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I wish I could show you when you are lonely or in darkness the astonishing light of your own being
- Hāfez of Persia

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ABSTRACT

Background – Mindfulness, the process of "paying attention in a particular way: on purpose, in the present moment, and non-judgementally" (Kabat-Zinn, 2012:1), has been taking a more and more important place in the work of therapists in Ireland during the past ten years. Numerous studies have already demonstrated the benefits of mindfulness for the therapist's well-being as well as for the patients and outcome of therapy. A study of the state of use of mindfulness within the therapy setting in Ireland in 2013 is reported here.

Results – All six participants interviewed for the purpose of the study gave a clear yet multifaceted definition of mindfulness. They all reported many benefits of mindfulness on their own personal well-being as well as on their therapeutic skills. They also strongly agreed on the fact that mindfulness improves the therapy outcome. They did not consider the question of the combination of mindfulness and psychotherapy – in regards to the ego – as a relevant one for their work with patients. Finally, most of them did not have any issue concerning the new acceptance-based therapies that integrate cognitive behavioural principles – changed based approach – while placing mindfulness at the centre of their model.

Conclusions – The findings confirmed the previous literature that highlighted the many benefits of mindfulness on therapists, patients and the therapy outcome. However, they discredited the view raised by some authors that psychotherapy and mindfulness cannot be compatible because of the question of the ego. Finally, they contradicted some previous literature that discredits the new acceptance-based therapies which integrate cognitive behavioural principles – changed based approach – while placing mindfulness at the centre of their model.

CHAPTER 1: INTRODUCTION

Whereas it belonged to the Eastern world for millennia, mindfulness – the process of "paying attention in a particular way: on purpose, in the present moment, and non-judgementally" (Kabat-Zinn, 2012:1) – seems to have invaded the Western world especially since the past decade. New programmes and certifications flourish every year, health professionals use mindfulness for themselves and for their patients, mindfulness finds its way in the work place through specific employee assistance programmes, it is also adapted to suit the specific needs of children in schools as well as those of people in prisons.

In the field of therapy, numerous studies have now demonstrated a working alliance between mindfulness and different types of therapies: cognitive behavioural therapy (CBT), psychodynamic, humanistic, person-centered or positive psychology for instance. In particular, this blossoming has given birth to new therapies – some calling them third wave therapies – that are derived from CBT but give a central place to the acceptance developed through mindfulness. Acceptance and Commitment Therapy is one of them for example: it "encourages patients to accept, rather than control, unpleasant sensations" (Germer, Siegel and Fulton, 2005:20). As much as this revolution of the CBT landscape has generated passion and enthusiasm, it has also raised a few eyebrows with some authors criticizing a new integration of what they believe are two incompatible concepts. These critics have their place and justification as one would easily imagine the challenges of combining a change-based therapy with mindfulness – an acceptance-based process. Other authors, attached to the importance of the ego in the therapeutic process, do not get how mindfulness – a process a priori supposed to be aiming at dissolving the ego, can be compatible with psychotherapy – a process seemingly supposed to be aiming at strengthening the ego. Again, at first sight, these

critics seem to have their place as one would have difficulty to understand how the ego could be torn apart in the middle of the therapy process.

This research aimed at understanding how mindfulness was currently used by therapists in Ireland. What was their understanding of mindfulness? What impact did mindfulness have on their personal and professional life? How did this working alliance work for them? The study also aimed at finding out if the question of the compatibility between mindfulness and psychotherapy as well as the question of the compatibility between mindfulness and CBT were relevant issues that translated into real struggle in the day-to-day work of therapists, or if these questions belonged to an intellectual debate that was far away from the therapist's concerns.

CHAPTER 2: LITERATURE REVIEW

2.1 Attempting to define mindfulness

A complex notion to grasp, mindfulness has been defined as "awareness, cultivated by paying attention in a sustained and particular way: on purpose, in the present moment, and non-judgmentally. It is one of many forms of meditation (...)." (Kabat-Zinn, 2012:1). Originally a religious concept only – one of many forms of meditations focusing on experience, mindfulness has since then been used to help enhance well-being of the general public and of both therapists and clients (Holmes, 2000).

It has originally been introduced in the UK through cognitive therapy (Claessens, 2009). The combination between cognitive therapy and mindfulness has given birth to what some call third wave therapies. These therapies, which place mindfulness at the heart of their principles, have become more and more popular because of their preventive approach to mental health and cost effectiveness.

Harrington and Pickles (2009) look at the origins of mindfulness and its numerous definitions, as well as its possible use and integration in therapy. As used in third wave therapies, mindfulness mainly comes from Zen Buddhism and is a cornerstone of Buddhist practice. While Buddhism is a multifaceted religion encompassing many different schools and philosophies, mindfulness can simply be described as an attempt to be in the present moment in order to see reality in a clearer way. One of the goals of mindfulness is to lower craving resulting from strong, fake attachment to oneself and environment. Clients are encouraged to do so becoming nonjudgmental observers of their own thought processes. Harrington and Pickles cite Segal, Teasdale, and Williams who describe mindfulness as being "fully present and attentive to the content of moment-by-moment experience" (2004:53). They also cite Robins, Schmidt, and Linehan who depict mindfulness as

“the intentional process of observing, describing, and participating in reality nonjudgmentally, in the moment, and with effectiveness (i.e. using skilful means)” (2004:37). Finally, they mention Bear who explains that clients learn to get an awareness of their thoughts but remove themselves from the substance of these thoughts (2003).

Despite their attempts to define mindfulness, Harrington and Pickles note that it is very difficult to give a clear definition of mindfulness. To illustrate this, they refer to Hayes and Wilson who have been mentioning numerous uses and meanings of mindfulness when used in therapy: meditation as a tool, psychological process, state of mind, value system and therapy outcome (2003). However, Hayes and Wilson believe that mindfulness might become a more consistent concept as more scientific studies will give ground to it.

2.2 Impact of mindfulness on the therapist's well-being

A good number of studies have been able to demonstrate the positive impact of mindfulness on the therapist’s skills as well as his well-being (Fulton, 2005; Shapiro, Astin, Bishop, and Cordova, 2005). Boudette (2011) feels more present and less reactive with the help of mindfulness. He feels he can hold clients better in the therapeutic space and is less inclined to judge whatever arises in the room. He feels he has better awareness of his own processes which allows him to choose better responses. He feels mindfulness takes a great role in preventing him from burnout. These benefits also extend far beyond the therapy room and give him a real sense of connection and appreciation.

In another study, an eight-week mindful therapy (MT) training programme specifically designed for mental health professional demonstrated an improved well-being for the participants as well as a better capacity to be mindful in clinical work (Aggs and Bambling, 2010).

2.3 Mindfulness and psychotherapy: a working alliance

As Mark Epstein explains, both psychotherapy and mindfulness help us to recover our capacity to feel as both of them encourage us to connect with ourselves (1998).

Robin Boudette - a therapist specialized in eating disorders - explains that mindfulness, by allowing patients to be in the present moment, offers them new choices (2011). They gradually learn to slow down, observe their inner and outer world, become aware of what surrounds and inhabits them, and are then better able to make different, better choices for themselves. By breaking their habits, they implement new behaviours. This process has been compared a lot to CBT.

Aggs and Bambling (2010) name the different authors that have reported a working alliance between mindfulness and psychotherapy: Safran and Reading examined the synergy between mindfulness and the psychodynamic approach (2008). Hayes, Strosahl and Wilson (1999) as well as Roemer and Orsillo (2008) explored the alliance between mindfulness and CBT. Andersen (2005) looked at mindfulness and the person-centred approach. Wallin (2007) studied mindfulness and the attachment based approach. Hamilton, Kitzman, and Guyotte (2006) wrote on mindfulness and positive psychology. However, Aggs and Bambling point out that the most widespread programmes appear to be the eight-week Mindfulness-based stress reduction (MBSR) training programme developed by Jon Kabat-Zinn (1982), the Mindfulness Based-Cognitive Therapy (MBCT) training programme developed by Segal, Williams, and Teasdale (2002), the Dialectical Behaviour Therapy (DBT) training programme developed by Linehan (1993), and the Acceptance and Commitment Therapy (ACT) training programme developed by Hayes, Strosahl, and Wilson (1999).

Roemer and Orsillo (2009) also mention Mindfulness Based Relapsed Prevention (MBRP), Dialectical Behaviour Therapy (DBT) and Acceptance Based Behaviour Therapy (ABBT). They developed the latter as a mean to treat generalized anxiety disorder. MBRP, DBT and ABBT are all part of a group of acceptance-based and cognitive behavioural therapeutic approaches. The authors

highlight the difference between CBT which aims to change thoughts and emotions, and acceptance-based approaches which focus more on awareness and self-knowledge. ABBT takes the acceptance part from the Buddhist tradition and the change part from the CBT approach. As unhappiness and anxiety seem to be the result of how one is relating to their internal experiences, rather than the experiences themselves, ABBT and other mindfulness-based therapies aim at helping patients to give up rejecting unlikeable thoughts and feelings. ABBT is made of three steps: patients are first encouraged to adopt a non-judgmental view of themselves; they then learn to become more flexible in their behaviour; they are finally encouraged to take more actions that have meaning for them as they become less afraid of their own feelings and less scarred of the consequences of their actions.

For binge eating, Kristeller, Baer, and Quillian-Wolever (2006) created the Mindfulness-Based Eating Awareness Training (MB-EAT). Part of this programme includes an exercise – called Eating like a gourmet, which encourages clients to give each bite a rating. Another teaching – the raisin exercise[1] – helps clients to become more aware of their eating habits (Segal, Williams and Teasdale, 2002). According to Moffitt (2007), mindfulness, when applied to binge eating, offers an opportunity to start over. By practicing mindfulness meditation, one learns to go back to the present moment each time the mind is caught wandering. This contrasts with the diet mentality that triggers immediate binge eating and postpones efforts to the next day.

However, CBT is not the only Western therapy linked to mindfulness. Marina Claessens (2009) is eager to demonstrate that existential therapy is the therapy that is closest to mindfulness despite the

[1] "Pick up a raisin and hold it in the palm of your hand. Look at it. Examine it. Describe the raisin. What does it look like? What color is it? How would you describe the texture? Now, feel the raisin in the palm of your hand. What does it feel like against your skin? Pick it up with your other hand. What does it feel like in your fingers? Is it slimy? Rough? Smooth? Soft? Hard? Squeeze it softly. What do you feel? Smell the raisin. Describe how it smells. Put the raisin in your mouth, but do not eat it. What does it feel like on your tongue? What does the texture feel like now? How does it taste? How does the taste compare to the way it smelled? Move it around in your mouth and notice every aspect of the raisin. Bite the raisin and think about what you taste. Now how does the raisin feel in your mouth? Finish chewing and eat the raisin. How did it taste? Describe the experience of the raisin. This exercise is about cultivating awareness and beginning to learn to focus on the here-and-now. It is about being in the present moment and not missing out on it. Sometimes, much of our anxiety or fear is a result of focusing our thoughts on the future - or the past - and forgetting to be present here in this moment. Right here, in this very moment, those things may not need or deserve our attention." Source: The Raisin exercise. (n.d.). Mindfulness Info. Retrieved April 12, 2013, from http://www.mindfulnessinfo.com/exercise-2-the-raisin/

fact that cognitive therapy and psychoanalysis are the most popular for mindfulness. She refers to the Four Noble Truths – pillars of the Buddhist tradition – to show the tight link between Buddhism and existential therapy. The first Noble Truth states that life is suffering and an integral part of human existence. Practicing mindfulness allows us to develop meta-cognitive awareness during times of suffering: we identify thoughts at an early stage as well as the physical sensations and feelings associated to them. By doing so, we become able to detach from these thoughts. This prevents relapse, in case of depression for example. The Second Noble Truth is about craving which is the cause of human suffering. Looking for immediate pleasure or trying to avoid painful experience at any cost is a way to forget our true nature and pain (the ultimate pain being death), a concept also developed by existential theory. Becoming mindful and aware of the transient nature of things allows us to let go off things and be more at peace with the passing time. Accepting this reality, rather than wanting to change it, is key in existential therapy as it is in mindfulness. Claessens cites Schwartz who used successfully in this context with patients suffering from obsessive compulsive disorder (OCD) (Schwartz, 2002). The Third Noble Truth enunciates that it is possible to escape from suffering by stopping the craving and fully accept our impermanence – another truth that can be realized with the constant practice of mindfulness. Existential therapy is also about accepting our condition. Finally, the Fourth Noble truth teaches the Middle Path: suffering can be avoided by avoiding extreme behaviours – self-mortification is as bad as self-indulgence; by acknowledging our emotions and mental states without identifying with them, we become more resilient when facing life's challenges. This approach is also at the heart of existentialism which invites us to welcome the fundamental truths of life.

Satitherapy – a therapy that integrates mindfulness, Buddhist principles and the person-centered approach developed by Carl Rogers – seems to be even closer to mindfulness. When explaining how satitherapy works, Nemcova and Hajek speak about "taming the demons" that lead to a client's suffering (2009:54).

Boudette (2011) also explains how practising mindfulness helps his patients by leading them to tune into their immediate sensations, thoughts and emotions. He describes the different short meditations that can be used at the start of a session in order to help clients connect with their direct experience: mindfulness of sounds, mindfulness of breathing. According to him, it is very important to experiment as clients can initially feel confused and frustrated. He sometimes makes recording – suited to each client need, his voice calming them and serving as a transitional object. Clients gradually develop an observing self: they learn to witness their own experience rather than reacting to it. They gradually build up the emotional resilience needed to observe without taking action and let the urge to pass (binge eating).

The impact of breathing – one of the main objects of attention for those practicing mindfulness, has also been explored through different studies. By practicing the mindfulness of breathing, therapists become able to tune into their own internal world as well as their client's internal world. Virginia Hunter (1993), a psychoanalytic psychotherapist, points out the clues given by the different breathing behaviours in both therapist and patient: hyperventilation, gasping, gulping, breath holding, sighs, exhalations, sneezing, coughing, yawning, sniffing, panting, and choking. Having this awareness is important as breathing patterns usually appear in infancy and can tell a lot about the mother-child relationship.

Positive outcomes have also been demonstrated in patients suffering from cancer: a study conducted in 2009 with Japanese patients showed that their Hospital Anxiety and Depression Scale (HADS) scores had decreased following a Mindfulness-Based cyclic Meditation training (Ando et al., 2009).

2.4 Combining mindfulness and psychotherapy: challenges

Some suggest that mindfulness (a key concept at the heart of Buddhism) and psychotherapy are not compatible as one aims at realizing the absence of ego whereas the other aims at building it

(Holmes and Perez-De-Albeniz, 2000). However, even for those willing to practice mindfulness (or those who choose the Buddhist path), it is commonly assumed that having a strong ego first is a key condition if one wants to be able to dissolve it. This paradox can lead to different interpretations. Some might suggest that mindfulness is more useful for therapists as a way to enhance their well-being and take care of themselves rather than a tool aiming at helping patients solve their issues. This could also suggest that mindfulness is only suitable for a certain type of patients: those who have been able to build a strong self and are now ready to practice mindfulness. Mark Epstein (1998) believes that psychotherapy and mindfulness are compatible. He does not agree with the view that psychotherapy is aimed at building the ego and believes that both mindfulness and psychotherapy help people to become happier by teaching them to give up control and free them up enough to engage with the world.

Furthermore, some studies managed to demonstrate that integrating mindfulness in psychotherapy is improving the therapy result (Grepmair, Mitterlehner, Loew, Bachler, et al., 2007) but not all did (Stanley, Reitzel, Wingate, Cukrowicz, Lima, and Joiner, 2006). This lack of positive results has been attributed to the fact that the first mindfulness training programmes – based on Zen meditation or such training programmes as MBSR – did not include any therapy specific skills. Even more, in the case of therapists in training using manualised treatments, increased mindfulness has shown to be counterproductive (Stanley et al., 2006). To tackle this issue, a mindful therapy (MT) programme was set up. It trains therapists on mindfulness from a therapist practice and self-care angle. A lot of studies have already shown the crucial role of therapist specific and relationship variables in regards to the therapy outcome (Lambert and Simon, 2008). These skills are tightly linked to the mindfulness practice (Germer, 2005). This explains why the MT training is focusing on these aspects.

Moreover, Aggs and Bambling (2010) point the absence of studies looking at mindfulness within the therapeutic space. For that reason, they have developed a clinically specific mindfulness

measure (the Mindful Therapy Scale: MT-S) aimed at measuring therapists' mindfulness relative to therapist-client variables. By doing so, they hoped this would help find out if teaching mindfulness to therapists translates into better therapy outcome, and if so what factors are influencing that therapy outcome.

Boudette himself, while acknowledging the positive impact of mindfulness on his clients, explains how he finds it difficult to bring mindfulness into the sessions. His own confidence is the first challenge: what he does in a group does not necessarily apply to one-to-one sessions. He mentions how crucial it has been for him to establish a personal practice of mindfulness meditation and receive mindfulness training. Another challenge is the word mindfulness itself which can scare clients. They would usually expect to talk about their feelings, not observe them. Mindfulness has to be subtly integrated in the practice (through mindful eating practices for example) and at a pace that is different for every client.

2.5 Combining mindfulness and CBT: challenges

CBT relying on a change-based strategy and mindfulness on an acceptance-based strategy, one can easily foresee the challenges of trying to combine them both.

Acceptance Based Behaviour Therapy (ABBT) for example, one of the third wave therapies mentioned earlier, combines the change aspect of CBT with the acceptance aspect from the Buddhist tradition. However, some criticize these new tool box therapies as they reduce mindfulness to another simple clinical strategy.

Lau and McMain (2005) examined this integration in Mindfulness Based-Cognitive Therapy (MBCT) and Dialectical Behaviour Therapy (DBT). They acknowledge both of them lead to positive outcome but highlight the fact that further studies need to be conducted in order to isolate the impact of mindfulness meditation.

Harrington and Pickles (2009) do not believe that such integration is possible. According to them, CBT principles are not compatible with the concept of mindfulness and mindfulness is meaningless outside of the Buddhist tradition that gave birth to it. Furthermore, they believe CBT is at risk of encompassing too many approaches – similar but different – which could make it loose its substance. However, they do not deny that meditation can be useful in therapy as a technique. They distinguish between the conceptual model behind a therapy and the techniques that the therapy is likely to use. Third wave therapies place mindfulness at the centre of their conceptual model which is what Harrington and Pickles question. Although some claim Buddhism and Western psychologies manage to gain the same insight – awareness of being present in the moment, Harrington and Pickles argue that this cannot be the case as Buddhism and Western psychologies are based on completely different theoretical models and worldviews. Claiming they have the same aim would be similar to equalling astronomy and astrology – both acknowledging the importance of observing the stars – or modern chemistry and medieval alchemy – both concerned with the process of chemical change. As for CBT and Buddhism, both aim to make us experience the present moment. However the goal of CBT would more likely be to desensitize the person from painful feelings whereas Buddhism would aim at transcending these feelings.

Also CBT aims at changing thoughts – which are believed to be the trigger for emotional disturbance. On the contrary, mindfulness therapies see thoughts as just being thoughts and do not aim at changing them (some talk about “radical acceptance”). They do not acknowledge the causal relationship between thoughts and emotional disturbance. Once thoughts are accepted – and not judged, they can be transcended. Emotional disturbance disappears as a result of this full acceptance. Authors argue that this full acceptance approach is relevant for some thoughts (depression, OCD, rumination) but not for all types of thoughts. For example, Rational Emotive Behaviour Therapy (REBT) – one of the main therapies representing CBT with Cognitive Therapy (CT) – does not consider all thoughts to be equal. This judgement determines how thoughts should

be dealt with in therapy – some fully or partially accepted, others changed. In this light CBT is radically different from mindfulness therapies. Harrington and Pickles highlight what they believe to be other paradoxes within third wave therapies: they claim they do not aim at changing thoughts but at the same time they require changing the thoughts one has on these thoughts – from "I am rejecting my thoughts" to "I am accepting my thoughts". These therapies claim this apparent contradiction can be overcome as the process is seen as mainly experiential and patients are expected to just go with it, accept it. Finally, Harrington and Pickles question mindfulness as a lifestyle as it is encouraged by third wave therapies. Would it really be better to live in a mindful society? This question has never really been explored in mindfulness literature so far.

CHAPTER 3: METHODOLOGY

3.1 Introduction

Many studies have already demonstrated the positive impact of mindfulness on the therapy outcome in various countries, therapy settings, and for different types of disorders. Many of them have also demonstrated the positive impact of mindfulness on the therapist's well being. So the aim of the research is not to make another demonstration of those positive effects but rather to provide the reader with a snapshot of the current use of mindfulness by therapists in Ireland in 2013.

Mindfulness being a very rich, difficult concept to grasp and experiential by nature, a qualitative research has been chosen for this study. Van Maanen describes qualitative research as “an umbrella term covering an array of interpretive techniques which seek to describe, decode, translate, and otherwise come to terms with the meaning, not the frequency, of certain more or less naturally occurring phenomena in the social world” (1979:520).

This study is mainly exploratory as the use of mindfulness by therapists is currently spreading at a fast pace in the Western world. The use of mindfulness in Ireland is indeed very different from what it was two years ago and will be very different too in two years time.

So while the interview is including a set of questions asked to each participant, space has been left for the emergence of unexpected themes and questions.

3.2 Research method

A semi-structured interview was designed in order to facilitate a deep exploration of the theme of mindfulness and allow participants to digress according to their own experience and reflections

around the use of mindfulness. As Merriam pointed out, “this format allows the researcher to respond to the situation at hand, to the emerging worldview of the respondent, and to new ideas on the topic” (2009:90).

Most of the questions (see interview guide in appendix 1) – but not all – were open-ended in order to gather as much qualitative data as possible. The type of questions used was quite broad as they included questions that explored the experience, behaviour, opinion, values, feelings and knowledge that each participant had about mindfulness. However, questions about experience, opinion and value were used the most as they were most likely to trigger qualitative answers directly related to the use of mindfulness by participants.

A funnel sequence was used for the interview: “the funnel approach is so named because it starts off the module with a very broad question and then progressively narrows down the scope of the questions until in the end it comes to some very specific points” (Oppenheim, 1992:110). So the interview started from very generic, non controversial questions around mindfulness (definition, personal practice) towards questions that were directly related to the use of mindfulness in therapy. It then finished with more personal questions aimed at getting the therapist's view on more controversial topics.

3.3 Research sample

The sample that was studied can be described as a convenience sample: “a non-random sample that is chosen for practical reasons” (McBurney and White, 2009:257). Indeed, all participants were based and interviewed in Dublin for convenient reasons but it was assumed that they represent the Irish population of mental health practitioners. Also only volunteering participants (six in total) were interviewed.

The sample can also be described as purposive: this type of sample “is common when special skills

are required to form a representative subset of population" (Singh and Mangat, 1996:7).

A convenience and purposive sample is not representative of the general population as it was selected in order to serve the purpose of the study.

Finally, it is a snowball sample as some initial interviewees suggested other people to interview: "in snowball sampling, the researcher collects data on the few members of the target population he or she can locate, then asks those individuals to provide the information needed to locate other members of that population whom they happen to know" (Babbie, 2010:193).

Participants sought for the study had to be practising therapy in Ireland. Six therapists eventually agreed to participate in the research: three males and three females, all practising in Dublin. One had been seeing clients (clinical practice) during the past twelve months and was in his final year of studies. One had qualified in November 2012 and was practising since then. Two had been practising between five and ten years. Two had more than 20 years of experience with patients. So there were no conditions in terms of qualifications: some of them could have 20 years of experience while others would only be finishing their studies. There were no conditions in terms of academic background: some studied psychology while others studied counselling and psychotherapy or psychoanalysis. Some of them performed their studies abroad while others (the majority) studied in Ireland. Some of them had their individual practice while some were working in hospitals and others in psychological centres. The majority would only see individual clients but some would also meet children and couples.

This very broad selection of individuals was a way to ensure that the study would capture the use of mindfulness by the broadest range of therapists currently practising in Ireland. The aim was to show that mindfulness has become popular and been integrated in different types of therapies – integrated in different ways.

3.4 Finding and interviewing participants

In order to find potential therapists, the researcher emailed a team of therapists working at a mental health charity (where she herself sees clients as part of her clinical practice) (see communications in appendix 3). She also searched online for therapists practising mindfulness and sent them individual emails. Finally, she asked a Facebook group called “Mindfulness Ireland” to post a message on its Facebook page. This reached more than 13,000 members of the general public interested in the topic of mindfulness.

Volunteers were then selected on a first-come first-served basis. The researcher met each one of them individually at a time and location that suited them best. Each interview session lasted between 40 minutes and an hour. Participants were handed the consent form (see consent form in appendix 2) and signed it at the start of the interview.

The researcher used a recorder and informed participants that they could stop the recording at any time if they wished so. The researcher also showed them the interview questions at the start of the session.

3.5 Ethical considerations

Ethical principles and guidelines for research, as mentioned in the Belmont report (1979), were respected while conducting this research. As stated in the report, participants were treated as "autonomous agents" (1979:23193). They were informed about the purpose of the study through the first email they received. They then got the opportunity to ask more questions when the researcher spoke to them on the phone to arrange an interview. Participants were also informed from the start that their participation was anonymous but not confidential. They agreed – by signing the consent form – that the information they would give during the interview could be used freely in the context

of the research project. The researcher did her best to ask all questions in a neutral and respectful manner. She emphasized with each participant their freedom to stop the recording or withdraw from the study at any time if they wanted to. Considering the healing purpose of mindfulness, the peaceful talks it triggered, and the nature of participants (all of them therapists), no help or support was offered at the end of the interviews as it would have seemed odd or inappropriate. Finally, participants were informed they could get a copy of the finalized research if they asked for it.

3.6 Data analysis

For this qualitative study, the gathered data was analyzed using the emergence of thematic content: "thematic analysis or qualitative content analysis (...) involves close scrutiny of texts in order to ascertain key ideas or themes" (Bagnall, Smith, Crawford and Ogborn, 2008:93). The six interviews were transcribed verbatim. Listening to each recording several times during the transcribing process allowed the researcher to get to know the content in detail.

The first set of themes, which helped to design the results chapter, were derived from the interview guide and included: participant data, definition of mindfulness, impact of mindfulness on the therapist's personal practice, impact of mindfulness on personal life, impact of mindfulness on professional practice, different types of mindfulness interventions and techniques, unhelpful mindfulness interventions, receptivity of clients to mindfulness, compatibility between mindfulness and psychotherapy in regards to the ego, compatibility between mindfulness and CBT.

The second set of themes, which helped to design the discussion chapter, was derived from the literature and results chapters and included: definition of mindfulness, impact of mindfulness on the therapist's well-being, the working alliance between mindfulness and psychotherapy, combining mindfulness and psychotherapy in regards to the ego, the challenges associated to combining mindfulness with CBT.

CHAPTER 4: RESULTS

4.1 Participants

Six participants were interviewed for the study: three males and three females. One of them was a final year student and had been seeing clients during the past year. The five others were qualified therapists. One started seeing clients during the previous year. Two had between 5 and 10 years of experience and the two others had more than 20 years of experience. Participants reported using the following therapeutic orientations: solution focused, person-centered, humanistic, CBT, psychodynamic, human givens, body-centered, sensorimotor and hakomi[2].

4.2 Definition of mindfulness

When asked how they would define mindfulness, two participants – both males – referred to the definition given by Jon Kabat-Zinn: "Paying attention in a particular way: on purpose, in the present moment, and non-judgementally." (2012:1). Four participants mentioned the ability to notice experience moment to moment, to be aware of the present experience. Four participants emphasized that mindfulness is something intentional. Two participants – both females – mentioned kindness as being an essential part of mindfulness. They used words like "gentle approach", "warmth", "invitation" or "encouragement" to refer to the qualities attached to mindfulness. One participant emphasized the importance of being able "to observe, to stop, to be still" and remembering "who you are, what you're doing, what you're about".

[2] Hakomi: a form of body-centered psychotherapy based on principles that show individuals ways to live in harmony with themselves and others. It teaches individuals to enter a state of awareness in which spontaneous and often nonverbal information becomes available and from which basic and unconscious beliefs stem and direct their lives (Fawcett and Kahn, 2008 :211)

4.3 Mindfulness personal practice

Two participants did not have their own formal mindfulness practice at the time of the interview. One of them deeply regretted it. He felt that something unconscious was stopping him from doing it, although he was well aware of the "huge benefits" of doing it. The other participant did not feel any regret in that regard and emphasized her informal practise: "I guess I have my own ways to meditate and that would be again to pay attention to what I am doing, to notice my own feelings, the way I experience situations, people I talk to, the way I just enjoy doing simple things." The four other participants – the therapists with the longest client experience and specific training in mindfulness – had developed a formal and an informal practice through the years. One meditated up to an hour every day and alternated between body scan, sitting meditation and mindful movement. However, he found it challenging to extend his mindfulness practice to every moment of the day: "Get it off the mat, bring it to life... I think that's the next step." For the three other participants, mindfulness was a way of life. It was deeply cultivated throughout the day. One of them declared:

> *I have met people who switch on being a therapist when they come here and switch off when they leave. To me it's a way of life, an ongoing thing that permeates everything I do. I have a bell at home that I ring when dinner starts for example. It's like a vocation really. I do all the things I am asking them to do otherwise I am wasting my and their time.*

4.4 Impact of mindfulness on personal life

Four therapists mentioned they felt more compassionate, caring, empathic and kind thanks to mindfulness. Three of them explained they were more attuned to themselves, more aware of what was happening for them which gave them choices. Among the many positive effects that

mindfulness brings were mentioned better sleep, better objectivity – not taking things personally, learning to relax and deal with anxiety, and being calmer and more peaceful. One participant explained it had helped him deal with childhood difficulties and had allowed him to integrate his intellectual self, physical self and emotional self. Another participant referred to his catholic upbringing and the way mindfulness helped him develop self acceptance:

> *It's about inner peace, acceptance, loving yourself. Most people don't – I didn't. I was brought up as a Catholic, but self love wasn't part of the programme, it was bad. Remember you're a sinner. 6 years of age. Hard to shake!*

4.5 Impact of mindfulness on professional practice

Two participants mentioned that it was very difficult for them to answer that question as they had always been practising mindfulness with clients and could not imagine how they would behave without it. One participant mentioned that mindfulness made him a much better therapist as he was more open and had a better presence. He felt he was more integrated with clients, less judging and "just listening". For another participant, a very core piece of mindfulness is that it allows drawing a gentle attention to the client and encourages them to not force themselves, to not be harsh on themselves, "to make them realize that what they may be saying to themselves is so different to what they may be saying to their friend". She also believed mindfulness gives hope:

> *It's also made me more aware that no matter how troublesome somebody's life is, there are always resources. Even if someone is feeling very isolated, usually there is an appreciation, or you know, something. And it mightn't be the same resource each time; but there is always a resource. And that's a very core principle for me. And it is in my experience too.*

Other participants reported that mindfulness helped them be less reactive and contain the space better, and gave them a better sense of humour when interacting with clients.

4.6 The different types of mindfulness interventions and techniques

All participants mentioned the mindfulness of breathing as the main mindfulness intervention used during the sessions. Each of them described different ways on focusing on the breath. For instance, they would make clients aware of the sensations in their nostrils or diaphragm, or they would use a technique called 7/11 breathing[3]. The other exercises cited by the participants were the body scan – cited by three participants, the mindful walking – cited by two participants, the raisin exercise – cited by two participants, the imagery or visualization of a beautiful object or a place that is safe – cited by two participants, audio CD to be listened to at home – cited by one participant. A therapist, trained in Hakomi, explained how she is framing a session and stays in the frame – a slice of experience – with mindfulness:

> *If we can't evoke an experience, we throw a little pebble in the pond, and something will emerge. And you know for some people that's enough. If it doesn't emerge that way we throw a bigger pebble. And so when the experience is brought up, whatever is the issue that brings them in therapy, we study that in mindfulness.*

[3] "1.Stand up straight with your feet hip width apart. Imagine that piece of thread attached to the top of your head, gently pulling you upwards - 'straight' and tall. Neck relaxed and free. 2.Feel your spine straightening and opening up your chest cavity - giving you more breathing space. 3.Place your hands on each side of your abdomen, just above the waist. 4.Take in a long deep breath to the count of seven and breathe out to a count of eleven - this is 7/11 breathing. Feel your abdomen swell underneath your hands, both front and back - your upper chest should hardly move at all. Pause briefly and then repeat the exercise several times until you feel more calm".
Source: Janes, H. (2011). Relaxation and breathing exercises - To release anxiety and ease depression. *Psychotherapy that works.* Retrieved April 12, 2013, from http://www.psychotherapythatworks.org/%22psychotherapy_that_works%22/Therapy_Blog/Entries/2011/6/26_Relaxation_and_Breathing_Exercises_-_To_Release_Anxiety_and_Ease_Depression.html

Only one participant mentioned having a very structured way of using mindfulness during a session with almost every client: he would ring a bell at the start of each session and do some breathing exercises at the end. The other participants would not have any set pattern and would make mindfulness interventions based on the need of the person. As one participant put it:

> *I am very conscious of not wanting to be a mindfulness fascist: "There's this wonderful thing, I find it good, you have to do it!" I am mindful of not doing that.*

4.7 Unhelpful mindfulness interventions

When asked to think about any unhelpful intervention, one participant answered:

> *When I'm in a state of business or in this period of time where I'm a big fan of mindfulness and I want the other to be a big fan of mindfulness and just do it; or you're talking about being present but clearly not being present while you're talking about being present.*

Another participant remembered a client who had been very resistant:

> *She did not want to go there. And in fairness she didn't ask to go there.*

Two participants could not recall any type of intervention that was not helpful. One believed it is because he strongly believes in it and it transfers to clients. The other explained she has a very gentle way of tracking and backtracking the client's need and feedback which allows her to constantly adapt her approach in a very gentle way. All participants highlighted the importance of the client relationship in making successful interventions.

4.8 Are some patients more receptive to mindfulness than others?

Three participants – two females and one male – answered positively to this question. They evoked the following reasons that could explain why some clients are more receptive to mindfulness than others: one participant recalled an experience with a Christian who had a negative reaction to mindfulness because it sounded esoteric to them. For another participant, a rigidity of beliefs and dogma is also an important factor, regardless of the type of belief – for instance, such clients could be Christians, Buddhists or Atheists. For a third participant, clients who do not trust their unconscious, are afraid to let go and have a strong need for control would be less receptive to mindfulness:

> *Part of it I think is that the person doesn't even trust their own unconscious. That in that case he was afraid to let go, that there would be demons, that it would be too much for him. And so he wasn't ready to let go to that extend. The big question is "Do I trust my own unconscious?"*

The three other participants – two males and one female – did believe that there is potential for everyone but that the key is in how the therapist delivers the message:

> *As a child I remember my father showing me priests – there was a place in Drumcondra. And every day they would do what was called the office. And that required them to read the Bible while walking around a square. And to me that was the Catholic Church practising mindfulness or a form of meditation. So when people tell me they're Catholic and I'm trying to teach them Buddhism or something else, I bring mindfulness into their beliefs. And that normally works.*

4.9 Compatibility between mindfulness and psychotherapy: the question of the ego

Five participants believed that mindfulness and psychotherapy are compatible. They would not see the question as being "black and white" or "either or". Rather, their view was that the two concepts can work well together:

> *I don't think it's either or. I do feel that there are some people where the ego absolutely needs help to be strengthened. And I think to put it in opposing camps for me anyway doesn't help. I feel that there is a way that when someone can begin to have a strong enough ego to sense that there is a bigger picture, they can then almost - seamlessly sometimes, move into being able to see a bigger picture or something opens out... to see that the waves, you know, are actually water. That ok they're waves and can be stormy but the true nature is water. I feel it's a very intellectual argument. And I don't know that it is in practice. I think it can set up a kind of a battleground within that I don't know is helpful.*

The sixth participant answered she did not feel equipped to give an answer: "I suppose I'm so immersed in this way that this question seems far end and I think "I can't talk that language"..."

4.10 Compatibility between mindfulness and CBT

Four participants – the four therapists with the longest client experience – acknowledged that they had no problem with the association between mindfulness and CBT. All emphasized that CBT, in their view, has evolved a lot and is now more about observing the thoughts, becoming aware of them, rather than changing them: "The old idea was to change the thoughts but the new way is just noticing... and to me it's wonderful. And I have no difficulty." One participant – the student

therapist – mentioned that he was struggling with this idea and often wondered what he should do first. However he got a sense that it would often be more beneficial to work with CBT first in order to change negative thoughts, and then use acceptance therapies.

CHAPTER 5: DISCUSSION

5.1 Definition of mindfulness

Five of the six participants gave a definition of mindfulness very close to the most commonly used one from Jon Kabat-Zinn: “Paying attention in a particular way: on purpose, in the present moment, and non-judgementally.” (2012:1). They were using expressions as “ability to notice experience moment to moment”, “be aware of the present experience” or “intentional thing”. Although Jon Kabat-Zinn's strict definition does not contain such words as kindness, gentle approach, warmth, invitation or encouragement – words used by two female participants to define mindfulness, Jon Kabat-Zinn himself places the theme of love and kindness at the very heart of mindfulness: “Ultimately, I see mindfulness as a love affair – with life, with reality and imagination, with the beauty of your own being, with your heart and body and mind, and with the world” (2012:2).

Despite the fact that most of the participants interviewed for the purpose of this study had a clear idea of what mindfulness represents for them and referred to the most commonly used words and definition given by the literature, they also used mindfulness to refer to other concepts such as a meditation tool – breathing techniques mainly, a state of mind or a value system:

> *I think is as been wonderful for me. How to say it more precisely I am not sure. You know it's so much part of what I do now. I don't know where I'd be without mindfulness. I think it has changed the trajectory of my life. It brings me in touch with the passing nature of things. One of the pieces I read about mindfulness recently was that at the end of our lives we're going to judge ourselves as to whether we savoured the good moments: were we able to savour what was good in our lives? So it has allowed me to savour the good as well as to really feel when it's difficult.*

This seemed to corroborate Harrington and Pickles's views on the fact that mindfulness is a difficult concept to define (2009).

5.2 Impact of mindfulness on the therapist's well-being

All participants reported a positive impact of mindfulness on their personal and professional life. At a personal level, they explained they were more compassionate, caring, empathic, kind, better attuned to themselves, more aware of what is happening for them – which gave them better control and choice. They also mentioned better sleep, better objectivity – not taking things personally, an ability to learn to relax and deal with anxiety, and be calmer and more peaceful. Two participants also mentioned their childhood and how mindfulness had helped them deal with early issues. At a professional level, participants reported being more open, more integrated with clients, less judging, less reactive, able to just listen as well as having a better presence and containing the space better in the therapy room. Among other qualities mentioned were gentleness and an ability to encourage clients rather than direct them:

> *When someone comes to therapy they are in pain, they want something to change, they often will say "I should be doing this" or "I should be doing that", and in some ways there is a kind of subtle forcing. Sometimes not such a subtle forcing. So not to do a violence to themselves I suppose, really. This shouldn't be a strain. It doesn't mean there won't be pain but there shouldn't be a strain that strains people outside of their resources.*

These findings corroborated what a number of studies had already demonstrated: that the therapist's skills and well-being are improved with mindfulness (Fulton, 2005; Shapiro, Astin, Bishop and

Cordova, 2005; Boudette, 2011).

5.3 Mindfulness and psychotherapy: a working alliance

Each one of the six participants interviewed for the purpose of this study was coming from a different background and had undergone different studies. Different therapeutic orientations resulted from such background diversity: solution focused, person-centered, humanistic, CBT, psychodynamic, human givens, body-centered, sensorimotor and hakomi. When asked if they thought that mindfulness was improving the therapy outcome, each participant strongly agreed:

> *I think if the person is able to stay more with what's going on, it would speed it (the therapy outcome) up. They're gonna be more resilient, they're gonna be more buoyant. If they're looking at things in psychotherapy for example or any other therapeutic mode, they need to be able to stay with what's coming up; so I suppose mindfulness might help them to do that.*

Another participant added:

> *Yes I think it can. Because if my client is able to sit down and quietly analyze the situation more objectively, that is the outcome we're looking for. They discover there are new ways they can deal with their problems; there are supports available. Or they can just ask; you know whatever, that there are different solutions, that the future can be different from what they think it could be. Their logical mind, their ability to analyze things and make connections is improved when they are calmer and mindfulness techniques help to do just that.*

Another participant also added:

> *I feel that when there are two people with an intention to be present, I think that can. I think often when people come because they have wounds from other people, and when there can be an attentive and an intention awareness by both people on the person who comes to therapy it's something of a corrective experience. It grows into a way that's "Not everything has to be the way it was". It's very powerful.*

These views confirmed what the literature has already shown: that psychotherapy and mindfulness do form a working alliance that allows an improvement of the therapy outcome. This has been shown by Safran and Reading who reported such a synergy between mindfulness and the psychodynamic approach (2008), while Hayes, Stroshal and Wilson (1999) as well as Roemer and Orsillo (2008) studied the synergy between mindfulness and CBT. Andersen himself looked at the working alliance between mindfulness and the person-centered approach (2005). The attachment-based approach (Wallin, 2007) and positive psychology (Hamilton, Kitzman and Guyotte ; 2006) have also been studied in the light of their association with mindfulness.

5.4 Combination between mindfulness and psychotherapy: the question of the ego

The literature is divided on the question of the compatibility between mindfulness and psychotherapy – the former's aim being perceived as dissolving the ego while the latter's aim being perceived as reinforcing it. Some, like Mark Epstein (1998), believe that psychotherapy and mindfulness are compatible. Epstein does not agree with the view that psychotherapy is aimed at building the ego and believes that both mindfulness and psychotherapy help people to become

happier by teaching them to give up control and free them up enough to engage with the world. Others, like Holmes and Perez-De-Albeniz, defend the view that mindfulness and psychotherapy are not compatible as one aims at realizing the absence of ego whereas the other aims at building it (2000). So it seemed like an interesting question to raise with the six therapists that participated in the study. However, no conflict of views or disagreement emerged from their responses. Furthermore, none of them saw the question of the ego as an essential, vital one. They seemed more surprised by a question that they did not feel was relevant to their work, to the reality of their practice:

> *I think people who say that just don't understand what they're talking about – fully – because they're not doing it. I think if they were doing mindfulness, if you like, they wouldn't think that.*

Another participant added:

> *I feel it's a very intellectual argument. And I don't know that it is in practice. I think it can set up a kind of a battleground within that I don't know is helpful.*

So it did sound from the findings of the study that the question of the compatibility of mindfulness and psychotherapy – in regards to the ego – is raised in literature by authors who have not experienced the benefits of mindfulness and do not understand that mindfulness is by nature experiential, and that it is vain to try to analyze its effects without living it.

5.5 Combining mindfulness and CBT: challenges

As for the question of the ego, the literature is also divided on the question of the combination between CBT and mindfulness. Harrington and Pickles hold the most extreme view as they believe that the two concepts cannot work together (2009). They do not think that mindfulness can be integrated to CBT as it would lose all its meaning and purpose outside of the Buddhist tradition that gave birth to it. However, this view was not shared by the therapists who participated in the study. On the contrary, four participants – the therapists with the longest client experience – acknowledged that they have no problem with the association between mindfulness and CBT:

> *I am not a purist and I think there are many routes to Rome. And whatever route you're on, even the smallest bit of mindfulness to me. I was absolutely amazed one day: I was listening to the radio and someone said "We're gonna have one minute of mindfulness"; some talk show; people rang to say how wonderful it was. One minute is enough. And that ability to reflect and have an observer self, even in the smallest ways. At the same that was probably the reason why CBT worked at the beginning: it started raising the observer self and a better awareness. So I'm all for it. I say bring it on!*

The two other participants did not answer to the question in such a straight forward way but acknowledged that the combination between mindfulness and CBT is possible, without being sure how this would work:

> *I like acceptance commitment therapy, I like meta-cognitive therapies, I like changing how one stands in relation to thinking but I also like changing the actual content of thinking. And I have an idea whereby one would work with CBT to change core maladaptive beliefs and*

then you could move to a meta-cognitive therapy whereby from then on you can relate to your thoughts differently. I have a pretty strong suspicion that if one moves straight to the acceptance stuff, that those core vulnerabilities might still be there – those core beliefs that they have about themselves - "I am not loveable" or "I am a failure". That they might be times when this acceptance is going to fail because they're still vulnerable. That maybe if you can work on these core beliefs first, then the acceptance stuff later might be more helpful. I don't know if that's the case, this is just my hunch and I often find myself thinking should I be using meta-cognitive stuff or cognitive stuff. Should I be trying to change their thinking or should I introduce the acceptance. And as much as I have read, as much as I have thought, I haven't got a good answer to that question.

Harrington and Pickles also denounce the fact that mindfulness is at risk of becoming a dry tool, a simple technique, and that it will lose all the richness that was brought from the Buddhist tradition. On this point, participants were more divided, one highlighting what he thought is a real risk, in case therapists do not get the right training:

I was fortunate that I had some good teachers who have guarded me against this. I think it is a really important point because it will to me tarnish the experience. People will think: "Oh I have tried mindfulness, mindfulness doesn't work".

Other participants appeared to be less concerned:

I have no problem with it being a tool. Depends on what you compare it to. You can have it as a tool and compare it to what it is in Buddhism, or you can compare it as a tool as opposed to not having it at all. I think in the West most people who wouldn't be exposed to

mindfulness or MBSR or MBCT or a therapist like yourself or myself introducing it, they're not going to get introduced to mindfulness at all. So if the option between not having any introduction to mindfulness and it being a tool, then I would rather have it being a tool.

So it appeared here again – as for the question of the ego – that therapists did not see insurmountable obstacles when contemplating the combination between CBT and mindfulness. The lack of proper mindfulness knowledge and training seemed to be the main concern raised by some of the participants.

5.6 Limitations

The main difficulty of the subject lied in the subject itself: mindfulness appears to be a very rich concept encompassing many different definitions, views and practices. As such, each participant, as well as the researcher, was interpreting the questions in the light of their own experience, view point and knowledge of the subject at the time of the interviews. This could lead to incomplete or off track responses that would make it difficult to interpret the results or shed some light on the questions.

On the specific issue of the limitation of the knowledge, neither the participants, nor the researcher, were practising strictly according to one of the so called third wave therapies mentioned in the literature review. The researcher believed that it made it more difficult for her to fully grasp the question of the challenge associated with the integration of mindfulness and CBT in those third wave therapies. She also noticed this struggle when analyzing the participant's responses: for instance, some would answer to the question of the integration by considering it time wise (combination of the two concepts one after the other), rather than space wise (one with the other) – which was the real issue highlighted by Harrington and Pickles.

Considering the newness of the subject – mindfulness was a barely known concept in Irish society ten years ago and is now booming, encountering huge success as far as the work environment, the researcher was even wondering if some of those new third wave therapies had even arrived in Ireland at the time of the research. For the purpose of the study, it would have been worthwhile to try to find a therapist representing each one of these new therapies but it was not possible because of the time constraints. That being said, each one of the six participants was integrating mindfulness in their work in a different way which gave a good overview of the use of mindfulness by different types of therapists in Ireland in 2013.

Finally, interesting themes emerged from the study, such as the question of the access route of mindfulness – the body or the mind? – or the question of the combination of psychotherapy and mindfulness – which one is essential and why? – or the question of the evolution of mindfulness in Western society. However, these questions could not be explored because of time constraints.

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APPENDIX 1: INTERVIEW QUESTIONS

1. What is your therapeutic orientation?

2. How long have you been practicing?

3. When did you discover mindfulness?

4. How would you define mindfulness?

5. Can you describe your current personal practice of mindfulness?

6. Can you describe the impact of mindfulness on you as a person – day to day life?

7. Can you describe the impact of mindfulness on you as a therapist?

8. In which ways does mindfulness manifests in the therapy room?

9. Which mindfulness techniques/exercises do you use?

10. When would you choose to use mindfulness techniques with your clients?

    Start/end/random time during session? Start/middle/end of therapy?

11. Do you think mindfulness can improve the therapy outcome?

    Follow up question: If yes, explain how?

12. Could you think of any mindfulness interventions/techniques you used that were particularly helpful? Follow up question: If yes, explain how?

13. Could you think of any mindfulness interventions/techniques you used that were not helpful? Follow up questions: If yes, could you figure out why they were not helpful?

14. Do you think mindfulness works better with some clients than others?
    Follow up questions: If yes, which ones? Would you be able to explain why?

15. Some argue than mindfulness and psychotherapy are incompatible as psychotherapy aims at building a strong ego whereas mindfulness aime at deconstructing it. What is your view on that?

16. Do you think mindfulness can be incompatible with some therapeutic approaches – CBT in particular? Follow up questions: If yes, which ones? Would you be able to explain why?

17. Do you intend to take on more training on mindfulness in the future?

18. Is there anything else you would like to add in relation to your experience with mindfulness?

APPENDIX 2: CONSENT FORM

I _____ agree to participate in the research project currently undertaken by Sophie Raphenne on the topic of Mindfulness and Psychotherapy as part of her BA in Counselling and Psychotherapy at Dublin Business School (Academic Year 2012/2013).

I understand that all information obtained in connection with the research project will remain completely anonymous. I also understand that I am free to stop and withdraw from the study at any time without prejudice.

Finally, I give my consent freely for information to be used in the context of the research project.

Participant's signature:

Date:

Researcher's signature:

Date:

APPENDIX 3: COMMUNICATION AIMING AT SOURCING PARTICIPANTS FOR THE RESEARCH

1. Email sent to therapists

Subject: Mindfulness & Psychotherapy

Dear team,

are you interested in mindfulness? Do you integrate it in your practice?

I am working on my thesis at the moment (BA Counselling & Psychotherapy, DBS) and am looking for therapists willing to be interviewed on the subject.

The interview will be an hour long and will happen at a place & time that suit you best.

You can contact me directly by email or phone: [phone number inserted here].

I really look forward to hearing from you and your experience with mindfulness!

Kind regards,

Sophie Raphenne

2. Communication published on the Facebook wall of the "Mindfulness Ireland" group

"Are you a therapist practising mindfulness in your life and with your clients? Would you be willing to share your experience with a student therapist writing her thesis on mindfulness?

If so do not hesitate to contact Sophie Raphenne on Facebook [email address inserted here]. She is already saying a thousand thank yous for your precious help."