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The Impact of Meditation on the Therapist and Therapy

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The Impact of Meditation on the Therapist and Therapy

Abstract

While meditation techniques have been used in therapy for at least the past 30 years (Kabat-Zinn, 1982), few studies have looked at the impact of the therapist having a personal meditation practice on therapist qualities and the effectiveness of therapy. The studies that have been conducted on this topic have looked at the effects of teaching therapists in training to meditate (Grepmaier, Mitterlehner, Loew, Bachler, Rother, & Nickel, 2007; Newsome, Christopher, Dahlen, & Christopher, 2006). The results of these studies support the hypothesis that having a personal meditation practice as a therapist may improve the effectiveness of the therapy provided. The present qualitative study involved interviewing six therapists about how they think that meditation has influenced them and their therapy. The study provides an exploration and development of the variables that may be influenced by therapist meditation. Participants reported that meditation has made them more effective therapists and allows them to build stronger alliances with their clients by increasing positive therapist characteristics including empathy, unconditional positive regard, and non-judgment. Because of their experience with meditation's beneficial impact on therapy, the participants suggested that meditation be taught to therapists in training and stated that they would not be the therapists that they are today without meditation. Finally, the participants reported that meditation allows them to handle the stresses related to being a therapist.

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THE IMPACT OF MEDITATION ON THE THERAPIST AND THERAPY

A THESIS

SUBMITTED TO THE FACULTY

OF

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DANIEL R. ZAMIR

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ABSTRACT

While meditation techniques have been used in therapy for at least the past 30 years (Kabat-Zinn, 1982), few studies have looked at the impact of the therapist having a personal meditation practice on therapist qualities and the effectiveness of therapy. The studies that have been conducted on this topic have looked at the effects of teaching therapists in training to meditate (Grepmaier, Mitterlehner, Loew, Bachler, Rother, & Nickel, 2007; Newsome, Christopher, Dahlen, & Christopher, 2006). The results of these studies support the hypothesis that having a personal meditation practice as a therapist may improve the effectiveness of the therapy provided. The present qualitative study involved interviewing six therapists about how they think that meditation has influenced them and their therapy. The study provides an exploration and development of the variables that may be influenced by therapist meditation. Participants reported that meditation has made them more effective therapists and allows them to build stronger alliances with their clients by increasing positive therapist characteristics including empathy, unconditional positive regard, and non-judgment. Because of their experience with meditation's beneficial impact on therapy, the participants suggested that meditation be taught to therapists in training and stated that they would not be the therapists that they are today without meditation. Finally, the participants reported that meditation allows them to handle the stresses related to being a therapist.

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INTRODUCTION

Since mindfulness was first formally taught to patients as a therapeutic intervention in the 1970's, it has been found to be effective in treating a wide variety of psychological disorders, including several which were previously viewed as treatment-resistant or untreatable (Brown, Ryan, & Creswell, 2007; Grossman, Niemann, Schmidt, & Walach, 2004; Ivanovski & Malhi, 2007; Kabat-Zinn, 1982). Most of the research on mindfulness in psychotherapy has been on programs in which mindfulness is taught to patients in order to reduce their symptoms, increase their ability to tolerate difficult emotions, and increase their ability to pay attention to and accept whatever they are experiencing in the present moment (Siegel, 2007). Aside from teaching meditation to clients, there are other ways that mindfulness may have an impact on therapy (Germer, 2005).

One way that mindfulness might influence therapy is if the therapist has a personal meditation practice. Few studies have looked at how meditating as a therapist might influence qualities known to be predictive of a strong therapeutic alliance and positive therapeutic outcomes. The few studies that have looked at the connection between therapist meditation and the predictors of positive outcome in therapy have been promising (Grepmaier, Mitterlehner, Loew, Bachler, Rother, & Nickel, 2007; Schure, Christopher, & Christopher, 2008). While researchers have just begun to look at the relationship between therapist meditation and therapy outcomes, there has not been any published research on how having a personal meditation practice as a therapist might influence therapist qualities such as empathy and unconditional positive regard. Any connection between therapist meditation and these qualities would be important because they have been shown to be predictive of strong therapeutic alliances and positive therapeutic outcomes (Farber & Lane, 2001; Hersoug et al., 2001; Norcross, 2001).

Background Literature

Introduction to Mindfulness

Mindful awareness has been defined in many different ways. It has been defined as “waking up from life on automatic, and being sensitive to the novelty of everyday experience” (Siegel, 2007, p.5) and as “the state of being attentive to and aware of what is taking place in the present” (Brown & Ryan, 2003, p. 822). Additionally, Ivanovski and Malhi (2007) defined mindfulness as “the expansion of attention in a nonjudgmental and nonreactive way to become more aware of one’s current sensory, mental, and emotional experiences” (p. 77). These three definitions can be combined into a more cohesive definition of mindfulness as a state of mind that can be cultivated in which one is acutely aware of one’s present experience and responds to this experience in a non-judgmental and non-reactive way. Mindfulness often leads to a sense of balance and psychological well-being (Carmody & Baer, 2008). The mindful-mediator does not try to create any particular state of mind, but attempts to just become aware of each thought, feeling, or sensation as it arises in the present moment and to let each thought, sensation, or feeling pass away without judgment or attachment (Segal, Williams, & Teasdale, 2002).

Mindfulness began as a spiritual practice (Miller, Fletcher, & Kabat-Zinn, 1995) and is most commonly associated with Buddhism, but it actually originated in yogic practices thousands of years before the advent of Buddhism. For thousands of years, people have practiced mindfulness meditation in order to become aware of the present moment in a focused and non-judgmental way. Buddhists practice mindfulness and other types of meditation in an attempt to attain enlightenment or release from suffering (Miller et al., 1995).

In the past 30 years, mindfulness meditation has been examined by many medical doctors, neuroscientists, and psychologists. In psychology, mindfulness meditation has been

found to be effective in treating depression, anxiety, psychosis, borderline personality disorder, and in decreasing suicidal and self-harm behavior (Brown, Ryan, & Creswell, 2007; Grossman, Niemann, Schmidt, & Walach, 2004; Ivanoski & Malhi, 2007). It has also been found to reduce substance use and recidivism in prison populations (Ivanoski & Malhi) and to increase positive emotions and the capacity to regulate negative emotions (Davidson et al., 2003). In the medical field, short term mindfulness meditation instruction has been shown to be effective in treating chronic pain (Miller, et al., 1995) and to decrease stress reactivity and improve immune system functioning, thereby reducing the chance of future illness (Davidson et al.).

Mindfulness-Based Treatments

Mindfulness was first used in a modern Western medical center by Jon Kabat-Zinn. In the late 1970's, he was teaching at the University of Massachusetts Medical Center. Kabat-Zinn (1982) conducted research to determine whether mindfulness could provide some benefit to patients suffering from chronic pain. His first patients were still in pain after exhausting all of the treatments that Western medicine had to offer. Furthermore, the causes of these patients' pain were diverse, ranging from psoriasis to back pain. Kabat-Zinn developed an 8-week program that he referred to as mindfulness-based stress reduction (MBSR, Kabat-Zinn, Lippworth, & Burnery, 1985). The MBSR program consisted of eight meetings that each lasted two hours and were held once per week. Each meeting involved instruction in mindfulness meditation, concentration meditation, and yoga. MBSR has demonstrated effectiveness in reducing subjective pain, decreasing anxiety, improving immune system functioning, speeding the healing process, and increasing self-reported levels of well-being (Davidson et al, 2003).

With the success of MBSR, mindfulness went from being a spiritual and religious practice used to achieve enlightenment, to being the active ingredient in an empirically validated

treatment used for treating medical problems at a well respected medical center. Kabat-Zinn's success brought mindfulness to the attention of many neuroscientists, psychologists, and medical professionals. After Kabat-Zinn's groundbreaking study, other scientists and practitioners started experimenting with other possible uses for mindfulness, including the treatment of anxiety disorders (Davidson et al., 2003; Ivanovski & Malhi, 2007). MBSR has demonstrated effectiveness in reducing symptoms of anxiety and panic in patients with generalized anxiety disorder, panic disorder without agoraphobia, and panic disorder with agoraphobia (Kabat-Zinn et al., 1992).

Mindfulness-based treatment programs have also been effective in decreasing rates of relapse among patients with chronic depression (Segal et al. 2002) and in the treatment of borderline personality disorders (BPD) (Linehan, 1993). In both of these cases, mindfulness-based interventions are being used to treat disorders that were not responsive to medication or traditional psychotherapy. Mindfulness-based cognitive therapy (MBCT; Segal et al., 2002) for depression and dialectic behavior therapy (DBT; Linehan, 1993) for BPD were developed to treat populations that had previously been seen as treatment resistant by mainstream psychology and medicine.

These treatments for psychological disorders that use mindfulness are promising in a number of ways. As mentioned above, they have been successful in treating populations that have not responded to traditional psychotherapy or psychiatric medication. More specifically, MBCT has been successfully used to decrease the rate of depressive relapse in individuals who have experienced three or more major depressive episodes and who have not responded to medication or cognitive behavioral therapy (CBT) (Segal et al. 2002). Similarly, DBT, which incorporates mindfulness, is the only current treatment for BPD with proven efficacy (Linehan,

1993). Before the advent of DBT, BPD was thought to be non-responsive to treatment, which is particularly concerning as BPD is associated with an extremely high rate of suicide (Linehan, 1993). Like MBSR, these treatments are unique in their success in treating patients previously labeled as treatment resistant. Furthermore, due to the group format of these treatment programs, they are highly cost effective and resource efficient.

How Mindfulness Is Used in Treatment

There are many ways in which mindfulness can and has been used in the treatment of psychological conditions (Germer, 2005). One way is to explicitly teach mindfulness meditation to patients. This was the approach used by Kabat-Zinn (1982). Another way that mindfulness can influence treatment is when a therapist has a personal meditation practice, but does not necessarily teach mindfulness in treatment. When a therapist has a personal meditation practice, meditation may have an impact on the therapist and may indirectly impact the therapist's clients.

A great deal of research has been conducted on therapist characteristics that impact therapy outcome, such as empathy and unconditional positive regard. The next section of this paper will review the research on several therapist characteristics that have been shown to predict positive outcomes in therapy. The following section will look at how a personal mindfulness practice can promote therapist characteristics that have been shown to predict positive outcomes in therapy. The final section in the literature review will review the limited research that supports a direct link between a therapist's personal mindfulness practice and positive therapy outcomes.

Predictors of Successful Psychotherapy

Before 1957, therapeutic techniques were commonly seen as the cause of therapeutic change (Norcross, 2001). Therapists in training are often taught that learning therapeutic techniques is more important than developing the personal qualities that make someone a good

therapist (Grepmaier et al., 2007). The supremacy of technique over therapist qualities was challenged when Carl Rogers (1957) stated that there are only three necessary and sufficient conditions for therapeutic healing. These three conditions are unconditional positive regard, congruence, and empathy. Rogers emphasized that therapist characteristics instead of techniques are the most fundamental ingredients in the change process.

A considerable amount of research has focused on therapist characteristics and how they influence therapy (e.g., Farber & Lane, 2001; Norcross, 2001). One major finding of this research is that a strong working alliance between a therapist and his or her client has been shown to be a consistent predictor of positive outcomes in psychotherapy (Hersoug, Hoglend, Monsen, & Havik, 2001). Relatedly, the following therapist characteristics are associated with a strong working alliance: less self-directed hostility, more perceived social support, higher degree of comfort with closeness in interpersonal relationships, empathy, unconditional positive regard toward clients, and genuineness (Hersoug et al.; Farber & Lane). If working alliances are predictive of positive therapeutic outcomes and these therapist characteristics are predictive of a strong working alliance, it is possible that these therapist characteristics may lead to positive therapeutic outcomes. For example, when the therapist has unconditional positive regard for his or her clients, then therapeutic outcomes are generally better (Farber & Lane).

In 2001 a task force was created by the American Psychological Association (APA) to investigate empirically supported therapeutic relationships (Norcross, 2001). When Rogers wrote his article in 1957, therapeutic technique was seen as superior to therapist characteristics and the therapeutic relationship. What therapists do was seen by many as more important than how they do it, or how they relate to clients (Grepmaier et al., 2007). In the field of psychology today, some believe there has been a return to focus on technique over therapist qualities (Norcross). With

the advent of empirically supported treatments (ESTs), manualized treatments that specify what techniques to use for a given diagnosis have become popular and heavily funded (Norcross).

The vast majority of EST research focuses on manualized treatments because these are the easiest treatments to study (Herman-Smith, Pearson, Cordiano, & Aguirre-McLaughlin, 2008). Furthermore, most research is conducted using homogenous samples that do not reflect the populations that clinicians are actually treating (Norcross, 2001). Norcross said that ESTs depict “disembodied therapists performing procedures on Axis I disorders. This stands in marked contrast to the clinician's experience of psychotherapy as an intensely interpersonal and deeply emotional experience” (p.346). Norcross further argues that the therapist and the therapeutic relationship have long been empirically supported. In fact, therapist characteristics have been shown to be more important than differences between different treatment modalities (Henry, 1998; Luborski et al, 1999). Norcross acknowledges the benefits of ESTs, but states that these treatments should take into account therapist qualities and the therapeutic relationship as well as specific therapeutic techniques and orientations.

As noted above, research has shown that less self-directed hostility, more perceived social support, higher degree of comfort with closeness in interpersonal relationships, empathy, and genuineness are all predictive of a strong therapeutic relationship, which in turn is predictive of positive therapeutic outcomes (Hersoug, et al., 2001). The next section will examine the research that has been done on two specific individual therapist qualities that are predictive of positive therapeutic outcomes: empathy and unconditional positive regard. This section will also explore how therapist meditation and other factors can lead to an increase in these qualities.

Empathy

Empathy has been seen as a necessary condition of therapy for many years. Rogers (1992) gave the following definition of empathy: “to sense the client’s private world as if it were our own, but without ever losing the ‘as if’ quality” (p. 829). This definition points out that empathy involves the understanding of another person’s experience, while maintaining a realization of our separateness from the other. In order to be empathic, one must be able to escape the natural human tendency to be self-centered. All of our experiences are seen through our eyes and everything is naturally interpreted in relation to our selves. Empathy involves suspending our everyday self-centered processing and allowing our minds to sense the experience of another.

An increase in empathy is seen as one of the many outcomes of the practice of mindfulness (Block-Lerner, Adair, Plumb, Rhatigan, & Orsillo, 2007). Mindfulness involves awareness of what is happening in the present and a non-reactive or non-judgmental response to whatever enters into one’s experience. The non-judgmental piece is helpful for breaking out of our typical and self-centered way of relating to the world. If we are not judging (not evaluating our experience in relation to ourselves) we are better able to focus on and experience the internal world of another. This logical argument for why mindfulness should increase empathy is backed up by preliminary empirical data. Shapiro, Schwartz, and Bonner (1998), for example, conducted a study that looked at the effects of having medical students engage in an 8 week MBSR program. After participating in the MBSR program, the students experienced an increase in empathy in relation to a wait-list control group. Similarly, Block-Lerner et al. (2007) randomly assigned participants to one of three conditions: 1) mindfulness instruction, 2) positive thinking instruction, and 3) a relaxation control condition and then assessed each participant’s self-centeredness and ability to take the perspective of others. The mindfulness condition involved

instructing participants to be aware of and accepting of thoughts and feelings as they arise. The positive thinking condition involved instructing participants to try to think positive thoughts. The relaxation control condition involved participants listening to a recording of sound waves. After their instruction, individuals in each condition were shown an emotionally evocative film clip and then instructed to write about the clip. Individuals in the mindfulness group took the perspective of others more and used self-referential language less than participants in the other groups. These results suggest that when individuals are in a mindful state, they are better able to take the perspective of others and are less self-centered.

There is another way in which mindfulness may help individuals cultivate empathy. Through the act of becoming aware of the present moment in an open and non-judgmental way, a person naturally comes to learn more about her or himself (Germer, 2005) By becoming aware of his or her emotional reactions and the events that trigger them, one develops greater understanding of one's habitual response patterns and emotions (Block-Lerner et al., 2007). Block-Lerner et al. argue that only through understanding of one's own emotions can one develop empathy for others. In other words, it is only through the understanding of our own emotions that can we come to deeply understand the feelings of others. Understanding of others and their emotions in a non-judgmental and non-attached way is empathy. Hughes, Tingle, and Sewin, (1981) found support for the assertion that being aware of our own emotions fosters empathy. More specifically, they conducted a study in which they randomly assigned children to listen to stories that were either happy or sad. They randomly assigned some of the children to a condition in which they were instructed to reflect on their own emotional reaction to the story and were then asked how they think the child in the story feels. Children in the other condition were also asked how they thought the child in the story feels, but were not asked to reflect on

their own emotional experience while listening to the story. The experimenters found that children who reflected on their own emotional experience were better able to identify the emotional experience of the child in the story. This finding suggests that a person's ability to be empathic is increased when they become aware of their own emotional reactions. Mindfulness allows us to become more aware of our own emotions and thus enables us to be more empathic (Block-Lerner et al., 2007).

Unconditional Positive Regard

While the relationship between empathy and mindfulness has been explored in several studies, the connection between mindfulness and other therapist characteristics has not been tested empirically. However, the connection between mindfulness and the other empirically supported therapist characteristics is quite plausible and has been supported indirectly. For example, the qualities of unconditional positive regard and less self-directed hostility have both been shown to be positively correlated with strong therapeutic relationships (Hersoug et al., 2001; Rogers, 1992). Unconditional positive regard for others and less self-directed hostility may be cultivated through a particular type of meditation referred to as Loving Kindness Meditation (LKM) or Metta Meditation.

Fredrickson, Cohn, Coffey, Pek, and Finkel (2008) conducted an empirical study that looked at how LKM influences people's experience of positive emotions. Similarly to mindfulness, LKM is a practice of inward attention, but unlike mindfulness which involves focusing on whatever experience arises:

LKM involves directing one's emotions toward warm and tender feelings in an open-hearted way. Individuals are first asked to focus on their heart region and contemplate a person for whom they already feel warm and tender feelings (e.g., their child, a close

loved one). They are then asked to extend these warm feelings first to themselves and then to an ever-widening circle of others (Fredrickson et al., 2008, p.1046).

From this description, it appears as though there is a good degree of overlap between LKM and the practice of unconditional positive regard toward one's self and others. Fredrickson et al. acknowledge that meditation is not just designed to cultivate positive experiences, but also to allow the practitioner to learn about their own mind. They further suggest that the insights gained from this practice change people's relationships with others and increase their empathy and compassion. To test their hypotheses, Fredrickson et al. conducted a randomized controlled trial in which participants were assigned individuals to one of two groups: 1) LKM or 2) a waitlist control group. They tested each participant's emotion at the beginning and end of the study and asked each participant to report about their experience each day. The results from this study indicated that LKM produces positive emotion that continues after meditation has ended and that this increase in positive emotion was experienced even on days when a participant did not meditate. Furthermore, people gained more positive emotion per hour of meditation once they had been practicing for a few weeks than they did at the beginning of the study. This finding is important because it shows that even novice meditators were able to develop a skill for creating positive emotions through meditation in a period of just 7 weeks. Since unconditional positive regard has been found to be a helpful quality for a therapist to have (Hersoug et al., 2001), it may be helpful to teach LKM to therapists in training. Fredrickson et al.'s study suggests that unconditional positive regard and empathy can be cultivated through LKM.

In summary, meditation appears to directly influence personality characteristics that have been shown to support successful therapy when they are present in the therapist. However, all of the research reviewed above assessed the indirect effect of meditation on therapy outcome. More

specifically, meditation appears to increase empathy, unconditional positive regard, and less self-directed hostility, and other studies have shown that these same qualities lead to a better therapeutic relationships and thus better therapeutic outcomes. While this research is promising, it is also important to examine research that directly measures the impact of therapist meditation on client outcome.

Direct Impact of Therapist Meditation on Treatment Outcome

Grepmaier et al. (2007) conducted a randomized, double-blind, controlled study to examine the effects of therapist meditation on client outcome. Grepmaier et al. conducted their study in Germany at a training institution for depth psychotherapy that is located at a 200 bed psychosomatic hospital. The study involved psychotherapists in training (PiT) who had the equivalent of a Bachelors Degree in psychology and were in their second year of internship. Eighteen PiT's participated in the study, all of whom were women. Each of the 18 PiT's who participated in the study was given daily meditation instruction from a Zen Master living in Germany. Nine of the PiT's were randomly assigned to the meditation (MED) group; these PiT's were instructed to meditate before each therapy session. The other nine PiT's were randomly assigned to the no meditation (noMED) group and were instructed to meditate at a time of the day when they were not conducting therapy. All PiT's were blind to the purpose of the study in that they did not know why they were instructed to meditate at certain times. The Zen meditation instructor was also blind to the purpose of the study. The clients were also blind to the purpose of the study in that they were not informed that their therapists were undergoing meditation instruction. The 18 PiT's conducted therapy with 124 inpatient clients during the course of the study. Clients were randomly assigned to PiT's. Clients completed the Session Questionnaire for General and Differential Individual Psychotherapy (STEP; Krampen & Wald, 2001), a 12-item

German scale that assesses the therapeutic process from the perspective of the client, after each session. Clients also completed the Veranderungsfragebogen des Erlebens und Verhaltens (VEV; Renner, 2007), a German questionnaire that assesses changes in experience and behavior. Finally, clients completed the Symptom Checklist 90 Revised (SCL-90-R; Derogatis & Cleary, 1977), a ninety-item self-report measure that assesses emotional and symptomatic distress. The clients completed the SCL-90-R at admission and prior to discharge. These assessments were used to compare the treatment outcomes of the MED and NoMED groups. The clients were treated for 9 weeks.

The results of the study were that the MED group had significantly higher evaluations on 2 STEP scales (Clarification and Problem Solving) and on the VEV. Clients of therapists in the MED group also showed a greater reduction in symptoms than clients of therapists in the NoMED group. Clients of therapists in the MED group had greater symptom reduction in the following areas as assessed by the SCL-90-R: somatization, insecurity in social contact, obsessiveness, anxiety, anger/hostility, phobic anxiety, paranoid thinking, and psychoticism.

Similarly, Newsome, Christopher, Dahlen, and Christopher (2006) qualitatively examined the impact of teaching masters-level graduate counseling students meditation, yoga, qigong, and conscious relaxation exercises. Students in the study attended a 15 week class that was designed to reduce stress and improve counseling ability through instruction in mindfulness techniques. Students in the course reported that learning to practice meditation provided a powerful tool for dealing with difficult emotions, stimulating personal insight, and increasing self-acceptance (Newsome et al.). A student in the class reported how learning meditation influenced them as a counselor:

I think that this course has helped me to feel less anxious in the room with clients. I think that this results in me being able to be more present, and being able to have more empathy for experiences they share with me. I think before this class my anxiety would override other feelings at times, and it was harder to be in touch with these. And even beyond the affective realm, I think that being mindful and more “centered” allows me to look outside of myself more, and observe my clients and my relationship with them more. (Schure, Christopher, & Christopher, 2008, p.52).

Students also reported that practicing mindfulness decreased their stress level, made them more comfortable with silence in therapy, and increased their quality of life (Schure et al., 2008).

Currently, the research on how having a personal meditation practice may improve positive therapist qualities such as empathy and non-judgment is promising but limited. The research thus far suggests that the therapist meditating before therapy sessions may lead to better therapeutic outcomes and that teaching therapists in training to meditate may help them to deal with difficult emotions, provide insight, and increase their self-acceptance. While these findings support the assertion that meditation does influence therapists and may improve their ability to form a therapeutic alliance with their clients, there has not been any published research that examines how therapists who have a personal meditation practice think that their therapeutic abilities have been influenced by their meditation practice. Therefore, the goal of this study was to interview therapists who are experienced meditators in order to get an understanding for how they believe that meditation has influenced their ability to form therapeutic relationships and provide effective therapy.

METHOD

Participants

Participants in this study consisted of six therapists, including two psychologists and four master's-level therapists, each with a personal meditation practice. Three participants were male and three were female. All of the participants have a current psychotherapy practice in the Portland metropolitan area. Number of years practicing psychotherapy ranged from 3 to 32. Number of years spent meditating ranged from 9 to 37. The current rate of meditation varied among participants with one participant saying that he does not currently have a formal meditation practice, one participant reporting that she sits once per week and all other participants reporting that they meditate daily for between ten minutes and an hour each day. The style of meditation currently practiced by the participants also varied. One participant practices chakra energy meditation. Another practices Tibetan visualization meditation. A third practices mindfulness meditation in the style of the MBSR program (see Table 1).

Design and Procedure

Participants were recruited via an internet search for therapists with a meditation practice in Portland, Oregon. Therapists and psychologists who met the criteria of practicing meditation were called and told about the study. Arrangements were made with participants by telephone. All of the interviews were conducted in the participants' offices. All interviews were conducted by the researcher. An audio recorder was used to record the interview. All interviews lasted between 20 and 45 minutes.

The data gathering method was a semi-structured interview (see Appendix A). The semi-structured interview format consisted of open-ended questions; follow-up questions were asked

Table 1

Participant Demographics

Participant number	Years practicing psychotherapy	Years meditating
1	10	20
2	12	37
3	8	10
4	32	30
5	14	14
6	3	9

to provide more detailed explanations to the main questions. Additional questions were asked to clarify content. Close ended questions were used to gather demographic data. Prior to conducting the interview, all participants read and signed a consent form (see Appendix B).

The recorded interviews were protected by the principal investigator at all times. An identification number was assigned to the participant being interviewed. This number was the only identifier of the participant throughout the study. Numbers were given according to the order of interview. Only the principal investigator had access to both the name and identification number of the participant. The resulting material was transcribed by the principal investigator. The participants' names did not appear on the transcripts. The audio-material was transcribed on a password-protected computer. A copy of each transcript was kept on a password-protected hard disk to serve as backup.

Data Analysis

Qualitative methods were used to analyze the data. The decision to use qualitative rather than quantitative methods was based on the belief that therapists' ideas about how meditation influences them and their therapy were too complex to gather using a survey, and that an interview would better capture the complexity of their opinions and experiences. According to Corbin and Strauss (2008), "qualitative research allows researchers to get at the inner experience of participants, to determine how meanings are formed through and in culture, and to discover rather than test variables" (p. 12). Qualitative methods are particularly useful and necessary in this case because there is little previous research in the area. A semi-structured interview was used because it is seen as a useful tool for exploratory analysis (Sue, 1999).

The researcher used a grounded theory approach (Corbin & Strauss, 2008). Following the transcription of the interviews, the principal investigator read and re-read each interview to get a

sense for each participant's language and the meaning of each interview as a whole. This is a way to gather information about the common themes and differences between the participant responses. This process is necessary as it sets up the next stage of coding each interview line-by-line.

The second stage was to use axial coding to determine themes and subthemes and to investigate possible relationships between themes (Corbin & Strauss, 2008). During this stage of analysis, both hard and electronic copies of the transcripts were used. First, the hard copies were color coded according to themes and notes about the themes and their relationship to each other were written in the margins. Next, the themes were typed out and quotes that represented each theme were cut and pasted from the transcripts. Coding was done using axial coding without the use of data analysis software because of the small sample size and the brevity of the interviews.

RESULTS

Open coding was combined with axial coding to produce categories that were organized into themes and subthemes (Strauss & Corbin, 2008). This allowed the researcher to develop categories with an awareness of how the categories were related to each other. During open coding, the transcripts are coded line by line. After every transcript has been coded, each line is considered on its own, as part of the individual interview, and in light of all of the other interviews. The purpose of this line by line coding is to identify recurring ideas. Axial coding was then used to identify interactions between ideas. Ideas that appear several times throughout the six interviews were labeled as subthemes. Subthemes were grouped together into more general themes that related several subthemes to each other and provided more structure and meaning to the data contained in the interviews (see Table 2). The overarching theme that all of the themes and subthemes relate to is therapist meditation. This is because the main purpose of this research was to learn more about how therapists perceive their personal meditation practice as influencing them and their ability to provide effective therapy. The four main themes discussed by the participants are outlined below in the following order: (1) teaching meditation in therapy, (2) meditation made me a better therapist, (3) meditation as clinical training, and (4) meditation as self-care. Each theme is discussed in turn and is broken down into subthemes that allow for a deeper analysis of each theme.

Teaching Meditation in Therapy

Five of the six participants reported that they brought meditation into the therapy room. Each therapist used meditation in therapy in a different way. Some of the therapists reported that they formally teach their clients how to meditate, while others brought meditation into therapy

Table 2

Themes and Subthemes Identified by Participants

Themes and subthemes	Number of participants who identified the theme and subtheme
Theme 1: Teaching meditation in therapy	6
Subtheme 1: Implicit	3
Subtheme 2: Explicit	4
Theme 2: Meditation made me a better therapist	6
Subtheme 1: Empathy	6
Subtheme 2: Unconditional positive regard	5
Subtheme 3: Non-judgment	4
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on an implicit level by asking their clients to start off the therapy with a moment of silence, or to take a breath and stay in the present moment when they were talking about a difficult subject.

Implicit

Three of the six participants reported that they do not teach meditation to their clients explicitly, but that they use their knowledge of meditation to guide their clients to become more aware of their experience in the present moment. One participant reported:

I teach people to focus on the breath and that when they do, their problems get smaller. They learn that they can stay with right now, which is a safe place to be. I think I use little bits and pieces, but I don't formally teach meditation.

Another participant reported bringing meditation into therapy in a slightly different way.

I start most of my sessions with my clients by having them center. Right now I have been having people center by relaxing and feeling into the hour that we have in front of us, so they can let go of hurrying and feeling like "oh my god, I have to do this" We have this hour together, so let's just be here and let it open up before us. I ask people to feel their body in the chair and feel their breath and take a minute to just settle in.

These participants bring meditation into therapy in subtle ways without formally teaching meditation. This implicit use of meditation in therapy is one of many ways that meditation can impact therapy.

Explicit

While some participants avoided formally teaching meditation techniques to their clients, two of the therapists interviewed saw teaching meditation as part of their role as therapists. One of these participants described how and why he teaches meditation in therapy:

People come to me often because they know that I am interested in Buddhism and I make it clear that I am not a Lama. I am not a formal meditation teacher, but there are certain types of practice and meditation that I do teach...I teach compassion practice, often I teach them different kinds of body visualizations.

Another participant reported that clients come to see her as a therapist because they meditate and they want a therapist who can help them with their meditation practice.

Meditation Made Me a Better Therapist

All of the therapists interviewed reported that their personal meditation practice has made them more effective therapists. Several participants said that meditation has increased their ability to form therapeutic alliances with clients. The participants reported that meditation has increased several of the therapist qualities that are predictive of positive therapeutic alliances, including empathy, unconditional positive regard, and the ability to be non-judgmental of clients. In addition, participants reported that meditation increases their ability to pay attention to their clients, provides tools that they use in therapy, allows them to be able to sit with their client's pain, and creates positive states of mind in them that "rub off" on their clients. One participant reported:

I make a good alliance with people. The rapport is there really fast and it is usually very positive and people...decide to work with me...that is part of what I am talking about, that ability to sit with somebody and form that kind of alliance. I think that is helped by my meditation

Empathy

All of the participants reported that their personal meditation practice has made them more empathic. Several participants reported that this increase in empathy is due to their ability

to recognize emotions in themselves during meditation. One participant reported, “I recognize the psychological things that happen in my clients in myself. I know the fear, I know the anger, I know all these things because I have studied myself and meditation is what has allowed that study to happen.” The participant said that in order to be empathic, you have to have a deep understanding of your own emotion before you are able to feel for the emotion of another. Another participant echoed this sentiment, “I think meditation has been crucial for opening my heart. I have a loving kindness meditation. I think empathy is basically the capacity to feel your own feelings: pain, sadness, fear, anger, love.”

Unconditional Positive Regard

Five of the six participants reported that their meditation practice has helped them to have unconditional positive regard for their clients. This capacity seemed to be related to empathy. Participants reported that their ability to relate to the basic human experiences of their clients allowed them to have positive regard for their clients even when they were acting in ways that the therapist did not approve of. One participant reported:

I sit with child abusers, drug addicts, and sex addicts. I sit with people who have done horrific things and I don't condone that, but it is about working through that and meeting it in its humanity, so I think meditation gives me that positive unconditional regard.

Another participant put it in a different way, “It (meditation) makes me somebody who is compassionate, who sees people in positive regard. It makes me see my clients as full of potential.”

Non-Judgment

Three of the participants reported that meditation has helped them to be non-judgmental of their clients. They reported that meditation made them more compassionate, accepting,

grateful, humble, and joyous and that these qualities made them less judgmental. One participant reported, “I think a big part of it (meditation) is acceptance and compassion and adopting a non-judgmental approach as much as possible and directing myself to develop these qualities.”

Increased Attention

Four of the participants reported that meditation increased their ability to focus their attention on their clients during therapy. The participants reported that they had a better attention span as a result of meditating, which prevented them from getting distracted by their own thoughts. Several participants reported that meditation allowed them to pay attention not just to the content of what their clients say, but also to the process in the therapy room. One participant reported:

I spend a lot of time in session reminding myself to stop trying to solve the problems or listening to the content of the words and I will just focus in on what is going on now for this person. What are they feeling? I think because I am able to focus, I am able to put my attention onto them in a more intense way because of my ability to meditate

Another participant reported that she was amazed that people who do not have a meditation practice are able to pay attention to their clients to the degree that is necessary to provide effective therapy. She was surprised that people who do not meditate are able to focus on everything that is going on in the therapy room.

Tools to Use in Therapy

All of the participants reported that their meditation practice provided them with tools to use in therapy. Some participants said that their meditation practice influenced the orientation from which they approach therapy. One participant reported, “I call myself a mindfulness based

therapist.” Other participants described meditation as the base of their therapy practice, with one participant reporting:

In a more experiential sense, mindfulness has helped me to be more centered in the therapy process itself. Being mindful of myself and being centered in my own body is one of my therapeutic touchstones and tools when sitting with someone.

All of the participants reported that they used techniques or ways of being in therapy that developed out of their personal meditation practice. There was a shared sense among the participants that meditation becomes part of who you are and it impacts the way that you interact with your clients in therapy. The participants reported that this way of relating to clients differently informs which techniques you use and how you use them, even if the techniques themselves are not related to mindfulness. One participant described the tools that she gained from her meditation practice and how it has impacted her technique:

What happens to me has changed my approach to therapy and today I see myself working more from the Buddhist psychology and more working on seeing processes, not just getting into content of what people bring. I do sometimes go into the past, but more checking with how they perceive things in the present, working a lot with the body and how they feel their experiences in the body.

Another participant reported how practicing meditation has expanded her abilities as a therapist:

It has given me a base to work with that is much bigger than my little ego construct. It adds perspective, it adds resilience, it adds clarity, and ...I have a much greater capacity...for dealing with people’s problems in a very open-handed, open-minded, effective sort of way.

Be Present with Pain

Five of the participants reported that their meditation practice allowed them to sit and be present with their clients' pain. A common report was that in meditation, one learns to sit with discomfort and pain without moving away, distracting, or avoiding pain. One participant reported, "I just sit fully with clients who are in pain and I can allow that discomfort because of course, when you meditate, you often feel discomfort. Part of the practice is being able to embrace and accept that discomfort". Another participant echoed this ability to sit with pain:

I am able to help my clients get into some pretty deep stuff. In my meditation practice I have gotten in touch with my deepest stuff, so I really believe that is what is increasing my comfort level. I can meet anybody's pain...I can be there with that pain.

Rub Off On Clients

Three of the participants reported that they were able to create positive states of mind through their meditation practice and that these states of mind affected or "rubbed off" on their clients. One participant reported:

I find that with my spiritual practice, I am able to just create moments, thirty seconds to a minute, where I touch into my own process of breathing into my body and then working with that to create an auric field of well-being around myself. It brings some sort of joy which I can then bring to other people, that joy, it is infectious. I think it is infectious for clients; it makes them feel better if you are somebody who is feeling good about themselves...I am full and my cup runneth over.

The participants reported that it was as if they were modeling positive emotions and states of being for their clients and their clients were able to learn to develop these states for themselves by modeling themselves after their therapist.

Meditation as Clinical Training

As part of the interview, therapists were asked if they think that meditation should be incorporated into clinical training for therapists in training. While the participants differed in their ideas about how meditation should be incorporated into clinical training, they all agreed that some form of meditation or spiritual practice should be taught to beginning therapists. Two common reasons given for why therapists should be taught to meditate were (1) the participants did not think that they would have been able to do therapy if they did not practice meditation, and (2) they thought that meditation is a tool for self-development and that you need to be able to develop yourself if you are going to help others do the same.

Couldn't be a Therapist without Meditation

Three of the participants reported that they never would have been a therapist if they did not practice meditation or other spiritual practices. One participant reported, "I couldn't be doing this work if I wasn't doing spiritual practice. Spiritual practice is everything...It is the heart of being a psychotherapist...I don't think I could be a therapist if I wasn't involved in spiritual practice." Another participant said, "I know I would not be doing the kind of work I am doing today if not for this training, this practice, and this perspective." These three participants seemed to share a deep appreciation for how meditation has impacted them and made them better therapists. They found that the impact of meditation on their therapy was so great that they could not imagine doing the work of therapy without a meditation practice to inspire and support their therapy practice.

Self-Development

Another reason given by five of the participants for why meditation should be taught to therapists in training is that meditation allows people to continually be improving themselves. They said that because therapists ask their clients to improve themselves, we must also be

constantly working on ourselves. One of the participants told a story that demonstrated this line of reasoning:

A mother took her son to Gandhi and said “tell my son to stop eating sugar.” Gandhi told the mother to come back in a week. She came back a week later with her son and Gandhi said to her son “stop eating sugar.” The mother says “why did I have to come back? Why didn’t you just say that to him last week?” Gandhi replied “Because last week, I hadn’t stopped eating sugar.”

She continued:

I think that encapsulates as therapists what should be our thing, which is the courage to acknowledge that we haven’t stopped eating sugar and that we need to know that for our clients and ourselves and we can only work with people as much as we have worked with our own issues.

Another participant said:

It just seems that anybody who is doing growth work has to be finding ways to grow...I think a healthy therapist is someone who continues to grow their edges and spiritual practice helps people to grow their edges...I can’t imagine as a therapist not trying to keep ahead of my clients...If your clients are growing more than you are, than you are not going to be able to help them. You can’t take your clients anywhere you haven’t been yourself. You can’t accompany them in a way that makes them feel known if you aren’t going there too. I think you have to be on the path.

These reports reflect the idea that meditation leads to growth and that only if we are growing can we help others to grow.

Meditation as Self-Care

A final theme that was mentioned by all participants was the use of meditation as self-care. Participants described two ways that meditation helps them to cope with the stresses of being a therapist: (1) they don't take what happens in therapy home with them, and (2) they are able to increase their positive mental states and decrease their negative mental states through meditation.

I Don't Take it Home with Me

All of the participants reported that their meditation practice has helped them to separate the emotions that come up in therapy from the rest of their lives. One participant said:

I sit and I am really present with them and I care about them and I really love my clients, but I don't take it home with me. Sometimes I think about them, but I don't angst over it.

I can just let it go and trust that they are working their own stuff out. This is part of having that bigger picture perspective...I go to consultation groups and talk to therapists and there are a lot of people struggling with stuff that I don't struggle with. It is OK;

there is a sense of security or comfort.

Several of the therapists said that the ability to not take their clients' problems home with them was made easier by their ability to distinguish their own emotional reactions and counter-transference from their clients' emotional reactions and psychological issues. One participant reported:

(My meditation practice) allows me to understand them better and kind of illuminates what is going on and when I am having my own stuff come up, which can sometimes be helpful and sometimes not. Being able to differentiate between the two I think is important.

Another participant described the protective effects of having a consistent meditation practice, “Meditation is helpful. I am able to leave my caring here. I don’t have to meditate to let the stress go. Maybe because of the meditation I have done, I am able to let it go. It is preventative.” These reports all relate the common theme of meditation practice allowing the therapist to be able to separate his or her own emotional reactions from the client’s issues and not taking the painful emotions stirred up in therapy into the therapists own life. It seems as if meditation is a shield which doesn’t block the therapist from caring deeply about his or her clients, but prevents their own lives from being negatively affected by the fact that they deal with peoples’ problems on a daily basis.

Meditation Makes Me Feel Good

Four of the participants reported that meditation helped them to develop positive mental states and dispel or reduce negative affect. One participant reported about how he uses meditation to cope with negative affect:

I know enough about it and it is sort of a part of my repertoire, so I use it as a self care tool in general. If I feel anxiety or am down or depressed about something, it is a coping skill that I use in general in my life.

Another participant discussed how mediation helps people tolerate negative emotion and gave an example from her own life:

When I do get in low moods, I know that I can look at it as something that is now here and that will pass. I am not drawn into it too much. For me this is quite clear. I found out that in many times of extreme stress, it really comes in handy. It helps me to center. Not to say that there are not times that I lose it...but it is helpful. One example that I can say is that we were driving from Washington D.C. to Boston with three kids and we had a

very bad car. The car broke on the way, we fixed it. The car broke again on the highway and the three kids were crying and I got out of the car and told myself “breathe in, breathe out”. I calmed myself with the breath, this is what is happening. It was difficult, we had to stop, but life presents difficulties all the time and it helps to breathe and pause and collect myself.

Another participant reported how he uses meditation to produce a positive mental state: I find that with my spiritual practice, I am able to just create moments, thirty seconds to a minute, where I touch into my own process of breathing into my body and then working with that to create an auric field of well-being around myself.

Finally, one client described meditation as a medicine that reduces negative affect and produces joy:

It is definitely the biggest medicine jar in the cabinet in terms of what soothes and what brings me the deepest joy and peace. It is free and it is always available, which is pretty amazing. I have it in my pocket when someone else has an anxiety pill. I can sit for an hour and I know that I will be better.

These descriptions of how meditation helps people to cope with the stresses of being a therapist are demonstrative of its utility as a self-care tactic for dealing with stress.

DISCUSSION

This goal of this study was to qualitatively investigate how therapists who practice meditation see their meditation practice influencing their therapy. This study was conducted because preliminary research supports the idea that meditating as a therapist may improve therapist qualities shown to be predictive of positive therapy outcomes. If therapist meditation has a positive influence on therapy outcomes, it could have significant implications for therapist training programs.

There were many commonalities in the reports of the six participants interviewed in this study. The participants reported that they used meditation in therapy, either by explicitly teaching meditation or implicitly encouraging their clients to be more aware of the present moment. Participants also reported that meditation has made them more effective therapists and allows them to build stronger alliances with their clients. They reported that meditation makes them better therapists by increasing positive therapist characteristics including empathy, unconditional positive regard, and non-judgment, increasing their ability to pay attention to their clients, giving them tools to use in therapy, allowing them to sit with their client's pain, and helping them to cultivate positive mental states that "rub off" on their clients. Because of their experience with meditation's beneficial impact on therapy, the participants suggested that meditation be taught to therapists in training, stating that they would not be the therapists that they are today without meditation and the potential of meditation as a tool for self-development as reasons why meditation should be taught to therapists in training. Finally, the participants reported that meditation is part of their self-care. They said that it allows them to not take their

therapy practice home with them and that meditation helps them to decrease negative affect and increase positive affect.

To the best of the author's knowledge, this study is the first to look at how therapists think that their meditation practice influences their abilities as therapists. The results of this study support past research which has shown that the therapist meditating before therapy may improve the outcomes of therapy (Grepmaier et al., 2007) and that teaching therapists in training to meditate makes them feel more centered, helps them cope with difficult emotions, decreases stress, makes them more comfortable with silence, and improves their quality of life (Schure et al., 2008). The reports of participants in this study supported the findings that meditation helps therapists provide more effective therapy, provides them with tools to cope with difficult emotions, and improves their quality of life. The current study is different from past studies in that the participants were not psychology students who had been trained to meditate, but were experienced therapists who had developed their own personal meditation practices. The current study expanded on previous studies in that the participants reported ways that meditation has influenced them as therapists, and to the best of the author's knowledge, this has not been reported in previous published research. There were several ways that the participants in this study reported that their meditation practice influenced them, which were not reported in previous studies. These include: increasing their capacity for unconditional positive regard, making them less judgmental, giving them tools to use in therapy, allowing them to sit with their client's pain, helping them to cultivate positive mental states that "rub off" on their clients, helping them to develop themselves, and allowing them to not allow the stress associated with dealing with people's problems to impact the rest of their lives outside of therapy.

The study has several limitations. First, because qualitative research is particularly useful in situations where the researcher is trying to identify variables rather than demonstrate the effect of one variable on another, these results should not be used to draw conclusions, but instead shed some light on what therapists feel and think about meditation (Corbin & Strauss, 2007). Furthermore, the small sample size in this study prevents the results of this study from being generalized to the beliefs of all therapists who meditate. This study was exploratory and has uncovered several variables which can now be tested with quantitative research. Further research should use empirical methods to evaluate the reports of the participants in this study. For example, future research should evaluate whether learning meditation directly enhances therapist empathy, ability to cultivate positive mental states and attention. While this study provides more questions than answers, it gives researchers who are interested in studying the effects of therapist meditation a place to start.

While this study has not provided any final answers to the question of how therapist meditation impacts therapist qualities and therapy outcomes, it has uncovered new variables that should be part of the discussion. This study has supported previous research that points to the benefits of therapist meditation and has also uncovered new variables. By asking therapists how their meditation practice has influenced them, the experimenter brought the experiences of individual therapists to the surface. The deeper understanding of how meditation may impact therapists and their clients that was made possible by this research will hopefully lead to an expansion of interest and research in the field of therapist meditation.

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APPENDIX A
INTERVIEW QUESTIONS

1. How long have you been a therapist?
2. How long have you been practicing meditation?
3. What types of meditation practice do you engage in?
4. How often do you currently practice meditation?
5. In what ways has your meditation practice influenced you as a therapist?

Probe: Do you think that your meditation practice has had an impact on your effectiveness as a therapist?

Probe: Do you think meditation has influenced your ability to feel and express empathy toward clients?

Probe: Has meditation influenced your ability to have unconditional positive regard for your client?

Probe: To be non-judgmental?

Probe: to pay attention to your clients?

Probe: To be more present?

6. Would you suggest meditation training as a part of the training to become a therapist?
7. Has meditation influenced your ability to handle the stresses related to being a therapist?

APPENDIX B

Informed Consent Form



Pacific University IRB

Informed Consent Form

1. Study Title

THE IMPACT OF THERAPIST MEDITATION ON THE THERAPIST AND THERAPY

2. Study Personnel

	Primary Investigator	Co-Investigator
Name	Daniel Zamir (Masters Candidate)	Michael Christopher, PhD
Institution	Pacific University	Pacific University
Program	School of Professional Psychology	School of Professional Psychology
Email	zami0546@pacificu.edu	mchristopher@pacificu.edu
Telephone	(805) 570-1680	(503) 352-2498

3. Study Location and Dates

The study will begin in April, 2009 and be completed by July, 2009. The study will be conducted in Portland, Oregon

4. Study Invitation and Purpose

You are invited to be in a research study on meditation. You were invited to participate because you are a therapist with a personal meditation practice. Please read this form carefully and ask any questions you may have before agreeing to be in this study.

5. Study Materials and Procedures

If you agree to be in this study, the researcher will conduct a face-to-face interview with you. The interview will take between 30 and 60 minutes to complete. All interviews will be audio-recorded using a digital recorder. All recordings will be stored on a password protected computer. Each interview will be transcribed and paper copies of the transcriptions will be kept in a locked filing cabinet in the office of the Thesis Advisor. Once interviews are transcribed, the audio-recordings will be deleted. The audio files and transcriptions of the interviews will be de-identified using coded participant numbers in place of participant names. There will be no master list that identifies which participant is linked to which number as the researcher is only interested in pattern of responses and not the responses of individual participants.

6. Participant Characteristics and Exclusionary Criteria

Only therapists who have at least five years of experience conducting therapy and at least one year of personal meditation practice will be allowed to participate in the study. Participants who do not meet the above criteria will be excluded from the study.

7. Anticipated Risks and Steps Taken to Avoid Them

Therapists may feel uncomfortable talking about how their meditation practice influences them as therapists. There is also a risk of a breach of confidentiality.

If participants feel uncomfortable sharing their personal experience of how their meditation practice influences them as therapists, these participants will be allowed to discontinue their participation in the study. The risk of the breach of confidentiality will be minimized by storing all audio-recordings of the interviews on a password protected computer. These audio files will be deleted once the interviews are transcribed. All audio-files and transcriptions will be de-identified using participant numbers in place of participant names. These transcriptions will be printed and kept in a locked filing cabinet in the thesis advisors office.

8. Anticipated Direct Benefits to Participants

There are no direct benefits to participating in this research.

9. Clinical Alternatives that may be advantageous to participants

Not applicable.

10. Participant Payment

There will be no compensation for participation in this study.

11. Medical Care and Compensation In the Event of Accidental Injury

During your participation in this project it is important to understand that you are not a Pacific University clinic patient or client, nor will you be receiving medical care as a result of your participation in this study. If you are injured during your participation in this study and it is not due to negligence by Pacific University, the researchers, or any organization associated with the research, you should not expect to receive compensation or medical care from Pacific University, the researchers, or any organization associated with the study.

12. Adverse Event Reporting Plan

In the event that you have an adverse reaction to the interview questions, the interviewer will debrief the situation with you and provide you with assistance if needed. A report of the incident will also be filed with the Pacific University IRB.

13. Promise of Privacy

The records of this study will be kept private and your responses will be confidential. To ensure that they cannot be linked to you personally this consent form will be separated from your interview responses and kept separately from your responses. Neither your name nor any identifying information will be requested on the interview responses. Additionally the consent forms and interview transcripts will be stored separately in locked file cabinets. If the results of this study are to be presented or published, we will not include any information that will make it possible to identify you as an individual.

14. Voluntary Nature of the Study

Your decision whether or not to participate will not affect your current or future relations with Pacific University. If you decide to participate, you are free to not answer any question or withdraw at any time without prejudice or negative consequences.

15. Contacts and Questions

The experimenters will be happy to answer any questions you may have at any time during the course of the study. Michael Christopher can be contacted at 503-352-2498 or mchristopher@pacificu.edu and Daniel Zamir can be contacted at (805) 570-1680 or zami0546@yahoo.com. If you are not satisfied with the answers you receive, please call Pacific University's Institutional Review Board, at 503-352-2215 to discuss your questions or concerns further. All concerns and questions will be kept in confidence.

16. Statement of Consent

I have read and understand the above. All my questions have been answered. I am a therapist with five or more years of experience conducting psychotherapy and I have had engaged in a personal meditation practice for at least one year. I have been offered a copy of this form to keep for my records.

Participant's Signature

Date

Investigator's Signature

Date

17. Participant contact information
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This contact information is required in case any issues arise with the study and participants need to be notified and/or to provide participants with the results of the study if they wish.

Would you like to have a summary of the results after the study is completed? ___Yes ___No

Participant's name: (Please Print) _____

Street address: _____

Telephone: _____