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The Influence of Therapist Mindfulness Practice on Psychotherapeutic Work: A Mixed-Methods Study

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Abstract

An increasing number of psychotherapists across therapeutic modalities are practising meditation. This two-phase study examined the influence of personal mindfulness meditation practice on psychotherapists and their work. In phase 1 of the study 40 psychotherapists from a variety of theoretical backgrounds completed a postal survey. The survey included measures of mindfulness and empathic capacity, as well as open-ended questions on the influence of mindfulness practice on participants and their work. In phase 2 follow-up face-to-face interviews were conducted with a sub-sample of 12 participants. These interviews were audiotaped and transcribed verbatim. Significant associations were found between meditation experience and mindfulness, and between levels of mindfulness and empathic capacity. Specific themes were identified in therapists' qualitative responses regarding the influence of mindfulness practice on their work. These included: enhanced attention and self-awareness, and improved ability to be present and to attune to clients. Mindfulness practice helped to internalise attitudes and qualities that have a positive influence on therapeutic work. It increased awareness of self-care needs and provided support in meeting them, and influenced perspectives on psychotherapy. Mindfulness practice also presented challenges for participants. The findings suggest that personal mindfulness practice can enhance key therapist abilities (e.g., attention) and qualities (e.g., empathy) that have a positive influence on therapeutic relating. Mindfulness practice could provide a useful adjunct to psychotherapy training and an important resource in the continuing professional development of therapists across modalities.

Key Words

Mindfulness, Psychotherapy, Therapeutic Relationship, Empathy, Mixed-methods

Introduction

The contention that mindfulness meditation practice has benefits for psychotherapists and their clients has received considerable attention in recent years (e.g., Bruce, Shapiro, Constantino, & Manber, 2010; Davis, & Hayes, 2011; Germer, Siegel, & Fulton, 2005; Hick, & Bien, 2008; Shapiro, & Carlson, 2009). Put simply, mindfulness practice may provide a way to develop the very attitudes and qualities associated with effective therapeutic relating (Lambert, & Ogles, 2004). In an interpersonal context, Bien (2008) argues that mindfulness *is* the embodiment of the kind of attitude characteristic of effective therapists: warm and accepting, kindly and compassionate, non-possessive and unconditional. Similarly, Bruce et al. (2010) suggest that mindfulness practice provides a method for cultivating relational qualities such as empathy, openness, acceptance and compassion. They contend that mindfulness is a means of self-attunement that develops the capacity to attune to others. In turn, this promotes client self-attunement, decreased symptom severity, greater well-being and more satisfying interpersonal relationships. A review of the literature suggests that the proposed benefits of mindfulness practice for therapists can be clustered into five inter-related categories: (a) attentional skills; (b) affect regulation; (c) awareness and management of relational dynamics; (d) self-compassion and empathy; and (e) stress reduction. However, empirical exploration of the influence of mindfulness practice on therapists and their work is at an initial stage (Davis, & Hayes, 2011).

It is not surprising that therapists who practise mindfulness describe improvements in regulating attention (Fulton, 2005; Tremlow, 2001), given the evidence of attentional benefits of mindfulness practice for non-therapist groups (e.g., Jha, Krompinger, & Baime, 2007). This is significant because the quality and flexibility of attention required of psychotherapists has long been recognised across modalities as a foundational element of effective psychotherapy (e.g., Mace, 2008; Martin, 1997; Speeth, 1982). Interestingly, Greason and Cashwell (2009) reported that levels of mindfulness among graduate counselling students were a significant predictor of counselling self-efficacy and that attention was a mediator of that relationship.

Therapists' ability to tolerate challenging emotions is essential to the quality of their engagement in the therapeutic process (Teyber, 2006). Correlational studies have reported significant associations between levels of mindfulness and effective emotion regulation (e.g., Coffey, & Hartman, 2008; Jimenez, Niles, & Park, 2010). Epstein (1995) and Fulton (2005) use the metaphor of a "container" to describe the capacity to regulate difficult affect. They propose that mindfulness practice provides a way for therapists to strengthen and deepen this container. Ryback (2006, p. 487) suggests that therapist mindfulness heightens the in-the-moment emotional connection between client and therapist, a "non-conceptual interconnectivity" where emotion can be fully experienced and co-regulated.

Authors from a psychodynamic perspective contend that mindfulness practice improves the ability to process the intersubjective dynamics of the client–therapist relationship (Epstein, 1995; Magid, 2002; Safran, & Reading, 2008). The term "metacommunication" is used by Safran and Reading (2008, p. 123) to describe a form of "mindful investigation" through which the therapist and client engage in a collaborative exploration of patterns in the therapeutic relationship. The authors suggest that the attentional flexibility, affect tolerance and empathy cultivated in mindfulness practice refine the therapist's capacity to skilfully use challenging counter-transference affect. Supporting this suggestion, Kholooci (2007) reported that levels of mindfulness and counter-transference scores were inversely related among a sample of psychologists and trainees. Kholocci argues that therapist mindfulness practice acts as a protective factor against engaging in harmful counter-transference behaviours.

Greater self-compassion may be an emergent feature of therapist mindfulness practice (Andersen, 2005; Shapiro, & Izzet, 2008). Shapiro, Brown and Biegel (2007) reported that increases in mindfulness were associated with heightened self-compassion among trainee counselling psychologists. Significantly, therapists who lack self-compassion and are critical and controlling toward themselves are more critical and controlling toward their clients, and record poorer outcomes (Henry, Schacht, & Strupp, 1990). Neff, Kirkpatrick and Rude, (2007) indicated that self-compassion is positively correlated with improved mental health and argue for its centrality in promoting empathy. In line with this position, Kingsbury (2009) reported that self-compassion fully mediated the relationship between mindfulness and aspects of empathy, such as the tendency to adopt the psychological viewpoint of others, among a non-therapist sample.

Therapist empathy has long been presented as a necessary condition for effective psychotherapy and according to some studies accounts for as much and probably more outcome variance than do specific interventions (Arkowitz, 2002; Bohart, Elliott, Greenberg, & Watson, 2002). However, research evidence suggests that it is difficult to teach and often diminishes over time (Walsh, 2008). In addition, therapists' subjective sense of being empathic matches poorly with clients' experience of feeling understood (Fessler, 1983). Significant positive correlations between levels of mindfulness and empathy have been reported among non-therapist samples (Bietel, Ferrer, & Cecero, 2005; Block-Lerner, Adair, Plumb, Rhatigan, & Orsillo 2007; Dekeyser, Raes, Leijssen, Leysen, & Dewulf, 2008; Kingsbury, 2009; Shapiro, Schwartz, & Bonner, 1998). Consistent with these findings is Greason and Cashwell's (2009) report that levels of mindfulness significantly predicted levels of empathy among graduate counselling students. Also, counselling psychology students demonstrated increases in empathy following a Zen meditation intervention in Lesh's (1970) study. This evidence suggests that mindfulness meditation practice may help to internalise key therapist qualities, such as empathy (Hick, 2008; Lambert & Simon, 2008; Shapiro, & Izzet, 2008). However, this proposition has not been tested among more experienced therapists who already have an established meditation practice.

Therapist well-being and adaptive psychological adjustment are consistently correlated with effective therapy (Beutler et al. 2004) – whereas effectiveness declines as personal distress increases (Sherman, & Thelen, 1998). Moreover, evidence suggests that younger and newly qualified therapists are particularly prone to occupational stress (Skovholt, & Ronnestad, 2003; Vredenburgh, Carlozzi, & Stein, 1999). Clinical studies support the efficacy of mindfulness-based stress reduction programmes (MBSR) for reducing stress and enhancing well-being (Eberth, & Sedlmeier, 2012). Empirical research also suggests that mindfulness practice can provide a useful self-care strategy in the management of trainee therapists' stress (Christopher, 2006; Cohen, & Miller, 2009; Schure, Christopher, & Christopher, 2008; Shapiro et al., 2007).

Indeed, the majority of published studies exploring therapist mindfulness practice have focused on the impact of mindfulness-based interventions with therapists in training. Schure et al. (2008) collected data over a 4-year period investigating the impact of a mindfulness-based course on 33 graduate counselling students. Emerging themes were consistent across

class cohorts. Students reported the following: (a) increased awareness and acceptance of personal issues and emotions; (b) increased mental clarity and organisation; (c) increased sense of relaxation and tolerance of physical and emotional pain; and (d) interpersonal changes such as increased capacity for compassion and empathy. In their counselling work students felt more attentive to the therapy process and more comfortable with silence. They incorporated meditative practices into their work and recommended specific practices to clients. They also continued their personal practice and in some cases changed their understanding of therapy. Analysis of semi-structured interviews with students who had taken the course two to six years previously indicated that changes at personal and professional levels were sustained over time (Christopher, Chrisman & Trotter, 2009).

Participation in an 8-week MBSR programme was also associated with lower stress levels and enhanced emotional regulation among trainee counselling psychologists, in a study reported by Shapiro et al. (2007). Compared to cohort controls, pre- to post-intervention scores indicated significant declines on measures of perceived stress, negative affect, rumination, and state and trait anxiety. Significant increases in positive affect and self-compassion were also observed. Furthermore, post hoc analyses indicated that increases in levels of mindfulness were related to several of the beneficial outcomes recorded.

The first prospective study to explore the influence of mindfulness practice on the work of trainee therapists examined the course and outcomes of 124 inpatients using a randomised double-blind controlled design. Grepmair et al. (2007) reported that patients working with therapists who received Zen-mindfulness training displayed significantly higher results on 10 of 11 outcome measures. They also recorded greater symptom reduction than patients who worked with non-meditating therapists. The findings suggest that the promotion of mindfulness in therapists in training can have positive effects on the course and outcomes of therapy.

Little attention has been given to investigating the influence of mindfulness practice on the work of qualified therapists, who already have an established meditation practice. A qualitative study by Cigolla and Brown (2011) explored the experience of six therapists who had been working for an average of 9 years and had practised meditation for 4 to 20 years. A "master theme" emerged in participants' accounts indicating that ongoing mindfulness practice promoted "a way of being" (2011 p. 717). Mindfulness was seen as influencing

therapy work "naturally over time" because of its integration into therapists' personal lives (Cigolla, & Brown, 2011, p. 714). Participants noticed positive changes in attention, and in their levels of awareness of self, clients and relational processes. Mindfulness encouraged greater affect tolerance, metacognitive insight and qualities such non-judgmental acceptance, openness, curiosity and compassion. It was also seen as fostering resilience in therapists because of the potential it offers for ongoing self-care. Mindfulness was modelled and embodied in the therapeutic relationship, and used "more explicitly by encouraging a present-centred and accepting attitude" (Cigolla, & Brown, 2011, p. 716). Participants' experiences support suggestions in the conceptual literature that ongoing mindfulness practice can help to internalise benefits for therapists, enhancing their capacity to relate to themselves and their clients.

An investigation of associations between mindfulness, well-being, burnout and job satisfaction among a sample of qualified counsellors, psychologists and social workers (N = 54) was conducted by May and O'Donovan (2007). Over a third (35%) had practised meditation for an average of 15 years, while nine others (16%) had practised yoga for an average of 10.5 years. Higher levels of mindfulness were positively correlated with life satisfaction, positive affect and job satisfaction, and negatively correlated with measures of burnout. The results indicate that it is likely that higher levels of mindfulness support therapists' well-being and, as a consequence, the effectiveness of their work.

The aim of the present study was to investigate the experience of qualified therapists who already have a meditation practice to find out if, and how mindfulness influences their work. The use of either qualitative or quantitative approaches in previous studies suggests that multiple methods of inquiry may be necessary to investigate the subjective and interpersonal realities of mindfulness practice and therapeutic relating. Therefore, a mixed-methods design was used to collect both qualitative and quantitative data. The choice of design also answered calls in the literature for research strategies that are sensitive to a range of theoretical perspectives and methodological approaches (Carmody et al., 2009; Christopher et al., 2009; Christopher & Maris, 2010; Grossman, 2008; Kabat-Zinn, 2005). The study proposed to address three questions. First, how do therapists working in clinical settings understand the impact of mindfulness practice on their work? Second, are levels of meditation experience associated with levels of mindfulness? Finally, are levels of mindfulness associated with the capacity for empathy (which was used as an indicator of positive therapeutic relating)?

Study Phase 1: Postal Survey

Method

Participants

A convenience sample of 40 psychotherapists was recruited from a population of professionally qualified therapists known to the researcher through professional contact (e.g., training, continuing professional development etc.). Baer et al.'s (2008) criterion for regular meditation practice of at least once or twice per week applied. Participants were recruited from diverse theoretical backgrounds and professional affiliations in an attempt to maximise representativeness. The researcher made contact with 33 prospective participants. Of those contacted 29 expressed interest in participating. Additional participants were recruited using a "snowball" sample method (Biernacki, & Waldorf, 1981). Eleven therapists contacted the researcher following referral from other participants. More females (62.5%) than males (37.5%) took part in the study. Participants' ages ranged from 30 to over 60 years. Over three quarters of the participants were Irish (80%). Six other nationalities were represented: American (2.5%); Australian (2.5%); British (7.5%); Dutch (2.5%); Indian (2.5%); Polish (2.5%). Participants' years of experience as psychotherapists ranged from 1 to 35 years, with a mean of 11.9 years (*SD* = 8.94). Eighteen participants reported one predominant theoretical orientation, 10 had two and 12 had three or more (Table 1). Over two thirds of the sample (70%) indicated that they had engaged in further psychotherapy training that included mindfulness-based practices.

[Insert Table 1 about here]

A wide range of meditation experience was represented (1 to 40 years), with a mean length of practice of 11.4 years (*SD* = 10.49). On average, participants meditated almost seven times per week (*M* = 6.8, *SD* = 3.68). Meditation sessions lasted between 5 and 60 minutes (*M* = 30, *SD* = 12.26). The number of days participants had spent on meditation retreats ranged from none to 4,000 (this outlying figure was reported by a senior meditation teacher). Over two thirds (72.5%) had spent more than 10 days on retreat. Over one third (37.5%) reported more

than 30 such days. More than half the sample (60%) indicated that their mindfulness practice was influenced by a particular meditation tradition. Most of these (96.6%) were influenced by Buddhist lineages. Participants identified a total of 23 mindfulness practices – both formal and informal – that they engage in.

Design and Procedure

The study was conducted using a mixed-methods sequential explanatory design (Creswell, & Plano Clark, 2007). The first phase consisted of a predominantly quantitative postal survey, which included standardised questionnaires and open-ended questions. Dublin City University Research Ethics Committee approved all components of the research design and protocol. A questionnaire, plain language statement, consent form and return envelope, were posted to participants following confirmation of their interest in taking part in the study. The researcher contacted participants by email or phone to address any questions or concerns arising from participation in the study. Forty questionnaires were posted to participants and follow-up contact was made with participants who had not returned questionnaires four weeks after posting. All 40 questionnaires were returned. All participants provided written informed consent.

Measures

A questionnaire was constructed by the researcher containing a series of questions and statements for the purposes of this study, as well as two reliable and validated self-report measures. Questions 1-13 sought to gather information regarding participant's socio-demographic details, professional background and meditation experience. Participants' perception of the impact of mindfulness practice on therapeutic work was examined through two open-ended questions and eight single items using a Likert scale. Participants were asked to rate their opinion of statements regarding mindfulness practice and therapeutic work on a 5-point scale ranging from *strongly disagree* (1) to *strongly agree* (5). Items included statements such as: "Mindfulness practice has improved the quality of my attention with clients" and "Mindfulness practice has improved my ability to tolerate difficult emotional states". For the purposes of this study the eight items were referred to as the Personal Mindfulness Practice and Psychotherapeutic Work Questionnaire (PMPPWQ). It demonstrated good internal reliability consistency, with a Cronbach's alpha coefficient of .82. Item–total correlations ranged between .44 and .73.

Mindfulness was assessed using the Five Facet Mindfulness Questionnaire (FFMQ: Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006). This 39-item questionnaire measures five inter-related aspects of mindfulness (Observing, Describing, Acting with Awareness, Nonjudging of Inner Experience, Nonreactivity to Inner Experience). Items are rated on a 5-point scale ranging from *Never or very rarely true* (1) to *Very often or always true* (5). The five FFMQ scales demonstrated adequate to good internal consistency reliability, with Cronbach alpha coefficients ranging from .72 to .92 in meditating and non-meditating samples (Baer et al., 2006; Baer, Smith, Lynkins et al., 2008). In the present study, the facets also demonstrated adequate to good internal reliability consistency. Cronbach alpha coefficients ranged from .81 to .89.

The Interpersonal Reactivity Index (IRI; Davis, 1983) was used as a measure of engagement in empathy. It contains 28 items representing four dimensions of empathy (Perspective Taking, Empathic Concern, Fantasy and Personal Distress). Items are rated on a 5-point scale ranging from *Does not describe me well* (1) to *Describes me very well* (5). A global empathy score can be derived from three of the subscales (Perspective Taking, Empathic Concern, Fantasy) (Dekeyser et al., 2008; Pulos et al., 2004). Cronbach alpha coefficients have ranged from .71 to .77 (Davis, 1983). In the present study alpha coefficients for the four subscales and Global Empathy scale of the IRI were also adequate to good (.73 to .82).

Results

Quantitative data were analysed using SPSS Version 15.0. The normality of the data was inspected using statistical and graphical methods before conducting parametric analysis. Inspection of histograms of the distribution of scores in each subscale of the FFMQ and IRI suggested that none deviated significantly from normality. The tests used for parametric analysis were: Pearson's product-moment correlation and *t*-tests. Spearman's ρ non-parametric test was used where data were not normally distributed. Cronbach's test for internal reliability consistency was also used. All significance tests were two-tailed.

A six-phase model of qualitative thematic analysis suggested by Braun and Clarke (2006) was used to analyse data generated in response to the three open-ended questions in the questionnaire. This included: (1) familiarization with the data; (2) generating initial codes; (3) searching for themes; (4) reviewing themes; (5) defining and naming themes; (6) producing the report. Cohen's Kappa reliability statistic was calculated to provide a measure of inter-coder agreement with an external auditor on a sample of data extracts from 10 participants (25% of sample) (Creswell, 2007). A high level of inter-coder agreement was observed, κ = .88 (Landis & Koch, 1977). Analysis yielded four main themes and sub-themes. Themes were checked by the auditor for internal homogeneity and external heterogeneity (Patton, 2002).

One of the objectives of the study was to examine associations between levels of meditation experience and levels of mindfulness. There was a significant positive correlation between meditation experience and two of the FFMQ facets (Nonjudging: $\rho = .39$, $N = 40$, $p = .012$; Acting With Awareness: $\rho = .34$, $N = 40$, $p = .033$). No evidence was found to suggest a relationship between months of meditation practice and the remaining three facets of the FFMQ. No evidence was found to suggest a relationship between days spent on meditation retreat and any of the facets of the FFMQ. Using a one-sample *t*-test, no significant difference was observed in mean scores on the FFMQ facets between meditators in Baer et al.'s (2008) sample and participants in the present study.

A second objective of the study was to examine the association between levels of mindfulness and empathic capacity. Correlations between mindfulness facets and subscales of the IRI can be seen in Table 2. There were significant positive correlations between three facets of the FFMQ and a measure of Global Empathy on the IRI (Observe: $r = .52$, $N = 40$, $p = .001$; Nonjudging: $r = .48$, $N = 40$, $p = .002$; and Nonreactivity: $r = .44$, $N = 40$, $p = .002$).

All five facets of the FFMQ were positively correlated with the Perspective Taking subscale of the IRI (Observe: $r = .60$, $N = 40$, $p = .00$; Describe: $r = .46$, $N = 40$, $p = .003$; Act With Awareness: $r = .44$, $N = 40$, $p = .004$; Nonjudging: $r = .57$, $N = 40$, $p = .00$; and Nonreactivity: $r = .57$, $N = 40$, $p = .00$). The Observing facet of the FFMQ was also significantly related with Empathic Concern ($r = .37$, $N = 40$, $p = .021$). There were significant negative correlations between four of the FFMQ facets and the Personal Distress subscale of the IRI (Observe: r = -

.34, $N = 40$, $p = .03$; Describe: $r = -.53$, $N = 40$, $p = .001$; Nonjudging: $r = -.33$, $N = 40$, $p = .04$; and Nonreactivity: $r = -.45$, $N = 40$, $p = .004$).

[Insert Table 2 about here]

All 40 participants thought that mindfulness practice had influenced their work. Four (10%) felt that it had some adverse effect on their work. Figure 1 shows participants' responses on the PMPPWQ regarding their perceptions of how mindfulness practice had influenced their work. Over 90% agreed that mindfulness practice had enhanced their levels of attention and self-awareness with clients, their level of self-compassion and their awareness of self-care needs. Over 80% felt that mindfulness practice had improved their capacity for empathy, while nearly all participants (97.5%) indicated that their ability to tolerate difficult emotional states had improved. Over three quarters (77%) agreed that mindfulness practice had positively influenced awareness of dynamics like transference and counter-transference. Two thirds (67%) thought that it had affected their understanding of psychotherapy.

[Insert Figure 1 about here]

Qualitative Responses

Analyses of data regarding participants' perceptions of the influence of mindfulness on their work produced main themes and associated sub-themes.

Theme 1: Mindfulness Practice "Enhances" Attention and Awareness

Two thirds of participants reported that mindfulness practice had "enhanced" their "attentional skills" and "level of awareness". For example, 14 noted a greater ability to regulate attention.

Sub-Theme: Benefits of Heightened Attention and Awareness

Heightened attention and awareness were understood as having a positive influence on therapy work. For example: improving the ability to be "present" and the capacity to relate effectively; facilitating "deeper listening" and greater "attunement"; "developing the ability to observe self and client from [a] warm, detached position"; and fostering greater insight

into the nature of cognitive and emotional processes. One therapist reflected many responses when he wrote:

> Mindfulness practice has deepened my levels of attention to both myself and my client, enabling me to have greater embodied awareness of the here and now. This facilitates meeting on a much deeper level. It can help cut through the dance of repeated patterns/dialogue. It facilitates a much deeper level of presence, which helps me respond rather than react or collude with a client.

Sub-Theme: Challenges of Heightened Attention and Awareness

Seven participants (17.5%) referred to perceived challenges that mindfulness practice had presented for their work. For example: being "more intensely aware and open to clients' pain"; deeper self-awareness can result in feeling "inadequate and lacking in the certainty of old"; or feeling "too passive with certain clients where I needed to be more directive".

Sub-Theme: Heightened Awareness and Therapist Self-Care

A related sub-theme concerned therapists' heightened awareness of their need for self-care. Two participants framed this in terms of a greater ethical appreciation of the implications of their "energy levels" and "fitness to practice". Four therapists saw mindfulness as a "significant contributor to occupational health activities": it helps manage and sustain workload, monitor energy and reduce anxiety.

Theme 2: "An Embodied Sense of Mindfulness"– Therapist Qualities

Regular mindfulness practice was seen as promoting specific qualities, including: acceptance, calm, compassion, confidence, curiosity, ease, non-judgement, openness, patience and respect. These qualities transfer to therapy work because mindfulness, as one participant explained: "influences me as a person". Seven participants noted that mindfulness practice makes us "sit" with our own "vulnerabilities and struggles rather than avoiding". This helps therapists in supporting clients "contact and move through painful and threatening emotional states". The idea of the therapist internalising the qualities of mindfulness practice was central to this theme. For example:

> In deepening my practice I find that I can bring an embodied sense of mindfulness into the subjective and inter-subjective space in the therapeutic dyad – enabling a deeper listening and holding container which in itself is therapeutic for the client – enabling a felt sense of safety, trust and compassion.

Theme 3: "The Bigger Picture" – Perspectives on Psychotherapy

Ten therapists reflected on how meditation practice has influenced their personal perspective on psychotherapy. For example: "I'm less and less solution focused!" or "I have developed more trust in the therapeutic process". Another wrote of connecting to the "the bigger picture … the transpersonal in the session". Mindfulness practice made one participant, "more respectful of the work of therapy … clearer about [its] value, its technical skill". For another, the assumption that "suffering is an inevitable part of life" prompted greater realism about the therapy process and its strengths and limitations.

Theme 4: Mindfulness as Intervention

Only six participants described the explicit use of mindfulness-based interventions with clients. All did so in the context of psycho-education. For example, mindfulness was used: to teach "centring and breathing"; as a "meta-skill" to help clients access their inner experience; or with clients who want "to stay in the present moment with their difficulty and anxiety". Five participants expressed caveats about the explicit use of mindfulness with clients. For example: certain mindfulness practices "can be harmful to clients without first paying attention to grounding – there is a need for a strengthening of ego before engaging in practices where there is a letting go of self".

Study Phase 2: Follow-Up Interviews

Method

Participants

In total 31 participants self-selected to engage in follow-up interviews by indicating their interest on the questionnaire in Phase 1. A purposive subset of 12 was invited for interview. Participants were selected in order to maximise the representation of gender, theoretical orientation and range of meditation and therapy experience. All participants invited to take part in the interview agreed to do so.

Design and Procedure

The second phase of data collection in a mixed-methods sequential explanatory design (Cresswell, & Plano Clark, 2007) consisted of 12 semi-structured one-to-one follow-up

interviews. It was intended to explore the experience of a subset of participants from Phase 1 in greater detail regarding the influence of mindfulness practice on their work. Participants' responses to the open-ended questions and the PMPPW questionnaire were used as the starting point for discussion. The researcher followed Rubin and Rubin's (2004) guidelines for semi-structured interviews. All participants provided written informed consent. The interviews were recorded and lasted between 40 and 61 minutes (M = 47.1, SD = 6.4).

Data Analysis

All interview recordings were transcribed by the researcher. Qualitative thematic analysis was conducted following Braun and Clarke's (2006) six-phase model, as described in phase 1 of the study. An external auditor provided a check of the research process. He separately coded three interview transcripts (25%). A comparison was made with the researcher's coding by calculating Cohen's Kappa reliability statistic. A high level of inter-coder agreement was observed (κ = .89) (Landis & Koch, 1977). The external auditor also judged themes for internal homogeneity and external heterogeneity. Preliminary analyses consisting of initial themes and data extracts were brought to two interviewees. They were asked to evaluate the credibility of the findings. Both supported the interpretation of data as presented.

Results

The process of analysis yielded seven themes regarding participants' perceptions of the influence of mindfulness practice on their work (see Figure 2). Letters are used as identity codes for participants.

[Insert Figure 2 about here]

Theme 1: Enhanced Awareness and Attention – "Refining the Channels"

Participants in Phase 1 reported that mindfulness practice had enhanced their levels of attention and awareness. Therapists in the sub-sample elaborated on this because, as one

explained: "our capacity to pay attention to our client is what makes us effective" (J). Interviewees used images to explain the impact of mindfulness practice on attention and awareness. Mindfulness "refined the channels of communication and awareness" (H) … like a "lens… cleaned or updated" (J), or "antennae … much more sharply focused" (K).

Personal practice was seen as contributing to greater voluntary control over attentional processes. One participant explained how this transferred to her therapy work:

> Mindfulness meditation uses this fine beam of attention in a narrow focus and then broadens to a wider focus. When you are doing that deliberately with a client, your capacity to explore their internal geography improves. You really become a much more sophisticated cartographer. (J)

Three interviewees reported an association between the regularity of meditation practice and their levels of attention and awareness in their client work. This can facilitate a deeper "receptivity" to the client, as one explained:

> The more that I have practised sitting meditation, the more I feel I am tuning in with more than my hearing sense or my sight, there is another sense which is part of the receptivity … I am more tuned into [clients] than I would have been initially … I am actually checking in on another level with the person. (C)

Theme 2: Benefits: "Being Present" – "Meeting at Depth"

Enhanced attention and awareness mediated other benefits. For example, eight therapists described being more "present" in their work. One explained:

> We talk about [being present] as something that's easy to do but it's really difficult … I think mindfulness is a really good methodology for being present with people, for being present with one's own life, one's own present moment. (E)

Being present was seen as a deliberate choice:

> There has to be an act of self in being present … [mindfulness] heightens being present… it expands the quality of presence. (H)

Mindfulness heightens somatic awareness and this influences the therapist's capacity to be present. For example:

> "The added bit that mindfulness gives is that notion of taking the time to come in and take your seat, to feel, 'Am I present? Am I in my body?' A lot of my patients have physical traumas and are slightly dissociated from their bodies. I've learnt to be grounded to help them ground themselves as well." (G)

Interviewees elaborated on the role of heightened attention and awareness in promoting greater subtlety in their perception of relational dynamics, including transference phenomena. For example, one explained:

> What I have found is that you're picking up a lot of the patients' transferences. You're perhaps more aware of their body language, their tone of voice – you can almost feel the fear, you can almost smell the depression … Because you're being empathic and listening, you also become aware of your own reactions. (I)

Three interviewees saw mindfulness as contributing to moments of "seamless awareness" between therapist and client. Two participants used Martin Buber's (1996) idea of "I–Thou" relating, to articulate this experience. One commented that mindfulness has:

> … led me to be aware of the self of the other … I've a sense of it leading me into greater depth … there's also awareness that it's a universal self … there's no separation. (H)

Theme 3: "The Hook and Twist" – Challenges of Heightened Awareness

In Phase 1 seven participants reported that mindfulness practice had presented challenges for their work. Eleven of twelve therapists interviewed asserted that mindfulness practice brought benefits but also challenges – the "hook and twist" as one participant put it. He described the "twist" as: "really learning to lean into my own pain, the places that you don't want to go, the places that scare you … the shadow" (L). Similarly, another explained: "that's been my experience: letting go your ideal self, letting go your conscious self. So, you really are coming down off those identifications into a much more uncertain place" (G).

Four participants described an intensity of awareness that they associated with the initial stage of mindfulness practice. For example, one explained:

> Within a short few months repressed trauma material vertically arose a bit volcanically and that was very overwhelming … So one of the things that the practice asks of us is that you find a way to be with whatever is present no matter what it is. (J)

Others spoke of a heightened sensitivity and sense of vulnerability that emerged in beginning phase of mindfulness practice. In relation to client work, one commented: "I was very sensitive to everything. It was as if every emotion was magnified. Client stories were very

upsetting – the positive sides were very joyful as well – it was a double-edged sword. That was definitely a challenge" (F).

Three participants spoke of how the intensity of awareness modulated over time. As one put it, "it made sense that it's going to be loud for a while" (J). They emphasised the importance of skilled support in negotiating the challenges presented. Heightened sensitivity can be particularly intense for therapists working in specific modalities, as one explained:

> I notice that sometimes you go into a room with somebody and you can almost smell or take on board what it's like to be them, and sometimes you just wish you weren't feeling it too much ... It's a very intense way of working – particularly people who work like I do, psychodynamically or interpersonally. It's very useful but also quite taxing. (I)

Theme 4: "Embodying Mindfulness" – Therapist Qualities

A range of attitudes and qualities similar to those listed in Phase 1 were identified as being associated with personal practice, including: acceptance, compassion, curiosity, empathy, equanimity, forgiveness, kindness, love, non-striving, non-judgement, openness, respect and trust. All interviewees saw a "personal commitment" to practise as helping to internalise attitudes and qualities that, in turn, influence therapy work. For example, the development of non-judgement and self-compassion was interwoven with the capacity to be compassionate with others:

> All these lovely notions of non-judgement and so on! One of the hard things that I had to go through was the level of self-judgement. It's much easier to understand Carl Rogers now. I've known it in a head sense for a long time, but now in a much deeper and more embodied way. That fundamental change is because I had to go through meeting that kind of stuff within myself in the practice, meeting a lack of compassion." (K)

Interviewees clarified why qualities such as "equanimity" and "steadfastness" were seen as vital contributors to therapy work in Phase 1. One therapist echoed the perception of others when he suggested that mindfulness practice helped him to be present and calm in the face of another's distress because it "taught" him to be present in a more profound way with his own. He continued:

> It's terrifying. I sit down on my cushion; I don't know what's going to come up here! … I became very familiar with the fact that no matter what I was feeling, it came and went, was very impermanent, very much a thing. So I became less dazzled by my own sordid psyche and, therefore, when I'm sitting with someone else's sordid psyche which is haemorrhaging all over the place, I find it's just the

> heart bleeding. It may need to bleed … I'm containing the space and keeping it safe. (E)

Ultimately these qualities were seen as "extending" the therapist's capacity to provide a therapeutic "holding container" (H). One interviewee described this therapeutic stance as "active presence".

Theme 5: Therapist Self-Care: Awareness and Support

Interviewees explored in greater detail the suggestions from Phase 1 that mindfulness is relevant to therapist self-care in two ways: it heightens awareness of self-care needs and provides a support in meeting those needs. Deeper self-awareness highlighted the ethical implications of therapists' self-care. One participant recounted how personal therapy and supervision are supposed to highlight "these edges" but "mindfulness does it for you on a daily basis" (G). Participants emphasised the importance of this kind of awareness because "many people in the therapy professions are more burnt out than they'd actually want to admit" (G). Two other participants drew attention to the need for balance and self-care especially among "mindful" therapists because of the heightened sensitivity they can experience in their work.

Mindfulness provided a key support in therapist self-care "on so many different levels" (L). Mindfulness "ends up allowing you be more responsive rather than reactive to what's happening" (J). Mindfulness practices helped in taking "pauses" in sessions, between sessions and during their day. "Breathing spaces" provided the opportunity to "come back to the present", to regulate and soothe physical tension and to interrupt stress cycles. Mindful movement, yoga and the body scan practice were identified as important supports in managing the physical impact of therapy work.

Three interviewees spoke of mindfulness helping them to address the excessive responsibility they felt about their clients. For one, it was instrumental in revealing the dynamics of a long-standing "urge to get involved" (G). For another, being fully present in client work means you can let go to it more easily: "You're dealing with what's there at the time rather than carrying extra weights around with you … then being able to clear from that and reconnect to that sense of stillness in yourself" (F).

Theme 6: Mindfulness as Intervention

Interviewees saw mindfulness practice as primarily influencing the person of the therapist and his or her capacity to relate rather than prompting the explicit use of mindfulness-based interventions with clients. One participant reflected: "I think the more integrated it is in me the more it's naturally arising and being used by me" (J). Interviewees described their perception of how mindfulness is present unobtrusively in the therapeutic process. One participant spoke of clients internalising the process over time, of "listening deeply to themselves" (D). Another explained:

> Everything that happens in a session … is really helping clients to be able to take the tools away with them… One thing they can do is certainly breathe into [distress] and not run from it. They can witness their thoughts as thoughts; they don't have to chase them, following them into emotional behaviours. Another thing is being aware of their body, aware of their senses, aware that there is another world, a bigger world than the world up in their mind. (A)

Two participants spoke of the value of concentrative practices, such as the "breathing space" as a way of helping clients to "ground". But as one put it: "I'd rarely, especially in the early days, name it as mindfulness" (D). Four interviewees emphasised the importance of proper training and thorough assessment of client suitability before using explicit mindfulness-based interventions. In this context one cautioned against the notion of mindfulness as:

> … the panacea … that this is the answer and will sort out everything and it's not. It clearly isn't an intervention for people in high levels of distress. (L)

Theme 7:"The Bigger Picture" – Perspectives on Mindfulness and Psychotherapy

Two thirds of participants in Phase 1 felt that mindfulness practice had changed their understanding of therapy in some way. Interviewees provided reflections on their conceptualisation of therapy and their role as therapists; the theoretical accommodation and dissonance between mindfulness practice and their therapy training; and the boundaries between psychotherapy and meditation.

Three participants spoke of recognising the "bigger picture" that comes from acknowledging "the basic essential goodness, the Buddha nature … the innate goodness of every being as a given" (C). Echoing other participants, one therapist commented on how this perspective can often be lost in results-driven, over-stretched health care settings:

> Real therapy is the capacity not just to heal or to deal with what are the most current symptoms a person's feeling but also to help them recover a sense of

> their potential and what they want and I think that requires a depth of appreciation for human beings. This recovery model we're talking about is really driven by something quite deep … And I think mindfulness may help us to get back to that. (E)

Two participants, one initially trained in CBT and the other in psychoanalytic psychotherapy, described mindfulness as constituting "a radical shift" in relating to suffering. They both used the phrase, "a search-and-destroy mission", to capture their previous approach to symptoms and defences. In contrast, mindfulness stops "trying to get rid of things". It allows space to develop a new way to relate to present circumstances.

One participant described the shift in her understanding of her role as therapist in a health system where clients are referred on the basis of diagnoses:

> Mindfulness doesn't have any diagnostic side to it … you're dealing from the very beginning with the notion of, "We're all human beings on a journey together. We're all in a difficult place". The therapist/patient divide, that's certainly shifted for me … "the fact that you might have an anxiety diagnosis is completely secondary to the common humanity that we share and it's only a particular kind of language anyway". (G)

Other participants spoke of seeing a wider significance to their work as a result of meditation practice. For example, two described their deepening realisation of the "interconnectedness" of reality and of the "connectedness" between therapist and client.

All participants spoke of finding theoretical accommodation and/or dissonance between the experience of mindfulness practice and their therapy training. For example, two saw similarities between "bare attention" in mindfulness and free association in psychoanalytic psychotherapy. Another two highlighted how mindfulness naturally facilitated the "cognitive defusion" and "decentring" of CBT approaches. Nine participants commented on the fit between humanistic-existential approaches and the assumptions and practice of mindfulness. Six referred to parallels with Rogerian ideas on human potential and therapeutic relating, and seven commented on similarities with the phenomenological, present-moment emphasis of approaches like Gestalt and Focusing.

Two participants felt that mindfulness had hastened a move from the more cerebral approach of their training in CBT and Systemic Therapy to a greater trusting in the unfolding of the therapy relationship. For three others mindfulness radically challenged how they understood

and worked with emotion in contrast with more "cathartic" therapy models. Two participants recognised through their experience of mindfulness that they had operated from a "technique-y" model of empathy.

Discussion of the boundaries between meditation and psychotherapy generated great interest. One interviewee highlighted the "developmental" trajectory of both disciplines, particularly psychodynamic therapy. Neither discipline is a "quick, short-term therapy": development in both "can take years … both are very respectful of the client's pace" (I). While one participant stated that meditation practice *is* therapy, others felt very differently. Two participants used the idea of "levels" to conceptualise boundaries between the disciplines:

> I think meditation is at another level, meditation nurtures your inner being, definitely strengthens your "big self" … almost the backdrop of who you are. There's no doubt of course, the steadier and stronger, more grounded that is the more you can bear the conflicts. But conflicts are often very specific, very historical, and very much to do with perceptions and narrative … and I do think they need their own space. (G)

Some participants cautioned against the risk of "blurring" the distinction between the two disciplines for therapists and for clients. For example, meditation practice could be used as an avoidance strategy from the conflicts of life. Returning to the boundary between therapists' personal mindfulness practice and therapy, one participant suggested:

> Mindfulness just increases the likelihood [that the elements of therapy] can happen because it deepens the sense of safety. Mindfulness is a very good container for the work that needs to be done… I see them going hand in hand. A good therapist for me are [*sic*] people who are present and able to be aware of me, of what I'm saying and hold the big picture, not just the little symptoms. (E)

Participants referred to the cultural dialectic taking place between Eastern and Western approaches to mental health. Some cautioned against "robbing [meditation] of its complexity and mystery … and the wisdom of personal, social and spiritual development" (I). Another felt it had been "psychologised" and "packaged" as "a tool you take out of the toolbox to fix some people" (L). Looking to the future, one participant hoped for a "creative merger" (G).

Discussion

This study addressed three questions: First, how do therapists working in clinical settings understand the impact of mindfulness practice on their work? Second, are levels of meditation experience associated with levels of mindfulness? Finally, are levels of mindfulness associated with the capacity for empathy?

The study findings suggest that mindfulness practice influences psychotherapists and their work in a number of ways. Results of the postal survey in Phase 1 found significant positive associations between participants' meditation experience and levels of mindfulness, and between levels of mindfulness and the capacity for empathy. Participants reported that mindfulness practice had positively influenced the following: the quality of therapist attention and self-awareness; awareness of self-care needs; capacity for self-compassion; capacity for empathy; ability to tolerate difficult emotional states; awareness of transference and counter-transference; and perspectives on psychotherapy. Seven participants (17.5%) indicated that mindfulness practice had presented challenges personally and/or professionally.

Analysis of follow-up interviews with a sub-sample of 12 participants elaborated on these findings. Seven themes related to the influence of mindfulness practice on participants and their work. First, mindfulness enhances therapists' levels of attention and awareness. Second, mindfulness helps therapists to be present, to listen deeply and to attune to clients. Third, mindfulness practice can present personal and/or professional challenges. Fourth, mindfulness can raise awareness of therapists' self-care needs and provide support in meeting them. Fifth, personal practice helps to internalise attitudes and qualities that have a positive impact on therapy work. Sixth, mindfulness practice influences therapists' perspectives on therapy and their role as therapists. Seventh, participants see mindfulness as an implicit and explicit intervention with clients.

Meditation Experience and Mindfulness

A positive association was found between participants' meditation experience and the Nonjudging and Acting With Awareness facets of mindfulness. The non-significant findings in relation to three of the facets were unexpected. Baer et al. (2008) reported that meditation experience was significantly and positively correlated with four of the mindfulness facets in their sample of meditating and non-meditating participants. They also found no evidence for a relationship between meditation experience and Acting With Awareness, whereas that relationship was significant in the present study. The divergent findings on four mindfulness

facets may be accounted for by differences in the range of meditation experience and the smaller size of the exclusively meditating sample in this study. The fact that no difference was observed in average scores on mindfulness facets between the present study and meditators in Baer et al.'s (2008) sample supports this interpretation.

However, the findings also raise questions about attempting to measure mindfulness meditation experience based on duration of practice. Mace (2008) points out that only two of the facets in Baer et al.'s (2008) study showed robust associations with meditation experience, while Kholocci (2007) reported that meditation experience did not affect FFMQ mindfulness scores in her sample of psychologists and trainees. Similarly, May and O'Donovan (2007) reported inconsistent associations between the duration of therapists' meditation practice and self-report measures of mindfulness. The diversity, intensity and quality of practice engaged in by mindfulness meditators are not reflected in differences in the duration of their meditation practice. Studies investigating the link between meditation experience and therapist mindfulness need to establish a more sensitive criterion for the assessment of meditation experience than duration of practice. The findings remind us of the challenge inherent in efforts to operationalise and measure mindfulness. Ceiling effects are likely in the measurement of mindfulness factors such as those included in the FFMQ. In addition, current self-report measures may not be sensitive to variables associated with long-term mindfulness meditation practice and more fluid conceptualisations of mindfulness (Christopher et al., 2009).

Mindfulness and Therapist Empathy

Participants' levels of mindfulness were significantly positively associated with their capacity for empathy. This finding is consistent with previous research with non-therapist samples and among therapists in training, and is important given the centrality of empathy in effective therapeutic relating (Bietel et al., 2005; Block-Lerner, Adair, Plumb, Rhatigan, & Orsillo 2007; Dekeyser et al., 2008; Greason & Cashwell, 2009; Kingsbury, 2009; Schure et al., 2008; Shapiro et al., 2007). It also highlights the complex relationship between therapist mindfulness and empathy. Three facets of mindfulness (Observing, Nonjudging, and Nonreactivity) were positively associated with a general measure of empathy. All five facets were positively correlated with the tendency to adopt the psychological viewpoint of others (Perspective Taking), while the Observing facet was associated with the tendency to experience feelings of warmth, compassion and concern for others (Empathic Concern). As

expected, four of the mindfulness facets (Observe, Describe, Nonjudging and Nonreactivity) were negatively associated with the Personal Distress subscale.

The association between therapist mindfulness and empathy on standardised measures was corroborated in participants' perceptions of the influence of mindfulness practice on their work. Over 80% of therapists surveyed felt that mindfulness practice had improved their capacity for empathy with clients. Enhanced awareness and attention were seen as mediating benefits for therapy work, including therapist empathy. Similarly, nonjudgment and nonreactivity were identified in follow-up interviews as qualities of mindfulness linked with therapist empathy. Mindfulness supported non-reactivity, a way of "being empathic without getting 'lost' or over-identifying with the pain of the client".

This quotation also reflects the inverse relationship in the quantitative data between mindfulness and feelings of personal distress in response to the distress of others. Nearly all participants (97.5%) indicated that their ability to tolerate difficult emotional states had improved with mindfulness practice. Qualities such as equanimity and steadfastness were understood by interviewees as contributing to this ability. The findings corroborate suggestions that mindfulness practice strengthens therapists' capacity to contain and regulate challenging emotion (Cigolla, & Brown, 2011; Epstein, 1995; Fulton, 2005).

Taken together, the findings support the proposition that mindfulness practice may provide a way to internalise qualities associated with positive therapeutic relating, even those considered difficult to teach and sustain, such as empathy (e.g., Lambert, & Simon, 2008; Walsh, 2008). Participants' accounts also endorse Shapiro and Izzet's (2008) theory that mindfulness meditation may cultivate empathy through three inter-related pathways: reducing perceived stress, developing self-compassion, and facilitating "reperceiving" – the ability to dis-identify from our subjective perspective.

The Centrality of Enhanced Awareness and Attention

The role of mindfulness in enhancing awareness and attention emerged as a major theme in the qualitative data and supported findings in the quantitative data. A significant association was found between meditation experience and Acting with Awareness on the FFMQ. Similarly, almost all participants indicated that mindfulness practice had improved their levels of attention and their self-awareness while working with clients. These findings support the

theorising and preliminary evidence that mindfulness practice enhances therapists' attentional skills and self-awareness (Cigolla, & Brown, 2011; Greason, & Cashwell, 2009; Hick, 2008; Fulton, 2005; May, & O'Donovan, 2007).

Enhanced attention and awareness were seen as crucial in augmenting therapists' ability to be present, to attune, to listen deeply and to engage with greater discernment in the therapeutic process. This is consistent with Greason and Cashwell's (2009) finding that mindfulness is a significant predictor of counselling self-efficacy and that attention is a mediator of that relationship. Refinement of attention and awareness has been suggested as a central process in mediating the therapeutic benefits of both meditation practices and psychotherapy (Mace, 2008; Martin, 1997; Walsh, & Shapiro, 2006). The centrality of enhanced attention and awareness in participants' accounts in this study lends further support to this theory.

Challenges of Heightened Awareness and Attention

A surprising finding of this study concerned participants' perception of the personal and professional challenges associated with mindfulness practice. Meditative traditions emphasise that mindfulness practice is a challenging discipline and participant accounts of heightened sensitivity and self-awareness match descriptions of naturally occurring side effects of insight practices (Chödrön, 2001; Kornfield, 1993; Welwood, 2000). Self-awareness and self-focused attention can be experienced as critical, ruminative or hyper-vigilant (Mor, & Winquist, 2002; Watkins, & Teasdale, 2004). Interestingly, Baer et al. (2008) reported that increased levels of awareness and attention (Observing) were associated with lower psychological distress in meditators but not in non-meditators. The authors suggest that the non-judgmental, non-reactive and other characteristics of mindfulness influence the tone of attention and awareness over time. Even among individuals with high levels of mindfulness, the abilities to pay attention and to maintain a non-judgmental attitude do not always develop concurrently (Lilja, Lundh, Josefsson, & Falkenström, 2012).

Heightened awareness was described as a potential "double-edged sword" in relation to client work. While mediating benefits, it also presented challenges; for example, being "more intensely aware and open to clients' pain". This may seem at odds with the evidence of improved affect tolerance and non-reactivity in the quantitative and qualitative data. Again, it may point to differences in the developmental trajectory of the various facets of mindfulness. Two interviewees noted how their experience of heightened sensitivity "modulated" over time

and identified the supportive role of meditation tutors and peers in negotiating this challenge. Others emphasised the importance of ongoing self-care in managing the impact of heightened sensitivity, particularly for therapists who work from a psychodynamic or interpersonal perspective. The experience of therapists in the study supports calls for greater exploration of the challenges encountered by meditation practitioners and for the provision of appropriate skilled support in managing the "risks" and "side effects" of insight practice (Grabovac, Lau, & Willet, 2011: Sears, Kraus, Carlough, & Treat, 2011).

Therapist Qualities: "Embodying Mindfulness".

The findings from this study support the proposition that mindfulness practice can provide a way to internalise attitudes and qualities associated with effective therapeutic relating (Bruce et al., 2010; Cigolla, & Brown, 2011; Elias, & Crane, 2006; Hick, & Bien, 2008; Lambert, & Simon, 2008). Mindfulness practice was seen as fostering qualities such as compassion, non-judgment, empathy and equanimity. Qualities were understood as being "embodied" through ongoing practice and transferred to therapy work because, as one participant explained, mindfulness "influences me as a person". Corroborating evidence for this was found in the diverse data collected in the study. For example, meditation experience was associated with the Nonjudging facet of therapist mindfulness. Nonjudging in turn was associated with greater therapist empathy on a number of levels; and participant accounts charted the integration of nonjudging from personal to interpersonal levels.

Qualities such as "equanimity" and "steadfastness" were seen as important contributors to therapy work. One interviewee echoed others when he suggested that mindfulness practice helped him to be "present and calm in the face of another's distress" because it "taught" him to be present in a more profound way with his own. Teyber (2006) and May and O'Donovan (2007) argue that mindfulness practice encourages openness in therapists to their own emotional exploration, rather than avoidance of emotions which may be detrimental to the therapy relationship. The findings of this study support their argument. Embracing the challenges of mindfulness practice identified by participants may be crucial in fostering greater emotional tolerance and associated qualities like equanimity.

The perception of personal practice as a way of internalising attitudes and qualities of mindfulness was fundamental to participants' understanding of how mindfulness influences their work. Despite the fact that over two thirds of the sample had engaged in specific

mindfulness-related therapy training, the majority saw mindfulness as primarily affecting the person of the therapist and his or her capacity to relate rather than prompting specific interventions with clients. This understanding mirrored the perception of therapists in Cigolla and Brown's (2011) study, who saw ongoing mindfulness practice as promoting a "way of being" that permeated their personal and professional lives.

Mindfulness and Therapist Self-Care

Therapists in the study indicated that mindfulness practice deepened awareness of self-care needs and helped in managing perceived stress at physiological, cognitive and behavioural levels. This is consistent with previous research suggesting that mindfulness practice provides a valuable resource in fostering resilience and in managing occupational stress for therapists' and trainees (Christopher, 2006; Cigolla, & Brown, 2011; May, & O'Donovan, 2007; Schure et al., 2008; Shapiro et al., 2007).

Mindfulness and Participants' Perspectives on Psychotherapy

Just over two thirds of participants (67.5%) in Phase 1 felt that mindfulness practice had changed their understanding of therapy in some way. Interviewees provided examples of how insights from mindfulness practice influence therapists' personal and professional worldviews. Even when participants understood mindfulness practice in a functional way as "attentional training", Buddhist ideas regarding suffering, impermanence and connectedness were evident in their evolving conceptualisations of psychotherapy. The impact of the philosophical assumptions of mindfulness practice on therapists and their work are varied and complex, and deserve further investigation.

Practical Implications

Basic training in mindfulness is an accessible resource for psychotherapists. Appropriate introductions for members as part of professional development programmes would provide a suitable setting to explore the theoretical accommodation and dissonance between mindfulness training and therapists' modalities. An important practical consideration concerns the quality of mindfulness training available because participants in this study supported calls highlighting the importance of access to skilled support in meeting the challenges and side-effects of mindfulness practice (e.g., Grabovac, Lau, & Willet, 2012). The study findings are consistent with research relating to the benefits of mindfulness practice for trainee psychotherapists. They suggest that mindfulness practice has a valuable role to play as an

adjunct to core curricula in psychotherapy training. However, practical questions regarding the overall approach, form, and quality of mindfulness training available need to be considered. Participants in this sample echoed voices in Cigolla and Brown's (2011) study, reminding us that embodying mindfulness and internalising attitudes and qualities can be a "long and challenging journey" that goes well beyond brief interventions during clinical training.

Methodological Issues

The complex relationship between therapist mindfulness and psychotherapy work requires flexible research designs that offer multiple paths of investigation. The mixed-methods approach used in this study allowed the corroboration of findings from different data sources within one study. It also facilitated the explanation of quantitative results through follow-up interviews exploring the rich, lived-experience of therapists. It has much to offer future investigations of mindfulness (Sauer et al., 2012). However, the sample size in Phase 1 of the study limited the power of the statistical analyses used and may have contributed to the divergence in findings from previous research regarding the association between meditation experience and mindfulness. While the validity of results on self-report measures in Phase 1 were enhanced by convergence with findings from follow-up interviews, the possibility of social desirability in responses on those measures and in face-to-face interaction with the researcher cannot be dismissed. Also, it is possible that the challenges of personal mindfulness practice for therapists were under-reported in Phase 1 of the study. Survey respondents noted challenges under a question that enquired about "adverse effects" on their therapy work. In follow-up interviews eleven of twelve therapists described how mindfulness practice brought benefits but also challenges. Confounding influences that might contribute to therapist mindfulness could not be controlled given the scale and retrospective nature of the study. For example, a number of participants noted that forms of therapy training most likely contribute to facets of therapist mindfulness, as currently conceptualised.

Future Directions

Research that is sensitive to a range of theoretical perspectives and methodological approaches could test the generalisability of the findings of this study and provide a fuller understanding of the complex relationship between mindfulness practice and psychotherapy work. Future research might explore in greater detail the specific areas of influence identified; for example, the role of enhanced attention in mediating clinical benefits of mindfulness

practice for therapists. Prospective designs incorporating multiple methods of enquiry could chart the trajectory of change associated with therapist mindfulness practice over time. This would allow comparative analysis with matched control groups of non-meditating therapists and facilitate exploration of the personal and professional challenges presented by ongoing practice. It would enable investigation of differences in the development of the attentional and attitudinal aspects of mindfulness, with important clinical implications for how mindfulness is taught. Multidimensional measures of mindfulness will also be required to better assess the impact of therapist mindfulness. Future studies might consider the perspectives of clients and supervisors, as well as the self-report and observation of therapists who practice mindfulness.

Conclusion

The study findings support the contention that mindfulness practice has personal and professional benefits for psychotherapists. Participants saw mindfulness practice as primarily affecting the "person" of the therapist and his or her capacity to relate with others. Mindfulness can enhance abilities and help internalise qualities that contribute to positive therapeutic relating, even qualities considered difficult to teach and sustain, such as empathy. This is likely to result in substantial benefits for therapists and clients, given the centrality of relationship factors in effective psychotherapy across modalities. Mindfulness can also provide an important resource in the occupational health of therapists working in a demanding profession.

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Tables

Table 1. **Predominant Theoretical Orientations of Study Sample (*N* = 40)**

Theoretical Orientation	*n*	%
Integrative	26	65
Humanistic–Existential	20	50
Psychodynamic	13	32.5
Body-Oriented	8	20
Cognitive-Behavioural	7	17.5
Systemic	5	12.5
Constructivist	3	7.5
Others	5	12.5

Table 2. **Pearson Correlations between FFMQ Facets and IRI Subscales (*N* = 40)**

	IRI Perspective Taking	IRI Fantasy	IRI Empathic Concern	IRI Personal Distress	IRI Global Empathy
FFMQ Observe	.60**	.11	.37*	-.34*	.52**
FFMQ Describe	.46**	-.19	.11	-.53**	.17
FFMQ Awareness	.44**	-.12	.28	-.29	.28
FFMQ Nonjudge	.57**	.16	.26	-.33*	.48**
FFMQ Nonreactivity	.57**	.04	.31	-.45**	.44*

*$p < .05$. ** $p < .01$. FFMQ = Five Facets of Mindfulness Questionnaire; IRI = Interpersonal Reactivity Index.

Figures

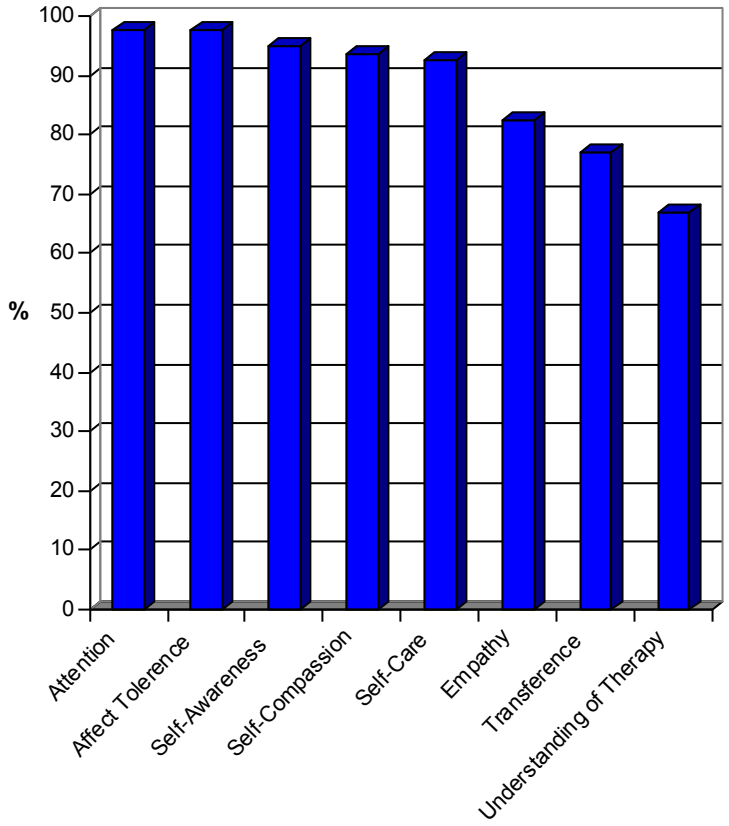

***Figure 1*. PMPPWQ: Item Responses in Percentages (*N* = 40)**

Note. Percentages refer to the proportion of the sample who agreed (*agree* or *strongly agree*) that mindfulness had a positive influence in the area specified on the PMPPWQ (Personal Mindfulness and Psychotherapeutic Work Questionnaire).

Figure 2. **Phase 2: Final Thematic Map Showing Seven Inter-Related Themes**