A Portfolio of Academic, Therapeutic Practice and Research Work

Including a ‘Survey of counselling psychologists’ experience of, and beliefs about meditative strategies for change’.

Submitted to the University of Surrey in 2001 in partial fulfilment of the degree of Practitioner Doctorate (Psych.D) in Psychotherapeutic and Counselling Psychology.

Dominic M J Addison
Statement concerning anonymity of clients and participants

In order to preserve the anonymity of clients and participants referred to within this portfolio, pseudonyms have been used throughout. Furthermore, potentially identifying details such as job titles and geographical areas have been altered where appropriate.

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Introduction

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Appendices
Introduction to the Portfolio

This Portfolio comprises of work submitted throughout the course in partial fulfilment of the Practitioner Doctorate (Psych.D) in Psychotherapeutic and Counselling Psychology. It contains three dossiers: Academic, Therapeutic Practice, and Research.

The Academic Dossier includes papers submitted for the following courses: 'Theoretical models of therapy', ‘Advanced theory and therapy’ (years one and two), and 'Issues in counselling psychology'.

The Therapeutic Practice Dossier contains descriptions of the three clinical placements as well as a personal account of integrating theory, research and practice.

The Research Dossier comprises of three research papers: a literature review and two empirical studies.
Academic Dossier

Introduction

This dossier consists of three essays selected from work submitted for the ‘Theoretical models of therapy’, and the ‘Advanced theory and therapy’ (years one and two) courses, and one report from the ‘Issues in counselling psychology’ course.
Compare and contrast the theoretical aspects and clinical implications regarding anger, of Freud and Klein.
Compare and contrast the theoretical aspects and clinical implications regarding anger, of Freud and Klein

Freud's writings provide the original psychoanalytic explanation of anger, or aggression. Klein's work describes more complex theories, which although they are significant revisions upon Freud's ideas, remain fundamentally rooted in the classical approach. This essay proceeds first with an analysis of Freud's work and follows on with descriptions of Klein's developments, and the implications for clinical practice.

It was only in the latter half of Freud's life that he recognised the role of anger within the human psyche. Neither of the words 'aggression' or 'sadism' appeared in the index to the 'The Interpretation of Dreams' (1900). However, the importance of the phenomenon of aggression, hate or anger was increasingly cited by Freud from around 1905 onwards. His early works demonstrate ambivalence toward the concept of an aggressive drive acting independently from the libido. For example, contrast these two statements taken from 'Three Essays on the Theory of Sexuality': “thus sadism would correspond to an aggressive component of the sexual instinct” and “It may be assumed that the impulses of cruelty arise from sources which are in fact independent of sexuality, but may become united at an early stage” (Freud 1914). In 'Beyond the Pleasure Principle' (1920), Freud moved further toward supporting the idea of an autonomous aggressive instinct: “The manifestations of a compulsion to repeat.....exhibit to a high degree an instinctual character and, when they act in opposition to the pleasure principle, give the appearance of some 'daemonic’ force at work”. However it was not until 1937 that he wrote unequivocally about separate aggressive and sexual drives:

“After long hesitancies and vacillations we have decided to assume the existence of only two basic instincts, 'Eros' and the ‘destructive
instinct’......The aim of the first of these basic instincts is to establish ever greater unities and to preserve them thus – in short, to bind together; the aim of the second is, on the contrary, to undo connections and so to destroy things. In the case of the destructive instinct we may suppose that its final aim is to lead to what is living into an inorganic state. For this reason also we shall call it the death instinct”.

(Freud 1937)

Freud described the death instinct as initially seeking the destruction of the self – ‘the return to an inorganic state’ which is the ultimate end of us all. However, as the ego develops, this aggressive force is diverted toward the external world. Outward aggression is viewed then as a secondary phenomenon - an ego function mobilised against external stimuli that cause discomfort: “the ego hates, abhors and pursues with intent to destroy all objects which are a source of unpleasurable feeling for it” (Freud, 1915). His view of what was not pleasurable seems to be very broad as he wrote that, “all that tends to increase [excitation] must be painful” (Freud, 1920). This would seem to imply that babies naturally find stimulation arising from the environment painful and so are hostile toward it. The clinical implications would then be to ‘protect’ the baby from stimulation; excessive stimulation would lead to an aggressive attitude against the environment. However, here again Freud was ambivalent as he went on to write that “man, and even as an infant a few days after birth, is eager for stimuli, needs them, does not always hate the world for its intrusion” (Freud, 1920).

If one were to accept Freud’s claims that the ‘death instinct’ is an innate drive (which few psychoanalysts do), then it seems that one would also have to accept the ultimate futility of trying to ‘rid oneself’ of aggressive tendencies – as such are ‘hardwired’ into our functioning. He seemed to view people as fundamentally sinful - “hate, as a relation to objects, is older than love’ (Freud, 1915) – a belief remarkably similar to many religious beliefs which he often disparaged.
So, for Freud, the death instinct cannot be avoided, as it “the most powerful impeding factor of all, and one totally beyond any possibility of control” (Freud, 1915). It appears that he used the word ‘control’ conditionally as he thought that death instinct could in fact be mobilised against either toward the outside world (acts of externally directed aggression) or inward, against the self (masochism) (Freud, 1933). Furthermore, he viewed the direction of the death instinct as reacting to environmental change: “and now we are struck by the...possibility that the aggressiveness may not be able to find satisfaction in the external world because it comes up against real obstacles”. He thought that when aggression is frustrated, it is taken up by the super-ego, increasing its aggressiveness against the ego.

The clinical connotations of such a pessimistic view must surely depend on the presenting problem. If, for example, a client's problems appear to arise from directing aggression inward, it would imply that the aim of therapy would be to enable the client to direct more aggression outwards. Indeed, he was explicit in this view; “it really seems as though it is necessary for us to destroy some other thing or person in order not to destroy ourselves.....a sad disclosure indeed for the moralist!” (Freud, 1933). Persons directing aggression inward were said by Freud to be suffering from “melancholia”, or depression, which he describes as, “a profoundly painful dejection, cessation of interest in the outside world, loss of the capacity to love, inhibition of all activity, and a lowering of the self-regarding feelings to a degree that finds utterance in self-reproaches and self-reviling, and culminates in a delusional expectation of punishment” (Freud, 1915). Freud found that depression may arise from the loss (perceived or real) of an object, which causes aggression originally directed toward that object to be turned inward onto the self. Depression may also arise when outwardly-directed aggression is frustrated – perhaps because it is too dangerous to express. For example, imagine a prisoner who feels it is too physically dangerous to express aggression towards his jailers, or a priest who thinks that it is socially and personally unacceptable, and therefore threatening to his sense of self, to think or behave in an outwardly aggressive
manner. In both cases aggression, which was directed towards others, may be frustrated and so be turned against the self.

On the other hand a person may channel too much aggression outwards with negative consequences for society and perhaps also himself. Such a person may be relatively unlikely to seek and maintain psychotherapy, as he would tend to view others as the problem, rather than himself.

In either predicament it appears that the therapist (and of course the client) is faced with a dilemma; to encourage social responsibility by channelling aggression away from external objects and towards the self, or aim to strengthen the client by facilitating the direction of aggression outward and way from the self. However, even if one were to accept this hydraulic aspect of Freud's theory, the situation might not be so pessimistic; the therapist could encourage the client to balance his anger between the external objects and the self. In this was neither the self, nor others are, or are experienced to be, destroyed by the client.

Freud's concept of the death instinct has not been popular amongst analysts, or indeed any other parties: Erich Fromm claimed that "the majority of analysts, while following Freud in every other way, refused to accept the theory of the death instinct" (Fromm, 1977). In 'Human Aggression', Storr (1968) also drew attention to the widespread criticism the 'death instinct' has received. In particular, he pointed out Freud's failure to see aggression as anything other than a destructive force. He thought that Freud's death instinct could have been largely set aside as irrelevant, had it not been for the important influence the concept has had upon other theorists; principally, Melanie Klein.

Klein's contribution can be traced to her experience in the analysis of children. She 'directly' explored children's' unconscious', whereas Freud relied solely upon the memory of adult patients. She started from a full acceptance of orthodox Freudianism and in many crucial areas she remained there. She too believed that
the libido comprises the sexual drive, and that there are two instincts, namely ‘Eros’ (the ‘life instinct) and the death instinct. Klein asserted that the destructive impulse, is “to some extent constitutional, though varying in strength and interacting from the beginning with external conditions” (Klein, 1963). This is a significant adaptation of Freudian thought on three counts. Freud made no mention of individual differences in the power of the destructive impulses. He believed that outward aggression is secondary to inward destruction and developed several months after birth along with the emergence of the ego. Further, he viewed the death instinct as essentially biological, and thus not modifiable.

Klein concluded that the impulses of hatred and aggression are the deepest cause and the foundation of guilt (Holbrook, 1971). This appears to be in contrast to Freud who laid greater emphasis on the sexual impulses as the primary source of guilt. Klein’s clinical advice would seem to be to include a focus upon the repression of aggression, whereas Freud emphasised the analysis of the repression of sexuality.

Klein believed that a primitive form of the ego exists from birth. This ego is capable of experiencing anxiety, fear and envy, of interacting with internal and external objects and of employing defence mechanisms. Some clinical implications of Klein’s innovations are readily apparent: as the strength of destructive impulses are, to a large extent, amenable to environmental influence, the therapist can assume greater optimism in effective nurturing, and so begin to discover methods in which destructive impulses can be tamed or minimised. Furthermore, as these impulses exist from birth, this indicates that analytically-aware rearing methods should be applied from birth. Klein’s positivism concerning the feasibility and importance of controlling aggression from an early age is apparent in the following quote:

“One cannot help wondering whether psychoanalysis is not destined... to influence the life of mankind as a whole. It cannot, it is true, altogether do away with man’s aggressive instinct as such... We are ready to believe that what would now seem a utopian state of things may well come true in those
distant days when, as I hope, child-analysis will become as much a part of every person’s upbringing as school education is now.”

(Klein, 1948)

She demonstrated great hope that psychoanalysis was capable of civilising our aggression, and thus set a very great challenge for clinical work. Klein agreed with Freud that the death instinct leads to aggressive thoughts and behaviour against the world but she disagreed as to the target of this aggression. Whereas Freud had claimed that the infant is indiscriminately aggressive against external stimulation, as it experiences it all as unpleasant, Klein believed that the infant’s aggression, and envy, is directed toward objects when they fail to gratify desire (e.g., a mother withholding feeding). In this latter case the withheld breast is the target not only of the child’s envy but also the projection of the infant’s death instinct.

Klein went further than Freud in tracing the causal effects of aggression. She claimed that much of the destructive effects of the death instinct were not due to the immediate impulse to annihilate the self, or an object, per se, but in the malignant effects of the emotions (anxiety, and fear) experienced subsequent to the impulse. Both Freud and Klein shared the view that the destructive impulse is innate and therefore impervious to therapy. However, it was Klein who emphasised that the subsequent anxiety could be manipulated. Her position is the more optimistic as it implies that we can do something to reduce aggression (i.e., gratify needs). For Klein, the task of the analyst is to find ways of reducing and ameliorating the damaging effects of this anxiety. In infancy this can be achieved through providing sufficient ‘good objects’ which can be introjected by the infant. These internal objects can then be employed by the ego to support in its fight for survival against persecuting bad figures (Guntrip 1961).

Klein believed the infant imagines that objects harbour destructive impulses similar to their own (i.e., ‘projects’ its aggression into the object). After the infant phantasises about attacking its objects (e.g., parents) it feels guilty, and also fears that
these objects may retaliate using similar force. Klein’s graphic descriptions of the infants destructive phantasises are so extraordinarily grotesque and violent that it is difficult to imagine what evidence she based them on (particularly as they occur at a preverbal, and therefore incommunicable stage):

“They consist of fears of violent, i.e. devouring, cutting, castrating, objects...Liquid foods are likened to milk, faeces, urine and semen, and solid food to faeces and other substances of the body.”

(Klein, 1932)

It is not difficult to appreciate that the fear of retaliation aroused by such phantasies would be very great; especially as the infant realises that it is fully dependent on these objects. In defence, the infant ‘splits’ this dark side off from good experiences in order to preserve the good. The infant ‘introjects’ the dark phantasies about the object into its mind, because it cannot tolerate the evil being ‘out there’ – seems safer to manage it as an internal object. This results in the infant perceiving the attacking object to be inside itself. Segal (1964) graphically described the infants torment; “a hungry, raging infant, screaming and kicking, phantasies that he is actually attacking the breast, tearing and destroying it, and experiences his own screams which tear and hurt him as the torn breast attacking him in his own inside”. For Klein, we live in two worlds; the world of inner reality, where the ego interacts with internal objects, and the world of outer reality. These two realities correspond with Freud’s unconscious and conscious respectively. Within both realities exist bad objects and good objects – which are split from each other in a defensive manoeuvre. At this stage the infant is said to be in the paranoid-schizoid position, and the infant struggles to prevent annihilation and disintegration through the methods of projection and splitting. If development is arrested at this stage the infant is in danger of becoming schizophrenic, with weak boundaries between the internal and external worlds. Therapy would be based around guiding the client toward an integration of split objects and a cessation of projection.
Following a normal developmental route, an infant will come to realise that these ‘good’ and ‘bad objects’ are in fact parts of the same object. At this stage the child shifts into the depressive-anxious position in which he fears not for himself, as before, but for his objects – he fears that the badness within the object may destroy the goodness.

To summarise Klein’s philosophy, psychopathology occurs when the infant becomes trapped within a destructive spiral. At first, aggressive impulses, are directed toward people and events that frustrate the infant, and this then leads to fear, guilt and anxiety which accentuate the aggressive instinct. This vicious cycle flourishes in the absence of good objects (love and nurture), and in the presence of bad objects (neglect, abuse). Such a situation leads to the preponderance of phantasy (inner reality) over outer reality and one is unable to accurately perceive outer reality and effectively interact with it. The fundamental task of therapy is therefore to draw out the individual from his dominant interior life into a more realistic contact with the outer world.

Ironically, despite the optimism of Klein’s theory, it seems that she remained “so busy analysing the endopsychic situation” (Guntrip, 1961) that she neglected the study of environmental influences and, therefore, of practical means of bringing about psychological growth. Later theorists, however, such as Winnicott picked up Klein's theories and took them to their natural conclusion – studying the detrimental effects of environmental factors such as poor mothering, parental hate of the child (conscious or unconscious), upon psychological development.
References


Contemporary use of countertransference in psychological therapy.
Contemporary use of countertransference in psychological therapy.

“The therapist inevitably has two patients to deal with, two people whose motivations he must scrutinise and understand – the patient and himself.”

E. Singer, 1965, p.163.

Introduction

It is difficult to overstate the extent to which notions of countertransference-countertransference have influenced psychoanalytic theory. The use of such ideas has recently been described as “the hallmark of psychoanalysis” (Bateman & Holmes, 1995). Not that its influence is limited to psychoanalysis; increasingly they are being applied within humanistic/existential approaches (Clarkson, 1995). Not surprisingly then the body of work on this subject is vast; so much so that an essay of this size can only offer an outline of the issues. The scope of this essay is largely constrained to the definition, and clinical use of, countertransference; defined as processes acting within the therapist. However, by way of an introduction, a rudimentary account of the origins of both transference and countertransference is made before the focus sharpens upon contemporary definitions and uses of countertransference.

Early Roots

The term ‘countertransference’ was instituted by Freud (1910) in ‘The future Prospects of psychoanalysis’. He identified a concept intimately related to the antecedent notion of ‘transference’, and thus it may be better understood by first describing this precursor. Freud first referred to the term transference in ‘Studies on Hysteria’ (1895d) to describe the phenomenon whereby the patient ‘transfers’, or displaces notions onto the therapist which properly belong to some other figure from the patient’s past. These notions consist of any aspects that are perceived as making up a person’s personality – characteristics such as aggressiveness or devotion, tastes and preferences such as a love of books or a mistrust of new experiences, and so on. Acting within a transference relationship, a patient might experience, and react to
the therapist as if he were her father. Imagine, for example, a patient who was physically abused as a child, flinching in anticipation of a blow, as the therapist raises his hand to scratch his head. In this case the behaviour from which transference phenomena can be deduced was a form of body language (flinching). Transference processes may be exhibited through any communicative medium – e.g. verbal expressions of thoughts, images and emotions; bodily smells; facial expressions etc. The therapist working with transference/ countertransference has then an array of indicators that can be used to discern transferential processes.

Freud initially believed that transference could only be problematic to an analysis; it was seen as a ‘contaminating influence’ hindering therapeutic catharsis. Transference represented the patient’s active distortion of objective reality within a session, which was viewed as diminishing the influence of the therapist. However, he later came to realise that, as ‘in vivo’ expressions of patients’ pathological childhood attachments, transferential processes could supply the therapist with important analysable information about the patient. Moreover, ‘positive transference’ (patients’ child-like affection for the analyst) was identified as the necessary motivational force that kept patients in analysis. Eventually, transference phenomena came to be viewed by Freud as the principal expression of unconscious mental life, and as such they were the analyst’s chief routes into the patient’s unconscious. Thus the concept became absorbed into the nucleus of Freudian psychoanalytic theory and practice.

One might ask ‘what are the forces that give rise to the transference?’. Within Freud’s go-psychology, transference is considered in terms of the repressed expression of instinctual wishes. However, Kleinians would explain it in terms of unconscious object-representations, while Kohutian therapists might refer to strivings to meet unfulfilled self-object requirements. Differing theoretical assumptions have given rise to various explanations as to the causes and uses of transference, and several denominational sub-categories of transferences have emerged. For example, Wolf (1988) identified seven types of transference which
are relevant to self-psychology theory (self-object; merger; mirror; alter-ego; idealising; creativity; and adversarial transferences). These theorised varieties are not mutually exclusive, rather they are variations on a theme, and it seems that they all adhere to basic tenets of transference and countertransference — as a process. As it is not my purpose to examine denominational sub-categories in detail (this would necessitate lengthy expositions of psychoanalytic theory), the remainder of this work is dedicated to more general countertransference processes which may be applied within a variety of theoretical and clinical models.

Freud coined the term 'countertransference' to designate the therapist's inappropriate responses (thoughts, feelings and behaviour) to the patient's transference. For example, the patient seeking love in the transference relationship might induce the therapist to feel romantically inclined toward the patient — feelings that might harm the analysis.

Freud recognised that the extent to which the analyst had been successfully analysed limited the work that could be done in an analysis — “no psychoanalyst goes further than his own complexes and internal resistances permit” (Freud, 1910, p.145). However, he actually had no term for psychopathology brought into the analysis by the therapist (Smith, 1999). He regarded countertransference as the therapist's problem because it was a process that impeded successful analysis — not because the problem arose from the therapist. Today, pathology brought into the therapy by the therapist is often termed as the 'therapist's transference' — although, confusingly, it has also referred to as countertransference. The field of psychoanalysis is remarkably free from discussions of therapists' transference, although what has been neglected by the many has been vociferously attended to by a few (Masson, 1990; Langs, 1974).

With such a restricted definition of countertransference, it is not surprising that Freud never came to a full appreciation of how it could prove a useful vehicle for the analytic work. He always maintained the stance that countertransference only
interfered with the perception of the patient’s unconscious processes. Nevertheless, successive generations of theoreticians and practitioners have greatly reworked and expanded upon Freud’s views, and currently countertransference is regarded as an important therapeutic tool which can illuminate both the therapist’s and the patient’s psychological processes, and the interaction between them.

Contemporary Definitions of Countertransference
Following on from Freud’s ideas, the notion of countertransference has expanded greatly in terms of how it is defined and how it may be used clinically. The expansion in clinical application was initiated by Ferenczi (1921), who challenged the notion that the therapist was a detached arbiter of what was reality (healthy), or phantasy (pathological), and he advocated far greater involvement between the therapist and the patient. However, Ferenczi stopped short of challenging the notion that countertransference was anything but the therapist’s personal difficulties in responding to the patient’s transference. Further expansion was predicted by the Balints (1939), but this did not really take off until the middle of the century with persuasive explanations by Winnicott (1949), Heimann (1950) and Little (1951). Through such works, the use of countertransference phenomena as indicators of unconscious processes has become widespread practice in psychoanalysis. This shift in attitude allows practitioners to use their countertransference responses to deepen their understanding of their patients, themselves, and the interaction in the sessions. For instance, drawing from the example given earlier, a therapist beginning to feel seduced by the patient might use those feelings as an indication of the patient’s unconscious desire, and may make an interpretation with this information.

Contemporary accounts of countertransference then encompass ‘analyst-derived countertransference’ described by Freud, and the more recently expounded ‘patient-derived countertransference’ (Langs, 1979). The former is detrimental to an analysis and should be minimised through successful therapy, while the latter can be used by therapists to reach a deeper understanding of their patients.
Running alongside the developments outlined above, a view of countertransference phenomena as inevitable was taking root; although this was not actually written until 1956, separately by Winnicott and Tower (Smith, 1999). This shift in thought has wrought considerable changes in practice. In viewing analyst-derived countertransference as inevitable, therapists are no longer encouraged to see themselves as having elevated themselves above it. It is if a taboo on the subject has been lifted, allowing therapists to more freely discuss incidents in which they feel that they might have failed to contain their patient's transference. Certainly in my own experience of supervision I have felt comfortable discussing occasions where I may have unwittingly complemented patients' transference, rather than recognising what was happening and using the information to further the therapy. If I had been trained in the earlier half of this century, I might not have enjoyed such a freedom.

Similarly, conceptualising patient-derived countertransference as inevitable may well have encouraged further theorising on this topic, and the greater use of countertransference in practice. These areas are discussed later in more detail.

The increasing recognition of countertransference was regarded as a great move forward by many (particularly in the British object-relations school and the Interpersonalists in North America) who briddled against what they saw as the cold, authoritarian ethos of earlier analysts and who wished to usher in a mood of greater equality and humanity. Therapists and their patients may benefit from the wider conceptualisation and usage of countertransference that is now standard practice. In discussing my reactions to my patients (during supervision) I have felt able to identify both analyst and patient-derived countertransference and that this has facilitated the therapeutic process. An example of the former arose when a patient was talking about a schooling that was similar to my own. Her account gave rise to feelings in me of mild outrage in relation to parental choices and school management. Spurred on by these thoughts and feelings I made an interpretation to my patient saying that it seemed as if a failure of her parents and her school to
recognise her qualities led to certain negative experiences (she viewed these problems as being of her own making). However, upon later reflection on the matter (partly in supervision), I came to feel that I had been motivated less by the patient’s material and more by my own personal history.

Another example is of patient-derived countertransference: I recall feeling very angry towards a patient’s mother. This was despite any obvious demonstration of similar affect by my patient, and no connections with my own history. Cognisant of these feelings and of countertransference theories, I told the patient that I imagined she must feel angry with her mother, and it seemed that this was difficult for her to express. This appeared to be well formulated, as it was followed by a release of affect and narrative reflecting the themes within the interpretation. Without the benefit of prior learning on countertransference, I would probably not have taken my feelings as an indication of what the patient may have been feeling, and missed a therapeutic opportunity. This last incident is an example of concordant countertransference (Racker, 1953), and it is to a discussion of this distinction that we now turn.

**Empathy and projective identification in countertransference**

Projective identification refers to a transference process whereby the patient projects disavowed aspects of himself onto the therapist, and thus perceives and relates to the therapist as if these aspects emanate from him. As a consequence of being used in this fashion, the therapist may become unconsciously identified with the characteristics being projected onto him and behave in a fashion that accords with those projections. This latter process is clearly a countertransferential reaction, but one of a special type which has been named ‘complementary countertransference’ (Racker, 1953). It is so called because the therapist feels, thinks and behaves in a way that complements the projections of the patient. To cite an example of this, again from my own practice, I recall a client who considered herself “irrational”, and thereby incapable of reaching important personal decisions. It seemed that she habitually recruited the help of other figures, such as medical Doctors and her
mother, in making decisions for her, but would later reject these figures and claim that their help was insufficient. I felt drawn into this dynamic on various occasions during her therapy – for example I have felt strong need to help; that I, an expert ‘in charge’, must help. Having on occasion offered such help I subsequently felt belittled, that my help had not been sufficient. It seemed that I identified with her projections onto me of being the ‘expert’ and then as an ‘inadequate’ rescuer.

Racker (1953) outlined another form of countertransference, ‘concordant countertransference’, referring to emotions that are in empathetic resonance with the patient. He sees this as not arising solely out of projective identification but also from affective attunement – this appears to accurately describe the ‘anger with mother’ example above where I felt an anger directed at the mother, which appeared to emanate from the patient. Kohut (in Elson, 1987) saw this kind of empathy as arising out of a temporary regression of the therapist resulting in a tentative merging with the patient. This can enable the therapist to identify the patient’s experiences and thus facilitates insight.

Who is doing what?
Lewin (1963) introduced the terms ‘proactive’ and ‘reactive’ to further qualify countertransference (and transference) according to whether the therapist is reacting to the patient’s stimulus or is proactively introducing a stimulus. These two categories are similar to Lang’s notion of analyst-derived and patient-derived countertransference. They can be overlaid with complementary/ concordant distinction to give rise to four categories of countertransference (Table 1).

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*Table 1: The four forms of countertransference*
Reactive-complementary countertransference describes the process in which the therapist reacts to the patient’s projections in a complementary way that fulfils the characteristics of the projection, for example in response to the patient’s transferential need to be told that he is clever, the therapist feels that the patient is intelligent. This type is equivalent to patient-derived countertransference.

Reactive-concordant countertransference describes a phenomenon where the therapist’s experiences a resonance with the patient. An example might be a therapist who experiences a desire to binge-eat, as if to fill an internal void, while he works with patients with eating disorders.

Proactive-complementary countertransference occurs when the therapist’s own transferences are elicited by the client’s transference. The therapist does not experience himself as if he were the person projected by the client, but as another person from the therapist’s own past. For example, in response to the transference needs of the patient to be admired by the therapist father-figure, the therapist may mobilise his own transferential dynamics and, for example, harshly deny this need to be admired – because this is what the therapist’s father used to do.

Proactive-concordant countertransference occurs when the therapist responds to the patient in way that might seem to echo the patient’s experience, but in fact is more accurately the reliving of an element of the therapists’ own experience. An example of this type from my own practice has been given already – the occasion when I believed that I was feeling the resentment toward school and parents experienced by the patient – but on further reflection it seems more likely that I was connecting with my own past.

When is countertransference harmful or useful?
Clarkson (1995) identified two further categories of countertransference relating to whether it plays a ‘facilitative’ or ‘destructive’ role within the therapy. A destructive complementary-countertransference occurs when a therapist, acting in
identification with the patient’s projections, reacts in a destructive way. For instance, recall the first example of transference given wherein the patient flinches from the therapist in expectation of being hit. Imagine the therapist identifying himself with the abusive object projected and feeling aggressive toward the patient with the result that he actually attacks him physically or verbally. However, if the therapist were to exploit his feelings of revulsion in order to deepen his understanding of the patient’s experience, then he might be able to use the countertransference to facilitate the therapy (i.e. facilitative countertransference).

Finally
Even though I do not practice psychoanalysis, I have found that understanding countertransference processes has helped me enormously within my practice of psychological therapy. I feel that it has enabled me to recognise and name dynamics within the therapy. It has enhanced my use of supervision, and my understanding of human interaction and the field of psychotherapy generally. Moreover, it has enabled me to better understand my reactions to the patient, and what this indicates about the patient, myself and our interaction. The ultimate benefits of these advances are that they have contributed to a lessening not only of my struggling (as a trainee psychologist), but also, I suspect, the suffering of my patients.
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In cognitive therapy, therapeutic change is not dependent upon the therapeutic system of delivery but on the active components which directly challenge the client’s faulty appraisals. Discuss.
In cognitive therapy, therapeutic change is not dependent upon the therapeutic system of delivery but on the active components which directly challenge the client’s faulty appraisals. Discuss.

One of my first reactions on reading this title was to ponder on the meaning of ‘therapeutic system of delivery’, and so before taking up any discussion of the central issues I will give a working definition of this term. At face value, the term refers to the ways in which the therapy is conveyed to the client. Cognitive therapy is usually applied in one of three ways - in individual sessions with a therapist, in group sessions, or by self-help methods (literature, audio and videotapes). Moreover, the delivery of therapy is affected by qualities within these three modalities, for example, how lucidly the therapy is communicated, and the nature of the relationship between the therapist/book/tape, group members and the client. So, the ‘therapeutic system of delivery’ could be said to have a macro aspect - the three modes in which the therapy is delivered; and a micro aspect – the particular factors affecting the quality of delivery within these modalities. Therefore, this discussion will cover the impact that these delivery factors can have upon therapeutic change, relative to the challenging components.

Across the ‘macro’ level, then there are three main ways in which cognitive therapy may be delivered – in individual therapy, group therapy and through self-help materials. Each of these modes is characterised by particular strengths and weaknesses in terms of its power to bring about therapeutic change. For example, individual therapy may provide a greater opportunity for intimacy - rapport and mutual understanding - between the client and the therapist than may be the case in group therapy. This intimacy helps a client’s situation to be clearly ascertained, and for an accurate formulation of his problems to be made. In turn there is a greater capacity for therapeutic interventions to be carefully designed to suit the client’s specific problems. A clear and accurate formulation is the cornerstone of an
effective therapeutic intervention. The more accurately a client’s predicament is understood, the better informed and more therapeutic any intervention (including challenging of faulty appraisals) can be. Effective challenging of faulty appraisals is then not a starting point; rather, it is built upon other factors, many of which are influenced by the system of delivery.

Intimacy between client and therapist is a function of numerous variables – the most apparent of which are, time, trust, and understanding. The more time there is for the client and therapist to communicate with each other, the greater the potential there is for each to become intimate with the other, and therefore in turn, the greater the capacity for therapeutic work to be done. Mutual trust between client and therapeutic method also facilitates intimacy. If a client does not trust in the therapist’s professional or personal qualities, or does not have faith in the way that the therapy is being delivered, he will be less likely to engage with it. He will be likely to disclose less, and therapeutic interventions will then be based on more partial accounts of his situation, and so will be less likely to be effective. Finally, mutual understanding is also an integral part of intimacy. Client and therapist may trust each other absolutely and may have an abundance of time together, yet if they do not understand one another there can be little hope of developing the intimate relationship necessary for therapeutic work.

Turning to the relative opportunities for intimacy provided within each of the three chief modes of therapeutic delivery (individual, group and self-help), it seems that the self-help option, wherein the client takes on the role of therapist, can provide the most interaction time between the client and the ‘therapist’, while group therapy may provide the least. On this point therefore, it would seem that self-help has the greater advantage, and group therapy the least. However, in the case of the other components, trust and understanding, the situation is different. Clients often present with a low sense of self-efficacy and/or self-esteem (i.e. are depressed), and so may not have a deep trust in their ability to resolve problems - even with expert guidance from books or tapes. The needs of those with low self-efficacy, self-
esteem, and motivation are probably not best served by self-help techniques. Rather, the support and encouragement of a therapist and/or peers within a therapy group may prove a necessary element for therapeutic progress. Similarly, a client who is experiencing much confusion (e.g. someone who is emotionally labile, has an anxiety disorders, or psychotic symptoms) is probably not in a very good position to understand themselves, and hence may benefit from group or individual therapy rather than self-help.

Whether someone who is depressed or confused is better served by group, or individual therapy depends on a number of issues. Individual therapy allows for more accurate formulations and tailored interventions, as there is usually much time for the client to talk about his situation, and for the therapist to draw out important issues. So individual therapy might be a better system of delivery for those with little self-insight, or with particularly complex problems. In a recently completed cognitive-behavioural group for anxiety problems in which I was co-therapist, it appeared that certain clients had great difficulty in applying the CBT method to their experiences - sometimes their problems were very complex or deeply ingrained. In such situations, individual therapy may have been more effective, as there would have been more time to unravel complexities and develop solutions at an appropriately profound and idiosyncratic level. In a similar vein, Ryle (1997) identified several “snags” in cognitive therapy; for example when a client’s therapeutic change is met by resistance from friends and family who wish to preserve the status quo in their relations with the client, or clients who feel that they do not deserve to get better. These are the kinds of complexities that sabotage therapeutic change, and may prove more of a hindrance to group therapy, where there is relatively little opportunity for the therapist to apply his expertise with individuals, than in individual therapy.

Nevertheless, group therapy has particular benefits – there is more potential for peer group support and comparisons, and it is arguably less likely to foster a relationship of dependence between therapist and client. In the aforementioned group, many
clients felt that one of the most important aspects of the therapy was that, through the group encounter, they had come to realise that they (and their problems) were not so rare, or strange, as they had thought. Subsequently they had come to feel more comfortable in themselves and within groups. So it seems that features of the system of delivery - the group encounter - precipitated challenges to faulty appraisals (e.g. “I have an bizarre, alien problem, I am bizarre and alien’’). These faulty appraisals were then spontaneously replaced by new, more functional ones, such as, “other people have similar problems and are ‘okay’, I am like others”. This clearly shows that it is wrong to make an absolute distinction between the system of delivery and the active components that directly challenge faulty appraisals. Moreover, it is possible that being amongst understanding people is therapeutic in itself regardless of any appraisal-challenging feature of their encounters (a client in my group said that it was the only opportunity he had all week to take his “mask” off and be himself).

Group therapy may also carry particular advantages for the treatment of relating, or social anxiety problems. The group situation can be forum for exposing and exploring feelings and cognitions in a ‘live’ socially interaction. This opportunity is not so readily found in individual therapy, where, relatively distant from their fears and beliefs, clients may be less aware of them.

The final point I would like to make about the three main modes of delivery is concerned with the relative feasibility of delivering them at all. Therapy does not take place in theory - in books and in essays - it operates in the ‘real’ world with all its financial and spatial limitations. People have varying ability to access therapy centres physically and financially. For people who are immobile or live in very remote areas, self-help cognitive therapies may be the only option; if this ‘system of delivery’ is not available then none is. Although it may be possible for a therapist to visit them regularly, it would be far more difficult for a therapeutic group to visit them. Clearly then the system of delivery here is vital to the creation of therapeutic change. As for financial restrictions, funds are very limited within the NHS -
certainly to the point that only a fraction of all the people who could greatly benefit from cognitive therapy can be offered it. Group therapy makes more efficient use of therapists' time, and so could be used to deliver therapy to a greater number of people. There is still an issue, however, over how this increased supply would weigh up against individual therapy, which may be more effective. Nevertheless, one can see here that the choices about the system of delivery – group or individual – may have huge ramifications upon levels of therapeutic change from a national perspective.

I will turn now to examine more closely delivery factors affecting therapeutic change at the 'micro-level'. By this I mean factors affecting therapeutic efficacy within all cognitive therapies; cognitive-behavioural/cognitive-analytic/rational-emotive; group/individual etc. Aside from challenging components, cognitive therapies share many other features - and if these features are not addressed within the system of delivery, the potential for therapeutic change may be severely diminished. For example, boundaries need to be established outlining confidentiality, length and timing of sessions, and so on. If such boundaries issues are not part and parcel of the delivery system, the therapy could flounder at any stage. For instance, if confidentiality has not been discussed, and the client believes the therapist is relaying all the details of the therapy to the family GP (some of my clients have had this fear), she may withhold important details of her situation for fear that sensitive information would be relayed to others with negative consequences for her. Or, if the rationale for the referral, and the nature of the therapy has not been communicated to the client, he may be left confused as to why he was sent to the therapist, what is expected of him, and what he can expect of the therapy. Such confusion would be likely to undermine the client's trust and understanding of the therapy and the therapist, and so therapeutic progress may be obstructed.

Finally, within any form of cognitive therapy it is important for the client to learn about cognitive theories and methods of change. Although some learning will
naturally emerge from the dialogue with the therapist, at other times the therapist will take an explicitly didactic role. Without an understanding of the cognitive therapy model, so much may go awry. The client is more likely to find the therapy confusing and unhelpful, and this may undermine his motivation to engage with the process, explore his cognitions, carry out homework etc. In turn this may erode his faith in himself, the therapist’s abilities, and ultimately in the possibility of change.

Also of great importance to therapeutic progress is the successful development of a ‘therapeutic relationship’. Within descriptions of cognitive therapy, the therapeutic relationship often appears to receive much less attention than the technical aspects. However Scott (1997) asserted that this was not because the relationship is seen as unimportant, but because it was been taken for granted that “a good therapeutic relationship is a necessary but not sufficient condition for client change” (p.169).

Trower (1999) identified some key features of such a relationship: confidence and competence – both client and therapist should feel confident in the therapist’s expertise in the therapy; and the therapist should demonstrate unconditional positive regard, empathetic understanding, and interest in the client. Bennun et al (1986) outlined specific general therapeutic skills: the therapist should have expertise in agenda setting, pacing and efficient use of time, giving feedback, understanding, relating to, and collaborating with the client. The therapist’s ability to incorporate these features into the delivery of therapy, as a matter of course, directly affects opportunities for therapeutic change. It would be far too lengthy to describe all the ways in which this might occur, however, a few examples follow:

Clients may feel that they are unworthy of the therapist’s help and attention, and may expect to be told that their problems are too trivial to warrant therapy, or conversely, that they are so serious that there is no cure. The therapist needs to be aware of such notions in order to resist being drawn into playing out the role expected, and also so that he can incorporate the information into assessments and
interventions. Moreover, the client may have unspecified problems that could seriously limit the success of the therapy. For example, he may be unable to read or write, or, for cultural reasons, he may have limited understanding of the therapist's language. This is not to say that there is no way of working therapeutically in such situations; rather the system of delivery should be carefully designed to meet the needs of the client. For example, if the client cannot understand reading material, or cannot write, the therapy should not involve reading material or keeping written diaries – rather, the therapy should be delivered through the spoken word. Also, the therapy should always involve feedback between client and therapist in order to check for mutual understanding. The therapist can help to ensure this by reflecting his understanding of the client's material (and noting the client's responses), and by directly asking the client about his comprehension.

However, just as the process of cognitive therapy does not start with challenging the client’s faulty appraisals, it also does not finish immediately after challenges. The client must ‘take home’ his new beliefs and apply them in problematic scenarios in order to replace faulty cognitions that lead him to be distressed. This is often not an easy process, and clients may find that they become so distressed that they cannot access new alternative cognitions. However, there are a number of devices which can help him to do this - for example, using cards, or evocative imagery to aid recall more functional cognitions in problematic situations. Therefore, the success of cognitive challenges may depend not only upon the accuracy of those challenges but also upon the ease with which the client can access those challenges in his life outside of the therapy room.

Even after cognitions have been successfully challenged - meaning that the client sees intellectually that his new beliefs are more realistic and functional than old beliefs, and is able to access the new beliefs - he may find that he gets as upset as he used to and responds in familiar, self-defeating patterns. There may be unidentified faulty cognitions still operating - perhaps previous cognitive analysis did not come close enough to the client’s core beliefs, or it may be that client is held back by
other, beliefs about change. Either of these scenarios calls for a reapplication of the cognitive process - assessment, challenging, homework - again the success of this depends not only on the challenging components of the therapy, but also upon many other factors including those outlined above.

A further hindrance to therapeutic change may arise if the client fails to gain emotional insight into his predicament, and has understood the therapy only on an intellectual level. This may be the case when, for example, the therapy has taken place during a period when the client was not actively depressed or anxious, and has not accessed the dysfunctional cognitive patterns which emerge in troubled times. In such scenarios the client may be helped by re-experiencing his distressed state in order to discover the cognitions operating there. This can be done either by the client entering a situation which evokes the problem (e.g. someone with claustrophobia going into a small space), or through a process of mood induction during the session (Gilbert, 1986). In either case, therapeutic change is clearly dependent not only upon the challenges of faulty cognitions, but also upon the therapist’s ability to recognise stumbling blocks to change and employ effective procedures.

Finally, cognitive therapy has a termination phase, in which therapist and client have to discuss the ending of the therapeutic relationship and overcome any serious problems this presents. If the therapist does not leave sufficient time for this, the client may feel frightened and abandoned, and this could undermine therapeutic progress. An integral goal of cognitive therapy is to help the client to see that he is not dependent upon the therapist for healthy functioning but can draw on his own abilities and upon the support of others in his life. Again, although a key element of this is the identification and challenging of dysfunctional cognitions, other factors are also necessary. For example, the therapist should show that the client can operate independently not only thorough challenging the client’s beliefs about his self-efficacy, but also by acting in such a way that demonstrates faith in the client’s ability to problem-solve. A technique that is useful in this respect is Socratic
questioning - where the therapist helps the client to gain insight not by giving instruction but by asking him questions until insight emerges. In using this method the therapist implicitly demonstrates a measure of faith in the client’s abilities to think for himself and generate his own answers. As Socratic questioning involves the client in the step-by-step process of identifying and challenging cognitions it may subsequently help him to understand and apply the cognitive-therapy analytic method. Moreover, it helps to ensure that the discourse stays relevant to the client’s circumstances and that the client and therapist share a similar vision of the problem.

In conclusion, I hope that I have shown that therapeutic change is sensitive to a wide variety of factors within the system of delivery, some of which precede challenges, and others that follow them. Although much of their therapeutic power may ultimately be derived from their influence upon effective challenging, they are also therapeutic in their own right. For many people, to be listened to, respected and understood by another human being can be an immensely beneficial experience.
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Academic Dossier, Paper Four

The use of meditation as an adjunct to psychological therapy
The use of meditation as an adjunct to psychological therapy

Introduction

This essay explores ways in which meditation may be useful as an adjunct to psychological therapy, with reference to current theory and research. This will be explored within the context of psychodynamic or cognitive-behavioural paradigms respectively, as these tend to be the dominant paradigms within counselling psychology. However, meditation has also been explored from Existential, Gestalt, Construct Theory, Transpersonal, and Buddhist perspectives (Addison, 1999). The personal use of meditation by therapists, general effects that meditation is claimed to have and the processes underlying these effects, and problems with meditation research, will not be looked at in great detail, as these areas have been covered in an earlier work (Addison, 1999).

Early psychoanalytic explanations of meditation took a disparaging view of Eastern meditation. Freud saw it as involving a pathological regression to a child-like state of infantile narcissism (Cooper, 1999), and Alexander (1931) viewed meditation as “induced catatonia”. Nevertheless, the practice has flourished in the West in recent decades, and many psychological therapists have advocated its utility in facilitating psychological well being. A recent PsycLIT search found around 1,500 separate references for books, chapters and studies on the subject of meditation (Addison, 1999), and West (1996) estimates that over 1,000 research studies have been conducted in the subject. Much of this extensive literature supports the use of meditation techniques in the treatment of psychological conditions, and in the past thirty years the use of such processes as an adjunct to traditional psychotherapies has grown considerably (Urbanowski, 1996). However, this appears to describe the American experience and not so much the British. Overwhelmingly, the literature originates from North America - 75% of the sources in one review were American (Addison, 1999), while none were British. The reasons for this are not clear; Wilkinson (1997) suggests that cultural and historical reasons may be partly
responsible. However, given the great contribution of America to the field of psychological therapy and practice, it seems enigmatic that British psychologists continue to neglect this area.

Moreover, regardless of the lack of interest in the therapeutic community, high numbers of British people are meditating. According to a Gallup pole, 12% of men and 11% of women in Britain meditate (reported in Prospect magazine, p.7, issue 50). Furthermore, an Internet search will reveal many hundreds of organisations around the UK which offer meditation courses, and few appear to have links with the British Psychological Society, UK Council for Psychotherapy, British Association of Counsellors and related organisations. It appears then that this widespread and increasingly popular technique, which is profoundly concerned with psychological well being, is being largely ignored by mainstream psychotherapeutic professionals in the UK. As an integrative discipline with a strong commitment to ‘research & development’, I believe that the field of Counselling Psychology is well placed to use and examine the therapeutic applications of meditation. If Counselling Psychologists are to meet the challenges of working integratively, and within the scientist-practitioner model, they should give serious consideration to a broad array of psychotherapeutic techniques. This seems to be especially true where such techniques are already extensively used outside the field. Furthermore, meditation usually takes places in groups or alone and so it is not expensive treatment. It is flexible in that it can be carried out anytime when one has a quiet moment, and, aside from ant therapeutic function, it can also become an enjoyable pastime.

The Psychodynamic Paradigm

Despite cynical explanations of meditation by many early psychoanalysts (none more so that Sigmund Freud), other renowned analysts have shown a positive interest in the practice, for example Karen Horney (1952), and Erich Fromm (1960), and there is now a wealth of psychodynamic commentaries on meditation. Some have explored it as a technique that may be used as an adjunct to psychotherapy (Walsh,
1992; Cooper, 1996; Carrington, 1975), while others have viewed it as a parallel process – a sort of ‘Eastern psychotherapy’ (Odajynk, 1988).

Those who have attempted the use of meditation as an adjunct to psychodynamic therapy appear to fall into two camps. There is the position wherein meditation is conceived as facilitating a controlled regression to infantile states wherein some reparative function may be performed. For example, Shafi (1973) claimed that in such a regressed state one may “re-experience union with [an] earlier love-object on a pre-verbal level of psycho-sexual development”, and thus an opportunity is presented for an adaptive re-experiencing of early psychodynamic conflict or deficit. Such a view of meditation appears to have grown out of Freud’s comments on meditation as it also views it as a regressive event. Other commentators have drawn attention to a transcendent function of meditation – facilitating growth beyond the self; and to a progressive function which enables psychodynamic insights into functioning (Goleman, 1981). Of particular relevance here is ‘insight meditation’ a technique where one tries to raise awareness of the gestalt by deepening one’s awareness with a fuller range of senses in a comfortable, quiet environment. It is said that one may pick up upon thoughts and emotions that are ‘weak’ (perhaps defensively reduced) and gain insight into patterns of thinking and feeling.

By chance, I have recently finished seeing a client in psychodynamic therapy who had practised meditation for a year prior to, and throughout the time of the therapy. The therapy was successful and progressed rapidly. While initially sceptical about practising meditation and undergoing psychological therapy at the same time in his life, this client later reported that he had found the mix to be beneficial in a complimentary way. Insights reached during his meditations were discussed in the therapy; the verbalising of these, and their ‘fine-tuning’ in dialogue with me appeared to bring about a deepened understanding of them. Furthermore, interpretations made during the therapy were subsequently observed during meditations, which again served to deepen his experience of certain dynamics. Such deepening appeared to move the client beyond intellectualised, ephemeral, insight
into one that was also felt to be emotionally ‘real’. While this anecdotal case proves little, two points can be made. Firstly psychodynamic therapy and meditation can be perceived to be complimentary processes; and secondly, that counselling psychologists may occasionally have clients who meditate. Just as psychologists should be aware of the potential effects of any psychoactive medications, or alternative therapies that their clients are taking (or have undertaken), so they should also be aware of the effects of meditation.

So there are a number of ways in which meditation has been claimed to facilitate psychodynamic therapy – but what of the research evidence? There are very few studies which support psychodynamic explanations, and there is a dearth of quality research in the area (Addison, 1996). Many commentators have relied upon case studies or anecdotal accounts to support their claims. This may be because the psychodynamic effects of meditation are extremely difficult to study objectively. Common problems lie with measuring effects, and controlling for the influence of confounding variables.

Another matter of concern for interested counselling psychologists would be how best to integrate the practices of meditation and psychotherapy. On the face of it, therapists could either teach the client meditation (which may be continued elsewhere), or they could refer the client to a meditation school. Either possibility carries potential problems for the therapist practising psychodynamically as it breaks the classic boundary that the therapist will not advise the client. Cooper (1996) illustrated the danger here by describing a case where a client of his “fled” from his former therapist after the meditation he had recommended led to an increase in anxiety. However, a counselling psychologist, practising integratively, may feel that this problem is not insurmountable – through perhaps by exploring with the client the possibility of meditation in a well known, trusted school. Further difficulties in using meditation as an adjunct to psychotherapy will be explored later.
The Cognitive-Behavioural (CBT) Perspective

The literature shows that meditation practice is commonly associated with reductions in insomnia, drug-use, anxiety, stress, and neurotisism (Delmonte, 1987). A variety of the models have been used to explain the behavioural effects of meditation including self-paced desensitisation relaxation, reciprocal inhibition, and classical conditioning (Delmonte, 1987). There is a considerable body of research to support these claims, although again, it is dogged with methodological weaknesses. Furthermore, a debate still rages as to whether such effects are unique to meditation or essentially similar to other relaxation strategies, such as biofeedback, listening to music, sitting quietly etc. However, the following studies are methodologically sound:

Kabat-Zinn et al. (1992) found that regular group meditation practice can reduce the symptoms of anxiety and panic in patients with generalised anxiety disorder, panic disorder (with or without agoraphobia). Alexander et al. (1989) showed that meditation practice by elderly people in residential care led to significant improvements on measures of behavioural flexibility, ageing and paired associative learning. Remarkably, the survival rate for the meditation group (after three years) was 100%, while 13% of an alternative relaxation treatment group, and 33% of the no-treatment control group had died. A study by Alexander (1993) indicated that meditation was effective in reducing measures of stress, trait anxiety, insomnia, fatigue and cigarette & alcohol use, in an occupational setting. Other investigators have concentrated on the cognitive aspects of meditation – Delmonte (1990) has claimed that meditation facilitates the loosening of cognitive constructs which in turn leads to increased awareness of previously excluded material, and more flexible and adaptive thinking.
Using meditation as an adjunct to cognitive-behavioural therapy should be less problematic than with psychodynamic therapy, as the teaching of coping strategies, anxiety reduction techniques etc., is already an integral part of CBT. Kabat-Zinn et al. (1992) highlighted that both meditation and CBT emphasise the tolerance of sensations and thoughts experienced as catastrophic. They also drew attention to differences between the two, and suggested that meditation practice could deliver unique therapeutic benefits to CBT. Meditation, unlike CBT, does not attempt to identify cognitions as positive or negative, but as right or wrong within a philosophical context (often Buddhist). Kabat-Zinn claimed that this facilitates the acknowledgement of potential limitations and inaccuracies of all thoughts, not just those that produce anxiety or depression. This idea seems similar to Delmonte’s (1990) claim that meditation facilitates the loosening of cognitive constructs which in turn leads to increased awareness of previously excluded material, and more flexible and adaptive thinking. Furthermore, Kabat-Zinn maintained that meditation has advantages over a pure CBT approach because meditation is a generic coping strategy facilitating a more adaptive ‘way of being’, rather than one attached to specific symptoms.

Even if meditation is not used as an adjunct to therapy, it may nevertheless exert an influence within the therapy. Dialectical Behaviour Therapy (DBT; Linehan, 1992), designed for people with borderline personality disorders, is an example of how meditative processes may be integrated into psychotherapy. DBT is primarily a skills-training approach, rooted in CBT, which integrates aspects of Eastern meditative practice. For example, the skills of ‘observing’, ‘describing’ and ‘participating’ are emphasised. ‘Observing’ refers to passively attending to the flow of events, emotions and other responses; ‘describing’ refers to the identification of experiential phenomena as thoughts, emotions, sensations etc. whilst noting their subjective nature; and ‘participating’ describes being fully involved with the flow of mental experience in a mindful manner.
Potential hazards in employing meditation as an adjunct to therapy.

There are several practical difficulties in using meditation in therapy. For example, it is a practice that some people maybe unwilling to engage with; they may view it as odd, self-indulgent or esoteric. Or, if people close to the client view it in negative ways (perhaps because it is seen as a solitary, and excluding practice) it may cause discord. Moreover, regular meditation requires considerable motivation and clients lack this they fail to keep up practice and feel that they had failed.

Any intervention powerful enough to be therapeutic is likely to also carry the potential for harm, and there is evidence to suggest that meditation might prove harmful in certain cases. For example, Walsh (1996) has written that meditation can give rise to episodes of anxiety, agitation depression and euphoria. Although he claims that such experiences may ultimately prove therapeutic if well-managed, he was also concerned that, for some borderline patients, they might be intense enough to trigger a psychotic break. Boorstein (1996) reported a case study in which meditation seemed to act in just such a way. Epstein (1990) warned that for people with obsessional thinking, ‘insight’ meditations might serve to perpetuate or encourage excessive ruminatory thought.

Finally Walsh (1996) reported that those who find meditation most useful may share certain traits. They seem to be more interested in internally stimulated experience rather than that stemming from, external, environmental sources; are more receptive of unusual experiences; and feel that they have strong self-control.

Conclusion
It appears that meditation is a largely untapped resource for counselling psychologists. There is a wealth of anecdotal accounts supporting the use of meditation as an adjunct to therapy, and therapists have begun to outline in what conditions and why meditation might be therapeutic, or harmful. Some innovators have integrated ideas drawn from meditative practice with mainstream psychological
theories. Although many studies have failed to provide solid evidence in support of the usefulness of meditation, this is largely the result of flawed research, and methodological problems inherent in studying meditation. Finally, whatever their opinions about meditation, counselling psychologists have a duty to be aware of the practice, as it is an increasingly popular strategy for personal development, both in the UK and internationally.
References


Therapeutic Practice Dossier

Introduction

The Therapeutic Practice Dossier is related to work carried out during the three years of clinical placements. It contains a description of each of the placements as well as a paper which discusses the integration of theory, research and practice from a personal perspective.

Further details of the client studies, process reports, placement logbooks and supervisors’ reports pertaining to this dossier are available to the examiners in a separate appendix. Due to the confidential nature of the material contained in this appendix it is not available for public access.
Description of clinical placements
First year placement: Student counselling services

My first year placement was within the Student Counselling Services of a degree-level educational institute. The service was based within the Student Services Centre, which provided a wide range of support beyond counselling; for example, personal tutoring for dyslexics, financial advice, a small general medical practice and careers counselling. The psychological counselling team consisted of one full-time Senior Counsellor, who also acted as my supervisor, and three part-time trainees including myself. There was little need for me to become professionally involved with the work of the other team members, and no reports were written to them.

The supervision consisted of weekly sessions of at least 90 minutes. Initially, the supervision was most concerned with establishing basic therapeutic skills – setting boundaries, developing a working alliance and formulation making. Later sessions involved discussion of more complex therapeutic matters, mostly within a general psychodynamic context.

The clients were all students between the ages of 19-28. Common presenting problems included developmental issues around adjusting to parental separation, evolving identity, and developing intimate relationships; coping with stress from financial, study/career, and peer pressures; and depression and anxiety connected to childhood difficulties. In accordance with many youth counselling services, the sessions were open-ended; I saw clients for a minimum of one and a maximum of eighteen fifty-minute sessions.

There were no opportunities for observation, or group work.
Second year placement: Primary care services

My second year placement was within Primary Care Services in an inner-city area, which offered short-term (12-week) individual psychodynamic therapy. Sessions were once-weekly and lasted for 50 minutes. The only other mental-health professional in the practice, the Practice Counsellor, was a psychodynamic counsellor, who also acted as my supervisor. Supervision sessions took place weekly and lasted for at least 90 minutes. The supervision was based around the development of psychodynamic formulations and interventions, in particular those drawing on Kleinian ideas.

Patients were referred to the Practice Counsellor by General Practitioners, often at the patient’s request, though occasionally the GP made the initial suggestion. The patients were generally high functioning in that most were employed and maintaining some satisfying relationships. Common presenting problems were general anxiety disorders, panic disorders, mild to moderate depression and difficulties in relating to others. At times I liased with the General Practitioner concerning medication, and after the therapy was finished I wrote to the patients’ GP to inform them of the issues covered in therapy and the outcomes.

There were no opportunities for observation, or group work during the placement.
Third year placements:

1) Rural Community Mental Health Team
2) Day Treatment Centre
3) Urban Community Mental Health Team

The final year placements consisted of one day a week in each of two settings; a rural Community Mental Health Team (CMHT) and an urban Day Treatment Centre (DTC). After six months, I finished working at the DTC and started another full day at the rural CMHT. This had been planned from the start of the year; as the DTC was a rich learning environment, but not one in which would provide sufficient clinical hours.

In the last three months of the year I started a third day of work at another CMHT (on the same site as the DTC) in order to obtain the extra hours needed to fulfil the requirements for attaining chartered status.

All individual therapy sessions took place in the CMHTs. In the main I practised cognitive-behaviourally, although I worked psychodynamically with some patients. All sessions were weekly and lasted for 50 minutes. I worked with patients suffering from a wide range of problems; eating disorders, drug and alcohol use, marital and separation difficulties, and relationship issues. The most common problems were mild to moderate depression, and generalised anxiety and panic disorders. The patients varied in age from eighteen years to fifty-two years old.

I had weekly supervision sessions of 90 minutes with a counselling psychologist working at the CMHT. The focus of the supervision was upon developing competency in practising cognitive-behavioural therapy; however, as my supervisor was an integrative practitioner we drew from a range of theories to inform the work.
Both CMHTs were staffed by a range of health professionals - community psychiatric nurses, clinical and counselling psychologists, health visitors, psychiatrists, and social workers. At the rural CMHT, I took part in weekly multi-disciplinary team meetings where patients were discussed and treatment plans developed. I observed two assessment sessions; one by a Community Psychiatric nurse and the other by a Counselling Psychologist. I had little professional involvement with staff at the urban CMHT, other than with my supervisor.

The DTC offered a variety of services to people with more severe and chronic problems; many had recently left in-patient units. The clinical staff included an art therapist, a counselling psychologist, a group therapist, psychiatric nurses, and occupational therapists. For the six months that I worked there I took part in weekly group supervision sessions with occupational therapists, other psychologists.

I was a co-therapist in two short-term cognitive-behavioural groups for the management of anxiety. Each of these groups met weekly for 90-minutes sessions over eight weeks. In the first group my role was as an observer/supporting therapist, whilst in the second group I shared a lead role with a trainee clinical psychologist. I also took part in nineteen weekly general discussion sessions on the men’s psychiatric ward located above the DTC. Although the group leader was a Psychodynamic Group Therapist, the group was not designated as a therapy group; rather it was aimed at improving morale and stimulating socialisation on the ward.
Counselling psychology and the integration of theory, research and practice: a personal account.
Counselling psychology and the integration of theory, research and practice: a personal account.

All clients’ names have been changed in order to protect anonymity, and potentially identifying details, such as placenames, professional roles etc., have been changed to protect confidentiality.

All client studies, process reports and supervisors’ reports referred to in this essay are shown in the appendix to the portfolio.

Introduction

Looking back across my practice, I have been most influenced by ideas within four therapeutic paradigms – client-centred, psychodynamic, cognitive, and integrative. In the main though, I describe my primary theoretical approach and practice as ‘integrative’. This reflects the doctrine of my training course, and of the services in which I have worked, as well as my own thinking and professional development.

This essay outlines the influences on my selection of various theories and techniques within my therapeutic practice. In this, I differentiate between selecting the main therapeutic paradigm in which to work with a client, and incorporating various theories and approaches within the therapy. Therefore, the essay addresses the twin requirements of finding an appropriate main therapy, and how to draw from the wealth and variety of psychotherapeutic approaches in an integrated and coherent way.

Moreover, I have used this essay as an opportunity to describe and develop a theoretical framework that I have used to guide my practice and the integration of
theory and techniques. This integrative framework is necessarily personal and experimental as it describes how, as a trainee, I have sought to combine the various theoretical tools that I have learnt about. As Slife (1987) pointed out, therapists must have a system for making judgements of diagnosis and prescription, which is a theory in itself, but not one which merely comprises several theories at once.

The presentation of this general framework follows shortly; having finished this I will describe the ways in which I have used various therapeutic theories within my practice and how this has developed as I have become more knowledgeable and capable.

Towards a framework describing my theoretical approach to integration

At the heart of my practice is a pan-theoretical philosophy; I do not believe that any one theoretical model gives a complete account of psychological disturbance, nor that differing models cannot be usefully integrated, even though they might paint quite different pictures of the how disturbance arises and how it can be treated. I feel, however, that I need an over-arching theoretical ‘frame’ to hang (understand, conceptualise) various techniques and approaches that I wish to employ. Without such, I risk confusing the client and myself.

The framework shown below outlines the main conditions and processes involved in my practice. It is chiefly an attempt to explain the thinking implicit in my practice, rather than a model that I consciously refer to. It is not intended to provide information on how to proceed with the details, the important minutiae of practice; these issues will be addressed after the framework has been described. Nor is it presented as a complete ‘grand-theory’. However, it does provide a frame into which various ideas can be inserted, which helps me to maintain an overall sense of a coherent and integrated therapy. This has been particularly useful given the context of training – a period of rapid learning of numerous theoretical approaches
and techniques, applied in four different placement settings with a broad range of client groups and presenting problems.

This framework is relevant to the aims of this essay, in that it helps to provide “an overview of my theoretical approach to practice” (University of Surrey PsychD Assessment Handbook). It also is useful in “describing the ways in which” I “integrate theory and research into my practice” (University of Surrey PsychD Assessment Handbook). The model stems not from one theoretician or approach, but from a range of theories, in particular self-psychology (Khan, 1997), Berne’s Transactional Analysis (Berne, 1967), Malan’s triangles of conflict and person (Malan, 1998), and were there are clear links, references are given. I have been influenced by the philosophy of meditation, and contemporary psychological interpretations of Buddhist philosophy, which I studied as part of my research work.

1) The therapeutic setting: the frame, and the “working alliance” (Clarkson, 1999).

As standard features of my practice, regardless of the setting of the therapy or the model being used, I strive to imbue the therapy with the following qualities:

- I aim to be unintrusive but attentive in the first few sessions. This means that I generally allow the client to discuss whatever is on their mind with a minimum of interruption from me – although I will intervene more often if it is apparent that this helps the client to feel safer. I endeavour to keep questions for the later stages of assessment, when greater rapport will hopefully have been established. Ideally, the clients will have had plenty of opportunity to express themselves, and I will have obtained the information I need in a way that does not break the natural flow of the discussion.

- I try to encourage empathy in the sessions by attuning to the client’s experience. One way of doing so is by attending to my countertransference feelings that are in resonance with the client – what Racker (1953) called ‘concordant countertransference’. Another way is by encouraging clients to describe their
subjective experiences. Following this I feel that it is important to for me to reflect my understanding to them.

- I aim to develop *unconditional positive regard* (Rogers, 1967) of the client by striving to listen closely to the client at all times and avoiding variable interest and concern. I try not to feel or to show disappointment, or dislike, and this is made much easier when a good rapport has been developed. I think that it is also important to show faith in the client by being careful not to act in ways that imply that the client is incapable.

- I strive to make the client feel that the therapy is *safe* and *confidential*. This can be achieved by being explicit about the boundaries of confidentiality and by addressing any worries that the client may have in this respect. Clearly, I would never talk about my work with other clients and avoid personal disclosures unless there are clear reasons why it might be useful to the client. For example I would be likely to answer a client’s question about where I am going on holiday, as to refuse might damage the rapport unnecessarily.

- I am mindful of establishing a client’s *faith in my abilities as a therapist and in the therapeutic process*. This can be facilitated by demonstrating professionalism – being punctual in beginning and ending sessions; talking clearly and without jargon; reviewing progress; and addressing difficulties the client may have with the therapy. Moreover, the client will be encouraged if he understand the model being used, and how it could help.

These elements may be therapeutic in their own right as they can help to provide emotionally reparative experiences – for example, it may be the first time that a client has experienced someone as not exploiting or neglecting them. However, these elements are also important in setting a firm basis for the more active and challenging therapeutic work:

2) The application of therapeutic models and techniques.

- *Offering the client information* about themselves, and their interaction with other people, in order to facilitate their awareness and insight. In
psychodynamic work this takes the form of interpretations of the client's predicament; whilst within the cognitive model this might be through a Socratic system of questioning, or psycho-education (e.g. teaching the cognitive approach to understanding and changing behaviour).

- Encouraging the client's efforts to resolve their problems, outside of the therapy. This is particularly relevant within cognitive therapy, for example keeping diaries, thought records and carrying out behavioural experiments.
- The therapist's provision of emotionally reparative experiences. As noted previously, these may come naturally as a result of establishing the frame and the working alliance. They can also be facilitated through the use of particular techniques such as the ‘empty chair’, or exposure to feared stimuli. Although I have not used the empty-chair technique in my practice (largely because I have no training in its use), I have experienced it within personal therapy and found it to be very useful.

To the extent that the above elements are achieved the client develops awareness and insight in to the nature of, and the interplay between, themselves, other people, and the world – both recent and historic. I use the ‘world’ to denote, for example, the ways in which society and natural phenomenon operate. Such insight and awareness facilitates a reflexive (Keefe, 1977), or observer self (Vigne, 1997); an ability to observe one’s behaviour and experience objectively and not to become enmeshed in it. The insight, awareness and observing self in turn lead to a heightening of self-esteem and self-efficacy, as clients gain a greater mastery over their lives; they are more able to appreciate what their needs are, and more able to meet them, and if need be, enlist the help of others. Moreover, for some the discovery that they can be understood also lifts self-esteem. In understanding the links between their present and past experience, and the influences of others and the world, a sense of connectedness with others and the world is enhanced. Again, this helps to elevate self-esteem and self-efficacy.
The model is integrative in that it allows characteristic functions of various models to be incorporated: in the outline above there are elements of client-centred therapy (unconditional positive regard); psychodynamic theory (therapist’s interpretation); Gestalt psychology (the empty chair); self-psychology (emotionally reparative experiences); and cognitive therapy (psycho-education, keeping of diaries/thought records).

I will now describe the ways in which I have chosen the main psychotherapeutic paradigm (i.e. cognitive-behavioural, psychodynamic, or occasionally supportive counselling); and have incorporated ideas from a variety of theoretical approaches:

Choosing between theoretical paradigms, and integrating ideas and techniques in therapeutic practice

In determining which approach is most appropriate, and what ideas and techniques might benefit the therapy, I have found that the following five areas should be attended to: (1) the research evidence for the differential use of particular models; (2) personal experience of what approaches work with whom; (3) advice given by experienced practitioners (supervisors and authors); (4) the requirements/preferences of the organisation worked for; and (5) my personal preferences/abilities in the practice of particular models. I will now deal with these issues point by point, citing examples from my practice where available:

Research evidence
Intuitively, it seems likely that certain problems, personalities and predicaments are better suited to particular models. However, some therapists have suggested that the best way to practice is to treat all patients and problems as the same and to apply one standard therapy (Michels, 1984); or that there is insufficient data for matching patients with specific treatments (Smith, 1991).
I have often been cautious of choosing a paradigm in which to work solely in response to the patients' problems - largely because it seems that the research findings often do not show clear preferences. For example, researchers have found that there are no differences in the effectiveness of various strategies and techniques in the treatment of mild to moderate depression (Bellack, 1985; Elkin et al. 1989). The great majority of my depressed clients (I can think of only two exceptions) have been in the mild to moderate range. Moreover, 'the problem of adjudicating' (Greenberg, 1994) which research studies should influence practice is not an easy one to solve. It seems that whatever model one might choose to take up with a particular patient there would be some research to support it and other research which would not.

Conversely, Clarking, Allen and Francis (1992) claimed that clinical research was beginning to suggest which strategies and techniques are most effective with particular patient problems. Certain research findings seem to be particularly strong; for example that cognitive-behavioural therapy is well suited to people with borderline-personality disorder (e.g. Linehan et al. 1991); as are cognitive-analytic approaches (Ryle, 1995).

Clearly it is important to be aware of the research evidence, from current and older studies, in matching therapies with problems. This is particularly true where a range of therapies are available to the client - either because the practitioner can offer various therapies, or because a variety of therapists work at the service. It is also important when working in specialist services, such as alcohol and drug services. To date my placements have been in more general settings, and ones where a variety of specialist therapies was not offered. This may also explain why I have tended not to think in terms of matching particular therapies with specific client groups. However, I am much more likely to use research evidence to guide the therapy, rather than in the selection of a particular paradigm. An example of this from my practice follows:
Towards the end of my second, psychodynamically-oriented placement, ‘Mr Saville’
presented with low self-esteem and mild depression; he had an unusual family
background having been adopted at an early age by a couple who had thought they
were unable to conceive. However only a few months after his adoption (at birth)
his adoptive mother gave birth. I remember initially having very few ideas about
how his problems may have arisen; other than the adoption, there did not seem to be
much that was unusual or disturbing in his history and family background. I raised
my concerns in supervision and was recommended to read a book on adolescent
disturbance (Brinch, 1990), and I also read research papers sourced from PsycLIT.
This reading helped me enormously in developing a formulation and in shaping
therapeutic interventions. The research suggested that the genesis of his problems
lay in the adoption and its consequences. For example, as he was told of the
circumstances of his adoption at a very early age, this may have caused a
psychological injury which could not “be mastered without certain inner emotional
and cognitive resources....not normally available to the child before...seven years”
(Brinch, 1990). Partly because of such information, I focused the therapy around
the adoption and his feelings of being an outsider and different from his family
members. This lead to the exposure of powerful fears of being rejected and of
being inferior and unloved, which in turn lead to insight and symptom relief.

Personal experience of what approaches work with whom

In my practice, I have found that cognitive-behavioural approaches tend to work
better with people suffering from depression or anxiety (e.g. panic attacks,
agoraphobia, social anxiety). Especially where there is no major childhood
disturbance, and the client is willing and able to work with the model. I also feel
that cognitive-behavioural approaches are well suited to people who seek
circumscribed change – for example in managing eating disorders, substance
misuse, and anger, and in developing social skills.

Alternatively, I have found that it is often more appropriate to work in a
psychodynamic way with clients who have particularly complex problems (often in relating with others); with disturbed or unusual childhoods (especially when those have remained unexplored and unexpressed); whose problems have been around for most of their lives; and who are interested and motivated by the 'inner world' of ideas, meaning and analogy. Finally, I have found that psychodynamic approaches focus upon the client's pathology are less appropriate with people who have on-going systemic problems, for example where there is on-going abuse from a spouse, or problems in adjusting to a prejudiced society (racism, sexism). At a time when I was not so aware of the importance of this last point, I adopted a psychodynamic approach with 'Caroline Peters' (fourth client study):

Miss Peters was an unemployed, Afro-Caribbean single mother who lived on an inner-city council estate, and whose children were about to leave home. She had been depressed for around a year, and in particular she felt that she had little to look forward to. It seemed as thought her sense of purpose and identity had stemmed largely from her role as a single-mother, and that she felt that these had dissolved, with no replacement, when her children became adults. Moreover, she appeared to have very negative beliefs about growing old and what life could now offer her. She appeared to have been worn down by a society that frowned on her status as a welfare-dependent black single-mother, and by the powerlessness she felt against a welfare system which continually let her down. For example, she had been unable to stop the council housing department from putting a series of problematic people in the next-door flat – a drug addict who had set fire to his flat, and a dying man with racist views. Finally, she suffered from back pain and a medical condition that made her skin dry and itchy.

In retrospect, I feel that the therapy was hindered by my working in a psychodynamic way that focused too much on her early childhood and relationships with her parents. Although this may well have been relevant in the genesis of her problems, it was probably not the sole, or even the most important factor. She did not view her past as very relevant to her current problems and did not show much
interest in interpretations that connected her past and her present. The therapy might have been more fruitful had it taken up a cognitive-behavioural approach focused upon the development of a new identity as a mother of adults, the management of her housing situation and her medical problems, or exploring and challenging negative beliefs about her situation.

Choosing a psychodynamic approach with Mr Hinton (the subject of my third process report) was more apt, and the reasons for my choice illustrate many of the themes described so far. Mr Hinton presented with a very specific relationship problem - he had twice become so agitated and panicky when girlfriends reciprocated love that he had ended the relationships, against his 'better judgement', in order to end his suffering. He also had an unusual childhood: he moved house often, and his deeply religious parents seemed to focus much of their care and attention on welfare of the poor and needy. Moreover, he was very interested in the inner world of his representations of self and others, he used interpretations effectively, and his problems were not connected with his current socio-economic context. At the end of the 12-week therapy, we were unable to know whether the therapy had been successful as he was not in a relationship. However, he decided to continue his therapy with a private psychodynamic therapy service, which I had helped him to find.

The requirements/preferences of the organisation

In both the cases just described the therapy took place in my second, psychodynamic, year of training, where short-term psychodynamic therapy was the standard model used in the service. This was the main reason why I chose to take up that model with these clients. Although with the benefit of hindsight I feel that a psychodynamic approach was not best suited to Miss Peters, in some senses, I do not regret using the model as I am unsure that I would have been able to deliver alternative approaches, given my inexperience and an absence of alternative supervisory support.
In selecting the most appropriate model I have been bound to the requirements of the placement setting. Many National Health Services provide only certain therapies, often because it is believed that certain models are best suited to the client base, and because supervision is only available for particular modes of practice. However, I have had some choice in determining the main model used, and I hope to become freer in doing so as I become more experienced.

My personal preferences, and abilities, in the practice of particular models

When I first started practising psychological therapy I was relatively inexperienced and lacking in ability. Being aware of this, I opted to concentrate on factors which required less therapist expertise. In the framework described above these were the first elements described, and those commonly associated with client-centred psychology - empathy, unconditional positive regard, confidentiality, and reflection of only the client's material. I felt that using more complex methods such as interpretation and psycho-education would be unhelpful because, while I was an out-and-out novice, they would be likely to be crude and inaccurate and so could undermine the therapy.

This tentative, client-centred stance is clear within my first Client Study on 'Miss Lang' where I wrote that I was working to the Rogerian beliefs that "a relationship based on 'unconditional positive regard' is the primary mechanism of therapeutic change" and that "the clients are the experts on themselves". Moreover, I wrote that "in seeking explanations most relevant to the client's predicament, I have attempted to avoid hasty theorising - which would open up the risk of 'trying to fit a round peg into a square hole' ". I was tentative in offering interpretations to the client, aware of the relatively high risk that these would be inaccurate. I justified this approach largely on the grounds that Miss Lang was "a young person struggling to express herself" and so "would benefit from the kind of faith that Rogerian attitudes place in the client's autonomy and identity". With hindsight, I feel that
my awareness of a lack of expertise was also an important reason for adopting approach.

My formulation of Miss Lang's problems reflects the themes described within my integrative framework, as I wrote that she had "disturbances in self-efficacy, and self-esteem". As this is insufficient as a formulation, I went on to draw from other theories, noting for example that her problems had "an existential slant: she seems to be looking for the answers to questions such as 'Who am I?, Am I normal?' and 'Am I able to cope with life's demands?'". I also drew on ideas from cognitive psychology, formulating that she had negatively-biased schema about men, her academic abilities, and what other people thought of her. I referred to scripts that she seemed to follow which set rules on how social interactions would be likely to proceed, and on how her life would progress in general.

As I am still in training, I remain cautious about my ability to take-up various therapeutic ideas and techniques at will. For example, I have not attempted to practice existential therapy, even if the client’s situation seemed to call for it, as I am not sufficiently trained in the model. I have however used existential ideas in developing formulations, and occasionally to shape interventions.

**Guidance from experienced practitioners and theoreticians**

As my skills and confidence have developed, I moved beyond client-centred techniques. This is indicated in my second client study where I wrote that I had used "Rogerian and Kohutian modalities". I became more knowledgeable and confident in my abilities in to use Kohutian ideas, and wrote that I acted in accordance with the idea that it is important to "understand and convey one’s understanding to the client" (Kohut, 1997). Although I felt more confident in disclosing some of my impressions and ideas to the client, I was nevertheless cautious about how I did so - noting that I "sought to interpret Miss Boyne's needs for mirroring in a tactful non-hurtful, non-humiliating manner". This sense of
caution was also reflected in my first supervisor’s report where it was noted that I showed “a dogged desire to follow the track of the client....he is very respectful of them...he could take a little more time to stand back and focus on the reasons for a client being the way he/she is [and] could be increasingly bold about using his own feelings”.

With such encouragement from my supervisor, and as I learnt more in classes and from practice, I progressed toward using theories and procedures in ways which required more active use of my perceptions and understanding. This progression is clearly indicated in my first process report where I wrote that:

“The therapy started within a Rogerian framework, wherein the therapist limited his interventions to those designed to deepen empathy with Miss Roy, and reflect that understanding to her (e.g. clarifying, paraphrasing, summarising, reflecting)... Later, when I felt I had reached sufficient understanding, I made interpretations of Miss Roy’s functioning, drawing from a variety of psychological theories. These interpretations were designed to evolve our insight into Miss Roy’s circumstances; and thereby help her to recognise, and develop more functional ways of achieving, her goals”.

Referring to the framework described earlier, I had moved from basing the therapy solely around the frame and alliance element, and into that application of more active techniques such as making interpretations based on psychodynamic theory. Moreover, it is clear from the last quote that I viewed therapeutic progress as raising insight, and thereby increasing self-efficacy.

Even when practising in a relatively purist cognitive or psychodynamic way, I am likely to use theory and techniques from a variety of sources. I often the ideas produced for ‘information only’. For example, when working cognitively I have frequently used psychodynamic ideas about countertransference to inform me about
the client’s thinking and behavioural patterns (an example of this from my work with ‘Mr Nairn’, is shown below under the heading ‘evaluating completed and on-going therapy’). At other times I may use the information in ways that more actively shape the therapy. In such cases I strive to do this in such a way that the intervention is not antithetical to the core model being practised. An example of this follows:

A client from my second year placement, ‘Miss Bower’, was frustrated at her inability to manage her panic – when she was calm she saw very clearly how her panic was irrational, that there was actually little to be afraid of. She felt foolish for having panicked at all and became angry with herself shortly after the panic subsided. Her descriptions of her state of mind while panicking were strikingly child-like in content; she described having childish thoughts and feelings, often ones that were particularly reminiscent of her childhood. I was spontaneously reminded of Transactional Analysis theory and I formulated that, when panicking, she moved from an adult to a regressed, child ego-state - she was the small, incapable child, surrounded by powerful adults.

This furthered my understanding of her behaviour and, after explaining these ideas to her, she seemed to understand herself better. She seemed relieved by these explanations, and that she had been understood. Moreover, when she panicked later that week she adopted a more gentle, therapeutic approach towards her behaviour – as if seeing herself as a child had stimulated an internal nurturing parental function. The core of the therapy was actually cognitive-behavioural, but as an integrative practitioner I felt that it was valid to employ theories from other models. In doing so I feel that my understanding of problems has often been facilitated, and that this has in turn influenced the therapy in beneficial ways.

The way in which I find theory and techniques to guide the therapy follows two routes. As in the most recent example, a client’s material may trigger the recall of theoretical knowledge, which I then use within formulations. At other times, my
Having discussed the ways in which I have integrated ideas and techniques within my therapeutic practice, I shall now move on to describe how I have sought to evaluate therapeutic work.

Evaluating on-going, and completed therapy

I will conclude with a few comments upon how I evaluate the therapy – as it proceeds and after it has finished. I feel that the therapy is going well when the client, repeatedly if not continually, demonstrates ease and engagement in the sessions, and keeps returning. This does not mean that the therapy was always easy or comfortable – especially with more disturbed clients, there may have been many uncomfortable moments. Secondly, I measure the success of the therapy through information the client gives me about their feelings, thoughts, and behaviour. I use a variety of sources to ascertain this. When practising in a cognitive way, I often ask the client directly how they feel the therapy is going and if what difficulties they are having. Within a psychodynamic framework, a more subtle approach is required and so I attend to communication from the client that may be conscious or unconscious, and direct or indirect:

An example of direct and conscious communication is when the client tells me that they feel better in themselves, about themselves, about others, and about the world. They may report that they feel less depressed and anxious, that they understand and relate to others better, and have a clearer appreciation of the upside of life. Indirect conscious communication occurs when their body language, affect, dress, reported activities of the week etc, indicates change. For instance, by the end of therapy, Mr Nairn (fifth client study) dressed more smartly, was more clean-shaven, had
returned to work having negotiated preferential changes in his duties, was communicating more openly with his wife and friends, and had abstained from drinking alcohol for a month. Moreover, he expressed confidence in the process of therapy by talking about how his (previously negative) attitudes to it had changed and that he wanted to know how he could pick it up again should he ever feel the need.

Unconscious communication occurs when I react to the client’s unconscious processes (i.e. countertransference). For example, in connection with something that the client has said or is doing, I may feel de-skilled or ineffective and I will then explore such feelings privately, or in supervision to ascertain its meaning. It could indicate that I am being drawn into the client’s transference neurosis (which is not a sign that the therapy is not progressing, but it is very important to recognise what is happening), or it may reflect a less uncomplicated and more valid negative opinion that the client has of the therapy.

My countertransference reactions are not necessarily feelings, sometimes they may be thoughts, or bodily sensations. An example follows: a client from my third year told me about how she was “getting nowhere talking to her brother”. She said that their conversations never went deep enough, and that there were certain things she had never told him. I thought that this was likely to be an unconscious comment about the therapy, although I did not feel much emotion, other than a little anxiety over how I could best manage this message. Later, with my encouragement we explored her feelings about the state of the therapy – she told me that she had not been very open with me, and that often had this problem with people in general. She saw more clearly how she put on a front with people, even with herself, and connected this to the need to disguise sexual-abuse (involving a pact to secrecy with her abuser).

In may use of anecdotes, dreams and other information that clients bring to the therapy I have been inspired by ideas from communicative psychoanalysis (Langs,
1998; Smith, 1999). Although, unlike many communicative psychoanalysts, I do not view such information as mostly commenting upon the therapeutic frame.

In summary, I evaluate therapy by reference to changes in the clients’ self-esteem and self-efficacy, and use a range of sources to gather information about this. The extent of this change is of course relative to my skills, but also reflects the client’s abilities, and the nature and source of the problems. Whether therapeutic change is ‘sufficient’, and what denotes sufficiency, is not easily ascertained and is partly dependent upon the expectations of the client. At best, the client will be leading a satisfying life as witnessed by themselves, the therapist and others. As a minimum the client and therapist should feel that, although serious difficulties may still be experienced, the client’s internal resources are operating well enough to bring about continued progress after the therapy has finished.
References


Research Dossier

Introduction

The research dossier contains three thematically connected pieces of research - a literature review conducted in the first year of the Psych.D course; a study using qualitative methods carried out during the second year; and a study employing quantitative methods which was completed in the final year. All three pieces are concerned with psychological therapists’ use of meditative strategies for personal and professional development. Each study has been prepared in accordance with the requirements of a specific academic journal, the title of which is shown in the appendices along with the ‘notes for contributors’.
Meditation may help psychological therapists to practice more effectively: To what extent is this thesis supported by literature?

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Meditation may help psychological therapists to practice more effectively: To what extent is this thesis supported by literature?

Abstract

This study reviews literature concerning any effects that meditation may have upon the psychological health and practise of psychological therapists. A number of anecdotal accounts were explored in order to extract key claims made for meditation. These were found to be that meditation promotes attentive ability, a calm psycho-physiological state, heightened awareness and a reflexive-self (an objective, observant sub-personality). It was suggested that these effects were personally therapeutic, and that this could facilitate therapists’ practice. Of the experimental studies reviewed, most found that meditation had significant positive effects upon various measures of psycho-physiological health. These included increases in measures of self-efficacy, and attentional absorption, and decreases in indicators of anxiety, stress and depression. However, many experimental studies were methodologically flawed. These problems were often related to characteristics of meditation which render it problematic to investigate. For example, it may take at least one year of daily practice to bring about effects, and researchers have found it difficult to complete experiments where randomly assigned participants all stick to such a demanding regimen. Current quantitative research techniques may not be sophisticated enough to allow the effects of meditation to be accurately gauged. It was suggested that qualitative techniques could be more successful in exploring the effects of meditation.
Meditation may help psychological therapists to practice more effectively: To what extent is this thesis supported by literature?

Introduction

The aim of this literature review is the investigation of the potential for meditation to enhance the work of psychological therapists. The author has a long-standing lay-interest in Eastern culture, and briefly studied meditation and Eastern religion/philosophy (in an academic way only) at under-graduate level. He is not affiliated to any religious denomination and does not practice meditation. The questions asked of the literature were:

1) Can meditation improve psychological health, and thereby enhance therapists' efficacy?
2) In what other ways might meditation enrich therapists' practice?

Attention is limited to the personal use of meditation by therapists, as opposed to its use as an adjunct to clinical work. Although it seems likely that what is psychologically beneficial for therapists might often prove healthy for their clients, this is not considered in this review. There is a scarcity of research studies looking directly at the effect of meditation upon therapists. Fritz and Mierzwa (1983), in a similar review, cited only one empirical study with therapists as participants (Orme-Johnson, 1973); and only one further such study was found for inclusion in this review (Brown & Robinson, 1993 - participants were post-graduate counselling students). However, there is a substantial body of anecdotal reports, or research studies relevant to psychological therapists by extension.
Rationale

The notion that the outcome of therapy is directly related to the psychological or emotional health of the therapist carries much intuitive weight, and a number of empirical studies support the idea (Robinson, 1988; Stadler, and Willing, 1988; Mahoney, 1991). It is a fundamental principle of psychological therapy that therapists cannot help a client to attain a level of psychological well-being beyond their own (Kelly, 1996). Therefore, the pursuit of personal psychological fitness can be seen as ethically and professionally important for therapists: "It is essential for a psychotherapist to make ceaseless efforts regarding his own personality growth" (Chung, 1990 p.28).

Meditation is claimed to advance and maintain psychological health in a variety of ways (Ferguson & Gowan, 1975; Delmonte & Kenny, 1987; Greene & Hiebert, 1988; Craven, 1989; Kabat-Zinn, 1992; Shapiro, 1992a) Furthermore, it is said to facilitate insight into clients' functioning (Carrington & Ephron, 1975), and help therapists to prepare (Halbrook, 1995; Kelly, 1996) and practice (Fritz & Mierzwa, 1983; Halbrook, 1995; Kelly, 1996;). Meditation has also been used as a tool to demonstrate intrapsychic and interpsychic processes, (idiosyncratic and generalised) to trainee therapists (Dubin, 1994). These studies are looked at in greater detail later in the review.

Furthermore, meditation and therapy appear to share many common goals. For example, both approaches have been said to aspire to; truthful living (avoiding the deception of self and others); the release of negative emotions; the integration of experience (accepting all sensations, emotions, cognitions); tolerance for that over which we have little or no control; forgiveness directed toward self and other; developing the capacity to give and receive love; heightened awareness and insight; non-judgemental attention; and liberation from social conditioning, and restrictive concepts of self and other (Vaughan, 1989). Investigations into the veracity of these
claims and, from a therapist's perspective, into the therapeutic potential of meditation, would then seem to be legitimate.

**Meditation in history, religion and contemporary practice.**

Referring to carvings from around 2000 BCE, Walsh (1992) described meditation described as "one of humankind's oldest therapies" (p.32). It has roots not only in Eastern religions, Buddhism, Hinduism, Confucianism, and Taoism, but also in Judaism, Islam and Christianity (Keefe, 1977). Thus, meditation can be said to have very substantial foundations, within several cultures, which extend back through millennia.

In the latter half of this century it has rapidly grown as a adjunct to psychotherapy and as a method of self development in its own right (Delmonte, 1986; Delmonte & Kenny 1987). Walsh (1996), perhaps over-enthusiastically, claims that over 1,500 publications have demonstrated psychological, physiological and chemical effects of meditation. PsycLIT searches conducted for this study revealed around 1,500 separate references for books, chapters, and research publications: many of which were meta-studies, and anecdotal reports. Of these, many research studies (and fewer anecdotal reports) reported inconclusive or negative findings on meditation. West (1996) estimates that over 1,000 research studies have been conducted; while Murphy and Donovan (1988) found 1,350 references for meditation studies. It appears that the overwhelming majority of reports on meditation emanate from North America (40 out of the 53 sources used in this review, 75%, were American, and none were British).

Meditation has then generated a huge amount of interest within contemporary culture - and from the broad field of psychotherapy in particular. In the United States, it is being used as a therapeutic tool, within mainstream psychotherapy, on a substantial scale. It would seem however, that this phenomenon has not been repeated in the United Kingdom. While the author is aware of several institutions in
the UK which teach meditative techniques within a religious context (or quasi-religious, such as the Transcendental Meditation (TM) organisation, which is further explored below), he has failed to find any secular or psychotherapeutic organisations which employ the technique. The reasons for this absence are not clear, but there are several possibilities. It may be that the British mental health professionals are less inclined to innovate than their American counterparts; or it may be that American society is more thirsty for spirituality: However, these are purely speculative ideas that would require further investigation to confirm or deny with any confidence.

Definitions of meditation

"Meditation refers to a family of techniques which have in common a conscious attempt to focus attention in a non-analytical way and an attempt not to dwell on discursive ruminating thought."

(Shapiro, 1982, p.268)

Although there are "literally hundreds of techniques which can be listed under the heading of meditation" (Carrington, 1998, p.17), many commentators distinguish between just two principal types; 'concentrative' and 'mindfulness' meditations (Ornstein, 1971; Odajnyk, 1988; Walsh, 1992; Carrington, 1998) A third meditative technique, 'integrated' meditations, are often referred to (Fritz and Mierzwa, 1983; Delmonte & Kenny, 1987), although, as a fusion of the first two techniques it could be said not to be a principal type. Researchers agree that the common factor between these types of meditation is a focusing of attention (Ornstein and Naranjo, 1971; Goleman, 1978). The most commonly used names for meditations are shown overleaf, subsumed under the three aforementioned categories:
CONCENTRATIVE | MINDFULNESS | INTEGRATIVE
---|---|---
Zazen, Soto Zen (J) | Zen Bare Attention (J) | Zen ‘Just sitting’ (J)
Transcendental Meditation (I, S) | Vipassana (I) | Open Focus (S) (Fehmi, 1977)
Mantra (V) | Insight (S) | |
Clinically Standardised Meditation (S) (Carrington, 1975) | Opening up (S) | |
Benson’s Technique (S) (Benson, 1975) | Receptive (S) | |

Origin of technique:
(J) Japanese Buddhist; (I) Indian Religions; (V) Various Religions; (S) Contemporary Secular

Table 1: Meditation types

Concentrative meditations consist of "a focus on a specific object within a field (zoom lens attention (Delmonte & Kenny, 1987, pp. 38-39). The practitioner of concentrative meditation attempts to focus attention solely upon an object, often a stone or one's breathing, gently refocusing their attention upon it whenever distractions arise. It appears that the goal is to develop attentive ability, so that something (anything) may be experienced more fully. In contrast, mindfulness meditation involves "a focus on the whole field (wide angle lens attention)" (Delmonte & Kenny, ibid.). The practitioner attempts to be aware of the totality of their current mental experience - thoughts, emotions, and sensorial inputs. They strive to be objective about their observations, and avoid attempting to control experience order to allow it to flow spontaneously. The object is to expand awareness. As with concentrative meditations, integrated meditations involve focus upon a single object, but attempts are also made to be mindful of distractions, and to identify or interpret them.

Novice meditators usually practice concentrative meditation at first and may progress to mindfulness and integrated meditations when sufficient poise, attentive ability and self-reflexivity have been established. Without these qualities mindfulness meditation may be psychologically overwhelming (Epstein, 1990 - this
is explored further under 'Theoretical counter-indications of meditation's utility' below).

Despite the ease with which meditations may distinguished and defined, investigative reports have frequently failed to do so (Shapiro, 1982; Rao, 1989). This serious and entirely unnecessary flaw is explored in detail later in this review.

Goals of meditation

Leafing through the literature it soon becomes apparent that there are three contexts in which meditation is practised; psycho-physiological self-regulation; psychological development; and spiritual development. Similarly, Shapiro (1994) describes three levels characterised by concerns with; (1) self-regulation; (2) self-exploration; and (3) self-liberation. Examples of issues typical at each level might be hypertension; relationship/communication problems; and existential concerns. Further support for this concept comes from Wilber (1982), who hypothesised an 'Ego' stage (in Jungian terms the goal is - "persona is reunited with the shadow so as to allow...adequate ego strength" p.64), followed by 'Existential/Centauric' (the integration of all aspects of the self to create a 'centred-self'), and 'Supreme Identity' levels (integration of the centred-self with the cosmos leading to an enlightened-self). Both these authors view the stages as on a hierarchical continuum, wherein one must achieve sufficient self-regulation/ego strength before self-exploration/integration can successfully take place, and so on. Meditations should be adapted to suit the particular concerns of these levels (Shapiro, 1994; Keefe, 1977; Delmonte & Kenny, 1987; Craven, 1989; Kelly, 1996). In this way, meditation practice reflects the needs of the practitioner, and its efficacy as a tool to meet these needs is enhanced.

It seems intuitively correct that self-development proceeds along a hierarchical continuum and that therapeutic interventions should be tailored to reflect this. However this raises questions as to the dynamics of the processes involved. For
example how advanced does one need to be at a certain level before moving on to the next; how can such advancement be judged; and what effect does meditation at one level have on the development at the other levels?

Most research studies have investigated concentrative meditations for self-regulation purposes (Shapiro, 1994), though many anecdotal studies (eg: Delmonte & Kenny, 1987; Forte et al, 1987; Odajynk, 1988; Epstein, 1990; Sweet & Johnson, 1990; Delmonte, 1995; Kelly, 1996; Dubin, 1994), and a few empirical studies (Greene, 1988; Emavardhana, 1997) have investigated the self-exploration stage, and a few anecdotal reports cover all three areas (eg: Shapiro 1994; Wilber, 1982; Bogart, 1991; Rao, 1989). Self-liberation phenomena, however, (eg: transcending the ego) are not easily understood within the framework of traditional Western psychological theory (Delmonte & Kenny, 1987; Halbrook, 1995; Bogart, 1991). For this reason, and to prevent the study from becoming unwieldy, the remainder of this review is limited to the fields of self-regulation and self-exploration.
The literature

Anecdotal and empirical studies are investigated with respect to the review questions. The anecdotal literature provides the most comprehensive account of meditation, while the empirical work is so patchy and riddled with methodological difficulties that it constitutes a fairly unsatisfactory source of information.

Anecdotal

The theoretical explanations of meditation lie either within psychotherapeutic or spiritual/transpersonal/religious paradigms. For reasons outlined already, this review is restricted to the former domain. Psychotherapeutic accounts of meditation can be further subdivided into the following:

General psychotherapeutic/trans-modal. (Keefe, 1977; Halbrook, 1995; Shapiro, 1992a; Craven, 1989; Bogart).
Psychodynamic. Including psychoanalytic (Leone); Freudian (Epstein, 1990; Delmonte 1990); Jungian (Odajnyk, 1988); Gestalt (Delmonte, 1990; Halbrook, 1995).

A fuller analysis of these accounts as embedded in their theoretical frameworks would be too lengthy an endeavour to carry out here. Furthermore, many of the apparent differences between the explanations of meditation reflect the distinctive terminology used, rather than fundamentally divergent interpretation. There follows a brief analysis of the main claims recurrent through anecdotal accounts, with an explanation of the potential effects on therapeutic practice (where this is not immediately apparent):
**Increased attentive ability**

Rao (1989) stated that the fundamental mechanism underlying the effects of meditation is an increase in attentive capacity. It is said to enhance the ability to consciously focus on an object for an extended time (Odajynk, 1988; Keefe, 1977). In psychoanalytic terms this has been conceptualised as giving the ego control over which objects become the focus of attention (Odajynk, 1988). Keefe (1977) contends that this facilitates the voluntary shifting of the therapists' attention between clients' verbal and non-verbal communications and their emotional reactions to the client. In other words, it helps the therapist to distinguish between transference and countertransference phenomena, the use of which is "the hallmark of psychoanalysis" (Bateman and Holmes, 1995, p.95). Furthermore, distinguishing between one's feelings and the clients' is seen as an essential part of empathy (Fritz & Mierzwa, 1983), and in turn, "empathy is...a primary tool in analysis" (Clarkson, 1995, p.86).

So, meditation is said to increase attentive ability, and this enhances the therapists' ability to attend to and distinguish between elements of their own, and the clients' experience. This may increase the therapists' control over what is attended to, and their empathic response to the client. The notion, already outlined, that meditation affects mental processes, rather than contents is implied here.

**Generation of a calm state**

Meditation is not a simply relaxation technique, as experiences may be intensely emotional (Walsh 1996), and unpleasant (Shapiro, 1982; Odajynk, 1988; Epstein, 1990; Vigne, 1997). Nevertheless, it is generally said to promote calm, low anxiety, and relaxation (Walsh, 1996, Shapiro, 1982). Several researchers report a lowering of psychological defensiveness; people are more willing to admit problems (to themselves and others) and open themselves to change (Epstein, 1990; Fritz & Mierzwa, 1983; Dubin, 1994). A frequent impression is of a safe holding space, wherein mental contents (cognitive, affective and sensory experience) are treated with equal objectivity, so that ordinarily threatening phenomena may be engaged
with (Walsh 1996; Epstein, 1990; Halbrook, 1995). Kabat-Zinn (1992) states that, "Emphasis is not placed on distinguishing thoughts as positive, negative, or faulty....rather the emphasis is on identifying thoughts as 'just' thoughts and acknowledging the potential inaccuracy and limits of all thoughts not just those that produce anxiety" (p.941). In this way, meditation techniques are said to encourage a kind of dynamic, impartial awareness (Keefe, 1977; Halbrook, 1995; Shapiro, 1992a). Speaking of similar issues but referring to Personal Construct theory, Delmonte (1995) explained that this "non-evaluative, free flowing attention" can lead to a suspension of habitual construing which allows for "the liberation of more emotional construing" (p.230). An additional advantage was suggested by Halbrook (1995): she claimed that experience of this space can be an example to the therapist of how the climate in the session should be - quiet, focused and clear, a state in which thoughts are acknowledged but not allowed to preoccupy one.

So it seems that meditation is claimed to give rise to a psycho-physiologically relaxed state in which ordinarily problematic issues can be experienced with some degree of equanimity.

**Heightened awareness**

The calm, balanced state, along with increased attentive ability (described above), is said to facilitate an expansion of the awareness of mental contents and processes. Unconscious, repressed, material is likely to arise (Odajynk, 1988; Shapiro, 1992; Keefe, 1977; Vigne, 1997; Halbrook, 1995). Boorstein (1996) describes two case studies ('Alice' and 'Harriet') in which meditation appeared to lead to the emergence of important psychodynamic material. Having emerged in consciousness, previously repressed material is available for psychotherapeutic use. At the very least this material can be taken to psychotherapy and processed in the sense of the therapeutic paradigm being practised (Shapiro, 1992a). However, this may not be necessary; many commentators assert that such material can be productively dealt with within the meditation. For example, Delmonte & Kenny (1987) claim that, "partially processed material is brought into consciousness and
worked off" (p.41). Several researchers have attempted to deconstruct this 'working off': Delmonte & Kenny (1987) suggest that covert reality testing of such phenomena may occur, leading to their desensitisation; Vigne (1997) hypothesised that the original traumatic event, re-experienced in a state of deep relaxation, becomes dissociated from the negative underlying emotion; Maupin (1962), and Carrington & Ephron (1975) utilised the concept of catharsis; and Keefe (1977) speaks of social conditioning being revealed, making possible the creation of more adaptive schemas.

The heightened awareness is of "one's own current experience; "imaginative flights away from one's current experience" are discouraged (Patrik, 1994, p.42. Similarly Keefe (1977) speaks of a cultivation of a 'present-centredness', which enables one to distinguish between the immediate (sensory) focus of attention, accompanying thoughts and emotions. Furthermore he claims that such awareness informs one's responses to interpersonal situations. Schuster (1979) linked this effect, increased awareness of the present, to therapists' capacity for empathy, which he views as the moment-to-moment experiential understanding of the client. The notion that heightened self-awareness leads to greater therapeutic efficacy is also conspicuous within Rogerian theory - "if I can be sensitively aware of, and acceptant toward, my own feelings then the likelihood is great that I can form a helping relationship" (Rogers, 1967, p.51).

**Reflexive self**

The elements outlined above give rise to a 'reflexive self' (Keefe, 1977), also called a 'watcher self' (Deatherage, 1975), 'observing-self' (Deikman, 1982), and 'observer-self' (Craven, 1989; Vigne, 1997). Keefe defines it as, "a secure subjectivity that allows full experience without judgement, defence or elaboration" (Keefe, 1977, p.314). In a psychodynamic explanation Chung (1990) wrote that, "the ego....is placed within the sight of one's awareness" (p.28). This development of the capacity for objective self-observation, is "a core and defining feature of all but the most advanced meditative techniques" (Craven, 1989, p.649).
Self-reflexivity is also valued throughout psychotherapeutic theory (Craven, 1989); indeed, the benefits to therapeutic practice wrought by self-reflexivity are so evident and numerous that they need not be fully analysed here. However, Keefe states that the objectivity brought about by the reflexive self helps the therapist to stay unrattled "by the stresses of emotional interaction...high-level empathy becomes more likely...and countertransference responses may be more accessible" (p.324). Similarly Carrington and Ephron (1975) report that meditation brings "greater staying power" across sessions, and "less sense of threat when confronted by...negative transference".

In summary, it seems that meditation, through processes outlined previously, enhances self-reflexivity. This allows therapists to monitor themselves more fully, and discourages premature cognitive commitments, flights of phantasy, and censorship of experiences, in favour of a more systematic and considered approach.

**Other findings**

Dubin (1994), a supervisor who works with “advanced doctoral candidates in psychotherapy supervisory groups” (Dubin, 1994, p.20), has found meditative techniques useful in providing 'raw material' for the teaching of interpersonal and intrapsychic psychodynamics. In particular, he describes how a concentrative meditation upon a stone, can be used as a projective technique to evoke “the students' characteristic defenses” and show how these “interfere with his or her ability to suspend usual preoccupations and enter into open-relatedness”. The students' findings can then be analysed either by themselves, or within psychotherapy.

Kelly (1996), (a psychotherapist, meditator, and lecturer on graduate counseling courses in the USA) has recommended short meditative exercises to prepare, or 'ground', the therapist prior to a session.
Finally, if meditation were to prove to be effective in enhancing therapists' efficacy, it has the further advantage of being a cost-effective strategy (Bogart, 1991).

Expressed very simply, the anecdotal accounts suggest that meditation develops attentive ability, and heightens awareness of self and other. Through these capacities one can learn about the nature of psychological phenomena generally, and in particular 'live' situations. There are intimations within the anecdotal accounts that meditation engenders a greater sense of control, paradoxically through learning to relinquish control where it is not appropriate or possible. There is a 'surrender to the present', which is reminiscent of therapeutic theory recommending 'being with the client' over trying to control outcomes.

Anecdotal counter-indications of meditation's utility

No hypotheses were found directly stating that meditation may be harmful, or just ineffective, as a strategy for enhancing therapist's effectiveness. However a number of reports of adverse effects have been made. Much of this pertains to people with psychopathology; for example there are warnings against the use of meditation with borderline psychotic or psychotic people (Carrington, 1998). The emergence of previously repressed psychodynamic material may give rise to substantial anxiety and without "suitable psychological preparation may induce psychosis like symptoms, suicide and destructive behaviour" (Ikemi, 1978, p.173). Boorstein (1996) describes two instances in which psychosis appeared to have been brought on by meditation ('Olivia', and 'Emily'). Epstein (1990) says that for people who struggle with a sense of identity, meditation may lead to a flooding from the unconscious; or it may provide 'fuel' for obsessive or hypochondriacal personalities. Of course, one hopes that trainee therapists would be psychologically strong enough not to succumb to such dangers; and if they did it would seem to act as a warning that they are not ready to practice. Nevertheless, this information should be a caution against prescribing meditation in clinical work.
Unsettling experiences may arise during mediation. Craven (1989) reports that some common adverse effects of meditation are nausea, dizziness, uncomfortable kinaesthetic sensations and mild dissociation. He goes on to say that these problems can be overcome within a supportive supervisory climate. Meditation may also lead to the production of jerky bodily movements (called kriyas in Sanskrit), which may be disturbing for the meditator (Vigne, 1997). Boorstein's (1996) case study of 'Jane' illustrates this phenomenon in practice. Why kriyas arise is not adequately explained in the reviewed literature, although they are not necessarily inauspicious: Buddhists may regard them as a sign of spiritual advancement (Boorstein, 1996), and their energy may directed toward therapeutic change (Vigne, 1997).

Kornfield (1989) reports some limits of meditation. He claims that in many areas, (such as the resolution of grief, fears, phobias, and early psychological wounds; the development of communication skills; maturation of relationships, sexuality and intimacy; career and work issues) traditional western psychotherapies bring about more effective change more rapidly than meditation. Likewise, Fritz & Mierzwa (1983, p.80), warn that "psychotherapists should not expect immediate effects", because it takes at least one year for the positive effects of meditation to be generalised to "in vivo situations, like a counseling encounter".

A psychoanalytic caution against meditation is that, practised without sufficient prior psychological work, it may lead to the construction of a spiritual-self resting hazardously upon 'faulty foundations' (i.e. psychic conflicts) (Welwood, 1980). It appears that psychological development should be achieved before the 'spiritual path' is taken (Wilber, 1982; Shapiro 1994).

Shapiro (1992c) stresses the need for psychological insight to complement the bare awareness of meditation. Meditation may be conceptualised as a technique or process that is (and should be) practised with a theoretical (psychological-philosophical/religious-spiritual) framework. Keefe (1977) notes that the various cultures that use meditation integrate it within their own context. Holy-men use it to
attain cosmic consciousness (Wilber, 1982); psychoanalysts for "controlled regression in service of the ego, and as a means of allowing repressed material to come forth into the unconscious" (Shapiro, 1994, p.108); humanistic psychotherapists to establish a sense of self-responsibility and inner-directedness; behaviourists for stress management and self-regulation; and cognitivists to reveal social conditioning (Keefe, 1977).

Finally, Kelly (1996) highlights some practical difficulties in practising meditation; some religions (including mainstream Christian factions) are wary of meditation, and thus it may be ill-received by some; others are uncomfortable with the terminology and metaphors that seem to reflect a bygone esoteric philosophy. Craven (1989) writes of the stigma in Western society for activities that appear to consist of indulgent 'sitting around'. West (1996), alluding to the solitary nature of meditation, contends that it can lead to discord with family members and friends who regard meditation as odd, or are actively hostile toward the practice. In common with all methods for psychological development, Deatherage (1975) stresses that the point that meditation will not be successful without 'sufficient motivation'.
The Empirical Evidence

Meta-studies
Studies into the effects of meditation on psychological, physiological and biochemical variables have been extensively reviewed (Delmonte 1990; Rao, 1989; Shapiro 1982; West, 1996; Fritz & Mierzwa, 1983; Walsh, 1992, & 1996). For this reason these overviews will be only briefly reviewed. Moreover, although on first sight the evidence seems to support the hypothesis that meditation could be effective in advancing therapists' efficacy, on closer inspection many of the studies reveal methodological flaws seriously weakening their conclusions.

Psychological Change
Fritz & Mierzwa (1983) produced a table of twenty-seven research studies investigating psychological changes, which they hypothesised would enhance therapists' practice. Twenty-six of these professed to show positive effects in areas such as attentional capacity (Davidson et al, 1976; Bennett & Trinder, 1977); diminished anxiety (Orme-Johnson, 1973; Puryear et al, 1976); increased empathy (Lesh, 1970; Leung, 1973); field-independence (Linden, 1973; Pelletier, 1974; but Reed, 1976, did not find a positive relationship); and self-actualisation (Shapiro, 1975; Russie, 1976). Walsh (1996) cites a number of studies with similar conclusions.

However, as Fritz & Mierzwa (1983) acknowledge, the credibility of many of these studies does not stand up to scrutiny. They fail to differentiate between types of meditations and mostly use cross-sectional designs (only two randomly assigned participants): both these faults are explored below in greater detail.
Physiological Change

Rao (1989), Walsh (1996) and West (1996) refer to several studies exploring the effects of meditation on physiological factors. These include those finding positive results in cardiovascular changes (fall in heart rate and blood pressure - Shapiro & Walsh, 1984; and Murphy and Donovan, 1998, in Walsh, 1996); and possible EEG alterations (Gleuck & Stroebel, 1975; Travis, 1976). However, the results are sometimes contradictory. While Walsh (1996) reports an increase in alpha waves, Travis (1976) found a lack of alpha EEG during meditation. Furthermore the studies cast doubt on the uniqueness of any effects of meditation -Gleuck & Stroebel (1975), Travis (1976), and Pagano (1976) found that there were no significant differences in EEG record between meditation and relaxation controls. It may be that such results reflect the grossness of EEG measures ("comparable to measuring activity in Chicago by placing a dozen microphones around the city"; Walsh, 1996, p.170), rather than the idea that meditation does not have unique effects.

Biochemical Change

Analysis of biochemical studies produces similar conclusions to those of the EEG studies. Wallace (1970) reported that "transcendental meditation produces a major state of consciousness which is ...biochemically unique" (p.63). However, Michaels et al (1976), did not find any significant differences between meditation and a relaxation control on a number of biochemical measures.

The reader may feel that analyses of physiological changes are far removed from questions of therapists' efficacy. Indeed, Walsh expressed precisely this sentiment in his criticism of research for paying "more attention to heart rate than to heart opening" (Walsh, 1996, p.174).
**Individual studies**

At first sight there appears to be an abundance of studies supportive of the idea that meditation may benefit therapeutic practice. Of the twenty-one individual studies examined for this review, seventeen set out to evaluate the effect of meditation on various physiological and psychological measures. Fifteen of these found that meditation had some positive effect on psychological and physiological health, and two were ambiguous. These are summarised in tables 2 and 3 below:
<table>
<thead>
<tr>
<th>Researchers, date; country.</th>
<th>Participants; length of treatment.</th>
<th>Design of study</th>
<th>Summary of results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearl and Carlozzi, 1994; USA</td>
<td>50 university students; eight weeks.</td>
<td>Random assignment to Clinically Standardised Meditation (CSM) or on-treatment control.</td>
<td>Demonstrated diminished anxiety after CSM- but showed no change on measures of empathy.</td>
</tr>
<tr>
<td>Zika, 1987, New Zealand</td>
<td>Unspecified number of university students; 6 weeks;</td>
<td>Random assignment to three treatment (hypnosis; TM; Western mindfulness meditation) and one control conditions.</td>
<td>TM and hypnosis group subjects showed significantly increased measures of self-actualisation over controls and a Western meditation group.</td>
</tr>
<tr>
<td>Langer et al., 1989; USA</td>
<td>73 residents of homes for the elderly; 12 weeks</td>
<td>Randomly assigned to three treatment (mindfulness training; TM; mental relaxation) and one control condition.</td>
<td>TM and mindfulness meditation groups (residents of a home for the elderly) significantly increased on scores of paired associate learning, cognitive flexibility, mental health, blood pressure, behavioural flexibility and ageing.</td>
</tr>
<tr>
<td>Forte et al., 1987; USA</td>
<td>110 people enrolled on meditation programs; 2 day, 2 week, and 3 month treatments.</td>
<td>Survey of mindfulness meditators, no random assignment or control groups.</td>
<td>A survey (statistically insignificant) on mindfulness meditation phenomenology revealed a number of dimensions coherent with anecdotal reports.</td>
</tr>
<tr>
<td>Greene &amp; Hiebert, 1988; Canada</td>
<td>24 university students; 2 weeks</td>
<td>Random assignment to two treatment groups (mindfulness meditation; cognitive self-observation).</td>
<td>Mindfulness meditation and cognitive self-observation groups showed reliable increases in measures of self-actualisation and decreases in measures of stress. (no control group)</td>
</tr>
<tr>
<td>Davidson et al., 1976; USA</td>
<td>58 university students; no treatment.</td>
<td>Survey of four groups (non-meditating; 1 month experience of meditation; 1-24 months experience; more than 2 years experience – All practising various techniques)</td>
<td>Longer term meditators scored significantly higher on measures of attentional absorption and positive affect and were lower on scores of anxiety.</td>
</tr>
<tr>
<td>Shapiro, 1992b; USA</td>
<td>27 long term meditators; 2 week and three month groups</td>
<td>Survey of long-term meditators attending either 2 week or three month vipassana meditation retreats.</td>
<td>Long-term meditators showed significant increases on positive modes of control, satisfaction and self-control after vipassana (mindfulness) meditation retreats.</td>
</tr>
<tr>
<td>Researchers, date; country.</td>
<td>Participants; length of treatment.</td>
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<tr>
<td>Alexander et al., 1993; USA</td>
<td>86 company employees; 3 months</td>
<td>TM treatment group, no treatment control.</td>
<td>Regular TM practitioners improved significantly more than controls on multiple measures of stress and employee development (decreased trait anxiety; job tension; insomnia and fatigue; cigarette and hard liquor use. Improved general health; job satisfaction; work and personal relationships.</td>
</tr>
<tr>
<td>Kabat-Zinn, 1992; USA</td>
<td>22 patients diagnosed with anxiety disorders; 8 weeks</td>
<td>Mindfulness meditation based stress reduction treatment, no control</td>
<td>Participants in a clinical mindfulness-meditation stress reduction program showed significant reductions in measures of depression and anxiety.</td>
</tr>
<tr>
<td>Rani &amp; Rao, 1996; India</td>
<td>39 children; no treatment</td>
<td>20 TM practising children were compared with 19 non-meditating children.</td>
<td>TM practising children were found to have higher attention regulation capacity than a non-meditating control group.</td>
</tr>
<tr>
<td>Brown &amp; Robinson, 1993; USA</td>
<td>103 university students; no treatment.</td>
<td>Four categories of students were compared (Meditating only; exercising only; mediating and exercising; and neither)</td>
<td>Meditating counselling students (various techniques) were found to have significantly higher measures of inner-directedness, and lower measures of anxiety.</td>
</tr>
<tr>
<td>Ferguson, 1992; USA</td>
<td>47 university students; no treatment.</td>
<td>TM practising and on-meditating students compared.</td>
<td>Art students practising TM were found to have higher scores on field-independence than non-meditating controls.</td>
</tr>
<tr>
<td>Beaufchamp-Turner &amp; Levinson, 1992; USA</td>
<td>134 participants (general public); no treatment.</td>
<td>Meditating (various techniques) and non-meditating people compared.</td>
<td>Frequent meditators (various techniques) were found to have significantly lower levels of anxiety, stress, hostility, depression and dysphoria and higher measures of positive affect, than infrequent meditators.</td>
</tr>
<tr>
<td>Jonowiak &amp; Hackman, 1994, USA</td>
<td>62 university students; eight weeks.</td>
<td>Randomly assigned to two treatment groups (mantra mediation; yogic relaxation).</td>
<td>Students practising a mantra (concentrative) meditation showed significant increases on scores on self-actualisation.</td>
</tr>
<tr>
<td>Emavardhana &amp; Tori, 1997, Thailand</td>
<td>504 school students; one week.</td>
<td>Students already enrolled upon vipassana program compared with no treatment control.</td>
<td>Following a vipassana meditation retreat, students showed positive gains in self-concept, and more mature ego defence mechanisms than controls.</td>
</tr>
<tr>
<td>Study</td>
<td>Design</td>
<td>Outcome</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>--------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td>Colby, 1991; USA</td>
<td>65 university students; 2 week.</td>
<td>Concentrative meditators reported the same number of non-sensory events before and after practising, while a control group showed an increase in non-sensory events (after reading, playing games).</td>
<td></td>
</tr>
<tr>
<td>Tloczyński, 1994; USA</td>
<td>10 university students; testing after two week and four week treatment.</td>
<td>Randomly assigned to opening-up and no-treatment group. A randomly assigned mindfulness meditation group showed significant increases on scores on anxiety and family problems above controls.</td>
<td></td>
</tr>
</tbody>
</table>
The most compelling studies were those randomly assigning participants to groups (Langer, 1989; Zika, 1987; Janowiak, 1994; and Pearl, 1994). Zika's (1987) study is interesting in particular for its suggestion that TM may be more similar to hypnosis than to other types of meditation, in terms of its effect on self-actualisation. This would appear to call for more research to be conducted into the differing effects of meditations and the underlying processes.

Langer's (1989) study is well designed, using random assignments to three treatment and one control condition. Attempts were made to equalise expectancy effects by using 'blind' administrators to orient participants in all groups, and pre-treatment tests indicated that there were no differences in expectancies. Standard personality tests (State-Trait Anxiety Inventory; Self-Rating Depression Scale; Internal Locus of Control Scale) were administered immediately before and after the interventions; retrospective self-reports of well-being were also made following treatment; nursing-staff ratings of participants' behaviour were taken 18 months after treatment; and longevity (survival rate) was measured 36 months after treatment. All test administrators and nursing-staff were 'blind'. The treatment period was comparatively long (12 weeks) and the sample size was fairly large (73 participants in eight homes).

Langer's study is illustrative of the kind of high-quality research that meditation should be exposed to. However, it may be that such a project was comparatively easy to carry out in a nursing home: accomplishing similar studies in naturalistic environments might prove problematic. Furthermore, even though the results indicate that meditation significantly improved psychological and physical health (11 out of 12 measures showed significant improvement - including longevity), generalising the findings (i.e. to therapists) is tenuous. The participants - retired elderly residents of a nursing home - represent a distinct group within society whose living conditions, sense of purpose, and physical health are likely to be far removed from the 'norm'. For example, it could be that the cognitive challenge provided by
meditation had a particularly significant effect on a population whose lives were comparatively unchallenging (an earlier study by Langer, 1976, demonstrated that increased personality responsibilities had remarkable effects on longevity amongst elderly residents of a nursing home).

Shapiro (1992b) may have demonstrated an intriguing effect of meditation with especial relevance to therapists' practice. Disillusioned with traditional definitions of locus of control, he hypothesised another dimension to this phenomenon - that of 'letting-go control' -"more of a sense of control may be gained from letting go of active control (acceptance) than from continuing efforts to try to change that over which we have no control" (p.2). He demonstrated that the most experienced meditators in his study scored highest on this measure and that the longer meditation interventions in his study resulted in larger increases in this dimension. This 'letting-go control' is similar to the anecdotal claims that meditation teaches one to merely observe mental contents, in order to allow experience to flow, and an engagement with the present (in turn similar to therapeutic avocations of just 'being with' the client over controlling the session).

The two studies on table 3 are ambiguous for the following reasons: Colby found that, after treatment, the meditation group had higher scores on present-awareness than controls - but analysis showed that this was due to the controls lowering their scores, and meditators scores were in fact stable. Tloczynski (1994) found that mindfulness groups reported an increase in anxiety and family problem scores. The ambiguity lies in the interpretation - either meditation was unhelpful as it increased anxiety and family problems; or perhaps these 'adverse' effects were a result of a deepening of experience. Both explanations are consistent with meditation theory.

Taken together, the results from all these studies, although often consistent with the anecdotal claims attributed to meditation, do little in the way of confirming them. Methodological flaws prevent them from doing so. The studies with sounder methodologies often show that meditation has a significant effect - but no more than
standard relaxation techniques, or hypnosis. Although Langer's study is an exception, the participant group is so particular that generalisations cannot be made.

**Criticisms of the research**

The body of research 'evidence' for meditation has received widespread criticism for a variety of methodological errors, and omissions (Walsh, 1992; West, 1996; Fritz & Mierzwa, 1983; Craven, 1989; Shapiro, 1994; Delmonte & Kenny, 1987; Rao, 1989). There is a lack of common terminology, research tools and treatment conditions. Researchers have failed to agree on theoretical and operational meanings of empathy (Fritz & Mierzwa, 1983). Assessment has rarely been carried out according to standardised criteria (Kabat-Zinn, 1992).

TM is overwhelmingly the most studied technique (Fritz & Mierzwa, 1983); although this may reflect the popularity of the practice, it also creates certain problems. As is established below, it appears that different meditative techniques have different effects: this diversity should be reflected in the research. Much of the TM studies set out to evaluate the effects of TM, and the development of theory and practice is neglected (West, 1996). Indeed, a cynic might say that many such studies are part of the marketing strategy of the TM organisation; two of the experimental studies reviewed here (Alexander et al, 1993; Ferguson, 1992) were conducted at the Maharishi International University, a part of the TM organisation. The TM technique may also maximise the expectancy effect as beginning practitioners within the TM organisation are exposed to publicity material informing of 'scientifically backed' claims; are asked to pay for services rendered; participate in group discussion about the effects of TM; and take part in what West (1996) describes as a "religious ceremony" (p.249). Furthermore, citing Rogers, and West (1980), West (1996) reports that people attracted to TM are more anxious and neurotic than the general population and are therefore more likely to exhibit larger changes on such measures (a study by Fenwick et al. 1977, cited in Shapiro, 1982,
found that subjects who were tense pre-meditation showed greater relaxation gains than those who were comparatively relaxed to begin with).

There has been a tendency to assume that various meditations are similar in their effects. Only two of the studies reviewed here compared different meditations with one another (Zika 1987; Langer et al, 1989); and there significant differences were found between the methods' effect on self-actualisation measures. Several compared meditation with relaxation exercises (Langer et al, 1989; Colby, 1991; Janowiak, 1994; Tloczynski, 1994) and one compared mindfulness meditation with a 'cognitive observation exercise' based on Ellis’ Rational Emotive Therapy (Greene, 1988). There may be little difference in effect between types: Delmonte & Kenny (1987) found one study that compared mindfulness meditation with concentrative meditation, finding them to have an equal effect in reducing anxiety (Fling et al, 1981). However, Fritz & Mierzwa (1983) cite two studies that suggest differential effects (Goleman, 1976, on cortical specificity; Brown, 1977, on EEG records). Considering also the scarcity of comparative research, it would seem a viable area for future research.

Similarly the research has tended to treat meditators as being a homogeneous group (West, 1996). This has led to the overlooking of contextual variables, which, it has been suggested, affect outcome (Shapiro, 1994; Bogart, 1991). There is some evidence that age (Delmonte, 1986), self-perception (Delmonte, 1986) and duration of practice (Shapiro 1992a, 1992b) influence the experience and outcome of meditation. For example, Shapiro (1992a) found that longer-term meditators were more likely to practise within a religious context and that length of practise was associated with movement up the aforementioned continuum of concerns with; self-regulation; self-exploration; self-liberation. Delmonte (1986) found that expectations of positive outcome, and favourable ratings of present-self in prospective meditators were positively correlated with ratings of beneficial effects after meditation.
Much research has failed to take account of self-selection processes. The random assignment of participants in meditation research is rare; 2/27 (7%) of the studies reviewed by Fritz & Mierzwa (1983), and 5/17 (29%) of the studies surveyed above, used random assignment. Without randomised selection of participants, control and experimental groups cannot be said to be initially equivalent and so results are severely compromised. There is good reason to believe that this is especially so with meditation: citing a number of studies, (Williams et al, 1976; Peters, 1977; Lazar, 1978; Gallanter and Buckley, 1978; Delmonte, 1980; Carrington et al., 1980) Delmonte & Kenny (1987) argue that prospective meditators are more anxious and neurotic and report a greater number of problems in general.

Moreover, researchers frequently do not acknowledge the weaknesses in the methodologies used. The study by Beauchamp-Tumer & Levinson (1992) is typical - they found a positive correlation between the frequency of meditation and measures of health, low-stress and positive affect (taken at one time only). From this they infer that "positive affect and sensation seeking were reliably increased in frequent meditators" (p.129), when in fact no such increase has been demonstrated - the higher ratings might easily be explained by self-selection processes. Similarly, Ferguson (1992) compared meditating students at the Maharishi International University (where meditation is incorporated into the standard curriculum) with non-meditating students at Iowa University and, finding the former to be more field independent, concluded that "it seems likely that [TM enhances field independence]" (p.1174). Causal relationships cannot be deduced from correlations, and it seems particularly spurious to do so with such potentially disparate participant groups.

Even when participants have been randomly assigned (Zika, 1987; Greene, 1988; Langer, 1989; Janowiak, 1994; Pearl and Carlozzi, 1994; Tloczynski, 1994;) there is no guarantee that the control and experimental groups are equivalent. A study by Otis (1973) found that randomly assigning participants did not have the desired
effect of equalising groups as both groups had higher expectations of meditation than of the control condition.

It comes as little surprise that commentators have observed that, "ninety-seven percent of meditation research is not worth the paper it is written on" (Smith, quoted in Rao, 1989, p.53). West (1996) concludes that from over 1,000 published research articles, the only unequivocal findings on meditation are (1) During meditation the body becomes quieter (2) regular meditation reduces anxiety (though this effect may be similar to relaxation); (3) Meditation is as effective as self-hypnosis in the treatment of problems such as insomnia and anxiety. Pagano & Warrenburg (1983 - cited in Rao, 1989) express similar sentiments in describing the failure of research to substantiate the claims that have been made in the name of meditation.

This expectancy effect problem draws us into a second arena of difficulties concerning meditation research that has less to do with methodological failings than with the complications inherent in studying meditation. Meditation is a long-term strategy; often practised across decades, it may take at least a year for the benefits to apply to life outside of the meditation sessions (Stroebel, 1978). Most research has, however, investigated people who have only been meditating in the short-term (Shapiro, 1982; Zika, 1987; Shapiro 1992a; West, 1996), and so may not have allowed enough time for substantial effects to be made manifest.

Furthermore, one cannot expect randomly assigned (or even all self-selected) volunteer participants to adhere to lengthy (a year or more) regimes. Participant dropout rates would be high, and every time a participant leaves a study, the bias of self-selection effects becomes more probable. Even if one successfully conducted a randomised trial across an extended period of time there would be another major methodological problem to counter: meditation is usually practised within a psychotherapeutic or religious framework (Shapiro, 1992a) - the effects that the beliefs, teachings and experience of the contextual background bring about cannot
be easily separated from those of meditation. This is especially problematic given the argument that meditation is a tool to actualise a philosophy (in the loosest sense of the word), which is redundant when abstracted from a context. Finally, long-term meditators are likely to have practised "a rich mixture of methods" (West, 1996, p.254); explicating the differential effects of these practices presents a further complication.

Problems such as these have led investigators to conclude that meditation research has revealed more about the limits of research methodology than the limits of meditation (West, 1996; Rao, 1989). Certainly it seems that practitioners of meditation are rarely in doubt as to its unique benefits ("in my opinion, unquestionable", Rao, 1989, p.16). Under the adage 'there's no smoke without fire' it is hard to believe that a technique that has been practised for 4,000 years, has inspired around 1,000 psycho-physiological research publications since the late 1960's, and continues to appeal to the general public and psychological professionals alike, has little more than a placebo effect.
Directions for future research

Considering the intentions of this review, the greatest challenge for future research is to make up for the dearth of studies into the direct effects of meditation upon therapists' psychological health and efficacy. Most research has investigated meditation as a self-regulation strategy; if it is to be more relevant to therapists, more research into the effects of meditation as a tool for self-exploration needs to be conducted.

The research evidence to date has not supported (or contested for that matter) the anecdotal claims for its potential in enhancing psychotherapeutic practice. Therefore these claims still need to be addressed through research: (1) Does meditation help to prepare therapists for, and sustain practice? (2) Can meditation help therapists to stay present-centred? (3) Does meditation improve the ability to distinguish between internal psychic phenomena (eg between countertransference and transference). (4) Can meditation be usefully employed as a method for teaching trainees about intrapsychic or inter-psychic processes? (5) Does meditation help to improve or maintain therapists' psychological health?

Given the prolonged nature of meditation, it would seem reasonable to assess its long-term effects. Short-term studies cannot do justice to the importance ascribed to meditation within many cultures, and individuals' lives. The need for sound methodology would mean such studies would be time-consuming and require considerable dedication. However, without more, high-quality, research, the many anecdotal benefits will remain unproven. Some methodological issues that require attention are; the use of random-assignment of participants; measurement of expectancies pre-treatment; use of standardised meditation techniques, terminology and assessments; and greater acknowledgement of the limitations imposed by methodological flaws.

Similarly, comparatively little research has been conducted with advanced practitioners (Walsh, 1996; Shapiro, 1992a). This gap in the research body requires
filling. Qualitative, phenomenological methods of inquiry may be a better method of capturing this esoteric practice. These may be revealing in their own right, and could also be useful in informing future research (West, 1996).

More research needs to be conducted into the differential effects of meditations. In particular, variance between the mindfulness and concentrative forms require study; and more energy should be directed outside of the TM technique. This would produce greater specificity in the description of effects, perhaps allowing for the prescription of certain meditation techniques for certain goals. A connected issue here concerns the effect of individual or group goals in meditation: what role do one's own goals for, and beliefs about, meditation play in its effects; and what effect do the aims and teachings of the meditations' philosophical context have?

Finally, given the central role of attentive processes within descriptions of meditations, the lack of research studies investigating these effects is a serious omission (Rao, 1989).

**Conclusion**

The prevalence of meditation as a technique for self-development through time and across continents is impressive. It has been, and still is, held in high esteem by a large number of people, experts or laymen, religious or secular, ancient or modern. Anecdotal reports praising its potential for physical, psychological and spiritual health abound. However, empirical research, despite over a thousand studies, and to which all psychological interventions should be accountable, has failed to prove the various declarations. On the other hand it has not refuted them either; at present, meditation may be better understood by studying personal experiences rather than research studies.

Partly because of a lack of methodological rigour and partly due to the difficulties inherent in investigating the phenomenon, we are little closer to understanding the
processes and effects of meditation than when the research first began in the 1960s. However, guided by the increasing sophistication of psychological research and the learning from past failures, more conclusive, powerful research may yet be undertaken.
References


experimental study with the elderly. *Journal of Personality and Social Psychology* 57, 950-964.


*Perceptual and Motor Skills, 44*, 690-714.


Appendix 1 – Notes for contributors,
Counselling Psychology Review

The study has been written in-line with the following requirements:

Notes for Contributors
Submissions
The Editorial Board of Counselling Psychology Review invites contributions on any aspects of counselling psychology. Papers concerned with professional issues, the training of counselling psychologists and the application and practice of counselling psychology are particularly welcome. The Editorial Board would also like to encourage the submission of letters and news of forthcoming events.

Academic and Practitioner submissions
Manuscripts should be typewritten, double spaced with 1" margins on one side of A4 paper. Each manuscript should include a word count at the end of each page and overall. Sheets should be numbered. On a separate sheet include author’s name, any relevant qualifications, address, telephone number, current professional activity and a statement that the article is not under consideration elsewhere and has only been submitted to Counselling Psychology Review. As academic and practitioner articles are refereed, the rest of the manuscript should be free of information identifying the author. Authors should follow The Society Guidelines for the Use of Non-Sexist Language contained in the booklet Code of Conduct, Ethical Principles and Guidelines. Four copies of the manuscript should be submitted with a large s.a.e. A copy should be retained by the author.

Bibliographic references in the text should quote the author’s name and the date of publication thus: Davidson (1999).

All references should be listed at the end of the text and should be double spaced in APA style. A guide to the presentation of references using the APA style is given in The British Psychological Society Style Guide, available at £3.50 per copy from The British Psychological Society, St Andrews House, 48 Princess Road, East, Leicester LE1 7DR, UK.
Low-quality artwork will not be used. Graphs, diagrams, etc., should be supplied in camera-ready form. Each should have a title. Written permission should be obtained by the author for the reproduction of tables, diagrams, etc., taken from other sources.

**Academic submissions only**

All academic submissions must include an abstract. The abstract should be no longer than 250 words (depending on the length of the paper). It needs to be double spaced, on a separate sheet and headed ‘Abstract’. The British Psychological Society’s Style Guide provides the following information on writing abstracts:

The purpose of the abstract is to allow the reader to assess the content of the article prior to reading the full text. In addition to appearing immediately below the author’s name, the abstract will be used for indexing and information retrieval by such services as Psychological Abstracts. It should, therefore, be written so that it can be understood independently of the body of the paper (p.6).

Proofs of academic and practitioner articles are sent to authors for the correction of typesetting errors only. The Editor needs the prompt return of proofs.

Contributors should enclose a 3.5" disk (either DOS or Mac format) with the document saved both in its original word-processing format and as an ASCII file. All diagrams and other illustrations should be saved in their original format and as a TIFF or an EPS.

**Other submissions**

Book reviews, letters, details about courses and notices of forthcoming events are not refereed but evaluated by the Editor.

However, book reviews should conform to the general guidelines for academic articles. Contributors should enclose two hard copies.

Deadlines for notices of forthcoming events, letters and advertisements are listed below:

All submissions should be sent to: Counselling Psychology Review, The Editor, Centre for Stress Management, 156 Westcombe Hill, Blackheath, London SE3 7DH.
Research Dossier, Study 2

An investigation into the perceived effects of meditation upon the psychological health, and practice of psychotherapeutic professionals.

Dominic Addison, MA
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Guildford

This article is not under consideration elsewhere and has only been submitted to the Counselling Psychology Review.
An investigation into the perceived effects of meditation upon the psychological health, and practice of psychotherapeutic professionals

Abstract

This study investigates the perceived effects of meditation upon the personal well-being and the professional practice of psychological therapists. Eight therapists were interviewed about their practice of meditation and the data analysed using a grounded theory approach. A variety of effects are described, as are related contextual factors. A model is outlined explaining the interactions between meditative practice, the perceived effects and the contextual factors.
1. Introduction

This research explores the perceived effects of ‘concentrative’ and ‘awareness’ meditation (these terms are explored in section 1.2) upon the personal well-being and the practice of psychological therapists. Therapists were interviewed about their meditation practice, and their accounts analysed using a grounded theory technique (Glaser & Strauss, 1967; Pidgeon et al, 1991). The research follows on directly from a literature review, which is summarised below (Addison, 1999). Three principal categories emerged describing and explaining the participants’ accounts. These are (1) contextual factors; (2) the effects of meditation; (3) processes – links among the effects, and links between the effects and the meditative process.

1.1 Research Aims and rationale

The principal aim is to describe and explore psychological therapists’ perceptions of how meditation has affected them personally and professionally. Specifically, the research questions are:

- What effects do therapists perceive their meditation practice has had?
- Are these effects experienced as enhancing or harming their personal well-being and psychotherapeutic practice?
- In what ways do the various effects seem to interrelate?
- How might they have emerged from the meditation practice?

Meditation is becoming increasingly common as a technique for psychological development (Delmonte & Kenny 1987; Walsh, 1996). Meditators, many of them therapists, testify to a wide range of therapeutic effects, which may also benefit
psychotherapeutic practice (Carrington & Ephron, 1975; Delmonte & Kenny 1987; Halbrook, 1995; Kelly, 1996). However, very little research has specifically investigated the effects that meditation has had upon therapists. There is broad agreement that general research into meditation has failed to confirm or deny its alleged psychological benefits (West, 1996; Rao, 1989). Moreover, there has been a lack of theoretical explanations accounting for its alleged effects (West, 1996).

1.2 Definitions

Concentrative and awareness meditations are “a conscious attempt to focus attention in a non-analytical way, and an attempt not to dwell on discursive ruminating thought” (Shapiro, 1982: 268). They usually last for between 10 minutes and an hour and are practised several times daily or weekly. In concentrative meditation one attempts to restrict awareness solely to a single object or process (such as one’s breathing; or a stone; or a chant). Awareness meditation is aimed at expanding awareness of experiential phenomena – thoughts, beliefs, sensations, feelings etc. This is done by noting these phenomena, perhaps labelling them – for example, ‘worry about X’, or ‘lusting for food’ – whilst trying not to become caught up with them. Some practices involve concentrative and awareness elements. For example in vipassana meditation, the meditator attempts sustained focus upon his breath while distractions are noted, but not dwelt upon, before attention is returned to the object.

Historically, these practices have been referred to as ‘Eastern’ meditations; as opposed to ‘Western’ meditation which involves analysing some topic through sustained ruminatory thought. However, this terminology is misleading. Schopen (1992) claimed that Western Christians from the 5th, 18th and 19th centuries AD used techniques comparable to those usually associated with the East. Furthermore, in recent years the use of ‘Eastern’ meditations in the West has greatly expanded, and several adaptations of ‘Eastern’ meditation have now been developed in the West (Carrington, 1998).
The current study was developed from the findings of a literature conducted by the author, a summary of which follows:

1.3 Summary of the Review (Addison, 1999)
This paper reviewed literature relevant to the notion that ‘concentrative’, and ‘awareness’, meditations could affect therapist’s psychological health, and practice.

Firstly, a number of anecdotal accounts were explored in order to extract key claims made for meditation. These were found to be that meditation promotes attentive ability, a calm psycho-physiological state, heightened awareness and a reflexive-self (an objective, observant sub-personality). It was suggested that these effects were personally therapeutic, and that this could facilitate therapists’ practice. Moreover some emphasised that meditation could be professionally useful to therapists by developing their understanding of defence mechanisms and projective phenomena (Carrington & Ephron, 1975; Dubin, 1994); and by helping them prepare for sessions (Halbrook, 1995; Kelly, 1996).

The empirical research evidence reviewed was ambiguous. Many of the studies reviewed (all experimental) found that meditation had significant positive effects upon various measures of psycho-physiological health. Others found no such effects. Much of the research reviewed was methodologically flawed, but it also became clear that researching meditation poses many problems:

1.4 Problems in previous research
There have been several explanations for the failure of research to satisfactorily explore meditation:
1) The research techniques used may not be sensitive enough to measure the effects. Walsh found that EEG measurements used to evaluate the effects of meditation were "comparable to measuring activity in Chicago by 12 microphones around the city" (Walsh, 1996:170). Shapiro (1992) similarly described the inadequacy of research tools in measuring the effects of meditation.

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2) Although meditation has been said to bring about changes at a sophisticated level - for example, profound shifts in personal philosophy - the scope of researchers' interest has been limited - “more attention has been given to heart-rate, rather than heart opening” (Walsh, 1996:174).

3) There has been an over-reliance on individuals' anecdotal accounts (Fritz & Mierzwa, 1983).

4) Most research has focused on short-term meditators, while meditation is said to require long periods of practice before major effects are realised (West, 1996).

5) As it may take many months for meditative effects to emerge, experimental studies must be conducted over long periods of time. Therefore, it has been very hard to avoid self-selection bias as randomly-assigned volunteers often drop out of lengthy studies.

6) There has been an over-emphasis on Transcendental Meditation (TM). This is problematic because it is only one of many techniques practised, and because there are many confounding variables associated with TM (West, 1996).

7) Little attention has been paid to the effect of meditation upon therapists (Fritz & Mierzwa, 1983).

8) Contextual factors have been overlooked, including: (a) the philosophical background in which the meditation is practised, e.g. Buddhist, secular/psychological (Shapiro, 1994), (b) the idiosyncratic aims of meditation (West, 1996); (c) and the length of practice (Shapiro, 1992).

9) Various types of meditation have been bunched together and treated as if they were identical (Delmonte & Kenny, 1987).

In general, there seems to be a tension between the anecdotal accounts which allow the alleged effects of meditation to be recognised, but not empirically verified, and the research work which carries authority of empiricism, but may have been too crude to measure the effects of meditation. West (1996) has suggested that qualitative approaches, as a compromise between these positions, may prove fruitful.
2.0 Method

2.1 Addressing the problems in previous research

In conducting this research, systematic attempts were made to avoid the problems above:

*Problems 1-3:* It was anticipated that the grounded theory approach could be more receptive to the subtle and wide-ranging effects that have been associated with meditation, than many of the methods used in previous studies. Earlier research often used quantitative data from structured questionnaires, based on a priori categories. Here, by using open-ended, semi-structured interviews, the participants were given the opportunity to ‘tell their own story’, rather than being limited by questions reflecting the researchers’ preconceptions. At the same time, in subjecting the data to a grounded theory analysis, it is hoped that the findings carry some empirical weight – a factor often lacking in the anecdotal reports reviewed in the author’s previous review.

*4:* Only participants who had practised meditation for at least one year were sought for interview - Fritz & Mierzwa, (1983) stated that the generalisation of benefits from practice to everyday life may take at least a year (thus problem (4) has been addressed).

*5:* Self-selection bias problems clearly could not be ruled out of this study. However, in writing up the findings this problem was acknowledged by tempering claims as to the generalisibility of the findings.

*6:* Care was taken to avoid interviewing adherents of the TM movement.

*7:* Clearly this research directly addresses this problem.
The participants were asked about their original aims in starting meditation, what type(s) of meditation they had practised and for how long, their model of psychotherapeutic practice, and any affiliation with belief systems (such as Buddhism, Christianity). Their answers were taken into account in the analysis.

Initially it had been hoped to find therapists who had practised only one method of meditation (concentrative). However, during the recruitment stage it soon became clear that this was not realistic; most of the applicants had practised a mix of concentrative, awareness, and integrated meditations. Nevertheless, at the interview and analysis stages care was taken to ascertain, if possible, which type of meditation was being referred to.

2.2 Recruitment

Posters describing the research project (appendix 1), and the participants needed, were sent to over fifty therapy training schools and meditation centres. Most participants were recruited in this way, approaching the researcher themselves. Personal contacts were also pursued and although none volunteered for interview, several were able to recommend colleagues who did. Potential participants communicated with the researcher by telephone, or via e-mail, to explore the nature and conditions of the research. If they met the inclusion criteria (appendix 2), and were interested in continuing they were sent an Information Sheet (appendix 3), and an interview was arranged at a time and location convenient for the participant. Where no convenient time and place could be arranged (on two occasions), the interview took place by telephone. All interviews were recorded on audiotape. Before interview, participants signed a consent form (appendix 4), and filled out a demographics form and preliminary questionnaire (appendix 5). In the case of the telephone interviews these forms were sent beforehand by post. The interview followed a semi-structured schedule (appendix 6)
2.3 Participants

The number of participants required was not decided beforehand – grounded theory procedures suggest that sufficient participants have been interviewed when the analysis of the data yielded reaches saturation (see below). After the analysis of the sixth interview very little new material was yielded, indicating that saturation was near. In total, eight participants were interviewed. Information on their therapeutic and meditation practice and demographics is shown in table 1 below:

Table 1: Information on participants

| Professional status | 4 BAC accredited Counsellors (2 dual BAC, UKCP accreditation)  
5 UKCP accredited psychotherapists  
1 BPS Chartered Clinical Psychologist. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic models practised</td>
<td>Buddhist; Cognitive-behavioural; Transpersonal; Integrative; Psychodynamic; Psychosynthesis; Transactional analysis.</td>
</tr>
<tr>
<td>Length of therapeutic practice – years</td>
<td>5, 6, 8, 12, 13, 17, 20, 35</td>
</tr>
<tr>
<td>Meditations practised</td>
<td>A range of practices with concentrative and awareness functions: Mantra, Vipassana, Tantric visualisation, Autogenic therapy. Contemplative meditation.</td>
</tr>
<tr>
<td>Length of meditation practice; years</td>
<td>3, 3, 4, 6, 10,14, 20, 30.</td>
</tr>
<tr>
<td>Frequency of practice</td>
<td>2-3 times daily for 10-30 minutes, 4 times weekly for 25 minutes, 30 minutes daily, twice daily for 30 minutes, 1-3 times daily for 30 minutes, twice daily for 40 minutes, 4 times weekly for 60 minutes,</td>
</tr>
</tbody>
</table>
| Demographics | Ages (years): 43, 45, 45, 50, 50, 53, 61, 59.  
Gender: Four female, four male.  
Ethnic groups: All were White North Europeans |
2.4 Grounded Theory – Theoretical considerations

Grounded theory was devised by Glaser and Strauss (1967) with the aim of allowing “theoretical statements to be clearly grounded in experiential data” (McLeod 1996: 71). Grounded theory has been applied from a variety of epistemological positions between the constructivist and realist paradigms. The particular approach taken in this research is constructivist and based upon methods outlined by Pidgeon (1991). This is a ‘bottom-up’ strategy where the researcher seeks to discover the significant aspects of some domain through analysing experts’ testimony. Essentially grounded theory is seen as a modelling exercise where the researcher takes responsibility for perceiving and creating structure in the data. To minimise researcher bias, the researcher would ideally approach the area as a ‘tabula rasa’; however, Pidgeon notes that the researcher will always have some previous knowledge. In this study the researcher clearly had significant prior knowledge of meditation. However, he had not practised meditation, and refrained from reading theory (including re-reading the review) in the months before and during the research. Only after the analysis stage had been completed was existing theory revisited. Care was also taken to avoid researcher prejudice in the applied method (see 2.5).

As grounded theory “is an art that relies on intuition and creativity that must be learned through apprenticeship rather than acquired by following a book” (McLeod, 1996), and the researcher was a novice in the use of grounded theory, he enlisted the supervision of psychologists with relevant expertise.

An outline of the grounded theory method (Pidgeon, 1991) used here follows:

2.5 Analysis – applied technique

Data Collection: Care was taken to develop a rapport with the participants, to make help them feel confident both in the research (e.g. by explaining confidentiality, and purpose) and socially with the interviewer. The participants were invited to ask questions at any stage, should they wish. The interview schedule (appendix 4) was constructed so as to avoid leading questions, and was structured in a systematic way.
Thus it started with reasons for beginning meditation, going on to the effects upon personal, then professional lives and finishing with views upon therapist use of meditation. The interviewer frequently reflected the participants’ accounts in the interview in order to check his understanding of them. The interview was semi-structured so as to allow the participants’ more freedom to ‘tell their story’ in their own way. In asking questions, the interviewer was careful to acknowledge any partial answers that might have been given previously. At the end of each topic participants were asked if there was anything else they would like to add before moving on. Also, at the end of the interview they were asked if there was anything else they had thought of subsequently, or felt they had not been asked about. The interviews varied from 40 to 90 minutes and were recorded on audiotape and then transcribed using pseudonyms to protect confidentiality. Each paragraph was individually numbered to allow for quick referencing.

Data Analysis; ‘Coding’: After a few interviews had been transcribed, an interview that was felt to be particularly rich was selected for the first analysis (appendix 5). Reading through the transcription in a measured, methodical fashion, labels were allotted to every new concept arising from the data. A description of the concept was written on a card with a reference to the paragraph from which it arose. The card was then filed according to conceptualised categories. For example, card 1.1 describes the first concept, ‘began meditation to cope with personal difficulties’, and was placed under the first category, ‘Reasons for starting meditation’. By the end of the analysis seven examples of ‘began meditation to cope’ had been collected from four participants, and eleven concepts had emerged under the category, ‘Reasons for starting meditation’. The intention was not to count all the incidents of a particular idea but to capture a range of its qualities.

Data Analysis: ‘Core analysis’: The indexing system was highly fluid throughout the analysis stage in order to facilitate adaptations to the data which were more grounded and coherent. Whenever it was felt that existing concepts or categories did not reflect the data as well as they might, they were redefined, divided or
combined accordingly. These on-going adaptations helped the analysis to become ever more grounded in the data. Clearly this involved judgement of the text – influenced by the goals of the research, the ways in which the participants expressed themselves and on the perceptions of the researcher. Throughout the analysis notes were made when any ideas arose as to the possible ways in which categories or concepts could be linked, redefined, or created. As this procedure continued the indexing system became ‘saturated’ (Glaser and Strauss, 1967), meaning that further data analysis was not producing significant adaptations or additions. The data thus eventually settled into a smaller set of stable core categories capturing the meaning of the material. These were then used to generate theory describing and explaining the participants’ accounts of meditation.
3.0 Results

Three principal categories emerged from the data: 1) Contextual Factors, 2) Effects, and 3) Processes. These categories cover factors mediating the perceived effects of meditation, descriptions of these effects, and understanding the effects, respectively.

Participants are frequently quoted throughout the results section to illustrate the fit between the findings and the data. Each participant has been given a pseudonym. The speaker of any particular quote is usually named so that the accounts are more personable, and to demonstrate the range of participants cited. Material presented in square brackets, [ ], was not spoken by the participant but has been added for ease of reading. A line of dots, ......, indicated where some words have been removed, again for ease of reading.

3.1. Contextualising Meditation

3.1.1 Commitment to meditation

Statements indicating confidence in the benefits of meditation were often made, as were those indicating some scepticism. However the words of Amanda: “I certainly wouldn’t stop doing it” appear to apply to all the participants. Jerry’s doubts seemed to have become less serious over time and he found they had a ‘Socratic’ function: “my cynicism....is still there, and in some ways not a bad thing as it keeps me on my toes about things... so I wouldn’t want to loose it altogether, and it is less intrusive in the sense that I don’t feel so undermined by it”. The participants’ lengthy involvement with meditation could be interpreted two ways. One could argue that as they have invested so much time meditating, they now have a vested interest in exaggerating effects so as to feel that they have not wasted time. However, it also seems likely that they would not have invested such a lot of time in the practice if it had been ineffective.
3.1.2 The relationship between meditation and professional/personal life.

Some participants strongly expressed a synergy between meditation and life in general. Hugh described his practice as “a preparation for the work of the day and the work of the day is a preparation for the contemplation......they form a fantastic whole... it’s like breathing in and breathing out, they go hand in glove”. Mat felt that the “real benefit” from his group and individual therapy came from subsequent reflection upon those experiences while meditating. Others stressed a blurred distinction between their practice and the rest their life – “meditation is something that doesn’t just take place when you are sitting...the more dynamic awareness through [meditative practice] has passed through into being interested in mindfulness in everyday life”. The role of meditation may be seen as enhancing a meditative approach to life in general, for example Fran said that meditation “is a training in sitting with things...which then spills over into the rest of my life”. The nature of a ‘meditative approach’ and some processes in which practice enhances this are explored later.

3.1.3 Meditation as experiential

It seems hardly surprising that participants’ accounts indicated the experiential nature of meditation. Some referred to this explicitly – “it’s more something that you live with than talk about” (Hugh). This view of meditation as primarily experiential is consistent with the difficulties many had in describing the effects of meditation – “it’s very difficult to talk about” (Amanda), “the language isn’t easy for me” (Mary). Fran combined these two aspects -“it’s a very experiential thing ....I don’t know if I can trace what happened in the process”. An advantage of the experiential nature of meditation may be that it simplifies the process of therapeutic change; Mat felt that meditation “makes life so much simpler” and Mary noted that she had found it useful that “there is so little input into... meditation”. This was in contrast to ‘Western’ meditations which were “very different” in that they needed a “lot of preparation... reading and chewing over texts”.

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3.1.4 Paradigms

There seem to be three paradigms within which meditation may be practised. These are:

1) **Psycho-physiological relaxation**: take for example Fran’s words “a lot of people use meditation without a spiritual dimension to it – it is almost seen as a method of relaxation or whatever”

2) **Psychological development**: participants frequently talked about ways in which they felt that meditation had been helped them toward psychological development. Many of these are described in section 3.2.

3) **Spiritual or transpersonal development**: for example, Kate described feeling a “a sense of connection with….something other”. There were mixed feelings as to whether these esoteric feelings arose from transpersonal or personal matter. Although Amanda had occasionally felt a “calling in on this figure”, she thought that “it’s all in our own mind really – I think that it is accessing a more creative way of thinking”. Jerry felt that both personal and transpersonal phenomena had arisen and that they were related; “there is a deeper part in me that links to something transpersonal”.

In general, participants clearly appeared to be most interested in the second and third categories, and some saw meditative practice limited to the first paradigm as reductive. Fran stated, “I think that there can be a secularisation which is devaluing, I don’t want to teach meditation as another way of coping with stress, unless I am doing in a context where I am also looking at other aspects of peoples’ lives and bringing a spiritual dimension to it”.

3.1.5 Stability of the effects

Some participants felt that the effects were on some level permanent - as Kate noted, “[they are] now part of me” - another level they fluctuated. This fluctuation was sensitive to “the immediacy of the meditation” and to factors such as general stress
levels. Thus the genesis of the effects was “not necessarily a linear process”, but in time they could be experienced as more stable background qualities.

3.1.6 Personality influences

Many of the effects seemed to be of particular relevance to individual characteristics. For example, Jerry found that meditation had helped him to overcome shyness (see below); Kate said that it had helped her to become more embodied, where she had had a tendency to dissociate from her body (see below); and Amanda found that meditation was “a good antidote, if you have a tendency to be quite hard on yourself”.

3.1.7 The interaction with belief systems and other practices

Belief systems: In some ways meditation seemed to be quite distinct from religious beliefs. Two participants with strong Christian backgrounds gave descriptions of the techniques, effects and processes of meditation which were very similar to the non-religious interviewees. For some meditation was just part of a greater way of life. Amanda practised meditation as “part of the package” of Buddhism. Similarly, Fran viewed meditation as one way of developing a “mindful” approach to life. Jerry indicated that he had found a “model of health and natural processes….. that are related to meditation” particularly useful.

Other practices: For many, the effects of meditation could not be clearly delineated from those arising from other practices such as personal and group therapy, supervision and general maturation. Rob felt that various factors had “played their part”; similarly Jerry felt benefits had resulted from “a combination of my own therapy and meditation”. Mat, felt that meditation and therapy were very similar in their effects, but that meditation was unique in that it offered the opportunity to be “present totally to myself….away from a dialogic relationship”.

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3.1.8 The need for tuition
Although meditation may be a solitary practice, the need for expert guidance was reported. Jerry felt that he “would not have got where [he] wanted to” without “experts in meditation” to guide him. Reflecting similar themes, Amanda felt that some people’s practice was “a bit dilettante”, and she had some doubts about how some meditation techniques were taught in the west.

3.1.9 Different meditative techniques have different effects
As explored in section 3.2.3, the effects and purpose of meditation may vary according to specific techniques. For example, meditating on how one could be different in the future was felt to have facilitated better adjustment to change - change that was desired (becoming less shy), or inevitable (ageing and death). On the matter of desired changes, Amanda warned of the potential amorality of meditation - “it has happened in the past, that Samurai swordsmen would meditate so that they could control their swords better to kill people...... that is an abuse of the technique”. She also warned that some “culture-bound” Buddhist practices, such as those “contemplating death and the loathsomeness of the body” could be misapplied, or less appropriate in the West.

So it seems that some of the effects depend upon factors such as the meditator’s nature, or meditative technique, and that there are complex interactions with therapy, and religious or philosophical beliefs. Nevertheless, there may also be more universal aspects of meditation. In section 3.3, a model is presented which can be usefully applied to explain and describe change notwithstanding these contextual factors. Various applications of meditation may result in a variety of specific effects but, at a general level, similar processes appear to be operating.
3.2.0 Descriptions of the perceived effects

The descriptions start with lower-order categories, working up to a superordinate category, subsuming the other three. The order of the categories loosely reflects the order in which the effects seemed to emerge and suggests causal relationships wherein change within the later categories is facilitated by that in the earlier. Occasionally, links between effects and reflections upon underlying processes are made. However, these are more coherently drawn together in the next principal category - '3.3 Processes'. There was very little counter-evidence for the effects described in the categories, but it is discussed where it emerged.

3.2.1 Increased Calmness

This was often the first effect to be described by the participants. There could be any number of reasons for this; however, it is consistent with the view that a calming effect is primary. Kate noted that “initially [meditation] had a huge effect, I felt much calmer”, likewise, Mat found that he became “immensely calmer” and described the resultant “stillness” as the “key” to a variety of benefits he felt meditation had brought to his life. For Rob the relaxation gained from meditation could be used as a coping strategy. He would “have a session...maybe if I am feeling more tired...under pressure”.

Calmness was not always forthcoming from meditation and it was not always seen as useful. Mary had occasionally found a mantra meditation “terrifying”; however this had a ‘silver lining’ in that it made her more aware of a personal problem for which she subsequently sought psychotherapy. Fran found that the calming effect of meditation may not be helpful as “sometimes it is useful to mirror the client’s state and allow oneself to feel the level of anxiety that they feel”. However she noted that “at other times I feel that it is important to provide a level of stability for the client and at those times to be able to go into a more calm state can be very useful”. Fran also felt that therapy groups that had begun with a calming meditation could
produce a "calm and peaceful" atmosphere that was antipathetic to creating therapeutically-useful dynamic energy.

3.2.2 Decreases in the presence or sway of restricting psychological phenomena

Meditation was said to decrease the incidence or sway of a variety of problematic psychological phenomena. Such phenomena were seen as blocks in the way of personal development, or more efficacious behaviour. Four specific types of phenomena emerged from the data:

Rigid, construct laden thinking: Jerry gives an explicit example:

"I was pretty shy as a kid and that was with me pretty much into my 20's, but I don't think of myself in that way anymore, and I think it was more of a personal construction than an actuality, so I think that one of the things that meditation has helped me with is 'who am I?' in actuality rather than in construct".

He further acknowledges the role of calmness in facilitating that change – "if I can get relaxed about that capacity [for more construct-free living] ....then I think that frees up the decision-making process [i.e. the range of choices one can consider]".

So, Jerry feels that meditation has facilitated a lessening of construct-governed thinking, by helping him to be calmer in the face of the anxiety associated with this process.

Defensive thinking: Mat gave an example within the context of his therapeutic practice; "so what it actually did ultimately was increase my capacity...the matter that gets in the way of the relationship, which is sometimes called counter-transference...the act of projecting out... disappeared". As did Mary; "it is about being here-and-now, not fleeing what is difficult...they [clients] might say 'she
really sticks through very intimate moments' and I hope that is what meditation helps me to do”.

Neurotic functioning: Fran; “I look at it as a process of training the mind to be more present and not run off into old habit energies of escape, which might be escape into anxiety states”. Kate said that “the biggest shift overall [is that] I am a lot less preoccupied with anxieties about the future”. She later indicated the role of calmness in this; “in being still you are not tied up with anxieties about something that might be happening in the future”. A decrease in distracted, unfocused thinking was also indicated, which Amanda summarised clearly – “rather than just aimlessly worrying, thinking, daydreaming or fantasising....you can be aware of what your mind is doing and whether that is what you want it to do doing”.

This last sentence of Amanda’s connects a decrease in distracting processes (“thinking daydreaming or fantasising”) with increased awareness (“you can be more aware of what your mind is doing”), and understanding (“and whether that it what you want it to be doing”) – effects outlined in further categories.

Ruminatory thought: While, of course, meditation is not aimless - participants talked about specific goals they had – it does seem to involve a decrease in conscious reasoning. Take for example Kate’s comments on her manner in the therapy session; “I don’t find myself thinking very hard in the sessions – not the kind of thinking that I would have to do if I was writing an essay, and sometimes when a client asked me what I was thinking, there really wasn’t anything going on – well there is, but I am not consciously, logically, rationally thinking”. From the dialogue before this, it is clear that she felt this manner was a consequence of “the stillness instilled from the meditative practice”, thus explicitly linking calmness and a decrease in ‘purposeful’ thought. Moreover she went on to describe a consequence of this decrease; “[when] thought does arise there is a lot of room to pay attention to it and think of what is relevant to what has been said and what has not been said”. The idea here is that by reducing conscious reasoning generally,
she is better able to employ such reasoning at certain times when it is felt to be particularly appropriate.

3.2.3 Increased awareness and insight

Many participants felt that meditation had led to a greater awareness and insight into various situations, and it appears that the changes described above facilitated this. For example, in lessening construct-generated thought and being calmer in the face of the associated existential angst, Jerry felt that he had become less shy. Much of this awareness and insight was associated with the present. A sense of being more ‘present-minded’ was frequently alluded to: Amanda felt that she was “a lot more present focused”; Fran “more present centred”; while Mary described meditation as “about being here and now”; as did Jerry - “meditation has helped me be more in the here and now”. Such sentiments allude to a clearer perception of, and engagement with ‘current events’; as Mary commented, “the is-ness of meditation – what is... something like ‘as things are’”. Mat illustrated a situation of particular relevance to therapeutic practice:

“It increased my capacity, and by increasing capacity we can experience more fully the other person’s being and the effect that their being is having upon my being - how it is coming and how it is going and what is producing it – what sense it is that I am picking it up with and again this is the focusing in vipassana on the senses.”

Two points are of particular interest here. From this quote it is clear that Mat feels that meditation had helped him to more accurately perceive his clients and to be more aware of counter-transferential feelings. Furthermore, in the last sentence he insinuates that the processes in which this happened were similar to meditative processes. This similarity is further explored below under section 3.3. Other areas where participants felt that meditation had facilitated a more vivid engagement with the present were more mundane, such as driving a car or loading a dishwasher.
Some of the implied qualities of this ‘present’ are that it is at a temporal boundary between the past and future, and that it is at the spatial boundary between ‘me’ and ‘not me’. Jerry felt that meditation had helped him to have “a clearer sense of [his] physical boundaries and who [he] was”. Similarly, Kate felt that meditation had helped her to get a “clearer sense of self” and went on to describe how this seemed to her – “the image I have is all sorts of strands that before I started meditation were all tangled up, and meditating has enabled me to appreciate them much more clearly and to separate them out”.

Some participants felt that they had also increased their understanding of past events and possible or inevitable futures (see also 3.1.9). Mat felt that he had gained personal insight from meditating upon the events of his group therapy; similarly Amanda spoke of reflecting on problems she had experienced “in a meditative way”. Jerry had used a meditation technique called Creative Relief which “helped [him] realise some things that [he] wanted in life by imagining that they were already true and experiencing the truth of them”. Mary had meditated upon death with the apparent aim of adjusting herself to its inevitability. This had been difficult for her, and she had taken some issues that had arisen to her personal therapy. Although it seems this practice had ultimately proved fruitful, Amanda’s earlier warnings about culture-bound practices (3.1.9) are echoed.

All these accounts, whether the emphasis was upon the present, past or future, illustrate that participants’ felt their awareness had expanded. Insight into themselves and into their patients was felt to have heightened, with the implication that meditation was useful both to themselves and to their therapeutic practice. We move now to explore the participants’ descriptions of the ultimate ways in which meditation had benefited them.
3.2.4 Enhanced efficacy – Movement toward being more grounded, centred, and/or integrated.

This is the superordinate category – it covers all the previous effects that have been outlined; increased calmness; decreases in interfering phenomena; greater awareness and insight. Some participants described a heightened faith in themselves, that they were more trusting of the subtle pushes and pulls of their thoughts and feelings. Jerry described it thus:

“I think also that it has helped me feel more integrated personally from the point of view that now if I am doing things intuitively there is probably a good reason – so I am in less conflict about doing things that I want to do or doing things that I feel right about, whereas before I think that I might have had some conflict about that.”

Kate touched on a similar effect; “I think I can say what has become stronger is my trust in my intuition, it’s not quite the right word – it’s just knowing when something is…..just knowing.” It appears that Kate had developed confidence that events in her life would turn out well. She did not necessarily identify with the source of this ability, as is indicated in this anecdote about crossing a foreign city to visit her sister:

“There was something in the possibility of being able to trust that things would be okay – that I’d be able to make this journey ok. There is something about trusting that if I am going to be looked after the more I can surrender to whatever is happening, and allow whatever is coming through to emerge, the more I get out of the way, and just allow whatever is trying to manifest in my life around me, the easier things get”.

Kate was not sure what it was that she felt “carried” her, but considered that it might be something of a transpersonal nature. Regardless of whether this influence
is conceptualised as personal or transpersonal, it was experienced as an esoteric and profound authority which could be trusted.

Moving on, many participants felt themselves to be more ‘integrated’, ‘grounded’ or ‘centred’. Exploring the first of these Mary said that:

“I feel this kind of letting go of something.....I feel like I am being put back together again.....I feel that on a kind of physical level, but I am sure that it happens on other levels, my spirit or my emotions feel like they are being put back together again, and as I get into the breathing, the deeper it gets...that integration seems to progress.”

While this was experienced within the meditation itself, others reported effects outside of their practise. Some participants felt that they were more robust, and centred when under pressure or becoming anxious. Rob felt that this “had a pay off in terms of therapeutic work [when] under pressure from other clients ... it’s the ability to remain centred in that session”. Similarly, Amanda spoke of “a sense of contentment I suppose, a feeling that you could work with your mental states, that you did not have to be blown around by them”. She found this particularly useful in her area of work:

“I work where ....there are a lot of issues of death and bereavement, and painful situations that people are in, and [meditation] has just helped in trying to find that balance between not being over-burdened and sucked-in, and loosing the ability to help, but not coming hardened and blasé and unable to help in another way....I don’t know how this works but I have this sense of being able to keep things in perspective.”

However, she later elucidated upon how this way have come about:
“You know some people say to me ‘how can you do this work, isn’t it too upsetting?’, and I think that there are 20 million people in the world with AIDS whether I work with them or not. Practising... meditation gives you a sense of more solidarity with other human beings. Whether I see what is going on or not, I know about it so I think that makes it easier to go in and face it, I don’t think that I have to be protected.”

Here (and there was another example in the interview) she is indicating that meditation has helped her to engage with suffering to the extent that it she feels it would be pointless to move away from painful issues in a physical way. It is as if she is aware of, and has accepted inevitable suffering, and so is less defended against it. As we are now beginning to explore processes, we turn to the next section:

3.3 Processes

This section aims to clarify two areas: how the effects described above interact together; and how the meditative process generates these effects. Although some new concepts are introduced, much of this work is drawing together themes already identified.

3.3.1 Interaction of effects

As outlined in section 2.0, the effects were described in approximate temporal order and in terms of becoming ever more inclusive. This order is shown in the following chart, which is essentially a reiteration of the order in which the effects were described above:
Increased Calmness  ⇔ Decrease in processes that restrict awareness:
- Rigid/construct-laden thinking.
- Defensive thinking.
- Neurotic functioning
- Ruminatory thought

Fig 1. Flow-chart of effects

Each effect in turn impacts upon those below it; so calmness is conceptualised as facilitating all the others, ending with increased efficacy as the ultimate achievement. It may be that some effects also impact on those above it. For example, it seems consistent that increased efficacy might also lead to greater calmness; or that increased insight might lead to a decrease in neurotic functioning.

*Increased Calmness*  ⇔ *Decrease in processes that restrict awareness.*

These are the early effects arising from the meditative technique. They are shown in a reciprocal relationship because participants indicated that not getting caught up with anxieties, daydreams etc. helped them to remain calm, and also that in feeling calmer they were less prone to such distractions. At an intuitive level these categories fit together very well, for example, it is easy to imagine that in becoming calmer one would also think in less neurotic and defensive ways and vice versa. It is unclear and perhaps extraneous to pose the question ‘which came first?’.
Increased Calmness $\iff$ Decreases in processes that restricting awareness

**Heightened awareness and insight**

It seems that lessening the sway of processes such as construct-governed or neurotic thinking, allows a fuller range of awareness. For example, Kate had often dissociated from her body, and felt that meditation helped her to be aware of the sensations in her body. Dissociation suggests defensive movement away from bodily sensations. It could be that in the calm meditative state, defensive manoeuvres slackened off, and so she was more able to tolerate being conscious of bodily sensations, and the beliefs, likes, hopes, affect associated those sensations. Acknowledging these phenomena (which might involve naming them) facilitates insight into the problem - i.e. one becomes conscious of the way that events (sensations, beliefs, thoughts, hopes) arise, interact and fade. In Kate's case becoming more conscious of bodily sensations (and perhaps accompanying beliefs - e.g. hypothetically, 'the body is vile'), may have provided more information from which she developed insight into her dissociative processes. Meditation could work in a similar way with a range of problems. The basic mechanism is that through lessening the cognitive or affective power of processes that restrict perception one can increase consciousness of formerly denied or neglected parts (i.e. for Kate this was her body, for Jerry his capacity to break life-scripts), and adapt accordingly.

**Heightened awareness and insight**

$\Downarrow$

**Increased efficacy**

Many of the quotes used so far have associated awareness and/or insight with improved self-efficacy. How might they be linked? It seems that just as being more aware of psycho-physiological phenomena is a key to insight, so insight enables more functional action. Because one's view becomes less determined by
obsfucating projections and distractions, the qualities of the object are more clearly perceived and so it is more possible to interact with that object in a fruitful manner.

3.3.2 Links between meditative processes and effects

What might the process be underlying these phenomena? Mat’s quote above (‘…..again this is the focusing in vipassana on the senses’) hints at a similarity between what was happening in the effect and what happens in the meditation. Indeed, there appears to be internal consistency between meditative processes and those underpinning the effects reported by the participants. Meditative techniques are fairly simple in principle. For example, in integrative meditation it is possible that the return to the breath breaks enmeshment with anxiety, daydreams etc. (presuming the meditation is successful) and this may partly explain both the calmness generated, and the decrease in such distractions. The refusal to linger may also serve to develop focal abilities, enabling the meditator to more readily break away from what are felt to be counter-productive or irrelevant processes and concentrate on what are felt to be beneficial ones. Such a process may explain this description from Rob - “[through] a withdrawal of energy from the exterior..you become more in touch with your own inner states, your own body”. Although there may be nothing particularly beneficial about focusing on the breath, the capacity for sustained engagement with a chosen object is enhanced. So, perhaps when the meditator attempts any task, such as practising therapy or washing the dishes, they are more able to commit to it in a mindful way.

Ideally, in vipassana meditation the attention paid to distractions is limited to just that which is enough to label or recognise it. It may be that naming distractions in this way helps them to be integrated into conscious functioning. At the same time the movement away from these phenomena ensures that they do not predominate and block the flow of experience. There is a parallel process – as the attention paid to certain phenomena decreases, so the attention potentially available to pick up on other phenomena increases. It is as if attentional ability has been freed up - or as Kate said “there is a greater capacity to receive what is happening” - which can
then be made available to process information felt to be more relevant information, or a greater variety of information.

It may also be that attending to the rhythms of the breath, or a mantra, has a hypnotic, soothing effect, which serves to decrease anxiety, and defensive or neurotic processes. Amanda’s description seems to indicate a mesmerising experience, “just watching the breath, watching your breath coming and going then you gradually watch everything in your experience coming and going, thoughts and feelings are the same”. Furthermore, Fran explained that after a meditation group the people might be “spaced out”. There may also be biological effects arising from the practice – for example it may be that there is more oxygen intake during meditation and this in itself improves mental functioning.

Finally, there appears to be a kind of liberal philosophy in meditative practice. For example, Mat said that all that matters is to observe “how things come and how things go”; the implication is that one need not morally evaluate one’s thoughts, feelings, beliefs etc, but just be aware of them. It may be that this libertine attitude helps meditators to integrate parts of themselves they previously had wished to disown.

4.0 Discussion

The perceived effects of meditation have been described, along with ideas about how these interrelate, and how they may arise from meditation practice. The mediating effects of contextual factors has also been taken into account. At a general level the effects are similar across the participants’ accounts, and this indicates some objective and common qualities of the effects and processes. While at a more specific level, the effects are sensitive to contextual factors such as the meditator’s goals, and personal philosophy. Benefits brought to the personal lives and the professional practice of the participants has been explicit throughout.
Therefore the notion that meditation can be beneficial for therapists’ personal well-being and practice is supported. Several links with previous experimental research findings can be made. Studies taking biological and psychological measures have found that meditation promotes a calm state of mind (Murphy & Donovan, 1988; Brown & Robinson, 1993). Others have reported lowered anxiety or stress (Pearl & Carlozzi, 1994; Greene & Hiebert, 1988). Several investigations have reported that meditation leads to lowered psychological defensiveness and increased openness to change (Dubin, 1994; Epstein, 1990; Fritz & Mierzwa, 1983). Other studies have show a positive relationship with attentional ability (Bennett & Trinder, 1977; Davidson et al, 1976). Finally, Shapiro (1992) reported that long-term meditators showed increased levels of self-control, and satisfaction after meditation retreats, and Jonowiak (1994) showed that a randomly assigned group showed significant increases on measures of self-actualisation.

The participants had come to meditate voluntarily, many expressed that it was merely their developmental method of choice. Meditation clearly suited them; it may not suit other therapists. Some participants were concerned that the power of meditation would be lessened if removed from a spiritual context, and so it may be that meditation would be less fruitful for therapists with secular beliefs. Nevertheless, in order for therapists to make informed decisions about their development they need to be aware of the relevant methods available. Although the use of meditation has expanded greatly in recent decades (Delmonte & Kenny 1987), many therapists may have insufficient awareness of the field to make informed choices about whether they might find it useful. One way of raising awareness would be through the publication of research such as this. Although there are many such published articles (Walsh, 1996, estimated over 1,500), it seems very few emanate from the UK (Addison, 1999).

A number of suggestions for future research can be made. The ideas put forward in this study require further investigation to establish their validity; a quantitative study could be useful in this. Because of the difficulties inherent in researching
meditation quantitatively, such studies would need careful and ingenious design. This study has indicated that meditation might be more useful for therapists with certain characteristics (e.g. those with a spiritual orientation); future research might seek answers to this issue. Similarly, it has been suggested that certain meditation techniques may help in resolving specific problems (such as body dissociation). However, many participants expressed reservations over using meditation in such a proscribed way. Further investigation of this area might shed light on what techniques are useful for what purposes, and/or the problems with such divisive use of meditation. Investigation into any occasions where therapists had found meditation unhelpful or harmful could be illuminating. Although the participants were asked about negative effects (and some were talked about), they were perhaps unlikely to have found practice problematic, given their lengthy practice and enthusiasm to talk about it. Finally, the idea that many therapists have insufficient knowledge of meditation to make informed choices about it is unsubstantiated; in order to justify disseminating information about meditation, this area would need further study.
References


Appendix 1 – Recruitment Poster

The following notice was printed onto University of Surrey, Department of Psychology headed paper and sent to various psychotherapy training centres and meditation schools:

Meditation Research

Interviewees are being sought to take part in a qualitative research project investigating the perceived effects of concentrative meditation upon the psychological well-being, and practice of psychological therapists (counselling/clinical psychologists, psychotherapists, counsellors). The interviewees should have regularly practised a form of concentrative/focusing meditation (eg: breathing, mantra meditations, TM) for at least one year whilst practising as a psychological therapist. They should be accredited members of the BPS, UKCP, BAC, BCP, or training to become such. The entire interview process should last for no longer than 45 minutes and can take place in a location at the interviewee’s discretion, or by telephone.

This project is being undertaken by Dominic Addison, a trainee Counselling Psychologist at the University of Surrey, under the supervision of Dr. Martin Milton and Dr Adrian Coyle (the Course Directors).

If you would like more information, want to volunteer, or are able to help in other ways, please contact Dominic Addison by post, telephone or e-mail at the points above.
Appendix 2 – Inclusion criteria

- Participants must be practising psychological therapists accredited by the British Psychological Society; The United Kingdom Council for Psychotherapy; or the British Association of Counsellors.
- They must currently be practising a form of concentrative or awareness meditation.
- Their meditation practice must extend back for at least one year.
- Their meditation practice must be regular – at least three times weekly for a minimum of 15 minutes each session.
- They should not be members of the Transcendental Meditation Organisation.
Appendix 3 – Information sheet

The following Information Sheet was printed onto University of Surrey, Department of Psychology headed paper:

An Investigation into the perceived effects of meditation upon the psychological health, and the practice of psychotherapeutic professionals

This project is being carried out by Dominic Addison, a post-graduate Counselling Psychology Student at the University of Surrey, under the supervision of Martin Milton and Dr Adrian Coyle from the University’s Department of Psychology.

This project will be investigating the effects, if any, that meditation has had upon the practice of psychological therapy, and personal psychological well-being, as perceived by psychological therapists (clinical/counselling psychologists, psychotherapists). Specifically it is seeking to examine the perceived effects of concentrative meditation – i.e. that which involves a focusing of awareness upon a single object, breath, or mantra. To investigate this, therapists who have practised a form of concentrative meditation for at least one year will be interviewed on their experiences within this area. Having first read this Information Sheet, potential interviewees will be asked a series of questions in order to assess their suitability for inclusion; candidates would then be asked to sign a consent form before going on to interview. The interview will begin with demographic questions, followed by a semi-structured interview. The entire process should last for about 45 minutes. The interviewer will be the chief researcher, Dominic Addison, and interviews can be conducted by telephone or in locations at interviewees’ discretion. The interviews will be recorded on audiotape and later transcribed; after transcription, the audiotapes will be erased. All information given by interviewees will be treated confidentially. This means that identifying information such as the names of people and of places will be replaced with pseudonyms.

Participants may decline to answer particular questions, and may withdraw from the study at any stage and without explanation.

No remuneration is available for participants. However, participants may receive a copy of the final report if requested.

If you have any further questions about this project please direct them to Dominic Addison at the points above.
Appendix 4 - Research Consent Form

I, the undersigned, voluntarily agree to take part in this study on the perceived effects of meditation upon the psychological health, and the practice of psychotherapeutic professionals.

I have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

I understand that all documentation held on a volunteer is in the strictest confidence.

I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and ask questions.

Name of volunteer ..................................................................
(BLOCK CAPITALS)
Signed ..................................................................
Date ...........................................

On behalf of all those involved with this research project I undertake that professional confidentiality will be ensured in regards to any audio tapes made with the above interviewee and that any use of the audio tapes or transcribed material from the audio tapes, will be for the purposes of research only. The confidentiality of the above interviewee will be protected: all audiotapes will be erased after transcription; and pseudonyms will be used in writing up the project.

Name of researcher ............................................................................
(BLOCK CAPITALS)
Signed ............................................................................................................................
Date .................................................

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Appendix 5 – Preliminary Questionnaire & Background Information

1) How long have you been practising psychotherapy/counselling?

____________________________________________________________________

2) What type(s) of psychological therapy do you practise?

____________________________________________________________________

3) Are you accredited ☐ or working towards accreditation ☐ with any of the following organisations (please tick):

The British Psychological Society ☐

...as a Chartered

__________________________________________________________

British Association for Counselling ☐

United Kingdom Council for Psychotherapy ☐

Other (please specify)_____________________________________________

4) Meditation practice -

E.G. Transcendental Meditation Summer 1994 - Now About once daily for 20 minutes

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<tr>
<th>Type</th>
<th>Period</th>
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Background Information

To begin with I'd like to get some basic demographic information about you. This information will be used to give a rough outline of the kind of people who were interviewed in this study. Please don't feel that you have to answer all of these questions if you do not wish to.

1) Male/Female.

2) Age: ___________________ years

3) Which of the following ethnic groups would you say you belong to?

- Black African □
- Black Caribbean □
- Black – other □
- Chinese □
- Bangladeshi □
- Indian □
- Pakistani □
- White □
- Other (specify) ____________________
Appendix 6 – Interview Schedule

Before I start the formal interview I’d like just to say a few things. Throughout the interview when I refer to “meditation”, I will always mean concentrative/focusing meditation; do you have any questions about this. [If ‘yes’ explore or continue if ‘no’] Okay then, in conducting this interview I am hoping to find out if you consider your meditation practice to have had any effect upon your psychological well being, and upon your practice of psychological therapy. If you feel that there have, or have not been any effects, I’d like to explore your understanding of why this is so - how you perceive the dynamics of any relationships, and/or why you feel that there was no relationship.

This may be quite a difficult task – to abstract these particular aspects of your experience – and so I’d like to stress that I am not looking for ‘right’ or ‘wrong’ answers - I am not looking to evaluate your responses – rather I am hoping to record your perceptions at this particular point in time, as accurately as I can.

Basically, I have four specific areas I’d like to cover: I’ll say what each of these are in turn, asking questions as we go along, until we both feel that that area of your experience has been sufficiently described and understood. I’d like you to take whatever time you feel you need and, please feel free to ask questions at any stage, if anything is unclear. So before we start is there anything you’d like to say or ask? [Explore if ‘yes’ otherwise start tape and first question]

1) So to begin, I’d like to take you back to the time that you started meditating. Could you tell me what led you to think about taking up meditation.

   a) So you thought that it might -------, how did you imagine that this would occur? // So you started meditating with no preconceptions about what effects it might have? Can you recall why you started then? [Explore answers, if there seem to have been no preconceptions go onto question 2]

   b) To what extent do you feel that meditation actually did-------?

   c) What do you think was going on that brought about this change? And did this happen in the way that you imagined it might? // Why do you think that the meditation did not have the effect that you had hoped that it would?

   d) How long did this effect last?

   e) Are there any other effects that you thought that it might have? [If so repeat 1a, b,c,d.]
2) The next question is about any concerns you may have had about starting mediation: Did you have any reservations before you began meditating?

   a) What were these? // Does that mean that you didn’t think that meditation might have unwanted consequences? If so, then: Okay I’m going to go on to the next question, but before I do is there anything else you would like to say about your expectations of meditating.

   b) So you thought that it might ------ ? How did you imagine that meditating lead to this?

   c) And did this, in fact, happen?

   d) And how did this happen (Did this happen in the way you expected it to?)

   e) How enduring was this effect?

   d) Are there any other reservations you had about meditating? [If ‘no’ then ‘Okay I’m going to go on to the next question, but before I do is there anything else you would like to say about your expectations of meditating.’ If ‘yes’, ask about it & repeat b, c, d.]

3) The next area I’d like to explore whether you feel that meditation has affected your personal life. You have already talked about how meditation -------------. Do you then feel that your meditation practice had any (other) effects upon your personal life?)

   a) So you feel that it ------, do you have ideas about how the meditation was connected to this change (what were the dynamics of this relationship?)

   //So you feel that meditation has not had any (other) effect upon your personal life. [If no, then ‘Did you feel that your meditation was no successful in this area then? & explore reasons why or why not.]

   b) So it seems as though ----------? Does that capture it?

   c) And how lasting was this effect?

   c) And are there any other ways in which you feel that meditation has influenced your personal life? [If yes repeat a, b. If ‘no’, ask ‘where there any ways in which meditation interfered with/hindered your personal life?] [If ‘no’ move on to next question.

4) I’d like to move on now and ask you about concerns any relationship that meditation may have had upon your practice as a [participant’s profession]. You have already mentioned some ways in which it impacted upon your personal life – did these changes in turn also affect your practice?
a) So as you feel it led to ------- in your personal life, it similarly led to ---- - in your professional work. Were the processes underlying these effects also similar? So those effects upon your personal life did not carry over some effect in you practice? [If affirmative then next question. If 'no' explore the confusion].

b) And do you feel that meditation led to any changes in your practice, which were not also related to those changes in your personal life? What were these?

c) In what ways do you think that this happened?

d) And, again, how enduring do you feel this change in your practice was?

d) So you have told me about ------- & ------- ; are there any other ways in which you feel that your practice was affected (perhaps, ways that were unexpected or problematic?). [If so repeat c, d]

6) How open are you with other therapists about the fact that you practice meditation? (What sort of reactions have you encountered?

7) To what extent would you recommend meditation to other therapeutic practitioners? To novice therapists?

We have talked about your expectations of meditation and the effects that you feel it has had upon your personal and professional life. The answers that you have given indicate your feelings generally about the utility of meditation for personal and professional development – it seems all in all that your are optimistic/doubtful. Is there anything else you would like to add to what you have said (Is there anything that you feel that has been missed?

[If 'yes' explore this, if 'No' move on to ending]

Ending

Right that concludes the questions I had, suffice to ask – Is there anything else you would like to tell or ask me – anything you feel that I have missed out, or may not have understood.

[If 'yes' explore that, if 'no' then finish]

Okay then I’ll stop the tape now and so the interview is finished.

I’d like to thank you very much for your time. This project is quite a challenge, especially from the point of finding interviewees and, aside from being essential for data gathering, your time and interest is very encouraging to me, so thank you. Do you have any other questions at all? Please feel free to contact me about the project later if you wish.
Appendix 7 – Transcript of ‘Amanda’s’ interview

R1 The first question is to do with your reasons for starting meditation – What you thought it might do for you.

P1 I was already interested in Buddhism and was looking to learn about Buddhism and meditation and had been reading bits and pieces about Buddhism for a while and actually I knew somebody in the states who was a meditator, and he gave us a talk about Buddhism and Behaviourism which was really interesting – I’d met two or three people who meditated and they had some quality of mindfulness – I wouldn’t have called it then – calmness, centredness – you know they just seemed like more their own person, and I suppose personally I had been through a difficult time so I saw someone advertising a meditation class and went along.

R2 So it was hopefully going to be a technique that would help you to develop on a personal level?

P2 Yeah – at the time it was more a thing I hoped would relieve suffering, and I had tried to do it on my own, instructions from books and so on and had not really got very far – thinking was this all that is supposed to happen? I think that I thought that you were supposed to have visions and be transported and I wasn’t so I thought that you were supposed to have visions and be transported and I wasn’t so I thought that I must be doing it wrong.

R3 So there was an escapist hope that it was not just a relaxation thing but that it was a bit like dreaming almost you could escape.

P3 Yeah I wouldn’t call it escape really, but I guess there was something in Buddhist theory about letting go of suffering and that was what I was drawn to and meditation was part of the package really.

R4 And did you find that any of these things came true?

P4 Well I didn’t have visions and get transported – not until recently – I guess yes and no, obviously enough to keep me doing it, but it had been up and down. I think that initially it had a huge effect, I felt much calmer. The first thing I realised was how much I was not in charge of my own thoughts. I’d sit down to meditate and someone would say ‘sit down and count your breath, and if you loose count go back to one’, and I thought ‘how could you lose count?’, and then of course I did – so then I realised how out of control my mind and thoughts were. But......

R5 That was an insight but one which you weren’t necessarily looking for?

P5 Well yes exactly – it’s one of the first things you learn as you meditate. But I did feel particularly during the meta-barvana, a sense of contentment I suppose, a feeling that you could work with your mental states, that you do no have to be blown around by them, so gradually or it is not necessarily a linear process – many
other things have had an impact upon me, but I certainly wouldn’t stop doing it now.

R6 So there is this increased capacity to work with and tolerate whatever is happening within you rather than getting lost in it or tied up with it?

P6 Yes, it’s – I mean that is what I feel about it now – It’s difficult if you are asking what is was like in the beginning, it’s not all that easy for me to say now what it was like. I can say that there was enough calmness of peace of mind to make me carry on doing it, but I wouldn’t say that it was very strong or powerful.

R7 So thinking now about your experiences generally – would you say – what would you say about the process of feeling that you can observe what is going on within you without getting tied up in it.

P7 I think that is what lead me to vipassana – when I went to see a teacher and he had a very slightly different angle on what I had been doing before with my breathing, it’s about noticing thoughts and feelings just as they are and not getting caught up in the whole story that you tell yourself, so…. There is something about that which – it’s almost like it slows down your experience so that if something happens, instead of getting caught up in the emotional reaction you can see the stages that lead from your emotion to the reaction and catch it before you get there and if you do get there you can sometimes unravel it – it’s just a feeling or a thought, not get caught up in it and let it go, not having to push away painful feelings but not getting caught up in them.

R8 Is this because you are instructed not to do so, and so you, that makes it easier – it is getting condoned that you shouldn’t get caught up in feelings

P8 Yes – or just somehow even just the suggestion that it is just a mental state that it is not something that you have to think why is this going on, analyse it and understand it, oh that’s interesting, and also just watching the breath, watching your breath coming and going then you gradually watch everything in your experience coming and going, thoughts and feelings are the same – I mean obviously sometimes you have to go and sort something out --if the same emotions keep coming up then it may be something that need attention, but sometimes, I mean sometimes I tend to think that it is just nerves firing – you are sitting meditating and suddenly you feel hate, it’s probably just some random firing and it doesn’t mean that you have to think why is this happening, what should I do about it – you can just notice it and move on.

R9 It’s like background noise in the forest – it is not necessarily significant to understand what all the sounds are?

P9 Yes, exactly, but if the same thing comes up again and again, you might have to get to the root of it.
So you feel perhaps that you have got some insight into the general background, and also into patterns which may need attention – you might take to therapy.

Or you might deal with somehow out of the meditation itself or even stop and reflect in a meditative way, but that would be a different technique in a way. And I think that vipassana teachers particularly focus on that, it isn’t exactly that I wasn’t doing that before but I think that mindfulness being taught more as a practice there is a bit more of a sense of trying to keep more to the breath and it felt a bit forced – these thoughts feelings, mental states were happening, I think there was a bit more of a sense of forcibly trying to change them or put them away rather than just letting them be, which may have just been because I was doing it wrong, but it just seemed that my practice got a bit stale and so I went to another teacher, the visualisation practice was a bit different in that again there was an object of concentration but there was quite a strong emphasis that that will change your mental state – it was more of a structured practice....and you know that could be more strong you go through a process where you visualise yourself as a deity and it can be quite powerful as long as that figure means something to you. The, I mean it is kind of, I did it just as a visualisation practice, but there is a whole tantric theory about what that is about.

And where you following that theory?

No, not specifically.

And so what were you hoping to get out of that particular practice?

I mean partly it was more of an emotional practice whereas pure vipassana and mindfulness can get a bit dry, I just felt that practice was more about connection, at a certain point in the visualisation you also visualise all beings – it is quite a strong emphasis on connectedness and compassion and well the theory behind it which to some extent I go along with is that at some level we have the, not just the potential for insight but actual insight at some level you know, it’s very difficult to talk about it, I mean the way that the traditional texts talk about it is that at some level outside of time and space we are not unenlightened, whatever that means.

So there is some transpersonal state where you are part of a godhead or something.

Yes it is a bit like seeing that you do not exist just in time and space but there is some other primordial being that we can connect with.

I would label that as a transpersonal, would you?
P14  Yes, yeah, yeah. Definitely, although there is a lot of question about is this a creation of one's own mind or is it connecting with something that is really out there? That is probably a more realistic way of thinking about it.

R15  And did you find that it had any effects in this way that you felt that you had connected with something?

P15  Sometimes – I felt sometimes that particularly if I had a problem I had a response to it that I felt that I could not have come up with myself – I suppose it's like if you pray, you get a response, I didn't know that – so if there is a higher part of one's mind you are maybe tapping into that, but also for me I think there was quite a strong practice of say an antidote to self-criticism, it's a very purifying practice based on pure and enlightened, so it's a good antidote if you have a tendency, as I have, to be quite hard on yourself. And I still do it sometimes, but just not as much.

R16  Some if the things you said there reminded me of dreams – of dream theory, where you get these creative things bubbling up and you get the sensation that you haven't actually thought about it

P16  Yes, yes.

R17  And there is meaning in it.

P17  Yes I think that is true, you think of something in a dream and something happens that wasn't quite what you expected – it means – you know I think that there is somewhere in my mind that I obviously knew that that was going on, just occasionally I think, I don’t get this very often, but occasionally I get this feeling of calling in on this figure and getting a response that felt like, I mean I am not a particular transcendentalist – I think it’s all in our own mind really – but I think that it's accessing a more creative way of thinking that I might not have been able to access otherwise.

R18  So you are integrating more capacities or whatever.

P18  Yeah – integrating?

R19  Integrating – the mind’s capacities or your capacities rather than shutting off certain capacities.

P19  Yes, yeah, yeah, it’s something about the limitations – if you’ve got a dilemma you sit down and think oh would I do this or this – it’s all very cognitive and rational and just calling on a figure even though you don’t really believe it is out there – it’s a bit like throwing the I-ching you don’t really believe it will particularly come up with something – it’s about lateral thinking.
R20 So can you think of any other ways in which mediation has affected your personal life – you have talked about transpersonal ways and feeling that you can observe what is going on in a more objective, perhaps, less neurotic way.

P20 Well it has had external effects – I think that I live a simpler life, instead of running around so much after money success prestige have become less important – I think that has come from the pleasurable side of meditation, when you know that you can readily access very blissful states from within, there is not quite the same compelling need to access them from outside, cos you know I don't get that many blissful states but some experience of concentration.

R21 Sounds like there is more of a self-sufficiency in very general ways of feeling that you don't have to strive elsewhere to consume things that are going to

P21 Yes, yeah. It's a richer inner life, my vipassana teacher said that people who meditate don't often get bored – it's quite striking and I think that is really true, if I am sitting, there is a sense that there is always something to do if you are living with awareness, there is always an opportunity to practice this.

R22 So it's not that you can meditate anytime and that the meditation then releases the boredom, it is also that having meditated whatever you are doing at the time can become more fulfilling?

P22 Yes, yes I think so having meditated, whatever you are doing you can bring yourself present and that has some sort of meaning, being now. Um, I had some experience recently loading the dishwasher at a friend's house and I noticed that I was not thinking what I would normally be thinking, that it is someone else's turn to do this, it's a horrible job and, I just had the thought that this is just another opportunity to be present – that's interesting – it was just this thought that went through my head – I thought that it's just another thing to do, you don't have to divide the tasks of the day into boring ones and pleasurable ones, and I am not usually like that, but if felt good.

R23 And you suspect, or attribute that to meditation.

P23 Yeah oh – I had been on retreat 2 weeks previously, spent 7 days in mindfulness, that could be something to do with it, so yeah as I say I think I lead a simpler life. I also feel that I am more ethical, I don't know whether that is because I meditate, or that these are the ethics that come part of the Buddhist package, but I think that meditation gives a bit more awareness of connectedness of life. I was already a vegetarian before I meditated, but now I am just stricter, um.

R24 You suggested there that it may have helped you to be more present minded.

P24 Yes I think so definitely, and even more aware of when I am not, if I am distracted, I was driving back from this retreat in Devon and I was very aware that sometimes my mind was present in the car driving along, a nice sunny day, quite a
pleasant drive, and at other times it was way ahead, what time am I going to get home, I wonder who has phoned or who has written, but even then I was conscious I was doing it - oh my mind is moving or it is still, so even when it was kind of wondering off, so obviously sometimes it is miles away wandering off like anyone else, but there is just that sense of being a little more aware of what is going on and a little more in control of it.

R25 This aspect where it has maybe facilitated feeling more still, centred at any time, but also more aware of when that is not the case.

P25 Yes, yes.

R26 And what does being more aware of when that is not the case do?

P26 I suppose that it means that I am more likely to think, where am I going and is this useful what I am doing, and do it with a bit more deliberateness or bring it back to now, rather than getting all caught up in it without thinking and sometimes it is just interesting - oh that is where my mind has gone - but mainly it’s just being not so subject to it - you know if I am thinking of what I am doing in six months time I may be a bit more aware of what I am doing.

R27 It’s like if you are more aware of something, aware of the issues, you can make an informed decision about rather than..

P27 Yes, rather than just aimlessly worrying, or thinking or daydreaming or fantasising, I think that is the key thing for me about meditation - you can be aware of what your mind is doing and whether that is what you want it to be doing, is it useful for yourself or for anybody else, and I think that that is quite important that meditation can be seen as quite self-centred and maybe it is in some ways.

R28 That leads me into another area that I wanted to talk about which is have you ever had any reservations about meditation, either fears that it might do something, or finding out that it was problematic in some way?

P28 Umm, I had painful experiences of it in that things came up which I didn’t know and had to deal with, not memories that I didn’t know, but emotional - things that I knew had happened in my life but that I had forgotten what they felt like emotionally and the emotions would come up and you have to deal with something. Umm I don’t think that I have had any doubts about meditation itself, I have had doubts about Buddhism, I have had doubts about different meditation groups and teachers, I have had doubts about different meditation techniques and how they are taught in the west.

R29 On that point, is there some trouble in translating Eastern methods to Western society?
Yes I think that we take some practices which do rely on people having quite strong self-esteem, contemplating death, and the loathsomeness of the body, and things like that which Buddhists contemplate – maybe it works in the East, or the whole Tantric tradition is so culture bound and that what we do in the West is so pick and choose, we don’t really stick to the one tradition, we’ve got access to the whole lot, it’s very hard not to dabble a bit, there is a smorgasbord of practices.

Are you saying that that can be a rather problematic thing, patchy un-integrated?

Yes, yeah, a bit dilettante really, when you can feel that the more practices you are doing the better it’ll be, and in some ways for me coming back to doing vipassana and mindfulness, that’s all you need really, although I think that there are other practices that are useful, though I think that I have a reservation, I haven’t done this myself, but I have known people who have accessed very blissful states and have become attached to them, so perhaps the meditation becomes an end it itself, sitting on a cushion and blissing out is an end in itself, and in the Buddhist tradition, meditation is to become a clearer wiser, kinder person, and in a way if you were really doing that you wouldn’t need to be sit on a cushion anymore.

So it is a kind of an abuse of the technique?

Yes, yeah I suppose so, and it has happened in the past, that Samurai swordsmen would meditate so that they could control their swords better to kill people and I think that that is a bit of an abuse of the technique. Yes so I suppose that would be my only reservation.

And these people that practised in that way – did you notice or suspect that there would be some bad effects.

Emm, I don’t know if there were bad effects, more that they were just missing the point, I suppose it could lead to more self-centredness, a bigger ego, and the whole point of Buddhism and vipassana is to let go of that sense of self, and I suppose that sort of meditation could build it up.

Do you think it could lead to or encourage a schizoid reaction, a withdrawing from society?

Well I don’t know really, maybe the thing is that if it is genuinely meditative experience, I think that it is also quite integrating, that level of bliss. I think that sometimes certain types of strict vipassana can be more alienating, more schizoid, people... again it’s hard to tell from the outside, but you see people eating a meal and it is like ‘I am lifting a fork’ and you think ‘for goodness sake’, but you know, on vipassana retreats you do very slow walking and it probably looks to anyone else that you are completely mad, but when you are doing it you know that it is not as alienating as it looks, so it is hard to judge other people. And I suppose the thing about mediation is that some of the people who come along are not very integrated,
or are a bit schizoid, or have psychotic tendencies, mental illness, whatever and meditation can be not necessarily successful, possibly harmful.

R34 Would you adhere to this general image that to do meditation – it's like you are building up and you need a firm foundation and if you have not got a firm foundation you may sink as it were.

P34 Well I think that main thing for me would be that if someone did not have a very firm foundation they would need more than meditation, or they need some good teaching, whether it was therapeutic, or Buddhism or another faith, but they need some philosophy, or dharma to go with it, but I think that quite a lot of people would need some therapeutic work as well, I knew someone who was quite psychologically fragile and was beginning to meditate and did not have anywhere to take it - it could lead to them being less stable.

R35 You mentioned yourself being aware of some of your own issues and that being a psychologist you will have known what to do about them and perhaps other people would not.

P35 Yeah, yeah and I had access, I mean at that time I went to see a therapist who was a practising Buddhist so there were times when it really helped, and that was on a retreat where there people to talk to and guide you, but if people went to meditate and were just plonked alone, they would not have known what to do with it.

R36 Moving on now to how it has affected your practice as a psychologist, some of the effects that you have mentioned already may have had an impact on your practice?

P36 Umm.. it has had some very practical effects, like I don't work full time anymore, so my career isn't going so well as it might have been, but it is a lot more enjoyable.

R37 That is because you have taken a lot more interest in Buddhism and mediation?

P37 Yeah, and just not wanting to be running around having work as the central thing in my life.

R38 So there has been an adjustment in you priorities which you have ultimately found fruitful?

P38 Yes, I think so – I occasionally think 'God, think of how much more money I could have had if I had worked full time' – I have been working part-time for 5/6 years, but I suppose in terms of practice a couple of things come to mind – I think that it does give a bit more perspective on working with people's pain, I work, the last ten years or so, I have worked among other things in the HIV field, where there
are a lot of issues of death and bereavement and painful situations that people are in; and it has just helped trying to find that balance between not being over-involved and getting sucked in, and losing the ability to help but not becoming hardened and blasé and unable to help in another way – there is something about having that – I don’t know how this works but I have this sense of being able to keep things in perspective.

R39  Centred position within the relationship with the patient?

P39  It’s partly the thing I said earlier about not being so blown around by my own mental states, so even if there is grief, something that has happened in other people’s life I can see it for what it is and not get so enmeshed in it.

R40  So it has connections with what you said before in your own emotional states you can be more objective about them and don’t get tied up and that is maybe happening when you are with patients – you are possibly suggesting that how you are with yourself is maybe how you see the other person, that you don’t get caught up in their emotions.

P40  Yes, they are probably caught up in them but I can see it a bit more objectively, but also for me I come home and leave work behind – I can put it down and – it is a mix of seeing it in perspective and also of knowing it is there whether I see it or not – You know some people say to me ‘how can you do this work, isn’t it too upsetting?’., and I think that there are 20 million people in the world with AIDS whether I work with them or not, practising particularly more loving kindness meditation gives you a sense of more solidarity with other human beings – how can I put it? Whether I see what is going on or not, I know about it so I think that makes it easier to go in and face it, I don’t think that I have to be protected.

R41  It seems more pointless to ignore negative things – you are somehow aware of them anyway?

P41  Yeah, it’s like some people said to me ‘how could you go to India, there is some much poverty?’ – and they are obviously implying that I was almost callous to go there, you know, I wasn’t very sensitive because I could handle it. I think that it does make me more robust as well, there is something in that – being emotionally stronger, it is more possible to work with people in pain. I think that more recently perhaps it makes it more possible to be present focused, this is something I am aware of since starting vipassana – sometimes I am at work and I have a million and one things to do and I haven’t got much time and things to think about, phone calls to make and then someone comes through the door and I see them, and this is something you have to learn anyway as a therapist but I think that meditation is a good training for putting all of your distractions, what you have to do next out of the room, and just be present and ah trust that you’ll remember afterwards what you have to do. So I think that is a good training in giving attention to the client in the same way that you attend to the breath almost. Just that you are completely there.
R42 So it is a kind of clearer radar for receiving other people.

P42 And less likely to think before the end of the session ‘oh my God I’ve 20 phone calls to make, am I going to do it? and by then the client has said something and I haven’t heard it and you know they can tell when I have become distracted. I think that happens to me less – that might just be clinical experience but I think that I am better however I am feeling, I could be quite tired and stressed but no, just be here for this person, in this room in this interaction and I think that meditation is quite a good training.

R43 You said that you’d just hope that everything later would take care of itself – were you talking about whatever worries you had about writing letters afterward

P43 Yeah.

R44 Or were you talking about clinical things that you might be doing with the patient.

P44 No I think that we worry that we won’t do things unless we keep a bit of our mind occupied with something otherwise we will forget what we have to do next. I don’t think we have to. And that sense you have in therapy that on the one hand you are with the conversation and also you do have to have a bit of a sense of a more open view at the back of your mind with it and I think that is easier to hold if you are used to sitting back and watching you thoughts. But as I say it is hard to know how much of that is partly what comes with practice as a therapist. There was something I read somewhere, that somebody compared, I think it was Freud’s, what did he call it, some expression that Freud used for just being..

R45 Evenly suspended attention?

P45 Yes I think that it was that, yeah and then someone was comparing it to bare attention in meditation and it is that sense that you just observe whatever comes up, you are not trying to control it in anyway.

R46 Sort of noticing, but allowing things to flow?

P46 Yes, yes and not imposing too much your own idea of what is happening, your own model or formulation of the client which may have fitted last week but doesn’t fit today so that you can be somewhat more open to something that you didn’t expect.

R47 Through greater perception of the present as is you are less likely to cling to your, err be more aware ways in which your theory doesn’t fit in with what is happening now?

P47 I think so yeah – I can’t think of an example of that, again I think that it’s probably partly experience, but I can think of times in the past when I think that this
is going on in this person and the whole intervention is based on that and then
suddenly finding that I have to change horse in mid-stream because it is not actually
like that at all, but I think that now I would probably notice and modify sooner....
And I think that it is difficult to know how much meditation has contributed to that
and maybe it’s just me, how I have changed.

R48 Just taking an intuitive guess at it would you say that mediation has had a
significant effect there?

P48 In terms of?

R49 The kind of processes that you have been talking about, meditation was
having a significant part in bringing about those effects or..

P49 I think that it has been a part of it, it’s very hard to quantify how much but I
think certainly that ability to be present and not to be blown about by one’s own
mental states as well – you know if there is something going on in my life that
might pull me away, I think that I am more able to leave that outside the consulting
room. I suppose some of the other things about how it has changed my way of
working, perhaps this is more to do with Buddhism, than meditation, but the whole
theory of Buddhist meditation and the mind I think to some extent has coloured what
theoretical models of therapy I follow – so I have gone off psychodynamic theory,
gone off the idea of the unconscious, you know, I have found out that an awful lot
of what is written in the cognitive literature and in solution focused work just seems
to fit far more the kind of Dharmic model of mind being, how we create our world
and construct our reality – that seems very much in-line with Buddhist philosophy,
the cognitive therapy model. It is more optimistic really, there is less of a sense that
people have got this great well of unconscious stuff that we never really get to.

R50 So it’s coloured which theories that you found most appealing within
psychotherapy and it has it also adapted your philosophy over and above what is
actually said in philosophy texts?

P50 I mean occasionally I find myself saying things to clients and think that I
wouldn’t have said that if I hadn’t meditated and very occasionally if I do anything
like session training, I do use a meditative component to it – you know I teach
mindfulness breathing and call it stress management and I am quite impressed
sometimes by how they take to it, but I think sometimes I maybe say things that I
have heard a Dharma teacher say in a particular context.

R51 So part of this is coming out of the theory that you have read and heard.

P51 Yes, rather than out of the meditation practice itself – there is one analogy
from the Buddhist texts which I use quite a lot about anger – when people talk bout
anger and how painful it is, but they can’t let go of it because so and so deserves it
and there is a story from Buddhist texts that being angry is like picking up hot coals
to throw at somebody, you miss the people and burn your hands, and most people
can relate to that – you know that kind of thing can be quite helpful. And I have occasionally had clients who are practising Buddhists and that can be a little different, although occasionally I have some who say they are practising Buddhists and they come out with all this stuff – God knows where they learned it, but I find that quite difficult – I mean I don’t really come out to them as a Buddhist so it doesn’t really matter, but people say ‘I am a Buddhist, so I think that it is all my Karma’ and if I was in a Dharma class I might say that that is not what Buddhism says, but it just doesn’t seem appropriate in that context, but I might look at the consequences of that belief, as if it is a core belief, and if someone thinks that it is helpful to think that what is happening to them is there karma that is fair enough even though I don’t think that is what it is all about.

R52 So are there any other effects that you have felt in which meditation has had an effect upon your practice?

P52 I suppose that one of things that comes to mind, perhaps more negatively is that it does give me a sense that the aims and scope of a spiritual discipline are much much greater than the aims and scope of psychotherapy, and occasionally I can feel a bit like frustrated that with other people that is not what I am doing – and I have done some teaching of Buddhism and I feel that situation I am really offering someone access to a tradition that is going to transform their lives much more than therapy can.

R53 So you are feeling restricted by the paradigm you are working in?

P53 And by what people are coming in and asking for yeah.

R54 Is it that you feel that you can’t offer more because there are not asking for it and may not want it, or that you can’t offer them more because it is not ethical?

P54 It is a bit of both really – partly they are not asking for it and they may have their own spiritual path, and I am wary of in anyway preaching or imposing. It has taken me quite a long time to be able to teach meditation at work. It was partly reading Kabat-Zinn which he calls stress reduction, as you have to call meditation, and sometimes people will ask ‘where did you learn this’ and I’ll often do this relaxation package and the meditation bit of it I’ll say is from Eastern meditation techniques. I suppose the other thing that I am a bit wary of is that mediation is not a relaxation technique, it can make people really aware of themselves and what they become aware of maybe not that easy so if you teach someone to meditate and they go way and do it for 20 minutes each day all sorts of things may come up and if they are not really aware that they are doing an Eastern tradition and that they ought to have a teacher to help them – there is an ethical point there.

R55 And the last area I wanted to talk about which you have been touching on already is – How comfortable are you with other psychologists or nurses, psychiatrists, about meditation? About the fact that you meditate – not in using it as an intervention.
P55 Right in terms of taking about it?

R56 Yes.

P56 I haven't come up against any huge problems – when I started the job I am in know we were having a department meeting and this woman was talking about this seminar, someone was talking about a clinical case where someone thought he was Jesus Christ – some delusion and a few people laughed and my head of department, he's a lovely man, but he said 'nobody is religious here are they' and he looked around and I thought 'Oh God, it was earlier than I had wanted to come out as it were. I suppose, I haven't had, I wouldn't say that I go shouting about it but I haven't had any particularly negative responses, umm, in my last job I worked with a Malaysian Doctor who was a practising Buddhist so that was nice, I haven't had very many colleagues who have meditated, I have worked with very few people who have practised themselves, but I suppose there are hospital managers or consultants who I wouldn't go and announce it to in case they thought I was weird. I haven't had any problems really – I have had some silly remarks, I remember a previous manager of mine – I came back from my first retreat and I was absolutely beaming – and he said 'oh where have you been' and I said 'oh I have been on a Buddhist retreat' and so he said 'are you Buddhist then' and I said 'oh I suppose I might be' and my manager said 'as religions go it is the least offensive', you know he said it with a slight chuckle, but he obviously thought it beyond the pale. So no it hasn't been a problem, I can see that there might be very conservative, for some reason I think of psychiatrists when I say this – I might just be completely biased but Drs in general really, managers there might be people who might be a bit suspect (sic). I can see that one suspicion might be that you were doing something weird with patients which will not do them any good, and I have had that as a supervisor working with one woman who was a Christian and I felt that she had some boundary issues with clients because her religion overrode her professional guidelines – she felt that God was calling her to do something – it was a nightmare.

R57 A clash of purpose and of ethics between the two?

P57 Yes and for her the religion took priority, whereas for me I think that it is different – there is no God telling you what to do, so it is very clear that in the professional context you have to have those boundaries, so no I haven't had – I can't think of any times that I wished I hadn’t mentioned it or that somebody has made assumptions about me.

R58 There is a wariness that some people may not take it very well, but it sounds like that doesn’t present any great trouble for you.

P58 Yes, that they'd be a bit flippant, the comments I get, if I am in a bad mood, 'oh you're a Buddhist you are supposed to be serene'. Or I remember one time in a department meeting we were talking about a trainee would had not wanted to engage in a department night out, they were going to go to the greyhound racing and she

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thought that it was unethical, and everyone was laughing about this and then someone looked at me and said 'oh you probably think that it is unethical too don’t you?'. I can find that quite difficult the group mentality about what is funny and what is interesting – they sometimes must think that I am a bit boring because I don’t necessarily join in. What I find is that people find their own way to relate to it – if people have their own philosophy of life, they say ‘oh yeah it is a bit like such and such’. And there is so much more of it around, and it is much more acceptable. It was interesting, when I went to the psychology of awakening conference I bumped into an old colleague of mine, a psychologist, and until then I had no idea that he was interested in meditation and he had no idea that I had.

R59 And to what extent would you advocate or condone meditation being part of a training to be a therapist?

P59 I mean I think that it is incredibly helpful, but I suppose...... it’s interesting I suppose that I do think that meditation isn’t quite a technique in the way that some things are – I suppose that you can learn some basic mindfulness breathing and that might be quite useful. I reviewed a book by a psychoanalyst, and American practitioner, and I found myself reading it thinking that he was making a very good case for the belief that all therapists should learn to meditate, because of the case of evenly suspended attention, but I think that there are some problems in reducing meditation to a technique, I have read some papers on the use of meditation where it felt that the person teaching it had just had a weekend workshop and if they didn’t have the meditation practice, doing it as a relaxation technique – I am not sure whether that is helpful or not. It’s like anything I suppose, we shouldn’t do anything that we haven’t tried ourselves; if I was teaching clients relaxation and I couldn’t do it myself I would think that a bit strange, but somehow that dilemma feels stronger with meditation.

R60 Cautious about pulling out bits of it, particularly by people who may not be well versed in it.

P60 Yeah, particularly, it’s that really – knowing what you are doing, it’s not just a relaxation technique, I do think that it accesses experiences that people might not have experienced any other way, and if the person teaching them doesn’t know what is going on if someone has come across unconscious stuff that they didn’t know about or even blissful states that they didn’t know about and are confused by what is happening – there is a certain state in meditation where feel that you loose control of what is happening and that can be quite scary.

R61 Meditation is open to the danger that there is no-one there to hold you, but if you are in therapy, there is also the therapist there to guide you through.

P61 Yes, yeah – but the therapist if they are just teaching meditation as a technique, they might no know how to hold – I mean I am thinking more of the clinical use of it – people teaching it without people really knowing what is going on. I suppose the other thing is, I haven’t really thought this through, I suppose that
I might have a different answer tomorrow, but there is something about you can’t
t really make people meditate, you can make them sit cross legged on a cushion for
20 minutes and say that this is part of you training you have to do this, but they
might just daydream so, in a way someone has to have a personal commitment to it. Having said that I was doing a seminar for my department the other day, and
afterwards I thought ‘that’s great I won’t have to do another one for a while,
because I have done one term’, but thinking all the way home what would I like to
do with them? I was doing a talk on HIV, and I thought that I’d like to do a
departmental seminar on mindfulness meditation and then we could do a 10/15
minute practice as part of the session. So you know there is another side of my
motivation there, I would really like to share it, because I do think that it is a very
profound way of working with the mind. You know, maybe I shouldn’t be so
precious about it, the more people teach meditation, the more places the better, even
if it is does done a bit divorced from philosophical tradition. I mean that is what
John Kabat-Zinn does – thousands and thousands of people have benefited from him
that would never have gone on vipassana retreats, would never have gone on
Buddhist courses.

R62 There is the dangers of reduction, of dumbing it down, reaching out to a
bigger audience but dumbing down?

P62 Yeah, yeah I suppose as long as the quality is there as well – if that’s all we
were doing in the West was taking out of it’s context and teaching it widely as
another technique to relax and make western life more easy, I think that would be a
shame, but I suppose that is, I mean in the East it is traditional that some people are
full-time practitioners and others are dipping in. I suppose that as long as there are
teachings and retreat centres for people that really want to pursue it, then really
maybe it’s alright to spread it about a bit. I think there my view maybe has changed
from my very limited experience of teaching it to people as a stress reduction
method, um, and I do a little stress reduction group for people with diabetes and it
is in this terribly inappropriate room, being the NHS, with hard plastic chairs, and
so I have thought there is no way I can teach mediation properly so I have tended to
focus on body awareness and breathing, and I have been really impressed by people
of all sorts of backgrounds and educational abilities have – a couple of people have
thought that it was a complete waste of time and were completely distracted, but
generally people think that is quite useful and one or two seem really committed to
carrying on doing it. So yeah there’s that and there is my other concern that things
may come up with that they won’t know how to deal with.

R63 Well I think that brings me to the end of the questions, with just a final
question being – Is there anything that you have thought of subsequently that you’d
like to add, or anything that you think I have not asked about which you’d like to
say?

P63 Umm – I don’t think so, I’ll probably think of something later......... No I
think that’s pretty comprehensive.
Appendix 8 – Notes for contributors,
Counselling Psychology Review

The study has been written in-line with the following requirements:

Notes for Contributors

Submissions
The Editorial Board of Counselling Psychology Review invites contributions on any aspects of counselling psychology. Papers concerned with professional issues, the training of counselling psychologists and the application and practice of counselling psychology are particularly welcome. The Editorial Board would also like to encourage the submission of letters and news of forthcoming events.

Academic and Practitioner submissions
Manuscripts should be typewritten, double spaced with 1" margins on one side of A4 paper. Each manuscript should include a word count at the end of each page and overall. Sheets should be numbered. On a separate sheet include author’s name, any relevant qualifications, address, telephone number, current professional activity and a statement that the article is not under consideration elsewhere and has only been submitted to Counselling Psychology Review. As academic and practitioner articles are refereed, the rest of the manuscript should be free of information identifying the author. Authors should follow The Society Guidelines for the Use of Non-Sexist Language contained in the booklet Code of Conduct, Ethical Principles and Guidelines. Four copies of the manuscript should be submitted with a large s.a.e. A copy should be retained by the author.

Bibliographic references in the text should quote the author’s name and the date of publication thus: Davidson (1999).

All references should be listed at the end of the text and should be double spaced in APA style. A guide to the presentation of references using the APA style is given in The British Psychological Society Style Guide, available at £3.50 per copy from The British Psychological Society, St Andrews House, 48 Princess Road, East, Leicester LE1 7DR, UK.
Low-quality artwork will not be used. Graphs, diagrams, etc., should be supplied in camera-ready form. Each should have a title. Written permission should be obtained by the author for the reproduction of tables, diagrams, etc., taken from other sources.

**Academic submissions only**

All academic submissions must include an abstract. The abstract should be no longer than 250 words (depending on the length of the paper). It needs to be double spaced, on a separate sheet and headed ‘Abstract’. The British Psychological Society’s Style Guide provides the following information on writing abstracts:
The purpose of the abstract is to allow the reader to assess the content of the article prior to reading the full text. In addition to appearing immediately below the author’s name, the abstract will be used for indexing and information retrieval by such services as Psychological Abstracts. It should, therefore, be written so that it can be understood independently of the body of the paper (p.6).

Proofs of academic and practitioner articles are sent to authors for the correction of typesetting errors only. The Editor needs the prompt return of proofs.

Contributors should enclose a 3.5" disk (either DOS or Mac format) with the document saved both in its original word-processing format and as an ASCII file.

All diagrams and other illustrations should be saved in their original format and as a TIFF or an EPS.

**Other submissions**

Book reviews, letters, details about courses and notices of forthcoming events are not refereed but evaluated by the Editor.

However, book reviews should conform to the general guidelines for academic articles. Contributors should enclose two hard copies.

Deadlines for notices of forthcoming events, letters and advertisements are listed below:

All submissions should be sent to: Counselling Psychology Review, The Editor, Centre for Stress Management, 156 Westcombe Hill, Blackheath, London SE3 7DH.
Research Dossier, Study 3

Survey of counselling psychologists’ experience of, and beliefs about meditative strategies for change.

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This article is not under consideration elsewhere and has only been submitted to the Counselling Psychology Review.
Survey of counselling psychologists’ experience of, and beliefs about meditative strategies for change.

Abstract

The study investigates claims that meditation can facilitate the personal well-being and professional practice of counselling psychologists in a variety of specified ways. It reports that despite growing international interest in meditation, it has been largely ignored within the field of counselling psychology in the UK.

One hundred and four counselling psychologists completed questionnaires concerning their experience with, and views about, meditation. The data were then analysed using various statistical procedures in order to ascertain overall levels of experience with and attitudes about meditation, and the differences between meditators and non-meditators on these matters. It was found that most respondents, collectively over 10% of all chartered counselling psychologists, had meditated regularly over a period of at least one year. The purported benefits of meditation were generally supported by both meditators and non-meditators. The support was more marked within the subgroup of meditators. Some differences were found between the meditators’ and the non-meditators' scores, although there were many similarities. Overall, the meditators’ responses appeared to be more conceptually coherent and were more positive. The results support the notion that meditation can be a useful method in developing the personal and professional health of counselling psychologists.
Survey of counselling psychologists' experience of, and beliefs about meditative strategies for change.

Introduction

For at least four millennia meditation has been used as a technique for the development of mental and physical capabilities. Walsh, an American psychiatrist has described it as "one of humankind's oldest therapies" (Walsh, 1992, p.32). Though it has a strong historic lineage, the practice is still very much alive today; and although it is popularly associated with Eastern religions, its reputation and application have grown rapidly within contemporary and secular western contexts. One such context is within the field of psychotherapy. In the last three decades, over 1,000 papers have been published outlining benefits that meditation may deliver to the client and the practitioner of psychological therapy (West, 1996). These studies have principally emanated from North America, and within the UK there appears to be a relative silence on the subject, and particularly so within the areas of clinical and counselling psychology. American psychological work has had a large influence on psychological therapy in the UK, and it is not clear why this relationship seems not to apply to the use of and interest in meditation. Wilkinson (1997) suggests that cultural and historical reasons may be partly responsible. It is possible that high levels of interest in religions within the United States may provide some explanation. Furthermore, compared with European nations, the North American population has a high population of people originally from Asia - the continent most closely associated with meditation. It may be that alongside this greater immigration, American culture has to a greater extent incorporated elements of Asian culture, such as meditation.

This study starts to redress this imbalance by surveying UK counselling psychologists' attitudes towards and experience of meditative strategies for personal and professional development. Emphasis is upon psychologists' personal use of
meditation, rather than on its use as an intervention with clients in therapeutic practice. The principal aims are to estimate the extent to which UK counselling psychologists have used meditative techniques, and how they have found meditation useful. It is also concerned with overall levels of interest in meditation and support for the benefits reported in the literature.

A fuller account and rational for this study will be made shortly, but before this a brief description and history of meditation, and summaries of relevant previous works by the author follows:

A brief description of meditation and its history in the West

At the most fundamental level, meditation has two basic forms, which are often referred to as ‘Western’ and ‘Eastern’ meditation, although this geographic distinction is inaccurate (Schopen, 1992). Western meditations involve analysis of a topic through sustained ruminatory thought, for example, Descartes’ (1642) “Meditations on first philosophy”. This study does not investigate meditation in this sense as it is a nebulous, vague and psychologically dilettante concept, essentially ‘thinking and reflecting on things’. Instead it concentrates solely upon the second form of meditation, which may be defined as conscious attempts to focus attention in a non-analytical way, and to avoid discursive ruminating thinking (Shapiro, 1982). Such meditations typically last for between 10 minutes to an hour and are practised several times daily or weekly. There are two chief sub-types, which are known by various names (see Addison, 1999), but will be referred to here as ‘concentrative’ and ‘awareness’ meditations. In concentrative meditation one attempts to restrict awareness solely to a single object or process (such as one’s breathing; a stone; or a chant). Characteristic aims of this practice are the development of a state of psycho-physiological calm, and the ability to control and focus cognitive processes. In comparison, awareness meditation involves attempts to relinquish such control in order to allow a flow of thoughts, feelings, sensations and affect. The nature of these phenomena may be noted, perhaps spontaneously
labelled as, for example, 'thinking about X', or 'feeling hungry', whilst trying not to become caught up with them. In this fashion, awareness of one's experience, and insight into underlying processes is said to be facilitated. There are also other forms of meditation where concentrative and awareness elements are drawn together, for example in 'vipassana' meditation, meditators attempt to sustain focus upon their breath while distractions are noted, but not dwelt upon, before attention is returned to the breath.

Finally, there are various techniques that incorporate elements of all the methods so far described (including Western meditation). Although they may be of interest to psychologists, they are comparatively rare. It would be difficult to find psychologists who have tried them, therefore they have not been explored within this study.

Therapists' initial perceptions of meditation were often negative and ill-informed (Kovel, 1985). Freud saw it as involving a pathological regression to a child-like state of infantile narcissism, while Alexander (1931) viewed meditation as "induced catatonia". In more recent decades, such attitudes are rare and there is widespread and growing interest in meditation amongst psychologists and allied professionals (Delmonte & Kenny 1987; Walsh, 1996, Urbanowski, 1996). Within the extensive literature, many have advocated meditation's utility in bringing about a wide range of beneficial effects, many of which were identified as facilitating the work of the psychological therapist (Carrington & Ephron, 1975; Delmonte & Kenny 1987; Halbrook, 1995; Kelly, 1996). Moreover, meditation is largely free from many of the criticisms of mainstream psychological therapy, for example that it is often inaccessible financially, geographically, and temporally, as well as being prone to the undue influence of the therapist's personality and preferences. Meditation can be learnt and applied in groups, and further practised alone with few restraints on time and location.
This study follows on from two previous works by the researcher; a literature review and a qualitative investigation. A brief synopsis of these follows:

Addison (1999) reviewed literature relevant to the question of whether meditation could help psychological therapists to practise more effectively. A number of anecdotal accounts were explored in order to extract key claims made for meditation. These were found to be that meditation promotes attentive ability, a calm psycho-physiological state, heightened awareness and a reflexive-self (an objective, observant sub-personality). It was suggested that these effects were personally therapeutic, and that this could facilitate therapists' practice. Most of the experimental studies reviewed found that meditation had significant positive effects upon various measures of psycho-physiological health (Zika, 1987; Langer, 1989; Shapiro, 1992).

Addison (2000), a qualitative study, investigated the perceived effects of meditation upon the psychological health and practice of psychotherapeutic professionals (counsellors, clinical psychologists, psychotherapists). Eight therapists who had meditated for at least two years were interviewed and the data analysed using a grounded theory approach (Glaser & Strauss, 1967; Pidgeon et al, 1991). A variety of themes describing the effects of meditation and some contextual issues emerged from the data, and factors of particular relevance to this study were used in the development of the questionnaire used in the current study. Meditation was said to lead to:

1) **Psycho-physiological calmness.**
2) **Decreases in processes that restrict awareness and insight:**
   - Rigid, construct-laden thinking;
   - Psychodynamic defence mechanisms, e.g. suppression, repression, projection;
   - Neurotic thinking;
   - Involuntary ruminatory and unfocused thinking.
3) **Heightened awareness of and insight into**-

- Personal psychological dynamics – cognitive and affective processes;
- Other people’s behaviour;
- Interpersonal dynamics;
- The ‘world’ or environment.

4) **Increased self-efficacy and self-esteem**

A further set of contextual factors relevant to this study also emerged from the interview data; these included:

- There is synergy between meditation and psychotherapy. Personal meditation was perceived as facilitating therapeutic work with clients, and as being similar to, and compatible with orthodox psychological therapies.
- There are three paradigms within which meditation may be practised. These are (1) Psycho-physiological relaxation; (2) Psychological development, and (3) Spiritual or transpersonal development.
- Some of the effects of meditation were perceived as being stable and permanent, and others as fluctuating over time.
- Many of the effects were seen as arising from personal goals and facilitating movement away from unwanted personal qualities such as shyness and worrying.
- The emergence of beneficial effects of meditation was viewed as dependent upon guidance and tuition.
- The effects and purpose of meditation were seen as varying according to which specific meditative techniques were used.

We return now to the current study, with explanations of the research goals and reasons why the research was conducted:
Rationale and Aims

As noted previously, most research studies have examined the use of meditation within the general population, and very few have specifically investigated the effects of meditation upon therapists' personal and professional lives. Evidence for such effects has largely been extrapolated from studies on the general population, or those with very small samples of therapists, often using therapists' anecdotal accounts (Addison, 2000).

Although UK psychologists do not seem to have taken up meditation in a noticeable way, high numbers of British people are meditating. According to a 1999 Gallup poll, 12% of men and 11% of women in Britain meditate (Prospect, 2000, p.7). A cursory web search revealed many hundreds of organisations around the UK that offer meditation courses to the general public. The author found none with clear links to mainstream therapy organisations such as the British Psychological Society (BPS), United Kingdom Council for Psychotherapy (UKCP) or the British Association of Counselling (BAC). However, several UKCP accredited schools of psychotherapy use meditation as a central or additional element of their trainings, no counselling psychology trainings are known to incorporate it. Moreover, it seems that meditation is rarely taught by psychotherapeutic professionals, or within the context of psychological therapy.

It appears that there has been no meditation survey of psychological therapists, in any country, and so it is difficult to estimate the use of meditation by psychotherapeutic professionals. The most effective way to measure the use of meditation amongst psychologists would be a survey, rather than evaluation by tangential means such as the number of research reports, or training courses that incorporate meditation. Without such a survey, there can be no clear estimation as to the prevalence of meditation within the community of psychological therapists.
This research focuses on counselling psychology because the absence of debate about meditation in this field is particularly conspicuous, and because the researcher is a trainee counselling psychologist. As an integrative discipline with a strong commitment to research and development, counselling psychology is well placed to use and examine the therapeutic applications of meditation. Moreover, as a technique that has been widely used for thousands of years and has become increasingly popular amongst the UK population and professional colleagues abroad, meditation seems well placed to enrich the practice of counselling psychologists.

**Research aims**

The research was generated to answer the following questions:

- To what extent have meditation techniques been used by the counselling psychologists?
- Do respondents agree with the purported benefits of meditating?
- Do they agree with the contextual factors influencing these effects?
- Do respondents see a role for meditation in psychotherapy?
- How much do respondents feel they know about meditation?
- To what extent do their views seem to be based on knowledge or ignorance?
- What reasons could explain variance amongst the respondents in their:
  - a) use of meditation?
  - b) interest in meditation?
  - c) views about the compatibility of meditation with psychotherapeutic practice?

The research is part exploratory – seeking answers in the absence of knowledge, and generating hypotheses; and part confirmatory – evaluating the extent to which counselling psychologists agree with a set of claims that have been made about meditation. A few predictions were made about the data that would emerge; these were:

1) Meditators would score more highly on the knowledge scale.
2) Meditators would score more highly on the interest scale.
3) Meditators would score more highly on the scales derived from the qualitative study than non meditators. If this were so it could be taken as further support for these claims about meditation.

4) Larger differences would be found on the scales dealing with the arguably less well-known effects of meditation – i.e. increased ability to deal with threatening situations, increased awareness of self and of other, increased self-efficacy; as opposed to increased calmness and cognitive focus which seem to be effects with which meditation is most commonly associated.

5) There was a tentative expectation that there would be stronger correlations amongst scale scores for the meditators than for the non-meditators. This would be indicative of more coherence in the views of the meditators; stemming from greater knowledge about and experience with meditation. It would also reflect a continuity of the meditators' views in this study with the views of meditators in the authors' previous studies, upon which the questionnaire was based. This would be particularly true regarding (a) relationships between the outcome factors (those inquiring as to the meditative effects of calm, efficacy, threat, focus, awareness of self, awareness of other); (b) relationships between the outcome factors and the interest, and compatibility scales; and (c) relationships for the less well known effects – the threat, efficacy, self-aware, other-aware scales.

If the purported benefits were supported in the data it would advocate opening up debate about meditation amongst counselling psychologists. This could take the form of more publications and perhaps the teaching of meditative strategies on training courses. These recommendations can be made all the stronger as it was found that many counselling psychologists (at least 13% of all chartered counselling psychologists) had used meditation techniques.
Method

Participants

Questionnaires were sent by mail to all 362 chartered counselling psychologists whose addresses were given on the BPS website; nearly all 369 chartered counselling psychologists in the UK (according to a BPS spokesperson in June 2001, personal communication). Questionnaires were also sent to a further 30 trainee counselling psychologists (all students at the University of Surrey). One hundred and four participants completed and returned the questionnaire, and the data was entered onto SPSS. Thus the response rate was 27% overall - 24% for the chartered group, 57% for the trainees. Twenty-four percent of all UK chartered counselling psychologists completed and returned the questionnaire; the corresponding figure for trainees is not known as the figure for the total number of trainees in the UK is not readily available.

The mean age of the participants was 48 years, and the mean number of years of psychological therapy practised was 14. Sixty-two (59%) were female, and forty-two (41%) were male; eighty-seven (84%) were chartered and seventeen (16%) were trainees.

Table 1. Participant's ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Frequency</th>
<th>% of all participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>UK, white</td>
<td>80</td>
<td>77%</td>
</tr>
<tr>
<td>Other European</td>
<td>17</td>
<td>16%</td>
</tr>
<tr>
<td>White American</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1%</td>
</tr>
</tbody>
</table>

As table one shows, the great majority of the participants were white and from the UK, only very few were of Asian ethnicity, and none were of Afro-Caribbean.
<table>
<thead>
<tr>
<th>Model</th>
<th>Frequency</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrative</td>
<td>69</td>
<td>66%</td>
</tr>
<tr>
<td>Psychodynamic</td>
<td>46</td>
<td>44%</td>
</tr>
<tr>
<td>Cognitive-behavioural</td>
<td>57</td>
<td>54%</td>
</tr>
<tr>
<td>Existential</td>
<td>20</td>
<td>19%</td>
</tr>
<tr>
<td>Transpersonal</td>
<td>10</td>
<td>10%</td>
</tr>
<tr>
<td>Transactional Analysis</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>Systemic</td>
<td>15</td>
<td>14%</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>17%</td>
</tr>
</tbody>
</table>

The respondents used a wide variety of theoretical models in their practice – over 90% used more than two, and so it seems that the vast majority practised integratively.

**Ethics**

Participants were informed that all data would be treated in confidence. This involved the questionnaires being anonymous, and assurances that potentially identifying details, such as length of practice, would be reported only in statistical form. The questionnaire did not inquire about sensitive issues and the participants were extremely unlikely to be distressed by their involvement in the study.

The proposal was viewed by others with a ‘critical eye’ and the drafts were subject to the University of Surrey’s Advisory Committee on Ethics. Following a few technical changes to the letter and Information Sheet which were sent to prospective participants (see appendix one), the proposed study was approved by the Advisory Committee on Ethics, which made no objection on ethical grounds at any stage.
Questionnaire design and development

The material used to ascertain answers to these questions was quantitative questionnaire concerning the following areas:
(a) use of meditation techniques;
(b) interest in meditation;
(c) knowledge of meditation
(c) attitudes toward the purported benefits of meditation;
(e) perceptions of contextual factors of meditation.

Given the original nature of this survey, it was necessary to develop a new questionnaire (appendix 2). No antecedent questionnaire was found which could supply information to meet the research goals. Moreover, as an aim of this research is to ascertain support for perceptions of meditation emerging from the researcher’s previous study it was appropriate to design a questionnaire based around these claims. The questionnaire comprised three sections inquiring into; [A] demographics, [B] personal use of meditation, and [C] perceptions of, and interest in meditation.

Section B covers questions on the frequency and length of practice (in minutes per sessions and years of practice) for [1] focusing meditation, [2] awareness meditation, and [3] other meditations. The main focus at the analytic stage is upon the first two types of meditation, the third was included in order to ensure that all types of meditation practice were captured.

Section C comprises 71 statements about meditation which the respondent is asked to respond to on a Likert scale of 1-7, where 1 indicates total agreement and 7, absolute disagreement. Participants also had the option of scoring ‘0’, indicating no discernible opinion on the item. This option was included so that where a respondent felt they had no opinion their response could be filtered out, and also so that the middle score, 4, was used to indicate a split or undecided opinion rather than no opinion. The frequencies of ‘0’ responses were taken as a measure of the
extent to which respondents felt that their answers were meaningful. Nearly all of the items were based directly upon factors emerging from the qualitative study; additional items were devised to measure [1] the respondents' knowledge (self-rated) about meditation, and [2] general interest in and attitude towards meditation. The 71 items were initially subsumed under 17 conceptual categories or scales (see appendix 3). Ten categories measured perceptions of outcomes of meditation, and 7 measured contextual issues.

Treatment of data

Before any data analysis was carried out, the scores on negatively scaled items were reversed so that in all cases higher scores indicated more positive attitude toward meditation and the premise upon which the scale was constructed (appendix 3 show which items' scores were reversed).

Scale scores were calculated as the mean of the scores upon the component items. Scale scores therefore vary from 1-7; scores of 1-3 signify disagreement with the premise of the scale while score of 5-7 indicate agreement.

All the analyses reported here are based upon treating ‘0’ scores (indicating that the respondent has no opinion) as missing data.

The data were exposed to six types of quantitative procedures in order to (1) revise the questionnaire scales; (2) describe the respondents’ experience of meditation; (3) explore the differences between meditators and non meditators; and (4) to explore the relationships between the scales for meditators and non-meditators. The results of these analyses now follow - each set of findings is introduced with a brief account of the statistical procedure used.
Results

Revision of the questionnaire scales

*Principal Components analysis* was carried out upon various scales in order to determine whether component items were being viewed as conceptually distinct by the respondents. It was thought that the respondents might treat items from various scales as conceptually similar, or items from a single scale as conceptually different. Subsequent analyses took into account the distinctions made by the respondent, as well as those of the researcher.

The scales about increased awareness of self, other, the world and interpersonal dynamics, and a further four scales concerning the changes in processes that restrict awareness were tested to find out whether it was more appropriate to aggregate them into fewer scales. Two further, conceptually broader, multiple item scales about the compatibility of meditation and psychotherapy, and increases in efficacy were analysed to explore whether they might better be split into more scales.

Both the 'graphical scree plot test' (Cattell, 1966), and 'Kaiser's criterion' (Stevens, 1996) were used to determine the number of factors. Under the terms of the scree plot test, where eigenvalues are plotted against number of factors, the factors retained are those which lie before the point at which the eigenvalues seem to level off. Under Kaiser's criterion the factors retained are those which have an eigenvalue of more than one. The Kaiser criterion has been recommended for situations where the number of variables is less than 30 and the average communality is greater than 0.70 (Stevens, 1996); these were the conditions under which it was applied here.

These analyses were the first to be conducted so that subsequent statistical explorations were based on the revised scales.
The scree plot test was used for analysing the compatibility and efficacy factors. The scree plots suggest that a one-factor solution is appropriate, as the line levels out after the first factor, and this was the action taken. In accordance with Stevens' (1996) guidelines outlined above, the Kaiser test, which recommends the use of all factors with an eigenvalues of over 1, was used for the four factors concerned with processes that restrict awareness, and the four factors describing increases in awareness. This was because the number of variables was less than thirty, and the average communality, as Table 3 shows, was greater than 0.7. In both cases two factors were identified with eigenvalues of over 1.
Table 4: Two-factor solution pattern matrix for items relating to processes restricting awareness

<table>
<thead>
<tr>
<th>Factor 1; '[P] Increased ability to deal with threatening situations' Eigenvalue 5.9</th>
<th>Component 1</th>
<th>Component 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meditation.....</td>
<td>.74</td>
<td>.10</td>
</tr>
<tr>
<td>...won't help you to accept what is happening in threatening situations.</td>
<td>.89</td>
<td>-.24</td>
</tr>
<tr>
<td>...makes it less likely that one would feel threatened</td>
<td>.89</td>
<td>-.28</td>
</tr>
<tr>
<td>...helps one to be less anxious about the future</td>
<td>.70</td>
<td>.14</td>
</tr>
<tr>
<td>...does not help people to break habitual patterns of thinking.</td>
<td>.57</td>
<td>.29</td>
</tr>
<tr>
<td>...does not help people to feel less panicky about problems.</td>
<td>.67</td>
<td>-.004</td>
</tr>
<tr>
<td>...is unlikely to reduce the threat you feel in problematic situations.</td>
<td>.58</td>
<td>.20</td>
</tr>
<tr>
<td>...helps people to appreciate a wider range of possibilities</td>
<td>.57</td>
<td>.18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Factor 2; '[Q] Decrease in ruminatory thinking' Eigenvalue 1.3</th>
<th>Component 1</th>
<th>Component 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>...increases concentration</td>
<td>-.12</td>
<td>.88</td>
</tr>
<tr>
<td>...does not facilitate focused thought.</td>
<td>.28</td>
<td>.66</td>
</tr>
<tr>
<td>...helps people to be less distracted</td>
<td>.40</td>
<td>.49</td>
</tr>
<tr>
<td>...does not give rise to more flexible, creative thinking.</td>
<td>.44</td>
<td>.49</td>
</tr>
</tbody>
</table>

Rotation Method: Oblimin with Kaiser Normalization.

The solution in table 4 gives rise to two-factors with clear conceptual differences; therefore it was decided to use these two factors to describe processes that restrict awareness, rather than the four factors first hypothesised. The first factor seems to describe an improved ability to manage psychologically threatening, probably emotive problems, and so it was named the ‘threat’ scale; while the second is concerned with the capacity for mental focus and productive/functional thought, and so it was titled the ‘focus’ scale.
Table 5: Two factor solution pattern matrix for items concerning increases in awareness

<table>
<thead>
<tr>
<th>Factor 1, 'Awareness of self' eigenvalue 1.5</th>
<th>Component 1</th>
<th>Component 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meditation...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>.. does not help you to be more self-aware.</td>
<td>.76</td>
<td>.02</td>
</tr>
<tr>
<td>.. helps you to understand yourself</td>
<td>.75</td>
<td>.08</td>
</tr>
<tr>
<td>.. raises awareness of thoughts</td>
<td>.76</td>
<td>.04</td>
</tr>
<tr>
<td>.. will not help you to be more aware of your body</td>
<td>.62</td>
<td>.06</td>
</tr>
<tr>
<td>.. does not heighten awareness of emotions.</td>
<td>.72</td>
<td>.20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Factor 2, 'Awareness of other' eigenvalue 7.2</th>
<th>Component 1</th>
<th>Component 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>increases understanding of relationships</td>
<td>.01</td>
<td>.89</td>
</tr>
<tr>
<td>.. does not increase understanding of the world.</td>
<td>.37</td>
<td>.71</td>
</tr>
<tr>
<td>.. is unlikely to help you understand other's experience.</td>
<td>.10</td>
<td>.82</td>
</tr>
<tr>
<td>.. helps people to understand others</td>
<td>.23</td>
<td>.61</td>
</tr>
<tr>
<td>.. help people to understand the world</td>
<td>.23</td>
<td>.73</td>
</tr>
<tr>
<td>.. helps people to understand relationship processes</td>
<td>.17</td>
<td>.87</td>
</tr>
<tr>
<td>.. raises awareness of others</td>
<td>.16</td>
<td>.70</td>
</tr>
<tr>
<td>.. does not make you more aware of interpersonal dynamics.</td>
<td>.08</td>
<td>.80</td>
</tr>
<tr>
<td>.. will not help you to be more aware of the world.</td>
<td>.04</td>
<td>.41</td>
</tr>
</tbody>
</table>

Rotation Method: Oblimin with Kaiser Normalization.

In the case of the items relating to increases in awareness, there is a clear conceptual difference between the first and second factors (see table 5). The first factor is concerned with awareness of oneself, while the second is concerned with awareness of others, the world and interpersonal dynamics. As this two-factor solution works both conceptually and statistically, it was used in place of the original four-factor construction. The first scale was titled 'self-aware' and the second 'other-aware'.

The scales were then subjected to reliability analysis, producing Cronbach’s alpha reliability coefficients for each scale, and improvements in coefficients resulting from any items being omitted were considered.
Table 6: Scale reliability measures

<table>
<thead>
<tr>
<th>Outcome Scale</th>
<th>A high score indicates the perception that ...</th>
<th>Reliab. Coeff: alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calm</td>
<td>Meditation facilitates calmness</td>
<td>.82</td>
</tr>
<tr>
<td>Threat</td>
<td>Meditation increases ability to deal with threatening situations</td>
<td>.88</td>
</tr>
<tr>
<td>Focus</td>
<td>Meditation decreases ruminatory thinking</td>
<td>.81</td>
</tr>
<tr>
<td>Self-aware</td>
<td>Meditation increases awareness of self</td>
<td>.78</td>
</tr>
<tr>
<td>Other-aware</td>
<td>Meditation increases awareness of other</td>
<td>.84</td>
</tr>
<tr>
<td>Efficacy</td>
<td>Meditation increases self-efficacy</td>
<td>.88* (ex. 57)</td>
</tr>
<tr>
<td>Knowledge</td>
<td>The respondent has a high level of knowledge about meditation.</td>
<td>.84* (ex.30)</td>
</tr>
<tr>
<td>Interest</td>
<td>The respondent has a high level of interest in meditation.</td>
<td>.84* (ex.43, 50)</td>
</tr>
<tr>
<td>Compatibility</td>
<td>Meditation and the practice of psychotherapy are compatible.</td>
<td>.85</td>
</tr>
<tr>
<td>Stability</td>
<td>The effects of meditation are stable over time.</td>
<td>.88</td>
</tr>
<tr>
<td>Personality</td>
<td>Personality influences the effects of meditation.</td>
<td>.70* (ex.19)</td>
</tr>
<tr>
<td>Tuition</td>
<td>Learning to meditate requires specialist tuition.</td>
<td>.60</td>
</tr>
<tr>
<td>Techniques</td>
<td>Different meditation techniques lead to different effects.</td>
<td>.56</td>
</tr>
</tbody>
</table>

The * indicates that an item (number in brackets) has been removed. This was done where removal led to a higher reliability coefficient and where there were also conceptual reasons why the item did not fit in well with the scale. For example, under the compatibility scale, item 19, “Changes stemming from meditation are influenced by personal goals”, differs conceptually from the other items in the scale which are concerned with the effects of personality upon meditation.

A coefficient of .8 or over indicates that the scale is very reliable (Bryman, 1999). A score of .7 or above was taken to be satisfactory, provided that the items were conceptually cohesive as a scale.

Table 6 shows that most of the scales, and all of the outcome scales, have satisfactory Cronbach’s coefficients. The exceptions are two of the context scales, ‘tuition’ and ‘techniques’; due to their low reliability rating and because they are
concepts which are not of central importance to the study, these scales were not used in subsequent analyses.

**Experience of meditation**

As part of the survey of participants' experience of meditation, the frequencies and mean number of years of practice for the three meditation types were calculated. This gives a sense of the variety and the extent of meditation experience amongst the participants.

**Table 7: Descriptive statistics for meditation experience**

<table>
<thead>
<tr>
<th>Meditation</th>
<th>Chartered</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Mean number of years</td>
<td>Frequency</td>
<td>Mean number of years</td>
</tr>
<tr>
<td>None</td>
<td>39 (45%)</td>
<td>0</td>
<td>10 (59%)</td>
<td>0</td>
</tr>
<tr>
<td>Any</td>
<td>48 (55%)</td>
<td>3.6</td>
<td>7 (41%)</td>
<td>2.8</td>
</tr>
<tr>
<td>Focusing</td>
<td>35 (40%)</td>
<td>5</td>
<td>7 (41%)</td>
<td>3.5</td>
</tr>
<tr>
<td>Awareness</td>
<td>21 (24%)</td>
<td>3.5</td>
<td>4 (23%)</td>
<td>2.1</td>
</tr>
<tr>
<td>Other</td>
<td>16 (18%)</td>
<td>2.5</td>
<td>0 (0%)</td>
<td>0</td>
</tr>
</tbody>
</table>

From looking at the results in table 7, it is clear that the majority of respondents had meditated, and the percentage of meditators was higher amongst chartered counselling psychologists. The mean length of meditation practice was also greater amongst the chartered psychologists. These differences do not seem surprising: given that the mean age of the chartered group was 20 years above that of the trainees, therefore they have had greater opportunities, temporally, to have tried meditation. Forty-eight chartered counselling psychologists had meditated, and so it is certain that at least 13% of all chartered counselling psychologists have meditated. In reality the figure is likely to be higher, as it is improbable that every counselling psychologist who has ever meditated received, completed and returned the questionnaire. Any particular meditation type had typically been practised for several years.
Evaluating attitudes on the scale factors

One-sample t-tests were calculated for all the scales to determine whether the means of the scores were significantly different from the mid-point on the scale (i.e. 4). This was done as a measure of the extent to which the respondents agreed or disagreed with the claims about meditation.

As several comparisons with the central score were made - 14 in total - the chance of finding a type one error increases to $0.05 \times 14 = 0.7$, which was clearly unacceptable. Therefore, the Bonferroni test has been applied so that the significance level required was changed from 0.05, to $0.05/14 = 0.0035$.

Table 8: Results from one-sample t-tests

<table>
<thead>
<tr>
<th>Context scales</th>
<th>High score indicates:</th>
<th>Mean</th>
<th>Stan. Dev</th>
<th>T val.</th>
<th>Sig. -2 tail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge*</td>
<td>High level of knowledge about meditation, self rated.</td>
<td>4.2</td>
<td>1.6</td>
<td>1.3</td>
<td>.212</td>
</tr>
<tr>
<td>Compatibility</td>
<td>Meditation &amp; psychological therapy are compatible.</td>
<td>5.3</td>
<td>1.5</td>
<td>8.6</td>
<td>.000</td>
</tr>
<tr>
<td>Stability</td>
<td>The effects of meditation are stable over time.</td>
<td>5.6</td>
<td>1.3</td>
<td>12.1</td>
<td>.000</td>
</tr>
<tr>
<td>Personality</td>
<td>Personality influences the effects of meditation.</td>
<td>5.1</td>
<td>1.1</td>
<td>9.8</td>
<td>.000</td>
</tr>
<tr>
<td>Interest</td>
<td>A high level of interest and a positive attitude toward meditation.</td>
<td>5.1</td>
<td>1.4</td>
<td>8.2</td>
<td>.000</td>
</tr>
</tbody>
</table>

$df = 103$. *mean number of zero scores was 3.4 per respondent.

<table>
<thead>
<tr>
<th>Outcome scales</th>
<th>High score indicates that meditation:</th>
<th>Mean</th>
<th>Stan. Dev</th>
<th>T val.</th>
<th>Sig. -2 tail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paradigm 1!</td>
<td>Leads to psycho-physiological relaxation</td>
<td>5.8</td>
<td>1.1</td>
<td>6.3</td>
<td>.000</td>
</tr>
<tr>
<td>Paradigm 2</td>
<td>Helps spiritual development</td>
<td>5.5</td>
<td>1.3</td>
<td>10.9</td>
<td>.000</td>
</tr>
<tr>
<td>Paradigm 3#</td>
<td>Facilitates psychological development</td>
<td>4.9</td>
<td>1.4</td>
<td>16.6</td>
<td>.000</td>
</tr>
<tr>
<td>Calm</td>
<td>Facilitates calmness</td>
<td>5.9</td>
<td>0.8</td>
<td>23.4</td>
<td>.000</td>
</tr>
<tr>
<td>Threat</td>
<td>Increases ability to manage threatening situations</td>
<td>4.7</td>
<td>0.9</td>
<td>7.1</td>
<td>.000</td>
</tr>
<tr>
<td>Focus</td>
<td>Improves capacity for cognitive focus</td>
<td>5.3</td>
<td>0.9</td>
<td>13.8</td>
<td>.000</td>
</tr>
<tr>
<td>Self-aware</td>
<td>Increases self-awareness</td>
<td>5.2</td>
<td>0.8</td>
<td>14.7</td>
<td>.000</td>
</tr>
<tr>
<td>Other-aware</td>
<td>Increases awareness of ‘other’ people and processes</td>
<td>3.9</td>
<td>0.9</td>
<td>-1.5</td>
<td>.141</td>
</tr>
</tbody>
</table>
Efficacy | Increases self-efficacy | 4.8 | 0.9 | 9.2 | .000

df = 103, except 199, #86

The premise stated in the second column of table 8 is the amalgamated concept drawn from scale items. A score of above 4 indicates support for the premise stated in the second column, whilst a score of below 4 indicates disagreement.

Of the contextual scales, the mean scores on 'compatibility', 'stability', and 'personality' are significantly higher than four. Therefore, it seems that the respondents agreed with the statements about meditation.

The exception to the positive scoring on the outcome scales is with the other-aware scale, where the mean is slightly lower than the mid-point, though not significantly so. This is true for both the meditators and the non-meditators, though there was more disagreement amongst the meditators' scores (standard deviation higher by 0.3).

There was less consensus, as indicated by the standard deviation, on the context measures (knowledge, compatibility, interest), than on the outcome scales. It appears that there was relatively little disagreement on the outcome scales. So it seems that the respondents agreed more with each other as to the effects of meditation than on the extent of their knowledge and interest, and the compatibility of meditation and psychotherapy.

**Exploring the differences between meditators and non-meditators**

A series of independent samples t-tests was conducted to explore differences in ten scales scores between meditators and non-meditators. Again, the Bonferroni correction was applied so that the required significance level was 0.05/14 = 0.0035.
Table 9: Independent sample t-test differences between meditators and non-meditators

<table>
<thead>
<tr>
<th>Scale</th>
<th>Meditated or Not</th>
<th>N</th>
<th>Mean</th>
<th>Stan. Dev.</th>
<th>t-value</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge*</td>
<td>Meditated</td>
<td>56</td>
<td>4.8</td>
<td>1.1</td>
<td>4.7</td>
<td>78</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>Not</td>
<td>47</td>
<td>3.4</td>
<td>1.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compatibility*</td>
<td>Meditated</td>
<td>56</td>
<td>5.1</td>
<td>1.3</td>
<td>-0.9</td>
<td>86</td>
<td>.339</td>
</tr>
<tr>
<td></td>
<td>Not</td>
<td>48</td>
<td>5.4</td>
<td>1.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stability</td>
<td>Meditated</td>
<td>56</td>
<td>5.5</td>
<td>1.1</td>
<td>-0.9</td>
<td>102</td>
<td>.391</td>
</tr>
<tr>
<td></td>
<td>Not</td>
<td>48</td>
<td>5.7</td>
<td>1.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personality</td>
<td>Meditated</td>
<td>51</td>
<td>4.9</td>
<td>0.0</td>
<td>-0.8</td>
<td>90</td>
<td>.445</td>
</tr>
<tr>
<td></td>
<td>Not</td>
<td>41</td>
<td>5.1</td>
<td>1.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calm*</td>
<td>Meditated</td>
<td>56</td>
<td>5.9</td>
<td>0.8</td>
<td>0.3</td>
<td>100</td>
<td>.731</td>
</tr>
<tr>
<td></td>
<td>Not</td>
<td>48</td>
<td>5.8</td>
<td>0.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Efficacy*</td>
<td>Meditated</td>
<td>56</td>
<td>5.1</td>
<td>0.8</td>
<td>3.1</td>
<td>91</td>
<td>.002</td>
</tr>
<tr>
<td></td>
<td>Not</td>
<td>44</td>
<td>4.5</td>
<td>0.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Threat</td>
<td>Meditated</td>
<td>56</td>
<td>4.9</td>
<td>0.8</td>
<td>3.2</td>
<td>99</td>
<td>.002</td>
</tr>
<tr>
<td></td>
<td>Not</td>
<td>45</td>
<td>4.3</td>
<td>0.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus</td>
<td>Meditated</td>
<td>55</td>
<td>5.5</td>
<td>0.7</td>
<td>1.9</td>
<td>98</td>
<td>.055</td>
</tr>
<tr>
<td></td>
<td>Not</td>
<td>45</td>
<td>5.1</td>
<td>0.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-aware</td>
<td>Meditated</td>
<td>55</td>
<td>5.5</td>
<td>0.8</td>
<td>3.0</td>
<td>98</td>
<td>.003</td>
</tr>
<tr>
<td></td>
<td>Not</td>
<td>45</td>
<td>4.9</td>
<td>1.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other-aware</td>
<td>Meditated</td>
<td>56</td>
<td>3.9</td>
<td>1.1</td>
<td>1.4</td>
<td>101</td>
<td>.151</td>
</tr>
<tr>
<td></td>
<td>Not</td>
<td>47</td>
<td>3.7</td>
<td>0.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest</td>
<td>Meditated</td>
<td>56</td>
<td>5.7</td>
<td>1.0</td>
<td>5.2</td>
<td>101</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>Not</td>
<td>47</td>
<td>4.4</td>
<td>1.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meditation leads to psychophysio. Relaxation</td>
<td>Meditated</td>
<td>56</td>
<td>5.8</td>
<td>1.1</td>
<td>0.2</td>
<td>99</td>
<td>.843</td>
</tr>
<tr>
<td></td>
<td>Not</td>
<td>45</td>
<td>5.7</td>
<td>1.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meditation helps spiritual development*</td>
<td>Meditated</td>
<td>52</td>
<td>5.6</td>
<td>1.2</td>
<td>1.5</td>
<td>84</td>
<td>.136</td>
</tr>
<tr>
<td></td>
<td>Not</td>
<td>41</td>
<td>5.2</td>
<td>1.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meditation facilitates psychol. Development.*</td>
<td>Meditated</td>
<td>51</td>
<td>5.1</td>
<td>1.5</td>
<td>1.0</td>
<td>85</td>
<td>.309</td>
</tr>
<tr>
<td></td>
<td>Not</td>
<td>36</td>
<td>4.7</td>
<td>1.2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Variances not equal.
The prediction that meditators would score more highly than non-meditators on the scales derived from the qualitative study had mixed support. The meditators' mean scores were higher on all of the outcome scales, but none of the context scales derived from the study. Only three of these differences are statistically significant - self-aware, threat and efficacy. However, as predicted, these higher scores by the meditators were on those effects that seem to be generally less well known.

As predicted, meditators scored significantly higher on the interest and knowledge items.

The standard deviations on the outcome scales were larger with the non-meditators' scores than with the meditators. Therefore, there was greater consensus amongst the meditators scores than amongst the non-meditators. The exception is on the awareness of other scale, where non-meditators' standard deviation was 0.8 and the meditators' was 1.1.
Exploring relationships between the scales for meditators and non-meditators

Pearson's correlations and multiple regression were carried out in order to find out which meditation outcome factors were important in predicting meditators' and non-meditators' (1) interest in meditation; (2) opinions on the compatibility of psychotherapy and meditation, and; (3) views on meditation increasing self-efficacy. As the intention was mostly exploratory - concerned with generating hypotheses in the absence of theory - the stepwise option was taken on the regression; this meant that the relationships described were driven by the data rather than by theory. Any findings would be tentative and would require confirmation in subsequent research.

Meditators and non-meditators were treated as separate groups in order to detect any differences in the thinking between these groups, and to fuel ideas that might explain these differences.

Pearson correlations

*Table 10: Correlations between outcome factors, interest & compatibility scales*

a) Meditators

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Threat</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calm</td>
<td>.389**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Efficacy</td>
<td>.747***</td>
<td>.569***</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus</td>
<td>.537***</td>
<td>.567***</td>
<td>.702***</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-aware</td>
<td>.512***</td>
<td>.491***</td>
<td>.613***</td>
<td>.641***</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other-aware</td>
<td>.361**</td>
<td>.205</td>
<td>.264*</td>
<td>.331*</td>
<td>.228</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compatibility</td>
<td>.442***</td>
<td>-.146</td>
<td>.377**</td>
<td>.291*</td>
<td>.239</td>
<td>.183</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Interest</td>
<td>.500***</td>
<td>.453***</td>
<td>.675***</td>
<td>.609***</td>
<td>.411**</td>
<td>.309*</td>
<td>.401**</td>
<td>1</td>
</tr>
</tbody>
</table>

204
As predicted, table 10 shows that correlations were stronger amongst the meditators than amongst the non-meditators. This was especially true for the following more obscure scales - threat, other-aware, and efficacy.
Compatibility and Outcomes

All six outcome factors – Efficacy, Calm, Threat, Focus, Self-aware, and Other-aware, were entered into a stepwise regression analysis to determine which factors were most important in predicting the extent to which meditation was viewed as compatible with psychotherapy.

1) Meditators

Table 11: Regression results for compatibility and outcome scales

<table>
<thead>
<tr>
<th>Significant models</th>
<th>β</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (adjusted $R^2 = .143$)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Efficacy</td>
<td>.399</td>
<td>.003</td>
</tr>
<tr>
<td>2 (adjusted $R^2 = .292$)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Efficacy</td>
<td>.681</td>
<td>.000</td>
</tr>
<tr>
<td>Calm</td>
<td>-.489</td>
<td>.001</td>
</tr>
</tbody>
</table>

Table 11 shows that efficacy scores predict 14.3% of the variance in meditators’ views on the compatibility of meditation and psychotherapy. If the calm scale is added then 29.2% of the variance in the compatibility factor is predicted. When other outcome variables are added as predictors, $R^2$, does not increase significantly. This is not to say these other outcome variables are unrelated to the compatibility scale – in fact, the threat, and focus scales for the meditators are highly correlated with compatibility (see table 10). Rather it implies that these scales do not go further in predicting variance already accounted for by efficacy. By excluding the focus and threat scales and not the calm scale, the regression results suggest that the variability in compatibility predicted by efficacy is very similar to that predicted by threat and focus (i.e. there is multi-collinearity), and that the variability predicted by calm is significantly different. On the Pearson’s correlations, calm is insignificantly and negatively correlated with compatibility – it would seem that its power to increase $R^2$ is connected to some unique quality in comparison with the other outcome scales – as far as the meditators are concerned. The problem of multi-collinearity could have been prevented by amalgamating those scales which are
highly correlated. However, it was decided not to do this as it was felt that this
would hide valid conceptual distinctions for the sake of statistical order.

2) Non-meditators

Table 12: Regression results for Compatibility and Outcome scales

<table>
<thead>
<tr>
<th>Significant model</th>
<th>$\beta$</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (adjusted $R^2 = .08$)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus</td>
<td>.320</td>
<td>.039</td>
</tr>
</tbody>
</table>

Only one of the outcome scales, focus, is a significant predictor of the variance in
non-meditators' views on the compatibility of meditation and psychotherapy, and
even this is not large. The focus scale is the only one that is significantly correlated
with compatibility on either the Pearson’s (at the 0.05 level) and the regression
analyses (focus predicts 8% of the variance in compatibility).

Predicting interest in meditation

Again, all six outcome factors were entered into a stepwise regression analysis, this
time to determine which factors were most important in predicting levels of interest
in meditation.

1) Meditators

Table 13: Regression results for interest and outcome scales

<table>
<thead>
<tr>
<th>Significant model</th>
<th>$\beta$</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (adjusted $R^2 = .448$)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Efficacy</td>
<td>.677</td>
<td>.000</td>
</tr>
</tbody>
</table>

There are similar themes here as with the analysis of compatibility above. Again,
efficacy is the sole significant factor drawn from the regression, and it is a very
significant predictor. 45% of the variance in interest is predicted by meditators’
views about efficacy, and the relationship is positive. However, all other factors
correlate significantly with interest, and so it seems that the variance explained by
efficacy is very similar to that explained by the other scales. Efficacy is the best predictor of interest for meditators, and calm, threat, focus, self-aware, and other-aware are also all significant.

2) Non-meditators

Table 14: Regression results for interest and outcome scales

<table>
<thead>
<tr>
<th>Significant model</th>
<th>β</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (adjusted R^2 = .395)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Efficacy</td>
<td>.640</td>
<td>.000</td>
</tr>
</tbody>
</table>

Efficacy is also a similarly powerful predictor of interest for the non-meditators, and although the other scales do not add predictive power, the threat, focus and self-aware scales are significantly and positively correlated with interest. The calm and other-aware scales are neither correlated with interest nor do they add predictive power when combined with efficacy.

Predicting views about meditation and changes in self-efficacy

The remaining five outcome factors were entered into a stepwise regression in order to explore which were most significant in influencing views about meditation leading to changes in self-efficacy.

1) Meditators

Table 15: Regression results for efficacy and outcome scales

<table>
<thead>
<tr>
<th>Significant models</th>
<th>β</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. (adjusted R^2 = .727 )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Threat</td>
<td>.856</td>
<td>.000</td>
</tr>
<tr>
<td>2. (adjusted R^2 = .808 )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus</td>
<td>.340</td>
<td>.000</td>
</tr>
<tr>
<td>Threat</td>
<td>.673</td>
<td>.000</td>
</tr>
<tr>
<td>3. (adjusted R^2 = .835)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Threat</td>
<td>.650</td>
<td>.000</td>
</tr>
<tr>
<td>Focus</td>
<td>.254</td>
<td>.002</td>
</tr>
<tr>
<td>Calm</td>
<td>.174</td>
<td>.016</td>
</tr>
</tbody>
</table>
Table 15 shows that threat, focus and calm scores together account for a very large 83% of the variance meditators' views about meditation affecting self-efficacy. All the outcome scales are highly correlated with efficacy – except for other-aware, where there is no significant correlation. All the relationships are positive, and so what seems to drive meditators' views that meditation leads to increased self-efficacy are opinions that meditation facilitates calm, cognitive focus, self-awareness and reduces the sense of threat.

2) Non Meditators

Table 15: Regression results for efficacy and outcome scales

<table>
<thead>
<tr>
<th>Significant models</th>
<th>$\beta$</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. (adjusted $R^2 = .676$)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus</td>
<td>.822</td>
<td>.000</td>
</tr>
<tr>
<td>2. (adjusted $R^2 = .727$)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-aware</td>
<td>.590</td>
<td>.000</td>
</tr>
<tr>
<td>Other-aware</td>
<td>.324</td>
<td>.010</td>
</tr>
<tr>
<td>3. (adjusted $R^2 = .777$)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus</td>
<td>.546</td>
<td>.000</td>
</tr>
<tr>
<td>Self-aware</td>
<td>.357</td>
<td>.003</td>
</tr>
<tr>
<td>Other-aware</td>
<td>.226</td>
<td>.006</td>
</tr>
</tbody>
</table>

With the non-meditators a quite different set of factors accounts for a similarly large amount of the variance in efficacy. Focus, self-aware, other-aware and threat all correlate significantly and positively with efficacy; although threat does not account for any significant variability beyond that explained by the first three. Unlike the meditating group, calm is not significantly correlated with efficacy, and it does not account for the variance in efficacy unaccounted for by the 3-factor model.
Discussion

The extent of meditation use; and views about outcome and contextual factors

In exploring the respondents' views, the research seeks to make reasonable comment upon the population of counselling psychologists. Inevitably it has not been possible to canvass the attitudes and the experiences of all counselling psychologists in the UK. Nor has it been possible to ensure that the respondents were randomly selected; the respondents are a self-selected group. Therefore, it is likely psychologists who are interested in meditation, and those who have meditated were over-represented in the sample. Nevertheless, a significant proportion of chartered counselling psychologists gave their opinions, and however unrepresentative they might be, their views form a major part of those of the profession as a whole.

Clearly, meditation has been widely used amongst chartered counselling psychologists. Already, it looks as if the lack of interest in meditation within the counselling psychology establishment does not reflect a lack of interest in meditation amongst its professionals. As the author's previous studies suggested, most meditation techniques used fell into the categories of 'focusing' and 'awareness' meditations (85%), with the focusing type clearly most popular. This is in-line with accounts of meditation given in the author's previous studies which described a hierarchy of meditation techniques, with focusing meditation as the most fundamental, easily applied and popular, followed by awareness meditations and then onto the more integrated and complex third forms. The mean number of years of meditation practice (3.6 for chartered, 2.8 for trainees) in itself suggests that the meditators are committed to the practice and that they find it useful.

The scores on the knowledge scale suggest that the respondents felt that they had neither a lot of knowledge about meditation nor a little. The low mean number of 'zero' scores per respondent (3.4) indicates that the respondents felt that their opinion was meaningful on the great majority of items (95%). It does not seem then
that counselling psychologists view themselves as unknowledgable about meditation; this could undermine the argument that more information about meditation should be made available within training courses, texts and journals. However, they also did not judge themselves to be knowledgeable about meditation. Furthermore, as the sample is self-selected it is likely to be biased in favour of those with more interest and knowledge about meditation. Therefore the actual extent of knowledge amongst the populations of counselling psychologists is likely to be less than was seen here.

On the three items concerning the paradigms in which meditation may be used - for relaxation, spiritual change, and psychological development - the mean responses are all highly significantly positive. There is however a clear preference for meditation to be viewed as facilitating relaxation (mean = 5.8) and spiritual development (5.5), rather than psychological development (4.9). The standard deviation on the scores on the psychological development question is also higher, so there was more disagreement amongst meditators on this question. These differences are similar amongst meditators and non-meditators. In some ways these distinctions seem unlikely. Relaxing is one of the more basic and simple human endeavours whilst spiritual development is arguably one of the most complex. Why is meditation viewed as intervening more at the fundamental and esoteric levels than at a psychological level? Perhaps the answer to this has to do with the relative absence of meditative techniques within mainstream psychology, and the seemingly stronger presence of meditation techniques in religious and physical health contexts. It may be that meditation is viewed less as a method for psychological development not because it does not fulfil this, but because it is not ordinarily applied within the clinical/counselling psychology sector.

The findings on the outcome scales generally support the perceptions that emerged from the quantitative study. The respondents agreed with nearly all of the premises of the scales based on the qualitative study. The agreement is highest on the calmness scale, which is in-line with the high agreement with the item about
meditation being viewed within the context of relaxation. Moreover there was a relatively high degree of consensus amongst the responses on the calmness scale. However, many authors on meditation, as well as one of the participants in the qualitative study, and one of the respondents of this study reported that meditating can be very agitating, so much so that it may precipitate psychotic episodes in vulnerable people. All this is consistent with the hypothesis that views about the effects of meditation are strongly influenced by the contexts (i.e. peaceful) in which it is practised, or is believed to be practised, and not just by the effects it actually brings about.

Nevertheless, the concept that meditation could lead to increased awareness of other people and interpersonal processes was clearly described in the qualitative study. Its failure to show up in this study may be because the concept can be hard to grasp, especially given the few seconds of thought that the respondents probably devoted to it, and so there is a tendency to answer in the negative. The qualitative method may have been better placed to extract this esoteric concept. The low mean score on this scale is significant for another reason; it suggests that respondents did not score positively because they thought it was what the researcher would like, or merely because they had a positive attitude towards and interest in meditation.

Differences between meditators and non-meditators

T-tests on the outcome and context scales
The results confirmed the first two predictions - meditators rated themselves as having greater knowledge of and more interest in meditation. As to the differences between the meditators and the non-meditators, there seems to be a split between the outcome scales and the context scales. Although the non-meditators responded more positively on all the context scales - compatibility, stability, personality, none of these differences is significant. Perhaps it seemed apparent to both sets of respondents that meditative effects can be short or long lasting and that personality should have some effect on these effects. As for the compatibility scale, it may be
that because the participants were self-selected, both groups scored similarly as they shared an interest in, and generally positive attitude towards meditation.

On the outcome scales, as predicted, meditators had significantly more positive views about meditation leading to efficacy, awareness of themselves, and reducing the sense of threat. Also in-line with predictions, the differences tended to be greatest on the factors that were surmised to be less well known – efficacy, threat, and self-awareness. Moreover, there were no statistically significant differences on the arguably better known effects of calmness and focus. Therefore, it appears that meditators view meditation as having a wider variety of effects than the non-meditators and that these effects are in-line with those outlined in previous research. Furthermore, it seems that the effects hypothesised as being less well known may not be fully appreciated as potential benefits of meditating by non-meditators. These results seem to advocate the dissemination of information about meditation to counselling psychologists – perhaps descriptions by meditating psychologists of how meditation has helped them to develop their self-awareness, self-efficacy and reduce the perception of threat.

**Relationships between the factors**
The findings suggest that for both the meditators and non-meditators, interest in meditation is best predicted by the extent to which meditation is seen as affecting efficacy. Intuitively this seems right - for the people in both groups their interest in meditation is largely mediated by the extent to which they view it as being able to help them to meet their goals. As predicted for the meditators, more scales were related to interest. For them, all the scales were significantly and positively related with interest, whilst for the non-meditators, calm, awareness of other, and compatibility were not significantly correlated with interest. In this the meditators' views seem to be more coherent, as one would expect interest in any practice to be correlated with views about what that practice can do for you. It seems as though the non-meditators are not as interested in being calmer as the meditators – it may be that within the meditators' personal philosophy, a calm state is seen as more
central to goal attainment. Perhaps meditators are more easily agitated and feel the need for a calming practice, or it may be that the philosophy that accompanies meditation emphasised the importance of calm.

Efficacy together with calm was the most significant predictors of compatibility for the meditators; threat and focus were also significantly and positively correlated with compatibility. For this group then, for meditation to be seen as compatible with therapy, it is important for it to be viewed as increasing self-efficacy, calmness, and focus, and reducing the perception of threat. Surprisingly though, self-awareness was not seen as relevant; even though the meditators' scores indicated that they viewed meditation as increasing self-awareness, and self-awareness is an integral part of the practice of psychotherapy. One would imagine that the more something is viewed as increasing self-awareness, the more it would be seen as compatible with psychotherapy. It may be that the meditators had not thought through the possible connection here because it is not immediately apparent. Other-awareness is also not seen as relevant to compatibility, and this seems quite likely to reflect the fact that meditation was not viewed as increasing other-awareness, and therefore unlikely to be relevant in relation to any other factor.

With the non-meditators, only focus was correlated with compatibility, although the relationship was not a strong one. This supports the hypothesis outlined above that the non-meditators' scores would be more weakly correlated than the meditators. This could well be the result of their relative lack of experience and knowledge about meditation giving their scoring across the scales a lack of conceptual cohesion. By contrast, the meditators may have a stronger intellectual and experiential sense of what meditation does and how the effects are linked together.

Looking at the relations between efficacy and outcomes, with the meditators, all of the other five outcome scales are highly correlated with efficacy. With the non-meditators, four are – calm, threat, focus and awareness of self. Again, this is in-line with the prediction that meditators' scores on the scales would be more highly
correlated than non-meditators', although the differences between the two groups in the extent of the correlations is not great. There is then some support here for the idea that non-meditators' responses would show weaker correlations, reflecting a relative lack of coherent knowledge about meditation. There are also differences between the two groups within the regression results, with the predictors of compatibility seeming to be more conceptually coherent in the case of the meditators (efficacy and calm) than the non-meditators (focus). On the predictors of self-efficacy, it appears that non-meditators' predictors are in-line with typical driving effects of psychotherapy (focus, increased awareness of others and of self), while the meditators' predictors are the more typical characteristics of meditation (calm, focus and reduced threat).
Conclusion

This research has shown that there is widespread interest in and use of meditation amongst counselling psychologists. There is general support for the views that meditation can facilitate factors contributing to psychological health, the attainment of personal goals, and professional development. The support is stronger amongst meditators than amongst non-meditators. It seems clear that a substantial proportion of counselling psychologists find meditation sufficiently rewarding to have established a regular practice over several years. This finding alone suggests that counselling psychologists could gain from further exploration of meditation; this could be driven by professional publications, training schools, or through personal endeavours.

Why meditation seems to have a lower profile within UK counselling psychology in comparison with related disciplines in the UK and abroad is not clear, although the results suggest that it is not an intentional, considered decision. Even the meditating psychologists tended to view meditation more in the light of relaxation and spiritual change rather than psychological change. However, this does not necessarily indicate that meditation is less appropriate within the field of psychological than within spiritual and relaxation contexts. Rather, it could reflect a general failure of UK applied psychologists to exploit the technique, with the result that meditation is rarely viewed in a psychological context in the UK. It may also reflect uncertainties in the relationship between the spiritual and the psychological domains. For example, a participant in the qualitative study commented that although she thought meditation could be usefully adapted and applied within psychological contexts, she would be reluctant to do so. She was concerned that wholesale importation of meditation strategies into the psychological domain could lead to misuse of the techniques; because it would trivialise meditation and because there was potential for meditation to be useless or even harmful if used outside of an appropriate philosophical/religious context such as Buddhism.
For the most part, the non-meditating respondents included in this research felt that they had a reasonable knowledge of meditation. However, they were self-selected for this project, and it is likely that they had more interest and knowledge about meditation than the population of non-meditating counselling psychologists. Moreover, some of their responses indicated that they may not have been aware of some of the less apparent, but nevertheless potentially powerful beneficial effects. Therefore, the results further recommend that more information about meditation should be disseminated within the profession.

As this research was largely exploratory, numerous questions remain unanswered. Just as with therapeutic models, it is not enough to have a thriving practice based solely on theoretical explanations. Consistent and integrated attempts should be made to discover when, and for whom meditation may be useful. This research, along with the author's two previous studies have gone some way to exploring and describing how meditation can be a useful tool for the psychological therapist, as a way of developing and maintaining a healthy therapeutic practice. If meditation is to be effectively applied within counselling psychology, further work should seek to adapt meditation techniques from the spiritual/relaxation paradigms in which they are currently embedded. This might involve changing the ways in which meditation is conceptualised, described, and practised, as well as exploring the use of meditation as a therapeutic intervention with clients.
References

Addison, D. (1999). Meditation may help psychological therapists to practise more effectively: To what extent is this thesis supported by literature? Unpublished: University of Surrey.


Descartes, R. (1642). *Meditations on the 1st Philosophy in which the existence of God, and the real distinction of mind & body are demonstrated.* Meditations.txt @ [www.ul.cs.cmu.edu](http://www.ul.cs.cmu.edu)


Appendix 1 – Letter and Information Sheet sent to prospective participants

The following letter was sent on University of Surrey, Department of Psychology headed paper:

Dear

Meditation research

I am a Counselling Psychologist in training within the PsychD programme at the University of Surrey. Currently I am investigating counselling psychologists’ use of and beliefs about meditation, and I hope that you may be able to help me by completing and returning the enclosed questionnaire (which would take around 15 minutes). If you are interested, please read the enclosed Information Sheet, and follow the instructions written there.

Yours sincerely,

Dominic Addison

Enclosed:
   Information Sheet
   Questionnaire
   Stamped addressed envelope
Information Sheet

This aim of this project is to survey and analyse counselling psychologists’ attitudes towards, and experience of, meditative strategies for personal and professional development. As such, it will explore the potential benefits and drawbacks to the use of meditative strategies for change. Previous research studies have supported the notion that meditation can facilitate personal development, and the practice of counselling and psychotherapy (see references). This study will further investigate these claims, and the findings will provide information and advice as to the use of meditative techniques within Counselling Psychology.

Meditation here is defined as a time-limited attempt to focus attention in a non-analytical way, and to avoid dwelling on discursive ruminatory thought. This may involve endeavouring to restrict awareness to a single object or process (such as one’s breathing; or a stone; or a chant); or it may be aimed at expanding awareness of experiential phenomena – thoughts, beliefs, sensations, feelings etc. Some practices may involve both of these factors. Historically, these practices have been referred to as ‘Eastern’ (i.e. Asian) meditations; although this term may be somewhat misleading.

It does not matter if you have no experience of meditating, or if you feel that you have no particular view on the subject – the only inclusion criterion is that you be a chartered counselling psychologist, or in training to be one.

If you are interested in taking part, please complete the enclosed questionnaire (which takes around 15 minutes) and return it to me using the SAE provided. This is the only commitment required. The questionnaires are anonymous – you do not need to state your name – and the information given will be treated in confidence. This means that within the final report, information will be presented in such a way that individuals cannot not be recognised.

The project is being conducted by Dominic Addison, a post-graduate Counselling Psychology Student at the University of Surrey, under the supervision of Dr. Martin Milton of the University’s Department of Psychology. It has been approved by the University of Surrey’s Ethic’s Committee. If you have any further questions about this project please direct them to Dominic Addison.
Appendix 2 – Questionnaire

Survey of counselling psychologists’ experience of, and beliefs about, meditative strategies.

This questionnaire is concerned with your experience, beliefs and attitudes about meditation. It doesn’t matter if you have little or no experience of meditation and feel unqualified to answer; I am interested in your responses all the same. However, if you feel that you have absolutely no opinion on an item, I would like you to circle ‘0’ in the right-hand column, indicating ‘no idea’.

The questionnaire takes around 20 minutes to complete. All responses are anonymous - the researchers will not know who completed them; all information will be treated confidentially – it will not be possible to identify individuals within the write-up of this research.
SECTION A – Demographic questions

First, I would like you to give me some information about yourself:

1) What is your age?
______________________years.

2) Are you
Female______ or Male______?

3) Are you a
chartered counselling psychologist______
a trainee counselling psychologist ______?
Other (please state) ____________________________________________.

3) How many years have you practised psychological therapy (including training years)?
______________________years.

4) What theoretical models do you use in your practice?
Integrative______ Psychodynamic______ Cognitive-behavioural______
Existential______ Transpersonal______ Transactional Analysis______
Systemic______
Other (please state) ________________

5) What is your ethnic group?
Afro-Caribbean______ African______ Asian______ British______
Other European______ Other (please state) ________________
SECTION B - Questions about meditation practice

Have you ever practised meditation? If so, please continue; if not, go on to section C.

B.1) Has your meditation practice involved focusing upon a single object (breath, stone, chant etc.)? If so please answer the next question; if not go on to question B2.

<table>
<thead>
<tr>
<th>a) How many times a week?</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>12</th>
<th>14+</th>
</tr>
</thead>
<tbody>
<tr>
<td>b) How many minutes long was a typical session?</td>
<td>0</td>
<td></td>
<td>10</td>
<td>20</td>
<td>30</td>
<td>40</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>60+</td>
</tr>
<tr>
<td>c) How many years did your practice last/has your practice lasted?</td>
<td>0</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10+</td>
</tr>
</tbody>
</table>

B.2) Has your practice involved meditations based on broadening awareness? If so please answer the next question; if not go on to question B3.

<table>
<thead>
<tr>
<th>a) How many times a week?</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>12</th>
<th>14+</th>
</tr>
</thead>
<tbody>
<tr>
<td>b) How many minutes long was a typical session?</td>
<td>0</td>
<td></td>
<td>10</td>
<td>20</td>
<td>30</td>
<td>40</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>60+</td>
</tr>
<tr>
<td>c) How many years did your practice last/has your practice lasted?</td>
<td>0</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10+</td>
</tr>
</tbody>
</table>

B.3) Has your practice involved meditations other than those above? If so please answer the next question; if not go on to section C.

How would you describe this type of meditation? ____________________________

<table>
<thead>
<tr>
<th>a) How many times a week did you practice this?</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>12</th>
<th>14+</th>
</tr>
</thead>
<tbody>
<tr>
<td>b) How many minutes long was a typical session?</td>
<td>0</td>
<td></td>
<td>10</td>
<td>20</td>
<td>30</td>
<td>40</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>60+</td>
</tr>
<tr>
<td>c) How many years did your practice last/has your practice lasted?</td>
<td>0</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10+</td>
</tr>
</tbody>
</table>
SECTION C – Questions about beliefs and attitudes towards meditation

Please indicate the extent to which you agree or disagree with the following statements, where circling ‘1’ indicates that you totally agree, and ‘7’ that you totally disagree. If you feel that you have absolutely no view on an issue I would like you to circle ‘0’ rather than ‘4’ (neither disagree nor agree).

<table>
<thead>
<tr>
<th></th>
<th>Totally agree</th>
<th>Both</th>
<th>Totally disagree</th>
<th>No idea</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think that meditation is an inappropriate practice for psychological therapists.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditation increases powers of concentration.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditation helps people to understand themselves.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditation does not help people to break habitual patterns of thinking.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditation does not lower anxiety.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I am knowledgeable about the processes by which meditation works.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I think that meditation is an appropriate activity for psychological therapists.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditation helps people to perceive what is happening in personally difficult situations.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditating does not help you to be more self-aware.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditation leads to psycho-physiological relaxation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditation helps people to understand others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditating won’t help you to accept what is happening in personally difficult or</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>threatening situations.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meditation could have an important role within psychological therapy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>The effects of meditation are transitory, lasting only in the short-term.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I know very little about meditation techniques.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>The effects of meditation are long lasting.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditating helps people to understand relationship processes.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Statement</td>
<td>Totally agree</td>
<td>Both</td>
<td>Totally disagree</td>
<td>No idea</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Meditation does not help people to be calmer.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Changes arising out of practising meditation are influenced by personal goals.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditating is unlikely to reduce the threat you feel in problematic situations.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditating helps people to appreciate a wider range of possibilities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditation can be well learnt and applied through reading/self-help methods.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>The effects of meditation are similar to those arising from psychotherapy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditating helps to raise self-esteem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditating helps people to be more aware of their thoughts.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditating will not help you to be more aware of the world.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditating requires specialist tuition.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I know very little about the effects of meditation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I am quite likely to explore meditation some time in the future.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>There are many different types of meditation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditating does not make you aware of interpersonal dynamics.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditating does not heighten awareness of emotions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Practising meditation will not increase self-efficacy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Some of the effects of meditation are permanent while others are short-lived.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditation has no role to play within the field of psychological therapy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditating helps people to understand the world.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditation is relaxing.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditation helps people to overcome problematic psychological processes.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditation does not give rise to more flexible, creative thinking.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditation is unlikely to help you understand other's experience.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Statement</td>
<td>Totally agree</td>
<td>Both</td>
<td>Totally disagree</td>
<td>No idea</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>The effects of meditation are influenced by the meditator's personality.</td>
<td>1</td>
<td>2</td>
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<td>4</td>
</tr>
<tr>
<td>Meditating helps to reduce defence mechanisms.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I don't have any particular feelings about meditation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Different meditative techniques have different effects.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditation does not help people to feel less panicky about problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditating will not help you to be more centred</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditation helps spiritual development.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditating does not facilitate focused thought.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>A particular meditation practice has similar effects regardless of individual differences.</td>
<td>1</td>
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<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditation is a fairly ineffective practice.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditation helps one to feel more whole.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditation helps people to be less distracted by unimportant things.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I am very unlikely to try meditation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditating raises awareness of other people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditating helps one to be less anxious about the future.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>The different types of meditation have broadly similar effects.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditating helps people to be more grounded.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditation increases understanding of relationships.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditation is fairly straightforward to learn and practice.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditating can enhance psychologists' professional practice.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditating does not increase understanding of the world.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I am intrigued by meditation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Meditation does not help people to realise their personal goals.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Statement</td>
<td>Totally agree</td>
<td>Both</td>
<td>Totally disagree</td>
<td>No idea</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>----------------</td>
<td>------</td>
<td>------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Psychological therapies and meditation practices are mutually enhancing.</td>
<td>1 2 3 4 5 6 7 0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I think meditation is unlikely to have significant effects on me.</td>
<td>1 2 3 4 5 6 7 0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have little interest in meditation.</td>
<td>1 2 3 4 5 6 7 0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meditating will not help people to become more functional.</td>
<td>1 2 3 4 5 6 7 0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meditation facilitates healthy psychological functioning.</td>
<td>1 2 3 4 5 6 7 0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meditation will not help you to be more aware of your body</td>
<td>1 2 3 4 5 6 7 0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meditation facilitates psychological development.</td>
<td>1 2 3 4 5 6 7 0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meditating could harm psychologists’ practice.</td>
<td>1 2 3 4 5 6 7 0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 3 – Original, and revised scales and items.
Discussion of reliability findings.

Original scales for contextual measures

<table>
<thead>
<tr>
<th>Scale</th>
<th>A high score indicates the respondents view that:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>He or she has a high level of knowledge about meditation.</td>
</tr>
<tr>
<td>B</td>
<td>Meditation and the practice of psychological therapy are compatible.</td>
</tr>
<tr>
<td>D</td>
<td>The effects of meditation are stable over time.</td>
</tr>
<tr>
<td>E</td>
<td>Personality influence the effects of meditation.</td>
</tr>
<tr>
<td>F</td>
<td>Learning to meditate requires specialist tuition.</td>
</tr>
<tr>
<td>G</td>
<td>Different meditation techniques lead to different effects.</td>
</tr>
<tr>
<td>O</td>
<td>A high level of interest and a positive attitude toward meditation.</td>
</tr>
</tbody>
</table>

Original scales for outcome measures

<table>
<thead>
<tr>
<th>Scale</th>
<th>A high score on which indicates the perception, based on the qualitative study, that:</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>Meditation facilitates calmness</td>
</tr>
<tr>
<td>I</td>
<td>Meditation reduces construct-laden, rigid cognition.</td>
</tr>
<tr>
<td>J</td>
<td>Meditation reduces the sway of psychological defence mechanisms</td>
</tr>
<tr>
<td>K</td>
<td>Meditation reduces neurotic thinking</td>
</tr>
<tr>
<td>L</td>
<td>Meditation reduces ruminatory, unfocused thinking.</td>
</tr>
<tr>
<td>M</td>
<td>Meditation increases awareness of:</td>
</tr>
<tr>
<td>Mi</td>
<td>Personal experience</td>
</tr>
<tr>
<td>Mii</td>
<td>Other people</td>
</tr>
<tr>
<td>Miii</td>
<td>The world</td>
</tr>
<tr>
<td>Miv</td>
<td>Interpersonal dynamics</td>
</tr>
<tr>
<td>N</td>
<td>Meditation increases self-efficacy</td>
</tr>
</tbody>
</table>

Revised scales following principal component analysis with item inventory

Outcome measures:
Calm: Meditation and calmness
Meditation does not lower anxiety.
Meditation leads to psycho-physiological relaxation. (-)
Meditation does not help people to be calmer.
Meditation is relaxing. (-)
Threat: Meditation and the ability to deal with threatening situations
Meditation does not help people to break habitual patterns of thinking.
Meditating won’t help you to accept what happens in personally difficult or
threatening situations.
Meditating helps to reduce defence mechanisms. (-)
Meditating helps people to appreciate a wider range of possibilities. (-)
Meditation helps people to perceive what is happening in personally difficult
situations. (-)
Meditating is unlikely to reduce the threat you feel in problematic situations.
Meditation does not help people to feel less panicky about problems.
Meditating helps one to be less anxious about the future. (-)

Focus: Meditation and ruminatory thinking
Meditation helps people to be less distracted by unimportant things. (-)
Meditating does not facilitate focused thought.
Meditation does not give rise to more flexible, creative thinking.
Meditation increases powers of concentration. (-)

Self: Meditation and the awareness of self
Meditation helps people to understand themselves. (-)
Meditating does not help you to be more self-aware.
Meditating helps people to be more aware of their thoughts. (-)
Meditation does not heighten awareness of emotions.
Meditation will not help you to be more aware of your body.

Other: Meditation and the awareness of other
Meditation helps people to understand others. (-)
Meditating is unlikely to help you understand other’s experience.
Meditation raises awareness of other people. (-)
Meditating will not help you to be more aware of the world.
Meditation helps people to understand the world. (-)
Meditating does not increase understanding of the world.
Meditating helps people to understand relationship processes. (-)
Meditating does not make you more aware of interpersonal dynamics.
Meditation increases understanding of relationships. (-)

Efficacy: Meditation and self-efficacy
Meditating helps to raise self-esteem. (-)
Practising meditation will not increase self-efficacy.
Meditation helps people to overcome problematic psychological processes. (-)
Meditating will not help you to be more centred.
Meditation helps one to feel more whole. (-)
Meditation does not help people to realise their personal goals.
Meditating will not help people to become more functional.
Meditation facilitates healthy psychological functioning. (-)
Interest:  **Interest in meditation.**
I am quite likely to explore meditation some time in the future. (-)
I am very unlikely to try meditation.
I am intrigued by meditation. (-)
I think meditation is unlikely to have significant effects on me.
I have little interest in meditation. (-)

*Contextual measures*

**Knowledge:**  
**Knowledge of meditation, self rated.**
I am knowledgeable about the processes by which meditation works. (-)
I know very little about meditation techniques.
I know very little about the effects of meditation.

**Compatibility:** The compatibility of meditation with the practice of psychological therapy.
I think that meditation is an inappropriate practice for psychological therapists.
I think that meditation is an appropriate activity for psychological therapists. (-)
Meditation could have an important role within psychological therapy. (-)
The effects of meditation are similar to those arising from psychotherapy. (-)
Meditation has no role to play within the field of psychological therapy.
Meditating can enhance psychologists’ professional practice. (-)
Psychological therapies and meditation practices are mutually enhancing. (-)

**Stability:** The stability of the effects of meditation over time.
The effects of meditation are transitory, lasting only in the short-term.
The effects of meditation are long lasting. (-)

**Personality:**  
**Personality influences upon the effects of meditation.**
The effects of meditation are influenced by the meditator’s personality. (-)
A particular meditation practice has similar effects regardless of individual differences.

**Tuition:** Learning to meditate.
Meditation can be well learnt and applied through reading/self-help methods.
Meditating requires specialist tuition. (-)

**Techniques:** The effects of different meditation techniques.
Different meditative techniques have different effects. (-)
The different types of meditation have broadly similar effects.
Meditation is fairly straightforward to learn and practice. (-)
A (-) next to an item indicates that the scores on that item were reversed so that all the items went in the same direction, where high scores indicated positive view about meditation, and agrees with the premise upon which the scale was devised.

**Discussion of the decision to not to use the tuition and techniques scales.**

Even though the alpha scores on the tuition and techniques scales are not high enough to allow these scales to be accepted as reliable, all the inter-item correlations for these scales are all significant at the 0.05 level. In the case of the tuition scale, it may be that the items simply do not measure a similar quality as it possible to imagine discordant scores on the items being valid. For example, the tuition scale consists of the following items:

- Meditation can be well-learnt and applied through self-help methods.
- Meditation requires specialist tuition.
- Meditation is straightforward to learn and practice.

It does not seem that it would be conceptually inconsistent to claim that learning to meditate, like perhaps learning a language, requires specialist tuition and can be learnt through self-study.

In the case of the techniques scale, the items are conceptually very similar:

- Different types of meditation have broadly similar effects;
- Different meditation techniques have different effects;

and they are correlated at the 0.001 level. The use of the word ‘broadly’ in the first questions may go some way to explaining why the correlation between the items is not stronger, as it is conceptually possible to have differing effects that are broadly similar. If the sample is split between non-meditators and meditators there is a marked change in the reliability statistic. Meditators answers to the items give an alpha of 0.43 while non-meditators give an alpha of 0.75. This could be explained by (1) meditators being more inclined to pick up on the subtle difference between the items due to the word ‘broadly’; or (2) that meditators are more generally inclined to respond positively to items that non-meditators. This second issue is further explored in the section describing difference between groups.
Appendix 4 – Notes for contributors,
Counselling Psychology Review

The study has been written in-line with the following requirements:

Notes for Contributors
Submissions
The Editorial Board of Counselling Psychology Review invites contributions on any aspects of counselling psychology. Papers concerned with professional issues, the training of counselling psychologists and the application and practice of counselling psychology are particularly welcome. The Editorial Board would also like to encourage the submission of letters and news of forthcoming events.

Academic and Practitioner submissions
Manuscripts should be typewritten, double spaced with 1" margins on one side of A4 paper. Each manuscript should include a word count at the end of each page and overall. Sheets should be numbered. On a separate sheet include author’s name, any relevant qualifications, address, telephone number, current professional activity and a statement that the article is not under consideration elsewhere and has only been submitted to Counselling Psychology Review. As academic and practitioner articles are refereed, the rest of the manuscript should be free of information identifying the author. Authors should follow The Society Guidelines for the Use of Non-Sexist Language contained in the booklet Code of Conduct, Ethical Principles and Guidelines. Four copies of the manuscript should be submitted with a large s.a.e. A copy should be retained by the author.

Bibliographic references in the text should quote the author’s name and the date of publication thus: Davidson (1999).

All references should be listed at the end of the text and should be double spaced in APA style. A guide to the presentation of references using the APA style is given in The British Psychological Society Style Guide, available at £3.50 per copy from The British Psychological Society, St Andrews House, 48 Princess Road, East, Leicester LE1 7DR, UK.
Low-quality artwork will not be used. Graphs, diagrams, etc., should be supplied in camera-ready form. Each should have a title. Written permission should be obtained by the author for the reproduction of tables, diagrams, etc., taken from other sources.

**Academic submissions only**

All academic submissions must include an abstract. The abstract should be no longer than 250 words (depending on the length of the paper). It needs to be double spaced, on a separate sheet and headed 'Abstract'. The British Psychological Society's Style Guide provides the following information on writing abstracts:

The purpose of the abstract is to allow the reader to assess the content of the article prior to reading the full text. In addition to appearing immediately below the author's name, the abstract will be used for indexing and information retrieval by such services as Psychological Abstracts. It should, therefore, be written so that it can be understood independently of the body of the paper (p.6).

Proofs of academic and practitioner articles are sent to authors for the correction of typesetting errors only. The Editor needs the prompt return of proofs.

Contributors should enclose a 3.5" disk (either DOS or Mac format) with the document saved both in its original word-processing format and as an ASCII file. All diagrams and other illustrations should be saved in their original format and as a TIFF or an EPS.

**Other submissions**

Book reviews, letters, details about courses and notices of forthcoming events are not refereed but evaluated by the Editor.

However, book reviews should conform to the general guidelines for academic articles. Contributors should enclose two hard copies.

Deadlines for notices of forthcoming events, letters and advertisements are listed below:

All submissions should be sent to: Counselling Psychology Review, The Editor, Centre for Stress Management, 156 Westcombe Hill, Blackheath, London SE3 7DH.

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