MINDFULNESS, EMPATHY, AND EMBODIED EXPERIENCE

A QUALITATIVE STUDY OF
PRACTITIONER EXPERIENCE
IN THE CLIENT/THERAPIST DYAD

by

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for the degree of Doctor of Education
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Abstract

This study explores the experience of eight psychotherapists, each with a substantial personal practice of mindfulness meditation. The purpose of the study was to investigate the nature, effects, and specific contributions of mindfulness to the participants’ experience of empathy. Semi-structured interviews were used as the method of data collection and a qualitative, phenomenological analysis provides the framework within which the lived experience of study participants is richly described, categorized, organized thematically, and reviewed in the context of current literature.

The study identifies four experiential categories, each containing secondary themes that offer refinement and differentiation of the data. In the subsequent discussion, the elucidation of participant experience is furthered by the identification of: receptivity as an underlying and unifying intention; and three core themes, each describing an aspect of receptivity found within the data set. The discussion includes an exploration of these core themes, and their relationship to relevant literature.
Drawing on the field of affective neuroscience, and a neurobiological account of intersubjectivity, a tentative conceptualization is presented in which study findings are combined with mirror neuron theory and the Buddhist teaching on *shenpa*. Embodied simulation, and a shared intersubjective field are theorized to create the opportunity for a therapeutic intervention that combines shared affect with the attitudinal stance of ‘shenpa work.’ Characterized by the essential features of mindfulness and capacities developed through a therapist’s personal practice of meditation, shenpa work in the bi-personal field is proposed as a viable model of intersubjective, affective, therapeutic exchange.

Though this conceptualization bears some similarity to other formulations of psychotherapeutic process, including some found within traditional psychoanalytic theory, it is differentiated from these by its faithfulness to the essential elements of mindfulness including unconditional receptivity, the absence of an interpretive framework, and an intentional stance that maintains an independent consciousness and a compassionate resolve to ‘turn toward’ discomfort. Concluding with a consideration of research strengths, limitations, clinical implications, and possibilities for future research, the study lends support to the growing body of theoretical and empirically based arguments in favour of the inclusion of mindfulness training as a component in the formal education of candidates preparing for clinical practice.
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Chapter 1: Introduction

The word ‘mindfulness’ has been part of the English lexicon for more than three centuries (Dryden & Still, 2006), and has been associated with research in various fields including political theory, health, business, and education (Langer & Moldoveanu, 2000). Briefly described as awareness of present experience with acceptance (Germer, 2005), mindfulness has, in the last three decades particularly, taken up a central position in the discourse related to counselling psychology and psychotherapeutic theory (Brown, Marquis, & Guiffrida, 2013; Davis & Hayes, 2011). In 1979 the psychologist Jon Kabat-Zinn established the Centre for Mindfulness at the University of Massachusetts Medical School and developed the Mindfulness Based Stress Reduction (MBSR) program as a novel approach to the treatment of chronic pain. The success of this model is evidenced in the flourishing of MBSR with hundreds of such programs now operating in hospitals and other treatment facilities around the world (Davidson & Kabat-Zinn, 2004). Though not initially conceived as an intervention model for the treatment of psychopathology, MBSR and the research associated with it has had a profound impact on the development of an array of therapeutic models that place mindfulness at, or near, the centre of the approach to therapy (Mace, 2007). Though not completely escaping a critique of its relevance (e.g., Toneatto & Nguyen, 2007), over the past 30 years mindfulness has clearly become the focus of a rapidly developing body of theory and research that has altered the clinical landscape, taking mindfulness from its historic position in Buddhist philosophy and placing it in contemporary culture as a vital construct in mainstream psychology (Brown et al., 2013; Cigolla & Brown, 2011; Davis & Hayes, 2011).
Despite the growth in recent years of mindfulness based theory and intervention models, including Dialectical Behaviour Therapy (DBT; Dimeff & Linehan, 2001; Walsh & Eaton, 2014), Acceptance and Commitment Therapy (ACT; Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Twohig, 2012), and Mindfulness-Based Cognitive Therapy (MBCT; Kuyken et al., 2008; Sipe & Eisendrath, 2012), and the growing body of research confirming the effectiveness of mindfulness-based approaches (Brown et al., 2013; Malpass et al., 2012), few studies have focused on the underlying mechanisms that govern the effectiveness of these models. Mace (2007) suggests that:

Realization of the potential range and modes of action of mindfulness in therapeutic settings may therefore mean that currently favoured methods of investigation need to be complemented by others. These would pay far more detailed and inclusive attention to what happens within and between therapists and patients in terms of awareness during therapeutic sessions. (p. 153)

Though there has been some general theory proposed regarding the mechanisms of change in mindfulness based approaches (e.g., Shapiro, Carlson, Astin, & Freedman, 2006), literature on the integration of mindfulness and psychotherapy has tended to focus on construct definition (e.g., Bishop, Lau, Shapiro, Carlson, & Anderson, 2004), intervention model characteristics (e.g., Linehan, 1993; Segal, Williams, & Teasdale, 2002) and outcome evaluations (e.g., Baer, 2003; Malpass et al., 2012). In addition, this literature is largely client focused, with intervention models that feature mindfulness-based training as part of a psycho-educational treatment protocol. Much less research has been undertaken to explore in depth how therapist mindfulness, cultivated within the therapist’s own personal practice, may have impact on what takes place in the context of a therapeutic exchange (Brown et al., 2013; Davis & Hayes, 2011).
Mindfulness is essentially concerned with the cultivation of attention to present moment experience with non-judgmental and accepting awareness (Germer, 2005; Kabat-Zinn, 1990). In the context of psychotherapy, therapist mindfulness also implies an intention and a skill set that closely align with a traditional understanding of therapeutic empathy. There is in fact a growing body of research literature that suggests a direct relationship between the cultivation of therapist mindfulness and a capacity for empathy (e.g., Aiken, 2006; Davis & Hayes, 2011; Kristeller & Johnson, 2005; Morgan & Morgan, 2005; Walsh & Shapiro, 2006). Following a review of the literature, Bruce, Manber, Shapiro and Constantino (2010), conclude that,

Preliminary evidence suggests that mindfulness practice may enhance a psychotherapist’s ability to create an empathic, attuned relationship with patients. Given the central role of empathy in the therapeutic relationship, these findings hold significant promise for psychotherapists and their patients. (p. 92)

Therapist empathy is widely considered to be an essential component of effective psychotherapy, and the body of research literature that supports this view is also substantial (Elliott, Bohart, Watson, & Greenberg, 2011). Carl Rogers (1957, 1961, 1980) refers time and again to the value of therapist empathy in creating a facilitative, therapeutic environment. He argues in fact that an accurate, empathic understanding of the client is a “necessary condition” of positive change. One of three such conditions, Roger’s notion of empathic understanding includes “sensing the feelings and personal meanings” (1961, p. 62), experienced by the client in each moment, perceiving these from the “inside,” coming to know these feelings and meanings as nearly as possible as they are known by the client. Freud (1912/1958) recommended the practice of an “evenly suspended attention” (p. 111). Indeed he insisted that the analyst “must turn his
own unconscious like a receptive organ toward the transmitting unconscious of the patient” (p. 115). Whether expressed in the language of humanistic psychotherapy, or within the context of psychoanalysis, the essential wisdom of attending to the client with an open, receptive consciousness as a way of strengthening a therapeutic alliance, and of gaining access to a client’s inner world, seems to have been, from the very beginning, central to our understanding of psychotherapeutic process. Within the discourse on psychotherapy and across therapeutic ideologies there is broad consensus regarding the critical role of empathy in facilitating a therapeutic relationship and the change processes that are possible within it (Elliott et al., 2011; Greenberg, Watson, Elliott, & Bohart, 2001; Lambert & Barley, 2001; Vanaerschot, 2007).

1.1 Study Rationale

Though in the past two decades there has been a revival of interest in empathy and its role in therapeutic process (Duan & Hill, 1996; Elliott et al., 2011; Greenberg et al., 2001; Lambert & Barley, 2001), and mindfulness-based applications have enjoyed an abundance of research attention, subjective accounts of experience regarding empathy, particularly as this relates to the experience of therapists who have a personal practice of mindfulness and meditation, appear to be under researched. The intention of this study is therefore to explore the lived experience of therapist empathy, and to expand our understanding of therapist mindfulness and therapist empathy as interconnected elements that affect the dynamics of the client/therapist dyad. This research intention is captured in three, interrelated questions that reflect the researcher’s own interest regarding: how empathy is subjectively experienced and understood, how it acts to serve therapeutic
goals, and how the capacity to engage empathically with clients may be affected by a practice of mindfulness and meditation. These research questions are intentionally broad and open ended, to preserve the qualitative potential for new insight to arise directly from the data, and to limit the impact of researcher presupposition.

1.2 Study Design

Using a qualitative, phenomenological research design that draws on the work of Wertz (2005), Groenewald (2004), and Hycner (1999), the study investigates the experience of eight participants, each with a well established personal practice of mindfulness meditation, and each currently engaged in the clinical practice of individual psychotherapy. Semi-structured interviews are used as the method of data collection and the participants are encouraged to provide rich, detailed descriptions of their experience. As part of the data analysis, discoveries made in the last decade in the field of neuroscience, particularly the neuroscience associated with embodied simulation (Gallese, 2003; Ginot, 2009; Iacoboni, 2008), are explored from the point of view of the psychotherapist who has a personal practice of mindfulness meditation. The discussion chapter includes a tentative formulation that seeks to integrate the study findings with the neuroscience of embodied simulation in an effort to identify mechanisms that promote the resolution of psychoemotional distress. The conclusion of the study reviews the strengths, limitations, practice implications, and possibilities for future research, and lends support to the growing body of theoretical and empirically based arguments in favour of the inclusion of mindfulness training as a component in the formal education of candidates preparing for clinical practice.
Chapter 2: Literature Review

The following review of relevant literature provides an historical and theoretical context within which to situate the present study. Aspects of the origins of mindfulness, its meaning as constructed in both traditional and contemporary scholarly writing, the construct of empathy, and a brief review of current neurological theory are presented. This review is intended to provide an initial exposure to relevant material and an orienting context for the development of the subsequent research inquiry.

2.1 Mindfulness: Roots, History and Emergence in Psychotherapy

A research project that involves mindfulness is situated in part within a rich and ancient historical context. Olendzki (2005) suggests that mindfulness, understood in its most essential terms as intentional awareness of the details of one’s current experience, is an aspect of human consciousness as old as human history itself. The formulation, however, of mindfulness as a structured, deliberate practice of disciplined attention seems to have its roots in ancient India. More than 4,000 years ago, within the culture of population centres strung along the Indus and Ganges rivers, a tradition of exploring “the nuances of perceptual experience” began to emerge. This was a practice that incorporated methods “that a modern scientist might recognize as empirical, experimental and repeatable, despite being entirely introspective” (Olendzki, 2005, p. 241).

The word ‘mindfulness’ has been part of the English language for about 300 years, and has been associated with psychology, psychotherapy, and even ethics. However, it is only in the last two decades that this term has come into common use within the discourse of these fields (Dryden & Still, 2006). A translation of the Pali word
“sati,” mindfulness is related to awareness, attention, and memory (Gethin, 2011). Buddhism was the philosophic system that, over 2500 years ago, claimed the practice of sati as its core teaching, and today, mindfulness can be understood as the central feature of Buddhist psychology (Germer, 2005).

According to Olendzki (2005), mindfulness is characterized by an emphasis on direct experience. In contrast to those Western philosophic and religious practices that rely on ritual, tradition, or the revelation of “ancient truths,” as the primary methods for understanding and ordering human behaviour, mindfulness draws attention to firsthand experience and the possibility of personal transformation through a process of experiential discovery. Olendzki (2005) writes:

Unlike the dominant Western religions, which are grounded in a historical story line and come equipped with specific belief systems, Buddhism and its contemporaries were much more agnostic on matters of metaphysical revelation and focused instead upon the practitioner’s direct experience. (p. 242)

An interest in Buddhism has been developing in the West for over a century, though the most significant expansion seems to have taken place since World War II. Dryden and Still (2006), suggest that Zen Buddhism caught the attention of a number of writers and theorists, partly due to the experience of American Psychiatrists stationed in Japan during the Second World War. Of particular interest at this time was the psychotherapy of Shoma Morita who had developed an approach to therapy based on Zen teachings (see Kato, 1959). In the sixties, a number of Western therapists began to engage with Eastern philosophy as a means of improving their own life experience, and before long were connecting aspects of their personal practice of meditation with their clinical work (Germer, 2005). The discourse on clinical psychology began, increasingly,
to reflect these emerging interests (e.g., Murphy & Murphy, 1968; Suzuki, Fromm, & Martino, 1963; Watts, 1961), with writing that included meditation as a component of psychotherapy, or in some cases as a form of psychotherapy in itself (e.g., Smith, 1975). Eventually interest in the potential of these new ideas became pervasive enough that in 1977, the American Psychiatric Association called for an examination of the clinical effectiveness of meditation (Germer, 2005).

Among the young psychologists investigating Buddhism, mindfulness, and meditation in the early sixties and seventies, was Jon Kabat-Zinn. In 1979 he established the Centre for Mindfulness at the University of Massachusetts Medical School and it was here that the now famous Mindfulness Based Stress Reduction program (MBSR; Kabat-Zinn, 1990) was developed. MBSR was created as an alternate form of treatment to serve hospital patients suffering with chronic pain, disability, or difficulties associated with a terminal diagnosis. According to Mace (2007), despite Kabat-Zinn’s insistence that MBSR was not intended to be understood as a form of psychotherapy, the impact of this treatment model, and “its influence on overtly therapeutic interventions, has been profound” (p. 150). Contemporary treatment models incorporating mindfulness, developed and described in the literature since Kabat-Zinn’s pioneering work, include: Dialectical-Behavioural Therapy (DBT; Linehan, 1993; Long & Witterholt, 2013); Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999; Hayes et al., 2006); and Mindfulness-Based Cognitive Therapy (MBCT; Segal, Williams, & Teasdale, 2002; Eisendrath et al., 2014). In addition to these models, rationales for mindfulness-based approaches have been proposed for the treatment of generalized
anxiety disorder (e.g., Boettcher et al., 2014; Evans et al., 2008), posttraumatic stress disorder (e.g., Frye & Spates, 2012; Khusid, 2013), disordered eating (e.g., Kristeller & Hallett, 1999; Caldwell, Baime, & Wolever, 2012); substance abuse (Britton et al., 2010; Price, Wells, Donovan, & Rue, 2012), and problematic gambling (e.g., de Lisle, Dowling, & Allen, 2014; Toneatto, Vettese, & Nguyen, 2007). Along with the development of these new treatment approaches, research investigating mindfulness-based interventions (MBIs) has produced considerable evidence of their effectiveness, and support for their use across both clinical and nonclinical populations (Malpass et al., 2012; Shapiro, 2009; Bohlmeijer, Prenger, Taal, & Cuijpers, 2010).

While the influence of MBSR in the development of novel approaches to treatment has been profound, the development of theory integrating mindfulness and psychotherapy has proceeded from within various psychological ideologies as well. In the psychoanalytic world of the early 1900’s, the influence of Eastern philosophy was already being felt. Epstein (1995) suggests that many of Freud’s early colleagues, including Otto Rank, Franz Alexander, and Carl Jung, were familiar with Eastern mysticism, and attempted to understand it from a psychoanalytic perspective. Freud himself struggled to reconcile these two bodies of thought, but in a letter to a friend in 1930, admitted that despite his efforts to “penetrate the Indian jungle,” such an integration was “beyond the limits of [his] nature” (Freud, 1960, pp. 392-393). In recent years, however, there appears to have been a rekindling of interest in meditation and its application to psychotherapy within the psychoanalytic field, reflected in part by Mark
Epstein’s *thoughts without a thinker* (1995). Epstein, a contemporary Buddhist scholar and psychiatrist, explores psychotherapy from a Buddhist perspective, arguing that:

Far from being a mystical retreat from the complexities of mental and emotional experience, the Buddhist approach requires that *all* of the psyche be subject to meditative awareness…Meditation is not world denying; the slowing down that it requires is in service of closer examination of the day-to-day mind. This examination is by definition, psychological. (p. 3)

Interest in the integration of mindfulness and psychotherapy continues to flourish, both in clinical applications and in the discourse in psychotherapy. As Germer (2005) suggests, we may indeed be witnessing:

the emergence of a more unified model of psychotherapy, [and] are likely to see more research that identifies mindfulness as a key element in treatment protocols, as a crucial ingredient in the therapy relationship, and as a technology for psychotherapists to cultivate personal therapeutic qualities. (p. 11)

Germer’s reference to a “crucial ingredient” in the therapy relationship, and potential regarding the cultivation of “personal therapeutic qualities,” are themes that appear frequently in recent and emerging psychological literature related to mindfulness. Indeed there is increasing evidence that therapist qualities associated with mindfulness enhance clinical effectiveness. Studies have begun to demonstrate that health care professionals who practice mindfulness meditation for example, show an increase in empathy, therapeutic presence, self-care behavior, and other health care related skills (Christopher & Maris, 2010; Horst, Newsom, & Stith, 2013; Irving, Dobkin, & Park, 2009; McCollum & Gehart, 2010). However, as research evidence supporting both the development of MBIs, and the practice of mindfulness by health care providers, mounts, it does so in the absence of a consensus regarding the precise nature, practice, application and measures of mindfulness. Chiesa (2013), for example, asserts that:
If one considers the increasing evidence about the clinical benefits and psychological and neurobiological correlates of current mindfulness based interventions (MBIs), it is surprising that significantly lower effort has been directed towards the achievement of a consensus about an unequivocal operationalization of mindfulness within modern Western psychology. (p. 255)

2.2 Mindfulness: In Search of a Working Construct

Despite the frequency with which the term ‘mindfulness’ has been used in the literature, definitions offered by different contributors to the field have varied. Examples include: “moment-by-moment awareness” (Germer, 2005, p. 6); “the clear and single-minded awareness of what happens to us and in us at the successive moments of perception” (Nyanaponika, 1972, p. 5); the cultivation of attentional control (Teasdale, Segal & Williams, 1995); a cognitive process that employs the creation of new categories, an openness to new information, and an awareness of multiple perspectives (Langer, 1989); and, the awareness that emerges through paying attention in the present moment, nonjudgmentally, to the unfolding of experience (Kabat-Zinn, 2003). Though these definitions seem to bear a ‘family’ resemblance, variations in both content and emphasis have caused confusion in the literature and detracted from the consistency in, and consequent value of, research (Chiesa, 2013; Mikulas, 2011). Bishop et al., (2004) observed that although mindfulness had been described by a number of investigators, this field of discourse and research had proceeded largely in the absence of an operational definition. Explorations of mindfulness and its potential applications had produced no systematic efforts to establish the “defining criteria of its various components or to specify the implicated psychological processes” (p. 231). Though in past decade, attempts have been made to address these important issues, there continues to be debate
regarding how best to conceptualize mindfulness within Western psychological theory (Bodhi, 2011; Chiesa, 2013; Gethin, 2011; Grossman, 2011; Mikulas, 2011). Having said this, the operational definition offered by Bishop et al., (2004) has provided a useful referent that has been frequently cited in the literature. This definition includes two primary components. The first of these involves the self regulation of attention to maintain a focus on immediate experience, allowing for increased recognition of mental events in the present moment. The second refers to the adoption of a particular disposition regarding one’s experiences of the present, characterized by “curiosity, openness, and acceptance” (Bishop et al., 2004, p. 232). Though the debate regarding the optimal conceptualization of mindfulness in its application to psychology continues, there appears to be a growing consensus that mindfulness includes at least the two components identified above, namely, the self regulation of attention directed to immediate experience, and the adoption of an open, curious, and accepting attitude (Chiesa, Anselmi, & Serretti, 2014; Germer, 2005). Consistent with the expanded description offered by Bishop et al. (2004, p. 234), mindfulness can perhaps be regarded as an internal condition of regulated attention in support of non-elaborative awareness, combined with experiential openness and acceptance. This condition of mindfulness supports a self observational stance that promotes non-attachment to thoughts and feelings, such that these can be experienced in terms of their subjectivity and transience. This view of mindfulness, combining deliberate attention with openness to experience, seems to align well with the underlying intentions of empathy, and the empathic presence that is particularly valuable in a therapeutic setting.
2.3 Empathy in Psychotherapy

Historically, the term empathy can be traced to the early Greeks who coined the term *empatheia* to denote affection, but also “passion with a quality of suffering.” Near the end of the 19th century, describing something similar, the German psychologist Theodore Lipps used the word *Einfühlung* to refer to: “the process of becoming totally absorbed in an external object such as a work of art, vivid or powerful, with meaning for the perceiver” (Barrett-Lennard, 1981, p. 91). *Einfühlung* was first described in English by critic and novelist Vernon Lee who suggested that *Einfühlung* was the equivalent of *sympathy* since it refers to the feeling of being, in some way, ‘absorbed into’ the object or form that we perceive (Wispe, 1987, p. 18). It is Lipps (1903, 1905) however, who is often credited with the ‘discovery’ of empathy, though his contribution can perhaps be better understood as the organization and development of theory relating *Einfühlung* to psychology (Wispe, 1987). Lipps suggested that knowing and responding to others involved projection and imitation, and that these preceded the experience of *Einfühlung*, such that “as imitation of affect increases, *Einfühlung* increases” (Duan & Hill, 1996, p. 261). For Lipps, *Einfühlung* referred to the “the self that feels itself striving [wherein] the apprehension of the sensible object involves an immediate tendency in the beholder to a particular kind of activity” (Wispe, 1987, p. 19).

Titchener (1909) coined the term *empathy* as the English equivalent of *Einfühlung*, and defined it as: “a process of humanizing objects, of reading or feeling ourselves into them” (Titchener, 1924, p. 417). In this Titchener emphasized a process that was both reactive and also projective, combining a perceptive awareness of the other
with a felt appreciation for his or her affect or experience (Duan & Hill, 1996, p. 261). Prandtl (1910) added to Titchener’s formulation by introducing an associative dimension to the experience of empathy, suggesting that a person can only know their own inner life, even if they believe they are understanding the experience of the other. Prandtl proposed two possible forms of empathy: “empirical empathy,” in which the other’s experience is not communicated directly but is inferred; and “empathy through feeling.” In the first case, the observer relies upon his or her own associations with previous experience to bring the empathic response to life. Empathy through feeling on the other hand is perhaps more closely aligned with Lipps’s view in referring to a spontaneous, less consciously reflective generation of feeling in the observer. As Wispe (1987) points out however, in both of these forms, empathy is “the characteristic experience that something is going on in the perceiver that also exists in the object” (p. 20).

Sigmund Freud (1905) contributed to the transition of empathy from its use in describing an aesthetic response to an object, to its application in psychology. Freud used empathy exclusively to refer to a facet of human experience and never to a projection of human feeling onto some aspect of the non-human world (Pigman, 1995). Freud’s conception of empathy “designates the process of putting oneself into another’s position, either consciously or unconsciously, [allowing] us to understand others, to realize that they have selves like our own” (p. 251). What also becomes apparent however is that, regarding the experience of the analyst at least, Freud clearly favoured the cognitive/intellectual aspects of empathy, over any affective/emotional dimension of empathic experience. As Pigman (1995) points out:
Perhaps the most striking aspect of Freud’s conception of empathy is his emphasis on its intellectual features and his relative neglect, even suspicion, of its affective ones... Freud hastens to locate the analyst’s empathic activity in the preconscious. The analyst’s ability to empathize is an intellectual matter, even though the patient may respond emotionally. (p. 252)

Even in these early stages of construct development, the relevance of empathy to psychotherapy was obvious. Linking forms of affective and cognitive experience to the phenomenology of interpersonal encounter, empathy provided a conceptual referent in the complex process of understanding and ‘feeling into’ another’s world (Hart, 1999). Duan and Hill (1996) note that,

It is not a historical accident that empathy became a very important concept for psychotherapists and counselling psychologists. From psychoanalytic theorists who view empathy as a part of the psychoanalytic cure (e.g. Kohut, 1977) to humanistic theorists who perceive empathy as a necessary and sufficient condition for psychological change (e.g. Rogers, 1959), empathy has been a key concept in understanding why and how therapy works. (p. 262)

Despite early recognition across ideologies of the significance of empathy as an important dimension of therapeutic process (Barrett-Lennard, 1981; Kohut, 1984; Raines, 1990; Rogers, 1980; Schwaber, 1984), as with mindfulness, empathy has been plagued by the confusion born of multiple definitions. Theodore Reik (1948) complained that the word empathy “sometimes means one thing, sometimes another, until it does not mean anything all” (p. 357). In part, this dilemma has been exacerbated by practitioners who, while working within various ideological frames of reference, have used empathy to describe aspects of clinical experience that reflect their own particular ideology (Carlozzi, Bull, Stein, Ray, & Barnes, 2002). Basch (1983) suggested that within the discourse on psychotherapy, it remained unclear as to whether empathy was “an end result, a tool, a skill, a kind of communication, a listening stance, a type of introspection, a capacity, a
power, a form of perception or observation, a disposition, an activity, or a feeling” (p. 102). Basch’s commentary draws attention to a confusing diversity of meaning construction, but also to the pervasive nature of empathic experience in psychotherapeutic work.

Reflecting this diversity of construction, Batson (2011) suggests that within contemporary culture, there are at least eight different psychological states corresponding to distinct concepts of empathy. These include: knowing another person’s internal state, including his or her thoughts and feelings; adopting the posture or matching the neural responses of an observed other; coming to feel as another person feels; intuiting or projecting oneself into another’s situation; imagining how another is thinking and feeling; imagining how one would think and feel in the other’s place; feeling distress at witnessing another person’s suffering; and, feeling for another person who is suffering (pp. 4-8). As Batson (2011) observes however, though each of these variants may represent a distinct and recognizable interpretation of the construct of empathy, the differences between them are subtle, and in every case they refer to a “process whereby one person can come to know the internal state of another and can be motivated to respond with sensitive care” (p. 11). Describing empathy as “a complex construct,” Gibbons (2011) suggests that as the discourse in psychotherapy progresses,

A more dynamic and complex construct of empathy is emerging. Understanding empathy as a complex construct is perhaps more like how a musician understands music – as a whole-bodied process to be increasingly mastered, through dedicated training and practice. (p. 250)
2.4 **Empathy as an Embodied Experience**

The history of empathy as a conceptual referent, though diverse in some respects, seems nevertheless to reveal a consistent theme. From Titchener’s (1915) observation of our natural tendency to “feel ourselves into what we perceive” (p. 198), to Barrett-Lennard’s (1981) “inner process of empathic listening, resonation and personal understanding” (p. 94), to Gibbons (2011) characterization of empathy as a complex, “whole bodied process” (p. 250), the word empathy has frequently been associated with forms of sensory, affective experience and feeling, arising in the body and consciousness of the person empathizing. Though these forms of experience are described, symbolized, assigned meaning, and acted upon in different ways, reflecting in part different ideological frames of reference, there seems to be a broad, implicit consensus that empathy involves, first and foremost, an affective sense or feeling. Rogers (1961), for example, suggested that empathy is related to “sensing the feelings and personal meanings” of the client. Rogers (1961), believed that:

> When the therapist can grasp the moment to moment experiencing which occurs in the inner world of the client as the client sees it and feels it, without losing the separateness of his own identity in the empathic process, then change is likely to occur. (p. 62)

Corcoran proposes a model for experiential empathy that builds upon Roger’s view. Drawing as well on the work of Schuster (1979), and Lesh (1970), Corcoran (1981) constructs the case for distinguishing the felt experience of empathy from the communication of that experience to the client. He argues that a tradition emphasizing a view of empathy as a communication process, “fails to enhance the ability to assume the continuous moment-to moment awareness” (p. 32), required to sense the client’s feelings,
and necessary to provide the content of the subsequent empathic communication. Distinguishing his theory of empathy from more cognitive, perception/communication models, Corcoran suggests that,

Rogers’ views may be taken one step further, where empathy is the therapist’s subtle experience of the client’s emotional responses and attitudes. It is not an intellectual-analytic process, but a phenomenon of mind-body. […] In this respect, empathy is itself an emotional or affective process in which the therapist’s emotional reactions correspond to, and reflect, the emotional reactions experienced by the client. (p. 32)

As an emotional or affective process, Corcoran identifies empathy as “a body phenomenon, since emotions are themselves body phenomena” (p. 32), and views Gendlin’s conception of the “felt sense” as particularly relevant to empathy as ‘embodied.’ Like Corcoran, Gendlin (1981) insisted that a felt sense is not a mental or intellectual experience but a physical one:

A felt sense is…a bodily awareness of a situation or person or event. An internal aura that encompasses everything you feel and know about the given subject at a given time - encompasses it and communicates it to you all at once rather than detail by detail. (p. 32)

Though Gendlin’s ‘felt sense’ has been most commonly associated with a client’s change process and the healing potential of body-centred self awareness, Corcoran argues that in the context of psychotherapy, therapist empathy begins with this same kind of felt sense, in the form of a direct sensory awareness of the client’s experiential context. For Corcoran, empathy is a body process which occurs initially at a ‘felt-level’ of experiencing. This is followed by an integration of the meaning of the experience, at the symbolic level, such that a symbolized and conceptualized representation of the empathic experience can be communicated to the client.
Empathy as a felt sense, and as a “cooperative, dialogical process that is at the same time vividly grounded in the body” (Dekeyser, Elliott, & Leijssen, 2011, p. 113), is a view, consistent with the descriptions of empathy found in theoretical formulations advanced by a number of contemporary authors (e.g., Bohart, Elliott, Greenberg, & Watson, 2002; Diamond, 2001; Cooper, 2001; Shaw, 2004; Wynn & Wynn, 2006). Vanaerschot (2007), for example, following Barrett-Lennard’s (1981) description of the first phase of empathy as resonance, and building on various contributions from within the discourse on person centred and process experiential theory (e.g., Elliott, Watson, Goldman & Greenberg, 2004; Gendlin, 1996; Greenberg, Rice, & Elliott 1993), describes a model of experiential therapy in which empathic resonance, as a felt sense, plays a central role. For Vanaerschot (2007), empathic resonance in therapeutic process refers to a way of experiencing the client whereby,

what the client expresses (what is said, what is not said, how it is said, and what the body language is) elicits a bodily felt sense in the therapist. This implies that certain aspects of the therapist’s implicit experience come to be in process and thus, can be felt in awareness. The therapist will then focus on his or her own felt sense and try to explicate aspects of it. (p. 316)

In his exploration of the role of the body in empathic experience, Hart (1999) goes even further, suggesting that empathic resonance can be experienced not only in response to what is being disclosed verbally by the client, or made obvious by his or her physical, expressive presentation, but also in ways that suggest a much more subtle, and even mysterious process of awareness and exchange:

There are sometimes moments when understanding of the other deepens beyond what I can easily explain. I seem to experience the other’s feelings directly in my own body or recognize patterns, history, or meanings that do not appear to come from interpreting the words and gestures that are exchanged. (p. 112)
Hart describes ‘deep empathy’ as a state in which a barrier is crossed, and a more direct kind of knowing of the other becomes possible. He suggests that through a “postconventional epistemic process” (p. 115), the activity of knowing moves toward subject-object transcendence and a “loosening of self-other boundaries” (p. 116). According to Hart, this kind of deep connection can facilitate an empathic experience in which aspects of the client’s world become directly available for understanding to the therapist, through the therapist’s own embodied and subjectively felt experience:

Falling deeply into the scene, including experiencing our reactivity to the client, can fuel the immediacy and richness of the encounter. A microcosm of the client’s world may open up…and, if the therapist is able to maintain some awareness, he or she has the possibility of using his or her reaction as rich empathic information. (p. 117)

Rogers (1980) also wrote of the transcendent, embodied aspects of empathic engagement, and the potential of his own felt reactivity to be used as a resource within a therapeutic relationship:

but when I can relax and be close to the transcendent core of me, then I may behave in strange and impulsive ways in the relationship, ways which I cannot justify rationally, which have nothing to do with my thought processes. But these strange behaviours turn out to be right, in some odd way. (p. 129)

Descriptions of empathic resonance found within humanistic traditions often bear a close resemblance to descriptions of therapist experience, found in the psychoanalytic literature. Indeed, psychoanalytic theory has a deep and rich history of exploration regarding the body as a ‘tool,’ offering a kind of portal into the psyche of the patient through the operation of various forms of somatic countertransference (e.g., Orbach, 2004; Ross, 2000; Stone, 2006). Heimann (1950) proposed that the analyst’s
countertransference was an important tool, and an “instrument of research” into the patient’s unconscious. In more recent writing, Stone (2006) adopts the image of a tuning fork to describe his experience:

In thinking about embodied countertransference I have found the notion of the resonance of a tuning fork helpful and I would suggest that resonance occurs when the analyst’s tuning fork vibrates with the patient’s psychic material through the unconscious. (p. 109)

Exploring a similar idea, Shaw (2004) investigates the somatic experience of psychotherapists during the therapeutic encounter, and links these experiences to ideas found within the philosophic school of phenomenology. Citing Merleau-Ponty’s work as a reference and “viewing this process as an intrinsically embodied experience” (p. 272), Shaw argues that knowledge of the therapeutic encounter “can be acquired somatically by psychotherapists [and] this knowledge makes a significant contribution to the therapeutic encounter” (p. 283). Shaw also cites Mathew’s (1998) earlier work in which she examines her own experience of somatic countertransference, and concludes that:

The body is clearly an instrument of physical processes, an instrument that can see, hear, touch and smell the world around us. This sensitive instrument also has the ability to tune into the psyche: to listen to its subtle voice, hear its silent music and search into its darkness for meaning. (p. 17)

From Gendlin’s description of the ‘felt sense,’ to the conception of empathy as a dialogical process “vividly grounded in the body” (Dekeyser et al., 2011, p. 113), there appears to be an abundance of literature that identifies the body as the medium through which an important aspect empathic experience emerges. Though, as suggested earlier, this experience may be expressed in various ways, there is nevertheless a consistent theme in this literature that represents empathy as, primarily, an embodied experience.
2.5 Empathy: In Search of a Working Construct

In the meta-analysis presented by Greenberg et al. (2001), reference is made to Barrett-Lennard’s three component construction, as the “clearest operational definition of empathy” (p.380). In this construction the first component or ‘phase’ includes the “inner process of empathic listening, resonation and personal understanding” (Barrett-Lennard, 1981, pp. 94-95). The second phase refers to the expression of this understanding, and the third, to the reception of this understanding by the person being empathized with. This trilogy of resonation, expression, and reception, describes the totality of an empathic process of exchange between therapist and client. As stated previously however, it seems clear that resonation, the core and initiating empathic event in this sequence of exchange, lies within the body and consciousness of the therapist.

There is much discussion in the literature regarding the legitimacy of attributing thoughts and feelings in the practitioner, to the client’s condition, expression, or state of mind. In terms of traditional psychoanalytic theory for example, all countertransference experience was thought to be attributable to the analyst alone, and was viewed as an obstacle to psychotherapeutic process (De Elejalde, 1970; Sandler, 1976). More recently however, theorists have come to adopt a more liberal view, one that sees the full spectrum of therapist experience as potentially meaningful in terms of the psychic state of the client. Though this experience may be combined with aspects of the therapist’s own unconscious material, it can nevertheless, with careful discernment and management, become fertile content in the psychotherapeutic process, and a legitimate and useful component of empathic exchange (Ginot, 2009; Khwaja, 1997; Shaw, 2004).
In light of the foregoing, perhaps empathy can be understood in the broadest sense as referring to the experience of resonance that affords an embodied understanding of the other. In the context of psychotherapy, empathy includes as a primary component, the spontaneous, prereflective, affective content of a therapist’s experience of encounter with a given client, such that this content makes possible an “experience-near understanding of the client’s world” (Bohart & Greenberg, 1997, p. 14).

2.6 Empathy and Neuroscience

Understanding something of the meaning, relevance and desirability of empathy in therapy leads naturally to questions regarding the mechanisms that support this central therapeutic process. An emerging body of research in neuroscience offers compelling evidence of neurological systems that may be linked with the ‘first person,’ sensory-affective potential of empathic attunement (Gallese, 2003; Gallese, Eagle & Migone, 2005; Ginot, 2009; Iacoboni, 2009; Meissner, 2007; Vignemont & Singer, 2006). Following the discovery of “mirror neurons” in the macaque monkey brain (Gallese, Fadiga, Fogassi, & Rizzolatti, 1996), subsequent studies have demonstrated the neurological operation of a Mirror Neuron System (MNS) in the human brain. According to Iacoboni (2009), neural mirroring solves the “problem of other minds” by making intersubjectivity possible (p. 653). The MNS in humans has been found to be involved in the imitation of movement, the perception of communication-related actions, and the detection of action intentions. There is also a growing body of evidence suggesting a shared dimension in the experience of affective states, underpinned by a shared neural substrate. Gallese (2008), describing the affective, empathic response suggests that,
We do not accomplish this type of understanding only through explicit inference from analogy. The other’s emotion is first and foremost constituted and directly understood by means of embodied simulation producing an “as-if” experience engendered by a shared body state. It is the body state shared by observer and observed that enables direct understanding. (p. 771)

MNS theory provides a tentative basis for understanding the neurophysiological dimension of an embodied, empathic experience. According to embodied simulation theory, the therapist’s capacity to empathically understand the client is made possible, in part, by MNS activity that makes the client’s experience real, alive, and present, in the body of the therapist. In this way embodied simulation provides the therapist with not only a symbolized narrative to interpret but a first hand, intimately felt, embodied experience of aspects of the client’s experiential world. In a sense, the therapist may feel directly, the distress of the client, or at least a subjectively generated version of it and in doing so, open the possibility of a richly informed and fertile intersubjective exchange. Complimenting this neurological perspective, intersubjectivity has been theorized from within the psychoanalytic tradition, and this body of theory includes the process which has been identified as projective identification.

2.7 Projective Identification

Projective Identification (PI), conceived by Melanie Klein (1946), and developed further by Ogden (1982), refers to an intersubjective process whereby an aspect of the self is projected into another, leading the other to internalize the projected content and make it part of his or her self experience. As Segal (1981) writes: “We see the patient not only as perceiving the analyst in a distorted way…but also as doing things to the analyst’s mind, projecting into the analyst in a way which affects the analyst” (p. 82).
There is in this formulation a thematic consistency with both the previous descriptions of embodied empathic experience, and the emerging neurological theory supporting such experience. Simply put, in each description we see the client, present in therapy with his or her distress, the therapist available and empathically receptive, and the phenomenon of a shared intersubjective field or affective space in which this distress becomes manifest as an aspect of self experience of the therapist.

Gallese, Eagle and Migone (2005) propose a conceptual integration of MNS theory, empathic attunement as embodied simulation, and PI as the theoretical model of exchange between client and therapist. Making reference to Ogden’s (1982) account of PI as a three-step process, they suggest that step three holds particular therapeutic potential. This third step concerns how the client may respond to the interpersonal pressure, brought to bear by the therapist, as a consequence of his or her modulated, or well regulated response to the client’s presentation or disclosure. Ogden views this process as therapeutic because of its potential to ‘metabolize’ or ‘digest’ the client’s projection. By remaining receptive to such a projection the therapist makes herself available for a kind of intervention wherein the ‘tamed’ and ‘metabolized’ distress is reprojected, facilitating a reinternalization by the client of the projected material, now in an altered and more acceptable form (Ogden, 1982). This conceptualization is also consistent with Bion’s (1959) formulation of PI, as described by Meissner (2007), wherein “the recipient detoxifies the projection and reprojects it in modified form; in the analytic setting, this model is used to describe the unconscious interchange between patient and analyst” (p. 97).
2.8 Conclusion

This review of literature, drawing on major themes from within the contemporary discourse related to mindfulness, to empathy, to empathy as an embodied experience, and to neurological theory, presents material relevant to this study and to its research intentions. It must be noted however that the literature related both to the integration of mindfulness with psychology, and to the nature of empathy, contains tensions and important theoretical debates. Among these is the debate concerning the legitimacy of mindfulness as an independent technique or practice, extracted from its origins within Buddhist teaching and placed within a contemporary Western psychological framework. For some, mindfulness has been conceptualized as an independent practice, suitable to complement a preexisting, therapeutic approach (e.g., MBCT; Segal et al., 2002). However, there are also those who view mindfulness as a more dependent element embedded within, and perhaps inseparable from, the larger philosophic and moral body of Buddhist teaching (e.g., Bodhi, 2011; Olendzki, 2011). In addition, there are divergent views concerning the essential nature of empathy. Some describe empathy as a cognitive process of ‘perspective taking’ (e.g., Galinsky & Moskowitz, 2000; Batson et al., 1997), while others have characterized empathy as a more affectively charged, preconscious response to the other (e.g., Corcoran, 1981; Hart, 1999). These debates form part of the conceptual and theoretical context for an informed inquiry into the experience of research participants. What follows is a description of the methodology used to pursue this inquiry, including a rationale for the selection of methodological approach, and arguments supporting the rigour and validity of the study findings.
Chapter 3: Methodology

The methodology employed in the development of a research project creates a framework of intentions, procedures, and limitations that have far reaching implications with respect to what is considered, what is discovered, and how this material is both represented and evaluated. It is important that decisions regarding the methodological approach, and the methods used within it, are informed not only by the interests of the researcher and his or her epistemic inclinations, but also by the nature of the subject material under investigation (Creswell, Hanson, Clark, & Morales, 2007; Denzin & Lincoln, 2011; Merriam, 2002; Smythe, 2012; Willig, 2001). This implies a careful consideration regarding “what we wish to research, what we wish to know, and how we wish to know it” (Lennie & West, 2010, p. 84).

3.1 A Qualitative, Phenomenological Research Design

This study explores the qualities of a particular form of human experience. More specifically, it is concerned with questions that relate to the nature of the encounter between client and therapist, in the context of the dyadic exchange of therapeutic process. This focus on the qualities and texture of experience, rather than on the identification of measurable cause and effect relationships, suggests a qualitative rather than quantitative research design. As Denzin and Lincoln (2011) have observed, the word ‘qualitative,’

implies an emphasis on the qualities of entities, and on processes and meanings that are not experimentally examined or measured...in terms of quantity, amount, intensity, or frequency. Qualitative researchers stress...the intimate relationship between the researcher and what is studied, and...seek answers to questions that stress how social experience is created and given meaning. (p. 8)
Whereas quantitative research involves an a priori hypothesis, the statistical analysis of numeric data, and the measurement of predetermined variables, in qualitative research “the focus turns to understanding human beings’ richly textured experiences, and reflections about those experiences” (Jackson, Drummond, & Camara, 2007, p. 21). Shifting the focus from explanation to understanding, and emphasizing the role of the researcher in the construction of knowledge (Stake, 1995), qualitative research reflects a primary interest in context, complexity, and the lived experience of “people, situations, and ideas as they naturally occur” (Schram, 2006, p. 15). As a research approach, the qualitative paradigm favours induction over deduction. Typically, findings inductively derived from the data take form not as postulates or hypothesis to be tested, but as categories, themes, concepts, and tentative theory (Merriam, 2002). In the attempt to understand the meaning that a phenomenon holds for those involved, qualitative researchers “build toward theory from observations and intuitive understandings gleaned from being in the field” (Merriam, 2002, p. 5).

The qualitative paradigm includes an array of research methodologies, distinguished by their data collection strategies (Wolcott, 1992), their underlying intention and focus (Schram, 2006), and by their association with various disciplines and fields of study (Creswell et al., 2007). As many as 25 distinct qualitative designs have been described (Wolcott, 1992), but as some have observed, not all are suited to investigations pertaining to psychotherapy, or to the nature of psychological experience. Creswell et al. (2007) have identified five qualitative approaches that offer procedurally distinct options, while remaining “most relevant to counselling psychology” (p. 238).
These include narrative research (e.g., Schwind, 2003), case study (e.g., Bird & Blair, 2010), grounded theory (e.g., Parker et al., 2014), phenomenology (e.g., Finlay, 2003), and participatory action research (e.g., Ward & Bailey, 2013). Schram (2006), and Petty, Thomson, and Stew (2012), propose a similar list, though these authors exclude PAR in favour of ethnography. In addition to these approaches, various forms of thematic, and interpretive analysis (e.g., Braun & Clarke, 2006; Rizzo, 1992), and life history research (e.g., Allport, 1942; Berger, 2003), have also been used as methodologies in psychological research. The three qualitative study designs found most consistently within the field of counselling psychology, however, appear to be: case study, grounded theory, and phenomenology (Creswell et al., 2007).

Case study has been described as “the science of the singular” (Simons, 1980, 2009), an approach that attempts to understand what is distinctive about a specific, complex system such as a clinic, a classroom, a program, or a policy (Petty et al., 2012). A case study collects data through interviews, observation, and document analysis, and represents this data in terms of codes, themes, and categories. Characterized as ‘story telling,’ or ‘picture drawing’ (Bassey, 1999), the value of a case study lies in its ability to facilitate an “appreciation of the uniqueness, complexity, and contextual embeddedness of individual events and phenomena” (Schram, 2006, p. 107).

Grounded theory, introduced by Glaser and Strauss (1967), developed further by Strauss and Corbin (1990, 1998), and later by Charmaz (2006), is a research model that generates theory to explain the functional relationships between various components of a complex social process (Creswell et al., 2007; Merriam, 2002; Petty et al., 2012).
Utilizing methods of data collection similar to those employed in case study research, grounded theory features concurrent data collection and data analysis, emphasizes discovery and abstraction rather than description, and maintains as its primary intention the generation of theory, ‘grounded’ in data collected from a relatively large sample (Creswell et al., 2007; Schram, 2006; Smythe, 2012). Grounded theory has been used to derive substantive theory regarding the management of chronic pain (e.g., McDonald, 2014), and high risk sexual behaviour in adolescent females (e.g., Weiss, Jampol, Lievano, Smith, & Wurster, 2008).

In contrast to the large data samples commonly used in grounded theory research, phenomenology investigates the lived experience of a relatively small group of people, regarding a particular concept or phenomenon (Creswell et al., 2007; Smythe, 2012; Wertz, 2005). Drawing on the philosophic writing of Husserl, Heidegger, and Merleau-Ponty, phenomenological research rests on the assumption that through a process of dialogue and reflection, the essential meaning of an aspect of shared experience, can be revealed (Schram, 2006, p. 98). In this approach, the researcher first collects data through interactive dialogue with study participants who have experienced the phenomenon under investigation, and then works toward the development of descriptions that represent the collective experience of these participants (Creswell et al., 2007). This approach emphasizes the importance of ‘in dwelling,’ returning, repeatedly, to the phenomenon under investigation with an unobstructed and open minded attitude, seeking detailed, ‘thick’ descriptions that capture the richness and complexity of an aspect of psychological life, as it is concretely lived (Wertz, 2005).
The present study is aimed at understanding more fully the nature of a particular form of experience as described by a select and relatively small group of study participants. Though the experience of encounter between client and therapist may be understood as both ‘social’ and ‘complex,’ it is unlike the complex, and relatively structured social systems typically examined in case studies (e.g., classrooms, clinics, and programs). Furthermore, though the present study does consider the theoretical implications of the data and extrapolates ‘theory’ from this data in the form of a proposed model of psychotherapeutic process, the primary focus and guiding intention of the study is the description and elucidation of experience, as represented by a relatively small study sample, and not the generation of theory to explain the functioning of a large, complex social process. These study characteristics and research considerations suggest a phenomenological, rather than a case study or grounded theory research design.

Phenomenological research can take form through a variety of methodological approaches, and incorporate various methods of data collection and analysis. According to Wertz (2005), however, the four primary features that define a form of research as essentially phenomenological include, a) the setting aside of bias and assumptions related to previously conceived theory, b) the securing of access to meaningful descriptions of psychological life as it occurs in its natural context, c) an analysis of the complexity found within these descriptions that reflects upon the psychological processes found within them, and d) the development of insight regarding what is essential to the psychological process under study (p. 175).
Several examples of research in the fields of nursing, health sciences, and counselling psychology, lend support to the selection of phenomenology as an appropriate choice of methodological design for the present study. These include studies related to the experience of: schizophrenia (e.g., Davidson, Stayner, Lambert, Smith, & Sledge, 1997), substance abuse (e.g., Williamson & Hood, 2013), depression (Ofonodu, Percy, Harris-Britt, & Belcher, 2013), empathic connection (e.g., Dollarhide, Shavers, Baker, Dagg, & Taylor, 2012) and the integration of mindfulness in psychotherapy (Cigolla & Brown, 2011). Each of these studies seeks to illuminate the experience of an individual, or relatively small group of individuals, using a phenomenological approach that includes the four methodological components described by Wertz (2005). In the study conducted by Cigolla and Brown (2011), for example, six qualified therapists with a regular practice of mindfulness were recruited to describe their experiences related to the integration of mindfulness with therapeutic practice. Semi-structured interviews were used to “capture and retain the complexity and diversity of individual accounts” (p. 711). These interviews allowed participants to share their understanding of mindfulness, their personal experiences in relation to mindfulness, and various ways that they use mindfulness in therapeutic work. Using a phenomenological analysis that features the ‘bracketing’ of preexisting ideas and assumptions, and the identification of emergent themes, this study culminates in the formation of a composite description that conceptualizes mindfulness ‘a way of being’ (master theme): a way of being in personal life (first subtheme), a way of being in therapy (second subtheme), and as a way of being that can be encouraged in others (third subtheme).
3.2 Participant Selection

Research approval for the present study was granted by the University of Toronto Office Of Research Ethics in September, 2010. Study participants were subsequently recruited through a selection process that considered applicant suitability with reference to the primary research intention (Groenewald, 2004). The study seeks to illuminate aspects of the experience of psychotherapists with a substantial, personal history of mindfulness based meditation practice. Here ‘substantial’ is meant to imply more than an introductory experience, and intended to refer instead to a sustained daily practice over several years. The selection process was also informed by the researcher’s previously stated interest in exploring how empathy is experienced and understood, how it acts to serve therapeutic goals, and how the capacity to engage empathically with clients may be affected by a practice of mindfulness and meditation. An underlying assumption embedded in this interest is that a connection between a practice of mindfulness, and the experience of clinical work as a psychotherapist, is both likely and desirable. This assumption is supported by a growing body of literature that suggests that therapist mindfulness may serve to enhance capacities that support and promote therapeutic processes (Bruce et al., 2010; Kristeller & Johnson, 2005; May & O’Donovan, 2007; Morgan & Morgan, 2005).

In an effort to optimize the potential of the study to produce meaningful description and insight, the criteria for participant selection were carefully considered. This consideration included a review of the selection criteria in studies with similar research intentions (e.g., Aiken, 2006; Cigolla & Brown, 2011), consultation with
psychotherapist colleagues and fellow mindfulness practitioners, and self-reflection regarding the researcher’s own experience of the relationship between mindfulness, empathy, and psychotherapy. The selection criteria that were established through this process included: a) self identification as a practitioner of mindfulness based meditation; b) a minimum of five years of experience with a daily, personal practice of such meditation; c) a minimum of five years experience as a practicing psychotherapist where the primary focus has been clinical work with individuals; and d) an awareness in the participant of a connection between their personal practice of meditation, and the clinical work that they do as psychotherapists, with some sense of the nature of this connection and how it has impact on the therapeutic processes in which they are routinely engaged.

Participants were drawn primarily from the Greater Toronto Area (GTA), though exceptions to this geographic restriction were made, limited by the viability of face to face interviews. Personal and collegial networks, as well as professional organizations related to the integration of mindfulness and psychotherapy were considered as source populations for the identification of potential participants. Initial contact was made either by telephone or email, and where there was an expressed interest, an information letter (Appendix A) and consent form (Appendix B) were sent either by conventional mail, or by email. A form of ‘snowball sampling’ (Groenewald, 2004; Noy, 2008) was also used as a method of expanding the participant group wherein participants, at their own discretion, forwarded the researcher’s contact information to others who they felt might be suitable. In the event that these additional, perspective participants were interested in participating in the study, they then contacted the researcher. As was anticipated, there
was a degree of diversity within the sample population, however priority was given to meeting the criteria mentioned above and participant selection was not guided by an intention to create an obviously diverse group. All of the participants were English speaking, and all of the semi-structured interviews were conducted in English.

The selection process included a discernment regarding the appropriate number of participants for the sample group. Boyd (2001), for example, argues that for phenomenological studies, a group of two to 10 is sufficient, and Creswell (1998) similarly proposes a sample of up to 10 participants. Wertz (2005), however, suggests that the required number of participants cannot always be determined mechanically in advance, or by formula, but should continue until a “redundancy of findings that fulfill the research goals, is achieved” (p. 171). With this guidance in mind, and considering the relatively narrow field of inquiry, it was initially determined that a sample group of between five and 10 participants, would likely be sufficient. Five participants were initially recruited and interviewed. However, reviewing the content of these initial interviews and assessing them for redundancy and adequacy in terms of ‘fulfillment’ of the research goals and intensions, it was determined that a larger sample would be desirable, and three additional participants were recruited.

3.3 The Participant Group

In order to protect confidentiality, the eight participants selected for this study are identified by pseudonym only. Pauline, Karen, Jocelyn, Suzanne, Laura, Annette, David, and Lawrence are the names used to represent the reported experiences of the eight individuals who participated in the study.
In her mid-thirties, Pauline is the youngest member of the sample group. Having completed graduate studies in psychology, she now works as a registered psychologist in a regional hospital. She first learned about mindfulness through martial arts training, and this initial exposure precipitated an interest in mindfulness that continued through her graduate studies, and is now woven into her clinical work with individuals and groups.

Karen, who was born and raised in the United States, studied counselling as part of her university training in social work. She discovered Buddhism in her early adult life and began then to find ways of using mindfulness in her clinical work. Later moving to Canada, she worked at a major mental health institution before turning her attention to a private practice in psychotherapy, and the facilitation of MBSR groups.

Jocelyn first studied occupational therapy, and then completed a master’s degree in counselling. She also discovered Buddhism and mindfulness as a young adult and brings her interest in, and experience with, mindfulness into her clinical work in a variety of ways. Now, in mid-life, she divides her time between her work as a counsellor at an urban community health centre, and her private practice in psychotherapy.

Suzanne completed graduate studies in psychology and now works as a psychologist in private practice. She, like Jocelyn, discovered Buddhism and mindfulness as a young adult, and has had a disciplined personal practice of meditation for over 20 years. She teaches, and also works with groups, using mindfulness as a foundation in a variety of educational and clinical settings.

Laura completed a master’s degree in counselling and has continued her education through a variety of additional programs of study. She has had a private
practice of psychotherapy for more than 18 years. She discovered Buddhism as an adult and now combines mindfulness with aspects of psychodynamic theory, in the delivery of an integrated psychotherapeutic approach.

Annette, like Karen, studied social work as an undergraduate and later went on to complete a master’s degree. She was introduced to mindfulness by a colleague at the hospital where she works as a clinical counsellor. Having completed a course in MBSR, she brings her training in mindfulness to her facilitation of group work and to her psychotherapeutic practice with individuals.

David completed graduate studies in psychology and, like Pauline, is now a practicing psychologist, working as a clinical counsellor and psychotherapist at a hospital in a large urban setting. He discovered mindfulness as a young adult and, like Suzanne, immediately began a regular personal practice of meditation. Complimenting his study of mindfulness, David has pursued studies in Buddhism and Buddhist psychology.

Lawrence also completed studies in psychology and has been in private practice as a psychologist for more than 20 years. He discovered mindfulness through a colleague, and recognized immediately its relevance to his clinical work as a psychotherapist. He completed training in MBSR for health care professionals and now, in addition to his practice as a psychotherapist, teaches and facilitates MBSR groups.

Having met the selection criteria, and having agreed to engage in the research process, these eight participants were asked to review the 10 interview questions that would frame our dialogue (Appendix C), and to sign and return the consent form (Appendix B). With the completion of these tasks, initial meetings were scheduled.


3.4 Data Collection

With informed consent granted, semi-structured, in-depth phenomenological interviews were conducted with each participant. In these, the empathic, heuristic and dialogical aspects of the interview experience were used to support the gathering of experiential data. As literal examples of inter/view, these encounters were understood to be an interchange of views between two people conversing about a subject of mutual interest (Kvale, 1996). This interchange was framed within a set of predetermined questions (Appendix C) intended to facilitate an open-ended dialogue with rich descriptions of the participant’s lived experience.

The research interviews were conducted in a variety of settings agreed upon in advance, in each case, by the researcher and the participant. Care was taken to identify locations and settings that would facilitate focus and uninterrupted attention. In most cases this was the private office space where the participant routinely met with clients. In one case however the meeting took place in an arts workshop/studio, and in another, in a private hotel room. It was anticipated that the time required for each interview would vary, but an initial expectation that it would likely require at least one and one-half hours was made explicit in advance. Again, the heuristic and dialogical aspects of a phenomenological inquiry suggested a relatively open ended and flexible stance regarding the time required to adequately collect relevant data. Consequently the interviews varied in total length from approximately 75 to 150 minutes. In two cases the interview was completed over the course of two separate meetings to provide adequate time for exploration. In two other cases, a portion of the initial interview recording was
lost as a consequence of technical failure. In each of these cases an additional meeting was arranged in order to complete the interview process and ensure that a relatively consistent data set was achieved across the participant group.

Each interview was recorded using a conventional cassette tape recorder. Hand written notes were occasionally taken during, or immediately following the interview in order to capture particular aspects of what was heard, observed, or experienced during the interview process. In addition, each recording was reviewed as soon as possible after the interview, providing an initial opportunity to reflect on the content and its significance regarding saturation. This initial review also allowed for reflection with respect to reactions, thoughts and feelings that contributed to the self reflective, heuristic aspects of the research. Preliminary notes and reflections incorporate interpretive processes, and therefore represent forms of preliminary analysis. Self awareness and reflexivity were essential at this early stage in order that the data not be prematurely categorized or ‘pushed’ into the researcher’s bias (Groenewald, 2004). The recorded interviews were carefully transcribed, and separate files containing the signed consent form, a copy of the interview questions, preliminary notes, the transcription of the interview, and the signed confirmation of the edited transcript, were opened for each participant. These were stored in a secure location to protect confidentiality.

3.5 Data Analysis

This study employs a version of Groenewald’s (2004) simplified model of Hycner’s (1999) method for analyzing interview content. Five procedural steps were used to organize and interpret the data collected through the interview process. These
steps included: bracketing and phenomenological reduction; editing and validating each interview; delineating units of meaning; clustering units of meaning to form themes; and extracting thematic content to create a composite summary.

Bracketing refers to the process by which the researcher consciously sets aside personal views and reactions, theoretical bias and preconceptions. By first bracketing to minimize the limitations of a subjective view, the researcher prepares himself to engage in a process of inquiry that seeks to ‘reduce’ the phenomenon to its essential nature, opening to the phenomenon “in its own right” and “with its own meaning” with an interest in discovering its “pure subjectivity” (Groenewald, 2004, p. 18).

In the second step, each interview was edited to eliminate word repetition, and improve readability, while taking care to preserve the unique voice of the participant and their individual contribution to the data set. To support validity, a ‘member check’ was then performed by taking this summary back to each of the participants for their review, comment, and signed approval. In each case the participant determined independently if the essence of the interview content had been captured and if not, how the edited version might be modified to better reflect the participant’s experience.

The third stage of analysis involved the identification and delineation of units of meaning. Short pieces of text (a phrase, a sentence, or short paragraph) that seemed in some way to illuminate the phenomenon being investigated, were selected from the interview transcripts. These units of meaning were extracted from the dialogue and carefully studied. Through a process of distillation, redundant units were eliminated, leaving only those that revealed aspects of the essence of the phenomenon.
In the fourth stage, meaning units were clustered in groups according to apparent
categories and themes representing identifiable aspects of participant experience. In
phenomenological research, the identification of themes is a critical step toward eliciting
“the essence of meaning of units within the holistic context” (Groenewald, 2004, p. 19).
Large cork boards were used to physically place and display the selected pieces of text so
that they could be viewed and considered in a comprehensive visual context. In this way
individual units were easily evaluated in relation to other units, weighed in terms of their
relative strength, and evaluated for their correspondence with a particular primary or
secondary theme. Through an extensive, reflective process of shifting, eliminating,
and/or consolidating meaning units, adjustments in the constellation of units within
themes continued until these achieved, in the view of the researcher, a quality of clarity,
specificity, authenticity and strength, in the representation of participant experience. As
Groenewald (2004) notes, this stage engages the researcher in a process that cannot be
precisely delineated, and must proceed according to his or her own judgment.

Finally, in the last stage of analysis, themes for all the interviews are gathered into
a single composite summary. This final summary is intended to reflect the context from
which the identified themes emerged, as well as the apparent meaning of these themes.
Coffey and Atkinson (1996) suggest that meaningful research is not generated by
rigourous data alone, but must also venture beyond the data in the development of ideas.
In this way the final stage of the analysis is used to support the development of a tentative
theory, ‘going beyond the data’ to propose new possibilities of insight, meaning
construction, and understanding of the phenomenon being researched.
Phenomenology is a research approach that recognizes the inseparability of the researcher from the research (Finlay, 2008; Groenewald, 2004; Hammersley, 2000; Holliday, 2005). In addition to the inherent subjectivity of interpretive processes used in the analysis of data (e.g., the selection of transcript excerpts, and the identification of categories and themes), the data base itself reflects the interests and selection priorities of the researcher in that the accounts produced by people in the research setting are inevitably offered in response to the researchers own elicitations (Holliday 2005). As Finlay (2008) points out however, in phenomenological research, the researcher is not striving to be “objectivistic, distanced or detached” but rather “fully engaged, interested and open,” simultaneously embodying “contradictory stances” of being both removed from, and open to, research participants, immersed in their own experiencing (p. 2). In light of this, Morrow (2005) suggests that researchers must begin by acknowledging that the very nature of the data gathered, and the analytic processes which follow, are grounded in subjectivity. If the researcher disregards the personal nature of the research process, they may leave themselves open to questions regarding “whose perceptions are really being described in the findings” (p. 254). Qualitative research in general, and phenomenological research in particular, therefore requires conscious attention to the implications of researcher subjectivity, and to the quality control measures that may be built into the research process to support the meaning and validity of the research findings (Dwyer & Buckle, 2009; Lincoln & Gubba, 1985, 1986; Morrow, 2005; Thomas & Magilvy, 2011; Whittemore, Chase, & Mandle, 2001).
3.6 Rigour, Validity, and Self Location in the Research

Though the evaluation of qualitative research is a field of discourse, “clearly emergent and in a state of flux” (Morrow, 2005, p. 257), with divergent views regarding the appropriate criteria with which to make assessments of value and meaning, some approach to the evaluation of a study’s design, findings, and conclusions is clearly desirable. Guba (1981), and Lincoln and Guba (1985a, 1986), were among the first to provide an outline for the development of ‘rigour’ or ‘trustworthiness,’ in the process of conducting and representing research, and this outline has been widely adopted, critiqued, and refined by researchers engaged in various forms of qualitative work (e.g., Petty et al., 2012; Thomas & Magilvy, 2011; Whittemore et al., 2001). This outline identifies four components of research trustworthiness, each associated with techniques or strategies that can be used to support the development of confidence or trust in a qualitative study and its findings. These four overlapping components include: confirmability, dependability, credibility, and transferability. Confirmability refers to the extent to which the findings can be seen as arising from the inquiry, and not simply from the bias or presupposition of the researcher. Dependability is reflected in the extent to which the study follows a transparent, explicated and ‘traceable’ process of strategies and procedures. Credibility reflects the degree to which the findings authentically represent the participants, and are recognizable or trustworthy, and transferability refers to the extent to which the findings can be seen as applicable to other settings, or to other participants (Petty et al., 2012; Thomas & Magilvy, 2011). In the present study, each of these four components has been addressed, using procedural methods as described in the following:
3.6.1 **confirmability**

Confirmation that the study findings are the product of the inquiry and not simply the independent, subjective creation of the researcher, can be supported by the explication of the research process, transcript verification and the use of transcript excerpts, triangulation, and researcher reflexivity (Petty et al., 2012). In the present study, confirmability is established by: a) providing a detailed description of the intent, structure, and procedures used in the study regarding participant selection, data collection, data analysis, and the representation of findings; b) the use of participant verified, verbatim transcripts as the primary data set, and the use of transcript excerpts to provide the reader with direct unmediated access to selected examples of participant voice; c) the use of triangulation in the generation of categories and themes, indentified where different participant descriptions “converge on a single discrete construct” (Breitmayer, Ayres, & Knafl, 1993, p. 238), and also in the validation of themes by their intersection, contrast, and comparison with relevant literature; and d) the researcher’s engagement throughout the study process in a consistent practice of reflexivity, defined by Rennie (2004) as “self awareness and agency within that self awareness” (p. 183). These reflexive practices have included: informal reflective journaling in which emergent ideas and insights about the ongoing research process were developed, tested against and contrasted with the data, recorded, and stored for future reference; and consultation, both formal and informal, with peers, colleagues, and with supervisory and other teaching faculty, providing a ‘community of practice’ with which to engage in critical, reflective and sustained discussion (Rossman & Rallis, 2003).
3.6.2 dependability

A qualitative study unfolds within a particular place and time, involves particular individuals, and produces research findings that are defined and limited by the researcher, the participants, and by the temporal and circumstantial context in which they meet. The consequent nature of a qualitative study as a unique event, or set of events, means that within this research paradigm a study cannot be precisely replicated (Petty et al., 2012). In addition, the creative activity carried out by the researcher during the research process will inevitably produce ideas and insights that change and develop over time, and over the course of the study. With reference to dependability, Guba (1981) asserts that qualitative researchers are “concerned with the stability of data, but must make allowance for apparent instabilities arising either because different realities are being tapped, or because of instrumental shifts stemming from developing insights on the part of the investigator-as-instrument” (p. 86). Dependability, or stability in the data set, is achieved in part when someone (an auditor) outside the research can follow the decision making process used by the researcher (Thomas & Magilvy, 2011). In the present study, the ‘audit trail’ generated through the explication of the research process (described previously), and the reflexive practices of the researcher, support dependability of the research findings by providing the means by which an independent judgment can be made regarding the stability of the data. Here, ‘stable’ is understood to imply that although the data are both temporally and contextually dependent, they are neither arbitrary nor entirely subjective, but arise as the consequence of a legitimate, traceable, transparent, and reflexive research process.
3.6.3 **credibility**

Qualitative research, with its focus on context and the rich description of lived experience, “seeks to explore the whole in all its complexity” (Petty et al., 2012, p. 382), without attempting to control or predict any aspect of the phenomenon under investigation. Credibility, as a measure of trustworthiness in the representation of participant experience, is supported by prolonged engagement with the field of inquiry, persistent observation, the triangulation of data, and the reflexivity of the researcher (Lincoln & Guba, 1986; Petty et al., 2012; Thomas & Magilvy, 2011). In the present study, credibility is supported by the use of long, semi-structured, phenomenological interviews, providing an initial form of ‘prolonged engagement.’ This interview format promoted depth and complexity in the exploration of the subject material, and a nuanced, preliminary understanding of the subject material. This understanding was complimented by the subsequent careful review and editing of the verbatim transcript material. Once the edited transcripts were verified by the participants, the researcher read and re-read these, multiple times, over an extended period (several months), facilitating an immersive experience of ‘indwelling’ (Maykut & Morehouse, 1994; Wertz, 2005), and a form of ‘persistent observation.’ An emergent, progressive understanding of the data was developed as meaning units were identified, and later, as categories and themes became apparent, arising as intersections or ‘points of convergence’ in the participant’s descriptions of experience. Finally, the reflexive practice of the researcher, as described previously, provided opportunities to refine the emergent understanding, and consider different options in the representation of the findings.
3.6.4 transferability

In qualitative research the findings are understood to be context specific and not a representation of ‘facts’ that can be generalized to reliably predict the experience of others. Instead, such research aims to provide a depth and richness of description, sufficient to enable others to determine if, and to what degree the findings are applicable to other settings (Lincoln & Guba, 1986; Petty et al., 2012; Thomas & Magilvy, 2011). This component of trustworthiness is supported in the present study by including in the research process the collection and representation of richly descriptive data reflecting the particular and contextualized experience of the individuals in the participant group. The study, however, claims only to offer a representation of the lived experience of its participants, and does not (necessarily) represent the experience of others. The responsibility for determining the degree of applicability of a research inquiry rests with those who may wish to apply its findings in other research settings (Petty et al., 2012).

3.6.5 self location in the research

Cultivating and sustaining self awareness, and disclosing contextual information of a personal nature, can reinforce a reflexive practice and provide a degree of transparency in the research process (Cole & Knowles, 2001; Groenewald, 2004; Holliday, 2005). As outlined above, reflexivity directly supports the rigour and trustworthiness of qualitative work, in a variety of ways, including through its contribution to the confirmability, dependability, and credibility of the research. What follows is a disclosure of personal information most relevant to the present study.
As researcher, I enter the research field as a white, Eurocentric, middle class and middle aged, traditionally educated male. In addition to these characteristics, three other relevant aspects of personal experience include: my own extensive engagement as a client of psychotherapy, my current work as a practicing psychotherapist, and my deep interest in Buddhism and Buddhist psychology.

My personal experience as a client of psychotherapy began in early mid-life, and spanned a period of several years. For two of these years in particular, therapy was an intense, often difficult, illuminating, and highly experiential process of engagement, framed within a blend of ideologies that included reference to psychoanalytic, Rogerian, gestalt, psychodrama, and affective-process theory. This experience of psychotherapy, and the benefits that ensued from it, ultimately played an important role in my decision to pursue graduate studies in counselling psychology. It was through the personal work of therapy that I discovered a passion and deep respect for interpersonal processes that facilitate healing and growth. My work as a therapist supports an intense interest in the application of theory to the practice of psychotherapy, and my interest in Buddhism has led to a personal practice of mindfulness meditation, and the integration of mindfulness in my clinical work. In addition, I have found substantial support through MBSR training (Kabat-Zinn, 1990), as well as in the writing of a diverse group of Buddhist scholars.

Though these experiences, and aspects of personal culture, no doubt affect the ‘lens’ of my perception as researcher, it is assumed that the methods and techniques outlined in the foregoing help to offset subjective distortion, and provide some assurance of value and trustworthiness in the research findings.
Chapter 4: Results

As described in the methodology section, this study employs a qualitative research approach that includes in-depth, semi-structured interviews. These interviews are used as the primary source of data, and the subsequent data analysis follows a multi-stage, phenomenological methodology. In this process, ‘meaning units’ are identified, extracted from the interview transcripts, and combined thematically in such a way as to represent the essential aspects of the experience of these participants, as they have described it. Four thematic categories of experience create the framework within which the results have thus been organized. These include: Participant Context; The Experience of Mindfulness; The Experience of Empathy; and Embodied Experience. The first category provides a window into the personal journeys of participants toward a relationship with mediation, mindfulness and psychology, and a context within which to appreciate their subsequent descriptions of experience. The second category explores various ways that these participants experience mindfulness, particularly in the context of clinical work. The third category reveals and illustrates an experiential understanding of empathy, and the fourth includes descriptions that refer specifically to empathy as an embodied experience. Each of these categories contains in turn, secondary themes that reveal detailed aspects of experience, common to all or some of the participant group.

In this chapter direct quotations have been used extensively, to allow for a clear representation of the participant’s voice, to illustrate the primary categories and secondary themes, and to provide the essential content for subsequent analysis and discussion. Wherever appropriate these quotations are verbatim, unaltered excerpts from
the transcript text. In some cases however, minor editorial adjustments have been made to eliminate superfluous language and improve clarity and readability. For example, the following excerpt from the transcript,

Because she was very mindful when she was sweeping. I knew she was very slow and attentive and I just really noticed the difference between us, at that place where I was, and where she was.

has been edited to read:

She was very mindful when she was sweeping, very slow and attentive, and I really noticed the difference between us.

Also, in some cases, where a particular idea or reflection is represented in more than one location in the transcript, these have been combined to read as a composite. For example,

And I say sense because I think that it’s below thought. So it’s not thought. It’s more like the capacity to sense, and be attuned to, and connected with the experience of another...I think it’s sense, that’s the word that always comes to me. It’s sense. You can’t think empathy, you have to sense it.

Davidson (2009) has suggested that transcription often includes a process of revision in which material is edited for particular research purposes. Mondada (2007) adds that such editorial changes may involve “adding but also subtracting details for the purposes of a specific analysis, or a particular recipient–oriented presentation” (p. 810). Where such adjustments have been made, care has been taken to preserve the essential meaning of the excerpt and respect the unique character of the participant’s voice. In order to ensure confidentiality and protect the identity of each participant, potentially identifying information has been changed or omitted, and the voice of each participant is represented by a pseudonym. As stated previously, the eight research participants are identified simply as: Pauline, Karen, Jocelyn, Suzanne, Laura, Annette, David, and Lawrence.
4.1 Participant Context: A Developmental Perspective

Study participants were invited to explore those aspects of personal history that helped to shape the development of a relationship with mindfulness, and with psychology. The accounts they produced can perhaps be understood as examples of ‘thick description’ of formative experience, personal stories that provide some developmental context within which to understand the participant’s later descriptions of mindfulness and empathy in the clinical work that they do.

Although these accounts reflect a broad diversity of experience, and include descriptions of life-history that vary widely in terms of circumstance and setting, they also contain thematic elements that are, to varying degrees, shared across the participant group. Five secondary themes emerge as significant components in the developmental process described by the participants. These themes include: personal suffering; working with suffering; experiences of recognition; training and study; and current practice: an integrated approach.

4.1.1 personal suffering

Four of the participants, Lawrence, Pauline, Annette, and Jocelyn, offer compelling accounts of personal suffering. These descriptions of suffering refer to events or circumstances that arose at different stages of life, and include examples from childhood, adolescence, early adult and adult life.

In the following excerpt, Lawrence makes reference to the physical and emotional abuse that he was subjected to as a child. He describes the abuse as something that was “extremely painful,” and as a body of experience that “has always affected me.”
[There were] things that were just extremely painful for me in my early life. My father was a physically and emotionally abusive man, from my earliest days. I was beaten as a baby, and as a toddler by my father. And the power of that in so many ways, while its always affected me, was never really something that I just sat with, that I got to befriend, or even take time with.

Though “the power” of his abuse experience is now apparent to him, as something that informed and influenced his life “in so many ways,” Lawrence notes that the experience itself was something that remained, for many years, unexplored. It was an injury left without real attention until much later in life, and in this regard Pauline’s experience follows a similar pattern. Her description of personal suffering refers to a difficult time in her adolescence, and a traumatic injury that left her with “depressive symptomology.” Hospitalized for psychiatric treatment, she had an experience of the mental health system that was “horrendous.”

I had some experience as an adolescent with the mental health system, and it was really kind of horrendous. It involved hospitalization after trauma. [And] for many years I struggled with the impact of that trauma, and the depressive symptomology that I carried for a long time following that trauma... The profound anger, the grief, this disconnection from myself. Its taken me a long time to bring together people who could really provide the right kind of support.

Like Lawrence, Pauline also suffered a traumatic injury that had a pervasive effect on her life. She too struggled “for many years” with the consequences of this body of experience before she was able to find adequate support and the right forms of attention.

Annette describes a kind of suffering that became problematic in her twenties and continued for more than a decade. Her experience of chronic fatigue combined with “significant physical pain,” for a time, dominated her life and compelled her to find ways of working with both emotional and physical forms of suffering.
In my twenties and through my early thirties, I was dealing with physical illness. They didn’t have a name for it then, but from what I know now it might have been Fibromyalgia, or Chronic Fatigue. It was that kind of low, low energy, and not really functional at times. It was also significant physical pain...So physically I wasn’t well, and I needed to do my own work at that point.

Annette’s description refers to suffering associated with a chronic condition rather than with a specific event or events. Her experience of chronic fatigue and physical pain in early adult life became the driving force behind a search for healing.

For Jocelyn, serious personal suffering was associated with the end of her marriage. In the following excerpt she characterizes her experience as “very traumatic,” one that left her “struggling with grief,” and with a “malaise” in her spirit.

After my marriage ended,...that was very traumatic for me you know, with a small child. And a year after that I was still struggling with grief, and nothing seemed to help, nothing seemed to make it better. I wore black a lot. I wore brown a lot. It was just a very, very sad time. I wasn’t completely disabled you know? I mean I could get out of bed. I could function. I could go to work. But there was this malaise in my spirit.

Jocelyn’s struggle with grief persisted for more than a year after her marriage ended and despite her determination to continue to “function,” she was unable to find relief from the underlying experience: “nothing seemed to make it better.”

In each of these accounts, Lawrence, Pauline, Annette and Jocelyn describe events or life circumstances that gave rise to experiences of personal suffering. Though these accounts are unique to each participant, and associated in each case with a different stage in life, they reveal common themes regarding the impact of personal suffering, as a formative element in a developmental process, and as a primary source of motivation in a search for healing.
4.1.2 working with suffering

The four participants that make reference to experiences of personal suffering, also describe experiences that offered some form of relief or healing. Lawrence, having been introduced to mindfulness and meditation through the writing of Jon Kabat-Zinn, attended a meditation retreat where he was afforded the opportunity to grieve the absence of a loving father in his life, stay present with difficult emotional material, and discover a new capacity to “know these thing with some real kindness.”

At the meditation retreat, I had three wonderfully difficult days of just grieving that I would never have a father in my life. That I was just not going to have an experience of a man who would love me, and be kind and supportive and help me to grow. So that was incredibly important to do...It was just a wonderful opportunity to ‘hang in there’ with some tough stuff. Stuff that I’d spent a lifetime attacking and diminishing. And really discovering what I could say to these things. To know that I could look at these things, and know these things with some real kindness.

For Lawrence, attending the meditation retreat meant experiencing “three wonderfully difficult days” grieving, allowing himself to sense the depth and intensity of his own feeling, and to know this experience with a new kind of intimacy and self compassion. Pauline also discovered through mindfulness, an approach to suffering “so that there could be a shift, something that would naturally occur.” Reflecting further on her experience of adolescent trauma she identified “mindfulness skills” as the means by which she had been able to “meet the day and keep going.”

And what I realize now is that what I needed was mindfulness…to be able to hold my experience, and own all of it…Truly applying mindfulness skills, bringing mindfulness to the experience of my body, when I was really down in the gutter, and realizing how powerful it was just to spend a few minutes moving mindfully, so that there could be a shift. Something that would naturally occur, in bringing that awareness, and starting to move mindfully. Then I could meet the day and keep going.
Referring to the healing power of “moving mindfully,” Pauline describes the application of mindfulness in her approach to working with the experience of depression. Her emphasis on movement, and on “bringing mindfulness to the experience of my body,” reflects a form of awareness and engagement with physical experience that became important to Annette as well. In the following excerpt, Annette describes the way that she learned to use her training in Transcendental Meditation to help her address the experience of physical pain. Her ability to “really be present” with her physical experience became a way to approach her pain, and provide a “pathway to calming.”

So when the pain became a significant factor, being able to do the mantra, being able to connect with the breath, allowed me to go into it, and to really be present with it, thinking in terms of allowing it to move where it wanted to move, and not blocking it...It was a pathway to grounding, a pathway to calming. This was in my early twenties and thirties and life was a little chaotic at that point.

Coming to know her discomfort as something that she could “go into,” and be “present with,” provided Annette with tools to reach for in challenging times, and an effective way to work with the suffering of physical pain.

Jocelyn, like Lawrence, discovered a way to work with painful experience when she attended a mindfulness meditation retreat. Still struggling with the grief associated with the dissolution of her marriage, Jocelyn found that by simply allowing herself to “be with” her grief, she could “feel it” as she was “in it,” and also feel it begin to subside.

I went to a meditation retreat. It was outside Montreal, in the Laurentians. I felt like I needed to give myself an opportunity to ‘test the waters.’ So I went, and for three days I sat on a pillow and I cried. And I just sat there, and I witnessed my tears, and I felt my grief, and I could feel it while I was in it, and I started to feel it also subside...It was just being there with it. And I cried buckets, and they weren’t loud sobs, it was just continuous weeping. That was how I started to heal. It was through being with my own grief.
For three days Jocelyn “sat on a pillow and cried,” giving herself the opportunity to feel deeply her sense of loss, but also feel the healing effects of simply “being with” intense emotional experience. Lawrence made a similar discovery as he engaged in three days that were both “wonderful” and “difficult,” grieving the absence of a loving, supportive father in his life. Pauline found a way through depression using mindful movement and a body-centred approach to working with suffering, and Annette discovered the healing potential of “going to” and staying “present with” physical pain. Though diverse in detail, each of these descriptions outlines an approach to suffering characterized by similar themes of introspection, an attentive awareness to the detail of the present moment, and a willingness to “stay with” the discomfort of difficult, often painful experience.

4.1.3 experiences of recognition

During the interview process, several of the participants offered descriptions of life events or encounters that involved an experience of recognition. These encounters captured the individual’s attention in some way, invoked a sense of meaning, and ultimately had a formative impact on both the personal and professional development of the individual. These descriptions of experience seem to reflect the presence of some internal referent, a way of knowing by making reference to some aspect of self-experience. The examples that follow illustrate four dimensions of participant’s experience of recognition: as a felt sense; as a re/cognition or ‘gestalt’ experience; as an intuitively sensed, personal aspiration; and as an aspiration held for another.
Karen, referring to her childhood and the life that she knew as a member of a fundamentalist church congregation, recalled her experience of “that kind of internal barometer” that facilitated the recognition of what was important, the felt sense that she associates for example with her baptism. Though as an adult, she no longer identifies with this particular religious form, Karen emphasizes the way that at the age of nine, she could “feel the importance of it.”

I think that everybody has that kind of internal barometer…I was raised as a fundamentalist Christian. As a child you were baptized when you reached an age when you could accept Jesus Christ as your personal saviour. I don’t know if that actually resonated with me, but what did resonate with me was that I could feel the importance of it…I have a hard time saying it now, but even then, I don’t think that’s really what I was saying. It was like: “So this is how you want me to express this feeling, so, okay, why not? The feeling is the important thing.

For Karen, the recognition of what might be important, even as a nine year old child, came as a felt sense. It was the feeling of something that “resonated” with her, informing her sense of what mattered and how to proceed.

In the following excerpt, Suzanne describes her experience as a young adult who, having begun university, found herself in an environment that she was “not relating to on a deep level.” Assuming, at first, that her vocation should align with the mathematical skills that she shared with other family members, she had an experience of re/cognition, a gestalt-like reorganization of thought that emerged from “what really spoke” to her.

When I look at my early undergrad years, I had a very strong math mind. My father is an accountant, my sister is an accountant, it runs in the family. So when I went into my undergrad, that’s the direction I was going, and I was actually signed up for majoring in math. And I remember in those first few days, looking around and thinking: I may be good at this, but I’m not relating to it on a deep level, to the people, to the subject, it just wasn’t a passion. And I switched my entire major within the first couple of days to psychology, because that’s what really spoke to me.
Suzanne’s gestalt-like experience, recognizing the absence of passion in her relationship to mathematics, shifted her vocational direction and changed the course of her personal and professional life. Like Suzanne, Lawrence also had an experience of recognition, associated with the earliest days of his undergraduate studies, that reorganized his thinking. In this excerpt he describes being “captured by psychology,” and discovering “the promise that we can understand.”

Somehow I stumbled into university and thought I’d take ‘Psyche 100,’ and I was just captured…I was just captured by psychology, the idea of the promise that we can understand, and ask questions about ourselves, and think of these things at an abstract level.”

Lawrence’s “stumbling into university” suggests an absence of a sense of direction, a condition that changed dramatically following his introduction to psychology. In saying that he was “captured,” Lawrence reveals the gestalt-like nature of recognition as an experience of unmediated, sense of meaning and potential direction. In a similar way, Jocelyn also describes being ‘captured,’ though in her case it was first as a child, by the image and idea of India, and later as a young adult, by what she recognized in an “old woman” that she met when she spent a period of time there.

I always knew that I was going to go to India. I knew that it was a very spiritual country. Even as a child, I was fascinated by the different gods. I knew that people prayed and meditated, and I was always very drawn to that.

Travelling to India as a young adult, she had an experience that gave her a glimpse of unrealized aspects of herself. As she witnessed the old woman’s “very slow and attentive” sweeping, she recognized qualities of patience, care and attention that she herself “aspired to.” She recalls that,
I did go to India. I volunteered at a children’s orphanage, and I started to do some Yoga there, in my early twenties...And I remember watching this old woman in the mornings, sweeping floors at the ashram that I was staying at. And I looked at her and I thought: “One day, I’m going to be like her. One day, I’ll be going inside.” She was very mindful when she was sweeping, very slow and attentive, and I really noticed the difference between us. And I knew that some day, I would be where she was. I aspired to it.

Jocelyn’s aspiration that someday she would “be like her,” suggests the recognition of something already resident in Jocelyn but not yet manifest, qualities and capacities that were in some way familiar but as yet unexpressed. In her perception of the “old woman,” Jocelyn recognized both the difference between them and simultaneously what might someday be the same: “I knew that some day, I would be where she was.”

Annette describes a body of experience from her senior years in high school in which she recognized an emerging capacity in herself, an interest in, and comfort with, a particular kind of interpersonal contact.

I felt very comfortable in conversations with people that weren’t necessarily superficial. They weren’t just about how the football team was doing, you know? So there was a natural interest, and a gravitating towards that type of contact.

Working in an underprivileged neighbourhood during this time, she had the opportunity to see “what these kids struggled with,” and felt this “pull something” from her.

I worked as a lifeguard at a public beach. It was a rough neighbourhood, so kids that had nowhere else to go would spend the day at the beach. And it pulled something from me. Just seeing what these kids struggled with. And just, in some way, wanting to be part of changing their experience. Seeing that potential, what had the potential to shift.

In this is seems that Annette’s sense of recognition helped to shape not only her own aspirations, but also informed the aspirations that she might hold for another.
In each of these biographical accounts, the experience of recognition emerges as a distinct theme. Though clearly related, the particular character of each description varies, revealing four different forms of recognition experience: as a ‘felt sense,’ knowing the importance of something by feeling a ‘resonance’ with it; as a ‘gestalt’ experience, a sudden shift in consciousness that makes possible a change in direction; as a personal aspiration, recognizing in another, an unrealized aspect of oneself; and, finally, as an aspiration for another, where suffering has been witnessed and understood, and a vision of possibility for the other has emerged. Each of these accounts describes an aspect of recognition, and also illustrates the formative impact of such experiences on the development of the personal and professional lives of the participants.

4.1.4 training and study

As outlined in the introduction and methodology sections, all of the participants in this study met selection criteria that included clinical experience as a psychotherapist, as well as experience with a personal practice of mindfulness based meditation. These two forms of practice, one professional and one personal are, for each participant, associated with various forms of training and study. For all of the participants the training associated with the practice of psychotherapy involved academic studies in either psychology, social work, or counselling. Studies associated with the practice of mindfulness and meditation however were pursued in various, largely non-academic ways including personal reading, experiential learning in various forms, specialized training, and mentorship.
For some, the training and study associated with the practice of psychotherapy was quite distinct and separate from that associated with mindfulness and meditation. Lawrence, for example, offered the following description of some of the academic work that led to his practice as a psychologist:

I was a research assistant and it was just extremely rich, and some of the research things that we were doing worked out really well. I published a couple of papers even as an undergraduate...I went on to graduate school, had scholarships and stuff like that, and chose medical psychology because I was aware that application was important and meant a lot to me.

Quite separate from his early training in psychology, and many years after establishing a clinical practice, Lawrence discovered mindfulness and meditation through a colleague who recommended the writing of Jon Kabat-Zinn. This initial reading was soon followed by various forms of training associated with meditation, and also with teaching the MBSR program.

There was a practitioner here, a colleague who mentioned Jon’s book, *Full Catastrophe Living*, to me about five years ago...Jon’s book got me pretty excited about mindfulness, and I was like: “why have I never heard of this before!” So then I ordered his meditation tape set and began practicing, with that guidance, at home...I subsequently signed up for the seven-day mindfulness-based course that they do at Omega, that Jon and Saki Santorelli teach to healthcare professionals...I continued practicing and reading more, and then made application to learn how to teach this, really for the purposes of therapy, but also just to teach the MBSR program.

Having been introduced to mindfulness, Lawrence furthered his exploration, first by reading about, and then by experimenting with, meditation. This experimentation led to a growing interest in mindfulness and its potential to inform his work as a therapist, both with individuals in psychotherapy, and in the context of MBSR groups.
In a similar fashion, Annette first pursued academic studies in social work and, like Lawrence, was introduced to mindfulness many years later by a colleague.

I finished high school and went into the Social Work program...My formal introduction to mindfulness came much later actually when a colleague arranged for me to be the participant observer in a mindfulness-based program at Toronto-Western Hospital. So I went and did the group as a participant, as a form of learning. Then he did a group here for the staff, and so I did that one as well...Part of my work now is doing the group here once a week, so that’s a regular immersion. Co-facilitating the groups has certainly been significant in terms of learning. There’s the participation, but I’m also learning to facilitate and how to lead meditation.

Though mindfulness and meditation are central features of Annette’s professional life now, working in a hospital setting and co-facilitating MBSR groups, her training in social work came long before her exposure to mindfulness and the potential for the integration of mindfulness in clinical work.

In contrast with these two descriptions, Pauline’s history of training and study reflects a more integrated process, one in which various forms of training were interwoven and overlapping. Beginning at a very early age, Pauline was exposed to meditation in the context of martial arts training. Later, while completing her undergraduate studies in psychology, she pursued further training in meditation through a mentor relationship with a meditation teacher.

There are different stories that I can tell about my relationship with mindfulness and meditation, but one is through the martial arts training that I did as a very young child, maybe five or six years old. Meditation was part of every class, taking 30 seconds to focus on the breath. And there were exercises of meditation in motion that we did...I became more interested and conscious of mindfulness and meditation during my undergraduate studies, when I began a mentorship relationship with a meditation teacher. That involved daily reading on various forms of Buddhism and philosophy, and also daily meditation practice.
Pauline’s interest in mindfulness was intensified with her discovery of, and subsequent training in, Shiatsu, and this was followed by graduate school studies in psychology that placed mindfulness at the centre of her research.

In the middle of my undergraduate studies, I received a Shiatsu treatment. I went on to training and that’s where more of the mindfulness practice came in. Every class would start with a mindfulness meditation practice, or a body-scan practice. I did two years of training, and an eight month apprenticeship… At the end of my undergraduate degree I was doing Shiatsu, and I had this interest in mindfulness. So I decided to do my thesis on the intersection between mindfulness, emotional development, and psycho-social well-being. And that continued into my doctoral studies, and became truly the centre of my professional development.

All of the study participants made reference to experiences of training and study and these include in every case forms of academic training in psychology, social work, or counselling. In addition, all of the study participants describe forms of study related to mindfulness and meditation. Taken together these reveal a broad diversity, in terms of the training itself, but also in terms of the relationship between formal academic study related to psychotherapy, and the less formal, usually non-academic study of mindfulness and meditation. Lawrence, for example, pursued a professional career in psychology, became a psychologist and practiced for many years before encountering mindfulness for the first time through a colleague. His subsequent reading, personal exploration of meditation practice, and training in MBSR, led to a current practice of psychology that is deeply influenced by mindfulness and meditation. In a similar way, Annette pursued academic studies in social work, long before being introduced to mindfulness. Her exposure to, and training in MBSR, fostered a personal practice of meditation that supports the clinical work that she does as a group leader in a hospital setting. By contrast, Pauline’s descriptions of training and study suggest a more blended
development of the personal and professional, one in which training in mindfulness and
meditation was often intermixed with more formal academic studies in psychology,
promoting an early integration of these two domains.

4.1.5 current practice: an integrated approach

All of the participants in this study, having pursued a formal education related to
counselling and psychotherapy, and also having discovered at some point in their lives,
mindfulness and meditation, have gravitated toward, and are currently engaged in, a
practice of psychotherapy that is deeply informed by mindfulness. In this sense their
practice reflects an integrated approach that combines clinical skills and training with the
cultivation of particular, personal strengths and capacities. The following descriptions of
current practice illustrate various ways in which these participants experience this
integration.

Pauline offers the following description of her current experience in which “there
is an embedding of mindfulness in daily life, and especially in professional life.” In her
daily routine she combines personal practice with teaching, co-facilitation of groups, and
work with individual clients of psychotherapy.

So the routine shifts. I would say that there is a daily routine that can involve
body scanning, or a sitting, or sitting with clients. I do sit, but it’s not a
regimented practice. When I actually do sit, there are wonderful moments, where
there is this attention, this breath, this clearing of space, where true intention can
arise, and clarity can arise…But I feel like there’s a kind of embedding. So even
if there is some time of no formal practice, there is an embedding of mindfulness
in daily life, and especially in professional life. So there is personal practice,
there is the teaching, the co-facilitation of mindfulness groups, and there is the
work with the usual clients.
For Pauline, the personal practice of meditation provides “space,” “clarity,” and “true intention,” qualities of personal experience that she carries with her into the professional settings of her clinical work, with groups and with individuals.

Jocelyn describes various ways that mindfulness has become an important feature of her personal life, but also an element that has been incorporated into her work as a therapist:

I took the precepts after that and I became a practicing Buddhist…Since then I’ve continued to sit, some days more, some days less. I had a relationship with a sangha, went on yearly retreats, continued to meditate individually, but also started to reinforce it in my work. I would do things like bring my meditation bells to meetings with colleagues. And I also started to meditate with clients, not pushing it on them, just presenting it as an option…Now it’s a very common practice when I meet with my colleagues. We’ll meditate for ten minutes before we go into our sharing about our clients. So, it’s a practice. And in my private life, it’s like brushing my teeth. I don’t go through a day without meditating.

With her personal commitment to meditation, Jocelyn has found a variety of ways to bring mindfulness into her work, both with clients and also with colleagues.

Like Pauline, the initiation of Suzanne’s long standing meditation practice actually predated her graduate studies in psychology. Though initially separate pursuits, her personal practice of meditation, and her professional development as a psychotherapist became thoroughly integrated in her doctoral studies.

My personal meditation practice, as I said, is twice a day. I’ve been on a number of retreats as well. I also facilitate mindfulness in my group work, and I incorporate mindfulness in my psychotherapy practice with individual clients. But probably the most important thing is my own personal practice of meditation. If I miss it, it’s like missing brushing my teeth…So, you know, I meditate when I wake up in the morning, and I meditate before dinner. And I’ll take little pauses throughout the day to feel my feet on the ground, or to bring my awareness back, between clients…So it’s integrated in daily life you know? If I find myself walking, and feeling over-whelmed, I’ll bring my attention back to my feet, and feel my feet on the ground.
For Suzanne, the “most important thing” is the personal practice of meditation that frames her working day. Meditating in the morning and again in the late afternoon, she also takes “pauses throughout the day” to help bring her attention back to the present, and bring her “awareness back,” between clients of psychotherapy.

Laura offers this description of current practice, noting that although her sitting meditation practice is more a part of her personal than her professional life, “you can’t really separate the two.”

As part of my preparation to see a client, there’s a small centreing practice that I do. And then I have, over the years, built [mindfulness] into various stages of the work. I always write up an assessment, and I always include a kind of meditative process in that. So when I’m putting my formulation together I always include a kind of outdoor, walking meditation…And I also try to sit for about half an hour every day, usually more on the weekend. That’s in my personal life and not so much in my therapy practice. But you can’t really separate the two.

Though Pauline, Jocelyn and Suzanne all bring mindfulness into their clinical practice in ways that are visible and overt, teaching meditation to, and occasionally “sitting” with clients as part of therapeutic work, Laura’s integration is more subtle. For her, mindfulness in psychotherapy takes the form of personal practices ‘behind the scenes’ that support her work, but do not appear explicitly to her clients of psychotherapy.

Annette describes mindfulness as something that “weaves through the day” noting that it fosters a “certain presence” as she moves through her daily routine with “a little more care.” Mindfulness and meditation became an integral part of both her personal and her professional life as she began to co-facilitate MBSR groups with a colleague at the hospital where she works.
When I began doing the groups, that’s when there was a commitment, and an intention around a six-day-a-week meditation practice, making it much more a part of my daily life...It weaves through the day now in numerous ways, starting in the morning with a sitting meditation, and from doing the sitting, just moving through the routine with a little more care...There’s a certain presence that happens in moving through that routine. Getting here, something about that transition, walking from the car. Often I will be aware of it as a kind of walking meditation, a slowing down, of coming into an awareness of my feet. I’ll take three minute breathing spaces through the day. It can be pretty chaotic around here, so I try to bring that into the day.

In her current practice, Annette begins each day with a sitting meditation. She notes the “presence” that is facilitated by this, and the way that she brings that presence with her to face what “can be pretty chaotic” in the clinical setting where she works.

Finally, Lawrence provides the following outline of current practice, revealing the extent to which his personal practice has been integrated with his professional work, especially through his teaching of mindfulness and meditation in the context of MBSR courses.

I continue to practice every morning. I get up at five thirty and I do a thirty minute sitting meditation. Through the day I just try to keep tuning in, reminding myself to be present...It’s just, you know, It’s always there. So I try to practice those kinds of lessons through the course of my days and my weeks. There are a couple of nights now when I’m teaching MBSR. That always provides me with some structure through the week, getting ready, and then teaching, and then reviewing the teaching afterwards. We also have a sangha now for past students of the class. On Tuesday nights I go and sit with them as well. So there’s a lot populating my life right now because of mindfulness and teaching.

Lawrence ‘populates’ his life with mindfulness in a variety of ways, noting that “It’s always there.” Beginning each morning with a sitting meditation, he goes through his working day “reminding myself to be present.” Teaching MBSR and joining others in a weekly sitting practice keeps mindfulness and meditation at the centre of both his personal and his professional life.
Pauline, Jocelyn, Suzanne, Laura, Annette and Lawrence, each provide a description of a personalized integration of mindfulness, meditation, and clinical practice. This integration, as Pauline suggests, ‘embeds’ mindfulness comprehensively, making it a part of both daily life, and of professional work. For some, meditation is also an explicit “tool” in the work that they do with individuals, and with groups. For others however, mindfulness acts invisibly, ‘behind the scenes,’ as a personal practice that supports them in various ways, nurturing personal capacities that assist them in their ability to remain ‘present’ with clients. Suzanne, for example, maintains a personal practice of meditating twice a day, so as to keep mindfulness and the ability to “stay present,” at the centre of her work. Finally, for some, a daily practice of mindful meditation is complimented by teaching meditation in the context of MBSR groups, and in Lawrence’s case, by attending weekly ‘sittings’ with former students. For all of these participants, meditation is part of daily life, and is either explicitly or implicitly a part of their professional work as well.

4.1.6 summary

Reflecting on aspects of personal history related to the development of their interest in mindfulness, and in psychology, study participants provided rich descriptions of formative experience. Five themes emerge in these descriptions, as significant components of the developmental process of each. These themes include: personal suffering; working with suffering; experiences of recognition; training and study; and current practice.
Lawrence, Pauline, Annette and Jocelyn provide examples of personal suffering related to childhood, adolescence, early adult and adult life. Each of these participants also found a way of working effectively with their suffering, and in each case this approach to suffering involved some kind of meditative practice, of bringing attention to and remaining present with, various forms of distress. Karen, Suzanne, Lawrence, Jocelyn and Annette describe experiences of recognition, a kind of knowing that arises as a felt sense, a gestalt experience, or a defining sense of aspiration. All of the participants give examples of training and study related to mindfulness, to meditation, and to psychology, in which they have participated, and finally, Pauline, Jocelyn, Suzanne, Laura, Annette and Lawrence each provide descriptions of current practice, one in which mindfulness has come to play an important role in personal as well as professional life.

Though each of the study participants has engaged in a unique developmental process, one that combines elements of personal suffering, healing, recognition and study in particular ways, the developmental trajectory shaped by a body of personal life history has in each case, ended at a similar point. Pauline and Annette can be seen as two examples that reveal diversity in the particular constellation of developmental themes (see Figure 4A), a diversity that is present across the participant group. Each of the eight study participants has a current practice that integrates mindfulness as a feature of personal life, with mindfulness as a central and defining element in clinical practice.
**Pauline:**

Training & Study  
Martial Arts training as a young child.  

Personal Suffering  
Trauma and hospitalization in adolescence.  

Training & Study  
Undergraduate studies in psychology  

Training & Study  
Mindfulness, Buddhism, and Shiatsu training.  

Wrkng/w Suffering  
Mindfulness as a path to healing trauma.  

Training & Study  
Graduate and post-graduate studies in psychology  

**Annette:**

Recognition  
As a lifeguard: “It pulled something from me.”  

Training & Study  
“I went into Social Work. I did a BSW.”  

Personal Suffering  
Fibromyalgia, chronic fatigue, and physical pain.  

Training & Study  
Transcendental Meditation (TM) training.  

Wrkng/w Suffering  
TM as a healing practice.  

Training & Study  
Mindfulness training and co-facilitation of groups.  

**Figure 4A.** An integrated approach. An illustration of two examples showing different constellations of experience, culminating in a similar current practice.

Current Practice  
Mindfulness and psychotherapy: An integrated personal/professional practice.
4.2 The Experience of Mindfulness: Attention, Presence, and Absence

The interview process provided participants with an opportunity to explore broadly, the experience of mindfulness in the context of psychotherapy. This exploration was intended to reveal the essential, experiential features that inform their understanding of mindfulness as a dimension of clinical work. Four interrelated themes, describing the experience of mindfulness, have been identified. These include: attention and the present moment; mindfulness and the body; mindfulness as presence; and mindfulness as absence. Within the first theme, participants offer descriptions of experience that highlight the importance of ‘paying attention,’ and suggest an intimate relationship between attention and the ‘in the moment’ field of personal experience to which this attention may be applied. In the second, mindfulness is described in terms that make explicit reference to the body, and emphasize the role of physical, sensory awareness. The third theme provides an outline of the ‘presence’ that seems to manifest when consistent attention is brought to bear on the field of present moment experience, and the fourth theme suggests that the experience of mindfulness requires an absence of egocentric, ‘self’ preoccupation, and conceptualization.

4.2.1 attention and the present moment

Two interconnected elements that characterize the experience of mindfulness, attention and the present moment, are apparent in five of the participant interviews. Though in the context of therapeutic work, one’s attention clearly must include attention to the other, the following excerpts emphasize a self-focused, reflective consciousness that facilitates awareness of the individual’s own current, internal condition or process.
In the following excerpt, Lawrence makes reference to “paying attention,” and suggests that mindfulness may be the main ingredient of effective therapeutic work. He points to a relationship between attention, acceptance, and the “open space” that supports self awareness.

It provides me, and I think a lot of people, with a handy reminder just to pay attention…I think that mindfulness is, in some ways, the unidentified, main ingredient of real therapeutic work, and of human growth. You know, any time we reflect on our life, even outside therapy, it involves that mindful paying of attention, with acceptance, to what’s going on…Essentially, it’s paying attention to the present. It’s a non-judgmental, open space that supports self awareness…Mindfulness allows us to stop, to explore, and to be interested. To feel into those things, and to take time to experience them more fully.

Lawrence emphasizes the importance of paying attention to “what is going on,” and suggests that mindfulness is the capacity to stop, explore, and “feel into” the nature of our experience. In a similar way, Karen describes mindfulness as a form of attention that includes noticing “what comes up” in her own, present moment experience.

Mindfulness is, you know, being aware, being in the present moment…Mindfulness gives you a way to be able to notice, and not just have an experience….That’s how you learn to be a psychotherapist, by really being present, and noticing, and noticing what comes up in you. I mean that is a mindfulness practice…If I notice I’m not involved, I can notice that. “Oh, you’re not involved. Oh, you’ve got opinions about all this. Isn’t that interesting?”…And what is it like if I find a way to honour what comes up inside me when you say or do that, but at the same time just be present with you. So I can hold both, sometimes three of four different things at one time.

In her description of the experience of mindfulness, Karen refers to a capacity to hold “three or four different things,” while remaining “present.” Those things that she can be aware of include the degree to which she is “involved” in the encounter with her client, as well as the nature of her own reactions to what has been shared.
For Annette, paying attention to the present moment requires an “open acceptance,” a willingness to neither “push away” nor “hold onto” experience as it arises. This self directed attention extends to include noticing “familiar stories” and the impact that such stories can have on her emotional state.

[Mindfulness is] paying attention, on purpose, in a particular way. Being present with whatever experience is arising in this moment, and moving toward an open acceptance of whatever that experience is. Being able to stay present with it, not pushing it away, and not holding on to it, but being aware of it…And also being aware of the impact. There’s one familiar story that I tell myself as I’m walking from the parking lot, coming in. And I can actually feel that I’m working myself up. Getting caught up, emotionally shifting because of the story I’m telling myself. So if I can come from the car, and be walking, and become aware of my feet, I can begin to relax into the day.

Annette refers to mindfulness as a capacity for self attention that allows her to notice when she is getting “caught up” in the familiar pattern of an old story, and redirect her attention to the field of her immediate experience. For Pauline, it is this attention to immediate experience that creates an “intimacy with the field of being with oneself.” Pauline suggests that mindfulness is both a practice, and a state of being. She identifies the “practice of mindfulness” as a process of present moment attention, and the state of mindfulness as a quality of “being” that emerges from this process.

I think of Jon Kabat-Zinn’s words: “Cultivating intimacy with the field of being with oneself.”…That seems most succinct, and it has a lot of meaning to me. Like when I’m thinking about intimacy, how to cultivate intimacy within the domain of being…I think the practice of mindfulness, of paying attention to develop concentration, and develop a wider field of perception, allowing us to see more of what is happening, to see things as they are, that’s kind of the process of mindfulness that can allow this emergent ‘being-ness,’ which is more a state of being…I’s in the quality of attention. It’s the attention itself. It’s the breadth of the ability to pay attention.
Jocelyn echoes Annette in the following excerpt, suggesting that attention to immediate experience supports “being present” in therapy. She describes a focus on self as the “foundation,” and suggests that this kind of attention makes it possible for her to “check in” with, and stay attuned to, her own reactions.

[Mindfulness is] being in the moment, being present in the moment. First of all, present within yourself. If I’m not feeling my feet on the floor, if I’m not feeling my breath, if I’m not aware of the quality of my mind or what I’m feeling emotionally, then it’s going to be really hard for me to be present on the outside…If you’re not present with yourself, then you’re not going to be in tune with your own reactions. You could be operating from an unconscious place. And I think mindfulness, the practice of mindfulness, is the act of consciously interacting with the environment, with others, and with yourself. It’s a form of consciousness…It’s the foundation. You know, starting from an awareness of myself before the client comes in. I check in with myself to see how I’m feeling. If it’s been a difficult session, I’ll start with my breath, and just watch where my mind is, and the quality of my mind

For Jocelyn, mindfulness is first a practice of being self aware, a form of consciousness characterized by attention to present moment experience. She suggests that self directed attention is what allows her to observe the “quality” of her own mind.

For each of these participants, attention and the present moment seem to constitute central, interconnected elements of mindfulness. It is attention to the present that allows them to “notice” the detail and quality of their own experience, including their experience of reactivity. Becoming aware of this experience “as it arises,” neither “pushing it away” nor “holding on” to it, they cultivate an awareness of the present that fosters an “intimacy with the field of being with oneself.” For these participants it seems that attention, particularly those forms of attention that emphasize a self-focused, reflective consciousness, brings the present moment into focus and creates the capacity for “presence” in therapy.
4.2.2 mindfulness and the body

Expanding their descriptions of the experience of mindfulness in therapy, four of the participants make explicit reference to physical experience, to “embodiment,” or an awareness of physical sensation, as an aspect of mindful awareness. For Pauline, the “intimacy in mindfulness,” facilitates a process of connection. She suggests that embodiment is central to her understanding of mindfulness, and to her application of mindfulness to clinical work.

There is a very important process of embodiment through mindfulness practice, and through the cultivation of this intimacy in mindfulness… I can see it when I guide a mindfulness practice, that bringing consciousness into the knee, or into the lower back, or into the spine. It’s a very intimate, connecting kind of process, being in the body, bringing consciousness down into that vertebra, into that disc, into that joint pain, sensing it from the inside…I come back actually to the ingredients of mindfulness, the foundations of mindfulness, and taking the beginner’s mind. It’s that sense of curiosity toward whatever is happening in my own body, my own self, my own experience.

In describing her experience, Pauline refers to “being in the body,” bringing consciousness directly into the felt sense of her physical experience. She links this consciousness to the “foundations of mindfulness,” to a capacity for curiosity, and for holding “tension.” Annette too draws attention to physical responses, and the way that mindfulness has supported the development of an attunement to “sensations in the body,” coming back to whatever is “happening in the moment.”

Whether it’s thoughts, feelings, or sensations. Whatever it is that’s happening at that moment, and coming back, and coming back…It connects me again, in taking three minutes to ask myself: “What’s happening right now?” “What am I thinking, what am I feeling, and what are the sensations in my body?” Being with the breath. Being with the fullness of the body…Being aware of my own physical responses, mindfulness has very much been a part of that. Really becoming more attuned to how I’m responding physically, sometimes reacting, but becoming much more attuned to that, and using it as a barometer in sessions.
Annette speaks of her awareness of sensation as a source of information about how she is responding to “whatever is happening.” She refers to the sense of connection with herself that is fostered by repeatedly “coming back,” directing her attention again and again to how she is “responding physically.”

Karen’s reflections regarding the experience of mindfulness, include the role of the “senses,” and noticing what it feels like to “have a body.”

Remember, with mindfulness, it’s about the ‘truth,’ and it’s about the truth that we experience with our senses...When you do the first practice in a mindfulness group, you talk about people coming into the body, you know? You’ve been brushing all around, and you may have been using your body but not even noticing that you’ve got one! So, inviting people to notice, to really notice what it feels like to have a body, in this room, and in this moment. That’s a different kind of experience, noticing these things, noticing heart rate, respiration, all that kind of stuff.

Karen emphasizes that mindfulness is about the “truth that we experience with our senses.” She suggests that this is a “different kind of experience,” one that includes an awareness of our current, physiological state or condition. Like Karen, Suzanne also describes mindfulness as a practice supported by bringing attention to the body, and the experience of sensation: sensations of breath, or of sound, or of feeling her “feet on the ground.” In the excerpt below she also suggests that a mindful awareness of her body enhances her “access” to the experience of the other.

Whether it is through anchoring yourself in your breath, or mindfulness of sound, or mindfulness of walking, it’s a technique or practice to be able to open up awareness to present moment experience, including the experience of my own body...If I find myself walking, and feeling overwhelmed, or scattered or whatever, I’ll bring my attention back to my feet, and feel my feet on the ground...Through my own practice out of the room, and before a client shows up, you know, even it it’s just a couple of minutes, just to bring myself into the ‘zone.’ My ability to access their experience, through my body, becomes greater.
Suzanne speaks of “anchoring” herself in awareness, including an awareness of her own body. Her reference to “an ability to access” the experience of the other also links this form of self awareness to a capacity for empathy.

Each of these participants describes the experience of mindfulness in therapy with reference to the body, and to an awareness of present moment, physical experience. They speak of an “intimacy” with physical sensation, and curiosity regarding whatever is happening “in the body,” coming back repeatedly to a present moment awareness of the way that they are feeling the present, physically. Suggesting that mindfulness is about “the truth we experience with our senses,” they emphasize the central role of an awareness of the body and, finally, link this awareness to the capacity for empathic connection to the other.

4.2.3 mindfulness as presence

Of the eight study participants, six made reference to ‘presence’ as a defining feature of mindfulness, and an aspect of therapy that seems to emerge in part, from the attention and self awareness described previously. Suzanne, for example, suggests that it is her personal practice of meditation that supports “truly being present” with her clients. In the following excerpt she refers to presence as “being open and connected to oneself,” and as an “immersion in the moment.”

It’s my personal practice that’s most important, because it allows me to show up for clients, and it allows me to be present. It allows me to have the capacity to work with them…You know, it’s what presence is, being open and connected to one’s self. A grounding, a sense of expansion, and immersion in the moment…Mindfulness as I see it is a practice of being present. And presence is the foundation of empathy. So, being present not only means my body is open, to become what they’re experiencing, but it means that I’m in tune with them.
Suzanne suggests that mindfulness is “the practice of being present,” and that this presence makes it possible for her to work with her clients. For Suzanne, presence means that she is “open” and receptive to what the other is experiencing, and in this way she makes a connection between presence and a capacity for empathy.

Like Suzanne, Annette also refers to “presence” in terms of a connection to oneself. In the following account of her morning routine, she describes “walking from the car,” slowing down and “coming into an awareness” of her feet. Annette sees the kind of presence that serves her work with clients as a practice of “turning into” herself and “grounding.”

There’s a certain presence that happens in moving through the routine, getting here, something about the transition, walking from the car. Often I will be aware of it as a kind of walking meditation, a slowing down, coming into an awareness of my feet…And not thinking about what I need to do tomorrow, and not being in the stories of my life, but really being here, and being present in sessions…I’m certainly more present, and people comment that they feel heard. We had eight people in a group and two of them got into a significant conflict, and it was me turning into myself, and grounding, that made a difference. I was concerned about where this was going to go. People were standing up and there was a moment when…But when I spoke, I heard the quality of my own voice, and they both actually paused and talked to me, and then talked to each other. I think that when we’re in a mindful space, that presence gets transmitted somehow. I think people hear it, they experience it.

Annette speaks of the presence that provides people with an experience of feeling “heard.” Referring to a group therapy session that required the resolution of a conflict, Annette recalls the quality of her own voice, and a kind of “presence” that can be transmitted in such a way that people both “hear it,” and “feel it.”
Making reference again to a form of self awareness, Pauline speaks of the “delicate process” that includes sensing her own moment to moment experience, maintaining a receptive presence that allows the “unexpected to emerge in a session.”

It’s this ability to stay present and silent with a sense of openness to the unexpected. It’s connected with mindfulness practice, connected with the person centred approach, and allows for the unexpected to emerge in a session…It’s a delicate process, one where the use of mindfulness skills is really important. Where I feel my own tracking of the relationship, sensing the moment to moment experience…There is a way that I can be that is just a kind of a foundation, a presence that helps the person connect with their own sense of foundation, as a supportive and grounding experience.

Here Pauline speaks of the use of “mindfulness skills” in maintaining an openness to the other, and the “presence” that supports the client in discovering “their own sense of foundation.”

Jocelyn refers to living a “mindful life,” and to the self-care that being “present” requires. For Jocelyn, presence is related to a self aware, physical state that supports a clear, open, and receptive mind.

It’s a lot of responsibility to live a mindful life, and to practice therapy from a mindful point of view, from a mindful stance. Because we are who we are as we sit in that chair. And the self-care that you have to practice, and what goes into being mindful. It’s a lot of work. It takes a lot of work to be present, present in your own life, present in your relationship with clients. I don’t think a lot of people really understand what goes into that quality of presence…If you’re able to be present, your heart rate is normal, and you are able to take things in. Your mind is open, your brain activity is at a level where you can think clearly.

Jocelyn suggests that “we are who we are” as therapists and emphasizes the personal “work” that is required for her to practice therapy “from a mindful stance,” personal work that allows her to bring presence into her relationship with clients.
For Karen, the “work” that Jocelyn refers to extends to include the creation of a suitable physical context for her clinical practice. In what follows she suggests that the focused attention and care that she brings to the setting for therapy, helps to communicate her intention to be “present” with her clients, and supports them in developing “presence within themselves.”

I’m trying to set the stage so that not only will it be true for me, but also communicate to them, that I’ve given a lot of thought to this being the time that I am going to focus on them...So you walk in, and then you come in more deeply, and then you sit down at the farthest part of the room. So to me, that is already setting up presence. Nothing else happens there. That’s the only thing that I use that space for. So it already sets up an experience that says: “I’m going to be present here with you.”...I think that people are not going to trust you with the stuff that they are ashamed of, or that they feel will not be accepted, if that presence is not there...I want them to be able to have presence with themselves too, so that they can notice when they’re discarding themselves, when they’re rushing to judgment, when they’re doing any number of things that cut them off from life.

In the physical setting that she creates, Karen communicates her intention “to be present” with her clients. She suggests that her presence in therapy fosters trust, and supports the client in noticing those things that “cut them off from life.”

Finally, Lawrence refers to presence as a “capacity to connect,” and an inherent part of being human. He describes presence as something that touches into our “receptive capacities,” and suggests that presence is shaped like a “universal grammar.”

I think that presence touches into receptive capacities and potentials that we have, potentials that are related to our survival as a species. This capacity to connect is in the blood, part of being a social animal...The ability to be present and to touch into presence is shaped perhaps like Chomsky’s universal grammar. I think there’s a whole language in there that can be stimulated, only in particular ways. We don’t learn about language from music, we learn about language from language. We don’t learn about ourselves, our humanness unless it’s played to, and fed by, the experience of presence and connection.
Lawrence continues, making the link between presence in therapy and mindfulness, suggesting that,

Presence is there when we’re present, and it’s something that can be cultivated, and nurtured…For therapeutic work, presence is one of the most elemental levels that we can be working with, mindfully paying attention to our own presence and how it’s being received. Seeing how we’re getting in the way of it with our own assumptions, and our own countertransference. Presence comes in on one of the finer levels that we can know.

Lawrence argues that presence is related to our humanness, and a fundamental capacity to connect with one another. He suggests that “presence is there when we’re present,” and in the context of therapy this includes “mindfully paying attention” to our own assumptions, to our own countertransference, and to whatever might be “getting in the way.”

For each of these participants, ‘presence’ emerges as a defining feature of mindfulness in therapy, and seems connected in various ways to capacities for attention and self awareness. They suggest that presence in therapy includes being “open and connected to oneself,” and also refers to “turning into” oneself, to support a quality of presence that can be both heard and felt. They describe presence as a “delicate process,” one that includes “tracking,” and sensing “moment to moment experience.” Presence in therapy is associated with a clear, open, and receptive mind, and communicates a thoughtful, focused attention on the other. Finally, for these participants, presence describes a quality that is a human, and universal, receptive capacity for connection. For these participants, presence refers to a quality that relates in various ways to attention and self awareness, supports therapeutic process, and contributes a foundational characteristic to the experience of mindfulness in clinical work.
4.2.4 mindfulness as absence

A final theme related to the experience of mindfulness, emerging in four of the participant interviews, is ‘absence.’ In the following, these participants describe an aspect of the experience of mindfulness that refers, ironically, to what is missing rather than to what is present. David, for example, suggests that it’s “what isn’t there” that is most significant about his experience of mindfulness.

So, mindfulness is presence, but I think that what is most important about mindfulness is what isn’t there. When you’re mindful, what isn’t there…So there’s only the present moment. And mindfulness is the state of presence, but what isn’t there is, to me, what’s really important…It’s interesting, because if you look at the words used in Buddha Dharmma to describe the ‘root poisons,’ greed, aversion, and delusion, the positive alternatives are actually the absence of these things. They’re not something else. So you’re basically just letting go of self, and you’re not putting anything else in there…With mindfulness there’s less of ‘me,’ but in a way that helps there to be less of ‘them,’ less self-story for us both. The self-stories that are often so limiting, so self-critical and judging. There’s less self-story to limit their experience of what’s going on for them, and more availability to be really in touch with what’s alive, what’s really there.

David suggests that his mindfulness practice supports him in “letting go of self,” and the limiting “self-stories” that inhibit his “presence” in therapy. He also suggests that in his work with clients, the “absence of these thing” helps there to be “less self-story for us both,” and consequently more opportunity to be “in touch with what’s alive.”

In this short excerpt, Pauline echoes some of David’s description of mindfulness as an absence of self, of “letting the who, drop,” and describes mindfulness as a practice that removes “obstacles to being.”

I think that [mindfulness] is more a realization, fundamentally, of the nature of what we are. And I say “what” because it’s not “who.” The who is an emergent process. And I think that the work of mindfulness is about giving way to being, to removing the obstacles to being. It’s about letting the “who” drop.
Like David, Pauline sees mindfulness as a practice that helps to remove the obstacles that interfere with an experience of “being,” an experience characterized by the absence of a limiting self identity. In this Pauline emphasizes that such a practice supports a connection with the “nature of what we are.”

In a similar way, Laura speaks of mindfulness as the “essential humanness,” that lies beneath the agitation that she brings to much of her life. For Laura, mindfulness is a practice of “shedding,” intent on emptying, cutting out and paring away whatever obstructs her “connection with life.”

I think mindfulness is what we find when we get rid of all that other stuff. I think of it as sort of essential humanness. I think of it as what’s left after you get rid of all of the wrangle…I think of the wrangle as the fighting, a kind of agitation, a kind of stressing. I grew up on a farm, and one of the most vital experiences as a kid was chasing cattle. You’re riding like a maniac on a horse over rough terrain. And then when you succeed, you have to wrestle with a cow or a calf or whatever…And so the wrangle that I’m trying to get rid of is that. That kind of anxiousness, wrestling and struggle, worry and fretting…the fight! My mindfulness practice is about emptying of that wrangle, and connecting with life. So, trying to cut out, pare away everything else, and just be in the stream of life. That’s the goal of the practice. It’s a process of shedding.

Here Laura suggests that the goal of her mindfulness practice is to experience the absence of “wrangle,” an absence of anxious wrestling and struggle, in order to be present “in the stream of life.”

Finally, Lawrence refers to mindfulness as a practice that deemphasizes conceptualization in order to know more directly what lies beneath our “representation of experience.” He suggests that the experience of mindfulness includes a focus on,

Just what’s there: The terrain without the map. We let go of the map, and of map making, the conceptualizing…Just the terrain. The terrain instead of the map, because the map is only a depiction of something, a representation of experience. Just as behind language is experience itself, it’s created, driven from experience.
Lawrence suggests that we let go of the preoccupation with the surface representation of things. For Lawrence, the experience of mindfulness is characterized by the absence of a “map,” of map making, and of the conceptualizing that separates us from the “experience itself.”

In each of these four descriptions, participants identify absence as a characteristic of the experience of mindfulness. Though mindfulness seems strongly related to ‘presence,’ ironically “it’s what isn’t there” that may be most important. These participants refer to the self that limits the experience of both therapist and client, and the value of mindfulness in supporting access to what’s “really there,” in the absence of “self-stories.” They suggest that by letting the “who drop,” and experiencing the absence of an egocentric ‘self,’ a connection with our “essential humanness” is made possible. Finally, the experience of mindfulness engages a consciousness of “the terrain without the map,” a direct encounter with experience made possible by an absence of conceptualized representation. For each of these participants, the experience of mindfulness in clinical work is described, in part, by an “absence” that, ironically, facilitates the capacity for “presence” in therapy.

4.2.5 summary

Participant interviews included an exploration of the experience of mindfulness in the context of clinical work. Within this exploration, four interrelated themes emerge, each describing an aspect of mindfulness. These four themes: attention and the present moment; mindfulness and the body; mindfulness as presence; and mindfulness as absence, appear as key elements shared by all, or some, of the participant group.
Six of the participants shared material relevant to a theme of attention and the present moment. This material includes reference to mindfulness as a “form of consciousness” that maintains a focused, self-aware attention, supporting an intimate, present moment connection to one’s current, inner experience. A second theme, mindfulness and the body, refers to specific forms of self experience related to physical sensation. Here, the experience of mindfulness is described as the “truth that we experience with our senses,” a curiosity directed toward sensation and the details of our physically sensed, immediate experience. Attention to the present moment and mindfulness of the body together create the conditions that support therapist presence. Emerging as a third theme, mindfulness as presence is described in terms of openness and connection to oneself, and an “immersion in the moment.” Finally, mindfulness as absence suggests that mindfulness is characterized by “what isn’t there,” the self-stories and other features of personal identity that can inhibit therapist presence. Here, mindfulness is described in terms of the “terrain without the map,” an encounter with “just what’s there,” free of abstraction or conceptualization.

4.3 The Experience of Empathy: Reception, Connection, and Attunement

Study participants were invited to consider ‘empathy,’ and to explore this as a component of therapeutic process. What emerges from this exploration is a blend of experience and understanding, thick descriptions that characterize empathy in the context of therapeutic work. These descriptions can be represented in terms of five themes: receptivity and acceptance; connection and a common field; presence, attunement and healing effects; a shared humanity, and self awareness and the absence of empathy.
The first theme highlights the role of reception of the other, and of the other’s experience, and reveals an intimate relationship between a capacity for reception and a capacity for non-judgment, or acceptance. In the second theme, the idea of intersubjectivity is introduced, referring to an empathic experience of connection that seems to transcend the simple, verbal exchange between client and therapist, and create the possibility of a more deeply meaningful, transformative form of engagement. The third theme is an extension of the second, emphasizing the role of attunement in a healing, therapeutic process, and the fourth provides a view of empathy as an experience grounded in, and made possible by, the shared nature of the human experience.

4.3.1 receptivity and acceptance

Seven of the study participants provided statements that refer to empathy in terms that imply a capacity for an unobstructed ‘reception’ of the other. This capacity is described by the participants in various ways, using terms that include: acceptance, openness, non-judgment, non-reactivity, spaciousness, patience and welcome. Within these descriptions, receptivity and acceptance are revealed as central, characterizing features of the experience of empathy.

Annette refers to the “spaciousness” of an empathic relationship, and the receptivity that creates “open space” for the client to experience whatever it is that might be coming forward for them, without imposition or resistance.

It’s about being receptive. If I can hold that open, receptive place, then I’m not imposing. It’s allowing what’s coming. When there’s a closing down, there’s a blocking, there’s a resistance of some kind in me, to what’s being said or to what’s happening.
Annette continues, describing how her mindfulness practice has deepened her ability to “sit with” her own emotional experience. She suggests that this has, in turn, deepened her ability to “stay” with the emotional experience of the other, expanding her capacity for receptivity.

One of the things that has shifted for me through mindfulness, as I’ve become more consistent in my own practice, is that my ability to sit with my own emotions has deepened, and so my ability to sit with somebody else’s has also deepened… I think that being able to “stay” comes from not being triggered so much. I can be more present with that person’s experience, and really be present in an open-hearted way. *Receptive* is the word I would use. I’m not putting up barriers, not pushing away, but really creating an open space where someone can experience whatever it is that they’re experiencing.

Annette describes receptivity and acceptance in terms of the absence of barrier, an ability to be present in an “open-hearted way.” Karen, in the following, adds to this description suggesting that it’s particularly non-judgment that promotes a capacity for receptivity and acceptance, a capacity for “taking in” the “full catastrophe.”

It’s listening to people, and using mindfulness to be able to be present in a non-judgmental way, even when, and especially when, they’re being really judgmental themselves…Taking it all in, *accepting* it all, you know, the full catastrophe. It’s all of it - the good, the bad, the ugly, the irrelevant, the silly, and the holding of it in a way that really cares about the person.

As an illustration of this, Karen provides the following account of her work with a particular client, whose parents are Holocaust survivors:

We have very different life experiences, she and I, but even more than this, there will be parts of her that will be less accessible to me, and I’ll need to really, really pay attention, because of the obstructions to empathy…There’s a way in which this is an experience that we all try to move away from, including probably her parents. So all of that would have been part of the empathy. I think that it’s kind of *taking it all in*, including the parts that are going to be a challenge, that gives you empathy…It has that awareness, in the moment, without judgment. And the non-judgmental part, I think is the really radical part of it, in the same way that with radical acceptance, it’s the radical part of making it accepted.
Jocelyn, like Annette, emphasizes the importance of being able to “sit with suffering.” She refers to the “openness” associated with a therapist who “knows pain,” and can “be there” with the client.

It gets back to the suffering, which is how I came into all of this, learning to sit with suffering. And it’s why so many people leave themselves, it’s because of that suffering. So to be able to sit with the suffering, that’s the value of mindfulness…It’s the openness. You know to the client, it is so important that they know that the person sitting across from them can be with their pain, not judge it, and not run away from it…So again, if you’ve got a therapist with you that knows pain, that knows pain from the experience of their own pain, then they can go into that very tricky territory. And they can very gently, very carefully, tiptoe into a little bit of that pain. Being there, with the client, noticing.

In a way that is quite similar to Annette, Jocelyn’s description of the experience of empathy draws attention to the receptivity and acceptance that she can extend to the client, through her capacity to “be with their pain,” without judgment.

Suzanne links her experience of receptivity and acceptance with an increased capacity to “really hear someone” without the interference that “gets in the way.” She suggests that it allows her to “take in” the other’s experience without judgment or interpretation, and provide the client with an experience of “feeling accepted.”

Mindfulness practice allows me to develop, more and more, the capacity to notice, to be with, and to describe experience without interpretation. Having the muscle that develops through a lot of mindfulness practice, builds the capacity to do that with myself, and so allows me to really hear someone else, without my own story, or my own interpretations interfering. Because I think that’s what gets in the way of being really empathic…There’s this ‘mindful muscle’ that gets developed through a lot of practice, and part of that means there is a developed capacity to be non-judgmental and accepting of my own experience, and the experience of others…Acceptance is everything you know? Acceptance is so much of what allows a client to feel heard and understood, and also allows them to access deeper levels of their experience.
For Suzanne, building “mindful muscle” makes it possible for her accept her own experience and in turn, accept the experience of others. She suggests that “acceptance is everything,” an important feature of empathy, allowing the client to feel heard without judgment and “access deeper levels of their experience.”

The receptivity and acceptance of empathy are also reflected in the following excerpt in which Laura refers to her capacity to accept the “bigness” of another person’s life, through knowing the bigness of her own.

One of the things that comes to mind is how [mindfulness] allows me to be alert to otherwise ridiculous ideas, right? That’s what I think. Mindfulness has allowed me to kind of accept that there’s a lot of room, for a lot of stuff in there, and you know, don’t discount it just because it’s impossible!...It’s an imagination freer too, right? Just because I could have never have imagined that, that does not mean that they can’t live there. That’s really important - the bigness of it. The bigness of another person’s life. And you can’t really tolerate that if you don’t have some sense of the bigness of your own.

For Laura, empathy includes an acceptance of the other’s experience, even when this experience exceeds the limitations of her own imagination. She notes that what may seem impossible to her can in fact be an important part of the other’s reality.

Pauline speaks of the “ability to be open” that facilitates empathy, and suggests that her practice of mindfulness reduces her “reactivity” to client material. Like both Annette and Suzanne, this reduced reactivity enhances Pauline’s capacity to receive, accept, and “be with” the emotional experiences of the other.

I’d call it a form of skill, bringing that quality of receptiveness, bringing that quality of acceptance…It’s an ability to be open, and present, and not reactive, which is essential if you are going to receive the ‘imprint’ of the other. [Mindfulness practice] builds my capacity to be with my own emotions, and hence to be with those of another…It reduces my reactivity in the session, and it increases my ability to sit with whatever comes up in that silence.
Pauline’s understanding of empathy and its relation to receptivity and acceptance is brought to life in the following description of a challenging client interaction.

I was working with somebody who had fairly extensive scarring, and asked me if I wouldn’t look at it. It was obvious that there was a lot of disgust for her. I could receive that she was feeling disgusted, and I could experience that, but at the same time I knew that what I needed to offer was simply my presence, compassionate, silent, presence. And my ability to embody that, without disgust, although she was feeling disgusted…I knew that it was very important, that moment of genuine, authentic, presence and receptivity. There was a certain strength of groundedness and determination that I was not going to be affected by her self rejection. I was not going to side with that - though there was also a pull towards that. I could sense it, almost physically, a kind of “let’s cut it off” you know? Of wanting to really disown that part. But I was determined not to reject, but to be present, accepting, compassionate and gentle.

Pauline’s description of her work with this client features receptivity as a capacity to understand, “embody,” and experience subjectively, her client’s feelings of disgust, while remaining open and compassionate. She notes that it was “very important” to remain receptive and accepting despite her client’s determination to “disown that part.”

Finally, Lawrence refers to the “patience” of empathy, and a capacity to accept the painful material presented by clients, not “turn away,” but welcome the other’s experience.

Patience is coming to mind. I think that I really believe more in what they can do, what we can do together. [Mindfulness] I think helps me not turn away, into my own thoughts, into my own head. I think it helps me just to stay there, and to welcome, to stay, and preserve, and maybe even deepen that welcome, to show that it’s not exhausted. I think that’s incredibly important, but also so subtle.

Lawrence, speaking of the experience of empathy, refers to a capacity to “just to stay there,” to not turn away into thought but focus instead on preserving and deepening a sense of “welcome.” Though this form of receptivity and acceptance of the other is subtle, he suggests that it is also “incredibly important.”
In their exploration of the features that characterize the experience of empathy, seven of the study participants make reference to some form of receptivity and/or acceptance. Receptivity and acceptance are described using terms that include: openness, non-judgment, non-reactivity, spaciousness, patience and welcome, all variations on a multi-faceted theme that implies an ability to “be with” the experience of the other, without judgment or imposition.

Receptivity and acceptance create the “open space” in which the client can find support in experiencing fully, whatever they may have brought with them into the encounter. The ability to create such open space, it seems, is linked to an awareness and acceptance of one’s own pain, a capacity that is nurtured by the practice of mindfulness and meditation. Therapist receptivity and acceptance create a condition that allows the client to feel “heard and understood” and thereby “access deeper levels of their own experience.” Finally, receptivity and acceptance refer to the capacity to “take it all in,” to extend and preserve ‘welcome,’ even when the client’s experience is disturbing and difficult to know. For each of these participants the experience of empathy is characterized by a capacity for an unobstructed reception and acceptance of the other, and mindfulness as a practice that cultivates these qualities.

4.3.2 connection and a common field

In their descriptions related to the experience of empathy, four of the participants make reference to some form of shared, common field, or “intersubjective domain.” These descriptions seem to refer to an experience of empathic connection in therapy that is characterized by its particular qualities of depth, sense of connection, and “potency.”
Suzanne, for example, refers to Buber’s “deep meeting,” and the potential for something “numinous,” as the experience of connection with the client deepens in the course of therapy. She also suggests that rather than feeling exactly what the client feels, the therapist and client are “in the domain together.”

I think there is an intersubjective kind of domain. As the client and I deepen in our connection in the moment, and deepen into presence together, there’s an intersubjective domain that gets opened up...But I think we need to be careful as therapists not to say that we feel *exactly* what they’re feeling, but rather that we’re in the *domain* together...I think there’s a place, a kind of meeting place, you know, Buber called it “deep meeting.” There’s something numinous that happens in that kind of space, that’s beyond just you and I. And in that space, there’s a kind of access. Because of the deep connection, there’s more openness with the client, to share with more safety...However we want to understand it, it’s a connection that allows access to a place, and to information, that might not be accessible through just that back and forth talking, at a cognitive level.

Suzanne speaks of the limitations inherent in a therapeutic exchange that includes only “talking at a cognitive level.” She refers to a place or domain that transcends the apparent isolation of “just you and I,” a kind of meeting characterized by a deep sense of connection, openness, and safety, a shared domain that provides access to “information” that might not otherwise be available.

Like Suzanne, Pauline also refers to the “intersubjective field,” and those moments in therapy when the “boundary is effaced,” moments when the therapist and client are engaged in a “common field.”

There is an intersubjective field, I’d say, absolutely. I think that it’s very important. I think there’s a whole process there that happens. I think at first, the boundary needs to be clear, and the orientation of the therapist needs to be toward their own resources, everything that helps them to be oriented toward health. And then, at a moment in the session, the boundary can disappear, in those *peak* moments, where that boundary is effaced, and there’s a sense of timelessness. And there’s a sense of potency in that too. We’re both engaged. We’re both in that field. It’s a common field.
For Pauline, the intersubjective field seems to refer to a form of deep connection with the other. Though she suggests that initially the “boundary needs to be clear,” she adds that there is a potential in therapy for moments of shared experience that seem to transcend the boundary between self and other, a form of engagement characterized by an experience of “timelessness” and “potency.”

Pauline’s description of an intersubjective field is echoed by Annette as she speaks of her doubt concerning the necessity of words, and refers to the “shared experience” that comes of being “in the connection” of a therapeutic relationship.

Sometimes I find myself wondering just how necessary the words are, and if they’re necessary at all. If just that shared container, that shared experience, whatever that is, if just being in the relationship, and in the connection, if the change happens there…There’s a kind of dance that’s happening. And I think that over time, part of what we do involves building the fluidness of that dance. So as trust builds, the dance becomes more fluid, you know? Whatever it is that’s going on under the words…So I do question whether words are necessary. I wonder if from an energetic perspective, if in that energy field, whatever it is, the container that gets created in a therapeutic relationship - if I can stay open to that, can the shift happen? Whether there are words being used or not.

Here, Annette suggests that perhaps change happens in the “dance” that goes on “under the words,” a dance that becomes more fluid as trust in the relationship builds. She refers to the shared container in which “the shift” can happen, whether there are words being used or not.

Karen also describes the experience of empathic connection as something that is “really shared,” suggesting that it “fills up the room.” Like Pauline, Karen refers to her sense of deep connection with the client as something that exists “outside of time,” created by the connection between two people engaged in a “common purpose.”
It’s a flow, there’s no real sense of time. It’s outside of time. I don’t have good words to describe it actually…I’m going to let it be this heart to heart, gut to gut connection between two people who are here together with a common purpose, and who love that common purpose, and are willing to struggle with it. So it’s really shared – we fill up the room with it. I am hesitant to start putting a lot of language around it, because it feels so…it feels so biochemical, it feels spiritual, and it certainly feels like the kind of connection that most of us would not want a life without.

Karen’s description of felt connection with the other as “gut to gut,” and “biochemical,” suggests once again a link between empathy and the physical, embodied dimension of experience. Speaking of the common ground that she shares with her clients as “spiritual,” she also echoes Suzanne’s reference to the ‘numinous’ quality of “deep meeting.”

These four participants describe aspects of the experience of empathy that seem to suggest a shared or common field of experience, arising during moments of deeply sensed connection with the other. With reference to a profound sense of meeting, and of being “in the domain together,” they describe empathy as something potentially “numinous,” and associated with an “intersubjective field.” This form of engagement is felt to be, in some ways, free of the normal interpersonal boundaries that separate self and other. It facilitates the “dance” that can unfold, and the “change” that may happen as a consequence. For these participants, this connection and the sense of common, experiential domain feels “biochemical,” “spiritual,” and as Pauline suggests, “outside of time.” In each case, the sense of deep connection with the other is linked to an engagement with something experienced simultaneously and in common, a “shared field” that seems for these participants to be a vital source of information, and a quality of connection strongly associated with the experience of empathy in therapy.
4.3.3 presence, attunement and healing effects

Five of the study participants offer descriptions of the experience of empathy that include references to “presence” and “attunement,” and the relationship that these qualities bear to the healing potential of therapist empathy. These descriptions reflect not only an emphasis on the central role of an attuned, empathic presence, but also on the role of mindfulness in creating the conditions that facilitate positive therapeutic processes.

Pauline refers to “empathic attunement” as the means by which she and her client, work cooperatively toward “reintegrating,” or “processing” difficult material. Returning to the example of a client experiencing disgust, she outlines a process by which she assists the client first by “being affected.”

I think it’s in the experience of empathic attunement. So, in a given moment I may not be experiencing, let’s say, disgust. Initially this is something that is not part of my self experience. There is disgust, and I know something about how this feels, but this is not my disgust. But then, there is a moment when I have to try this on, because that’s part of the process – being affected. And when there’s no resistance to this thing in me, and I’m able to stay present, receptive and compassionate, then there can be some healing…Somehow she, and we could go to mirror neuron theory here, she would have that experience, starting to build on her own capacity to be in this new way toward herself…When we’re talking about empathic attunement, it’s a process that I experience in my own body, in my own self. And my work is to support the client in having it happen in them, that experience of reintegrating, of processing or digesting that material.

Pauline suggests that the experience of disgust that her client brings with her into therapy is initially understood by Pauline as something that she recognizes by its description but is not experiencing herself: “this is not my disgust.” At some point in the course of the interaction however, Pauline admits the necessity of ‘taking in’ the experience of the other, engaging the healing potential of being affected by it, while remaining “present, receptive, and compassionate.”
In a similar fashion, Annette suggests that sustaining an “open empathic space,” free of her own barriers and “limiting energy,” helps the client to “emerge in their own way and time.”

When I think of my intent in doing that, it’s to allow the person to emerge. I guess part of my belief is that if the space is there, then they will move naturally towards healing. So being in that open, empathic space, and being able to hold that, allows people to emerge in their own way and time. And that’s about not putting barriers up, not sending out that kind of limiting energy, but instead, offering a receptive presence that supports emerging, and healing. I really do believe that when the conditions are right, when those conditions are in place, then we naturally move towards healing.

Here again Annette refers to the value of “space” in supporting a process of “emerging and healing.” Like Pauline, she suggests that her own receptive presence creates the conditions that assist the client in moving “naturally towards healing.”

Suzanne also refers to a process of healing that is supported by her being open, allowing herself to “feel all the dimensions” of the experience of the other, “tuning in” to “weave down” and “move deeper.”

When I’m fully there, when I’m present, when I’m in a state with the other, when I’m open with myself, I think that can be very healing. It allows them to feel that someone is there...Just being fully with someone in the room, has a healing effect...It’s allowing ourselves to feel all the dimensions of what might be going on for that person. Because, when I can be fully present with you, then I am tuning in, and I’m tuning in cognitively, but also emotionally, to let your experience in. The client, I think, feels that opening, and feels the safety of someone being there with them. And that in turn allows me more access to what’s going on for them, to weave down, to move deeper.

Suzanne suggests that the process of healing involves her being attuned, “in a state with the other.” Echoing her previous comments regarding intersubjectivity and a “common field,” Suzanne links her capacity to be with the other, with the client’s experience of “safety,” and the potential for a “healing effect.”
Laura describes therapy as “a different kind of sitting and talking,” characterized by the presence that is expressed in her “interest,” and “openness.” She suggests that this provides an “expansiveness” that reduces the experience of isolation, and supports the client in having “a sense of being in the world.”

They are registering my desire to know them, my interest, my openness, my willingness. And I think they get that because my thinking is fairly calm. There’s not a lot of distraction. You know, when you’re starting to work with a client, they’re often uncomfortable with the stillness of it. And will comment on it. But even for clients who comment on the discomfort of it, it seems like it’s also important to them. It’s a different event, it’s a different kind of sitting and talking... I think it’s an expansiveness by and large. It gets them out of isolation in their own skin. And then they can experience not-aloneness in some ways. They can experience I think a sense of being in the world in a way that they often couldn’t have made contact with.

Laura speaks of the “willingness” that communicates to the client a desire to know them, a form of empathic presence that helps to erode the client’s experience of “isolation in their own skin,” and support a new sense of being in the world.

The “willingness” to know her client that Laura speaks of is echoed by Jocelyn as she refers to the value of being “with them.” Jocelyn suggests that the kind of presence and attunement that can be offered in a therapeutic relationship facilitates trust and challenges the client’s assumption that they must tolerate their distress alone.

That attunement can increase their ability to regulate themselves. But it’s through a relationship. It’s the presence of that attunement, the quality of that attunement... You might be silent, you may not be saying anything, but your eye contact, the quality of your presence, you’re staying where you are you know, you’re not moving around, or fidgeting in your chair, it tells the client that you’re not going anywhere. You’re here, you’re with them, and you’re solid... And they begin to feel like: “Maybe I don’t have to tolerate this all on my own. Maybe I can share some of what happened to me. Maybe there’s a solidity here that I can trust. Maybe the shame that I feel can start to rise.”
For Jocelyn, the healing potential of a therapeutic relationship lies in the “presence of that attunement,” and in the “quality of that attunement.” She refers to the empathic presence that can be sustained even in silence, communicated in a variety of ways that suggest that her presence is “solid” trustworthy, and dependable.

In each of these five excerpts, participants offer descriptions of presence and attunement, and the various ways that this attunement facilitates healing in therapy. They refer to attunement as a kind of engagement that allows them to be subjectively “affected” by their clients’ disclosures, and suggest that healing and reintegration is supported by a willingness to feel the affect while remaining “present” and “receptive.” They speak of the “open, empathic space” that supports the client in a natural movement toward healing, and suggest that this allows “all the dimensions” of the client’s experience to emerge. For each of these participants, presence and attunement bring them into intimate, personal contact with the client’s suffering, reducing their sense of “aloneness,” enhancing their experience of safety, and creating the shared, “open space” that facilitates the reintegration central to positive therapeutic process.

4.3.4 a shared humanity

A fourth theme in this exploration of the experience of empathy identifies it as being rooted in a what is common, simply by virtue of being human. Four of the study participants made reference to the “common ground” of human experience, and the natural compassion that arises from an appreciation of what we share. In the following excerpts, these participants describe the experience of empathy in terms of a shared humanity that underlies their encounter with clients, and facilitates therapeutic work.
Pauline makes reference to an earlier comment regarding the “imprint” aspect of empathic experience, and suggests here that such imprinting is made possible by what is “common,” by virtue of being human.

First, there is the notion of imprinting. And the second thing is that I cannot conceptualize this suffering as something coming only from the client, because it is the common human experience…I think it is a kind of global consciousness, the healing process as a global process. I think when I, or anybody, is cultivating that gentle awareness, we are cultivating awareness of something that is anchored in our DNA, because everybody has in some way experienced trauma. It’s in the lineage, part of our human existence…So I wonder sometimes about empathy as just the opportunity to become fully human.

Pauline describes healing as a “global process,” related to the universal nature of traumatic experience. She suggests that the potential for empathic connection with others lies in our capacity to cultivate an awareness of something “anchored in our DNA,” and in our shared potential to “become fully human.”

Karen echoes Pauline in her view of empathy as being related to the condition of “being human,” and therefore “not alone in one’s experience.” She suggests that empathy has a reciprocal nature, and fosters “acceptance,” in both the person being empathized with, and also in the person empathizing.

I think that empathy is about being human. I mean about the value of not being alone in one’s experience. And so, if we are able to pay attention to what someone else is experiencing, it connects us in a way that is both valuable to the person that you’re empathizing with, but also for the person that is doing the empathizing. It makes for a very soulful connection…With some people, my caring for them can pave the way for me caring for myself, about whatever comes up in my work with them. So that also makes me more accepting of, you know, here we are, we’re both in this room, just two people, two of the same human race, having the struggles that people have…You and the other are not really separate. That’s just some kind of wild idea that we have.
In Karen’s exploration of empathy, she refers to the acceptance that characterizes her relationship with clients, an acceptance that acknowledges a shared human experience. She suggests that she and her client are just two people, “having the struggles that people have,” and discovering that as part of the same human race we are “not really separate.”

For David too, empathy is an experience fundamentally related to an “absence of separation,” and a recognition of “this common space.”

I think it’s obviously the ground for compassion, where compassion arises. And I think it’s a place, or an experience, where there’s an absence of separation…I find that really, empathy is a kind of coming in touch with, and recognizing that this is not a solo endeavour. There is this experience of being incarnate, in a sense body, with relational beings. And in those times when there’s empathy, it’s really being in tune with that. In those times there’s no separation. It’s this common experience, this common space.

David proposes that in our empathic connection with others, we recognize that “this is not a solo endeavour,” and that our awareness of a common experience creates the ground for compassion, a place in which there is “no separation.”

Finally, Lawrence suggests that the experience of empathy is “one person experiencing another,” with an appreciation for the “shared nature of the human condition.”

It’s an experience of feeling felt, as I experience what another person is experiencing, in conversation or in the room. It’s human experience, one person experiencing another, pre-verbally, without words, without the construction, the other experience being experienced. It’s what we do. It’s what we’ve been doing as social animals always…I understand empathy as caring for another person, and the shared nature of the human condition…Its based in one’s own compassionate relationship with oneself. Understanding what it’s like to feel, and to hurt, and to be plagued by all the different adaptive and maladaptive things that a person goes through.
Lawrence argues that the experience of empathy is “pre-verbal,” and “without construction,” a human experience based in a universal capacity to know “what it’s like to feel, and to hurt.”

These four participants offer descriptions of the experience of empathy that make reference to a shared humanity. They suggest that as part of the same human race, we are not alone or ultimately isolated from one another, and that this “absence of separation” is the ground of compassion. The experience of empathy is characterized as being “pre-verbal,” rooted in the shared nature of the human condition, and offers the opportunity to “become fully human.” For each of these participants, the experience of empathy is intimately related to, and made possible by, what is universal and shared in our experience of simply being human.

4.3.5 self awareness and the absence of empathy

Several of the participants drew attention to the potential for the absence or loss of empathy in therapy, and the self awareness that is essential for reestablishing an empathic connection with the other. Annette, for example, speaks of losing that “open space” of empathy, and the mindful self awareness that allows her to “reconnect.”

There certainly are times when I’m mindful of having lost that open space, and it’s mindfulness that allows me to reconnect with that spaciousness. Retuning to the breath, and being present in the body, allows me, if I’ve lost that empathic connection, it allows me to reconnect...The longer I practice mindfulness, deepening the relationship with myself, deepening the relationship with my own inner experience, the deeper, more full connection I can have with the other...I realize that when I’m present, I’m not really aware of it. But if there’s a tightening in my chest, then that catches my attention. I found a few times this week that I caught myself, I caught that tightening, and I thought: “Breathe, bring back that spaciousness.” Its that coming back, noticing and coming back. I think that for me, that’s what being in an empathic place with someone is about.
Through her mindfulness practice, “deepening the relationship” with her “inner experience,” Annette cultivates a self awareness that allows her to notice the “tightening” in her chest that she associates with the loss of empathic connection. This self awareness also creates the conditions of attention, particularly attention to felt, body-centred experience, that facilitates reconnection with the other. David too, refers to “tightening,” and the self awareness that allows him to recognize the “absence of empathy.”

One of the things that becomes apparent for example, is that when you calm the body, you become more aware of when it’s not calm, when it tightens. So it’s an interesting alternative, recognizing the absence of empathy rather than the presence of it. I would say that moments of empathy, moments of real, deep connection, stand out in contrast to those moments when that connection is not happening. You know we become more aware of being present, and in the moment, and so more aware of what happens when we’re not.

David suggests that his self awareness makes more apparent those moments when a deep empathic connection is absent. Like Annette, this awareness is body-centred, cultivated through attention to self experience, noticing when his body is “not calm,” and recognizing this as evidence of “when that connection is not happening.”

Karen also draws attention to the importance of self awareness in noticing the absence of empathy. In the following excerpt she describes her encounter with a client, and the resistance that Karen felt to knowing “what it was like,” a resistance that would have kept her from “really knowing” her client.

That would have kept me from really knowing her. And I could feel that, the obstruction that she had put in place, and I had hammered down, to my really empathizing with her. Because of course she didn’t really want to feel that either – how much that hurt. Who would want to feel that?...And what I learned from that was that the absence of empathy felt really bad to me. I learned that I was going to have to pay close attention to that, because she wouldn’t be able to. It’s not like she was going to be able to say to me, “Karen, you missed that.”
Karen notes that she “could feel that,” the obstruction to empathy that her client put in place and that Karen herself, initially, accepted. Becoming aware of the absence of empathy as something that “felt really bad,” Karen came to understand more fully, the nature of her own resistance, the value of self awareness in the relationship with her client, and the necessity of paying “close attention.”

Jocelyn, in the following excerpt, refers to the “mindful connection” that is “essential” for a meaningful, therapeutic relationship. She describes aspects of the self awareness that such a connection requires, and suggests that this awareness is “based on honesty with yourself.”

If you cannot connect with yourself, and with what’s going on inside, then it’s very hard to be connected with others in a meaningful way. The quality of the connection is different. It’s a completely different kind of connection. It could be a grasping connection. And I’m talking about a mindful connection, which is essential for a therapeutic relationship...And noticing, for example, when you’re confused. If I’m not mindful of myself, I’m not going to notice that I’m confused...It’s really based on honesty with yourself, and therefore with the client. We can’t betray ourselves as therapists.

For Jocelyn, the quality of the relationship with the other is based on “honesty,” a kind of self awareness that supports connection with oneself and with the truth about “what’s going on inside.”

For each of these four participants, the experience of empathy in therapy is not assured, nor can it be maintained without honesty, effort and attention. Self awareness, cultivated within a mindfulness practice that deepens the relationship with one’s own “inner experience,” seems to enhance the ability to be aware of the absence or loss of empathy, and also to recreate the conditions of self attention in the present, that help to reestablish an empathic connection with the other.
4.3.6 summary

Within this broad exploration, study participants provide descriptions that characterize for them, the essential features of the experience of empathy in therapy. These features can be represented in terms of five, closely related themes: receptivity and acceptance; connection and a common field; presence, attunement and healing effects; a shared humanity; and, self awareness and the absence of empathy.

Within the first theme, participants describe the experience of empathy with terms that imply a capacity for an unobstructed ‘reception’ of the other. Acceptance, openness, non-judgment, non-reactivity, spaciousness, patience and welcome, are all terms used by these participants to describe an aspect of empathy that promotes the experience of safety, and invites the client into “deeper levels of their experience.”

Four of the study participants also provide descriptions of the experience of empathy that include the suggestion of a common experiential field, or “intersubjective domain.” These descriptions make reference to the “dance” that goes on beneath the words, an intersubjective experience of “deep meeting” in which the boundary between self and other seems to be temporarily effaced. This sense of connection and common experiential field is characterized as “timeless,” and “numinous,” and creates an opportunity for access to detailed, nuanced information about the client’s inner life.

Extending the concept of a shared experiential field, several participants offer descriptions of the effects of empathy, as these relate to conceptions of “healing” in psychotherapy. For each of these participants, empathy includes the experience of empathic attunement that connects them intimately, and to some extent subjectively, with
a client’s distress. They suggest that this attunement includes the experience of “being affected,” allowing in “all the dimensions” of the experience of the other. This in turn supports therapeutic process by enhancing the experience of safety, promoting trust in the relationship, and supporting a “natural movement toward healing.”

The fourth theme refers to a shared humanity, and the “shared nature of the human condition.” Four of the study participants provide descriptions that characterize empathy as arising from a sense of “common ground,” an underlying quality of connection that helps to reduce the client’s sense of isolation by providing the ground from which to feel less “alone in one’s experience.” Our shared humanity is identified as the source of our compassion, and related to the potential “to become fully human.”

The fifth and final theme in this exploration of the experience of empathy draws attention to the potential for empathy to be absent or lost, and the self awareness that is necessary for the reestablishment of an empathic connection with the other. Self awareness includes awareness of the body, of the experience of “tightening,” and the self honesty, effort and attention that facilitate an intimate, present moment knowledge of the therapists own “inner experience.”

4.4 Embodied Experience: Sense, Resonance, and Feeling

The semi-structured interviews conducted in this study provided the framework for conversations that focused primarily on the participant’s experience of empathy, and the various ways in which mindfulness informs that experience. Woven into the fabric of these conversations are multiple examples of explicit reference to empathy as an experience that implicates the body, and includes a sensory, often quite physical,
phenomenological aspect, identified here within the primary category of embodied experience. Within this category, two secondary themes emerge, characterizing particular features of therapist embodied experience: a sense experience; and, resonance, feeling, and the body. In the first of these, empathy is described as an experience of the senses, a form of encounter that involves more than a merely thoughtful or imagined picture of the other’s experience, but also includes elements of nuanced, sensory, and felt experience. In the second theme, the dimension of sensory experience is extended to include more explicit references to the body, and to shared, body-centred phenomena.

4.4.1 a sense experience

All eight study participants produced statements that refer to empathy as a ‘sense’ experience. These statements not only, frequently employ the word ‘sense,’ but also provide descriptions of experience that suggest something different from, and in addition to, cognitive, imagined constructions of the experience of the other. In the following excerpt, David suggests that “you can’t think empathy,” but rather that empathy refers to something that is “below thought.”

I guess I would say that it’s a sense - a sense of the experience of the other person. And I say sense because I think that it’s below thought. So it’s not thought. It’s more like the capacity to sense, and be attuned to, and connected with the experience of another…So I think it’s that sense of non-separation. It’s the connection. I think its sense, that’s the word that always comes to me. It’s sense. You can’t think empathy, you have to sense it.

David’s description characterizes empathy as primarily a sense experience related to attunement and connection. In this he notes that it is an experience of the other that brings to the encounter a quality of “non-separation.”
Annette echoes David in her description of empathy as the ability to use all of our senses to “touch in,” and to “go where they’re going.” She draws attention to what she thinks of as an “energy piece,” and even questions the necessity of words.

I think for me that’s what empathy is about. It’s about being able to be present with, and not just in a cognitive way, but to be able to touch in, and to go where they’re going. Not put barriers up. And in developing a mindfulness practice, this ability has deepened…We use language about creating a container, and for me there’s a cognitive piece to that, but there’s also an energy piece…I do wonder how necessary the words are. I mean I know that’s what we do, but we also see, people and that’s another part of it. And I would say we receive: we see, we hear, we feel. All of our senses are present.

Annette suggests that the experience of empathy goes beyond merely being present with another “in a cognitive way.” For her there is something energetic in the quality of her connection with clients, something that relies on her capacity for reception. She emphasizes that empathy requires that “we see, we hear, we feel,” and that all of our senses are engaged.

Suzanne describes empathy as a “felt sense,” something that goes beyond simply imagining the experience of the other in an attempt to know “what it might be like.”

It’s a level of not just trying to, you know, project into what it might be like for you. Because even if I went through the same experience, what it was like for you might be different from what it was like for me…So, it’s that other part too that we’re referring to. Which is that it’s not just imagining what it might be like, but also having a felt experience…Its not just a cognitive understanding, it’s a felt sense.

Suzanne suggests that a cognitive understanding, our ability to imagine the experience of the other, is limited by our subjectivity and the inevitable difference in our experience of things. She insists that an empathic relationship requires not just a cognitive understanding, but also a felt sense of the other.
Karen, like Suzanne, suggests that empathy includes a “sense” of the other’s experience, and that imagination alone cannot provide an empathic understanding of the other. She describes listening carefully to gather the information that she can, but then emphasizes that imagination is “not the whole picture,” and does not provide the “whole sense of one’s experience.”

I will listen carefully, and use reflective listening to make sure that I have it, you know, as close as I can. But at the same time I know very well that I am not you. Imagination is part of it, you imagine what it would be like, and you try to put yourself in that place. But that’s not the whole picture. Because imagination, at least the way we think of it in lay terms, does not incorporate the whole *sense* of one’s experience. And we try in fact to incorporate as much of the wholeness of our experience as we can…I will sometimes close my eyes when I listen, because I want to make sure that I really am hearing for just a moment, leaving out one sense, so that I can check in with the others.

Karen’s description of the experience of empathy is made vivid by the following example of an encounter with a particular client. In this excerpt Karen refers to a “gestalt” experience, a sense of coming to understand the experience of the other in a way that cannot be explained by imagination alone.

I recently had someone come to see me for the first time, and they were telling me their story. And it suddenly popped into my head, the thought: “Oh my god, your parents are Holocaust survivors.” And I just let that go. And a few minutes later she said: “And my parents are Holocaust survivors.”…I was seeing her face, her expression, her body as she talked. Noticing how she sat, what it was like as she walked into the room, as she took her seat, how she looked at me. [Clues] were, I’m sure, just flooding in and were getting incorporated in ways that I might look back at and say, maybe it was that. But it was more the *gestalt* of it, the whole experience of sitting in the room with the person. I know it’s not just imagination, but I find it difficult to describe…I could feel that with her, for a moment, in that nanosecond, *sense* what that would be like. It was when I really got it, when I got what that would be like…(gasp!) your parents *never* felt safe…And when I had that, when I had that thought, it wasn’t just a thought. It was awhhhhh…I mean it really touched something deeper.
In the following, Jocelyn also cites an example of an experience with a client. She describes developing an acute sense of the other, not primarily through an act of imagination, but rather through an ability to “feel for him.” She does this by referring to her own experience, but also by sensing his denied feelings as they act “through” her.

I immediately think of one particular client - he really springs to mind. When he talks about his childhood, I feel for him as a child, and what he went through. And I can feel my eyes start to well up, and I can feel my heart open, and I can feel such compassion for him. And what is so interesting is that he doesn’t feel anything for himself. It’s almost like it’s going through me, because he’s so totally cut off from that part of himself...And it’s not like I’m being stuck with my own pain, you know, the pain of my own little girl. It’s not about that. It transcends that...But it’s using that, using it as a base from which to sense that, to really feel for his child.

Her sense of connection with this client seems to touch something in Jocelyn deeply, as her “eyes well up” and she feels her compassion for him rising. While this compassion may have a foundation in her own memories of childhood, her affective experience of empathy “transcends that,” goes beyond what is simply familiar, providing her with an embodied sense of “what he went through” even in the absence of his own feeling experience.

Laura refers to empathy as a practice of introspection, an action or a process in which she tries to “sense the experience” of the other by internalizing their words, and then attempting to understand how she herself has been affected.

I prefer the term empathic introspection, because for me it’s an action. Or maybe it’s easier for me to talk about it as an action. So I take it up as a practice, of trying to sense the experience of the other by understanding my own experience of them, while they are describing their experience. So when we’re together, and they’re talking, and I’m trying to see what they’re saying, I’m also trying to take what they say inside myself, and feel it, feel its resonances. That’s how I try to understand what they’re telling me, what they’re experiencing.
For Laura, the experience of empathy involves an active practice through which she takes the clients’ disclosures “inside” herself in order to “feel” them. Through this practice of introspection, her understanding of the client is facilitated by understanding her own sense experience.

Pauline describes empathy in terms of receiving a sense imprint, a “footprint on the heart,” and the ability to be “touched” by the suffering of another.

It’s in this whole idea of being imprinted, the capacity to be imprinted by the client’s different presentations of self experience…It’s as if someone makes a footprint on your heart - that’s their footprint…It’s the capacity of receiving that, of sensing the emotional, but also visceral experience…It’s the ability to be deeply touched by the suffering that can come up as a person uncovers, for example, what they think is unacceptable about themselves.

Pauline’s experience of empathy is anchored in her capacity to receive an “imprint” of the other, a sense experience that is both emotional and “visceral.”

Finally, Lawrence refers to empathy as a capacity for sensing “where people are” and an ability to “stay with them” in that place.

So,…I think I just feel where people are, and can stay with them in that place that I am feeling or sensing that they are, and not need to move out of it. Not need to move this thing along, because we need to have some kind of “success.”

All of these participants provide statements about the experience of empathy that include the word “sense” and refer to aspects of experience that go beyond cognitive or imagined constructions of the other. They suggest that “you can’t think empathy, you have to sense it.” They refer to an “energetic presence” that goes beyond being present “in a cognitive way,” a felt sense of the experience of the other that may come in a gestalt like moment. In such a moment they may be “touched” by “something deeper,” something that cannot be explained by imagination alone. The experience of empathy for
these participants “transcends” what is merely familiar, providing a more direct connection with the feeling experience of the other. In receiving the sense “imprint” that is both “emotional” and “visceral,” they describe a capacity to sense the other’s distress,” taking what they say “inside.” Each of these descriptions suggests a component in the experience of empathy that is grounded in a physical response, a sense experience that implicates the body and expresses itself in various forms of resonance.

4.4.2 resonance, feeling, and the body

A second theme that emerges for five of the eight participants in this exploration of empathy relates more specifically to empathy as a body-centred experience. Here participants expand their previous descriptions of empathically “sensing” the other, to include subjectively embodied experience that often relates in specific ways to the content of a client’s disclosures. Suzanne, for example, suggests that her felt sense of the other’s experience arises as a consequence of her capacity to access a “body resonance.” For Suzanne this resonance frequently offers her important, sometimes quite literal information about the client’s experience.

What they experience, we don’t know. We experience a percentage of it, or a resonance with it…When I’m at my best I can access my body resonance and check in with what I feel. I’m resonating with their experience and in order to do that my mind needs to be clear…But, as I mentioned before, it’s not just a cognitive understanding, it’s a felt sense, a felt experience. I sometimes will notice that I have chest pain you know, and the person will start talking about the pain in their chest!

Suzanne goes on to offer the following description of an encounter with a client that illustrates the extent to which her experience of resonance can inform her understanding of the other.
I was working with a client and I was really there with them, and they were speaking about what had been going on for them, and suddenly I had an image of a fire! And I had to check in with myself and ask, you know, what is this? But I took a risk and I told them that I saw a fire, that I was getting an image of a fire. And I said: “How does that fit for you?” They just started to cry, and then talked about their family, and how their house had burned down. It opened up a whole other body of feeling for them...When you are really connecting in a bodily way, you’re also accessing a level of emotional resonance with what’s going on. So that’s why empathy needs to go beyond the simple description, beyond what someone is saying. It needs to include what you feel in your body, and from their body. Do you feel the tightness? Do you feel the constriction?

Here Suzanne emphasizes the importance of “emotional resonance” in her work with clients. She argues that for therapy to be optimally effective, one must “go beyond the simple description,” and be able to feel the underlying qualities of physical, visceral experience, often present beneath the client’s words.

Jocelyn also makes reference to a form of resonance in the responses of her own body, that provides her with a kind of portal into the emotional experience of the other.

Returning again to her encounter with a particular client she suggests that,

As therapists, we use all that we are, our whole totality. We use our own history, and we use our own bodies, in the here and now...It’s feeling the loneliness, the pain, the hopelessness, it’s all of that, and feeling it in your own body...You know, you can try to feel for someone, just out of your head: “Oh that must have been very hard.” This is different, because you’re actually, momentarily, in it. You can feel what it must have been like, in your own body, for that little child, so alone, the isolation, feeling the emotion. Even though, ironically, he’s not feeling anything for himself.

For Jocelyn, understanding the depth and intensity of the other’s distress requires that she use the “totality” of her own body “in the here and now.” This kind of connection provides her with an intimate, revealing experience of the other by combining a description of suffering with the subjective sense of being “momentarily in it.”
Pauline describes body sensations as the “first point of entry,” and “tension” in her body as information that assists her in understanding the client. For Pauline, resonant, embodied experience is a focus that provides “guidance” in the “moment to moment therapeutic process.”

Fundamentally, for me, that’s my first point of entry. What I’m experiencing in the body. It’s the beginning. For something important it will be the first point of entry: the solar plexus, the chest, or throat. Sensory experience...Somehow for me it will come as a tension in my body. It will have a definition in my body. I will be able to locate it in my body. [The process is] very much intuitive, and guided by what’s going on in my own body. It’s guided by this, and it becomes very instrumental in the moment to moment therapeutic process. It will direct for example how much I am silent, how much I say, what I bring attention to, and what I invite the client to pay attention to.

Pauline’s work with clients is guided by the subjective experience of her own body, deepening her understanding of the other and influencing the direction and content of her work with clients.

Laura describes her experience of empathy in terms of “the tuner function,” a capacity to sense the “fidelity” in her received impressions. She refers to what seems “dissonant,” or lacking in “resonance,” in the introspective process that helps her to understand the client’s disclosures.

It’s both appreciation of the words, the tone, the gesture, the construction of someone’s presentation. But then it’s also the ‘tuner’ function, which is to see if the received impressions can achieve any kind of fidelity, any kind of coherence, and to check out the accuracy...If I can’t get it, I have to say so. And then we work at it to see if we can find out what is dissonant, or lacks resonance. Like the things that I can’t get are things that just don’t cohere in me. It doesn’t really make sense to me. I can’t make sense of it. So that’s why I like empathic introspection. It’s gathering their data, but it does also have to go through that introspective process.
Referring again to her conception of “empathic introspection,” Laura describes the process through which she checks for the presence or absence of “resonance,” and those things that “just don’t cohere in me.” She suggests that while it is important to gather the data, her impressions must also undergo “that introspective process.”

Finally, in the following excerpt Karen describes a therapeutic encounter in which her own embodied discomfort became evidence of an empathic connection with the client, and with the client’s experience.

There was this odd discomfort in her body, and with herself...Just so much itchiness there you know, a kind of uncomfortableness with what was going on inside her, that I couldn’t quite empathize with. I could feel that part of me that resisted, that didn’t want to empathize with that, and that’s the interesting part – the empathy!...Because obviously that’s empathy. I mean I was obviously taking that in or I wouldn’t have not wanted it, you know? I’m obviously feeling it, or I wouldn’t want to not feel it. And then of course, we’re both sitting there having a shared uncomfortable feeling!

In an interesting reversal of the informative potential of resonance and embodied experience, Karen describes the felt sense of her own resistance to the “discomfort” and “uncomfortableness” that was present in her client, and recognizes this resistance as evidence of her own empathic response. She notes that she was “obviously feeling it,” for how else could she have known that this was something she did not want to feel.

In these descriptions Suzanne, Jocelyn, Pauline, Laura and Karen, provide examples of experience that involve some form of physical “resonance,” and/or body-centred feeling. They suggest that their work with clients is more effective if they are “accessible on a body level,” and open to an “emotional resonance with” the client’s current experience. Jocelyn insists that as therapists, we must use “all that we are” including our own “bodies in the here and now,” and suggests that this affords an
intimate experience of the client’s distress by being “momentarily in it.” Pauline describes various forms of physical experience as the “first point of entry,” and her work with clients as being guided by “what’s going on” in her own body. These participants are aware not only of the client’s presentation, but also of the “fidelity” that checks for resonance in a process of empathically connecting with the other. In each of these examples, the participants’ experience of empathy is rooted in, and informed by, body-centred experience and various forms of embodied resonance.

4.4.3 summary

Extending their descriptions of the experience of empathy, several of the participants make reference to subjectively experienced, visceral, sensory phenomena, or embodied experience, that arises during periods of strongly felt, empathic connection with the other. These participants outline key features of this embodied experience through descriptions that can be organized within two, related themes: a sense experience, and, resonance, feeling, and the body.

All eight participants make reference to some form of ‘sense’ experience in their exploration of the embodied aspects of empathy. In this they describe what goes beyond, or is in addition to, cognitive based processes of speculation and imagination. These descriptions suggest that empathy includes experience that is “below thought,” and must be “sensed,” drawing attention to a “felt experience” of empathy that is both emotional and visceral. For these participants the embodied experience of empathy touches “something deeper,” engaging aspects of subjective experience that “transcend” and lend additional meaning to, a thoughtful, imaginative construction of the other’s experience.
Building on their exploration of embodied empathy as a sense experience, five of the participants make reference to ‘resonance’ as a description of the physical sensations that may be associated with the experience of empathic connection. These participants describe an “emotional resonance” that often provides important, sometimes quite literal information about the client, feeling in their own bodies aspects of the client’s emotional and physiological experience.

4.5 Results Summary

The results of this study have been organized within a framework of four experiential categories, each representing a different facet of participant experience related to therapist mindfulness, and the various effects of mindfulness on the therapist’s experience of empathy. These categories include: Participant Context; The Experience of Mindfulness; The Experience of Empathy; and Embodied Experience. The first of these provides a window into the personal history of participants, outlining the development of their relationship with meditation, mindfulness and psychology. The second explores various ways in which these participants experience mindfulness, particularly in the context of clinical work. The third category illuminates the characteristic features of the experience of empathy for these participants, and the fourth extends this theme with the inclusion of examples that make specific reference to body-centred, physically sensed phenomena, particularly those associated with instances of deeply felt empathic connection with the other. Each of these primary categories contains secondary themes that emerge across the participant group, providing ‘thick’ description and revealing more detailed aspects of experience that are common to all or some of the participants.
The first experiential category, Participant Context, is associated with those interview questions that prompted participants to consider their own history, and describe those events, circumstances and experiences that contributed significantly to the development of an interest in psychology, and in the practice of mindfulness and meditation. These explorations of personal biography produced information that contextualizes the participants’ later descriptions of experience, related to mindfulness and empathy in clinical practice. Within this primary category, five secondary themes emerge, identifying more detailed aspects of experience, common to all or some of the participant group. The five secondary themes contained within the representations of participant context include: personal suffering; working with suffering; experiences of recognition; training and study; and, current practice: an integrated approach.

Four of the participants provide accounts of personal suffering, associated for each with a different time of life. Childhood, adolescence, early adult, and adult life are all represented in this sampling of painful life experience. These four participants also describe a corresponding process of discovery in which they found ways of working productively with their suffering. In each case, this ‘working with suffering’ has involved an attentive awareness to the experiential detail of the present moment, and a willingness to sustain this awareness, as Annette suggests, neither “putting up barriers” nor “pushing away” whatever is current within the field of present moment experience.

Several of the participants provide examples of life experience that refer specifically to ‘recognition,’ a way of knowing that refers to a felt sense, a ‘gestalt’ experience, an intuitively sensed personal aspiration, or an aspiration held for another.
These experiences captured the individual’s attention in some way and invoked a sense of meaning that ultimately informed their development. In some cases the experience of recognition was specifically related to the discovery of mindfulness, and in others it was the birth place of an interest in psychology. Both of these fields of interest and inquiry were further developed through various activities of training and study. In their descriptions, the participants reveal a variety of permutations of formal academic training in counselling, psychology, and social work, combined ultimately in some way with less formal studies in mindfulness and meditation. Though each path is unique, in one important respect the eight study participants all end at a common point, with a current practice that integrates mindfulness as a feature of personal life, with mindfulness as a central and defining element of a professional, clinical practice in psychotherapy.

The second category, The Experience of Mindfulness, gathers together participant descriptions of the essential characteristics of the experience of mindfulness in the context of clinical work. These characteristics are further differentiated through the identification of four secondary themes: attention and the present moment; mindfulness and the body; mindfulness as presence; and mindfulness as absence.

In their descriptions of the experience of mindfulness, participants reveal an inseparable, interconnected relationship between attention and the present moment. They suggest that it is this attention that permits an acute awareness of the detail of one’s own inner experience as it arises, and fosters an experiential intimacy with the “domain of being.” This present-centred, reflective consciousness supports the capacity for a detailed awareness of both self and other.
Attention to the present moment creates more specifically, the mindful field of awareness that brings the detail of sensory, body-centred experience into focus. In describing the experience of mindfulness, these participants refer to a sustained, open curiosity regarding subjectively experienced, physical sensation. They suggest that mindfulness is about the “truth we experience with our senses,” and that this ‘truth’ creates the potential for an empathic connection to the other.

The experience of mindfulness is further characterized by the secondary theme of mindfulness as presence. Here the participants extend elements of the previous two subthemes linking attention in the present, with therapist presence. This capacity for presence seems to arise as a consequence of being “open and connected to oneself,” a condition that they suggest also communicates a thoughtful, focused attention on the other. For these participants, mindfulness as presence refers to a receptive capacity for connection that is both “human, and universal.” In contrast with this ‘presence,’ a final component of the experience of mindfulness refers to absence, and to what is “not there” when mindfulness is present. Participants refer to the ‘self’ that limits the experience of both therapist and client, and the ‘self stories’ that create obstacles to the experience of what is “essential humanness.” The experience of mindfulness engages a consciousness of “the terrain without the map,” a more direct encounter with experience that is possible only in the absence of conceptualized representation.

The third experiential category, The Experience of Empathy, gathers together statements that contribute to a ‘thick description’ of empathy as experienced by these participants in their work with clients. Five secondary themes, differentiating and
elaborating the experience of empathy, have been identified and include: receptivity and acceptance; connection and a common field; presence, attunement, and healing effects; a shared humanity; and self awareness and the absence of empathy.

In their exploration of the experience of empathy, seven of the study participants make reference to some form of receptivity using terms that include: openness, non-judgment, non-reactivity, spaciousness, patience and welcome. These participants suggest that receptivity and acceptance create an empathic “open space,” a capacity to “take it all in” that provides a welcoming reception of the other’s distress. This patient, non-judgmental reception in turn supports the client in an unencumbered self exploration.

The experience of empathy is also characterized for these participants by moments of deeply sensed connection with the other, moments that seem to reveal a shared or common field of experience. Making reference to “deep meeting” and an “intersubjective field,” they describe an intimate form of engagement that is felt to be unconstrained by the normal, interpersonal boundaries that separate self and other. This form of connection is described as a “dance” in which there may be an exchange that feels “biochemical” and/or “numinous.”

Five of the participants offer descriptions of presence and attunement that relate these experiential qualities to the potential for ‘healing’ in therapy. This potential is linked it seems with an ability to be “affected” by the client’s distress, while remaining present and receptive. A “natural movement toward healing” is facilitated, they suggest, by an experience of attunement that brings them into intimate, subjective contact with the client’s suffering, reducing in turn the client’s experience of isolation and “aloneness.”
This potential for reducing the client’s sense of isolation, through an intersubjective experience of deep meeting, presence and attunement, is perhaps made possible by an underlying truth about the nature of the human experience. Four of the study participants offer descriptions of the experience of empathy that make reference to a shared humanity, and suggest that we are “not alone” or ultimately isolated from one another. For these participants, the experience of empathy is linked to something “pre-verbal” and rooted in the shared nature of the human condition.

Though there may be a universal potential based on this shared condition, to experience receptivity and acceptance, deep connection and attunement, these dimensions of the experience of empathy are not sustained consistently without effort and attention. Four of the participants suggest that mindfulness practice supports an awareness of one’s “inner experience,” and the subjective, experiential cues that signal the loss of empathic connection with the other. Ironically it is this self attention in the present moment that also facilitates the ‘repair,’ and supports the reestablishment of connection.

The fourth and final experiential category emerging in this study of therapist experience is, Embodied Experience. Identified as a dimension of empathy, embodied experience refers to those aspects of empathic experience that make reference to the felt sense of body-centred, physically experienced phenomena. Within this theme, two secondary themes provide additional detail and refinement in the descriptions of the experience of these participants. These two secondary themes are: a sense experience; and resonance, feeling and the body.
All of the study participants provide descriptions of the experience of empathy as something that goes beyond a merely thoughtful orimaginative construction of the other’s experience. They suggest that “you can’t think empathy, you have to sense it.” The ‘sensing’ of empathy is likened to an awareness of the energetic presence of the other, or felt sense of the experience of the other. As a felt sense, empathic connection makes possible the experience of being “deeply touched” by the client, an experience that “transcends” what is merely familiar or imagined. Referring to the “imprint” of material that is both emotional and visceral, these participants describe taking what the client presents “inside” themselves to “feel its resonances.”

As the final theme in this exploration, resonance, feeling and the body, includes descriptions of explicitly body-centred dimensions of empathic experience. Jocelyn insists that as therapists, we must “use all that we are” including our own “bodies in the here and now” if we are to achieve an adequate understanding of the client’s distress. This possibility of intimate connection, of being “momentarily in” the experience with the other, affords a direct, first hand, experiential sense of the other’s world in which the visceral becomes a “first point of entry,” engaging various forms of sensory resonance and subjective feeling in a process of empathically connecting with other.
Chapter 5: Discussion

The primary intention of this study was to explore the lived experience of psychotherapists with a personal practice of mindfulness meditation, in an effort to expand our understanding of therapist mindfulness and therapist empathy as interconnected elements in the dynamic of the client/therapist dyad. As stated in the introduction, the research question was intentionally broad and open ended in order to preserve the qualitative potential for new insight to arise directly from the data collected. The results chapter presents this data within a structure of four experiential categories, each representing a facet of therapist experience. Taken together, these four categories and their respective secondary themes provide an overview of the experience of these participants, their development as psychotherapists, and the place that mindfulness holds in their work and in their experience of empathy.

The following discussion extends the preliminary analysis offered within the presentation of the results themselves by first identifying receptivity as an underlying and unifying intention that runs through all four categories of experience (see Figure 5A). In addition, three core themes are identified as related components that reflect the cultivation, presence and function of receptivity in therapeutic work (see Figure 5B). These three core themes: mindfulness as the cultivation and practice of receptivity; receptivity as the essential feature of empathic responding; and empathic receptivity as an embodied experience, serve to highlight the central role of receptivity in psychotherapeutic process, and combine in such a way as to suggest receptivity itself as a critical form of therapeutic intervention.
**Figure 5A.** Receptivity as an underlying intention. An illustration showing the relationship of the four categories of experience described in the results chapter. Here receptivity is identified as a master theme that runs through all four categories of experience, connecting them with a common and underlying intention.
Figure 5B. Receptivity as intervention: Three core themes. An illustration showing the relationship of the three core themes that emerge from the data. These themes are theorized to combine in such a way as to create the conditions for a therapist’s embodied, experiential engagement within an affective/intersubjective field.
In this discussion, the three core themes are considered in the context of relevant literature, comparing and contrasting each in turn with representations found in the academic discourse related to mindfulness, empathy, and embodied experience. By identifying common ground as well as differences, this analysis serves to highlight the essential features of each theme. Building on this analysis, and consistent with the final stage of the methodological process, an attempt is also made to “go beyond the data” by proposing a theoretical model of client/therapist interaction. This model combines the implicit aspects of the data with current neurological theory and the Buddhist teaching on shenpa, to illuminate the potential role of receptivity and therapist engagement with affective material, in a mindfulness-informed psychotherapeutic process.

**Theme 1: Mindfulness as the Cultivation and Practice of Receptivity**

The Oxford English Dictionary (1971) defines receptivity as “a readiness to receive or take in” (p. 237), and this definition is consistent with descriptions of mindfulness found in the data and presented in the results chapter. Here the study participants describe in detail the experience of mindfulness in terms that suggest a capacity for receptivity and “a readiness to receive.” Speaking of a practice that supports an intimate connection with one’s current inner experience, including sensory experience, they portray mindfulness as a potential of consciousness critically related to the open reception of, and immersion in, the experiential present. From these descriptions mindfulness can be understood as a state of receptivity but also as a practice that serves to cultivate a capacity for such an immersion, a practice that cultivates an unobstructed and attentive openness to the full spectrum of experiential possibility.
The literature associated with the construct of mindfulness is extensive and includes contributions from Buddhist teachers and contemplative scholars, as well as from contemporary clinicians and researchers within the fields of psychology and psychotherapy (Williams & Kabat-Zinn, 2011). There are however, both within and between these bodies of literature, differences in terms of what is included, i.e., what is subsumed under mindfulness as a classification of experience or practice, and also what is privileged or thought to be essential within such a practice.

Regarded as the first Western writer on Buddhism to explore the practice of mindfulness at length, Nyanaponika Thera (1986) introduced the term ‘bare attention’ to describe the essential nature of sati, a Pali word found within Buddhist liturgy and commonly translated as mindfulness. In describing the transformative potential of mindfulness Nyanaponika suggests that although often linked with other more conceptualized aspects of Buddhist teaching, including reflections regarding the right purpose or suitability of an action, the power of mindfulness lies primarily in its “basic, unalloyed form” as bare attention. In this presentation, bare attention is understood to be “the clear and single-minded awareness” of what happens "to us and in us” as we move experientially through successive moments of conscious perception. Here, the word ‘bare’ is used to denote the absence of reactive “deed, speech, or mental comment,” and to draw attention instead to the potential for a “purely receptive state of mind.” According to Nyanaponika, mindfulness as bare attention supports the cultivation of this receptive state by slowing down habituated and reactive patterns, deferring action, minimizing interference, and suspending judgment (Nyanaponika, 1986, p. 3).
Though the cultivation of a receptive state, free of interference or judgment is understood by Nyanaponika as a description of the essential nature of mindfulness, other Buddhist scholars have contested this, emphasizing instead the inseparability of various components that must be combined if one is to understand the true nature of mindfulness, as it is represented in traditional Buddhist teaching. Making reference to the Pali Canon, Bodhi (2011) for example, argues that mindfulness includes both sati and sampajanna, lucid awareness and clear comprehension. In this interpretation mindfulness begins with a “lucid awareness of the phenomenal field” but requires the additional component of clear comprehension to lend meaning to what has arisen by situating it within “the teaching as an organic whole” (p. 22). According to Bodhi, the mindfulness practitioner not only observes with bare attention, but also interprets the presentational field by deliberately placing it within a particular, conceptualized context. Olendzki (2011) similarly describes a “layered approach” in his interpretation of the construct, one which renders mindfulness as more than “mere attention.” He argues that mindfulness is an advanced state of constructed experience in which attention has become “confident, benevolent, balanced and fundamentally wholesome” (p. 64). Gethin (2011) also suggests that a rigorous translation of traditional texts portrays mindfulness as something “rather more sustained and developed than mere bare attention or present moment non-judgmental observation” (p. 273). He argues that from a Buddhist perspective, bare attention does not of itself constitute the presence of mindfulness, but rather “sets up the conditions that will conduce to its arising” (p. 274).
Though these scholars have contested Nyanaponika’s narrow focus on bare attention, and the essential nature of mindfulness as a purely receptive state, it appears nevertheless to be this aspect of mindfulness that has been most consistently recognized and adopted by contemporary Western practitioners. In the last decade a great deal of literature has been produced related to mindfulness, its nature, practice and application, and within the psychological discourse many descriptive constructs have been proposed. These include: “receptive attention to and awareness of ongoing events and experience” (Brown & Ryan, 2004, p. 245); the self regulation of attention to immediate experience with an attitude of “curiosity, openness and acceptance” (Bishop et al., 2004, p. 9 ); an awareness of the present moment that is “open, accepting and discerning” (Shapiro, 2009, p. 556); and a more recent construct that includes sensation, description, awareness, non-reactivity, and non-judgment (Fatter & Hayes, 2013). Though there are very few qualitative studies that specifically investigate the experience of therapists with a personal practice of mindfulness, those that do include similar descriptions. Cigolla and Brown (2011) for example, in a study that explores the lived experience of six therapists with a substantial history of mindfulness practice, summarize mindfulness as “a way of being,” characterized by an awareness of the present moment with an “open and accepting attitude towards everything that arises in consciousness” (p. 709).

Despite variations in detail and emphasis, the descriptions above appear to be variations on a theme, each describing an open attentiveness to current experience, and each referring, either explicitly or implicitly, to the receptive qualities of bare attention, and ‘a readiness to receive.’
In short, mindfulness as the cultivation and practice of receptivity, the first of three core themes emerging from the data of this study, is a construct that appears to be largely consistent with those found within the literature related to mindfulness. Though some scholars, making reference to the Pali Cannon, argue that a full appreciation of mindfulness, faithful to the original teaching, requires a more complex, multi-layered and contextualized understanding, others have proposed that even within this teaching, the essential value of mindfulness lies in the cultivation of bare attention and a “purely receptive state of mind” (Nyanaponika, 1986, p. 3). This emphasis on receptivity as a fundamental characteristic is also expressed, either explicitly or implicitly, in more contemporary Western formulations of mindfulness, including those that emerge in recent qualitative studies investigating the experience of therapists who have a personal practice of mindfulness.

Though mindfulness as the cultivation and practice of receptivity has obvious implications regarding a therapist’s capacity for self experience, it has important implications as well regarding a therapist’s experience of the other. For the participants of the present study, receptivity, cultivated in part through mindfulness practice, is employed in their work with clients, informing their experience of empathy, and supporting their capacities for empathic responding.

**Theme 2: Receptivity as the Essential Feature of Empathic Responding**

In their descriptions of the experience of empathy, the study participants emphasize interpersonal openness, spaciousness, and welcome, capacities that demand the suspension of judgment and interpretation. They suggest that in this way, the client is
provided with an experience of unconditional and unobstructed reception. This receptivity creates the opportunity for “deep meeting,” and a sense of the common experiential ground that constitutes an intersubjective domain. By receptively taking in “all the dimensions” of the other’s experience, these participants engage an empathic process that subverts the client’s sense of isolation, and supports a natural, unfolding movement toward healing. Here, empathy, and the healing potential associated with empathic attunement, appears to begin with a willingness to be affected by the other, and continues through a sustained condition of open, empathic receptivity.

This emphasis on receptivity as the essential feature of empathic responding is consistent with some, but not all of the formulations of empathy, found within the extensive body of literature associated with this complex construct. Indeed, as many authors have concluded, there is complexity not only in current conceptualizations of empathy (Decety & Ickes, 2011; Gibbons, 2011; Rameson & Lieberman, 2009), but also in its developmental history (Barrett-Lennard, 1981; Duan & Hill, 1996; Wispe, 1987).

Tracing this history, Wispe (1987) describes a path that has become “overgrown with redefinitions, reinterpretations, and benign neglect” (p. 17). Although Lipps (1905) and Prandtl (1910) are generally credited with the early identification of the German word *einfühlung* for its potential to describe aspects of both aesthetic and interpersonal experience, it was Titchener (1909) who first coined the term *empathy*, and later developed the concept suggesting that empathic ideas are “the converse of perceptions; their core is imaginal, and their context is made up of sensations, the kinaesthetic and organic sensations that carry the empathic meaning” (1915, p. 198).
In the decades that have followed, the concept of empathy has been constructed and reconstructed in various ways, corresponding in part to the conceptual frames of different emerging and developing psychological ideologies (Carlozzi et al., 2002). Though there is now an abundance of research literature, much of this research begins with a proposition regarding the nature of empathy in terms of ideologically relevant components, and then seeks to measure the presence or absence of these components in experimental settings. Empathy has been described and measured as a personality trait (e.g., Davis, 1983), as a state (e.g., Batson, 1987), as a multi-component phenomenon (e.g., Elliott et al., 1982), and as a multi-staged process (e.g., Barrett-Lennard, 1981; Rogers, 1957). Measurements have been taken through self report, observer ratings, and using various physiological measures (Duan & Hill, 1996). Few studies however, specifically explore the subjective, experiential nature of therapist empathy. Instead, constructs of empathy tend to emanate from the work of theorists and practitioners, drawing not on qualitative research data, but on their own personal reflections. As Gladstein (1984), examining the roots of empathy research suggests, psychotherapy theorists have tended to construct empathy “from their own practical, clinical experience” (p. 49). This perhaps helps to account both for the diversity of view, and for the contemporary, common observation that there is little agreement regarding the definition of empathy (Batson, 2009; Bohart & Greenberg, 1997; Gibbons, 2011).

Within this complexity, one debate in particular is both prominent in the current literature, and relevant to the present study. Formulations of empathy appear to fall on a spectrum that represents the ground stretching between two alternative frames of
reference. At one end of this spectrum are those constructions of empathy that emphasize conscious, deliberate, intellectual understanding, referred to in the literature as cognitive empathy or perspective taking (e.g., Batson, Early & Salavarani, 1997; Galinsky & Moskowitz, 2000; Ruby & Decety, 2004; Slaby, 2014), and at the other end are those constructions that emphasize a preconscious, involuntary, affective experience of the other, referred to in the literature as affective empathy (e.g., Corcoran, 1981; de Waal, 2008; Feshbach, 1975; Hart, 1999). Though there are many who occupy a ‘middle ground,’ advocating for example a ‘dual processing model,’ combining aspects of both cognitive and affective functioning (e.g., Bozarth, 2011; Decety, 2011; Dekeyser, Elliott, & Leijssen, 2011; Keysers & Gazzola, 2007;), there are also those whose views clearly gravitate toward one end, or the other, of this spectrum.

Batson et al. (1997) for example, suggest that “adopting the perspective of another perceived to be in need” (p. 751) is the primary mechanism in the evocation of empathy. Though their research indicates that imagining how the other feels, produces different empathic effects from those produced by imagining how you would feel in the other’s place, the primary mechanism in each case is assumed to be perspective taking, an intellectual process that requires cognition, conscious intention, and imagination. Taking a similar view, Galinsky and Moskowitz (2000) propose that the “active consideration of imagining how a target is affected” (p. 708) produces empathic arousal, while Ruby and Decety (2004) add that empathy involves putting “ourselves in someone else’s place,” imagining how the person is affected while maintaining a “clear separation between self and other” (p. 988).
This emphasis on imagination and conscious perspective taking that also emphasizes the separation of self and other, contrasts sharply with the results of the present study, and with other descriptions found in the literature that suggest a more affective, experientially engaged view of empathy. Feshbach (1975) for example, argues that the empathic response “is a reflection of the relationship [and] is defined as a match between the affective response of a perceiver and that of a stimulus person” (p.26). This view is supported by de Waal (2008) who suggests that empathy is a mechanism that allows one to “quickly and automatically relate to the emotional states of others” (p. 282). Although cognitive processes may be involved, de Waal claims that these constitute a secondary development and emphasizes that effective social functioning requires that humans be capable of responding first without relying primarily on cognitive processes. He suggests that the “lowest common denominator” of empathic potential is that one party may be directly “affected by another’s emotional or arousal state” (de Waal, 2008, p. 282). Corcoran (1981) goes further in drawing out this difference, contrasting Rogers’ early description of empathy with a subsequent rendering by Truax and Carkhuff (1967). Whereas Rogers’ (1957) definition implies subjectively felt experience with the intention “to sense the client’s private world as if it were your own” (p. 99), Truax and Carkhuff characterize empathy more simply as the ability to perceive and communicate the affective aspects of the client’s disclosures. Corcoran (1981) points out the qualitative difference between these two views suggesting that in the latter, the definition of empathy has been reduced to an intellectual process in which “sensing the client’s experience has been replaced with perception and communication” (p. 31).
Situating the results of the present study within this debate, participant descriptions of empathic experience seem to affirm the views of Rogers (1957), Feshbach (1975), deWaal (2008), and Corcoran (1981). Participant disclosures regarding the experience of empathy fall clearly at, or near, the spectrum pole that corresponds to an understanding of empathy as, primarily, an experiential phenomenon rooted in a preconscious, affective response. Without denying the reality of secondary cognitive processes, these participants see empathy as belonging to a domain of engagement that is initiated, and made meaningful by, an affective experience of the other. Such openness implies a precondition of receptivity, ‘a readiness to receive’ that takes in the other and facilitates a level of engagement qualitatively different from what is possible through cognitive appraisal and intellectual understanding alone. Indeed, Kohn (1990) argues that: “There is a real danger that one’s cognitive and imaginative capacities will become so sophisticated that one has ceased sharing the experiences of real people” (p. 119).

Kohn’s reference to shared experience draws attention to a particular potential of affective empathy, central to these participants and the therapeutic processes in which they engage. In their descriptions of empathy they refer to “deep meeting,” and the intersubjective space that a therapist and client may enter together, recognized by the quality and depth of connection felt with the other, a “common field” of experience in which the boundary between therapist and client may be temporarily effaced. They suggest that it is within such an environment that possibilities of transformation are realized, not only through the progress of understanding that follows from an exchange of ideas, but also through a shared, intersubjective and experiential process.
The terms ‘intersubjective,’ and ‘intersubjectivity,’ have a long and complex history associated with the tradition of psychoanalytic psychology, closely linked to the related concepts of countertransference, enactment, and projective identification (Bohleber, 2013). In recent years, it seems, there has been a progressive movement, across ideologies, toward models of psychotherapeutic process that feature an intersubjective orientation. These models increasingly characterize psychotherapy as a process that involves a relationship between two subjects, rather than a relationship between a subject and an object, in order to emphasize intersubjectivity. Bohleber (2013) however observes that there is a diversity of view regarding the meaning and operation of intersubjectivity, reflected in part by the variety of terms, including ‘encounter,’ ‘moments of meeting,’ ‘the third,’ and the ‘bi-personal field,’ used to describe this apparently potent feature of the dyadic encounter. Hart (1999) for example, uses the term ‘deep empathy’ to refer to a “postconventional epistemic process” (p. 115), in which “knowing moves toward subject-object transcendence or a loosening of self-other boundaries” (p. 116). Hart suggests that this process can be understood as intersubjectivity, a state or condition in which client and therapist form a single psychological system. This is achieved not through a distant observing stance but through an alternative form of engagement in which the therapist “enters the play rather than remaining in the background” (p. 118), and in so doing becomes “a direct participant in the other’s world” (p. 119). Stern (2004) also speaks of the intersubjective encounter, and the significance of the present moment as the temporal context in which two subjects become part of one singular structure, sharing the same ‘mental landscape.’
In the present study, intersubjectivity is described by the participants in terms that seem largely consistent with the views of Bohleber (2013), Hart (1999), Stern (2004), and others, that draw attention to those aspects of experience that arise concurrently for therapist and client, within a shared experiential field. In addition, these descriptions point to the emergent, phenomenological nature of intersubjective experience in which conceptualization follows after experience, and after an experience of recognition. Bromberg (2006) suggests that when the analyst gives up her attempt to understand the client’s disclosures, and allows herself instead to know the client through her direct experience of the intersubjective field, an act of recognition, rather than intellectual understanding takes place, in which “words and thoughts come to symbolize experience instead of substitute for it” (p. 12). It is through this act of recognition that something ‘new’ can occur, emerging out of the shared, phenomenological field of experience. Bromberg seems to suggest that by setting aside any preconceived interpretive structure, and entering instead the unknown territory of what might be revealed through deep, receptive contact with the other, conceptualization follows after the fact of experience, rather than in advance of it, attempting to predict or alter it.

For the participants of this study, deep contact, and the potential of the bi-personal field, is realized it seems through the relational stance and capacity of the therapist. By cultivating in herself a condition of empathic receptivity, the therapist ‘opens a door’ to the other, inviting in the full potential of shared experience, of being affected by the other so as to participate fully with them. Empathic receptivity seems however to be associated not only with affect and cognition, but also with experiences that are explicitly sensory
and physical. Study participants emphasize that the experience of empathy lies in “sensing the emotional, but also visceral experience” of the other. It is in this respect that empathic receptivity can perhaps be understood as a complex, intersubjective potential that includes thought, feeling, and embodied experience, arising in moments of deeply felt connection with the other. “We see, we hear, we feel, all of our senses are present,” as we take what they say inside ourselves and “feel its resonances.”

**Theme 3: Empathic Receptivity as an Embodied Experience**

Sensing a ‘resonance’ with the other implicates the body as the physical medium through which the felt, sensory potential of shared experience is made manifest, apparent and knowable. Several of the study participants provide descriptions of experience that affirm the reality of embodiment, and the subjective, somatic dimension of therapeutic encounters. These descriptions include examples of client distress, brought to life in the body of the therapist apparently as a consequence of the therapist’s capacity to sustain an open, affectively receptive awareness of the other. For these participants, empathy “needs to include what you feel in your body, and from their body.”

The French phenomenological philosopher, Merleau-Ponty (1962), asserted that “it is through my body that I understand people” (p.186), and the role of the body in the practice of psychotherapy has been the subject of much investigation, particularly within the field of psychoanalytic psychology. Though the traditional focus of this literature is the body of the client, the ‘lived experience’ of the body of the therapist has become increasingly a subject of interest in its own right. Shaw (2004), for example, suggests that meaning in therapy is constructed from “the encounter between two bodies,” wherein
the body of the therapist becomes an “organ of information” related to the “intersubjective space between therapist and client” (p. 273). Similarly, Stone (2006) describes the analyst’s body as being like a “tuning fork” that “vibrates” with the client’s psychic material. Orbach (2004), however emphasizes that the body of the therapist is neither ‘natural’ nor ‘neutral’ but is, in each case, a body that has been ‘created’ by a particular therapeutic context. She argues that as a transference object, the body expresses the “relational complexities between the two people in the room” (p. 149).

Whether characterized as an ‘organ of information,’ a ‘tuning fork’ or a site for the expression of relational complexity, these writers, like the study participants, recognize the body of the therapist as both implicated in, and potentially valuable to, therapeutic process. What ‘comes alive’ in the therapist draws attention to the complex phenomenon of countertransference, and to what may be aroused in the analyst by the particular presentation of distress and personal characteristics of a given client. *Somatic* countertransference extends this conceptualization to include the physical domain, making the sensory world of the therapist a relevant and vital source of meaning within the dyadic encounter. Ross (2000), for example, observes that it is often the case that distress associated with early-life trauma can be “reawakened in the therapy room with the therapist and in an embodied therapist” (p. 465). Such somatic events can be seen however as “an expression of hope and evidence of an ability to affect and be affected by an other” (p. 465). For Ross, the therapeutic potential of these events lies in the receptivity of the therapist, noting that to be an embodied therapist “demands that the therapist be in a close, intimate, and interested relationship to their own body” (p. 466).
The material gathered in this study raises questions regarding the mechanisms that may underlie an embodied experience of empathy. Reflecting on her experience of therapeutic encounter, one of the participants refers to mirror neuron theory and its relevance to “a process that I experience in my own body.” In the last two decades, work undertaken in the field of affective neuroscience has contributed to a theory that proposes a shared neural mechanism as the source of an experientially vital, pre-reflective ‘link’ between self and other. Described by a number of contributors to the field as the Mirror Neuron System (MNS), this link has been proposed as the “neurological substrate” that underlies the experience of empathy (Corradini & Antonietti, 2013; Ginot, 2009; Iacoboni, 2008, 2009). These researchers, and others, suggest that the MNS may be responsible for an “unmediated resonance” (Goldman & Sripada, 2005) and an “embodied simulation” (Gallese et al., 2005) that enables an experiential understanding of the other. MNS theory presumes that embodied simulation functions as a prereflexive mechanism operating involuntarily and out of awareness, an “effortless, automatic and unconscious inner mirroring,” (Iacoboni, 2008, p. 120) that generates a ‘first-hand,’ felt sense of the other’s world. Ginot (2009) argues that neuropsychological mechanisms lie beneath the nonverbal communication that flows between patients and analysts, and these mechanisms set the stage for a process of “reciprocal, nonconscious, emotional give and take” (p. 296). In a recent exploration of MNS theory and its relevance to our conceptualizations of empathy, Corradini and Antonietti (2013) conclude that a “vast array” of empirical data now appears to confirm that “mirror neurons are the neural basis of our empathic capacities” (p. 1152).
The accounts of empathic experience offered by the participants align well with this neurological, conceptual framework. The embodied aspects of an apparently common, intersubjective field often form the content of participant descriptions – descriptions that tend to emphasize a subjective, experiential engagement in a shared affective process. As one of the participants suggests, an empathic presence consists of more than an imaginative reconstruction of the other’s experience: “This is different, because you’re actually, momentarily, in it.” Being “in it,” with the client, creates perhaps the opportunity for a particular form of intervention characterized by mindfulness, receptivity, and the therapeutic potential of a shared affective process.

**Receptivity as intervention: Mindfulness and Shenpa in the Bipersonal Field**

Intersubjectivity, shared affective states, and experiences of empathic attunement, are associated for these participants with the healing potential of psychotherapy. By offering a receptive, empathic presence, and by engaging the capacity to be in a shared affective state with the other, participants of the present study support their clients in reintegrating, processing, and digesting psychic material. This reintegration is apparently facilitated by the participant’s practice of open, receptive awareness in which “there’s no resistance to this [material] in me, and I’m able to stay present, receptive and compassionate,” open to an encounter with all of the dimensions of affective and somatic experience that may arise. Opening without resistance to the full spectrum of self experience is the central intention of mindfulness, and has particular relevance to the Buddhist teaching on shenpa, and to shenpa work.
The teaching on shenpa is a centrepiece of Buddhist training and the self-focused process work that supports both the pursuit and maintenance of psychological health. Within the traditions of Buddhist teaching, shenpa is described as the energy that lies beneath reactivity, arising as the raw, preverbal experience that quickly generates thoughts and emotions (Chodron, 2010). More broadly it can be understood as the intense affective energy associated with any form of difficult emotional experience including fearfulness, anxiety, rage, bitterness, or grief, and any of the possible variations that contribute to the full spectrum of symptomatic psychoemotional experience (Kaza, 2005; Kongtrul, 2009; Singh, Lancioni, Winton, Karazsia, & Singh, 2013).

The teaching on shenpa suggests that when this distress energy is present, there is often an automated response that seeks immediate relief through some form of ‘escape.’ Grecco (2013) suggests that psychological distress often carries with it an intensity that is compelling and seems to ‘demand’ immediate resolution: “It’s as if we’re caught in the middle of a storm and we want to seek shelter as quickly as possible” (para. 13). Rather than ‘acting out’ the habituated pattern of thought and behaviour aimed at relief and an instant resolution, one can instead, according to this teaching, choose to engage the potential of mindfulness, resisting the temptation to act, change, or deny the experience in any way, and simply pause in the fullness of the distress energy as it presents in the body, allowing it to arise without resistance in an unconditionally open and compassionate space of present-centred awareness. In this way it may be possible to observe the visceral qualities of the experience with the same sense of curiosity and wonder that one might have towards a distant thunder storm. From a safe ‘distance,’ the event can shift from
being an intensely distressing experience that demands immediate action, “to a wondrous event we know will have a beginning, a middle, and an end” (Grecco, 2013, para. 14). The notion of ‘distance’ here is not meant to imply a condition of separation from, nor denial of, experience but is rather a way of describing a relationship of non-attachment to it. The dramatic, often turbulent energy of the affective ‘thunder storm’ can be witnessed but simultaneously deeply experienced. This possibility is poignantly reflected in the disclosure of one participant who recalls, “I just sat there, and I witnessed my tears, and I felt my grief, and I could feel it while I was in it, and I felt it also subside.”

This example models an approach to healing that is focused on the affective experience of grief itself, quite apart from any interpretation or narrative associated with it. Shenpa work seems to be characterized particularly by this focal attention on the underlying, affective energy that arises in the body. This energy can quickly ‘breed’ the construction of thought, narrative, blame, and abstraction that, if not observed and gently resisted, can become a distraction, a form of denial or escape from the raw discomfort of ‘sitting with suffering’ (Chodron 2010; Daya, 2005). Sitting with suffering, allowing the fullness of the body-centred, affective material to arise unconditionally, implies a form of non-action, an essentially receptive stance that permits this energy to be fully known, experienced, and felt through the temporal cycle of beginning, middle and end. Though the teaching on shenpa acknowledges that with deeply entrenched patterns of reactivity, resolution may require a return to the same material many times, noticing these patterns as they emerge, resisting the temptation to act (out) quickly, while remaining receptive in the face of discomfort, promotes a gradual shift of experience (Chodron, 2010).
Though within the traditional presentation of shenpa work, the focus is the individual and the healing work that can be done independently, the results of this study also suggest that shenpa work may represent an appropriate and useful model with which to describe a potential form of engagement between therapist and client within a mindfulness-informed, intersubjective psychotherapy. In this conceptualization, the capacities of the therapist, cultivated in part through a personal practice of meditation, are applied to the affective material shared intersubjectively with the client in the present moment. Shenpa work is undertaken by the therapist on this affective energy as it is encountered subjectively through an experience of ‘deep contact.’ In this way, the therapist effectively ‘acts upon’ shared material by allowing it to arise without judgment, action or interpretation, passively and compassionately experiencing it to the fullest possible extent, while retaining an independent framework of consciousness that supports the provision of a consistent intentionality. This passive intervention may alter the content of the intersubjective field by providing a site for material to be encountered, affectively processed and, in effect, returned to the bi-personal field.

In their description of a similar process of intersubjective exchange, Gallese et al., (2005) make reference to Ogden’s (1982) account of Projective Identification (PI), wherein ‘A’ (the patient), and ‘B’ (the analyst) interact reciprocally. In this conceptualization A first projects material ‘into’ B, thus creating an opportunity for a therapeutic intervention that takes the form of B’s “modulated and tempered reaction.” According to Ogden, this form of reciprocal interaction has therapeutic benefit because it effectively metabolizes or digests A’s projection, returning it to A in an altered, more
acceptable form. Gallese et al., go on to say however that to use the terms ‘metabolize’ or ‘digest’ suggests an ‘ordinary’ process, one that may simply reflect the various ways in which B “deals [differently] with affects and feelings that A finds unacceptable and unmanageable” (2005, p. 148).

This critique seems to reduce the intersubjective exchange proposed by Ogden (1982), to one of reciprocal modeling. Though a conceptualization of therapeutic process that references shenpa work includes modeling by the therapist of a practice of ‘sitting with suffering,’ it also suggests something beyond the simple demonstration of an alternate disposition with respect to the client’s independent affective state. The realization of an embodied, intersubjective field within the client/therapist dyad creates the opportunity for a dynamic exchange in which the boundary between self and other is partially effaced, and the intersubjective domain becomes an environment of affective interaction. The essential nature of this interaction is, it seems, experiential and not conceptual, abstract, or theorized. Unlike some other models of therapeutic process, healing in this case is conceived to be a naturally unfolding, phenomenological process in which there is a limited requirement for an interpretive framework, and there is no predetermined or clearly defined therapeutic agenda. Most particularly there is no agenda for immediate change, as the intention to change any aspect of experience, within a mindfulness perspective, is understood to be a gesture of control and/or denial. What has arisen in the body and consciousness of the therapist is simply allowed to be, in its fullness, without judgment, without condition, and without an active intervention, through repeated, temporal cycles of beginning, middle, and end.
As the client is able to engage with the bi-personal field and sense through their own growing capacity for embodied experience, the spacious, and receptive environment in which shared affective material is consistently held by the other, there may be a gradual softening of defense, an increased capacity to encounter the present as a shared experience, and a corresponding gradual shift in the experience of affective distress.

This model of intersubjective, affective exchange is directly supported by the data and the descriptions provided by the participants. What follows is a kind of poetic bricolage of statements taken from the results, combined to create a thick description of the study findings that lend support to the proposed model:

*I think that mindfulness is...the unidentified main ingredient of real therapeutic work...a non-judgmental open space that supports self awareness...it allows us to stop, to explore, to feel into things and to experience them more fully...being present with whatever experience is arising in this moment...it’s about the truth, and it’s about the truth that we experience with our senses...my body is open to become whatever they are experiencing...it means that I am in tune with them...it’s about being receptive...really creating an open space...taking it all in, accepting the full catastrophe...to receive the imprint of the other...and to sit with whatever comes up in that silence...there is an intersubjective kind of domain...as the client and I deepen in our connection in the moment, and deepen into presence together...a kind of meeting place, that’s just beyond you and I...there’s something numinous that happens in that kind of space...in those peak moments where the boundary is effaced...we’re both in that field...it’s a common field...sometimes I find myself wondering just how necessary the words are.*
The content of psychotherapy clearly includes more than a wordless exchange in a prerereflective and intersubjective process. In this model however, therapeutic dialogue may be conceived as being situated within, and emerging from, the shared, interactive, and unfolding affective field. Ideally this dialogue serves to reinforce the intentional stance of mindfulness by continually reflecting “the truth that we experience with our senses” in an embodied awareness of the present moment. In this way the explicit dialogical exchange reflects the implicit affective/experiential exchange, and the intentions of an open, compassionate and unfettered reception of the present moment. Though the bricolage presented above clearly suggests the receptivity of mindfulness, the embodiment of empathy, and the possibility and potentiality of an intersubjective domain, a more explicit description of therapeutic process is provided by Pauline in her account of working with “disgust”:

Initially this is something that is not part of my self experience. There is disgust, and I know something about how this feels, but this is not my disgust. But then, there is a moment when I have to try this on, because that’s part of the process – being affected. And when there’s no resistance to this thing in me, and I’m able to stay present, receptive and compassionate, then there can be some healing…Somehow she, and we could go to mirror neuron theory here, she would have that experience, starting to build on her own capacity to be in this new way toward herself…When we’re talking about empathic attunement, it’s a process that I experience in my own body, in my own self…that experience of reintegrating, of processing or digesting that material.

Here Pauline articulates a subjective process of ‘digestion’ in which she acts upon something that has come initially from the client. Her receptivity includes the capacity to be “affected,” to fully embody the experience of something that is simultaneously being experienced by the client, and to remain “present, receptive, and compassionate.”
The three core themes, and their relationship to each other, are represented earlier in this discussion (see Figure 5B) as components that interact in linear relationships, suggesting a progressive system of cause and effect. Although, for example, mindfulness as the cultivation and practice of receptivity may well enhance the capacity for empathic responding, and the empathic response may well arise initially as an embodied experience, these themes can perhaps be better understood as co-emergent, mutually informing phenomena, rather than events that unfold in a linear, temporally sequential process. Mindfulness, empathy, and embodied experience, are perhaps better described as primary facets of a single, complex event, arising within the temporal context of the present moment. Figure 5C offers a final representation of this conception wherein the three core themes arise concurrently as dimensions of experience within a receptive field. This figure illustrates the relationship between receptivity, mindfulness, empathic responding, embodied experience, and the emergent opportunity for shenpa work.
Figure 5C. The interaction of the three core themes. An illustration showing the overlapping, temporally integrated, and mutually informing nature of the three core experiential themes. Here mindfulness, empathic responding, and embodied experience (including effects of mirror neuron activity), all aspects of receptivity, combine to create the opportunity for shenpa work as a form of shared engagement in the bipersonal field.
In sum, the preliminary analysis offered within the presentation of the results is extended in this discussion by first identifying receptivity as an underlying and unifying intention running through all four categories of experience found within the results data. Further to this, receptivity is seen to emerge as a component in each of three core themes: mindfulness as the cultivation and practice of receptivity; receptivity as the essential feature of empathic responding; and empathic receptivity as an embodied experience.

These core themes serve to emphasize the primary role of receptivity in psychotherapeutic process, and combine in such a way as to suggest receptivity itself as a critical form of therapeutic intervention. With reference to the OED (1971), and the definition of receptivity as “a readiness to receive or take in” (p. 237), each of the core themes is considered in turn in light of the literature related to mindfulness, to empathy, and to embodied experience.

Mindfulness, both as a component of traditional Buddhist teaching, and as a feature of contemporary psychotherapy, refers primarily to the development and maintenance of a receptive state of mind, cultivated in part through a meditative practice aimed at slowing reactive patterns, deferring action, and suspending judgment (Nyanaponika, 1986). Mindfulness as the cultivation and practice of receptivity emphasizes the development of capacities related to an open reception to the full spectrum of self experience, and therefore to one’s empathic experience of the other.

The extensive literature related to empathy includes a debate regarding the extent to which empathy is primarily a cognitive process requiring conscious imagination and perspective taking, or an essentially prereflective, affective process that provides first
hand, subjectively felt experience related to the client’s experiential context. The study data clearly aligns with the latter view providing examples of affectively engaged, sensory responsiveness to clients. This openness to the affective experience of the other implies a precondition of receptivity, ‘a readiness to receive’ that seems to facilitate a capacity for intersubjective experience, an alternative epistemic process in which knowing moves toward subject-object transcendence and a softening of the boundary between self and other.

By cultivating a condition of empathic receptivity, study participants invite the potential of being affected by the other, thereby able to participate with them experientially. This participation is associated not only with affect and cognition, but also with forms of experience that are explicitly sensory and physical. The physicality of affective empathy implicates the body as an ‘organ of information’ in the experience of intersubjectivity between client and therapist. The therapeutic potential of such experience requires that the therapist maintain a “close, intimate and interested relationship to their own body” (Ross, 2000, p. 466).

The physical nature of affective empathy also draws attention to the field of affective neuroscience and the substantial body of research supporting the view that mirror neurons form the neural basis of our empathic capacities and make possible an embodied simulation of the other’s affective experience. The study data aligns well with this neurological framework providing descriptions that suggest a subjective, experiential engagement in a shared affective process.
Finally, in an attempt to address the last stage of the methodology described in Chapter 3, and ‘go beyond the data,’ therapist receptivity is proposed as the basis for a psychotherapeutic intervention that makes reference to the Buddhist teaching on shenpa. This teaching is characterized by a focal attention on the affective energy that arises in the body, associated with various forms of psychological distress. Shenpa work emphasizes a receptive attentiveness to self experience, free of narrative, judgment, or interpretation. In this study, shenpa work is conceived to be appropriate as a model of engagement between therapist and client, wherein shenpa work is undertaken by the therapist on the affective material encountered intersubjectively through the experience of ‘deep contact.’ This essentially passive intervention is proposed to alter the content of the intersubjective space by providing a site for material to be encountered, affectively processed, and returned to a mutually accessible, shared experiential field.

This study set out to explore the complex fields of mindfulness and empathy, seeking to better understanding therapist mindfulness and therapist empathy as interconnected elements that affect the dynamics of the client/therapist dyad. As the concluding stage of analysis, this discussion forms a response to the initial research question, a question that was intentionally broad and open ended to preserve the potential for new insight to arise directly from the data. This insight takes the form of three core themes, each emphasizing the primary role of receptivity, and combining in such a way as to suggest receptivity itself as the essential feature of a passive, intersubjective, therapeutic intervention, in a mindfulness-informed, psychotherapeutic process.
Chapter 6: Conclusion

The present study, with its selective focus on the experience of mindfulness and empathy, unfolds within the particular research framework of a qualitative, phenomenological methodology. As previously discussed, this form of research is influenced in multiple ways by the subjectivity of the researcher, and also by the nature of the participant/researcher relationships that facilitate the interview/data collection process. Though subjectivity and relationship have been claimed in qualitative research as valuable, even essential, resources (Cole & Knowles, 2001; Gough & Madill, 2012; Lawrence-Lightfoot & Hoffman-Davis, 1997), it is important, nevertheless, to acknowledge that the results of this study represent one particular thematic organization of a particular data set, and one relevant, but not definitive conceptualization of therapist experience. The study, as undertaken, has strengths but also limitations, and these in turn suggest both implications for clinical practice, as well as possibilities for further research.

6.1 Strengths of the Research

The primary strengths of the present study include its unique perspective and choice of research methodology. As suggested in the introduction, though the integration of mindfulness and psychotherapy has received much research attention in recent years, and there is an abundance of literature related to empathy as a component of therapeutic process, very little research has attempted to capture the essence of the psychotherapist’s experience within these domains. The majority of research found in the current literature related to mindfulness and psychotherapy, for example, is quantitative in nature, and concerned primarily with defining constructs, establishing measurement tools, and
attempting to quantify the presence, absence, or effectiveness of mindfulness as a component of clinical work. In addition, this body of research is also heavily client-focused, presenting mindfulness as a technique to be delivered as a component of psychoeducation in support of the client’s self attention and acquisition of therapeutic skill (e.g., MBCT; Eisendrath et al., 2014; Kaviani, Javaheri, & Hatami, 2011).

In contrast to this, the present study is qualitative and phenomenological in nature, focused exclusively on therapist experience, and seeks to capture an in-depth, and richly detailed, understanding of the phenomena under investigation. In so doing it provides valuable insight into the experiential world of a therapist delivering a psychotherapy that is deeply informed by a practice of mindfulness. As a qualitative and phenomenological investigation, the study also represents a response to concerns raised by other scholars regarding the need for more research to complement the currently favoured methods of investigation. Mace (2007), for example calls for inquiry that studies the “range and modes of action of mindfulness” through “more detailed and inclusive attention to what happens within and between therapists and patients” during therapeutic sessions (p. 153).

The insight arising from this study offers a nuanced understanding of the experience of mindfulness in the service of therapy, tracing constituent elements of the unfolding experiential process, and offering valuable information regarding mechanisms that may underlie and affect the potential of therapist mindfulness to support therapeutic processes. This complements the work of other researchers currently investigating the mechanisms related to mindfulness as a component of therapy (e.g., Chiesa et al., 2014; Grabovac, Lau, & Willett, 2011; Vago & Silbersweig, 2012).
Several other factors support the strength and value of the study findings. Adding to the procedural strategies detailed in the methodology chapter, and used in the execution of the study to support trustworthiness, adequacy of the study sample was confirmed by the apparent ‘saturation’ reached regarding data collection (Morse, 1995). In addition, though, as previously stated, in a qualitative inquiry research is not pursued with the intention of producing findings that can be generalized, the transferability potential of the findings is well supported by the specificity of the inquiry, and the rich, and contextualized descriptions provided by the participants. Some limited generalizability is also supported by the diversity within the participant sample regarding age, sex, personal/biographical context, training, and study.

6.2 Limitations of the Research

This study, as a contextualized exploration of experience, is limited in a number ways, some specific to the researcher and participant group, and some generally associated with qualitative inquiry. Four limitations in particular are worth noting and these include: the restricted source, and volunteer, self selected nature of participant recruitment; the small size and limited diversity of the study sample; the limited nature of the interview process; and limitations in the participants’ and/or the researcher’s personal understanding of, and ability to adequately describe, a complex lived experience.

As outlined in the methodology, participants for this study were recruited primarily from the GTA, though exceptions to this geographic restriction were made, limited by the viability of face to face interviews, and the travel distance required to facilitate meeting. Personal and collegial networks, as well as professional organizations
related to the integration of mindfulness and psychotherapy, were considered as source populations for the identification of potential participants. In addition to the limitations of a restricted geographic territory and the source populations considered, this process was also limited by the self selected nature of volunteers responding to the invitation to participate in the study. Given the fact of their self selection, it can be assumed that all of the study participants were predisposed to: an interest in the study subject material; a favourable view regarding the integration of mindfulness in psychotherapy; and various aspects of theoretical bias and presupposition regarding the mechanisms and effects of their own practice of mindfulness. Although some of these represent explicit selection criteria for participation in the study, and support the production of relevant findings related to specific research questions, they also impose limitations in the study by restricting diversity of culture, practice context, and point of view.

Although, as stated previously, apparent saturation was achieved in the data collection process, suggesting that the size of the study sample was adequate to produced meaningful results, it can be argued that a larger study sample would have produced a broader and more diverse body of data. A larger sample would certainly have produced more ‘raw’ data from which to derive meaning units, categories and themes, and these might well have been different, supporting a different final representation. Given the qualitative intention to expand understanding through the analysis of rich description, a larger sample including a more intentionally diverse participant group representing, for example, visible minorities, different cultural contexts, and greater age diversity, might facilitate a deeper understanding of the phenomena under investigation.
The semi-structured interviews used in the data collection process also represent a study limitation. Though they were conducted with the intention of facilitating open-ended dialogue, they were constrained by the limited number and specific nature of the interview questions and, in each case, by the limitations of time. Although the interview questions provide a framework supporting focus in the dialogical process of meaning creation (Cassell, 2005; Denzin, 2001), they also, necessarily, limit the scope and content of the emergent dialogue. As with some of the selection criteria this represents both a strength, supporting relevance in the data set, but also a limitation, because of what is not asked, and consequently not considered, in the analysis that might have been of value. In addition, practical considerations including the restricted number and duration of interviews reflect a further constraint in terms of what can be explored, described, and made available to the research process. As a result there are likely gaps and omissions of information, representing content that might have been relevant. More time might have allowed for more variety and complexity in the descriptions, and consequently a greater depth of understanding of phenomena under investigation.

Finally, the dialogue that constitutes a given interview is limited by the depth and complexity of understanding possessed by the researcher, and by the participant, at the time of the interview. What emerges in the dialogue is determined, and limited by, what is accessible and understood, and by what can be expressed by each, in the context of the interview. Though this may well change and develop in the meaning construction process of the interview itself, it is nevertheless a process limited by the resources available to each party, and by what each is willing and able to bring to the encounter.
6.3 Practice Implications

This study is primarily an investigation of therapist experience regarding empathy, and in particular the role of mindfulness in that experience. The study findings suggest that for this participant group, receptivity is a key, unifying and underlying intention, running through all four identified categories of personal and clinical experience. Arising from the data, three core themes capture three principle ways in which this receptivity is manifest and expressed in therapeutic work. These three themes and their interrelationship, demonstrate how mindfulness, as the cultivation and practice of receptivity, directly supports empathic experience, a form of experience which by its very nature is embodied. As a dimension of this empathic, embodied experience, intersubjectivity creates the opportunity for a form of therapist intervention, grounded in receptivity and supported by personal capacities cultivated in the practice of meditation.

This study, as a qualitative and phenomenological inquiry, is exploratory in nature and integrative in its findings. It provides a vividly detailed description of the therapists’ experience of psychotherapeutic process, and combines this with a vision of how this process can be optimized by the presence and capacities of mindfulness. In so doing it provides a strong endorsement of mindfulness as a component of psychotherapy, and suggests at least four different implications for clinical practice.

First, the study supports and complements a growing body of theory and research that associates therapist mindfulness with positive therapeutic effects. These include effects related to the cultivation of therapeutic relationship (e.g., Bruce et al., 2010; Hick, 2008; Lambert & Simon, 2008), and more specifically to the cultivation of empathy
within these relationships (e.g. Aiken 2006; Morgan & Morgan, 2005; Shapiro & Izett, 2008; Walsh, 2008). The present study constitutes an additional voice contributing to theoretical inquiry and research that focuses on mindfulness as a dimension of therapist capacity, as opposed to mindfulness as a deliverable skill, provided psychoeducationally to the client. Given the focal imbalance in the research to date, more study supporting and investigating the impact of therapist mindfulness is indicated. As such research emerges, it may be discovered that, as this author believes, it is in the domain of therapist capacity and skill that mindfulness finds its most important therapeutic application.

As an extension of this proposition, the present study supports, generally, the development of mindfulness in therapists currently working in clinical practice. This development would include both the pursuit of training opportunities, and the integration of, and commitment to, sustained practices related to mindfulness based meditation. Many opportunities for training and study are now available, including the MBSR training programs offered in various community health facilities, and introductory courses offered within public education, and through various private institutions.

6.4 Future Research

This study supports a growing body of research indicating the potential value of mindfulness training as a component in the education and development of therapist trainees (e.g., Buser, Buser, Peterson, & Seraydarian, 2012; Christopher & Maris, 2010). More research expanding this trend is indicated. Such research could explore further the cultivation of specific skills related to, for example, mindfulness as therapeutic presence, effective listening, therapist affect tolerance, and countertransference management.
Finally, more research investigating the client’s experience of therapy, with therapists who practice mindfulness and meditation, would be desirable. This would complement the present study, and other qualitative inquiries related to therapist experience, by providing a more comprehensive picture of the operation and implications of therapist mindfulness and its effectiveness in supporting therapeutic process. As a form of outcome research, study designs could include either quantitative or mixed method approaches to provide variety of perspective, analysis, and representation.

6.5 Closing remarks

In closing, it is perhaps fitting to refer again to Germer (2005), and his observation that we may be witnessing the emergence of a more unified model of psychotherapy, one that sees mindfulness move from its early position as a novel adjunct to therapy, to a place at the very centre of therapeutic process. The writer and educator Parker Palmer, well known for his contributions to education theory, is credited with the expression: “We teach who we are.” In a similar way, as therapists, acting as instruments of service in contemporary psychotherapy, we practice who we are, and though what happens in therapy is never determined by the capacities of the therapist alone, it is clearly these capacities that warrant our best attention. It is hoped that the present study, exploring the nature of therapist mindfulness, empathy, and embodied experience, contributes to the emergence of Germer’s ‘more unified model,’ one that embraces therapist mindfulness as a primary and dynamic process, facilitating the intersubjective possibilities of deep meeting, and the healing potential of the client/therapist dyad.
References


Appendix A

Information Letter

Mindfulness, Empathy and Embodied Experience:
A Qualitative Study of Practitioner Experience
In the Client/Therapist Dyad

Investigator: Gordon A. Dalziel, Ed.D. (Candidate)
Ontario Institute for Studies in Education
University of Toronto
(519) 822-8058

Faculty Supervisor: Dr. Roy Moodley, Ph.D., C. Psych.
Ontario Institute for Studies in Education
University of Toronto
(416) 978-0721

I am conducting a study at the Ontario Institute for Studies in Education (OISE) at the University of Toronto, to investigate the experience of psychotherapists who maintain a personal practice of mindfulness meditation. The study will focus particularly on the relationship between mindfulness and empathy, and how these two fields of experience may influence and inform each other. Attending to clients with an open, receptive consciousness as a way of strengthening a therapeutic alliance and of gaining access to the client’s inner world, seems to have been from the very beginning, central to our understanding of psychotherapeutic process. Today across ideologies there is broad consensus regarding the critical role of empathy in facilitating a therapeutic relationship, and the change processes that are possible within it (Greenberg, Watson, Elliot, & Bohart, 2001; Lambert & Barley, 2001).

I am interested in exploring how empathy is experienced and understood by you, how it acts to serve therapeutic goals, and how your capacity to engage empathically with clients is affected by your practice of mindfulness and meditation. To complement the body of literature that currently centres on the delivery of forms of mindfulness training to the client, this study will focus instead on the experience of you, the practitioner.

Although your participation in this research may not benefit you directly, the information gathered in the study will I hope, contribute to the current understanding of therapeutic process, and lend support to the growing body of theoretical and empirically based arguments in favour of the inclusion of mindfulness training as a component of personal and professional development in the education of practitioner candidates, preparing for clinical practice.

This research involves participating in an interview process. As one of five to ten study participants, you will be expected to engage in at least one, 90 minute interview during which you will be asked to explore your understanding of empathic experience and its role in the work that you do. You will also be asked to reflect, as someone who maintains a personal practice of mindfulness and meditation, on the impact of this practice on your experience of empathic engagement. The interviews will be conducted by Gordon Dalziel, M.Ed., a graduate student at
the Ontario Institute for Studies in Education, under the supervision of Dr. Roy Moodley. The information gathered will be used as part of Gordon Dalziel’s doctoral research. In the spirit of phenomenological inquiry, the exact duration of the interview will be determined within the context of each interview experience, and in some cases, more than one interview may be indicated. The number of interview meetings, and the duration and physical setting of each, will be determined jointly by the researcher and the participant. Participation in the study is completely voluntary. You may withdraw from the study at any time, and you may withdraw any, or all, of the information that you have provided during any interviews, prior to your approval of the final transcript material. As a participant, you will be free to decide what you are comfortable talking about, and what you do not wish to discuss.

Interview sessions will be recorded by audio tape and these recordings will be transcribed and summarized for later analysis. The researcher may take notes during and/or after an interview, and these notes will also be used in the analysis. Transcripts will not contain names or other identifying characteristics. Audio recordings and all other materials related to the interview will be filed anonymously using a numeric identification code and stored in a secure location, accessible only by myself and my supervisor, Dr. Roy Moodley. Following transcription, the audio tapes will be erased. A summary of the transcribed material selected for use in the analysis will be provided to you for your review. You will then have the opportunity to assess this material and add, delete, or clarify any aspect of the transcribed content. Once the necessary revisions are complete and you are satisfied with the summarized transcription, you will be asked to sign a release, indicating your approval. No revisions will be possible after this release has been signed.

It should be noted that this study will be used in the development of a doctoral thesis to be published through the University of Toronto and made available to the public. Verbatim excerpts from the interview transcripts may be used in the presentation of research findings, and despite the measures listed above; it is possible that someone who knows you might recognize you from the interview content being quoted.

Though it would seem unlikely given the relatively benign nature of what is being explored, it is nevertheless always possible for an interview to evoke unexpected vulnerability and/or painful experience of some kind. Self-assessment regarding suitability for participation in this study should be made with reference to the potential of the subject matter (mindfulness, empathy and embodied experience) to activate problematic material of some kind. Though care will be taken to provide a sensitive interpersonal interview environment, participants are expected to have access to appropriate resources to provide any necessary personal support. At the conclusion of the study you can receive written information regarding the results, if you choose, by filling out the attached request for information form.

If you have any questions regarding your rights as a research participant you may contact the Office of Research Ethics, by phone at: 416 946-3273, or by email at: ethicsreview@utoronto.ca.

Thank you for your consideration,

Sincerely,

Gordon Dalziel, M.Ed., Ed.D. (Candidate)
Appendix B

Consent Form

Mindfulness, Empathy and Embodied Experience:
A Qualitative Study of Practitioner Experience
In the Client/Therapist Dyad

Investigator: Gordon A. Dalziel, Ed.D. (Candidate)
Ontario Institute for Studies in Education
University of Toronto
(519) 822-8058

Faculty Supervisor: Dr. Roy Moodley, Ph.D., C. Psych.
Ontario Institute for Studies in Education
University of Toronto
(416) 978-0721

I have read the attached Information Letter and acknowledge that the research procedures
described in it have been explained to me. Any questions that I have asked have been answered
to my satisfaction. I understand that the study proposal has been reviewed and approved by the
ethics committee of the University of Toronto, and that the study is being supervised by Dr. Roy
Moodley. I understand that the study will include gathering information through an interview
process, and the potential risks associated with my participation in this process have been
explained to me.

I know that I am free to withdraw from the study at any time without consequence, and free to
withdraw any, or all, of the information that I have provided during any interviews. I understand
that I will be provided with a copy of the edited interview transcript prior to the completion of the
study, and will be given the opportunity to clarify or delete any part of this, prior to its inclusion
in the final study document. I consent to the use of information that I have contributed to this
study, for research and educational purposes, with the understanding that all records will be kept
anonymously and confidentially. I acknowledge that I have been provided with a copy of the
information letter and this consent form.

I hereby consent to participate in the study.

____________________________________
Print Name

____________________________________
Signature

____________________________________
Date
Appendix C

Guiding Interview Questions

Mindfulness, Empathy and Embodied Experience:
A Qualitative Study of Practitioner Experience
In the Client/Therapist Dyad

Following a brief review of the purpose of the interview, and confirming consent, the following questions will be used to guide an open-ended dialogue exploring both the conceptual and experiential dimensions of mindfulness and empathy. Care will be taken by the researcher to preserve the semi-structured nature of the interview such that the dialogical, phenomenological and hermeneutic potentials may be as fully realized as possible.

1. Tell me about the history of your relationship with mindfulness and meditation?
2. How would you define mindfulness?
3. How does mindfulness play a part in your daily life experience?
4. How did you come to study psychology and/or psychotherapy?
5. What kinds of training have you pursued in your study of psychotherapy?
6. What effect does your personal practice of mindfulness have on your clinical work as a psychotherapist?
7. How would you define empathy?
8. How is your experience of empathy affected by mindfulness?
9. Do you ever sense that your presence, during periods of empathic attunement, directly affects the client in some way?
10. How would you describe or explain this?
Appendix D

Request for Information Form

Mindfulness, Empathy and Embodied Experience:
A Qualitative Study of Practitioner Experience
In the Client/Therapist Dyad

I would like to receive a summary of this study’s findings by:

☐ Email. My email address is: ________________________________

or,

☐ Regular mail. My mailing address is:

Name: ________________________________
Street: ________________________________
Apartment #: ________________________________
City: ________________________________
Postal Code: ________________________________