

**Mental health practitioners' experiences of the Mindfulness-based
Stress Reduction programme: An explorative qualitative inquiry.**

Iram Osman

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of Social Science in Clinical Psychology in the School of Applied Human
Sciences, College of Humanities, University of KwaZulu-Natal**

Supervisor

Professor Anna Meyer-Weitz (PhD)

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DECLARATION

I declare that this dissertation is my own unaided work. All citations, references and borrowed ideas have been duly acknowledged. It is being submitted for the degree of Master of Social Science (Clinical Psychology) in the School of Applied Human Sciences, University of KwaZulu-Natal, Durban, South Africa.

None of the present work has been submitted previously for any degree or examination in any other university.

Signature: _____

Iram Osman (216072312)

Date: _____

DISCLAIMER

The Researcher of this study specifically disclaims all responsibility for any liability, loss or risk, personal or otherwise, which may be incurred as a consequence, directly or indirectly, of use of this report or any of the material in it.

DEDICATION

This dissertation is dedicated to:

My parents, Iqbal and Halima Essa,

My husband, Imtiaz Osman,

And finally, the lights of my life;

My children, Abdul Gany, Naseeha, Muhammed and Khadija.

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I would like to express my gratitude to the following:

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- The participants who took the time and effort to fill in the questionnaire,
- And finally, to the God Almighty for blessing me with this opportunity to research a topic about which I am passionate.

ABSTRACT

This study explored the experiences and perceived outcomes of the Mindfulness-based stress reduction programme on mental health practitioners. Particular attention was given to the practitioners' experiences of mindfulness as a way to reduce stress. Additionally, the process of imbuing mindfulness, its effect on the way the practitioners related to others both at a personal and professional level and how they integrated mindfulness into their clinical practices were also considered. A qualitative approach was used to gather data, in the form of an open-ended qualitative online questionnaire, which was analysed using thematic analysis. The link to the questionnaire was posted on mindfulness discussion forums and social media sites. Sixty-two people responded but only sixteen met the criteria and filled in the forms completely. All sixteen participants were over the age of 18, had completed an MBSR programme and considered themselves to be mental health practitioners.

Five super-ordinate themes emerged from the data which were further divided into several sub-themes. The five super ordinate themes were: experiences of mindfulness; personal outcomes; mindfulness as a therapy resource; challenges around the process and further aspects for consideration.

The findings suggested that mindfulness instilled the mental health practitioners with qualities such as non-judging, increased awareness, and present moment focus. These characteristics enhanced the practitioners' sense of well-being and influenced the way they responded to stressors in their lives. This subsequently led to feelings of being grounded and experiencing themselves as more effective therapists. Although the views that were expressed were very positive about mindfulness, there were mixed experiences regarding the required processes of imbuing these qualities and practices. Most participants felt that the formal meditation aspect of the MBSR programme was very time consuming and required dedicated discipline. However, this study has supported previous research findings that point to the positive outcomes of mental health practitioners practicing mindfulness which can act as a therapeutic technique valuable for both self-care and subsequent positive client outcomes. Thus, emphasising its potential worth as a workshop to be offered for both personal and professional development of mental health practitioners.

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CHAPTER ONE

INTRODUCTION

1.1. Introduction

Unmanaged chronic stress is detrimental to the physical and psychological health and well-being of individuals. Stress can lead to many physical and mental disorders such as asthma, cardiovascular disease, hypertension, cancer, migraines, depression, and anxiety (Sue, Sue & Sue, 2006). Work stress has been identified as having a high financial cost due to workplace absenteeism, declining job performance and turnover. It has an impact on the morale of workers as well as affecting their recovery quality, well-being, mood, and resilience (Hansen, 2016).

Mental health practitioners are usually under a great deal of stress themselves due to the nature of their work which includes heavy caseloads, long hours, minimal control over the environment and rigid organizational structures for those that work in institutions and organisations (Irving, Dobkin & Park, 2009). The long-term effect of chronic stress on mental health of practitioners can be significant as this is likely to lead to emotional fatigue and negatively influence the quality of care and effectiveness of the interventions used for clients in need of mental health services. These stressors however, are part of the mental health practitioner's working environment and not much can be done to change these factors. It has been suggested that equipping the helping professionals with more enhanced coping mechanisms could be a way to reduce the effect of chronic stress in the mental health field (Park, 2014). An evidence-based coping mechanism found to be effective as a stress and anxiety reduction tool is Mindfulness. The Mindfulness-based Stress Reduction programme (MBSR) developed by Dr Jon Kabat-Zinn in 1979, is the most widely studied mindfulness programme, and has been found to have many mental and physical health benefits validated by neuroscience and psycho immunology (Davidson et al., 2003).

This dissertation explored the subjective experiences of mental health practitioners, specifically the process of imbuing mindfulness through the MBSR programme and the influence this had on

the way the practitioners relate to stressors. It was assumed that mindfulness would also impact the way practitioners related interpersonally both at a personal and professional level. The aim of this study was to add insight and increase understanding about the benefits of offering mindfulness training workshops to mental health practitioners as an effective, evidence based alternative to reduce stress, especially work related stress.

1.2. Background

The word Mindfulness originated from the Pali word, *Sati*, which means “awareness, attention and remembering”, according to Bodhi (cited in Davis & Hayes, 2011, p.198). It is a 2500-year-old concept from Buddhist philosophy aimed at alleviating personal suffering and transformation (Anderson et al., 2004). This transformation is cultivated by increasing awareness of four general aspects of an individual, that are: body and posture, emotions, cognitive processes, and mental content. This increased awareness practiced over time is argued to lead to a sense of detachment from and objectivity to oneself, with moments of insight into behaviour, motivation and underlying psychological processes (Stuart, 2012).

Though mindfulness has its roots in Buddhism, its philosophical ideas are universal and applicable to any culture or religious group. It is best seen as a fundamental idea of the working of the human mind and the way it affects the rest of the person’s being. The cultivation of mindfulness has been argued to be therapeutically healing and transformative, by simply bringing us back to our body and lives by attending to the present moment and assists with both reflection and introspection (Kabat-Zinn, 2013).

The term mindfulness holds many meanings including: a form of meditation practice, a way of being, a mindset of being fully conscious and aware, attentional control or a way of processing information. From these definitions, we can gather that mindfulness can refer to a psychological state, a method of processing information or a characteristic. For this study, mindfulness was viewed as a state of, “paying attention in a particular way, on purpose, in the present moment, and non-judgmentally” (Kabat-Zinn, 1994, p. 4). Another useful way to look at mindfulness is, as a skillset that can be cultivated. According to Baer et al. (2008), there are five core mindfulness skills: observing, describing, non-judging, non-reactivity and awareness. Earlier, Linehan (1993),

argued that mindfulness consisted of six skills: three that relate to *what* the person is doing i.e. *observing* what is happening in the present moment, *describing* that experience of being completely present, and *participating* completely in that; and three, that relates to *how* the person is doing it, i.e. *non-judgementally*, with *focused attention* on the task at hand and *performance quality* that implies utmost effectiveness. Thinking of mindfulness as a specific skillset, assist in understanding its relationship to variables like psychological adjustment and subsequent well-being (Baer et al., 2008).

The qualities of mindfulness can be further understood by examining the other end of the spectrum, that is, when one is not paying attention to one's actions. It's inherent for the mind to wander either to the past or to the future, changing rapidly from one subject to the other. Much of a person's time is spent on automatic pilot, functioning mechanically, beyond the realms of awareness (Kabat-Zinn, 2013). Mindfulness helps to gently bring back the attention and awareness to the present moment.

In recent times, especially in the last half of the 20th century, ideas about mindfulness have captured the interest of mental health clinicians and researchers all over the world and particularly the Western world. It seems to hold a promise of alleviating both mental and physical challenges. The most prominent pioneer to bring mindfulness to the Western medical establishment and increased its credibility through rigorous research and practice, was the medical doctor Jon Kabat-Zinn.

In 1979 at the University of Massachusetts Medical Centre in the United States of America, Jon Kabat-Zinn developed an eight-week programme to cultivate the concept of mindfulness known as the Mindfulness Based Stress Reduction Programme. This programme was located in behavioural medicine and considers the integration of body, mind, and emotions and how each impact the other. His primary concern was the patients that he felt were falling through the cracks in the medical system. These were patients who were living with chronic physical conditions e.g. HIV and AIDS, high blood pressure, continuing pain as well as mental disorders such as anxiety, psychosomatic conditions, depression etc. He explored the idea that the way we process emotions, perceive our situations, and choose to behave, influences the way our body deals with illness and healing. His programme required rigorous training to cultivate an art of conscious living that moved people towards greater health and well-being (Kabat-Zinn, 2013).

1.3.Cultivating mindfulness

The state of mindfulness can be achieved in many ways for example by practicing yoga, tai chi and meditation. However, the most researched and empirically sound way of cultivating this state has been found to be through mindfulness meditations. The word meditation comes from the Latin word *Mederi* which means *to cure*. And the word *mederi* stems from the Indo-European word which means *to measure*. Similarly, meditation should be seen as a measure of one's inward state of being through increased awareness and self-observation that leads to a state of being 'cured' by accepting oneself non-judgementally (Kabat-Zinn, 2013).

Mindfulness meditation programmes consist of both formal and informal mindfulness practices (Willaims & Penman, 2011). Formal practice is where one sits in a state of meditation sustaining attention on an object and is accepting of whatever comes to mind for that period (Lee, 2013). Informal practice is the application of this state of mind practiced during formal meditation and using it in everyday life. An example of an informal practice would be to pay attention to one's breathing to calm yourself down, or to listen carefully to the sounds in the environment which assists in keeping the mind in the present.

1.4.Mindfulness based interventions in psychotherapy

Mindfulness and psychotherapy may at the surface level seem very different, yet both have the goal of alleviating suffering by increasing insight and awareness. Mindfulness has moved from being an obscure Buddhist practice to an acceptable construct in mainstream Western psychotherapy (Davis & Hayes, 2011). The coming together of the ideas of mindfulness and psychotherapy is profoundly beneficial, in that we are now able to reap the maximum benefits of awareness practices in an evidence-based therapeutic framework. Advocates of mindfulness have emphasized the benefits of the practice for both patients and therapists. It has been said to be an unstated shared construct in psychotherapy interventions included in psychodynamic, humanistic, existential, and integrative approaches (Davis & Hayes, 2011).

There exists a variety of ways to incorporate mindfulness in psychotherapy in that the therapist could simply approach the session mindfully, use mindfulness as the theoretical framework for

their own conceptual understanding/formulation or teach mindfulness practices to clients (Stuart, 2012).

In contemporary psychotherapy, the concept of mindfulness was used to develop the third wave of cognitive behavioural psychotherapeutic interventions. The four mindfulness based approaches that are formal and supported empirically are:

- Mindfulness Based Stress Reduction(MBSR) used mainly to enhance mental and physical well-being and pain control.
- Dialectical Behaviour Therapy (DBT) used mainly for borderline personality disorder to enhance emotional regulation.
- Acceptance and Commitment Therapy (ACT), used to encourage acceptance instead of resisting adversity.
- Mindfulness Based Cognitive Therapy (MBCT) an application of MBSR found to be effective for depression and faulty thinking patterns (Corey, 2013).

For this study, Mindfulness Based Stress Reduction was chosen due to focus of the study and the extent of clinical research that documented its effectiveness in addressing a wide variety of medical and psychological conditions including the reduction of stress (Baer, 2003; Lee, 2013).

1.5.The Mindfulness Based Stress Reduction programme (MBSR)

The MBSR programme aims to teach people how to become more aware of and modify the way they relate to their thoughts, feelings, and experiences by increasing awareness and cultivating non- judgmental observation of incoming stimuli (Lee, 2013). These aims are achieved through an eight-week programme which requires a commitment of two and a half hours a week for formal meditation practices. These practices include:

- A “Body Scan” which is like the psychotherapeutic intervention of progressive relaxation but differs in that each body part is simply brought to awareness and arising sensations observed without attachment to any idea or intent.

- “Sitting Meditation” involves sitting for a period focusing on one’s breathe while becoming aware of any sensations, thoughts or feelings that may arise.
- “Hatha Yoga” involves stretching exercises, breathing and postures aimed at relaxing the muscular skeletal system that are non-exertive and done with a conscious awareness of what the body is physically experiencing moment to moment. This exercise is also known as mindful movement and encourages strength, balance and flexibility (Kerr, Joysula & Littenberg, 2011; Lee, 2013).

The informal component of MBSR is incorporated throughout the day for 45 minutes a day, six days a week for eight weeks. It is the more practical application of the mindfulness programme and includes everyday activities done mindfully for example:

- “The power of breathing” in which you learn to use your breath as an anchor to bring about a state of mindfulness.
- “Mindful eating” which formally involves eating one’s food very consciously, savouring each moment and considering the appearance, origin, smell, touch, sound and taste of the food. Biting, chewing and swallowing are done slowly and deliberately. To give an idea to the time factor of this practice, to eat a single raisin in this exercise should take ten to twenty minutes.
- “Walking meditation” is a simple exercise of walking and being aware of that fact. It is to bring attention to the act of walking and includes the sense of the muscles, the coordination and rhythm of the movement etc. The walking is done in circles to relay the message that there is no need to go anywhere and it’s fine to be here, right now (Kabat-Zinn, 2013). This concept of using walking as a metaphor for broader activities in life and therapeutic benefits is like the evidence based practices of maze running and labyrinth walking (Munro, 2010).

The MBSR programme trains individuals in mindfulness to increase self-regulation to reduce stress and manage emotions. It works by fostering an attitude of gratitude that changes one’s outlook of life by appreciating the present moment. It is designed to break the negative patterns of habitual reactivity to thoughts, emotions and behaviour while equipping the person with a new way to respond and cope in relation to oneself and the world (De Vibe, Bjorndal, Tripton,

Hammerstrom & Kowalski, 2012). This moment of pause before action and subsequent positive reappraisal is thought to be the foundation of mindfulness based programmes. This concept of positive reappraisal will be discussed in more detail in the theoretical framework section at the end of the next chapter.

1.6. Rationale for this research

Mental health practitioners experience high levels of stress and often subsequent burnout due to the nature of their work (Irving, Dobkin & Park, 2009). Therefore, a need exists for self-care using effective coping mechanisms and stress reduction techniques. MBSR has proven itself, over the years through numerous trials and studies, to be an evidence-based stress reduction programme. Programme efficacy was established across a range of issues i.e. reduction of stress particularly among mental health professionals (Felton, Coates & Christopher, 2013; Hansen, 2016); quality of life improvement and increased compassion for self and others (Dorn, 2014; Zamir, 2009), as well as in improving symptoms of burnout and general health (Shapiro, Brown & Biegel, 2007; Howe, 2015; Park, 2014; Felton et al., 2013; Irving et al., 2009). It can therefore be argued that mindfulness would be valuable as an additional training component for future mental health practitioners or offered as part of a self-care technique to qualified mental health practitioners. It should be noted that mental health practitioners in this country have an additional stress burden brought about by limited available resources and a huge treatment gap (Williams et al., 2008).

While numerous clinical trials proclaiming the efficacy of the mindfulness programme have been conducted, few qualitative studies have investigated understandings of the mindfulness concept (Browne, Ryan & Creswall, 2007), experiences with the programme as well as the process of change that practitioners undergo during and after completing the MBSR programme (Kerr et al., 2011), including its personal value and its role in meaning making.

The lack of studies that highlight the actual processes of mindfulness and how it is perceived by practitioners, as well as the impact of mindful therapists on client outcomes, have been outlined by Shapiro et al. (2007). Future research on the outcomes of MBSR interventions into work schedules of health care professionals as a critical way to prevent burnout and increase job and life

satisfaction was also recommended (Shapiro, Astin, Bishop & Cordova, 2005). In addition, the need for further research was reiterated in a review of empirical studies on MBSR among clinicians (Irving et al., 2009).

1.7. Aims and Objectives

The overall aim of the study was to qualitatively explore mental health practitioners' experiences with mindful-based stress reduction programmes in lieu of understanding the likely value of offering mindfulness training to mental health practitioners as a technique to change the way they personally respond to stressors and subsequently enhance their therapeutic effectiveness.

The objectives of this study were:

- To qualitatively explore the experiences of mental health practitioners who have incorporated the concept of mindfulness in their lives.
- To explore the actual process of imbuing mindfulness through formal programmes namely MBSR.
- To explore in what way, if any, mindfulness had impacted the practitioner's lives.
- To explore mindfulness as a resource that could enhance therapeutic effectiveness.
- To explore the use of mindfulness as a stress reduction tool.

1.8. Ethical Considerations

This study was approved by the Humanities and Social Science Research Ethics committee (protocol ref no: HSS/0374/016M). Care was taken to provide adequate information about the study to likely participants and informed consent was obtained before the questions could be accessed by interested participants during a qualitative online survey. Ethical concerns were addressed by highlighting the anonymity and confidentiality of data and voluntary nature of participation.

1.9. Outline of this dissertation

In Chapter one of the dissertation, a background to the concept of mindfulness is provided: the basic principles, its place in psychotherapy and the MBSR programme. This chapter also includes the rationale for conducting the current study and the aims and objectives of the research.

Chapter two consists of a thorough review of the literature on stress, mindfulness and its role as a coping mechanism, specifically for mental health practitioners. The chapter concludes with a theoretical framework, the transactional theory of stress, explaining the mechanisms of mindfulness, and a hypothesis on how it alters the perception of the stressor.

Chapter three presents the study's research methodology, challenges and issues of trustworthiness.

Chapter four presents the study's findings, and discusses these findings in relation to previous research done in this field.

Chapter five presents the conclusions, limitations and recommendations emanating from the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

A literature review entails investigating the available body of knowledge in the field of interest (Mouton, 2013). The review starts by explaining the physiology of stress and its physical and psycho-social consequences. Work stressors involved in the mental health field and their impact on mental health practitioners are also examined. This is followed by a discussion on the benefits of mindfulness, focussing specifically on the MBSR programme and its outcomes at the intrapersonal and interpersonal levels. Finally, the mechanisms of mindfulness are explained by putting it into context using the shared theoretical underpinnings of Lazarus and Folkman's Transactional Theory of Stress (1984) and the Mindful coping model (Garland, Gaylord, & Park, 2009), with a specific focus on positive reappraisal (Folkman & Moskowitz, 2000).

2.2 The Physiology of Stress

According to the World Health Organization's Global Burden of Disease Survey (1990, 2005 & 2010), mental disease, including unipolar depression and stress-related disorders, will be the subsequent leading cause of disabilities by the year 2020. The most prevalent leading cause of disease has been reported to be coronary heart disease with stress, once again being one of the critical factors related to poor disease outcomes (Kalia, 2002). However, stress is an unavoidable part of modern life due to its inherent constant distractions, advanced technology, globalisation and busy lifestyle. Subsequently, central to staying healthy is not so much avoiding stress as rather handling it (De Vibe et al., 2012). In fact, Kalia (2002), who assessed the economic impact of stress referred to stress as "the modern day hidden epidemic" (p.49).

Human beings respond to stress through the "fight-or-flight" response. This automatic response is activated by the sympathetic nervous system, altering the functioning of the body to get it ready to act in emotional, stressful or dangerous situations. The mobilization of the body takes place in one

of two ways, namely; through the direct activation of the sympathetic division of the automatic nervous system, causing the medulla to secrete epinephrine and norepinephrine. The secretion of epinephrine and norepinephrine affects the cardiovascular, digestive and respiratory systems (Brannon & Feist, 2010). The other way that the body is mobilized into action is through the hypothalamic-pituitary-adrenal (HPA) axis. When a person perceives a situation as a threat, the hypothalamus and pituitary gland respond by releasing hormones, one of which is cortisol. The secretion of cortisol raises the blood sugar levels in the body to provide the extra energy required for the task at hand and additionally has an anti-inflammatory effect defending the body against likely injury during this period (Brannon & Feist, 2010).

The fight or flight response in the short term is therefore adaptive and ensures our survival. As mentioned, it is supported by many physiological responses including changes in the immune system to prevent infections and enhance healing of any injury (Segerstrom & Miller, 2004). In the case of acute stressors, low energy consuming immune action is enhanced and high energy consuming ones are suppressed, channelling the energy required towards more physical activity (Segerstrom & Miller, 2004). However, longer lasting stressors are associated with suppression of the immune system that are not adaptive, for example cell production and functioning are negatively impacted (Segerstrom & Miller, 2004). The effect of stress at a cellular level will be discussed in more detail in the next section in which the physical consequences of long term stress on the body is discussed.

2.2.1. Physiological consequences of prolonged stress

Chronic stress is usually associated with a perception of threatened resources overwhelming the coping ability of the person involved (Lazarus & Folkman, 1984). When the resources are threatened, the body reacts by directing energy away from the immune system towards gearing the person into action (as discussed above) (Segerstrom, 2007), but what happens when this perception and reaction is long term? Prolonged activation of the sympathetic nervous system results in allostatic load, which overcomes the body's ability to adapt. Part of the stress response is the release of many neuro-hormones that affect immune functioning, namely, corticosteroids that have

a strong immunosuppressive action. Endorphins also appear to decrease the strength of natural killer cells that influence the body's ability to fight tumours (Sue et al., 2006).

Tumours can be either benign or malignant, however for the interest of this study the attention will be on the malignant type. Malignant tumours are a form of cancer in which cells divide rapidly, without control or order, invading and destroying surrounding tissue (Vasille, 2016). In a meta-analysis investigating the association between stress and incidence of breast cancer, it was found that although a direct association between breast cancer and stress could not be made, it was critical not to eliminate high intensity stress as a potential risk factor for cancer (Santos et al., 2009). Literature studied over the years have shown that there is in fact a strong relationship between stress and cancer which was moderated by a third variable, that is a low immune system (Vasille, 2016). A reason for this could be that high levels of stress are usually correlated with infectious diseases, due to the decreased levels of the immune system's key components called lymphocyte which consist of B-cells, T-cells and NK cells. B-cells have the role to produce antibodies against foreign invaders in the body; T-cells detect and destroy these foreign cells; and the NK or natural killer cells are critical to the detection of tumours and preventing the growth of tumours (Lutgendorf & Costanzo, 2003; Sue et al., 2006).

In a meta-analysis that studied the relationship between psychological stress and the human immune system over a period of 30 years (Segerstrom & Miller, 2004), it was found that though chronic stressors suppressed both cellular and humoral immunity, the effect of stress varied according to the type of stressor and presence of other compromising factors like older age and other immune pathologies. The final word on the relationship between stress and disease seems to be that stress does not directly cause infections, but decreases the immune system's efficiency which makes the person more vulnerable to disease (Koh, 1998).

Another way that chronic stress effects human health is by the fact that it shortens our telomeres, which are the specialized DNA repeat sequences found on all chromosomes that are essential for cell division. They shorten as the person ages, but have been found to accelerate the aging process in people who are chronically stressed, subsequently affecting longevity (Epel, Daubenmier, Moskowitz, Folkman & Blackburn, 2009). Shortened telomere length has been linked to a variety of disease states including cardiovascular disease (Brouillette, Singh, Thompson, Goodall & Samani, 2003), vascular dementia (Von Zglinicki et al., 2000), degenerative conditions such as

osteoporosis (Valdes et al., 2007) and an increased risk for general diseases and health risks factors e.g. obesity and insulin resistance (Gardner et al., 2005).

However, a point to be noted as mentioned by Vassile (2016) is, *“In our time, the structures subject to most stress are not the muscles, bones or internal organs, not anymore; the emotional area, namely the mind and the soul are now subject to it.”* (p. 73), which brings me to the next section of this review, the psycho-social consequences of prolonged stress.

2.2.2. Psycho-social consequences of prolonged stress

Chronic stress is likely to lead to unproductive rumination that forms a vicious, self-perpetuating cycle contributing to more stress. Furthermore, stress can lead to both a decrease of resilience factors such as hope and a capacity to forgive, as well as diminished mental health (Chiesa & Serretti, 2009). Stress has in fact, been found to play an essential role in the onset of psychological discomfort, behavioural disorders and social adaptation with both intense, acute, and chronic stress contributing to the development of mental and somatic disorders (Franczak, 2012).

The recognition of stress as a risk factor to mental disorders has now been given more attention as evident in the DSM 5 inclusion of a separate section on trauma and stressor related disorders. A criterion for diagnosis to be made from any disorders of this section is an exposure to a stressful or traumatic life event (American Psychiatric Association, 2013). However, psychological distress following a stressor can manifest variably in symptoms ranging from fear and anxiety to more aggressive and externalising disorders or even dissociative states (American Psychiatric Association, 2013).

Nevertheless, recent research shows that the most common disorders associated with stress seem to be anxiety, depression, panic disorder and post-traumatic stress disorder with their aetiology being linked to the hormone changes related to the HPA axis (Gu, Wang, Wang & Huang, 2016).

Another study explained the link between chronic stress and mental disorders slightly differently (Chetty et al., 2014). They argued that chronic stress generates long term changes in the structure and connectivity of the brain, making them more vulnerable to mental disorders such as anxiety

and mood disorders. However, they concluded that still more research was required to fully understand the mechanisms that caused this vulnerability.

These findings were similar to an earlier study that investigated the effect of stress hormones on the structures of the brain throughout human development (Lupien, McEwen, Gunnar & Heim, 2009). The results of this study showed that chronic exposure to stress hormones affected the structures of the brain irrespective of the stage of development. This had subsequent effect on the cognition and mental health of the person. However, the exact outcome of the stressor could not be specified since these were affected by the type and duration of the stressor, as well as, the life stage, environmental factors and premorbid characteristics of the person. One interesting finding though was that chronic stress was associated with a decreased hippocampal structure and functioning, which are usually also found in patients with depression and PTSD.

An alternative hypothesis explaining how stress effects mental disorders refers to changes in behaviour because of stress e.g. engagement in reckless activities to manage the demands of the stressful event for example alcohol or drug use to make the person feel better (Kiecolt-Glaser & Glaser, 1988). In fact, Matsuoka et al. (2005) found a relationship with stress and the suppression of the Prostaglandin E receptor (EP 1) neural process that controls behaviour. Its suppression is equal to behavioural disinhibition which can lead to impulsive and/or aggressive acts, defective social interaction and subsequent negative impact on the individual and society at large.

An effective way of coping with stress has been found to be seeking social support through close interpersonal relationships (Franczak, 2012). However, findings show that stress can lead to anti-social behaviour and negative perceptions of the intention of others (Ralston, 2012). In a study that investigated the impact of stress on social behaviour (Ralston, 2012), it was found that stressed individuals tended to help others less frequently and had lower opinions of their trustworthiness and fairness. These findings were replicated in a study that looked specifically at the impact of stress on the 'social brain' (Sandi & Haller, 2015), where it was found that stress was associated with social withdrawal, aggression and a lack of ability to deal with challenges. However, these findings were mediated by the life stage of the person, time and severity of the stressor. Another study showed contradictory results in that they found that stress could have a prosocial effect on the victim of the stressor prompting to reach out and help others which is referred to as, "altruism born of suffering" (Staub & Vollhardt, 2008, p. 267). However, Sandi and Haller (2015), explained

that this altruistic act is only possible if the stressor was not very severe and intense, while prolonged stress was found to decrease empathy and prosocial behaviour.

Apart from the physiological and psycho-social consequences outlined above, stress negatively impacts the work place as well. These work-related stressors will be discussed in the next section with a specific focus on health care professionals especially mental health practitioners that have their unique set of challenges.

2.3. Work-related stress among Health Care Professionals

Work related stress can be defined as an employee's perception that their job requirements exceed their resources to deal with it, which in turn then causes detrimental physical and psychological responses in the employee (Levi, Sauter & Shimomitsu, 1999). Work-related stress is an increasing concern due to its detrimental consequences. In an article that assessed the economic cost of stress (Kalia, 2002), it was found that the disability caused by stress related disorders were just as great as those caused by other medical conditions such as hypertension, arthritis and diabetes. It was even found to be equal to disabilities caused by workplace accidents.

Some of the serious consequences of work related stress include higher financial costs due to workplace absenteeism (Kalia, 2002), declining job performance (Cohen, 1980), employee disengagement and employee turnover (Dane & Brummel, 2013). Stress has an impact on the morale and commitment of workers (Dane & Brummel, 2013), as well affecting their recovery quality, well-being, mood and resilience (Hansen, 2016). Workplace stress was also found to affect work engagement and ability to relate to others in that it was found to reduce the frustration and tolerance threshold, altruism, sensitivity to others and also accuracy (Cartwright, 2000). As altruism and empathy are of critical importance to the effectiveness of mental health practitioners, stress will impact their functioning negatively. The unique challenges that mental health practitioners face daily will be discussed below.

The work of mental health practitioners can be highly rewarding but also personally taxing. Apart from the everyday stressors that most people are exposed to, mental health practitioners have additional stress due to the nature of their work, which includes heavy caseloads, long hours,

minimal control over the environment and rigid organizational structures (Irving et al., 2009). As professionals in the helping field, they engage intimately with their clients, listen closely and provide empathy while maintaining integrity and balancing professional boundaries. At the same time, they must manage their own thoughts, emotions, behaviours and responses. It is not surprising, therefore, that the mental health profession suffers from stress related disorders and has one of the highest occurrences of burnout (Acker, 2008; Howe, 2015; Irving et al., 2009; Maslach, 1982; Maslach & Jackson, 1981; May & O'Donovan, 2007; Sprang, Clark & Whitt- Woosley 2007).

A study conducted by Shapiro, Astin, Bishop and Cordova (2005), addressed the stress issues inherent among health care professionals. Their study was replete with evidence that work-related stress in health care professionals led to “depression, decreased job satisfaction and psychological distress” (p.164), concluding that health care professionals needed support in addressing these work-related issues. Interestingly, in a later study Shapiro et al. (2007) confirmed that mental health professionals specifically, were more at risk for occupationally related psychological problems. In this study, they found the consequences of stress on mental health professionals to include increased depression, anxiety, emotional exhaustion and psychosocial isolation e.g. loneliness. In addition, the researchers found that stress also decreased mental health professionals’ job satisfaction, self-esteem and also disrupt their personal relationships. Moreover, they found that mental health therapists also struggled with reduced abilities to concentrate, make decisions and relate to patients, which were all critical components of their job requirements. Earlier studies among health care professionals have found that stress leads to increased depression (Tyssen, Vaglum, Gronvold & Ekeberg, 2001), disrupted personal relationships (Gallegos, Bettinardi-Angres & Talbott, 1990), and even suicide (Richings, Khara & McDowell, 1986).

Psychological problems induced by stress are highly prevalent amongst therapists, especially those directly exposed to clients with emotional challenges including abuse, trauma, grief and bereavement (Bride, 2007). One of the reasons cited for these consequences are that they are expected to not only deal with the stressors of others, but also work in highly demanding settings like hospitals and health care clinics (Shapiro et al., 2005). The significance of the long-term effects of chronic stress on mental health practitioners is critical, for stress can lead to emotional fatigue and negatively affect the quality of care and effectiveness of the psychotherapeutic

interventions used for clients in need of mental health services, both as reported by patients (Garman, Corrigan & Morris, 2002) and therapists themselves (Shanefelt, Bradley, Wipf & Back, 2002). These factors are hypothesised to also lead to vicarious trauma and compassion fatigue and ultimately burnout which will be discussed in more detail below (Howe, 2015).

Vicarious trauma

Vicarious Trauma or secondary traumatic stress is a term that describes the negative impact on mental health professionals through the continued and close interaction with trauma survivors. By being exposed to the details and emotions of clients' trauma, helping professionals themselves start to experience impairment of their own mental and emotional well-being resulting in a shift in their own worldview (Howe, 2015). Vicarious trauma is aptly summarised by the words of Pearlman and Saakvitne (1995, p. 31) as stated: "*Vicarious traumatization refers to the cumulative effect of working with survivors of traumatic life events. Anyone who engages empathetically with victim or survivors is vulnerable*". Secondary trauma is considered inevitable in mental health workers that deal with trauma (Herman, 1992), regardless of age, gender, race or level of training (Rudolph, Stamm & Stamm, 1997). However, other studies show that novice therapists are more at risk, especially those with a personal trauma history (Pearlman & MacIain, 1995).

In a quantitative study conducted by Kanter (2007), mental health professionals were found to manifest secondary traumatic stress by internalizing the client's detailed description of their personal traumatic event. Additionally, mental help professionals provide emotional support; assist clients in developing coping strategies and adjusting clients' behaviour following a traumatic life event. These have the potential to increase the helping professional's predisposition to developing symptoms of secondary traumatic stress, impeding their capacity to remain objective, determine appropriate interventions and offer effective services.

Another aspect inherent in vicarious trauma is **compassion fatigue**. Compassion fatigue refers to the overwhelming state of tension and pre-occupation with the client's trauma. This constant state of tension leads to profound physical and emotional erosion, and a persistent feeling of helplessness that they are unable to refuel and regenerate. Compassion fatigue can develop from exposure to many traumatic experiences, but has also been found to develop from exposure to one

traumatic event (Howe, 2015). The symptoms associated with compassion fatigue include anxiety, depression, emotional numbing and avoidance of cues associated with reminders of the event (Howe, 2015). The risk of developing compassion fatigue is increased by the mental health professionals' own experiences of trauma, their personal unresolved feelings and level of experience working with trauma victims (Adams, Figley & Boscarino, 2006). These have been found to negatively impact the overall quality and efficacy of care provided to clients and even the ability to maintain personal therapeutic relationships (Figley, 1995).

Burnout

Burnout is a term used to describe the psychological and physiological responses to prolonged exposure to stressors, usually of an interpersonal nature, in the workplace (Howe, 2015). Burnout consists of three components namely; feelings of emotional exhaustion, depersonalisation and perceived lack of achievement (Lakin, Leon & Miller, 2008; Maslach & Lieter, 2016). Emotional exhaustion is usually used to describe the feeling of being overwhelmed and perceiving emotional energy resources as being depleted (Lakin et al., 2008). Depersonalisation is experienced through a sense of detachment from people and treating them without empathy (Maslach, Schaufeli, & Leiter, 2001). The third component of burnout is perceived lack of achievement, usually experienced as a feeling of incompetence in one's ability to perform a good job (Maslach & Jackson, 1981; Maslach & Lieter, 2016).

Burnout results in similar health and psychological conditions as discussed above. The negative consequences of chronic stress and burnout experienced by health care practitioners include health problems such as fatigue, coronary heart disease, depression, hypertension, diabetes, and premature aging (Miller, Stiff & Ellis, 1988). Additionally, it is common for them to experience occupational hazards such as anxiety (Gunderson, 2001), substance abuse (Miller & McGowen, 2000), and increased rates of suicide attempts (Shanafelt & Habermann, 2003). It has also been found to impair job performance and the ability to work efficiently with clients (Sprang et al., 2007).

2.4. Need for effective interventions to support mental health workers

Throughout the world there seems to be a shortage of mental health workers, but particularly more so in sub-Saharan Africa (Williams et al., 2008). In South Africa, statistics show that in 2008, for every 100 000 people there were only one psychiatrist, eight psychiatric nurses, four psychologists and twenty social workers (Williams et al., 2008). These figures highlight the need for taking care of the mental health practitioners that are in practice and to prevent stress-induced burnout.

It is difficult to minimize the work stressors that mental health practitioners experience. A suggestion is thus made that while stressful situations cannot be avoided, emphasis should be shifted to minimize the practitioners' perception of stress (Hansen, 2016). One suggestion is to enhance coping mechanisms to manage the demands of the job (Hansen, 2016). With the multitude of stressors that have been acknowledged as part of the working environment of mental health practitioners, it would be useful to fully understand effective coping mechanisms in managing job related stress and anxiety. Evidence based stress management interventions have found to share common factors, namely: positive reappraisal, relaxation skills and strategies to reduce the intensity of the stressors (Park, 2014).

Positive reappraisal is a cognitive process in which people learn to focus on the positives of every situation or occurrence, either introspectively or retrospectively (Folkman & Moskowitz, 2000). Positive reappraisal can take many forms which include seeing problems rather as challenges and opportunities for personal growth, perceiving their own personal growth retrospectively through life's challenges and viewing their strengths and capabilities. It can also encompass becoming aware of how issues were resolved through their own efforts and how their experiences can be used to help others (Folkman & Moskowitz, 2000). By using positive reappraisal, the perception of the meaning of the situation is changed thus the person experiences positive emotion and psychological well-being (Folkman & Moskowitz, 2000). This concept of positive reappraisal will be discussed in more detail under the theoretical framework section.

An evidence based stress management intervention that uses positive reappraisal, and relaxation strategies is mindfulness. Mindfulness as argued by Kabat-Zinn (2013), can provide the paradigm shift needed to create a greater sense of interconnectedness with oneself and the environment which could alleviate a lot of the suffering caused by the stressors of current times. Mindfulness

is an emerging coping mechanism that can help employees enhance their sense of positive reappraisal and thus decrease work-related stress, which has a positive effect on their psychological well-being, recovery quality and resilience in the face of challenges (Hansen, 2016). Which brings us to the next topic of this review, that is the evidence for the positive impact of mindfulness on stress reduction and mental health promotion.

2.5 Evidence for the positive impact of mindfulness

Mindfulness programmes are a new branch of body-mind and integrative evidence based stress reduction interventions (Kabat-Zinn, 2013). The effect of mindfulness is described by Kabat-Zinn in the following words: *“It was clear that there is something about the cultivation of mindfulness that is healing, that is transformative, and that can serve to give our lives back to us, not in some romantic pie-in-the-sky way, but because simply by virtue of being human.”* (Kabat-Zinn, 2013, p.xxxvii).

Various studies had similar findings supporting the positive outcomes of mindfulness as illustrated in the studies below. In a meta-analysis of 19 mindfulness studies, Katherine Weare (2013) wrote: *“Amongst adults there is reasonably strong evidence for the positive impact of mindfulness on a wide range of mental and physical health conditions, on social and emotional skills and well-being, and on learning and cognition. There is also good evidence from neuroscience and brain imaging that mindfulness meditation reliably and profoundly alters the structure of the brain to improve the quality of both thought and feeling”* (p.2).

Over the years’ numerous clinical trials have highlighted the benefits of mindfulness meditations with the most interesting ones showing actual changes in the structure of the brain. The term used to describe this phenomenon is neuroplasticity, which states that the brain changes its connections in response to experiences (Siegel, 2014). An example of neuroplasticity is apparent in a study of Lazar et al., (2005) in which it was found that the structure of the brain changed after many years of meditation, the most pronounced being the brain surface called the insula. The insula oversees the way we relate to others, and controls qualities such as empathy, kindness and compassion. This study highlighted the fact that mindfulness not only changes how we function cognitively, and relate to self, but also, how we relate to others. Similarly, Cahn and Polich (2006), found more

neural activations in the middle prefrontal cortex (PFC) part of the brain in mindfulness meditators. The PFC region of the brain is associated with traits of increased awareness, metacognition and self-observation. These are all traits that enhance social relations. This concept of mindfulness affecting our interpersonal relationships will be discussed in more detail later in this review.

Another example of neuroplasticity was found when a functional magnetic resonance imaging (fMRI) scan was used to assess the brain before and after the completion of a mindfulness programme (Holzel et al., 2011). The researchers found that the grey matter in the different regions of the brain associated with learning, memory, emotion regulation, the sense of self and perspective taking thickened, while the amygdala which oversees the fight or flight responses became thinner. The degree of thinning was correlated with improved scores on a perceived stress scale.

Another earlier interesting study documented by Davidson, Jackson and Kalin (2000) who used fMRI scans, found that people had an emotional set point with which they are born. This meant that no matter what happened over life, the person's disposition did not vary a lot, their so called emotional thermostat remained constant. However, in another study conducted a few years later by Dr Davidson and his colleagues amongst mindfulness meditation practitioners, positive effects on the brain were found, with people becoming happier, more energized and less anxious than they were before practicing mindfulness (Davidson et al., 2003). Neurologically they found that mindfulness meditators had more activity in the left-sided anterior part of the brain which was associated with reductions in anxiety, negative affect and increased positive affect, as well as more adaptive responses to stressful situations and increased resilience compared to non-meditators in the control group. In addition, they also found an association with the increased left-side activation of the brain involved with enhanced immune functioning. They concluded that even a short mindfulness meditation programme (in this case an eight week MBSR programme) could have demonstrable effects on the brain and immune functioning.

According to Siegel (2014), mindfulness meditation practitioners live not only healthier but also longer lives. He prescribed this to the fact that the more present we are in life, the higher the level of the enzyme telomerase in our bodies which maintains the life preserving ends of our chromosomes. As mentioned earlier, through natural progression and aging these chromosome caps wither away, more so if confronted with chronic stressors, implying that chronic stressors

enhance the aging process. The increased level of telomerase is hypothesised to be another explanation for the enhanced immune system of mindfulness practitioners.

Mindfulness through the years has gained legitimacy due to increased neuroscientific and empirical evidence. It has been found to have positive benefits at all levels of functioning. Research has found that mindfulness practice has many beneficial health effects for example it has been found to: reduce blood pressure and cortisol levels (Carlson, Speca, Faris & Patel, 2007); enhance immune functioning (Davidson et al., 2000); and to increase telomere activity (Siegel, 2014). Psychologically, mindfulness has proven to be a beneficial clinical intervention for mental disorders such as anxiety (Hoffman, Sawyer, Witt & Oh, 2010), depression (Teasedale, Segal & Kabat Zinn, 2007), chronic pain (Kabat-Zinn, 2013), and substance abuse (Bowen et al., 2006). Further than that, mindfulness also has been found to enhance psychological well-being (Chiessa & Serretti, 2009), improve cognitive functioning (Jha, Krompner & Baime, 2007), increase information processing speed by increasing ability to focus (Moore & Malinowski, 2009), and most importantly, for mental health practitioners, to enhance cognitive flexibility and ability to self-observe (Davidson, Jackson & Kallin, 2000). The concept of enhanced psychological well-being will be explored further in the next section both at an intrapersonal and interpersonal level.

Intrapersonal benefits

Mindfulness based interventions emphasise present moment awareness, non-striving and acceptance, which is paradoxical to stressful situations. This could be a reason that mindfulness has consistently shown positive results not only in stress reduction but in imbuing positive qualities in individuals.

This fact is highlighted in an explorative qualitative study of experiences with MBSR by university students with performance anxiety (Hjeltnes, Binder, Moltu & Dundas, 2015). Salient themes that were recurrent in most of the students' experiences were that they felt they had an inner source of calm; they shared common struggles and thus were not alone; they could stay more focused in the present moment; they moved from an attitude of fear to curiosity; and finally, felt more self-acceptance when faced with difficult situations.

This theme of ‘calmness vs. stress’ and ‘another way of being’ as I perceive it, has been found in many studies and across different samples. In a meta-analysis focusing on MBSR as a stress reduction method among predominantly mental health practitioners, Chiesa and Serretti (2009), found MBSR to be an effective intervention both for reducing stress in healthy individuals, as well as for improvements in spirituality, empathy and compassion, and a decrease in ruminative thoughts. Moreover, in a systematic meta-analysis of 31 randomized, clinical trials assessing the effectiveness of MBSR in improving health, quality of life and social functioning in adults, DeVibe et al. (2012) concluded that MBSR appeared to have consistent and large improvements on measures of personal development, including empathy, coping, enhanced present-moment focus and a sense of coherence, while improving symptoms of stress and mental health.

In earlier research, the pilot study conducted by Shapiro et al. (2005), regarding the MBSR as an intervention for short term stress management in health care professionals, suggested that the eight week MBSR programme was an effective intervention for health care professionals in terms of stress reduction, increasing quality of life and self-compassion. In the later study of Shapiro et al. (2007), discussed previously, on the self-care of care givers who completed the MBSR programme, found a significant decline in stress, negative affect, anxiety, and rumination, with increased levels in self-compassion, emotional regulation and positive emotional states.

In a qualitative research study on the impact of mindfulness training on counselling students’ perceptions of stress, it was concluded that those students who practised mindfulness appeared to be more present in the moment, with increased awareness of bodily and feeling states regarding stress, and increased confidence and self-compassion (Felton, Coates & Christopher, 2013).

According to Howe (2015), MBSR has also been shown to be an evidence-based intervention that helps professionals learn stress reduction skills and promote self-care. It was found to be effective with symptoms of burnout, and provided a sense of coping with job related stressors. Similarly, in a review of eight empirical studies on MBSR among health care professionals, the results consistently showed significant increases in relaxation, positive mood and affect, increased life satisfaction, and self-compassion, with also decreases in burnout, perceived stress, anxiety and depressive symptoms, health related complaints and over identification of clients’ issues (Irving et al., 2009).

In a study conducted to explore the usefulness of mindfulness in traditional psychotherapy, Dorn (2014) suggested that mindfulness interventions were operative in psychotherapy in the following ways:

- 1) It provided a paradigm to understand and treat a variety of mental health disorders;
- 2) It appeared to aid the therapeutic alliance by allowing the therapist to remain grounded, present and authentic in interactions and
- 3) It also seemed to promote self-care and assist the clinician to be their most effective self in therapy by being able to help regulate affect in themselves and their clients.

In the therapeutic setting, mental health practitioners are critical in facilitating the change process. This highlights the fact that mental health practitioners should take extra care of themselves by setting appropriate boundaries to maintain a balance of self and compassion for others, giving of just the right amount of themselves to bring about change but also to prevent personal burnout. Practising MBSR assists in shifting mental health practitioners from a ‘doing’ mode to a ‘being’ mode; this invites acceptance of the present circumstances without the pressure, and to trust the process of unfolding time. It provides an effective skill to increase meta awareness and emotional regulation to break negative emotional states and mental modes (Lee, 2013).

This new way of being which embodies a sense of well-being, awareness, openness and acceptance serves as a good model for clients. When a practitioner is more relaxed and self-attuned, it leads to better quality and outcomes for the sessions. In the following section the impact of a mindful practitioner with an enhanced sense of well-being on the quality of the therapeutic relationship and therapy outcomes will be reviewed.

Interpersonal benefits

Kabat-Zinn (2013) summarises the way mindfulness effects relationality in the following words, *“Over the years, I have increasingly come to realize that mindfulness is essentially about relationality-in other words, how we are in a relationship to everything, including our own minds and bodies, our thoughts and emotions, our past and what transpired to bring us, still breathing,*

into this moment-and how we can learn to live our way into every aspect of life with integrity, with kindness towards ourselves and others, and with wisdom.” (p. xxxvii).

The therapeutic relationship has been found to be the most prominent factor to account for success in therapy irrespective of the theoretical orientation (Fulton, 2005). The act of providing mental health services requires a high degree of mindfulness. A therapist must be aware of subtle verbal and non-verbal cues, paying attention to not only content but context; what is and what is happening in the present moment in therapy (Naidu & Ramlall, 2016). Additionally, also being able to identify and respond to the client’s emotions with a non-judgmental attitude. All these processes that are part of effective therapy are in a sense, being mindful. Mindfulness has been shown to be very effective in developing qualities, such as empathy, awareness and attention, as well as a non-judgmental stance and compassion that could enhance the therapeutic relationship (Lee, 2013; Davis & Hayes, 2011; Fulton, 2005; Shapiro et al., 2007).

A few studies were conducted among psychotherapists or counselling students in training regarding the impact of mindfulness meditation on client outcome. Grepmaier et al. (2007) examined the extent to which the promotion of mindfulness in psychotherapists in training would influence clients’ outcomes. They found that clients of trainees who meditated showed faster rates of change, greater reductions in symptoms, greater sense of well-being, and perceived treatment to be effective. Older studies have shown no correlation between therapist mindfulness practice and client outcomes (Brown & Ryan, 2003; Stratton, 2006). However, a four-year qualitative study with a sample of counselling students in which the influence of the different components of the MBSR programme was examined (Schure, Christopher & Christopher, 2008), it was found that other than the personal positive effects of enhanced physical, emotional, spiritual and interpersonal changes, the students additionally reported a positive impact on their counselling skills and therapeutic outcomes as well. The students spoke of improved empathy and awareness as well as increased comfort levels with silence and even negative emotions. They also noticed that they were more attentive to the therapy process due to what they reported as increased insight and greater perspective due to the enhanced ability to reflect.

In later years, in the study of Stuart (2012), with a sample of trainee psychological therapists who practised mindfulness, the therapists reported feeling better in sessions due to an increased capacity

to be present with negative emotional states, having greater self and process awareness and a strong sense of trust, as well as feeling more empowered in themselves and the process. This study also highlighted the enhanced relational depth felt by the therapist; in the sense of just being with and totally connecting to the client seemed to lead to much deeper connections and enhanced outcomes.

Similarly, the impact of mindfulness meditation, specifically its impact on therapists and the therapy process was also explored. In a study aimed at exploring the relationships between mindfulness, well-being, burnout and job satisfaction of 58 individuals working as therapists, findings indicated that mindfulness was associated with higher levels of cognitive and affective well-being, and job satisfaction, and lower experiences of burnout (May & O'Donovan, 2007). The findings also showed how mindfulness was linked to higher functioning of the therapists, subsequently leading to positive client outcomes. In an unpublished master's thesis (Zamir, 2009), the qualitative study findings pertaining to mindfulness indicated that therapists felt that their alliances with their clients were strengthened with an increase in their own positive qualities namely, increased empathy, positive regard and non-judgmental stance (Zamir, 2009). This study implied that mindfulness meditation facilitates the therapeutic relationship as a strong working alliance has been shown to be a consistent predictor of positive outcomes in therapy (Hersoug, Hoglend, Monsen, & Havik, 2001).

At a more personal level of relating to others, mindfulness has been associated with improved relationship satisfaction (Barnes, Brown, Krusemark, Campbell & Rogge, 2007). Some of the reasons for this improved interpersonal way of relating becomes apparent in the study conducted by Dekeyser, Raes, Leijssen, Leysen & Dewulf (2008), who found that mindfulness was associated with increased emotional honesty, transparency, and ability to handle the stressors of relationships. As well as, decreased social anxiety and less distress contagion. Mindfulness was also associated with an increased ability to forgive which enhanced emotional recovery and decreased over identification of anger which made the participants more resilient (Johns, Allen & Gordon, 2015).

So, what makes mindfulness so effective on so many different levels? This is the question that will be dealt with in the next section.

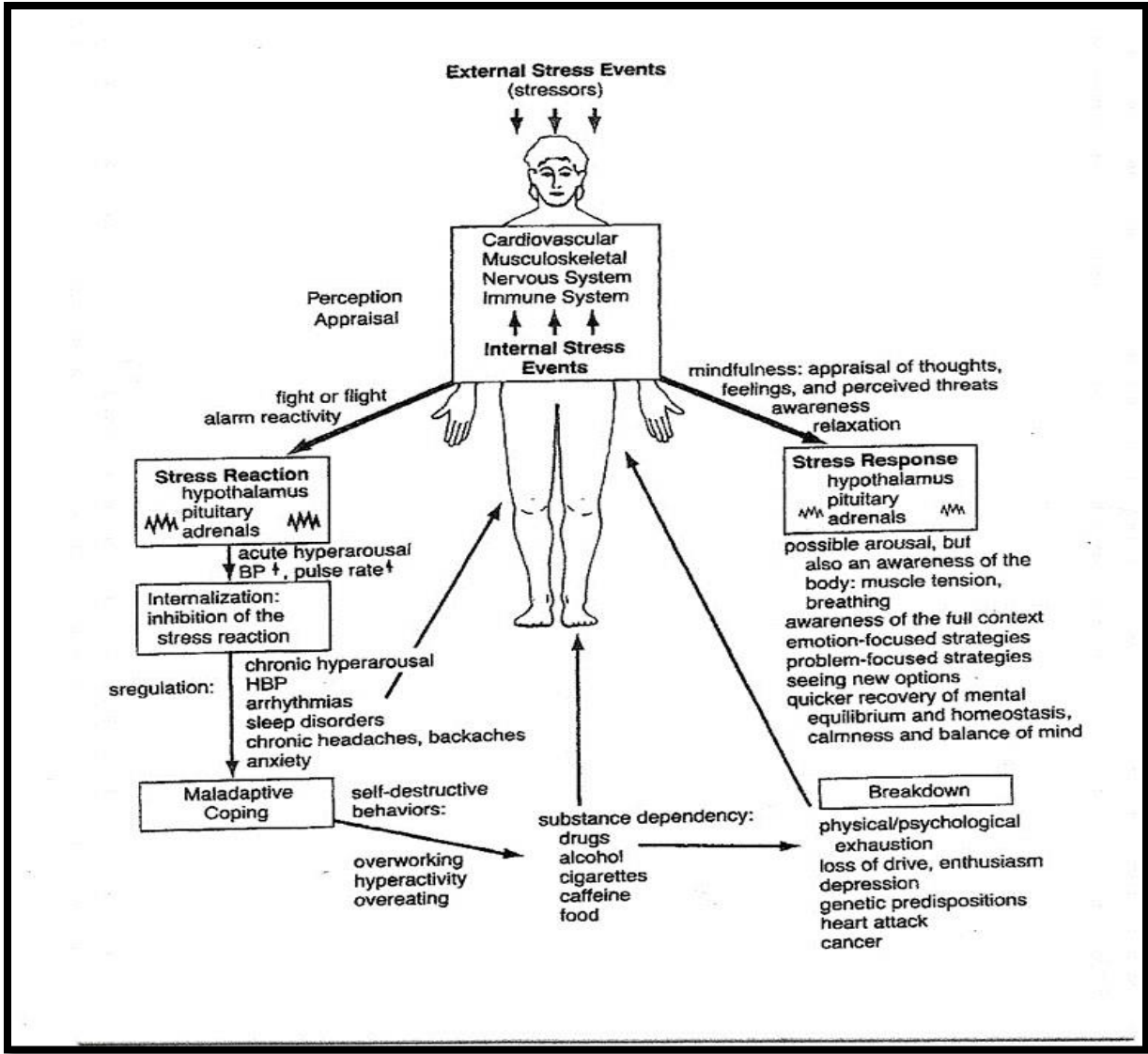
2.6. Shared theoretical underpinnings of the transactional stress and the mindful coping model

Mindfulness has been practised for over 2,500 years and as mentioned earlier, has its theoretical orientation in Buddhist psychology (Lee, 2013). However, it shares conceptual ideas with many other philosophical and psychological traditions, including phenomenology, existentialism, naturalism, transcendentalism and humanism (Brown, Ryan & Creswell, 2007).

Currently Mindfulness is used as part of psychotherapy to increase awareness to mental processes that contribute to emotional distress and maladaptive behaviours and aid clients to view their situations from a different perspective and respond skillfully with healthier coping strategies (Bishop et al., 2004). Contemporary psychological research has reformulated the concept of mindfulness into many different abilities such as: “attention, intention and attitude” (Shapiro, Carlson, Astin & Freedman, 2006, p. 374); self-regulatory capacity (Brown & Ryan, 2003); meta cognition (Bishop et al., 2004) and composure, acceptance and non-attachment (Hayes & Feldman, 2004).

A common underlying concept with these qualities is a meta cognitive form of awareness that involves a process of decentering. Decentering or re-perceiving is a shift of cognition that enables a reframing or alternate appraisal of life events with a non-judgmental attitude (Garland et al., 2009; Holzel, Lazar, Gord, Schuman-Olivier, Vago & Ott, 2011). This re-perceiving allows a shift from reactivity to stressful events to instead having a choice to respond to the stressors (refer to figure 1: The coping with stress diagram on next page).

Mindfulness has also been hypothesized to play a causal role in emotional regulation through a process called positive reappraisal coping. Positive reappraisal refers to a cognitive strategy for reframing a situation to see it in a more positive light (Folkman & Moskowitz, 2000). Mindfulness allows the shift from stress appraisal to positive reappraisal by making one aware that thoughts are transient, psychological events rather than reflections of absolute reality (Garland et al., 2009). This change in relation to thoughts has been hypothesized to be the reason that mindfulness leads to enhanced emotional regulation (Holzel et al., 2011). Positive reappraisal has been found to be a critical component of meaning-based coping, like existentialistic principles, that involves individuals being able to adapt more successfully to stressful life events by finding positive meaning in them (Garland et al., 2009).



Coping with stress diagram: respond vs. react to stressor (Kabat-Zinn, 2013)

Emotional regulation is defined as the alteration of ongoing emotional responses through the action of regulatory practices (Oschner & Gross, 2005). Emotional regulation can be tested by measuring physiological reactivity during tasks. Studies support the proposition that meditation training leads to decreased emotional reactivity and facilitates a return to emotional baseline (Davidson et al., 2003; Holzel et al., 2011). In the latter study, where a team of scientists used an electroencephalogram (EEG), to measure the activity in the brain, the findings showed that MBSR practice led to increases in left side anterior brain activation which is usually associated with experience of positive emotions. These findings support the claim that mindfulness practice

influences the physiological aspects of positive emotions and thus leads to positive emotional processing.

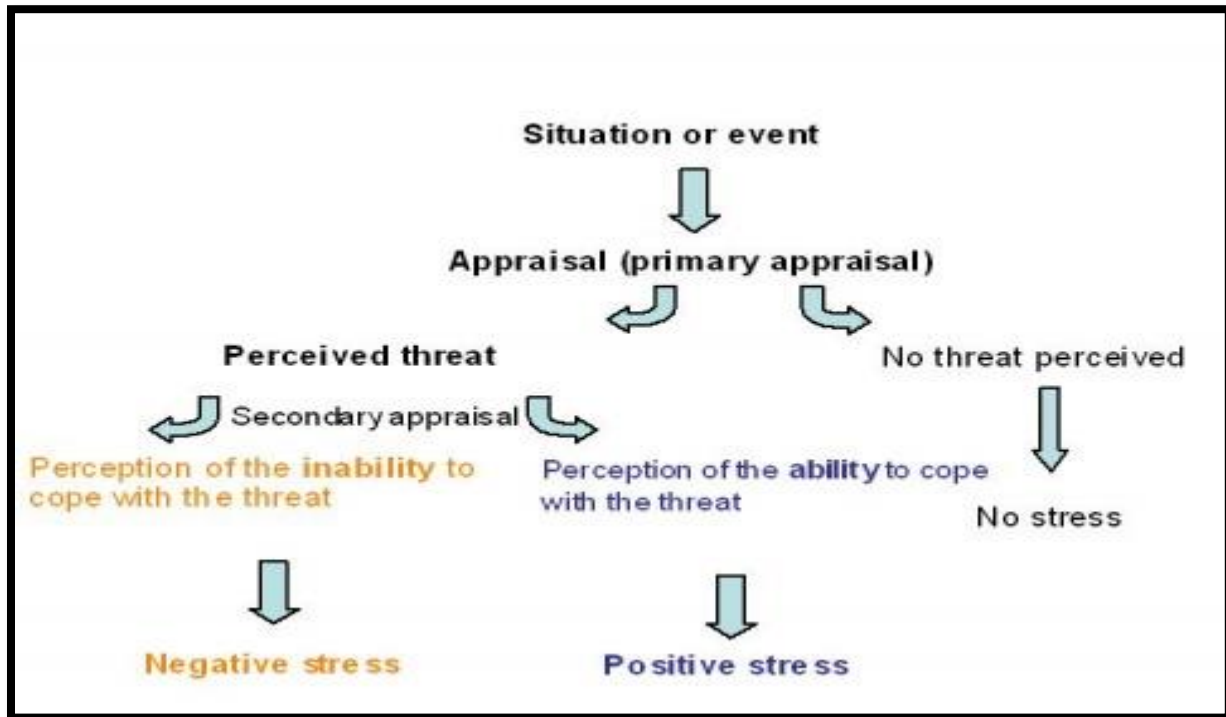
To explain how the mechanisms of positive reappraisal work in relation to stressors, it is critical to understand the stress response and the cognitive workings behind it. For this study, I have used the theoretical framework of Lazarus and Folkman's Transactional Theory of Stress (1984) to explain the role of mindfulness and its hypothetical effect on positive reappraisal.

Lazarus and Folkman's Transactional Theory of Stress (1984)

According to Lazarus and Folkman (1984), it is not just the stressor that affects us, but the way we perceive it. When a person is confronted with a stressful situation they engage in a cognitive process that entails a primary and secondary appraisal. The primary appraisal entails evaluating a situation in relation to one's well-being and classifying it as positive, negative or irrelevant. A situation perceived as negative would then further be classified into possible harm, threat or challenge. If the classification is harm or threat, it usually elicits negative emotions like fear and anger and stimulates the hypothalamic-pituitary-adrenal (HPA) axis and the subsequent stress response discussed in chapter 2 under the physiology of stress. However, if the potential stressor is classified as a challenge, it elicits positive emotions such as hope and enthusiasm and not necessarily the stress response.

Furthermore, if the situation had been perceived as negative, secondary appraisal would occur to evaluate if the person considered themselves able to cope with it in accordance to their resources. Based on this secondary appraisal, they would consider their options and decide on the way forward on how to deal with their stressor. The level of stress experienced and activation of the HPA axis, is largely based on this evaluative process of gauging their available resources in relation to how much the stressor will require of them (Garland et al., 2009). Research supports the claim that the physiological stress response depends partly on whether the stressors are cognitively appraised as challenging or threatening (Refer to Figure 2, The Transactional Theory of Stress). It should be noted that this definition emphasises relationality, the critical role of appraisal and conscious choice.

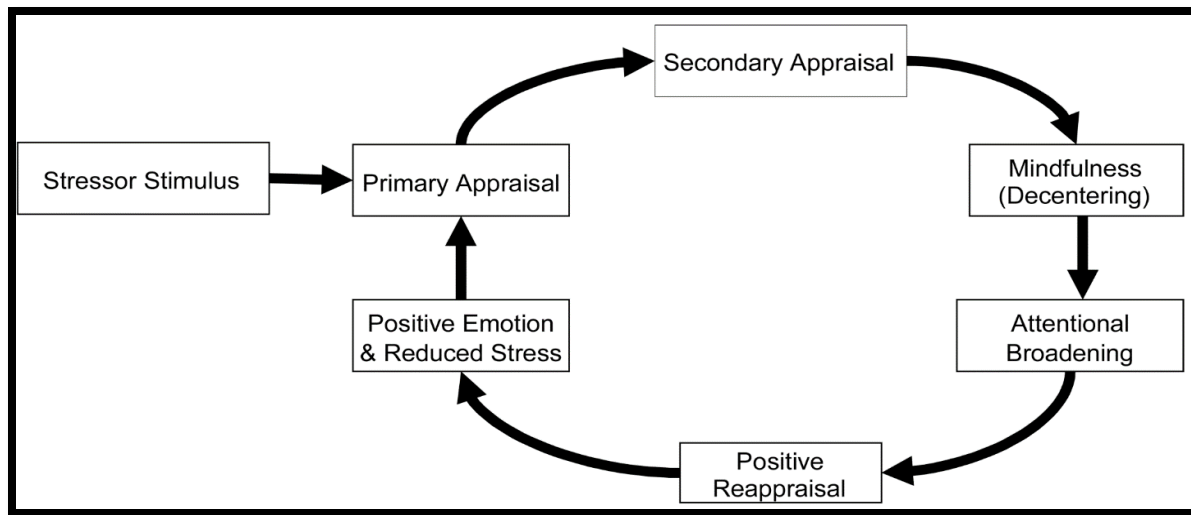
Figure 2: Transactional Theory of Stress (Lazarus & Folkman, 1984)



Being mindful, as discussed earlier, involves attention to the present moment and awareness of self and thoughts (Brown & Ryan, 2003). These qualities allow for a realistic appraisal of the demand as a threat or challenge and to evaluate the coping mechanisms accordingly (Hansen, 2016). It is also pertinent to remember that mindfulness was associated with reductions in physiological reactivity and increased positive emotions, thus allowing for enhanced emotional regulation and reactivity (Davidson et al., 2003) (Refer to Figure 3: The Mindful Coping Model).

Positive reappraisal has been found to have a critical role in reducing distress in the face of a number of stressful situations by imbuing positive meanings (Folkman, Chesney & Christopher-Richards, 1994). It can be an active coping strategy that is usually the first step in reengagement with a stressor event (Garland et al., 2009). It allows the person to feel that they have a choice in the situation and thus to reappraise events as an opportunity for change rather than being helpless and hopeless.

Figure 3: The Mindful Coping Model (Garland, Gaylord & Park, 2009)



The mindful coping model explains the relationship between mindfulness and positive reappraisal, as well as, the mechanisms behind mindfulness as an ‘emotionally-focused coping process’ (Garland et al., 2009). It appears to provide the rationale for mindfulness training as a clinical intervention to enhance the meaning-making coping process for clients experiencing stressful situations. However, it is critical to recognise the fact that this model does have some limitations as explained by Garland et al. (2009). These are: First, the presence of such a mechanism may be difficult to substantiate due to the actual appraisal and reappraisal processes being so brief. Secondly, mindfulness may facilitate coping through pathways other than positive reappraisal. And finally, positive reappraisal seems to be in paradox with mindfulness principles of non-judgement. However, instead of seeing positive reappraisal as what we are striving for, it is seen as a result of a decentred mode of awareness that allows for new cognitive appraisals and meaning-making processes.

Mindfulness thus allows for a different set of lenses to be used in viewing stressful situations and the meaning attached to it. It is fundamental to a positive relationship with stress, in that it allows for awareness and attention to what is unfolding in the moment, realistically appraising it and choosing wisely. This idea is well summarised by the developer of the MBSR programme Kabat-Zinn who said, that if we change the way we see, we subsequently change the way we respond and this has a profound impact on our stress levels and its consequences on our health and well-being (Kabat-Zinn, 2013).

CHAPTER 3

METHODOLOGY

3.1. Introduction

Research methodology concerns itself with the methods and procedures used when studying the phenomena under investigation. The focus is on the research process and the kind of tools used to answer the research questions efficiently (Mouton, 2013). This chapter begins by providing an overview of the research design used to effectively achieve the aims of the study, followed by an explanation on the selection of the participants. The research instrument and the data collection method are discussed after which a detailed explanation of the data analysis employed is presented. The chapter concludes with a reflection section and furthermore how this study aimed to maintain a sense of trustworthiness.

3.2. Research Design

A research design is a plan or blueprint of how the researcher intends to conduct the research (Mouton, 2013). A point of departure is the research question and what kind of evidence is required to address the research question adequately. Simply put, it is the strategic framework for action that serves as a guide for collection of data and analysis in a manner that aims to combine relevance to the research purpose with economy in procedure (Terre Blanche, Durrheim & Painter, 2006). Thus, the goals of the study dictate the type of approach used and should be determined by the research question and objectives not the preference of the researcher (Marshall, 1996). This study was based on the interpretive paradigm which concerns itself with understanding phenomena from the participant's perspective and within the participant's context, in an empathetic manner (Terre Blanche et al., 2006). The interpretivist paradigm assumes that the researcher cannot separate themselves from their knowledge and values which become inherent in the research process (Cohen & Crabtree, 2006). Though some may see this as a disadvantage, the benefit of

working from this paradigm is that it provides an opportunity to gain deeper insight into the research question (Andrade, 2009). Moreover, it allows for the researcher to become a ‘passionate participant’ by not just observing the views of the respondents but also making sense of their views and converting it into an understandable format (Neuman, 1997). Aligned to this paradigm and the aim to gain a deeper understanding of the phenomenon studied, a qualitative approach was adopted for which the rationale will be discussed in more detail below. The aims of this study were exploratory in nature due to the study being a preliminary investigation into mental health practitioners’ experiences with the MBSR programme, a relatively novel area of research within South Africa. The methods employed in an exploratory research are open, flexible and inductive since the methodology looks for new insights into an existing phenomenon.

3.2.1 A Qualitative Approach

Qualitative research is a term used to define a variety of research approaches which share certain elements. It is research that is not focused on causal laws but is centred in peoples lived experiences, beliefs, values and meaning systems from their own perspective (Terre Blanche et al., 2006)). Methods used in this type of research are by nature more subjective, considered to be holistically with consideration of the social context (Brink, 1993). The aim of a qualitative approach is to increase insight and understanding of phenomenon relevant to answer the research question (Vaissmoradi, Turunen, & Bondas, 2013). The overall aim of the study was to gain insight into mental health practitioners’ experiences and the likely value of offering mindfulness training as a technique to mental health practitioners to change the way they respond to stressors in their lives and subsequently enhance their therapeutic effectiveness. Specific attention was paid to mental health practitioners’ experiences of imbuing mindfulness through the MBSR programme. This was achieved by exploring how mental health practitioners, who completed the MBSR programme, experienced mindfulness in their lives, both at a personal and professional level as well as intra and interpersonally. Since the data required to answer the study’s research questions focused on the participants’ experiences, the qualitative method was determined to be the method of choice. Qualitative research methods entail systematic collection and interpretation of textual material which in this case was derived from an online open-ended instrument, but can also be

derived from observation and interviews (Malterud, 2001). The advantage of using this type of research methodology was that the researcher could elicit richness, depth, nuance, context, multi-dimensionality and complexity of data that would have been lost in more quantitative methods (Mason, 2002). This advantages were summarised aptly in the following words, “*These methods aim to answer questions about the ‘what’, ‘how’ or ‘why’ of a phenomenon rather than ‘how many’ or ‘how much’, which are answered by quantitative methods*” (McCusker & Gunaydin, 2015).

It is best to view quantitative and qualitative research as complementary as opposed to contradictory due to the strength of each method being different, but the fundamental principles being the same (Malterud, 2001). Though the procedures for analysis are different due to the different type of data being used and types of questions being answered, one method should not be considered as superior or more useful than the other. However, qualitative research is still viewed with scepticism by the scientific community due to its subjective nature, so called lack of scientific rigour and absence of facts (Malterud, 2001). The trustworthiness of qualitative research is often questioned by positivists because their concepts of validity and reliability cannot be addressed in the same way as empirical work. However, frameworks for ensuring rigorous trustworthiness have been in existence for years (Shenton, 2004). The framework that I chose to ensure the trustworthiness of this study is that of Lincoln and Guba (1985), which will be discussed in more detail at the end of this chapter.

3.2.2. Online, Qualitative Survey

Data was collected via an online, qualitative survey. Surveys are usually defined as “...*a systematic method for gathering information from (a sample of) entities for the purpose of constructing quantitative descriptors of the attributes of the larger population of which the entities are members.*”(Groves et al., 2004, p.4). From this definition, it becomes apparent that surveys were predominantly used for quantitative research. However, according to Fink (2003), surveys can also be used qualitatively to allow for the exploration of experiences, meanings and values. Furthermore, it allows for variation or diversity of views on the topic of interest to be expressed as well as the commonalities of the participants’ experiences (Jansen, 2010)

The rationale for using an online qualitative survey, in the form of an open-ended questionnaire, was that it has become a method of choice, especially with qualitative researchers due to the advantage of making it possible to communicate via geographical distances and time zones at the convenience of both the participant and researcher (Im & Chee, 2012) and allowing access to participants that otherwise would have been difficult to reach (Whitehead, 2007). There are many additional advantages i.e. being less expensive (Sue & Ritter, 2007) and quicker to disseminate (Ahern, 2005) than paper based questionnaires or face-to face interviews. Data is already in electronic format which makes data analysis simple since it can be loaded directly into the data analysis software (Sue & Ritter, 2007) for quantitative studies in particular, but in this case, NVivo 10 software (QSR, 2012) was used which is specifically designed for qualitative analysis. In terms of advantages to the respondents, it has been found to require minimal effort to access and send which according to Sue and Ritter (2007), should increase response rate and generate rapid responses. Respondents can access the survey at their own convenience (Jones, Murphy, Edward & James, 2008), and can stay anonymous which should encourage more honest answers and as mentioned before should increase response rate.

However, as easy, inexpensive and convenient the online data gathering method is (Hunter, 2012), it is not without some disadvantages. An example of this is that online questionnaires seem to actually yield lower response rates This phenomenon will be further discussed in the study limitations section of chapter five. According to Comley (2000), most online surveys show a response rate of 15-29%. Some reasons cited for this low response rate are that some people are 'technophobic' (Hunter, 2012), feel they lack the necessary skills to fill in an online questionnaire or some respondents with slow internet connections or older computers, may feel to upload their answers or download the questionnaire will take too long or be too expensive (Stewart, 2003). They may also not be motivated to complete all the questions (Whitehead, 2007) and elicit briefer answers (Velez, Buletti & Volz, 2004) than an interview set up or interviewer administered questionnaire.

However, Hunter (2012), concluded that electronic questionnaires are one of the most convenient, easy to access and quick way to collect data if the researcher follows certain strategies to maximise response rates and data quality. A method used in this study was to use not just purposive but also snowball sampling techniques by approaching recognised mindfulness practitioners and

organisation, to increase response rates. More of these strategies will be discussed further in the recommendations section of chapter five.

3.3. Participant Selection

The sampling procedure used in this study was non-probability sampling. Non-probability sampling according to Terre Blanche et al. (2006), is the type of sampling in which the way respondents are chosen is not random. Both purposive and snowball sampling techniques were used to gather the data. Purposive sampling entails looking for respondents not just on the criteria of availability and willingness to participate but also for specific traits that are relevant to answering the research question (Terre Blanche et al., 2006). In this case, it was the specific inclusion criteria of practicing as mental health practitioners and have completed a MBSR programme. Furthermore, a snowballing technique was also employed in that I approached known mindful mental health practitioners and organisations and requested them to not only fill in the questionnaire, but to also pass it on to others who are known to them who have completed the MBSR programme.

The rationale for using purposive sampling over non-purposive sampling was to attempt to increase the response rate as online surveys have been reported to have generally low response rates. A higher response rate was viewed as necessary to gain a thorough understanding of the mental health practitioners' experiences of a mindfulness practice and its influence on their personal and professional lives.

Participants i.e. mental health practitioners were recruited via the internet by posting information about the study on social media sites e.g. Facebook, LinkedIn, Twitter, online mindfulness discussion forums, and Google mindfulness research groups. If they were interested, a web link was provided to take them to the study. The online qualitative survey hosted by the Monkey Survey website. Participants who were known MBSR practitioners that were approached, were sent the link directly via email and as mentioned above, requested them to send it to others who have completed the MBSR programme and were willing to participate in the study.

Data was intended to be collected until theoretical saturation was reached. This implied that the researcher intuitively decided when enough data had been collected to answer the questions of the study adequately and was not predetermined (Eisenhardt, 1989). However, in this case the decision was also based on pragmatic criteria (Morse, 2000), namely; the number of people that responded in the allocated time of two months and the quality of the data they provided. The sampling range that was kept in mind though, was between 10-30 respondents. The number of respondents that completed the questionnaire amounted to 16. Due to the qualitative nature of this study and time constraints, the number of participants was considered adequate. Terre Blanche et al. (2006) suggested that a sample size of six to eight sources is adequate if the information is rich and the sample is homogenous. However, they further suggested that shorter interviews or data sets, as was the case in this instance, can be adequately answered by a sample size of ten to twenty sources (Terre Blanche et al., 2006).

3.4. Research instrument

The data collection instrument as mentioned above was an open ended online questionnaire that provided the necessary structure for online self-administration but also allowed for opportunities to share views and experiences regarding the MBSR programme. (See research instrument in Appendix A). I did not anticipate any risk of physical or mental harm to participants from the research process and refrained from asking any personal or emotionally distressing questions. I also ensured that the questionnaire was convenient in that it was easily accessible via the internet, could be completed in the comfort of their own space, was brief and quick to complete, and questions were in simple, neutral language without the use of jargon. The survey comprised of three parts namely; the informed consent form, the bio-demographic questions and the questions exploring the mental health practitioners' experiences. These three parts will be discussed in more detail.

Informed consent part:

The first part of the questionnaire was the informed consent form (Refer to Appendix D). The inclusion criteria for study participation was stated first (see below) followed by the relevant information about the study i.e. information about the aims and objectives of the study, ethical

principles i.e. voluntary participation, right to withdraw from the study, confidentiality, anonymity of data and how data would be stored and disposed of. A more detailed account of these topics can be found in the ethical procedures section.

The following inclusion criteria were used for the study, the participants had to be:

- over 18 years of age
- have completed the 8-week Mindfulness Based Stress Reduction Programme
- Practice as mental health practitioners (e.g. Doctors, psychologists, counsellors, etc.).

Bio-demographical section:

The second part of the questionnaire consisted of first seven questions which were concerned with demographical information i.e. sex, age, level of qualification, details of their mental health practice, types of clients and issues they worked with, length of time working as a mental health practitioners and the date of when they completed the MBSR programme.

MBSR questions:

The third part consisted of ten questions developed by the researcher to explore mental health practitioners' experiences of the MBSR programme based on previous findings and aligned to the objectives of the study under the following five subtopics:

1. Experiences with the concept and process of cultivating mindfulness i.e. meaning, surprises and challenges.
2. Motivation to enrol in the MBSR programme i.e. expectations, personal or professional goals.
3. The impact that cultivating mindfulness had on their personal lives (intra and interpersonal ways of relating).
4. The impact that cultivating mindfulness had on their profession lives (therapeutic efficiency and client outcomes).
5. The role of mindfulness in self-care to enhance their coping skills in relation to stressors.

3.5. Data collection and procedures

The qualitative online survey was put on the internet in the form of a weblink that took interested participants to the Monkey Survey website where the survey was setup. Once they accessed the

link, it opened on the informed consent page. If the participants met all the inclusion criteria required for the study and agreed to the ethical principles i.e. voluntary participation, right to withdraw, confidentiality, anonymity of data as well as storage and disposal of data, they had to select the option 'willing' to enable access to the next section i.e. the MBSR questions. Once the questions have all been answered the participant had to click 'done'. This automatically submitted the questions to the Monkey survey website, which was followed by an automated email notification to the researcher, who could then access or export the answers as required.

Ethical Procedures

This study was approved by the Humanities and Social Science Research Ethics Committee (protocol ref no: HSS/0374/016M) (See Appendix B). Care was taken to provide adequate information about the study and consent was obtained before the questions could be accessed by interested participants. The consent form contained detailed information on the aims and objectives of the study, clarifying that it was a compulsory part of my Master of Social Science in Clinical Psychology degree. Ethical concerns were addressed by highlighting the fact that this study was completely anonymous; at no point, would participants be asked their names or identifying details. Precautions were taken to ensure confidentiality, which was made possible due to the on-line, anonymous nature of the study. Data was securely stored in an online version which was accessible by the researcher only. Electronic data is to be kept for five years in the Discipline of Psychology. Participants were informed that their participation was purely voluntary, with no rewards or negative consequences if they chose not to participate. Their involvement was purely by choice and for academic purposes. The participants were provided with contact details of the researcher, research supervisor and an administrator of the Humanities and Social Sciences Ethics Committee of the University of KwaZulu-Natal should they require any further information.

3.6. Data Analysis

Data was analysed using thematic analysis (Braune & Clark, 2006), which is a simple, flexible method that allowed data to be reduced into themes that were common to all participants (Smith,

1992; Green & Thorogood, 2004). It was chosen due to it being proven to be a theoretically and methodically sound way to analyse rich, detailed accounts of information (Braune & Clarke, 2006). This was accomplished by using an inductive approach to theme development (Vaismoradi et al., 2013). Even though I started off with vague speculations of what I could expect based on prior research, I allowed inherent themes and repeated patterns to emerge from the data set. The advantage of this approach was to gain a deeper understanding of meanings people attach to their experiences (Terre Blanche et al., 2006). The standard steps of thematic analysis were followed from familiarisation with data to producing the report. The stages undertaken in the analysis were based on thematic analysis as outlined by Braun & Clarke (2006), and the qualitative data software programme, NVivo 10 (QSR, 2012).

Though the steps are presented in an orderly manner, the analysis rarely follows this form. Keeping in mind that qualitative analysis is usually an iterative process; the following key stages were followed to ensure a systematic and audible process (Stuart, 2012; Smith, 1992; Braune & Clarke, 2006):

Step 1: Familiarization with data:

The completed questionnaires were imported from Monkey Survey to NVivo 10 (QSR, 2012). I then immersed myself into the data by reading over it multiple times. By the end of this process I had an idea of what kinds of themes were going to emerge and be supported by the data.

Step 2 & 3: Generating initial codes and searching for themes

This stage entailed inducing codes and themes. Induction means inferring general rules from specific instances. Themes are recurring response patterns or meanings that arise naturally from the data (Vaismoradi et al., 2013; Braune & Clarke, 2006). Once the data was imported to NVivo 10 (QSR, 2012), it was categorized into nodes/themes using the questions as the labels. By comparing the individual questionnaires, I sought to identify patterns of meaning in how the participating mental health practitioners experienced mindfulness as a concept, and the process of imbuing it through the MBSR programme. Meaning patterns were identified when the comparative experiences of several participants had a high degree of convergence (Binder, Holgersen & Moltu, 2012). Initially data was analysed across cases to find common themes. However, as themes

developed data was scrutinised more closely to find differences, exceptions and individual meanings. This ensured minimum data loss and objectivity. I therefore attempted to move beyond merely summarizing the data in this form and looked deeper into the processes, functions, underlying factors and contradictions.

Step 4: Reviewing themes:

During the activity of inducing themes, data was simultaneously being coded by marking different sections that were relevant instances of themes. This process was aided by NVivo 10 (QSR, 2012), which abled me to cluster similar themes together. The themes were only identified if they were common to five or more participants. If they were common to fewer than five, they were incorporated and discussed into bigger themes or as exceptions to the norm. This helped me to find an optimal level of complexity in that I managed to condense the 10 themes into five main themes and sub themes.

Step 5: Defining and naming themes:

Defining and naming of themes entails breaking the data down into a form quite different from what was initially observed. This gives a fresh view of data and allows a careful comparison of sections of text that belong together. Exploring themes more closely in this way is called elaboration. The purpose of this stage is to capture the finer nuances of meaning not captured by the initial, crude coding system. This is also an opportunity to revise the coding system. This was achieved by discussing the themes I had found with my supervisor who suggested moving certain subthemes (child nodes) to different parent nodes. As well as, re-labelling some of the themes to give my readers a clear understanding of what was being described.

This process also provided an opportunity to the researcher to reflect on one's own role in the data collection and interpretation process. Although qualitative methods are by nature subjective, it is an important part of data analysis to make explicit one's own relationship with phenomena and the way it could have influenced the way data was collected and analysed (Vaismoradi et al., 2013). I attempted to make my values and biases apparent and bracketed them as much as possible by writing a reflection on the methodology process, specifically dealing with data analysis and my preconceived bias towards mindfulness as well as, dealt with the subject of confirmability

(objectivity) under the trustworthiness section. Both these sections can be found later in this chapter. This stage took quite a few attempts and was constantly being revised till consensus was reached with my supervisor to ensure that we were doing justice in representing all the relevant data in the most authentic way, generating clear apt definitions for each theme. See table 1 below for the themes that were defined:

Table 1: Themes Defined

Themes	Sub-themes
Experience of mindfulness	Non-judging Increased awareness Present moment focus
Personal outcomes	Respond vs. react to stressors Greater sense of well-being A different way of relating to others
Mindfulness as a therapy resource	Self-grounding Alternate therapeutic intervention Increased effectiveness of therapist
Challenges around the process	Time consuming Requires discipline
Further aspects for consideration	Process not enjoyable Not for everyone

Step 6: Reporting:

As the dissertation was being written, I got a final opportunity to review the themes substantiated by the respondents' extracts and to make sense of it. As I was writing up my final report, I reworked some of the themes, changes the names and moved certain sections about. This refining of data is a critical step in analysis since it allows the researcher to get a bird's eye perspective of the study and see how everything starts to make sense and come together by relating the research questions, objectives, data analysed and literature reviewed.

3.7. Reflection on challenges

In this section I will draw on some of the key aspects of my reflections on the different aspects of the research process. I found the **data collection** process a bit challenging for it was my first experience in collecting data through an online method. Though this gave the study the advantage of being able to collect data across different countries, it was a challenge to find an adequate number of participants to complete the questionnaire via an online platform. Though the open-ended questionnaire consisted of only 17 questions, that was estimated to only take about 20 minutes to complete, there were many incomplete response sheets. The consent form was read by 62 people who gave consent to participate, but only 16 completed all the questions. This was at times frustrating and since the study was completely anonymous there was no control over this. Given these factors, the study sample was not as large as I initially envisaged.

In terms of **data analysis**, though it was exciting to first look at the responses, I felt disappointed to notice that some of the answers were quite brief and lacked depth and detail. While it was expected that online participants would not provide detailed answers, I anticipated that those who were passionate about the topic would be more motivated to share their experiences in more detail. However, the participants did not elaborate too much nor give concrete examples where requested. A personal interview situation would have yielded more in-depth information as the interviewer would have been able to probe further on views and motivate the participants to elaborate on issues of interest.

Though I tried to remain as conscious of my own influence on the data interpretation process, I felt it was difficult to remain unbiased since I hold a very positive view of mindfulness. I had to make a conscious effort to keep these biases and influences in mind. As mentioned before, and addressed below in the trustworthiness section, qualitative research methods are subjective but an important part of attempting to maintain a sense of objectivity or conformability is to make the part of the researcher explicit and bracket any preconceive notions they may have before analysing the data to enable the voices of the participants to be heard rather than the voice of the researcher's opinions (Shenton, 2004).

3.8. Trustworthiness

Trustworthiness is a term used in qualitative research to establish when research findings reflect the intended meanings described by the participants as closely as possible (Lincoln & Guba, 1985). The framework I have chosen to discuss the concept of trustworthiness is that by Lincoln and Guba (1985) that uses four criteria to discuss trustworthiness. These four criteria are credibility, transferability, dependability and confirmability. In this section, I review how this study procedure attempted to uphold trustworthiness based on these four.

- **Credibility** (internal validity) - this criterion concerns itself with ensuring that the study measures what it was intended to (Shenton, 2004). Qualitatively it asks, are the findings congruent with the participant's reality? The credibility of this study was ensured by the following:
 - The adoption of research methods that are well established such as data was gathered using a qualitative online survey. Data was analysed using thematic analysis which entails looking for recurrent themes across the data set.
 - The development of an early familiarity with the topic area and net platform used before data collection starts. This was accomplished by me first completing an

MBSR course online and participating in the online discussion forums to already establish rapport, trust and understanding of the topics discussed.

- Triangulation was achieved in two ways. One in terms of data sources and the other in terms of site, in those individuals were from different parts of the world and from different mental health occupations; this ensured a rich, varied picture of the description of the mindfulness experiences.
 - Ensuring honesty was attempted through making the study completely voluntary with a chance to withdraw at any time without any negative repercussions. The participants that chose to complete the survey did so completely freely and were prepared to share their experiences.
 - Iterative questions were used in that many questions were rephrased to ensure data was congruent and without discrepancy. The final write up also describes in detail that the data showed some differences from the norm and the possible reasons for this. This is discussed in the data analysis section.
 - Background, qualifications and experience of the investigator is a critical factor to be considered to ensure the trustworthiness of a study. I thus ensured that I had experience with the MBSR course before I endeavoured to study the phenomena thus adding to my understanding of the participants' experiences. Additionally, I am a trainee clinical psychologist and am becoming aware of the working environment that mental health professionals are exposed to. In addition, I worked in close collaboration with my supervisor.
- **Transferability** (external validity) – is concerned with the extent to which the study's findings have applicability in other contexts (Lincoln & Guba, 1985). It is a common notion that by nature, qualitative work is generally quite subjective and has limited external validity. This study's transferability was affected by its low response rate, (26%) i.e. 16 participants, which was most likely due to the online nature of the qualitative survey. The

issue of limited transferability will be discussed in more detail in chapter 5 under the limitations section. However, some of these issues were pre-empted and I attempted to ensure maximum response rates and data quality by following the suggestions of Hunter (2012), by taking the following actions:

- Targeted respondents on Mindfulness social media sites so that they found the questionnaire relevant and met the inclusion criteria.
 - Employed a snowballing sampling technique in addition to purposive sampling by approaching known mindfulness organisations such as the university of Bangor, Oxford Mindfulness Centre and Institute of Mindfulness South Africa, as well as known practitioners who wrote some of the mindfulness articles and requested to them to complete and disseminate the email link for the research.
 - Attempted to motivate participants by providing a cover letter to what the research was for and how their responses could contribute to the growing field of knowledge concerning mindfulness.
 - Made every attempt possible to ensure easy access to the survey by providing links on many sites.
- **Dependability** (reliability) – has to do with a study’s procedure being replicable and the process through which findings are derived should be made explicit. This criterion is closely linked to the credibility of the study (Lincoln &Guba, 1985). To increase the dependability of the study I included detailed descriptions in the following sections:
 - The research design and procedures were discussed in the methodology section.

- Established research methods were used in the form of a qualitative online survey for which a detailed discussion of both its advantages and disadvantages were included.
 - The operational detail of data gathering was provided in describing the forums used for the survey and a copy of the research instrument.
- **Conformability** (objectivity) – is established by ensuring the findings are based on the participants’ experiences rather than the ideas of the researcher (Lee, 2013). However, a disadvantage of qualitative research methods is the likelihood that interpretation can be clouded by the researcher’s subjectivity. This is one of the reasons why qualitative inquiries have been treated with some scepticism by the scientific community (Brink, 1993). I was therefore critically aware of the need to reflect on my own views and bracket them in the following ways:
- Steps to minimize positive bias since the participants and I were all keenly interested in mindfulness as a therapeutic intervention and stress reduction tool, I had to be aware of skewing all the information in a positive light. This issue was addressed in the analysis and interpretation by noting the themes that were not just recurrent but also those that were different. This ensured no views were ignored especially those that were critical of MBSR.
 - Open ended questions - Except for the biographical data, all the questions used were open ended and asked for examples to elaborate. This was done to ensure a neutral stance and not to pose leading questions that would biased the responses. However, due to the nature of the study, some participants did not provide sufficient elaboration which was a limitation that will be discussed in more detail in the limitations section in chapter five.

- Questions to elicit balanced views: Explicit questions were asked on challenging aspects, processes that the participants did not enjoy and aspects that surprised them of the MBSR process.
- Using direct quotations of the participants: Direct quotes were included convey the participants' voices authentically and to reduce my own bias as much as possible. This also demonstrated that the findings and interpretations were grounded in the findings.

3.9. Summary of Chapter

To summarise, this chapter entailed the procedures used to answer the research question. It began with details on how the research was designed and the reasons for these decisions. A short section on the sampling procedures i.e. purposive and snowball sampling was presented. The qualitative online research instrument was discussed in more detail. The thematic analyses process was discussed and the themes that were found were mentioned, which will be discussed in more detail in the next chapter. Reflections on what I found challenging about the research process were also discussed. This section concluded with steps the researcher took to increase the trustworthiness of the study. In the next chapter, i.e. chapter four, the findings of the study will be presented and discussed in detail with consideration of the researcher's interpretations of the findings in relation to the literature.

CHAPTER FOUR

FINDINGS AND INTERPRETATIONS

4.1 Introduction

This chapter reports on the details of the bio-demographics of the research participants and the findings i.e. the themes derived from the analysis. Five super-ordinate themes and sub-themes linked to the objectives of the study i.e. experiences of mindfulness, personal outcomes mindfulness as a therapy resource, challenges around the process and further aspects for consideration will be presented and substantiated with appropriate direct quotations. The findings will be discussed and relevant literature will be integrated into the discussion.

4.2 Demographic details of participants

The demographic characteristics of the participants are depicted in table 2 on the next page. The total number of respondents who consented to participate were 62, but only 16 met the inclusion criteria and completed all the questions in the survey. Most of the participants were female with the sample consisting of 13 females and three males. The ages of the participants ranged from the youngest being 25 years old, to the oldest being 67 years. These were the two outlying ages, with most participants being between the ages of 32 and 59 years. The mode and median of the participants were 42 years, and the mean was 41 years. This highlights the fact that most participants were in their middle adulthood (40+), which fits into Erikson's psychosocial life stage of generativity vs. stagnation (Berk, 2013). This stage involves the concept of generativity which means giving to the next generation. This can be through caring for others or achieving productive work. The outcome is the acquirement of meaningful accomplishment (Berk, 2013)

Table 2:

Demographic details of participants

Participant No.	Age	Country	Gender	Highest Level of Education	Occupation	Work Experience	Year Completed MBSR
1	42	U.K.	Male	Territory	Personal development trainer	Work with clients that have phobias, depression etc.	2015
2	67	U.K.	Female	Master's	Psychotherapist	Use imagery and compassion based CBT with individuals and couples for depression and anxiety	2013
3	36	R.S.A.	Female	Master's	Psychologist	Work with children who experience emotional and behavioural difficulties.	2013
4	35	R.S.A.	Female	Master's	UX consultant	Consults clients with mental and physical health related issues. Health promotion using technology.	2009
5	42	New Zealand	Female	PhD	Teacher	Provide crisis support and manage peer support	2016
6	34	India	Female	Master's	Psychologist	Cognitive Behaviour therapy practitioner	2016
7	35	Ireland	Female	Master's	Mental Health Nurse	Work with people over 65 with mental illness	2015
8	32	Ireland	Male	B.A. (Hons)	Psychotherapist	Works with trauma	2011
9	50	R.S.A.	Female	Master's	Psychologist	MBSR trainer and psychologist in private practice	2008
10	44	U.S.A.	Female	PhD	Psychologist	Work as psychologist and lecturer in a medical school	2004
11	41	Canada	Female	Master's	Therapist	Focus on children's, adolescents' and adult mental health issues	2015
12	59	R.S.A.	Female	PhD	Psychologist	Work in State hospital, counselling patients.	2016
13	55	Ireland	Female	Medical Degree	General Practitioner	First point of access to community for health issues.	2012
14	50	R.S.A.	Female	Master's	Psychologist	Private practice	2011
15	25	R.S.A.	Female	B Psych	Trauma counsellor	Worker with rape victims and trauma survivors	2015
16	42	R.S.A.	Male	Matric	Life Coach	Life coach for business and personal development	2012

According to Super's Developmental Self Concept Theory (Super, 1980), which views vocational development as the process of developing and implementing a self- concept, people from the age of around 40 to 60 years are in the maintenance phase of their career development. This phase has the major task of preserving one's gains and developing non-occupational roles for things one always wanted to do. This can be accomplished by accepting one's limitations, identifying new problems to work on, and developing newer skills to stay efficient. Focusing on essential activities, and preserving achieved status and gains, is also a critical part of this stage (Super, 1980). In my opinion this is also a critical stage when burnout, compassion fatigue or disengagement could set in as Schreiner (2012), observed that this phase consisted of a great deal of dissatisfaction and possible disillusionment, thus a possible reason for completing the MBSR programme as a self-care strategy to reduce stress. The MBSR course could be a way of enhancing coping mechanisms through an evidence based technique. It is likely that the increased burnout risk in this lifespan stage prompted participants, in search for effective self-care strategies, to complete the MBSR programme. The data is also showing that most participants completed the MBSR course in the last five years.

An interesting observation pertaining to the time of completion of the programme was that though ten (62 %) of the practitioners were over 40 years of age and thus in the mental health field for an average estimated time span of 17 years, most of them completed the MBSR course in the previous 5 years (88%) as mentioned, with four (25%) completing the MBSR in the previous year (2016). The longest practising practitioner had been practising for 20 years, but formally completed the MBSR course 12 years before (in 2004). The greater uptake of the MBSR in the last five years is likely due to not only because of the growing interest in mindfulness as a viable stress reduction technique, but also greater access of the MBSR course to people via the internet irrespective of geographical distances and time constraints. Online MBSR programmes allow for formal practices to be conducted by following guided meditation videos and the informal practices to be followed and written in a log. Some courses are even freely available, while others like the original MBSR course provided by the University of Massachusetts Medical School can be bought of their website (Santorelli & Mcleo-Meyer, 2016), making it accessible globally and having the added advantage of being able to practice at one's own convenience (Please see Appendix C for full course outline).

Which brings us to the next topic related to demographical factors that is the participants' geographic locations.

The participants were from many different countries across the world but many was from South Africa i.e. seven of the participants (44%). This could be due to the active recruitment of mental health practitioners through more local social media sites and known mental health practitioners who had completed the MBSR course. There were 3 participants (18% of the sample) from Ireland which could be due to mindfulness being a part of their postgraduate psychological training, a fact that was highlighted by one of the Irish participants. There were only two participants from the United Kingdom while two were from Canada and The United States of America (12% of the sample)

Most the participants were psychologists i.e. six of them (37.5%), followed by three psychotherapists (12.5%). However, the rest of the sample were from diverse backgrounds including medical doctors, mental health nurses, and a teacher. This ensured an interesting array of responses from different backgrounds and experiences. The area of work specialisation of the respondents ranged from emotional to behavioural issues. The most common area of focus was personal development and trauma care and support, followed by depression and anxiety. Many practitioners spoke of various mental health issues but did not give much detail on what exactly these were. The most unusual work context was that of a participant who works as a mental health UX consultant – a person who is involved in the design and development of applications and website parts that the end-user interacts with. She motivates people to stay fit both physically and psychologically by designing websites and applications to encourage desired behaviours. She was inspired to complete the MBSR programme to enable her to work on physical health issues at both a personal and professional level with a focus on eating mindfully.

The next topic relates to how the mental health practitioners experienced mindfulness. Though thematic analysis divides the data into separate themes there was significant overlap within and across themes, therefore many of the themes' discussions were combined.

4.3. Finding as per themes

The findings in this study confirmed the notion of Kabat-Zinn (2013), that mindfulness was all about relationality. Relationality towards oneself, others and the way one approached all aspects of life. Mindfulness seems to make people aware of a different way of being, a way in which each moment is savoured and appreciated with an attitude of curiosity and appreciation. The themes in this study will be discussed in the order of inwards going out, that is from intrapersonal ways of relating to one's self and the environment to interpersonal ways of relating to others. The different themes identified i.e. Experiences of mindfulness, Personal outcomes, Mindfulness as a therapy resource, Challenges around the process and Further aspects for consideration will be discussed in detail, providing direct quotes from the respondents and relevant literature to enhance understanding.

4.3.1 Experiences of Mindfulness

The MBSR intervention was designed to teach participants to become more aware of what was happening in relation to bodily sensations, emotions and thoughts and to enable the practitioner to relate differently to it. This new way of relating was cultivated by increased awareness and a non-judgemental acceptance of what was happening in the present moment (Shapiro et al., 2005). These programme objectives have been further confirmed in this study as the mental health practitioners explained their experiences in terms of non-judging, increased awareness and present moment focus.

4.3.1.1 Non-Judging

Around half of the participants reported that being mindful meant an increased sense of acceptance of self, others and circumstances. The respondents' views aligned with Kabat-Zinn's opinion that having a non-judgemental attitude increased compassion for self and others, as well as a sense of distance from the issue. This distance or space can be seen as the ability to use metacognition to observe the self instead of getting caught in the trap of ruminating (Harris, 2008). It seems to be

an ability to think about what one is thinking. This ability to self-observe and remain objective is apparent in the following statements:

“... and observing with curiosity and non-judgement what is arising” (P3).

“... observing with non-judgement and willingness” (P11)

“... And not judging myself for just being” (P7).

Mindfulness is cultivated by paying close attention to the present moment and here and now experience while not getting caught up in the convention of labelling those experiences (Kabat-Zinn, 2013). This orientation allows a more neutral or objective view of what is happening rather than through our own distorted perceptions. By being an observer of our own thoughts and emotions, we are better equipped to make rational decisions instead of reacting emotionally with our typical automatic thoughts. The basis of empathy towards self and others seems to rely on this ability to be non-judgmental as reflected below:

“Being present in the moment and unconditional positive regard for others and myself” (P2).

“I’m more aware of my own self-criticism and try to be more compassionate with myself” (P7).

This sense of self-compassion was also described by participant 4, who experienced mindfulness as: “Simple awareness, practising self-compassion, being less reactive, less critical of self”. For her, mindfulness meant: “self-awareness, compassion, non-judgement, equanimity”. Participant 4 also spoke of the changes she experienced since completing the mindfulness programme: “... I am kinder to myself; I don’t beat myself up mentally as much anymore; greater self-acceptance”.

The idea of non-judgment being an important component of mindfulness that leads to enhanced empathy, compassion for self and unconditional positive regard in others, is similar to the findings of Zamir (2009) who explored the impact of meditation on therapists and their therapy practices. In his qualitative study with a sample of six therapists, he found that therapists who meditated were more effective therapists due to the stronger alliance they built with their clients. This rapport or stronger alliance was hypothesised to be due to increased positive therapist qualities that included empathy, unconditional positive regard and non-judgement. Similarly, Birnie, Speca and Carlson

(2009), found that mindfulness had theoretical connections to self-compassion and empathy. Self-compassion according to them was in fact a prerequisite to empathy, as the ability to identify how others are feeling requires one to first recognise one's own inner state. According to Neff (2003), self-compassion entails three components namely: 1) being kind and understanding towards oneself as opposed to judgmental and harsh; 2) seeing one's experience in perspective as part of common experiences shared by others not unique to oneself and; 3) being objective and creating space between one's experiences, feelings, thoughts and one's self, thus not over-identifying with these. However, to attain this trait of self-compassion and subsequent empathy or attunement to others, enhanced awareness of present moment experience is a prerequisite (Birnie et al., 2009).

4.3.1.2 Increased Awareness

Most participants found that mindfulness promoted a greater sense of self awareness of internal experiences and that of the environment (external experiences), which seemed to promote a greater sense of body-mind connection.

This increased awareness and sense of paying attention is apparent in the way Participant 5 experienced mindfulness, she said:

“Taking notice, slowing down and continuing with some of the exercises taught in the group”.

This sense of slowing down the experience of time, perhaps leading to enhanced abilities to be open to bodily sensations and better access and connection to self is also found in a study with trainee therapists' experience on mindfulness practice (Stuart, 2012). In this study the trainee therapists describe how, by becoming more aware, they realise how much of life they are actually missing out on, due to living on 'auto-pilot'. By slowing down and becoming more aware of themselves, they describe being able to reconnect with self at a much deeper level. Prior research supports these experiences of increased awareness as mindfulness training has been found to be associated with greater neural activity in the dorsolateral prefrontal cortex and medial prefrontal cortex which are the regions of the brain known for self-awareness (Farb et al., 2007).

Participant 7 said she experienced mindfulness as being more aware of her own self-criticism, as mentioned in the non-judgment theme. She similarly described her life changing because:

“I’m probably more self-aware of my frustrations and intolerances in life”.

It seems that by being more mindful and increasing awareness to all the senses in the present moment, one can realistically assess and accept things as they are, with an attitude of curiosity and non-judgement (Brosan & Westbrook, 2015). This theme is aptly summarised in the words of Kabat-Zinn (1994), who described awareness as: “*not the same as thought. It lies beyond thinking, although it makes use of thinking, honouring its value and its power. Awareness is more like a vessel which can hold and contain our thinking, helping us to see and know our thoughts rather than getting caught up in them as reality*” (p. 548).

4.3.1.3 Present moment focus

Most participants, when asked what mindfulness means to them, described the concept of being fully present in the moment, they reflected:

“It means to pay attention to what is unfolding in each moment as it is” (P3).

“Staying focused in the here and now and just being rather than doing” (P7).

“Paying attention to the breath and being aware of trying to be present in the present moment” (P9).

“Living in the moment...the now. Being fully present and aware in my personal life and with my patients/students. Acceptance of what is”. “It keeps you in the moment. Most of us can tolerate anything for a moment. Prevents us from past regret and future anxiety by being here now” (P10).

“Being present in the moment, It keeps you focused on facts rather than opinions/interpretations. It reduces the illusion of control over the future and rumination on the past. It helps you stay focused on your own experience of the present, which in turn helps you be aware of what you need in terms of self-care” (P11).

“It means intense concentration on the moment and heightened awareness of the body and immediate environment and emotions at the present. It means meditation” (P12).

Participant 16 saw mindfulness as: “Being in the moment”. He valued the experience of being present in the following ways: “being completely present and focusing on one thing at a time”. He believed that his life had changed after the MBSR course and described it as: “I have changed in that I don’t value multitasking as much as I used to, and advocate mindful presence instead now”.

Siegel (2010), summarises the importance of present moment awareness in the following words: *“Rather than being consumed by worries about the future or preoccupations with the past, living fully in the present is an art form that liberates the mind to relieve mental suffering”* (p.49).

The participants’ responses are highlighting the effects of being completely present and grounded in the present moment which allow them to consciously choose and conduct their actions with purposeful intent, be flexible in their responses and not closed or judgemental to what is happening but completely open and receptive to the ‘here-and-now’. This concept of ‘response flexibility’ is discussed in more depth in the next section in which we look further into how this impacts the mental health practitioners at a personal level. The concept of mindfulness entailing a present moment focus is supported by existing literature, as is apparent in the following studies; Bishop et al. (2004), found that mindfulness entailed being completely present in the moment and perceiving events with a sense of curiosity and acceptance. So too, Steiner (2014), discussed the importance of being completely present as playing a part in alleviation of suffering caused by being too consumed by thoughts and considered the present moment embodiment advocated by mindfulness as a panacea to mental suffering.

4.3.2 Personal outcomes

Given the importance of the mental health professional in terms of their pivotal role in treatment outcomes, as well as considering the demanding nature of the job, it would seem critical to ensure practitioners were functioning at an optimal level themselves (May & O’Donovan, 2007; Siegel, 2010). Also, actions of establishing a mindfulness practice through a formal programme such as MBSR for this sample was motivated by one of two reasons: one for professional development

and the other personal development. In terms of personal development, it seemed that MBSR facilitated a different way of relating to themselves and their world which led to a greater sense of contentment as highlighted in the following sub-themes; respond vs. react to stressors, greater sense of well-being and a different way of relating. These three subthemes are discussed in further detail.

4.3.2.1 Respond vs. React to stressors

All the participants agreed that mindfulness played a major role in stress reduction which indicated to the success of the MBSR programme in addressing stress management, and was in line with one of the objectives of the study i.e. to explore the use of mindfulness as a stress reduction tool. Slightly more than half the participants thought that mindfulness reduced stress because it increased awareness and enhanced emotional regulation that assisted in the realisation that one has a choice to consciously respond to the stressor instead of automatically reacting to it. This becomes apparent in the following responses:

“Awareness, an awakening to what is happening in the moment, pausing for a moment, becoming acutely aware of the body, thoughts and emotions, coming to the breath in the body, resetting the state of mind, creating space in oneself through awareness, curiosity and non-judgment, and then from that place making a decision whether to react or respond or none - this I feel is an important strategy using mindfulness as a tool to cope with stress” (P3).

Participant 1 elaborated on this notion of mindfulness in the different views e.g. “Becoming aware of your experience and responding instead of reacting”. He further explained that, for him, mindfulness was experienced in everyday life in the following way: “I am calmer and more aware of my responses to situations that occur”. In response to the question whether anything in his life had changed since the MBSR programme, he wrote: “Yes, I think more about my responses to situations than I did before. Rather than reacting, I try and see things for what they are and not just as it appears based on interpretation”. This idea of responding instead of reacting is also reiterated when he talks about mindfulness as a way to cope with stress: “Calming your mind so that you can make better decisions. Seeing situations from a different point of view to the first reaction that we

usually act upon. Thus, noticing that we actually put a lot of stress on ourselves in our daily lives as we misrepresent and misinterpret situations and as such act on them in a disempowering way”.

Victor Frankl (2006) summarised these ideas years ago, when he wrote about the notion that between any stimulus and response there is a space to choose and it is within this space that we find freedom and growth. Mindfulness seems to be a way that enable that ‘pause’ instead of getting caught up in the endless loop of our old thoughts and behaviours (Brosnan & Westbrook, 2015). This pausing before acting can also be called ‘response flexibility’ and is promoted by mindful awareness (Siegel, 2010).

The notion that participant 1 seems to be reiterating in his responses is that his cognitive processing with mindfulness has moved from a ‘top-down’ to a ‘bottom-up’ approach (Siegel, 2010). This bottom-up approach entails using one’s senses or breathing be to completely present in the moment helping one to see things with a fresh perspective and choose to respond to just what’s happening in the here-an-now. As opposed to a top-down approach, which uses prior learning and memory to emotionally react to what has happened in the past which skews one’s perception and restricts behavioural options (Siegel, 2010). In terms of neural functioning this type of informed responses entail the cortex being activated first and thus being able to reason and inhibit the function of the limbic system and amygdala, which are associated with the fight-or-flight response and emotions (Arden & Linford, 2009), which explains the enhanced sense of self and emotional regulation that will be discussed in more depth under the next subtheme.

Participant 13 also spoke of the importance of mindfulness as a stress reduction technique and the critical role of awareness in regulating the self. Her response was similar to that of Participant 1, in that she reiterated her motivation to do the MBSR programme as: “Managing own stress levels. Increased knowledge of mindfulness to use and advise in own practice”. Mindfulness for her meant: “Responding not reacting. Being present”, and her experience of mindfulness was described as: “I try to be aware of my reactions to stress. I try to be aware of my body”. The importance she places on responding to stress, instead of reacting, is seen once more in her answer to the challenging aspect of mindfulness practice: “Remembering to do it and not getting sucked back into worry and feeling stressed, having time to meditate formally”. When asked, what had changed in her life since the programme she responded: “More aware of my own stress levels and

managing them better.” In terms of how mindfulness helped her deal with stress, she wrote: “Being aware of stress and the body’s reaction to it. Focus on breathing to calm the mind”.

What this participant is experiencing with this increased awareness is a concept Daniel Siegel (2009), describes as ‘body regulation’ which encompasses techniques to balance the nervous system in terms of stimulating the parasympathetic nervous system to attain the ‘relaxation response’ (Benson, 2000), which is the opposite of the fight-or-flight response. This relaxation response can be attained by activities like focusing on the breath, meditation and stretching exercises like Yoga (Arden & Linford, 2009) which are all incorporated in mindfulness training. Participant 13’s comment has highlighted two important aspects namely; the use of increased awareness of bodily sensations and the importance of breath to bring attention back to the body to ground the person in the present moment and thus be less cognitively ‘reactive’. The important role of breath in this process is discussed further at a later stage in this chapter.

4.3.2.2 Greater sense of well-being

Well-being, as understood from the participants’ responses, was described as a sense of peace, relaxation and grounding that participants experienced as an outcome of their mindfulness practice. This sense of well-being described by the participants also seemed to encapsulate a better sense of self and emotional regulation. They wrote:

“ improved sense of well-being in general, I’m able to observe my emotions and thoughts most of the time without being hooked into the stories and reacting less, taking time to make decisions instead of rushing into something, I am cultivating a self-kindness and love each day and learning not to take on more which will inevitably lead to burn out - improved self-care, developed a deeper awareness of catching my automatic thoughts and patterns, the doing mind and moving towards the being mind, generally a heightened awareness of mindfulness and its impact it has had in my life” (P3).

“deal with emotions better, more relaxed and happy”. “A way to relax and gain insight into the capacity we have to control our minds”. (P5)

This greater sense of self-regulation that these participants have described has neurological evidence in that Davidson et al. (2000), found that mindfulness practice alters neural circuits of various affective styles and bolsters nonreactivity. When under stress, mindfulness practitioners' brain activities seem to shift to the left prefrontal cortex which is known to evoke positive reappraisals of experience, as discussed in the theoretical framework section, and furthermore lead to more positive affect. Furthermore, their limbic-amygdala neural activity seems to be inhibited compared to non-meditators thus enhancing the neural affect regulation pathways and leading to less emotional reactivity (Cresswell, Way, Eisenberger & Lieberman, 2007).

An interesting factor to take note of that was highlighted in many of the responses, was the critical role that the breath plays in this sense of well-being. The profound effect of focusing on the breath is apparent in the following responses:

“The profoundness of the breath and its impact on our well-being, emotionally, physically, cognitively and spiritually - the very choice of bringing awareness to the breath in the body has an enhancing effect on all aspects of life...” (P3).

This general sense of well-being is also apparent from her response:

“I have a daily formal practice of sitting and breathing mindfulness practice. I start my day with this. I then bring mindfulness into my daily life by making a conscious decision to be awake to each moment and to check in to myself from time to time by coming back to my breathing and my body - both such important anchors. I eat mindfully, walk mindfully, but firstly need to set an intention for the day - without the intention, the day passes by mindlessly”.

Participant 9 speaks of using the breath to ground her when asked how she experiences mindfulness daily: “STOP moments when I realise the busyness of life has taken over; using the anchor of the breath to anchor my thoughts, feelings and body sensations, as well as formal practice”. She goes on to describe how this ‘anchoring’ allows her to handle her stress reactions more effectively: “Mindfulness and the anchor of the breath allow me to ‘centre’ myself despite the chaos of the world around me. “Breathing”. Furthermore, she said she would recommend the MBSR course to others due to this enhanced ability to handle stressors, she wrote: “Yes, our

response to stressors really can be managed. Trust that we can use our breath and body to live better and not just our thoughts and mind”.

This response points towards a feeling of holistic well-being which moves away from the perception of fragmentation and isolation and instead incorporates a sense of wholeness and integration of both the internal and external world and reflective coherence (Siegel, 2010). This concept of the breath acting as an anchor has research support from Arden and Linford (2009), where they speak of it in their book which describes how focusing on breathing, the body-mind connection is emphasised. The neural evidence for this is that the superior temporal cortex that oversees breathing when activated, is said to lead to “*a sense of neurodynamic harmony between autonomic and cortical functioning.*” (Arden & Linford, 2009, p. 251). Furthermore, the use of the breath according to Williams and Penman (2011), is said to be important for the following reasons; by bringing attention to our breathe we are focusing on important aspects of life that we just take for granted, shows us how life can happen despite of us, so we don’t always need to be in control, it grounds one in the here and now, it can act as a monitor for physical and emotional reactions and finally, provides an anchor for attention. Siegel (2010), explains the importance of breath by highlighting the fact that breathing is rhythmical and the nervous system functioning is very sensitive to rhythm thus, by simply focusing on the rhythm of the breathing it elicits a state of calm and clarity, which seems to be supported by the responses of the participants.

Another common positive feeling evoked through mindfulness was a sense of relaxation. This feeling is described by Participant 12, a 59-year-old psychologist from South Africa who completed the MBSR course to help her cope with her own grief after she had lost her father. She wrote:

“I feel more relaxed and attuned to my body and emotions of the moment” and “...it gave me time to reflect and learn to relax my body”.

Siegel (2010), defines this idea of awareness and knowing of self that the participant is describing as ‘intrapersonal attunement’ which assists in the process of ‘body regulation’ to balance out the working of the sympathetic-parasympathetic nervous functioning. Though participant 12’s next comment would probably fit better in the next subtheme about a different way of relating, I am

placing it here to understand her context and how mindfulness helped her feel better through a trying time. In her comment on what surprised her about the process she said:

“...I became more aware of another way of thinking - less intense, more accepting of life in general”.

This comment corroborates prior research on mindfulness that suggests it helps individuals attain a more positive sense of well-being through supporting psychological need satisfaction including relatedness, competence and autonomy, which increases their sense of purposefulness, coping capabilities and positive emotions that encourage more positive appraisals of situations (Hansen, 2016). A part of this reappraisal process could be due to mindfulness changing one’s perspective from ‘doing’ to ‘being’. The concept of ‘being versus doing’ has been repeated many times in the participants’ accounts and is a common phrase used by mindfulness practitioners since it is a core principle tied to the theme of non-judgmental curiosity. It provides another way of relating to the world around us by seeing things differently.

Participant 3 especially seems to understand this concept and uses the idea of not expecting any specific outcome when asked of her motivation to complete the MBSR course; instead, she described her curiosity about what was to unfold. This idea of non-striving could be a reason for the greater sense of peace and calmness being felt by mindfulness practitioners. The words of Participant 3 to describe her goal (in this case lack of it) were:

“I have had a long-term interest in the philosophy of mindfulness and how that impacts mental well-being. So after having read and researched this more, I decided to embark on the journey. I was drawn to the integrity of it and the thorough neuroscience research work that has been done to show the benefits. I didn’t have any expectations or goals other than to be curious and explore - see what unfolded”.

Participant 1 speaks of being calmer and thus able to make better life decisions. Participant 14 linked the idea of being less stressed and feeling calmer, and also the sense of being more philosophical. This idea of calmness is repeated by Participant 5 who saw mindfulness to mean:

“relaxation, enjoyment, meeting like-minded people, insight”.

Participants 4 and 5 similarly valued the change in perspective that they had experienced since practising mindfulness, and saw it as a stress reduction technique due to:

“the ability to tune in and get perspective” (P4).

This change in perspective seems to be twofold: one by having a greater sense of acceptance and two by gaining an ability to see the bigger picture. She wrote how her life changed since the MBSR course:

“Mindfulness promotes a sense of bigger picture wholeness, reducing stress and panic, providing a degree of clarity”.

Participant 6 sees mindfulness to mean:

“peace and silence within me”.

She spoke of the way she has changed in her reactions to situations:

“I am more calm in panicking situations, generally composed in actions and thought process”.

As a way to reduce stress she described mindfulness as: “It’s a great way to lead a peaceful life, and be more useful towards our day to day activities”.

A common thread through the participants’ responses seem to be a greater experience of interconnectedness but also objectivity in that by being more accepting of the present moment and curious to what was to unfold with no expectations, the mindfulness practitioners could acquire a greater sense of peace and happiness. It could be inferred that this greater sense of peace could also be due to a greater sense of spirituality in that imminent in most responses is the faith that things will work out well, believing that everything is interconnected, a sense of being a small part of a bigger picture in that we are merely observers and should observe with awe, curiosity and gratitude. This faith that I mention could be responsible for allowing the participants the opportunity to ‘just be’. The belief that a higher power is in charge could be liberating for it takes away a lot of the pressure of humans and moves us away from the ‘doing mode’. As mentioned in the first chapter under the background section, mindfulness concepts have their roots in Buddhist philosophy in which these meditations were practiced with the aim of freedom from desire or

aversion and thus ultimate self-transcendence in which one was unattached to outcomes, thus attaining peace (Stuart, 2012). Recent studies show that despite one's religious background (Stuart, 2012), practising mindfulness encourages a sense of spirituality and interconnectedness leading to reduced psychological distress and self-reporting of health-related complaints (Carmody, Reed, Kristeller & Merriem, 2008; Greeson et al., 2011). Additionally, spirituality is associated with a better quality of life and sense of well-being (WHOQOL, 2006), and health and longevity (Koenig, King, & Carson, 2012).

Psychological well-being and mood states are known to be influenced by physiological aspects to the likes of sleep and pain. Both these aspects will be discussed in the following paragraphs. Apart from the general sense of well-being, a participant who has been practising mindfulness for 20 years, the longest period among the sample, also spoke about the value of mindfulness for pain relief. She explained:

“Practicing mindfulness for the past 20 years has given me peace in my life. I have more empathy and compassion for others and myself. After a serious bike accident and 2 spine surgeries, it has helped me better cope with chronic pain” (P. 10).

This observation correlates with previous studies conducted in the medical field, looking specifically at the role of mindfulness in pain reduction. In fact, the MBSR programme was first devised to treat chronic pain. Over the years, it has been found to be effective in treating chronic pain partly by decreasing stress reactivity (Williams & Penman, 2011; Kabat-Zinn, 2013), and improving immune system functioning (Davidson et al., 2003; Miller, Fletcher & Kabat-Zinn, 1995). Evidence for pain reduction is found in a study (Zeidan et al., 2011), that showed that even brief mindfulness exercise of four to twenty-minute attention to breathing, reduced pain ratings by 57% and pain intensity by 40%. These findings can be explained by a study conducted earlier (Grant, Courtemanche, Duerden, Duncan & Rainville, 2010), who found that meditators compared to non-meditators were less sensitive to pain experiences and intensity due to the thickening of grey matter in certain regions of the brain known to be involved with pain reduction.

Participant 10 further elaborated on how her mindfulness practice helped her cope with the pain and subsequently led her to experience more restful sleep, she wrote: “I'm more surprised by how

it has helped me cope over the years. Although we all face challenges in life, having a mindfulness practice has helped me be at peace. I sleep well😊”.

Although the relationship between sleep and mindfulness has been mentioned, it is not fully understood. It has been hypothesised that having trouble sleeping may be a signal that there is some stressful situation that needs to be resolved, and once this is achieved the sleeping pattern resolves itself (Kabat-Zinn, 2013). In the case of Participant 10, it could be due to the pain relief and the experience of more positive emotions e.g. self-compassion and peace. Furthermore, Kurshid and Vythilingam (2016), argued that mindfulness was an effective self-management strategy for pain relief which improved not only sleep quality but psychological health and quality of life. Similarly, Caldwell, Harrison, Adams, Quin and Greeson (2010), found that increased mindfulness was directly related to improved quality of sleep. They understood this relationship by taking into consideration that mindfulness enhances mood and reduces perceptions of stress. Similarly, two recent studies investigating the effect of mindfulness on sleep patterns also report on its effectiveness, especially among older adults (Black, O’Reilly, Olmstead, Breen & Irwin, 2015; Spira, 2015). These results were assumed to be due to reduced worry and enhanced mood due to present moment focus.

4.3.2.3 A different way of relating to others

In this subtheme, views about mindfulness as enriching the repertoire of relating were common. Mindfulness therefore did not only impact on experiences of their internal world but also their external world and others in it. Statements that focus on this aspect of relating is provided below:

“Small and accruing changes - cognitive, emotional and physical - how I engage with others - what I listen to others, paying attention to what they are saying, and just listening” (P3).

“...in therapy with my patients...it has helped me become more empathetic and compassionate. (P10).

“...and able to take care of myself and others so much more effectively” (P11).

Many participants spoke of mindfulness as not only increasing self-compassion as discussed earlier, but also empathy, which is in line with previous research (Birnie et al., 2009; Kristeller & Johnson, 2005). For this study, empathy will be defined as the ability to attune to another person's mental perspective (Siegel, 2010). The relationship between mindfulness and empathy is hypothesised to be due to enhanced perspective taking and a decreased focus on personal distress (Birnie et al., 2009). These findings add evidence to the study conducted by Lazar et al., (2005), who found structural changes in the 'social' brain region which lead to increased compassion, empathy and kindness. Additionally, mindfulness was found to have a positive effect on mirror neurons (Siegel, 2009). The notion that humans were neurologically wired to feel empathy and attunement to others was confirmed by Marco Iacoboni (2008) with the discovery of neurons in humans that fired and neural circuits that are activated when performing a behaviour or when observing someone else performing the behaviour. These neurons were called mirror neurons and allow for not just mimicking another person but suggests they enable one to feel what others are feeling i.e. empathising with others. This kind of interpersonal attunement does have some conditions though, these are that the person observing should be paying attention (Siegel, 2010), the act observed should be intentional (Siegel, 2010) and the observer should have enough intrapersonal attunement and self-compassion to be able to connect to another (Arden & Linford, 2009). Mindfulness has an impact on all three of these conditions and thus not only effects the interpersonal attunement that the mental health practitioner can achieve with the client but also serves as a model for the client to mirror thus enhancing their therapeutic outcomes (Zamir, 2009).

This brings us to the end of the personal outcomes section in which we explored the reported benefits of mindfulness on stress reduction, increased sense of well-being linked to a different way of relating to self and the environment. We now move on to the professional reported outcomes of the participants in which mindfulness is looked at as a therapy resource.

4.3.3 Mindfulness as a therapy resource

In this theme, we move away from the focus on the personal influence of mindfulness on the mental health practitioner and consider the impact of mindfulness practice on the clinical and professional domain. The themes that emerged on how mindfulness worked as a therapy resource

will be discussed under three subthemes that are self-grounding, alternate therapeutic intervention and increased effectiveness of therapist.

4.3.3.1 Self-Grounding

The mental health practitioners in the current study explained how their experiences of being more grounded has affected them in setting a therapeutic space in which they could be more present and empathetic, which seemed to impact on not only the therapeutic relationship but modelled a different way of being to the client. Examples of this new way of being in therapy is apparent in the following statements:

“In my morning meditation. In therapy with my patients...being fully present to their experience. Awareness of my thoughts and feelings in the moment. Being in tune with my senses and my surroundings. It has helped me become more empathetic and compassionate” (P 10).

“I use the mountain meditation and the walking meditation which I find helpful in grounding me and also the patients” (P7).

“I use mindfulness breathing and eating to ground myself.” (P15).

Aside from mindfulness being taught in therapy, there are other ways that mindfulness may have an impact on the therapeutic process. One way is that if the therapist practice mindfulness and models the relevant characteristics, this might influence the therapeutic alliance and client outcomes in a positive way (Zamir, 2009). The therapist being more authentic to self and present encourages the client to be the same.

The qualities required for an effective therapist using any modality are for the therapist to be totally present, non-judgmental and aware of what the client is communicating through body language and words (Naidu & Ramlall, 2016). A mindful therapist ideally has all three qualities. From the respondents comments it seems that a good place to start with being completely present is to ground oneself. The word ‘ground’ in psychotherapy can mean many things for e.g. it can mean intense attention or awareness to what is unfolding in the here-and-now, a sense of purpose (Schure

et al., 2008), unconditional receptiveness or even be a coping strategy to connect oneself to the present moment (LaCombe, 2014). This is usually attained by being fully present in the body and giving full attention to whatever is going on in that moment, which could be, for example, breathing, eating or walking as is evident in the comments above. Mindfulness allows the rapport or therapeutic alliance to be more grounded in the present moment and subsequently consists of less of the clinician's perception distorting what's occurring; in other words, less countertransference - getting mixed in to the relationship (Dorn, 2014). This could be a possible reason for the respondents experiencing positive outcomes with the sense of self-grounding.

4.3.3.2 Alternate Therapeutic Intervention

As mentioned in Chapter one, there exists a variety of ways to incorporate mindfulness in psychotherapy in that the therapist could simply approach the session mindfully with an attitude of non-judgemental curiosity, use mindfulness as the theoretical framework for their own conceptual understanding/formulation or teach mindfulness practices to clients (Stuart, 2012). Approaching the session mindfully seems to have had an impact on the mental health practitioners themselves and their clients. Below, the findings pertaining to using mindfulness in therapy i.e. using it with clients in therapy but also teaching clients how to imbue these characteristics in their lives, will be addressed.

All the participants in this study advocated mindfulness techniques and believed that it helped them achieve their goals and thus recommended it to others. There was, however, some scepticism in accepting it as a panacea to all problems, which will be discussed in more detail in the section, "not for everyone". However, the majority saw it as a useful alternate therapeutic technique as is highlighted in the following responses:

"Yes I think everyone will gain something from it. Maybe my expectations were a little unrealistic before I did the MBSR course. I thought it would solve all my problems" (P7).

"I would recommend it to peers and patients. I think it's a very good approach for learning how to calm the mind" (P15).

“I also teach it to clients which has seemed to calm them down quickly” (P15).

The use of technology and other techniques to aid the process of attaining mindfulness was observed by the following participant:

“I find that clients can be initially sceptical but are most responsive to the concepts of reason mind, emotion mind and wise mind. When I highlight the presence of these in their own functioning during the course of their sessions, and review the way that mindfulness can specifically help with this, it eventually wins them over. Use of recommending apps to help them get the hang of it is typically crucial as well” (P11).

The concepts of reason, emotion and wise minds, are those used in Dialectic Behaviour Therapy (Linehan, 1993), who differentiates between the three as follows. Reason mind is the logical, objective part of the mind that focuses on concrete, observable events while emotion mind is that part of the perception that becomes clouded according to our mood distorting reality as such. The middle ground or ideal, is the wise mind, that balances the two by being completely present and aware which leads to a deep sense of intuition. The participant’s response seems to imply that mindfulness is a tool to attaining the wise mind.

Participant 8 seemed to advocate for an eclectic approach in therapy by recommending using mindfulness in conjunction with other psychological therapeutic interventions, for example, when asked about stress reduction he wrote:

“I would use Daniel Siegel’s wheel of awareness, the Chinese concept of wu-wei” and “I use it in conjunction with the Internal Family Systems psychotherapy model for myself and with others”.

Similarly, participant 2 used mindfulness with imagery and compassion based CBT with individuals and couples while participant 3 used it with children in schools. Mindfulness seems to increase the repertoire of the therapist and when combined with other forms of therapy becomes a useful additional tool, irrespective of what modality the therapist follows. The value of mindfulness across domains and the lifespan is reflected in Participant 8’s comment of using mindfulness with family therapy and participant 2 talking of using it in work with children. Higgins-Klein (2013) devised a programme called Mindfulness-based play family therapy, that incorporated the two and was achieving amazing results in calming children down and creating a

safe space in therapy in which the family unit could reconnect. Schure et al. (2008) combined mindfulness meditation with Yoga and Qigong, while Park (2014), combined mindfulness meditation with biofeedback to reduce stress. These are just some examples of how mindfulness can be incorporated in the therapeutic session with other psychological theories and modalities.

Most participants were strong advocates of mindfulness and described the significant impact it could have on the clients. There seemed to be consensus on its effective use with self and others. For example, Participant 12 wrote:

“I have suggested part of what I learned to clients. I am not sure if I have received any tangible feedback, but I think it might have been reassuring. One client wanted to follow the course”. When asked if she would recommend the course to others she further explained: “Yes, I would, as it is a different form of therapy from the talking mode usually used with my clients”.

Participant 14 saw mindfulness as a: “Useful new intervention for psychology”.

Participant 1 had incorporated it into his coaching practice with clients and taught it to his coaching students as well; he felt that it helped them make better decisions instead of just reacting to situations based on their first interpretation.

Participant 2, an art and cognitive behavioural therapist who used imagery and compassion based Cognitive Behavioural Therapy with individuals and couples for depression and anxiety, wrote about how she could integrate mindfulness in her therapy process:

“As a meditator and cognitive therapist, I was aware of its necessity in treatment of anxiety and depression”.

Since mindfulness was first introduced as an alternate therapeutic intervention in the 1970s, it has been found to be effective in a wide variety of psychological disorders including several that were previously viewed as untreatable, for example, Borderline Personality Disorder (Brown et al., 2007; Zamir, 2009). It has also been found to be very effective in the treatment of Depression, reducing the risk of relapse by 50% (Teasdale et al., 2007). In addition, it helps in the reduction of anxiety symptoms due to its effectiveness in emotional regulation and awareness of the stress response (Kabat-Zinn, 2013).

Participant 3, a counselling psychologist who works with children who experience emotional and behavioural difficulties through play therapy interventions and parental support said: “I have just begun to use mindfulness in my practice with children and have found that they are innately drawn to it”.

Participant 4, a mental health UX application consultant who focuses on health benefits, especially on eating healthy, has incorporated mindfulness in her practice by using components of the MBSR course, for example, the Yoga practice to help change their self-image; she also works with mindfulness to change their self-talk and their relationship with self. Mindfulness has been found to be effective in two main ways with eating healthily namely; in eating disorders and promoting self-acceptance, especially in socio-cultural environments that idealize ‘thinness’ (Astani, 2016). As well as, assisting in weight reduction in a healthy way by reducing reward driven eating, promoting awareness of hunger, enhancing self-regulation and control (Mason et al., 2016).

Participant 10 saw mindfulness as “mind/brain training” that was “a way of being at all times in all aspects of life”.

Participant 15 recommended it to both peers and patients alike for she saw it as:

“A very good approach for learning how to calm the mind”.

Though most of the respondents agreed that mindfulness was a viable therapeutic intervention, a critical voice was found in participant 16 who said he would recommend mindfulness as a concept but felt it did not require such complicated, time consuming methods to imbue it. He instead saw mindfulness as: “more an attitude than an intervention” that could be acquired by “more effective shorter courses...”. This will be elaborated on later as further aspects for consideration.

4.3.3.3 Increased effectiveness of therapist

One of the objectives of the study was to explore mindfulness as a likely resource that could enhance therapeutic effectiveness. Similar to previous research, most of the mental health practitioners who participated in the study argued that by achieving a greater sense of well-being,

self-compassion and being more present, they were able to gain a new perspective in their practices and life worlds, resulting in them becoming more effective therapists according to their own accounts. This can be understood from the following statement by Participant 11:

“It is life changing. I am more actively engaged in my own life, more aware of my body, thoughts and feelings and able to care for myself and others so much more effectively”.

She further explains: “I am less stressed and anxious.... and as a result, I am more effective in my work. I also find my outlook on life is much more relaxed and I waste much less energy on trying to control what cannot be controlled”.

Participant 8 explains:

“It is a way to avoid conflict - both inner and outer. It is access to self”.

The emotional health of the therapist is not just of personal importance, but is a fundamental part of their professional effectiveness (May & O’Donovan, 2007). A positive correlation has been found between successful therapeutic outcomes and therapists’ well-being and positive psychological adjustment (Beutler et al., 2004). This is a critical area for discussion since it makes sense to assume that, just as research suggests that mindfulness can improve the psychological and physical well-being of the clients, so too can it improve these factors in the therapists who treat them (Shapiro & Carlson, 2009). This increased effectiveness is hypothesized to be achieved in two ways: by the therapist experiencing more positive emotions and being more at ease with self and by reducing stress and its related hazards i.e. burnout; compassion fatigue; and vicarious trauma. The combination of these two factors would allow clinicians to work more efficiently with their clients as is suggested in this study.

Participant 16, though a bit sceptical of the MBSR course, felt that to some degree it had helped him find new ways to relate to his clients, and practise new techniques that developed his own potential and those of his clients as well. He believed that this was made possible by learning to be mindfully present in the moment, which helped him reduce his stress reactions and sense of burnout.

Another interesting phenomenon as mentioned earlier as one of the factors that increased therapists' efficiency, was that mindfulness could be used as an important available resource to therapists in helping them to cope with vicarious trauma. This is highlighted by Participant 8:

“It has changed my life in that it helps me prevent conflict in my relationship and it protects me from vicarious trauma in my practice”.

This participant, however, gave a contradictory statement regarding the use of mindfulness in his practice with trauma patients where he felt it could possibly do more harm than good, due to the associations trauma survivors might make with the voice of the person guiding the formal meditation practices in the MBSR programme. However, his statement seems to be in contradiction to research in the field. A systematic review conducted on the benefits of Mindfulness for Post-Traumatic Stress Disorders (Banks, Newman & Saleem, 2015), found that mindfulness-based interventions had overall positive outcomes especially with increased acceptance of the event and a reduction in avoidance symptoms. This point is discussed in detail in section 4.3.5 ‘aspects for consideration’

Respondents that did find mindfulness beneficial in dealing with trauma stated the following:

“...I work with client populations at high risk for suicide for example and would struggle sometimes at the end of the day, worrying about them and wondered if I did enough to help. This has greatly improved...” (P11).

“Yes, excellent for secondary trauma” (P14).

Like the above two participants, Participant 15, who worked with intense trauma and rape, found that mindfulness helped her deal with vicarious trauma and increased her effectiveness by: “being at peace with self”, “more aware of what is happening in self and others”, which changed her life by making her “more accepting of self and others as well as able to deal better in my job without things getting me down so quickly”.

According to Hansen (2016), mindfulness is a tool that can provide practitioners with a sense of detachment from work tasks and work related thoughts; this aids recovery and helps the individual to be more attuned with the present moment and appraise the current situation realistically, by

separating typical stimulus-response connections. It aids resilience, which in this context is the ability to accept, survive and thrive in the face of challenging situations and constant stressors. This resilience is made possible through the practitioner being more emotionally stable, open to experience and flexible to job demands (Tugade & Fredrickson, 2004) as mindfulness has been found to increase emotional regulation (Oschner & Gross, 2005), reduce physiological reactivity (Ortner, Kilner & Zelazo, 2007) and improve mood states by reducing distractive, ruminative thoughts (Jain et al., 2007). But most importantly, the data suggests that mindfulness leads to decreased emotional reactivity which leads to quicker recovery and baseline functioning.

The mindfulness qualities/experiences of non-judgement, present moment focus and increased awareness influence the way practitioners function in their professional lives. It seems that the participants believe that by developing these characteristics, they can both model the qualities they desire for their clients, and relate to them at a deeper level by being more present, aspects also supported in prior research (Lee, 2013; Stuart, 2012; Zamir, 2009). The words I would like to conclude with are those of Participant 3 who seems to capture the essence of how mindfulness enable mental health practitioners to be more effective:

“I am cultivating a self-kindness and love each day and learning not to take on more, which will inevitably lead to burn out - improved self-care, developed a deeper awareness of catching my automatic thoughts and patterns, the doing mind and moving towards the being mind, generally a heightened awareness of mindfulness and its impact it has had in my life”.

4.3.4 Challenges around the process

Mindfulness has been argued to be a simple and effective stress reduction technique, however, the participants seem to agree that mindfulness practice has challenges, as most seemed to have experienced, during the process of practising formal meditation (through the MBSR programme) especially in the first eight weeks. Participant 4 commented on the difficulty of acquiring mindfulness since it was a very abstract concept and not quantifiable, she said, “measuring mindfulness” was a challenge for her. In addition, the process of imbuing mindfulness was described as time consuming and a practice that required discipline, as discussed below.

4.3.4.1 Time Consuming

A point to note is that most participants felt that formal meditation practices took time; something that they found both surprising and challenging as illustrated below:

“Discipline and setting time aside for myself in the morning and dedicating the time for cultivating self-love and self-kindness. I bust myself with many things during the day and if I don’t set my intention and time for mindfulness practice, the day runs away...” (P3).

“Allocating fixed daily time for formal practice. I get annoyed with myself, still, I struggle to focus during formal practice which is counterproductive” (P6).

“The discipline of finding time to attend to formal practice daily” (P9).

“It required time to follow the instructions of the course in between the designated meeting day” (P12).

Participant 5 also acknowledges the time factor and the external challenges of finding an appropriate space to meditate in, she wrote:

“Having time and being quiet at home”

She went on to describe her struggle to attend the formal aspect of the course: “I found it hard to commit to eight evenings which were long, but at each time, did not seem long in practice”.

Participant 15 when asked if she would recommend the course to others wrote:

“I would recommend it to peers and patients. I think it’s a very good approach for learning how to calm the mind. However, it’s time consuming for the first eight weeks, so I would warn them about that”.

A reason that participants found the programme so time consuming could be that the MBSR programme consists of formal and informal practices as discussed in the background section. The formal practices require two hours a week to be set aside for seven weeks, and 40 minutes a day for eight weeks. These two hours are broken up into meditations, Yoga, readings, talks and a body scan that is based on a similar concept to progressive relaxation techniques. The meditation

sessions start from around 20-40 minutes and build up to a full day of just meditation and silence in the final week. Though the MBSR programme can differ slightly depending on the trainer, most are similar to the curriculum attached in Appendix C which is derived from the University of Massachusetts Medical School's online course (Santorelli & Mcleo-Meyer, 2016).

Participant 10 summarised the issue of formal meditation being particularly challenging but mindfulness as a trait itself as being simple to practice; she wrote:

“Time for formal practice. However, mindfulness is a way of being at all times, in all aspects of life. There are opportunities to practice throughout each moment.”. She further clarified, “Mindfulness is mind/brain training. Initially, it can seem overwhelming...we can be flooded with thoughts. Keep practicing. It can help - focus on the breath...or use a mantra. It's a practice.”

Her views suggest the importance of discipline in cultivating mindfulness which brings us to the next subtheme that describes the respondents struggles to maintain discipline, a requirement for the cultivation of mindfulness.

4.3.4.2 Requires Discipline

As much as mindfulness is about being curious to ‘what unfolds’ and not expecting anything, a prerequisite for its effectiveness is to learn how to quieten their mind and be completely present in the moment. Participants found these essential prerequisites very challenging. They described their challenges as follows:

“Quieting my mind when there is so much going on” (P1).

“I struggle to keep a mindfulness practice going. I live mindfully as much as I can every day. I notice feelings such as anxiety brewing and I go slowly for myself” (P8).

“Sometimes I feel like I am doing a great job at being mindful which is more of an ego based approach, this leads to feeling good in an ego based way. Then when that breaks down, I feel bad and guilty for not maintaining my mindful life. The challenge for me is not to get caught up in

these ways of thinking. Thanks to this survey, I am realising right now that mindfulness, for me is less building a muscle and more spinning a plate” (P8).

“Remembering to do it and not getting sucked back into worrying and feeling stressed, having time to meditate formally” (P13).

An exception to many comments was one made by Participant 11, who found the trait of mindfulness difficult to acquire and described how some saw it negatively: “Takes a while to really get the hang of it. Other people sometimes don’t understand when I am able to stay very calm during stressful situations (i.e. they judge this as apathy). Hard to break habits related to specific stressors but continued practice and awareness eventually helps this shift”.

Finding research that explains the challenges around practicing mindfulness was difficult but according to Juntilla (n.d.), it is generally a lot of hard work, progress can be slow and detaching oneself from outcomes can be frustrating. However, like participant 11 suggested, Juntilla (n.d.), also advocates mindfulness as a practice that gets easier as times goes and should not be given up but rather be viewed as a process of growth to be embraced.

4.3.5 Further Aspects for consideration

While themes are inductively produced, emerging from qualitative data, there were many themes that I knew were typical of mindfulness practice due to prior research in the field. However, there were some that was related to the challenges of mindful practise that caught me unaware. The view that while mindfulness was a simple and effective technique, the process of putting it into practice was not, and that this process was also not necessarily enjoyable. Mindfulness that therefore seen as not a practice for everyone.

4.3.5.1 Process not enjoyable

As mentioned before, the MBSR course comprises two aspects of practice; formal and informal. The informal has to do with simple ideas of how to stay present in the day while the formal consists

of longer meditations and exercises. The formal is similar to building the muscle and the informal, to testing it. However, some participants did not enjoy the formal aspect of the course and questioned it. Some examples of these are:

“... So I feel though I benefitted from the program, it can be achieved in other simpler ways than two hour meditations. I don't question its effectiveness, but do question the process of learning it” (P16).

“I would recommend learning mindfulness but not the MBSR course. I think there are other more effective shorter courses that would be practical for my clients who would not spare such effort, example Acceptance and Commitment therapy” (P16).

“Whilst it can be quite difficult to quiet the mind, the beauty is that mindfulness does not have to take a long time. Simple exercises like mindfulness walking and quiet breathing will suffice as you build upon practice” (P1).

“I'm not sure. I felt that going from no practice to having a practice of 40 minutes daily was unrealistic for me. I feel that a gradual increase in the time spent on daily practices may have worked better for me” (P7).

Some participants had a slightly different view in that they felt that though understanding the concept of mindfulness took some time, practising it was critical to being successful at it. Examples of these are:

“It was really hard at first, even though the concepts are simple. Also practice really does make all the difference in the world with it” (P11).

“Most useful lesson - don't try to be good at it, just do it” (P13).

“Yes; however, one can develop their own practice through study and experience. A formal program provides guidance and support” (P10).

The view that the actual process of imbuing mindfulness, especially in the form of MBSR, as not enjoyable, seems to be a novel finding as I have not come across a similar finding in the existing literature.

4.3.5.2 Not for everyone

There was not much consensus on the use of mindfulness and whether it affected clients' outcomes. Some practitioners thought that it was an excellent technique to use for stress, anxiety and depression as discussed in the previous theme; however, others felt it was not for everyone.

“Some people are open to using mindfulness practice and some are totally anti” (P9).

“...I also teach it to clients which has seemed to calm them down quickly. It's been effective as a technique so far, but I feel it's not for everyone. Some people don't understand it” (P15).

“I have attempted to explain its principles to my clients but it has not been relevant to all. Some people find it useful for anxiety, but my business clients find it too laid back and wishy washy” (P16).

These responses are supported by Didonna (2009), who suggested that even though mindfulness based therapies have been found to be highly effective in treatment of many conditions across populations, it should still not be seen as a 'cure-all'. Careful consideration of the following factors is suggested to support the decision to use mindfulness in therapy namely; is it suited for the person and the condition, can it be integrated with other evidence based interventions and can the clinician provide a rationale for its use.

An interesting observation of Participant 8 who works predominantly with trauma was that:

“Mindfulness, when used with people that have suffered trauma, can do more harm than good potentially. When I am recommending listening materials, I will use more than one source because some beginners may feel averse to mindfulness itself, but it may just be the particular voice that they are listening to that troubles them”.

This observation corroborates with findings from another study on mindfulness in traditional psychotherapy in which the researcher found that although there was agreement amongst the participants that mindfulness was beneficial with traumatised clients, it was to be used with caution (Dorn, 2014). It was hypothesised that being mindful of emotions and having bodily awareness, could at times activate and exaggerate re-traumatization in clients. It was, however, stated that if

used appropriately, mindfulness was a powerful tool that could make a difference with trauma symptoms.

To conclude this chapter I would like to use the words of a participant who believed that mindfulness could be used universally. This is important, since a point to note is that all 16 participants were willing to recommend mindfulness to others, and only one did not recommend the MBSR course itself. Participant 3 wrote:

“I have just begun to use mindfulness in my practise with children and have found they are innately drawn to it - the challenge is universal - discipline and practise... One can only bring about awareness and then from there a very personal choice to continue or not” (P3).

4.4. Summary of chapter

This chapter compromised of the findings and interpretations of the qualitative data collected online. The voices of the respondents were shared, the findings explained and supported by prior research in the field. If there were any dissenting views, they were also presented and explored. In the next chapter of the study, Chapter 5, the conclusions drawn from the findings, the limitations of the study and finally suggested recommendations will be presented.

CHAPTER 5

CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

5.1. Introduction

In this final chapter a short summary and conclusion section will be presented followed by the limitations of this study. The chapter will conclude with recommendations for future research and interventions.

5.2. Study Summary and Conclusions

The goal of this study was to qualitatively explore the experiences of mental health practitioners who completed the MBSR programme. Mindfulness was viewed to be an effective coping mechanism to handle job stressors that would affect the way practitioners relate to themselves and subsequently their clients as well. This “new way of being” was assumed to affect the therapeutic relationship and result in positive client outcomes.

The findings of this study allowed me to achieve this goal and gain insight and understanding of mental health practitioners’ experiences related to the MBSR programme and to suggest possible ways in which this programme can be made more accessible to others as a self-care technique. An example of this is that most participants felt passionately about mindfulness, considered it to be helpful in achieving the goals they had when enrolled in the programme i.e. to reduce their stress levels and use it as an intervention with their clients and were unanimous in that they would recommend it to others.

The participants reported using mindfulness both in their personal lives to reduce stress and for their clients in therapy as a way of being more present in the moment. They reported that the daily practice of mindfulness increased their sense of well-being and induced a sense of calmness,

interconnectedness and curiosity into how and what would unfold. These new-found qualities seemed to make them more effective mental health therapists as well, since they could be more grounded with their clients and better able to take on a non-judgemental perspective.

A common topic raised was that by having this non-judgmental and curious stance they could attain more self-compassion but also greater empathy with clients, making them as mental health practitioners more accessible to their clients and thus better able to build a more trusting and deeper therapeutic alliance. The explanations offered were that being better at self-care result in less burnout and vicarious trauma which in turn makes them more available to their clients.

In terms of personal impact, the participants all spoke of greater contentment due to stress reduction which was made possible by the awareness of a choice to respond instead of reacting to stressors. They seemed to achieve this by focusing on their breath or bodily sensations which brought them back to the present moment, in which they were more equipped to make better decisions. The calmer way of being had a profound impact on their general sense of wellbeing and all aspects of their lives. By modelling a calmer, accepting, non-judgmental way of being in the world, they seemed to have greater insight and a positive perspective that effected the way they related to themselves and their clients as well.

What I did find interesting and quite surprising was that all participants advocated for mindfulness per se, but not all the specific practices used to cultivate it for e.g. the formal aspect of mindfulness meditations especially in the first eight weeks of the course. The common challenges were that the process was too time consuming and the discipline required, enormous. Participants found it difficult to commit to these practices in terms of finding the time and an actual quiet space, as well as having the ability to sustain attention and focus on the meditation practices for the required time. Personally, I had also experienced these challenges and they seem to be a universal. However, the way these challenges can be dealt with for future training programmes are discussed further in the recommendations section.

To the best of my knowledge, this study is the first of its kind to explore how mental health practitioners experienced the programme itself (MBSR), their practice of mindfulness and the way

this influenced their professional life. There are many studies that explore mindfulness in novice therapists, nurses, social workers, etc. but none to date that explored the experiences of mental health practitioners across different levels and geographic locations.

Another interesting finding was that of mindfulness and trauma. Most of the participants used mindfulness for stress reduction and many of them spoke specifically about its benefits for vicarious trauma. However, one view was that guided mindfulness meditations could have adverse effect on certain patients. This topic will be discussed further in the recommendations section for further research.

5.3. Limitations

The limitations of a study are those characteristics of the research design and/or methodology that have influenced the interpretation of the findings. In this case the relevant limitation was that despite the different attempts to ensure maximum participation through putting the study links on known mindfulness sites and using snowball sampling, the sample size was still limited, as only 16 qualitative survey questionnaires could be used. Writing these limitations is a subjective process in which I have tried my best to evaluate the impact these limitations have had on this study are outlined below:

- Measure used to collect the data and its effect on sample size and depth of information

The open-ended qualitative online survey used affected the sample size and to some extent the depth of the responses. The low response rate was on par with literature available on online surveys that highlighted the fact that though online surveys are highly effective, their dependability (reliability) is effected by the low response rate (Lefever, Dal & Matthiasdottir, 2006). According to Comley (2000), most online surveys show a response rate of 15-29%. In this study, only 26% of respondents who showed interest in the study completed the questionnaire resulting in a sample size of 16. Though this was a qualitative research study and a sample of 16 is acceptable, I personally had hoped for a bigger sample seeing that it was conducted online and had an

international reach. This would have made this study more robust and results more transferable. However, due to the nature of the data collection method no incentives could be offered that is likely to have resulted in an improved response rate.

Furthermore, due to the anonymous identities of the participants and electronic data collection method, authentication of participants as credible respondents was not permitted. However, an attempt was made to deal with this problem by recruiting participants from specific Mindfulness websites. Another possible way to ensure verification would be to use a third party programme in which participants could log in and register to participate, without the researcher having any access to the personal information of the respondents. However, this process could be time consuming and financially demanding as well.

Due to the nature of the data collection method i.e. the online qualitative survey depth of the responses was affected in that I was not able to probe or gain clarification. In addition, a face to face interview would have probably kept participants interested and motivated to share more in depth information, for example it would have been possible to gain a deeper understanding of their work and how mindfulness influenced their approaches.

However, keeping in mind that the goal of the study was to explore the experiences of the mental health practitioners of the MBSR programme, I feel that despite these limitations, valuable insights were gained from the data which highlighted topics that could be used for further research and highlighted the value of MBSR as a stress reduction intervention in mental health practitioners.

5.4. Recommendations for further research

This study uncovered various aspects that could now be studied further, possibly using more quantitative methods or a qualitative method with a larger sample. Further in-depth one-on-one interviews or an option to conduct interviews via Skype for online engagement is suggested to explore the topic in more depth, on particularly the following issues:

- Challenges around the process of imbuing mindfulness:

Though most respondents wrote very positively about the outcomes of their mindfulness practice, they found the process of imbuing mindfulness through the MBSR programme challenging and not enjoyable. Thus, ways to make the process of imbuing mindfulness more enjoyable would be a useful topic that could be explored in future research since it could make mindfulness practice more accessible and appealing to people. The question is however whether a shorter and less intensive process would yield the same results that have been proven to effected real changes to the brain and immune system. Experimental research will be needed to assess whether a shorter mindfulness programmes can achieve the same outcomes. However, with regards to the challenges of the processes involved, the participants were of the view that as mindfulness is a practice, one should be consistent with it and that it eventually would become easier.

- Mindfulness and trauma

As mentioned before, mindfulness by the nature of its practices that advocate body awareness and present moment focus, is a method of choice for trauma survivors. However, a point was made that certain voices used in the guided meditations could be associated with the trauma and cause flashbacks and induce more anxiety. This was an interesting perspective that should be explored in future research and suggests that in the absence of evidence, the integration of mindfulness in trauma counselling should be done with care and sensitivity.

- The relationship between mindfulness and sleep

The relationship between mindfulness and sleep has been studied previously but to date it has not been completely understood. Prior research point to the possibility that sleep is induced by the outcomes of mindfulness i.e. mood enhancement, anxiety reduction, neurological changes in the brain and even simple pain reduction. Further research into this topic would be extremely helpful using both quantitative and qualitative methods.

- The profoundness of breath

‘The power of breath’ an integral part of the MBSR programme, has been elaborated on in previous literature. However, the reported impact of this elementary, but usually taken for granted technique, seemed profound as most participants felt it played a very critical role in regulating

themselves and their emotions. They also highlighted how their sense of well-being was enhanced by breath. The mere impact of mindful breathing is another topic that warrants further investigation.

5.5. Recommendation of mindfulness interventions for mental health practitioners

This study has supported previous research in its findings that point to the benefits of the MBSR programme and has also highlighted the potential impact of practising mindfulness on the way mental health practitioners relate both intra and inter personally. By being more aware, present and non-judgmental of self, they could respond better to clients, feel more grounded and better able to quieten their own self-doubt and anxieties. This facilitated greater empathy and compassion towards others. By being more mindful, the mental health practitioners themselves seemed to model the qualities that they desired from their clients and felt more competent in handling what was happening in the moment. The findings of this study combined with previous supportive findings could be used to advocate for mindfulness as a therapeutic technique valuable for self-care for novice mental health practitioners as part of their training, as well as, for qualified practitioners as part of on-going learning, to reduce the risk of burnout.

5.6. Conclusion

My hope for this research is to contribute to the growing body of literature on mindfulness and to highlight the likely benefits of integrating mindfulness into the basic training of mental health practitioners who by the nature of their work, are exposed to stressors during their studies and then also many job-related stressors. By understanding both the demands of the actual process of internalising its practice but also on the personal and professional benefits, I would like for interest to be piqued and practitioners to see it as a viable coping mechanism that can be learnt.

On a personal level, I particularly chose this research topic as I had just entered the mental health field. I have found that my practice of mindfulness was extremely useful as I faced many stressors

and anxiety provoking situations during my study year. I also found myself using it in therapy to ground myself and clients as well. It was with an attitude of curiosity that I wondered whether others have had similar experiences. Being fully aware of my positive bias, I opened my mind for dissenting experiences. However, the profound reported impact of mindfulness training on other mental health practitioners nationally and globally, supported value of mindfulness training for mental health practitioners.

To conclude I would like to use the words of Geeta Cowlagi (2014), who summarised the experience of mindfulness in the following words: *“Mindfulness brings back the joy of adventure in our daily lives. With great tenderness and curiosity, we are invited to be present to every thought in our mind and every emotion in our heart regardless of them being pleasant or unpleasant. Without judgement, we watch ourselves start living our lives with grace and gratitude.”* (para.2)

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APPENDICES

Appendix A: Research instrument

Open Ended Online Questionnaire

1. How old are you? _____
2. Are you male or female? _____
3. Which country are you from? _____
4. What is your level of education? _____
5. What is your occupation? _____
6. Please give some background to your work as a mental health practitioner? Please elaborate

7. When did you complete the Mindfulness Based Stress Reduction Programme?

8. What motivated you to do the Mindfulness Based Stress Reduction programme? State any expectations and/or specific goals that you had.

9. Did the mindfulness course meet these expectations and/or goals?

10. What does Mindfulness mean to you?

11. How do you experience Mindfulness in your everyday life?

12. What are the challenging aspects about mindfulness?

13. Have you noticed any change in yourself in the way you relate to people both in professional and personal context? Elaborate and give concrete examples.

14. How would you describe mindfulness as a way to cope with stress or self-care tool at a personal level?

15. Do you use Mindfulness in your professional practice? What have been your experiences?

16. Would you recommend mindfulness course to others for example your patients or peers?
Please give reasons.

17. Is there anything else you want to share about your mindfulness experience? e.g. Anything that surprised you about the process or you feel has not been asked.

Appendix B: Ethical clearance form



18 April 2016

Mrs Iram Osman 216072312
School of Applied Human Sciences-Psychology
Howard College Campus

Dear Mrs Osman

Protocol reference number: **HSS/0374/016M**
Project Title: **Exploring the experiences of the Mindfulness Based Stress Reduction program by Mental Health Practitioners: An Explorative Qualitative study**

Full Approval – Expedited Application

In response to your application received 8 April 2016, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Dr Shonuka Singh (Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

Cc Supervisor: Professor Anna Meyer-Weltz
Cc Academic Leader Research: Dr Jean Stoen
Cc School Administrator: Ms Ayanda Ntuli

Humanities & Social Sciences Research Ethics Committee

Dr Shonuka Singh (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag X64001, Durban 4009

Telephone: +27 (0) 31 290 5887/58604887 Facsimile: +27 (0) 31 200 4008 Email: ethics@ukzn.ac.za / anymeyer@ukzn.ac.za / rhuhung@ukzn.ac.za

Website: www.ukzn.ac.za



Funding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

Appendix C: MBSR online training course general overview taken from Soundstrue. com (Santorelli & Mcleo-Meyer, 2016)

“Course Overview

Session 1:

Here you will receive an overview of the course and establish the learning context for the rest of your experience. You will learn the theory and evidence of mind-body medicine and how to apply it in your life. You'll be experientially introduced to mindful eating, mindful breathing, and the body-scan method, with a special emphasis on what it means to be fully engaged in the present moment.

Session 2:

Perception is key in mindfulness—how you see things (or don't see them) will determine in a large part how you respond. This week's session and practices will ask you to examine your perceptions, assumptions, and the way you view the world. You will learn to use the body-scan practice to cultivate more awareness of how you react to stressful situations. Changing the way, you perceive and respond to difficulties and challenges will impact the short and long-term effects of stress on your mind and body.

Session 3:

In this session, you'll practice several distinct yet interrelated mindfulness practices—mindful hatha yoga, sitting meditation, and walking meditation. This is an ideal time to share your insights about your experiences with formal practice and integrating mindfulness into your daily life. You will discover that there is both pleasure and power in being present—you'll directly attend to and investigate how your experiences create such reactions as pleasure or discomfort in the mind and body.

Session 4:

By practicing mindfulness, we cultivate curiosity and openness to the full range of our experience, and through this process our ability to pay attention becomes more flexible. This week, your practice will focus on the development of your ability to concentrate and systematically expand your field of awareness. You'll learn about the physiological and psychological bases of stress reactivity, and experience mindful strategies for responding in positive, proactive ways to stressful situations.

Session 5:

At the halfway point in this course, you should now be familiar with the foundations of mindfulness and can focus on applying it more rapidly and effectively to specific challenges and stressors in your life. This week you will begin to pay attention to the places where you might be stuck in repeating, unhealthy patterns that you can disarm through mindful awareness. You will

also learn how to apply mindfulness at the critical moment when you experience a physical sensation, intense emotion, or condition, with special attention to exploring the effect of reactivity in health and illness.

Session 6:

Resilience or "stress hardiness" is our ability to return to equilibrium after stressful situations. This week, you will focus on transformational coping strategies to broaden your inner resources and enhance your resilience through mindfulness practice. You'll also learn the fundamentals of interpersonal mindfulness—applying awareness and presence at times when communication becomes difficult or fraught with strong emotions. You'll gain direct experience of a variety of styles for more effective and creative interpersonal communication.

All Day Retreat

This daylong guided retreat will take place between weeks six and seven. The intensive nature of this six-hour + session is intended to assist you in firmly and effectively establishing the use of MBSR skills across multiple situations in your life, while simultaneously preparing you to utilize these methods far beyond the conclusion of the program.

Session 7:

Mindfulness is most effective when it is a lifetime commitment. This week, you will explore the many ways that you can integrate mindfulness more fully and personally into your life. While having a dedicated regular practice for mindfulness meditation is important and beneficial, it is just as important to bring a broader sense of awareness and presence to every moment in your life, and to use non-judgmental mindfulness in your self-reflection and decision-making processes. You'll learn how to maintain the discipline and flexibility of daily practice as circumstances change over the course of your life.

Session 8:

In the final week of the program, you will have a complete review of everything you've learned over the course, with an emphasis on carrying the momentum you've built forward into the coming months and years. You'll learn about resources available to you to pursue mindfulness in new directions as your life and practice evolve, as well as the support systems that exist to help you continue to integrate, learn, and grow. The final lesson creates a satisfying closure by honouring both the end of this program and the beginning of the rest of your life.”

School of Applied Human Sciences
Discipline Psychology
College of Humanities
University of KwaZulu-Natal
Howard College Campus
Durban, South Africa

INFORMED CONSENT FORM: PARTICIPATION IN AN ONLINE RESEARCH STUDY

Exploring the Experiences of the Mindfulness Based Stress Reduction program by mental health practitioners: An Explorative Qualitative Inquiry.

Dear Participant

My name is Iram Osman. I am a Social Science Master Student in Clinical Psychology studying at the University of KwaZulu-Natal, Howard College Campus, South Africa. For my research dissertation, which is a compulsory part of my course, I am interested in doing a study on the Experiences of the Mindfulness Based Stress Reduction programs of mental health practitioners. This research study involves a web based open ended questionnaire.

If you are interested to participate in this study you need to be:

- 18 years and older
- Have completed a Mindfulness Based Stress Reduction Program,
- A mental health practitioner for example psychologists, doctors, counsellors etc.

To gather this information, I am interested in asking you some questions; however, it would be best to read, understand and give consent before we go any further.

Aims and objectives:

- The research aims at gaining a deeper understanding of what practitioners' experience on a personal and professional level when using Mindfulness programs namely MBSR as an intervention for stress and other mental health related issues.

Ethical concerns:

- Any information given by you cannot be used against you, and the collected data will be used for the purpose of this research only.
- Your confidentiality and anonymity will be guaranteed by the nature of the online study.
- Data will be stored in secure storage and destroyed after five years.
- You have a choice to participate, not participate or withdraw from the research process at any time. You will not be penalized for taking such action nor suffer any other negative consequences should you withdraw participation.
- This study poses no risk to participants.
- It is purely voluntary in nature with no financial benefits or loss if decide not to participate. Your involvement is purely for academic purposes

Please note that:

- Participation usually takes 20-30minutes.
- Please indicate by clicking the applicable box at the end of the page whether you are willing or not willing to participate and answer the online questionnaire.

Contact Details:

If further information is required feel free to contact me at:
Iram Osman via email at nazia.osman9@gmail.com
Cell no: 0814949296

My supervisor is Prof Anna Meyer-Weitz who is located at the School of Humanities, Discipline Psychology, Howard College Campus, Durban of the University of KwaZulu-Natal.
Contact details: email at meyerweitza@ukzn.ac.za.
Phone number:031 260 7618

You may also contact the University of KwaZulu-Natal's Research Office:

P. Mohun
HSSREC Research office,
Tel: 031 260 4557 email: mohunp@ukzn.ac.za

Thank you for your contribution to this research!

Click on the options

Willing	
Not willing	