that leads to the end of suffering, refers to the enlightenment of the clinician and client that there is a path to the end of one's suffering (Lopez, 2013). As discussed in Buddhist psychology and based on the findings of this study, using mindfulness in practice may assist clients in finding the path to non-suffering by allowing them to work towards non-judgmentally accepting their thoughts and emotions. This study found that using mindfulness techniques in personal life and in therapy may assist clinicians and their clients in attaining a less reactive stance in stressful experiences and in reducing the amount of their perceived suffering.

Overall, the findings imply that mindfulness is beneficial for clinician self-care and as an intervention for a variety of mental health populations. The findings also imply that mindfulness can positively impact the therapeutic relationship by allowing the therapist to remain grounded, present, and authentic in interactions with clients. However, the findings identified that language and cultural aspects may create barriers to the effectiveness of mindfulness. Further research should be directed towards the understanding of how mindfulness can impact the clinician, client, and therapeutic relationship in clinical education and practice.

Limitations

This research topic presented certain challenges. First, because of the scope of the project, the sample size was limited and the data collected could not be generalized.

Because the topic of mindfulness can be very personal to the practitioner, the personal definition and experience of mindfulness and the uses in practice did vary slightly among practitioners. Furthermore, the relatively small sample size caused the data collected in the interviews to be vast and though themes emerged, the information gathered pointed to the need for further research in a variety of areas mentioned in the discussion section.

Conclusion

Mindfulness, though an ancient tradition, is only just recently coming to the forefront of psychotherapeutic care. The findings of this study support the literature that suggests mindfulness as an effective addition to therapeutic interventions. The findings conclude that further research should be conducted in areas regarding how mindfulness impacts clinician and client care, the therapeutic alliance, and how access to mindfulness in western culture can be represented in an authentic and effective way to promote self well-being, compassion and non-suffering.

When we are mindful, deeply in touch with the present moment, our understanding of what is going on deepens, and we begin to be filled with acceptance, joy, peace and love. – Thich Nhat Hanh

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Appendix A**CONSENT FORM
UNIVERSITY OF ST. THOMAS****Mindfulness in Traditional Psychotherapy: A Qualitative Study****IRB#-533146-1**

I am conducting a study about the use of mindfulness in traditional psychotherapy. I invite you to participate in this research. You were selected as a possible participant because of your understanding of working with clients with mindfulness/meditative methods and because you have insight into Buddhist psychology as it can be related to psychotherapy. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by Andrea Dorn, a graduate student at the St. Thomas School of Social Work and supervised by Dr. Kendra Garrett.

Background Information:

The purpose of this study is to examine the use of mindfulness in psychotherapy. In light of the literature suggesting the benefits of integrative approaches to traditional therapeutic interventions, specifically in the area of Eastern Buddhist traditions, this research study will explore the applications and implications of mindfulness/meditation in traditional psychotherapy. This study will be conducted by interviewing professionals who utilize mindfulness techniques in their own practices and will explore the perceived effects that mindfulness can have on the clinician, the clinician's work with his or her clients, and on the therapeutic alliance.

Procedures:

If you agree to be in this study, I will ask you to do the following things: Participate in a 1-hour to 45-minute audio-recorded interview. This interview will be transcribed, coded by the researcher, and findings will be presented at the St. Thomas Clinical Research presentation day. Your name will never be associated with the data or findings at any point during this process.

Confidentiality:

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. The types of records I will create include recordings, transcripts and computer records. All records will be kept in a locked safe in my home. All computer documents will be kept in a password protected computer file. All audio-recordings and transcriptions will be destroyed no later than May 20th, 2014.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University or the University of St. Thomas. If you decide to participate, you are free to withdraw at any time up to and until one week after your scheduled interview. Should you decide to withdraw data collected about you will only be used with your permission. You are also free to skip over any questions I may ask.

Contacts and Questions

My name is *Andrea Dorn*. You may ask any questions you have now. If you have questions later, you may contact me at any time. You may contact my university chair, Dr. Kendra Garrett. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study and for my interview to be audio taped. I am at least 18 years of age.

Signature of Study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

Appendix B

Interview questions:

1. Can you give a brief overview of what you would consider your “practice/therapeutic philosophy/theoretical orientation” to be?
2. What population of clients do you work with?
3. How would you describe your understanding/idea/definition of mindfulness?
 - What are your current mindfulness practices (if any)?
4. How does mindfulness benefit you in terms of self-care?
5. How does mindfulness benefit you in terms of perceived therapeutic ability?
 - Did your education/training involve any self-care education? Did this education include mindfulness in any way?
 - What are your current self-care practices?
 - How do you think your mindfulness practice affects your ability to “treat,” your client?
6. How do you perceive mindfulness education/techniques benefit the client in session?
7. How do you perceive mindfulness education/techniques benefit the client in life?
 - What mindfulness techniques do you use with clients? (mindfulness informed vs. mindfulness based interventions)
 - How do you “teach,” client about mindfulness?
 - What benefits do you see occurring with the interventions?
8. How does mindfulness affect the therapeutic relationship?
 - Are you aware of the term “relational mindfulness?” Is this something you actively practice?
 - Does mindfulness assist you with overcoming feelings of countertransference?
 - Does mindfulness assist your client with overcoming feelings of transference, in your opinion?
9. What are the challenges and/or implications of using mindfulness in a therapeutic setting?
 - Are there any clients that mindfulness has not been effective for?
 - Have you ever received resistance by agencies, clients, insurance providers, etc. for using mindfulness-informed approaches with clients?
 - Any other implications?
 - Do you have any thoughts on mindfulness as it is rooted in eastern spirituality vs. mindfulness as used in the western tradition?
10. Do you have any resources you would recommend for those interested in developing a more mindful-based practice?

Appendix C

Mindfulness Resources

The following is a list of resources for clinicians and clients compiled from participant suggestions and researcher findings.

Child/Parent Focused

Title	Author/s	Best Suited For
Peaceful Piggy Series	Kerry Maclean	Child
Sitting Still Like a Frog	Eline Snel	Child/Parent
Zen Parenting	Jurgen Haven	Parents Self-help
Mommy Mantras	Bethany Casarjian, Diane Dillon	Parents Self-help
Parenting from the Inside Out	Daniel Siegel, Mary Hartzell	Parents Self-help
DBT with Adolescents	Miller, Rathus, Linehan, & Swenson	Clinician/Parent

Adult Focused

Title	Author/s	Best Suited For
Awakening Joy	James Baraz	Client/Clinician
The Mindfulness Solution	Ronald Siegel	Client/Clinician
Radical Acceptance	Tara Brach	Client/Clinician
Yoga for Anxiety	Mary NurrieStearns	Client/Clinician
Buddha's Brain	Rick Hanson	Client/Clinician
Living your Yoga	Judith Lasater	Client/Clinician
MBSR Workbook	Bob Stahl, Elisha Goldstein	Clinician/Client
DBT	Marsha Linehan	Clinician
Attention & Interpretation Therapy	Amit Sood	Clinician

Recommended Authors:

Pema Chödrön

Richard Davidson

Steve Hagen

Thich Nhat Hanh

John Kabat-Zinn

Daniel Siegel

Eckhart Tolle

Electronic Resources:

Apps:

iPhone/iPad/iPod/iOS	Android	iOS and Android
The Smiling Mind	Nature Sounds Relax and Sleep	Headspace on the Go
Relax with Andrew Johnson	Meditation Helper	Relax Melodies
Take a Break!	Dharma meditation trainer	Meditation helper
Omvana	Qi Gong meditation relaxation	Breathe2Relax
Anxiety Free	Relax Melodies: Sleep and Yoga	

Websites:

www.dailyohm.com

www.mindfulness.org

www.oceandharm.org

www.investigatinghealthyminds.org

www.dharmafield.org