Institute for Clinical Social Work

THE IMPACT OF MINDFUL AWARENESS ON LISTENING IN PSYCHODYNAMIC PSYCHOTHERAPY

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By

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ABSTRACT

This study describes qualitative findings from 15 interviews, exploring experiences of mindfulness in psychodynamic listening. Embracing Freud's admonition to maintain "evenly suspended attention" to foster unconscious-to-unconscious communication in-session, this sample of seasoned psychodynamic clinicians disclosed attitudes and beliefs formed from years of experience, integrating their practices of mindfulness and psychotherapy. Transcripts from 90-minute interviews provided the phenomenological basis for analyzing their narrative data. Participants reported a common understanding of mindfulness and experienced it as integral to good quality psychotherapy. *Depth* of mindfulness in conjunction with psychodynamic appreciation of the unconscious mind sensitized their attention to cues of unconscious-to-unconscious communication in-session. For example, mindfulness helped participants remain clearer about their own associations and manage reactivity to the patient's processes. Because mindful awareness increased their in-session capacity for psycho-dynamically informed listening, participants could sustain attention to their own mind/body experiences, enhancing recognition of unconscious communication from the patient. This research was context sensitive to the migration of "mindfulness" from its traditional Eastern roots to its therapeutic Western setting. Findings support the benefit of long-term mindfulness practice in concert with psychodynamic training as well as understanding of *how* unconscious-to-unconscious communication is accessed in psychodynamic psychotherapy.

DEDICATION

To my parents and my beloved husband.

ACKNOWLEDGMENTS

An immense debt of gratitude is owed to my committee members: Joan DiLeonardi, who helped me keep my process in mind so that step-by-step I would finish; Dennis Shelby, who readily helped me think beyond my writing impasses to expand the scope of my thinking; Sherwood Faigen, whose insights brought me to new depths of understanding listening and the unconscious. Sincere appreciation also goes Constance Goldberg and Lynne Tykle, who served as readers for this project, for their feedback and for their ongoing loving support over the years. Without the generous and engaging participation of my research participants, this project would not have been possible.

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CHAPTER I

INTRODUCTION

Drop a coin in the river, and look for it in the river.
What is the coin? What is it that you're looking for in this practice?
~Dogen, cited in Magid (2002, p. 7)

The human mind is known today as a fascinating and complex system, especially because the mind is not isolated in the brain, but grows and functions in a context of multiple relationships (Siegel, 2007). Whether those relationships are physical, emotional, cognitive, spiritual or interpersonal, they are interdependent so that change in one type of relationship can affect the rest. But how does one begin to relate to the mind so one can understand its essence or message? How does one listen to the mind? A Tibetan Buddhist teacher responds, "The method for beginning to relate directly with mind is the practice of mindfulness" (Trungpa, 1991, p. 1).

A vast amount of research currently explores the benefit of mindfulness as an antidote to anxiety, depression, and various ailments. However, little research investigates how the psychotherapist's own mindfulness practice affects their therapeutic work, and specifically how they listen. What does mindfulness have to offer to psychodynamic psychotherapy? How do psychodynamic practitioners, who practice mindfulness, experience mindfulness affecting their therapeutic work?

General statement of purpose

This dissertation intends to clarify how those psychodynamic psychotherapists, who practice mindfulness, experience mindful awareness affecting their listening stance, particularly in regard to perceiving, registering and comprehending latent, unconscious meaning and process.

Significance of this dissertation for clinical social work

Whether one is listening to conscious or unconscious communications from a psychodynamic perspective, sustaining attention in the therapy session is difficult. So much has to be attended to, yet one is *not* to give attention to any one thing, if one applies S. Freud's prescription of evenly suspended attention (1961a). Freud recognizes the propensity for attention to be captured by the patient's conscious self-presentation or defensive patterns, drawing attention away from unconscious processing. He instructs practitioners to apply the discipline of evenly suspended attention to correspond with the patient's practice of free association (1961a). He contends that such an open, relaxed way of attending clears a path to intuition of unconscious processes. Accordingly, one must *not* try to fix anything, but catch the drift of the patient's unconscious with her own unconscious, attuning to and facilitating unconscious communications between the patient and the therapist. To surrender into this kind of listening process seems to require a deep acceptance and capacity for simply being in the present moment – listening.

Nonetheless, attention is not explicitly theorized in psychodynamic thought (Coltart, 2000; Shedler, 2010a). Subsequent authors (E.g., S. Ferenczi, E. Sharpe, T.

Reik, O. Fenichel) have revised the simplicity of Freud's recommended technique and sponsored a notion of "oscillation" between simple listening and cognitive processing, which T. Reik called "free floating attention" (Epstein, 1988, p. 178). Yet, there is still much to learn about how one develops and sustains evenly suspended attention and how this mental state influences the therapeutic process. A rapidly growing number of controlled studies demonstrate that "mindfulness meditation increases ability to direct and sustain attention" (Shapiro & Carlson, 2009, p. 19). So, many psychodynamic therapists today apply mindfulness to enhance their practice of evenly suspended attention. Some of these apparently experience a positive influence of their mindful state upon their practice of psychodynamic listening.

Insight into psychoanalytic listening has developed in the context of psychoanalysis, which some authors use interchangeably with "psychodynamic," a term introduced after World War II and used as a synonym for "psychoanalytic" (Shedler, 2010a). Over time, "psychodynamic" has evolved to refer to "a range of treatments based on psychoanalytic concepts and methods, but which do not necessarily take place five days per week or involve lying on a couch" (Shedler, 2010a). Grotstein (2009) addresses a short chapter to the effect of different frequencies of sessions on psychotherapy and articulates the importance of the psychodynamic psychotherapist being "psychoanalytically informed." Grotstein recognizes the fact that any patient's unconscious communications can be given attention at appropriate times when a therapist is attuned to this possibility. Evenly suspended attention can apply as well in psychodynamic therapy as in psychoanalysis. For however frequent the sessions are, the

attention to conscious and unconscious communications is a matter of proportion. No analyst attends *only* to unconscious communication. A psychodynamic psychotherapist preferably does not attend *only* to conscious communications.

Throughout in this paper, "unconscious" refers, not only to what has been repressed, but to what has been denied, disavowed, and never been registered in symbolic language, including what originated in a pre-verbal stage of life and never became something able to be thought of in ordinary language. And, for the purpose of this dissertation, the terms "psychoanalytic" and "psychodynamic" are considered interchangeable.

During the past thirty years, the surge of interest in the clinical use of mindfulness practice highlights the relevance of studying how the therapist's mindful awareness contributes to the psychodynamic listening process in which an open, nonjudgmental attitude creates the possibility for latent meanings to be received and understood. Since many seasoned clinicians bring a mindful awareness to their work with patients, their self-reports can help illuminate how mindful awareness affects psychodynamic listening.

Statement of the problem studied and specific objectives achieved

What can psychodynamic psychotherapists tell us about the impact of their mindful awareness upon their listening stance during sessions? Specifically, what can they tell us about how mindful awareness affects listening for unconscious meanings and processes during sessions? Addressing such a problem accomplishes three objectives:

1) provide information to the clinical field about its practice of psychodynamic listening,

2) clarify the potential for integrating mindfulness into psychodynamic psychotherapy and

3) contribute to clinical process theory.

CHAPTER II

LITERATURE REVIEW

> *Have patience with everything unresolved in your heart and try to love the questions themselves as if they were locked rooms or books written in a very foreign language.*
>
> ~Rainer Maria Rilke (1875-1926), *Letters to a Young Poet.*

A wonderful Chinese proverb declares, “To say you don’t know is the beginning of knowing” (Nhat Hanh, 1988, p. 24). This dissertation draws upon literature at the juncture of not-knowing and knowing, literature researching psychoanalytic listening and / or mindfulness. This literature shows that a phenomenological exploration of the psychotherapist’s subjective experience of “evenly suspended attention” in the psychodynamic treatment process would be worthwhile to understand the influence of mindfulness in psychodynamic listening. This section reviewing the literature develops with five parts. First, Freud’s meaning of “evenly suspended attention” has been understood in a variety of ways within the psychoanalytic tradition. Next, some authors critique Freud’s prescription for how to develop evenly suspended attention. Third, a summary of recent research shows how a scientific definition of mindfulness has been sought to ground and enable further empirical research. Fourth, since context impacts the meaning of words and ideas, a summary of recent literature shows what impact the

meaning of mindfulness has on practitioners, as it migrates from a traditionally Eastern concept ("traditional mindfulness") into the context of the Western psychotherapy tradition ("therapeutic mindfulness"). Fifth, a meager literature, researching the effects of a psychotherapist's mindfulness on patient outcomes and on therapist well-being, suggests a benefit for the study of mindfulness in psychodynamic listening during therapy sessions. Due to the limits of psychological research literature, which specifically addresses the linkage between mindful awareness and evenly suspended attention, the following review of prior work represents this researcher's selection and integration of qualitative and quantitative research literature, which are relevant and potentially informative about the topic.

Psychoanalytic Listening and Attention

Freud clearly prescribed a radical stance in his central psychoanalytic technique as early as 1912. He describes this technique as:

> A very simple one. As we shall see, it rejects the use of any special expedient (even that of taking notes). It consists simply in not directing one's notice to anything in particular and in maintaining the same "evenly suspended attention" (as I have called it) in the face of all that one hears . . . . It will be seen that the rule of giving equal notice to everything is the necessary counterpart to the demand made on the patient that he should communicate everything that occurs to him without criticism or selection. If the doctor behaves otherwise, he is throwing away most of the advantage which results from the patient's obeying the "fundamental rule of psychoanalysis." The rule of the doctor may be expressed: "He should withhold all conscious influences from his capacity to attend, and give himself over completely to his "unconscious memory." Or, to put it purely in terms of technique: "He should simply listen, and not bother about whether he is keeping anything in mind" (Freud, 1961a, pp. 111-112).

Although attention itself has not been explicitly theorized in psychoanalytic thought (Eaton, 2009, p. 108), a few authors (i.e., H. Deutsch, S. Isaacs, A. Reich, W.R. Bion, H. Kohut, R. Schafer, & J. Chassequet-Smirgel) have noticed and supported the therapeutic benefits of a singular state of mind in analysis (Epstein, 1988). For example, Deutsch attempted to elucidate Freud's original concept by explaining that the analyst grasps with "analytic intuition" the unconscious dynamic in the patient and re-projects the material via interpretations (Deutsch, 1926, 136). She portrays the analyst's conscious activity as consistent with evenly suspended attention toward the unconscious. Later, Bion describes psychoanalytic listening as an optimal state of mind, which enables the analyst to be receptive to what is not yet known without "mental activity, memory and desire" (Bion, 1970, p. 42). Kohut, too, emphasized "the emergence and use of the analyst's prelogical modes of perceiving and thinking" as an active discipline (Kohut, 1977, p. 251) and considered empathy (i.e., vicarious introspection) as *the data gathering tool* of psychoanalysis (Kohut, 1959, p. 460). What Freud described above is a simple state of attention that does not become captured by cognitive processing or an interpretive frame, but remains open, curious, and exploratory (Bohm, 2002), which allows the analyst's unconscious to catch the drift of the patient's unconscious communication.

Other analysts, however, have struggled to apply Freud's prescription of an evenly suspended attention to their analytic efforts because they found cognitive processing to be a notable feature of their experience, dissonant from simple listening. A simple stance was characterized as "ideal", but not practical. Such well-known analysts as S. Ferenczi, E.F. Sharpe, T. Reik, D. Fenichel, R. Fliess, R.R. Greenson, J.D.

Lichtenberg, J.W. Slap, R. Langs, and N. Freedman are included in the history of authors who felt the need to revise Freud's initial formulation into a process of oscillating attention (Epstein, 1988). Ferenczi, for example, elaborated what is required "to grasp intuitively the expressions of the patient's unconscious," but concluded:

> In time, one learns to interrupt the letting oneself go on certain signals from the preconscious, and to put the critical attitude in its place. This constant oscillation between free play of phantasy and critical scrutiny presupposes a freedom and uninhibited motility of psychic excitation on the doctor's part, however, that can hardly be demanded in any other sphere (Ferenczi, 1919, p. 189).

Ferenczi was the first to accentuate the idea of oscillation of attention between "identification on the one hand and self-control or intellectual activity on the other" (Ferenczi, 1928, p. 96).

Although T. Reik's (1933) earliest expositions on psychoanalytic listening favored Freud's original precepts, his work in 1937 argues for attentional oscillation in a way that is not apparent in his earlier work. On the one hand, Reik defends Freud's position, but on the other he cautiously reintroduces the necessity of selective attention (Reik, 1937, p. 46). Then, Fenichel's subsequent book drew upon Reik's book and solidified the idea of attentional oscillation by calling for a return of reason to analytic listening and by warning that evenly suspended attention involves "hardly any work at all" (Fenichel, 1939, p. 442). Nine years later, this line of thinking resulted in the term "free-floating attention" (Reik, 1948), in which evenly suspended attention is described as oscillating between simple listening and cognitive processing.

Freud's prescription for "evenly suspended attention" nonetheless has as its purpose to "withhold all conscious influences" in order to receive the patient's unconscious meanings. Later in his career, Freud wrote:

> Experience soon showed that the attitude which the analytic physician could most advantageously adopt was to surrender himself to his own unconscious mental activity, in a state of evenly suspended attention, to avoid so far as possible reflection and the construction of conscious expectations, not to try to fix anything that he heard particularly in his memory, and by these means to catch the drift of the patient's unconscious with his own unconscious (Freud, 1961d, p. 239).

Following Freud's method, the psychoanalyst's own unconscious becomes the reliable source for interpreting the patient's unconscious communications. The psychoanalyst's capacity for evenly suspended attention enables recognition of the unconscious patterns or processes communicated by the patient. Bion suggested that the "only point of importance in any session is the unknown. . . . Out of the darkness and formlessness something evolves. . . . This evolution must be what the psychoanalyst must be ready to interpret" (Bion, 1967, p. 272).

Coltart links what is required in waiting for the unknown with a "negative capability," which in her view is one of the benefits of mindfulness:

> One of its [mindfulness] richest fruits can be a deepening of a quality, which is essential for the good-enough practice of psychoanalysis. I refer to something for which there is no one exact word, but has to do with patience, with waiting, with "negative capability" which, inseparably linked with the continued exercise of bare attention, create the deepest atmosphere in which the analysis takes place. The more one just attends and the less one actually thinks during an analytical session the more open one is to learning to trust the intuition, which arises from the less rational and cognitive parts of the self, and the more open one is also to a full and direct apprehension of the patient and of what is actually going on (Coltart, 2000, pp. 174-175; bracket mine).

Coltart refers here to a way of being, this "negative capability," which John Keats found important in creativity, "when man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason" (Adams, 1995, p. 474).

Schwaber (1981, 1983, 1986, 1995) has repeatedly returned to reflect upon her own experiences of aspects of psychoanalytic listening in order to elaborate the meanings of empathy, psychic reality, attunement to patient's perception, and impasses. She has sponsored the recognition of the analyst's mode of observation as a rigorous mode of entering the patient's world, which must be free from a theoretical bias that claims to know "the psychic reality." The psychoanalyst must be free simply to experience.

Carlson's discussion (2002) of "free-swinging attention" emphasizes the analyst's capacity for rapidly shifting levels of attention. He compares the need to establish meaning in the analytic context with the task of a child learning language and highlights the analyst's role as a child in relation to what is unknown in the patient's communication. Carlson cites Freud's comment about "swinging over from one mental attitude to the other" as a basis for his term "free-swinging attention," but confuses "evenly suspended attention" in-session with Freud's idea of swinging from an "in-session attitude" (evenly suspended attention) to an "after-session attitude," which is discursive and analytical.

Speeth (1982) illuminates psychotherapeutic attention by differentiating between concentrated attention, panoramic attention and witness consciousness. *Concentrated* attention holds a narrow focus and becomes invested in a specific object; *panoramic*

attention maintains a wide focus, investing attention evenly over multiple objects; and *witness* consciousness maintains awareness of the kind of attention, the objects of attention and correlated events. Psychotherapy, in her view, requires the development of capacity for all three forms of attention. However, panoramic attention is identified with evenly suspended attention, while witness consciousness refers to the part of attention that observes impartially the flux (i.e., when and how) of concentrated and panoramic attention. Her definitions help to clarify different functions of these forms of attention as well as relationships between them.

Bollas (2007, 2009) eloquently describes the possibility of listening to the patient's unconscious communications from a simple attentional stance. Yet, he recognizes that this is not the attentional stance of a Zen master. Commenting on Freud's text from 1923, Bollas says:

> Let us take notice of this definition of the analyst's frame of mind. The psychoanalyst should "surrender himself to his own unconscious mental activity." Well, those of you who are into Zen may take note that these are not the words of a Zen master, but of Freud, who makes it very clear here that, so far as the observing ego is concerned, one must abandon it in order to surrender to one's own unconscious. Unlike Zen, Freud does not privilege this moment because it empties the mind. He is aware that this action allows for unconscious reception on his part and he will learn something, but it will be learned through unconscious processes of thought. Let us note further what he says. The analyst is "to avoid reflection." He is to avoid, so far as possible, "the construction of conscious expectations" and, finally, he is to "try not to fix anything he heard particularly in his memory." So, he is to avoid reflection, expectation, and memory (Bollas, 2007, p. 13).

Psychoanalytic listening occurs within "the Freudian Pair," Bollas' term for the analyst and patient engaged in the analytic process (Bollas, 2007). The analyst's discipline of

evenly suspended attention in-session corresponds with the patient's discipline of free association, which forms a partnership in this discipline of bringing the unconscious communications of the patient into awareness.

While these studies of psychoanalytic listening emerge from reflection upon self-reported analytic experiences, they clarify aspects of psychoanalytic listening that describe a unique discipline and mental state. Psychoanalytic listening intends to receive the patient's unconscious communication; it sustains attention upon experience with the patient in the present moment; and it maintains an impartial attitude for what emerges in the consciousness of the patient and psychoanalyst. Evenly suspended attention during the psychoanalytic session preserves openness to the creative and avoids theoretical agendas. A concentrated, discursive, analytical use of attention is reserved for after the session when the psychoanalytic psychoanalyst may be working toward case formulation.

Developing evenly suspended attention

Freud recommended that every analyst undergo a personal analysis. The training analysis was originally intended to sensitize the analyst to his own complexes and thereby protect the patient (Freud, 1961a). Implicit in the training analysis, though unrecognized by Freud (Rubin, 1985), was development of a capacity for free association, the patient's parallel practice to evenly suspended attention.

> The ability to achieve and sustain such a mode of attention does not come easily, although it may be cultivated. . . . This open way of being may serve as a profound mode of access to revelatory manifestations of the depth dimensions and ultimately as a source of authentic action or transformation (Adams, 1995, p. 475).

What Freud espoused in psychoanalytic listening was known to require an intensive training, even in his day, and requirements for analytic training have preserved this standard. Recognizing the challenge in cultivating attention for psychoanalytic purposes, Karen Horney wondered whether Zen Buddhist practice could profitably apply to psychoanalytic training as early as 1952 (Morgan & Morgan, 2005). “An intensive discipline of unlearning is necessary for anyone before one can begin to experience the world afresh, with innocence, truth and love” (Laing, 1967, p. 11). But Freud recommended what to do, not how to cultivate evenly suspended attention. In its turn, the psychoanalytic community has not developed a systematic procedure or specific recommendations for cultivating the “evenly suspended” quality of attention to be found in analytic sessions.

Whereas practices that train the mind to concentrate serve the purpose of limiting the focus of attention, a practice of mindfulness opens the focus of attention toward impartial attending to whatever occurs. Recent attempts to validate the benefit of mindfulness practice on attention have proved positive, so that a “growing number of controlled studies [are] demonstrating that mindfulness meditation increases ability to direct and sustain attention” (Shapiro & Carlson, 2009, p. 19). Psychoanalytic authors who have discussed evenly suspended attention, by and large, either emphasize the importance of listening in this special way or imply that it can be developed. Like Freud, however, they blur the distinction between the will to listen with evenly suspended attention and the capacity to do so; or they write of the capacity already developed. Freud’s suggestions for removing the hindrances to listening are an essential element in

refining listening, but they do not constitute a way to generate an optimal capacity in listening.

During the past twelve years, encouraged by the rapidly growing body of research on applications of mindfulness practice to psychotherapy, authors have proposed ways to equip psychoanalysts with an evenly suspended attention for use with patients, including core principles and mindfulness exercises (Twemlow, 2001; Morgan & Morgan, 2005; Surrey, 2005). During the three years when this research was conducted, other authors (Bobrow, 2010; Rubin, 2009) have entertained the possibility of partnering mindfulness with psychodynamic psychotherapy. These contributions have endorsed the benefits of mindfulness for increasing concentration and the therapist's capacity to remain present, for decreasing a sense of separateness, and for reducing self-criticism and a judgmental attitude. However, they have also noted that mindfulness practice tends to focus "on deconstructing experience into its component parts, rather than decoding its meaning" (Rubin, 2009, p. 99). Without a psychodynamically-informed perspective, mindfulness can miss what lies outside awareness or what appears in terms of primary process, which is characteristic of unconscious mental activity. Mindfulness informed by a psychodynamic perspective on unconscious communication can enhance listening to the manifest and latent meanings of the patient. Their respective contributions can make for an integrated whole in terms of mindfulness in psychodynamic practice.

Mindfulness: The search for a definition

Some thirty years ago, mindfulness research began by studying the effects of

mindfulness practice on the treatment of chronic pain, depression, eating disorders, cancer and suicidal behavior (e.g., Kabat-Zinn, 1982). Mindfulness-based programs for stress reduction (MBSR) and mindfulness-based cognitive therapy (MBCT) taught patients how to practice mindfulness through meditation and found positive outcomes, comparing before and after self-reports. In 1998, two hundred and forty (240) such mindfulness-based programs could be documented (Salmon, Santorelli & Kabit-Zinn, 1998); by 2007, over six hundred (600) mindfulness-related reports had appeared in psychological and medical research with widely variant methodological rigor (Brown et al., 2007). Today (2014), the Mindfulness Research Guide offers

> a comprehensive electronic resource and publication database that provides information to researchers, practitioners, and the general public on the scientific study of mindfulness and publishes Mindfulness Research Monthly for the purpose of informing the latest advances in mindfulness research and practice (*www.mindfulexperience.org*).

The accelerating interest in mindfulness has spawned thousands of mindfulness research projects.

Studies from mindfulness-based programs have tested whether patients' use of meditation practice would have a salutary effect upon specific conditions during the eight to twelve week period of the study. Although meditation practice was *not* taught to patients associated with religious beliefs, the teachers *had* usually drawn their mindfulness training from exposure to the Buddhist religious tradition. Baer (2003; Baer et al., 2006) provides reviews of mindfulness-based interventions, which refer to a variety of exercises or meditations for building awareness and compassion in patients. For example, patients participate in an eight to twelve week program, meeting weekly for two

hours for instruction, for practice in mindfulness meditation skills, and for discussion of stress, coping and homework assignments. An all day, eight-hour retreat is scheduled to occur about the sixth week of the program. Patients are taught, for example, how to complete a body scan, attending sequentially to areas of the body (e.g., foot, leg, hip, torso, hand, arm, shoulder, neck, face), lying down with eyes closed. Accordingly, such "mindfulness-based interventions" teach mindfulness to patients as a component of their treatment modality. Historically, research on mindfulness-based intervention is significant for this dissertation topic because such research has promoted further definition and exploration of mindfulness in the clinical setting. Gradually, a shift from research on patients' mindfulness practice to therapist's mindfulness practice has occurred and now provides a context for studying therapist's mindfulness experience during the psychotherapy session.

Recognizing that research depends upon clear definitions, discussions among researchers have sought to clarify and tighten the definition of "mindfulness" with the intent of refining questions and utilizing results for developing further studies. Germer (2005, p. 6) observes that the same word "mindfulness" is used with three distinct referents: a theoretical construct (mindfulness), a practice of cultivating mindfulness (e.g., mindfulness meditation), and a psychological process (being mindful). While a clear theoretical construct is fundamental to discussion of mindfulness, interest *here* focuses on the psychological process and clinicians' experiences of the influence of their mindfulness on psychodynamic listening to unconscious meanings and processes (communications).

Ten quantitative measures of mindfulness have articulated, promoted and tested the qualities to be included in order to define mindfulness clearly as a theoretical construct. However, research literature provides little critique of these efforts to quantify mindfulness (Brown et al., 2007). Positivist and instrumentalist approaches are typically critiqued in social science research (Hick & Bien, 2008, p. 9). What follows here attempts both to describe and compare researchers' efforts to define "mindfulness" and to summarize briefly the psychometric instruments developed to measure mindfulness.

Defining mindfulness

Discussions of definitions of mindfulness in Western psychotherapeutic literature frequently refer back to Kabat-Zinn's definition: "paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally" (Kabat-Zinn, 1994, p. 4). Since then, Bishop et al. (2004, p. 232) developed a consensus paper which defined mindfulness as "self-regulation of attention so that it is maintained on immediate experience, thereby allowing for increased recognition of mental events in the present moment" and "adopting a particular orientation toward one's experience that is characterized by curiosity, openness and acceptance." The first part of this more elaborate definition re-words the elements of Kabat-Zinn's definition; the second part elaborates the attitudes without which mindfulness cannot be achieved. Germer (2005) prefers a more concise definition ("awareness of present experience with acceptance"), in which one can recognize three elements (awareness, acceptance, and the present moment) intertwined.

To elucidate both the simplicity and complexity of mindfulness, Shapiro et al. (2006) propose a model, which includes three essential components: intention, attention and attitude. Each component is understood to develop along a continuum. For example, *intentions* can shift "from self-regulation to self-exploration and finally to self-liberation and selfless service" (Shapiro & Carlson, 2009, p. 9). *Attention* can be cultivated to become "discerning and non-reactive, sustained and concentrated, so that we can see clearly what is arising in the present moment (including one's emotional reactions, if that's what comes up)" (Shapiro & Carlson, 2009, p. 10). *Attitudes* refer to how one pays attention. Siegel (2007) formulated the acronym COAL to refer to four important qualities of attention in mindfulness: curiosity, openness, acceptance and love. Practicing mindfulness aims to realize these three components in consciousness *at once*. Comparatively assessing psychoanalytic listening in these terms, one can differentiate its intention, its quality of attention, and its attitude. Having differentiated these components in both mindfulness and psychoanalytic listening, a focus on similarities and differences between attention in mindfulness and psychoanalytic listening can be elaborated (Cf. Appendix A).

Brown and Cordon (2009) draw on two rich traditions of historical and contemporary scholarship to discuss the nature of mindfulness: phenomenology, particularly the Husserlian school, and Buddhism, particularly the Theravadin tradition. Husserlian phenomenology offers a rich analysis of subjective states of mind that can help understand the Buddhist psychology of mindfulness. More important, however, is the hope that various points of intersection between phenomenology and Buddhism may

help to show which features of the conscious experience (that define mindfulness) extend beyond Buddhist cultural traditions. If such features could be identified, they might address questions about whether mindfulness can be extracted whole from the Buddhist religious tradition. Goleman (1996) elaborates the purposes, methods and languages of developing mindful awareness from eleven different traditions, certifying that mindfulness is not a capacity, exclusive to a religious tradition.

A thoughtful debate, however, appeared in the literature arguing just this point. Harrington and Pickles (2009a) contended that mindfulness lacked meaning outside the Buddhist religious tradition and so should not be linked to the Cognitive Behavioral Therapy (CBT) model (as a "third wave" CBT). They argued that the foundational principles and attitudes of CBT do not align with mindfulness. For example, CBT works to change thought patterns, not merely accept them. Baer and Sauer responded that mindfulness *is* a meaningful concept in scientific clinical psychology because, although debate continues about "how it should be defined, conceptualized and measured and how it relates to recognized psychological variables," nonetheless, there is "a general consensus that mindfulness is a particular type of attention or awareness in which qualities such as openness, acceptance, non-judging, non-reactivity, curiosity, and compassion are brought to bear on present-moment experience, regardless of how pleasant or unpleasant these experience are" (Baer & Sauer, 2009, p. 325). When Brown and Ryan (2003) reviewed research dedicated to studying mindfulness as a nonreligious construct, they concluded that "mindfulness is a reliably and validly measured characteristic that has a significant role to play in a variety of aspects of mental health"

(p. 844b). Even so, Harrington and Pickles rebutted Baer and Sauer's response by arguing that the defining features of mindfulness are contradictory and fail to represent a coherent scientific definition. They point to the claim that "mindfulness is fundamentally a non-judgmental stance, but at the same time one that involves making certain judgments." That is, *how* attention is applied to the present moment includes value judgments (e.g., open, compassionate). Thus, since it is a concept that is based on Buddhist values, they continue to challenge the idea that mindfulness can be conceptualized as a secular state of mind (Harrington & Pickles, 2009b, p. 335).

Returning to Brown and Cordon, phenomenological studies of consciousness have identified two primary modes of conscious processing, which Husserl called the natural attitude and the phenomenological attitude. The former attitude is

> an orientation toward ourselves, others, and the world in which events and experiences are treated as objects upon which cognitive operations are made. . . . Our experience becomes what we conceptualize it to be. . . . What comes into awareness is often held in focal attention only briefly, if at all, before some cognitive and emotional reaction to it occurs (Brown & Cordon, 2009, p. 61).

The phenomenological attitude turns our attention toward reality "simply as it appears or is given to us, that is, simply as a flow of phenomena or appearances" (Brown & Cordon, 2009, p. 62). One can immediately recognize the similarity between the phenomenological attitude and mindfulness. Brown and Cordon (2009) see promise in using this phenomenological attitude to explicate the essence of mindfulness and how it is associated with emotional well-being, core affect, emotional content, emotional regulation and affective processes. Similarly, this study sees promise in using this

phenomenological attitude to explicate the essence of mindfulness in psychoanalytic listening in-session.

The majority of writers who seek to define mindfulness appear to believe that a scientific definition can eventually be arrived at, given sufficient thought and testing. They contend that premature closure should be avoided in defining a complex and elusive experience like mindfulness. The objections posed by Harrington and Pickles, while legitimate, appear to be more concerned with preserving a conceptual purity in the CBT model and opposing a paradigm shift implicit in "third wave" CBT, based on assumptions that "reality is not fixed, but in a process of continuous change, and that thought content is largely irrelevant to emotional disturbance" (Harrington & Pickles, 2009a, p. 315). Their concern for the integrity of CBT falls outside the concern of this inquiry, which is located within psychoanalytic theory and technique.

Measuring mindfulness

Since measuring mindfulness requires clarity in its definition, developing a psychometric tool becomes a practical exercise testing the clarity of one's definition. When a definition is in the making, a reliable measure engages the creators in working on both their measure and their definition. For example, should acceptance be regarded as a component of mindfulness (Dimidjian & Linehan, 2003) or an outcome of practicing mindfulness (Bishop et al., 2004) or a skill that fosters mindfulness (Brown, Ryan & Creswell, 2007)? Such nuanced assumptions will be reflected in particular inventories or questionnaires, whether they are trait-based or state-based. Trait-based questionnaires

have been designed to measure *an ongoing disposition* of mindfulness, a trait-like *general tendency* to be mindful in daily life, what some call "dispositional mindfulness." In contrast, mindfulness may be view as a state-like quality that occurs when attention is *intentionally directed* to sensations, thoughts, and emotions, with an attitude of curiosity, openness and acceptance.

Attempts to measure mindfulness contribute to this dissertation topic by supporting links between disposition of mindfulness, increased capacity for attention to self and decreased dissociation (Buchheld, Grossman & Walach, 2001; Walach, Buchheld, Buttenmuller, Kleinknecht, & Schmidt, 2006). These links suggest that there is a positive influence between dispositional mindfulness, a therapist's well-being and capacity for evenly-suspended-attention. But the discussion of differences between attention and awareness is a work in progress: Is mindfulness a specific aspect or use of attention? Is mindfulness a form of awareness, which transcends attention? Answers to these questions will shape inventory designs to measure mindfulness. Many consider awareness to refer to a stable and specific state of consciousness, while attention signifies an ever-changing factor of consciousness (Siegel et al., 2009). Findings (Brown & Ryan, 2003) support the conceptualization of mindfulness as a multifaceted construct, but finalizing the definition of mindfulness has been elusive.

The construct "decentering" identifies an ability to observe one's thoughts and feelings as temporary, objective events in the mind, as opposed to reflections of the self that are necessarily true. So, decentering provides a valuable concept for the proposed dissertation research because it refers to a metacognitive awareness, in which a

perceptual shift redirects attention from the subjective meaning of thoughts, feelings, or sensations (what they are "about") to attend to them as objects or events arising in the mind. In this way, thoughts/feelings are experienced as mental events, which are affect neutral, rather than identified as the self (Carmody, 2009; Teasdale, 1999). Others have shown that the capacity for this kind of perceptual shift can influence a therapist's emotional regulation and support more efficient allocation of attentional resources while listening to a patient (Slagter et., 2007; in Carmody, 2009, p. 273).

The Migration from Traditional Mindfulness to Therapeutic Mindfulness

Prior to wondering what impact mindful awareness has on the psychodynamic listening stance, the experiential process of mindful awareness must be brought into the experience of psychodynamic listening (or vice versa) for evaluation. But the original traditions, which describe these mental processes, differ significantly in origin and in approach. As noted above, mindful awareness (or simply mindfulness) refers to a process described in traditional Buddhist psychology, whose fundamental assumptions differ from those of psychodynamic psychology (Jiang, 2006b; Twemlow, 2001a). To address this problem, *traditional* mindfulness, originally defined in Eastern Buddhism, has been gradually incorporated (some say, "integrated") into Western psychotherapy, but redefined as *therapeutic* mindfulness (Didonna, 2009, p. 19). Now, changing contexts may sponsor unexpected changes, so this matter deserves careful consideration: whether (or how) a traditionally Eastern concept (mindfulness) changes as it migrates into the context of the Western psychotherapy tradition (therapeutic mindfulness). Four steps

address the question here. First, context must be recognized for its significant impact on the meaning of words and ideas; conversations and conversions between differing contexts can result in six possible outcomes of meaning: rejection, addition, reduction, corroboration, translation or transformation (Everett & Bachmeier, 1979). Each of the last five can refer to its outcome as "integration." Second, traditional mindfulness must be understood in its original context in Buddhist psychology, connoting awareness, attention and remembering. Third, therapeutic mindfulness must be understood in its Western scientific context, connoting non-judgment, acceptance and compassion. And finally, a discussion of the transition from traditional mindfulness to therapeutic mindfulness must address whether and how these definitions preserve the meaning of mindfulness as it moves from its traditional Buddhist context into the context of psychodynamic psychotherapy.

Context and cross-cultural comparisons

The context of a word has significant impact on its meaning. When a word and its meanings are drawn from one context to another, the change in context can produce a change of meanings (Jiang, 2006b). This is especially so when a therapeutic word such as mindfulness has thoroughly developed in one culture and subsequently been embraced by another culture.

> Cross-cultural comparisons in therapies for true self-awareness . . . are intellectually exciting and fraught with problems. Such studies are exciting in that they seek to locate and elucidate perennial problems in human self-awareness and in the understanding of one's social and physical environment. Comparisons can provide heuristic devices for probing different cultural imagery and definitions and for constructing analytic tools to examine the coherence and assumptions

> found in general claims about human experience. By specifying similarities and differences one can clarify issues that may provide the basis for new constructive formulations of recurrent human efforts at understanding and life enhancement. At their best they help to distinguish structural elements from incidental forms, the typical from the culturally accidental. The dangers arise from oversimplification of important distinctions in vocabulary, assumptions and structural approaches. The difficulties in determining "original" meanings, in assuming the relative importance of concepts in a more comprehensive structure of understanding, and in intuiting the intention of (especially religious or salvific) claims are legion (Streng, 1992, pp. 233-234).

Jiang (2006a) provides an excellent example of this type of attention to and clarification of heuristic process in regard to Eastern and Western meanings of the Subliminal / Unconscious Mind. When similar concepts from two psychologies are compared, the integrity of each psychology deserves respect in the process of clarifying the comparison. Jiang (2006a) points out, for example, that Eastern and Western notions of the Unconscious / Subliminal Mind reveal different attitudes about whether or not these concepts include direct access to consciousness and, even more, that assumptions of their transcendence or immanence in experience sponsor different practices.

Psychological disciplines develop around specific loyalties, theories and practices, which make them distinct and different (Everett & Bachmeier, 1979). The Buddhist psychology of mindfulness derives from Eastern traditions and practices, which have their meanings rooted in assumptions, concepts, and theories that differ from Western psychodynamic psychotherapy. While some practices or concepts, such as mindfulness, appear similar or useful to Western psychotherapy, the research literature is full of examples of reducing Buddhist notions to the measure of modern psychology, without regard for the differences between the two (Rubin, 2003). A modern psychologist can easily ignore the historical, cultural and religious context of Buddhist notions rather than

probe into paradigmatic assumptions about the "mind" in mindfulness. Cross-cultural comparisons require diligence to avoid ethnocentric outcomes and can result in six possible variations: rejection, addition, reduction, corroboration, translation or transformation.

Mindfulness in traditional Buddhist psychology

Mindfulness is a deeply personal, subjective experience that has been widely cultivated, particularly in Eastern cultures through Buddhist psychology. Typically, one must directly experience mindfulness to understand properly its meaning. However, a brief description of traditional mindfulness, put forward here, will serve as a basis for the cross-cultural discussion below.

The ancient meaning of "mindfulness" (in Pali, *sati*) connotes awareness, attention and remembering (Siegel, Germer & Olendzki, 2009, p. 18). The connotation of *awareness* suggests its inherent power in relieving suffering and *attention* suggests that focusing awareness introduces still more power. *Remembering* highlights the intention of mindfulness practice (i.e., remembering to be aware and pay attention). Remembering leads one to be present (and has *no reference to past events*).

The practice of traditional mindfulness fulfills one of eight spiritual principles, known as the Eightfold Path (i.e., Right View, Right Intention, Right Speech, Right Action, Right Livelihood, Right Effort, Right Mindfulness and Right Concentration). Following these principles leads an aspirant to wisdom, ethical conduct and mental development. However, right mindfulness cannot be practiced successfully without

practice of the other seven principles because each contributing principle to the Eightfold Path is inherently related to and dependent upon all the others.

Traditional mindfulness (i.e., Right Mindfulness) is the mental ability to see things as they are, with clear consciousness. This means perfecting the ability of the aspirant's mind to know, beginning with the perception of sense impressions and thoughts, but clarifying *how* they develop and fade in consciousness. Right mindfulness enables the aspirant to observe actively the workings of the mind, to penetrate impressions without getting carried away by them. Traditional mindfulness is developed by attention to four fundamental directions of consciousness: the body, subjective feelings (positive, negative or neutral), states of mind (e.g, clear / distracted, angry / calm, contracted / spacious), and phenomena in general (e.g., hindrances to meditation, elements of experience) (Kornfield, 2008, p. 103). Ultimately, the aspirant discovers that she is not her own thoughts, emotions and perceptions.

Two other principles are closely related to right mindfulness in developing mental abilities that contribute to the cessation of suffering: right effort and right concentration. Without effort, nothing can be achieved. Right effort is a prerequisite for all other principles of the Eightfold Path because it avoids confusion, whereas misguided effort leads to distraction. Right concentration refers to developing one-pointedness of mind, meaning a state where all mental faculties are unified and directed to a particular object. Following the Eightfold Path makes real the aspirant's journey toward the cessation of suffering, the Fourth Noble Truth. So the meaning of traditional mindfulness is implicitly

linked to the Four Noble Truths and practicing the Eightfold Path toward ethical conduct, a virtuous wisdom and mental acuity.

Each of the Four Noble Truths provides contextual meaning to traditional mindfulness by interpreting the meaning of suffering in life. First, life means suffering. Second, the origin of suffering is attachment. Third, the cessation of suffering is attainable. Fourth, the Eightfold Path provides a way to end suffering. Mindfulness practice then is oriented to the complete cessation of suffering "by cultivating insight into the working of the mind and the nature of the material world. The mindfulness practitioner is actively working with states of mind in order to abide peacefully in the midst of whatever happens" (Siegel, Germer & Olendzki, 2009, p. 18).

Implicit in the Eastern tradition of mindfulness are a number of concepts which deviate from typical Western ways of thinking. Four examples illustrate this point. First, a fundamental unity of mind and body exists in Buddhist thought. The Buddhist concept of mind allows aspirants "to explore the dimension of their own physicality in an autonomous, spontaneous and decentered manner" (Didonna, 2009, p. 5). Second, the Buddhist concept of health defines suffering as an interaction between body and mind. Illness is not just pain, but refers to an unhealthy response to pain (i.e., greed, hatred, delusion). Third, the Buddhist meaning of mind denies the reality of a permanent self; traditional mindfulness leads to discovery of emptiness or no-self. Fourth, Buddhism distinguishes four layers of consciousness, all of which are embodied forms of mind. The first two layers of consciousness (i.e., mind-consciousness and sense-consciousness) refer to the brain and the senses as well as the functions they perform (i.e., mind-consciousness

~ worrying, analyzing, judging, planning; sense-consciousness ~ seeing, hearing, tasting, touching, smelling). The second two layers of consciousness (i.e., store-consciousness and *manas*) are deep forms of consciousness, which are easily distinguishable from the first two layers of consciousness because they are always functioning (even when we are asleep). Store-consciousness, called *alaya-vijnana*, refers to the "deepest" layer of consciousness: receiving, processing, storing and making "many decisions without participation of mind consciousness" (Nhat Hanh, 2006, p. 31).

Nhat Hanh begins to describe store-consciousness by drawing on the metaphor of a museum, but then goes on to explain how attention to store-consciousness leads to awareness of no-self (i.e., recognition that a separate, permanent self is only a belief, to which one is clinging).

> Store consciousness is like a museum. A museum can only be called a museum when there are things in it. When there is nothing in it, you can call it a building, but not a museum. The conservator is the one who is responsible for the museum. Her function is to keep the various objects preserved and not allow them to be stolen. But there must be things to be stored, things to be kept. Store consciousness refers to the storing and also to what is stored—that is, all the information from the past, from our ancestors, and all the information received from the other consciousnesses. In Buddhist tradition, this information is stored as *bija*, seeds. . . . All the seeds are of an organic nature and they can be modified. The seed of hatred, for example, can be weakened and its energy can be transformed into the energy of compassion. The seed of love can be watered and strengthened. The nature of the information that's being kept and processed by the store consciousness is always flowing and always changing. Love can be transformed into hate, and hate can be transformed back into love. . . . In store consciousness there are elements of ignorance—delusion, anger, fear—and these elements form a force of energy that clings, that wants to possess. . . . Deeply seated in the depths of store consciousness is this idea that there is a self that is separate from non-self elements. The function of *manas* is to cling to store consciousness as a separate self (Nhat Hanh, 2006, p. 31).

Manas, the fourth layer of consciousness, represents the deep-seated belief whose

function is to cling to store consciousness as a separate self. While Buddhist store consciousness and *manas* have recognizable similarities with the Freudian unconscious, equating the two would be plainly naïve (Jiang, 2006a). "*Manas* consciousness has at its root the belief in a separate self, the belief in a person. This consciousness, the feeling and instinct called "I am," is very deeply seated in store consciousness" (Nhat Hanh, 2006, p. 34). Like the Buddhist notion of store-consciousness, the meaning of traditional mindfulness is deeply rooted in Buddhist culture and connotes more than might be understood at first within a Western cultural context, like psychodynamic psychotherapy.

Therapeutic mindfulness

Interest in conversation between Buddhists and psychoanalysts dates as far back as the mid-Twentieth Century with Carl Jung, Karen Horney, and Eric Fromm (for the earliest representative articles, cf. Molino, 1998). The relevance of Buddhist psychology for psychodynamic thought is captured in compilations and books, edited or written by practicing Buddhist psychoanalysts (Rubin, 1996; Safran, 2003; Didonna, 2009; Bobrow, 2010). Journal articles, articulating this conversation, have gained frequency in publication (cf. Rubin, 1985, 1999, 2009; Twemlow, 2001). For example, Epstein (1988) argues that a simple "evenly suspended attention" can fulfill Freud's prescription, using mindfulness practice to corroborate this possibility.

The influence of psychotherapy on the dispersion of Western Buddhism has been compared to the powerful influence Taoism had on the dispersion of Buddhist thought in China (Jiang, 2006a, p. 1). Some of this influence has come from cognitive psychology,

which began to provide psycho-education regarding mindfulness, stripped of its traditional religious teaching. Programs, now known as Mindfulness-Based Stress Reduction (MBSR), Mindfulness-Based Cognitive Therapy (MBCT), Dialectical Behavior Therapy (DBT) and Acceptance and Commitment Therapy (ACT), sponsored clinical interventions which could provide research data and a testing ground for mindfulness inventories. As reviewed above, researchers began to challenge the limitations of their definitions of therapeutic mindfulness by increasing the scientific rigor of their methods. During the 1990s, efforts to design a reliable inventory assessing mindfulness began in earnest to establish a basis for further research, which resulted in multiple operational definitions (cf. Appendix B). Writing in 2009, Didonna recognized that "as mindfulness is adopted by Western psychotherapy and migrates away from its ancient roots, its meaning is expanding" (Didonna, 2009, p. 19; italics mine).

A recent model definition, mentioned above and adopted here for purposes of comparison, provides an experienced elaboration of this research effort. Therapeutic mindfulness is "the awareness that arises through intentionally attending in an open, caring, and non-judgmental way" (Shapiro & Carlson, 2009, p. 4). Notice again that this definition is composed of three core elements: intention, attention, and attitude. *Intention* refers to a value-based direction, which is related to one's personal vision. As one practices mindfulness over time, *intention* can presumably evolve from self-regulation to self-exploration to self-transcendence to self-less service. Intention follows a value, without "grasping" or "striving" toward a goal or specific outcome that brings clarity (Shapiro & Carlson, 2009, pp. 8-10). *Attention* refers to a return to things themselves,

apparently like that suggested by Husserl (Brown & Cordon, 2009), suspending (or noting) all the ways of interpreting experience and attending to experience itself as it presents in the here and now (Shapiro & Carlson, 2009, p. 10). Attention may be sustained, scanning or concentrated, so that one can see clearly what is arising in the present moment, including one's physical and emotional reactions. But attention is non-reactive and discerning, what some describe as "decentered" because attention is not captured by or lost in external or internal experience. *Attitude* refers to a combination of qualities that have been given the acronym COAL: Curious, open, accepting and loving (Siegel, 2007). Therapeutic mindfulness can be used by both patients and therapists because it is part of what makes us human; it is an inherent capacity to be fully conscious and aware (Didonna, 2009, p. 17). It is a special skill that one can learn to sustain moment-to-moment awareness, especially in the midst of emotional turmoil. But to truly understand mindfulness, we have to experience it directly because mindfulness points to something intuitive and pre-conceptual. The purpose of therapeutic mindfulness is primarily to relieve intractable psychological conditions.

Clearly, therapeutic mindfulness has changed the definition of traditional mindfulness and reformulated its meaning for its therapeutic context. Because of its limited scope within the therapeutic setting, therapeutic mindfulness has narrowed its purpose to *some* suffering, reducing the focus of traditional mindfulness from *all* suffering. Therapeutic mindfulness is for patients and their therapists whereas traditional mindfulness assumes that all humans are patients because human life means suffering. Since therapeutic mindfulness does not have an implicit context of ethical principles, like

the Eightfold Path, mental qualities (including non-judgment, acceptance and compassion) must be made explicit in its definition. Adding these mental qualities to the definition of therapeutic mindfulness compensates to a limited extent for the loss of context in the Eightfold Path. But the addition of non-judgmental and accepting attitudes only translates the wider context of traditional mindfulness into the definition of therapeutic mindfulness. This is why Didonna admits that "the definition of 'mindfulness' has been somewhat modified for its use in psychotherapy, and it now encompasses a broad range of ideals and practices" within the therapeutic milieu (Didonna, 2009, p. 18).

Some anticipate that experience with therapeutic mindfulness will eventually lead to deepened appreciation for moral integrity and the foundations of traditional mindfulness practice (Olendzki, 2010, p. 4) and a transformation of psychotherapeutic practice. If so, clinicians may eventually link their codes of professional ethics to the practice of therapeutic mindfulness as another way to address concerns similar to those of the Eightfold Path. Nonetheless, the definition of therapeutic mindfulness now limits its focus to positive qualities, like acceptance, being applied to sustained attention and awareness of the present moment. Changes of definition have been introduced (i.e., addition, reduction and translation) to represent traditional mindfulness, but without transforming it. R. Siegel gives evidence of how new therapeutic mindfulness is to the mindfulness landscape when he asks, "Is mindfulness for everyone?" He observes,

> We are just beginning to understand the effects of these different practices, and have little research to guide us. . . . We're just beginning to understand more about which objects of attention are best suited to which mind states. . . . Traditionally, wisdom and compassion are seen as two wings of a bird or two

> wheels of car – both necessary for awakened action. . . . In the clinical arena, this manifests as: seeing how all phenomena are interrelated and multi-determined, concern for the effects of our actions near and far, holding constructs lightly, not taking things personally, and being open to new experience (2013, pp. 8-10).

Much is to be learned yet in the West in a respectful transformation of both the century old tradition of psychodynamic psychotherapy and the 2,500 year old mindfulness tradition.

Because mindfulness refers to an inherent human capacity, which both traditional and therapeutic mindfulness employ, the capacity for mindfulness is hardly a hostage to one context. Goleman (1988) describes how mindfulness is a phenomenon that has been cultivated in many cultures with varying vocabularies, strategies, and intentions, but gives evidence for a common pattern of development. In all these cultures, achieving mindfulness for any length of time requires cultivation of virtue (ethical conduct), concentrated attention, and sustained awareness. So, from this experiential perspective, therapeutic mindfulness has *not* changed traditional mindfulness: both traditions return to an experiential practice to cultivate the desired state of mind with its implicit demands.

While the therapeutic mindfulness tradition is still in its pregnancy by comparison to traditional mindfulness, careful observation of one's sensations, emotions, thoughts, and experiences is not the exclusive birthright of Buddhist psychology. Western philosophical traditions, such as phenomenology, have explored how experience and knowledge forms, too. Phenomenology studies conscious experience as experienced from the subjective or first person point of view. Recently, Husserl's phenomenological perspective has been utilized to interpret therapeutic mindfulness in a Western idiom because of its "interest in discovering the operation of the mind through first-person

experience, specifically by closely observing our subjective and sensory experiences" (Brown & Cordon, 2009, p. 61). Illustrating that therapeutic mindfulness can be understood from a Western perspective as well as a Buddhist perspective, Brown and Cordon apply Husserl's insight that the phenomenological attitude aims toward something beyond itself and yet tends to turn toward what is salient at a given time. That is, awareness is not self-enclosed, but gives attention to what affects us (Brown & Cordon, 2009, p. 63). The use of Husserl to explain therapeutic mindfulness corroborates the conclusion that a permanent self is not found behind awareness. But introducing Husserl only complicates cross-cultural comparison with yet another theory of mind.

Twemlow, too, in his brief review of Western thinking about the question of a permanent self behind / within consciousness, notes that "self requires inter-subjective experience. It is built up out of interactions with others" (Twemlow, 2001a, p. 13). Corroborating the predominant opinion in Buddhism, Twemlow gathers Western points of view (e.g., Winnicott, Lacan) to confirm his conclusion that the self is constructed of interpersonal exchanges and anchored language. Twemlow, of course, is arguing for an enrichment of psychodynamic thought and practice by introducing Zen Buddhist concepts and practices: emptiness, impermanence, nonattachment, paradox, attention to here-and-now, and compassion. His input stimulates reflection upon how to open and train one's approach to psychodynamic practice, but Rubin (2009) alleges that psychodynamic understanding of unconscious, primary process contributes to a transformed psychodynamic practice by placing each member of the dialogue (Freud and the Buddha) on a respect-filled par. Traditional mindfulness meditation "provides an

operationalizable technique for cultivating evenly hovering attention and thus deepening psychoanalytic listening. But one additional element is indispensable for ideal listening: understanding the language – and logic – of the unconscious" (Rubin, 2009, p. 99).

Rubin integrates traditional mindfulness with psychodynamic listening by distinguishing two "stages: (1) quieting and focusing the mind through meditation and then (2) examining and investigating whatever arises with an abiding interest in the meaning of what you hear and a sensitivity to the language – and logic – of the unconscious" (Rubin, 2009, 103). Bobrow (2010), too, envisions mindfulness and psychodynamic listening overlapping, like the separate strands of the double-helix structure in DNA: separate but connected; distinct but mutually supporting. Although both mindfulness and psychodynamic traditions include concepts of an "unconscious," Rubin and Bobrow regard the psychodynamic "unconscious" as essential to psychodynamic psychotherapy and not to be confused with Buddhist meanings of "the unconscious." So, again, mindfulness must be informed by a psychodynamic understanding of primary process characteristics of "the unconscious" to satisfy the goals of psychodynamic psychotherapy. As mindfulness moves from its traditional Buddhist context into the context of psychodynamic psychotherapy, therapeutic mindfulness attempts to preserve the experiential practice of traditional mindfulness while still searching for a theoretical and conceptual basis that supports its usefulness in the Western therapeutic context.

Mindfulness and its Influence on the Therapist-Patient Dyad

Whereas the empirical studies, reviewed above, describe the effect of patient mindfulness on patients themselves or attempt to identify the mechanisms involved, a randomized, double-blind, controlled study showed positive effects on patients whose psychotherapist-in-training had engaged in mindfulness training (e.g., Grepmair et al, 2007). Grepmair et al. (2007) examined whether, and to what extent, promoting mindfulness in psychotherapists in training (PiT) influenced the treatment results of their patients by comparing the therapeutic course and treatment results of 124 inpatients, treated for nine weeks by 18 PiTs. These subjects were randomly assigned to one of two groups: (i) those practicing Zen meditation (MED; n = 9) or (ii) a control group, who did not perform meditation (noMED; n = 9). The results of treatment (according to the intent-to-treat principle) were examined using three measures: a) the Session Questionnaire for General and Differential Individual Psychotherapy (STEP), b) the Questionnaire of Changes in Experience and Behavior (VEV) and c) the Symptom Checklist (SCL-90-R). Compared to the noMED group (n = 61), the patients of PiTs from the MED group (n = 63) evaluated their individual therapy significantly higher (according to the intent-to-treat principle) on two STEP scales, clarification and problem-solving perspectives. Their evaluations were also significantly higher for the entire therapeutic result on the VEV. Furthermore, the MED group showed greater symptom reduction than the noMED group on the Global Severity Index and eight of the SCL-90-R scales (i.e., Somatization, Insecurity-in-Social-Contact, Obsessiveness, Anxiety, Anger/Hostility, Phobic Anxiety, Paranoid Thinking and Psychoticism). This study concludes that promoting mindfulness

in PiTs could positively influence the therapeutic course and treatment results in their patients and provides a support for the hypothesis that mindfulness practice could influence psychodynamic psychotherapy positively.

McCollum and Gehart (2010) completed a qualitative study of the effects of meditation practice on the development of therapeutic presence in 13 masters level psychotherapists in training (PiTs; seven males, six females; age range = 22 to 60), through thematic analysis of their journal entries. PiTs were taught a simple meditation method and asked to practice five to ten minutes each day. PiTs were required to submit a one-page journal entry reflecting upon their mindfulness practice for each week of a semester (12 weeks). There was no control group. Authors recognize that their sample group was small and that PiTs might be catering to their instructors (the authors), overemphasizing positive aspects of their practice. Conceivably, PiTs might be repeating what they had read or been told about the effects of mindfulness would be. While this qualitative study adds limited support to the conclusions of Grepmair's quantitative approach, its positive outcomes are further limited by clear design weaknesses.

Finally, positive effects were found for therapists who practiced mindfulness by Jha, Krompinger, and Baime (2007), who used mindfulness training to investigate its influence on three attentional subsystems: alerting, orienting and conflict monitoring. Defining mindfulness simply as paying attention in the present moment, they investigated the hypothesis that mindfulness training may alter or enhance specific aspects of attention by examining three functionally-and-neuroanatomically-distinct-but-overlapping-attentional subsystems: alerting, orienting, and conflict monitoring. *Alerting* attention

refers to a steady, uninterrupted attention to one's experience; *orienting* attention involves effective scanning and situationally appropriate selection of information in the perceptual field; and *executive* attention concerns a conscious examination of one's reactions and responses to environmental events, monitoring a potential for conflict. The functioning of each subsystem was indexed by performance on the Attention Network Test (ANT).

Then, two types of mindfulness training (MT) programs were examined, and behavioral testing was conducted on participants before (Time 1) and after (Time 2) training. One training group consisted of individuals naive to mindfulness techniques who participated in an eight-week mindfulness-based stress reduction (MBSR) course that emphasized the development of concentrative meditation skills. The other training group consisted of individuals experienced in concentrative meditation techniques who participated in a one-month intensive mindfulness retreat. Performance of these groups was compared with that of control participants who were meditation naive and received no MT. At Time 1, the participants in the retreat group demonstrated improved conflict monitoring performance relative to those in the MBSR and control groups. At Time 2, the participants in the MBSR course demonstrated significantly improved orienting in comparison with the control and retreat participants. In contrast, the participants in the retreat group demonstrated altered performance on the alerting component, with improvements in exogenous stimulus detection in comparison with the control and MBSR participants. The groups did not differ at Time 2 in conflict monitoring performance, which is a function of executive attention. These results suggest that

mindfulness training may improve attention-related behavioral responses by enhancing functioning of specific subcomponents of attention. Whereas participation in the MBSR course improved subjects' ability to orient attention by themselves, retreat participation appeared to allow for the development and emergence of receptive attentional skills, which improved alerting attention. Since both conflict monitoring and orienting are forms of voluntary attentional selection, authors suggest that concentrative meditation may indeed alter functioning of the dorsal attention system to improve voluntary response and input-level selection processes.

The results of this study link mindfulness with these three primary attention networks and encourage further study in order to refine the benefits of meditation training (MT) for developing attention in patients and therapists. However, the primary benefits suggested here are with concentrative attention rather than with evenly suspended attention.

Based on previous research indicating that long-term mindfulness practice is associated with altered resting electroencephalogram patterns (suggesting long lasting changes in brain activity), Lazar et al. (2005) used magnetic resonance imaging to assess cortical thinking in 20 participants with extensive insight meditation experience, which involves focused attention to internal experiences. Brain regions associated with attention, sensitivity to internal stimuli, and sensory processing were thicker in meditation participants than matched controls, including their prefrontal cortex and right anterior insula. Between-group differences in prefrontal cortical thickness were most pronounced in older participants, suggesting that meditation might offset age-related

cortical thinning. The thickness of two regions correlated with meditation experience. This neurological research supports the benefit of mindfulness training on patient as well as therapist general well-being.

Siegel (2007) has highlighted the significance of some research on neural integration, which provides an intriguing insight into the nature of mindful awareness and of our experience of self. The study compares the brain imaging findings of two groups, one trained in mindfulness meditation and the other awaiting such training – the novices. The results reveal that in all subjects during the stimulation of the storytelling circuits of our human neural architecture, the medial prefrontal regions (mPFC) were activated, consistent with numerous prior studies suggesting that our “narrative circuitry” includes these midline structures, just behind the forehead. The findings establish an important basic step in the illumination of the possible mechanisms by which mindfulness training may help cultivate well-being. With mindfulness practice, the intentional creation of a state of mindful awareness enables the individual to differentiate previously inseparable streams in the flow of information of the mind. The author notes that such ability may help in 'objectifying' the mind, a process in which individuals are able to dis-identify from mental activities as being the totality of who they are, like “decentering” described above.

While the bulk of articles about mindfulness in the clinical literature are about a) the benefits of training patients with various conditions, b) the components of such training programs and c) the requirements for training teachers, there are still a few

articles that consider and support the benefits of mindfulness training for therapists and the influence of therapist mindfulness in the clinical setting.

Summation of literature review

Based on this review of the literature, the psychodynamic psychotherapist's development of mindful awareness would appear to affect the capacity for evenly suspended attention and the listening experience within the therapeutic milieu. What psychodynamic psychotherapists can tell us about *how* mindful awareness affects their attention to the unconscious remains to be explored.

CHAPTER III

THEORETICAL AND CONCEPTUAL FRAMEWORK

> *Only in quiet waters things mirror themselves undistorted.*
> *Only in a quiet mind is adequate perception of the world.*
> ~Hans Margolius, cited in Didonna (2009, p. 447)

The purpose of this study is to clarify how psychodynamic psychotherapists use mindful awareness to affect their listening stance, particularly in regard to perceiving, intuiting and comprehending latent, unconscious meaning and process.

Psychodynamic listening occurs within the context of psychodynamic psychotherapy. Although the setting of psychodynamic psychotherapy is often taken completely for granted, as it was by Freud (Modell, 1990, p. 23), this setting provides the foundation for both psychodynamic treatment in general and Freud's specific techniques of free association and evenly suspended attention.

> Psychoanalytic treatment is not so much a matter of making the unconscious conscious, or of widening and strengthening the ego, as of providing a setting in which healing can occur and connections with previously repressed, split-off and lost aspects of the self can be re-established. And the ability of the analyst to provide such a setting depends not only on his skill in making 'correct' interpretations but also on his capacity to maintain a sustained interest in, and relationship with, his patients (Rycroft, 1985; quoted in Modell, 1990, p. 23).

The therapeutic relationship itself embodies the psychodynamic setting. Consequently, the theoretical framework in this research assumes both a general psychodynamic

approach and a theory of psychodynamic listening. The general psychodynamic approach includes seven distinctive features (Blagys & Hilsenroth, 2000; Gabbard, 2010; Shedler, 2010b): 1. focus on affect and expression of emotion; 2. exploration of attempts to avoid distressing thoughts and feelings; 3. identification of recurring themes and patterns; 4. discussion of past experiences (developmental focus); 5. focus on interpersonal relations; 6. focus on the therapy relationship; and 7. exploration of fantasy life. The theory of psychodynamic listening includes a theory of evenly suspended attention as proposed by Freud (1961a; 1961b) and explicated by Bollas (2007; 2009a; 2009b). So, the theoretical framework here assumes the technical ideal of the therapist's evenly suspended attention and the patient's free association in the context of the therapeutic relationship: the Freudian Pair.

Psychodynamic listening consists of attending to multiple sources of data without preconceptions. First, a patient's surface as well as depth disclosures (both verbal and non-verbal) deserve attention because this is how one comes to know another. The patient begins presenting what is on his mind and conveys by associations what unconscious links occur. Second, though on a par with the first, a therapist's experience of her responses to a patient provide data about the patient or how others in the patient's world might respond to him. Third, one can listen to content of the patient's self-report, to what is left unspoken, to the patient's intention, or to the process or manner of the patient's presentation. Maintaining a non-judgmental attitude provides psychic space for the patient to be authentic and spontaneous in the exploration of experience (Schlesinger, 1994).

As Rycroft suggests, the therapeutic relationship is meant to do more than comprehend the unconscious: the therapist has engaged in a human relationship with the patient. The uniqueness of the therapist / patient dyad, even when psychodynamic listening brings about comprehension of the unconscious, leads inevitably beyond comprehension of human experience and requires a capacity to tolerate the anxiety of not-knowing what remains unknown (Kurtz, 1989). Of course, the patient may not know what is occurring in their experience, which is why they come to the therapist. But the therapist may not know for some time what is present in the patient's experience, yet undisclosed or disclosed implicitly. The therapist's overly rigid reliance on her particular theoretical approach can leave the patient misunderstood, isolated or disregarded. Following an ideal for unbiased, decentered listening obviously derives from development of Freud's psychoanalytic technique.

Psychodynamic listening requires great mental training and discipline because "to experience the patient's words openly, without passing them through a preformed cognitive screen, can occasion great anxiety" (Kurtz, 1989, p. 4). The present study sought essential data from psychodynamic therapists' experiences of listening and focused on *how* they listen rather than on *what* they listen for. Presumably, assumptions regarding psychic content (e.g., unconscious patterns of defense, transference, counter-transference, selfobject needs) govern what psychodynamic therapists' listen for. But every psychodynamic approach depends upon *how* one listens because the process of listening itself affects what one hears. How various schools listen for specific phenomena in the therapeutic process (e.g., conflicts, defenses, transferences, unconscious anxieties,

and empathic ruptures) shape how they pay attention to the patient. Presumably, the ideal of evenly suspended attention sponsors an unbiased form of attention in the psychodynamic psychotherapy: open, accepting, alert, and sustained. Applying this conceptual framework to evaluate and analyze the data from subjects intended to sponsor an attitude on a par with the phenomenological attitude of the proposed method (see below), which intended to gather and look upon this data without preconceptions and bias.

Question explored

How do some psychodynamic therapists, experienced with mindful awareness, describe the impact of mindful awareness on their listening stance?

Theoretical and operational definitions of major concepts

Psychodynamic Psychotherapy: A psychotherapeutic approach that provides a setting in which healing can occur and connections with previously repressed, split-off and lost aspects of the self can be re-established.

The Freudian Pair: The therapist-patient relationship, constituted for the purpose of helping the patient attend to unconscious communications or patterns by practicing free association (patient) and evenly-suspended-attention (therapist).

Unconscious material: Not only that which has been repressed, but that which has been denied, disavowed, or never been registered in symbolic language, including what

originated in a pre-verbal stage of life and never became an experience able to be thought of in ordinary language.

Unconscious processes: Primary process thinking is a mode of unconscious thinking that operates differently than secondary process thinking, which applies the rules of logic and reality-testing. “Primary process is characterized by the absence of any negatives, conditionals, or other qualifying conjunctions; by a lack of any sense of time; and by the use of allusion, analogy, displacement, condensation, and symbolic representation” (Campbell, 1981, pp. 484-485). Secondary processes exercise an inhibitory function protecting the organism from both internal and external dangers.

Evenly Suspended Attention: Many states of attention are needed during the psychodynamic treatment process from the initial contact to the final farewell. Participation in psychodynamic therapy implicitly requires an on-going training of attention. However, when attending to the patient’s experience in-session, the prescription of evenly suspended attention directs one simply to listen and not trouble keeping in mind anything in particular. “All conscious exertion is to be withheld from the capacity for attention and one’s unconscious memory is to be given full play” (Twemlow, 2001b, p. 23). This practice reduces selection of a particular type of patient material, eschews the introduction of the therapist’s values and beliefs, and minimizes the impact of her personality.

Evenly suspended attention is comparable to activities in psychodynamic listening, such as empathy (“I-thou” listening), which uses attention to the other’s experience without regard for the self. Evenly suspended attention allows for integration

of both “I-me” with “I-thou” listening, so that it can take in awareness of both subjectively and objectively derived data in the clinician’s experience. Subjective data derives from the clinician’s attention to her own reactions; objective data comes from one’s attempt to gather data from outside her self. Giving attention to how one is listening to the patient, as one does in reverie, is well within the scope of evenly suspended attention, which offers the willingness to get-to-know the patient’s experience from experience with the patient. So, evenly suspended attending precedes development of the effort involved to empathize with patients or to understand what the patient is trying to convey or to notice some point of urgency as in reverie (Baranger, 1993; Twemlow, 2001a; Schlesinger, 1994).

Reverie: The capacity to sense (and make sense of) what is going on inside the patient, which requires an act of faith in unconscious process, essential to true understanding; a concept developed by W.R. Bion, which some regard as equivalent of D. Stern's “attunement,” or D.W. Winnicott's “maternal preoccupation.”

Communication of Unconscious Processes: Psychodynamic psychotherapy facilitates the patient’s bringing whatever is on their mind in a spontaneous, unedited way. A goal is to enable the patient’s unconscious communication to occur freely and to permit the therapist to hear and register latent meaning. Although various psychodynamic schools define what to anticipate in terms of unconscious conflicts, defenses, anxieties, or empathic ruptures, the purpose of Freud’s original technique was to make the unconscious conscious, whatever the content. Making latent processes explicit gives the patient more control over his life, allowing for decisions based on more information.

Clarifying the nature of the therapeutic relationship includes those phenomena emerging from unconscious processes.

Mindfulness Awareness: Just as 'evenly suspended attention' refers to how one listens, 'mindful awareness' refers to how one attends to experience. Awareness here refers to the background consciousness from which attention is directed and modified. A 'mindful' awareness contrasts with an awareness sustained upon a specific object. Mindfulness refers to a use of awareness to observe and experience both conscious and unconscious, internal and external events. "The experiencing self is maintained with equal weight with the observing self, a healthy form of splitting of attentional focus" (Twemlow, 2001b, p. 29). Therapeutic mindfulness is defined here as "an awareness that arises through intentionally attending in an open, caring, and nonjudgmental way" (Shapiro & Carlson, 2009, p. 4). This is an experiential process, manifesting as freedom of mind (that is, freedom from reflexive conditioning and delusion) (Shapiro & Carlson, 2009, p. 7). Therapeutic mindfulness is believed to contribute to the common factors influencing therapeutic change (i.e., relationship variables such as empathy, unconditional positive regard and congruence between therapist and patient).

The subject of study here includes evenly suspended attention as a listening technique. Such a technique, used in all psychodynamic approaches, embraces a discipline that does not choose, or favor, or edit what the therapist listens for. The emphasis here is upon how data, disclosed by the patient, is being gathered and received accurately by the therapist. Mindfulness training is relevant for the listening process because it disciplines the mind to refrain from shaping the patient's data to fit a

preconceived mindset (Rubin, 2009; Twemlow, 2001a; Twemlow, 2001b) and contributes the decentered attitude needed for psychodynamic work.

Statement of assumptions

1. Psychodynamic therapists value the practice of evenly suspended attention.
2. Evenly suspended attention represents an unbiased form of listening in psychodynamic psychotherapy.
3. Psychodynamic therapists have a way of listening that enables them to recognize and understand latent fantasy, ideas, thoughts, of which the patient is unaware.
4. Mindful awareness impacts psychodynamic therapists' experiences of listening.
5. Psychodynamic therapists think about issues related to their efforts to listening with evenly suspended attention and will honestly share these thoughts with the researcher.
6. The sample population of psychodynamic therapists are experienced in mindfulness practice.
7. The therapists interviewed for this study will be able to articulate in a meaningful manner how they experience mindfulness impacting their listening stance.
8. The methodology used in this study will be able to capture the meaning of the experiences articulated during interviews.
9. All psychodynamic psychotherapists value not only the manifest content but more importantly try to get at the unconscious communication from their patients.

CHAPTER IV

METHODOLOGY

> *Natural objects . . . must be experienced before any theorizing about them can occur.*
>
> ~E. Husserl, cited in McCormick & Elliston (1981)

Type of study and design

The research question above draws attention to a rather specialized, complicated and individual experience within the clinical setting, hoping to clarify the essence of this lived experience: how psychodynamic psychotherapists experience mindful awareness affecting their listening stance, particularly in regard to perceiving, registering and comprehending latent, unconscious meaning and process. Phenomenology values human experience and holds that something fundamental (an "essence" of experience) can be distilled from the study of individual experiences of the same phenomenon. Phenomenological methodologies are designed to give descriptions that impart understanding of the experiences themselves. The phenomenological method prescribes great care in eliciting and collecting the subjective data of experience in such a way that the researcher's objectivity is preserved and the researcher's preconceptions do not contaminate the data of participant self-reports (Creswell, 2007, p. 59). The Stevick-

Colaizzi-Keen method, adapted by Moustakas (1994), informed the collection and analysis of interview data.

This phenomenological method supports exploration of experience, with the assumptions that exist in the proposed study, because reality is inextricably related to one's consciousness of it. The reality of an object is only perceived within the meaning of the experience of an individual. The adopted method allowed for description of 15 clinicians' subjective experiences of mindfulness-and-evenly-suspended-attention-in-the-clinical-setting to understand what influences occurred in their experiences and to discover what themes emerged from their reflections. The research design employed a phenomenological method, detailed by Moustakas (1994), to forge a common understanding of participant therapists' experiences.

Scope of study, setting, population and sampling, sources and nature of data

Participants were seasoned psychodynamic clinicians whose capacity for mindful awareness prepared them to reflect upon their experience of mindful awareness in their listening stance during their clinical work. However, other essential criteria included that these clinicians were sufficiently interested in discussing the nature of the relationship between mindful awareness and the psychodynamically informed use of their attention in listening to 1) participate in a lengthy interview, 2) grant the right to audio-record and transcribe the interview, preserving their anonymity, and 3) publish the data in a dissertation.

Research participants were located by preparing a statement describing the nature and purpose of the study and presenting this to professional circles where psychodynamic psychotherapists themselves also valued the practice of mindfulness. An announcement was placed in a quarterly journal of a local British Object Relations group advertising the researcher's intent to recruit research participants. Flyers were distributed during an annual international conference for Evolving British Object Relations. During a "Zen and Psychotherapy" workshop, the researcher discussed her research project with workshop attendees and distributed fliers. Purposive and snowball sampling were utilized in subsequent recruiting of research participants. Respondents were screened, using the criteria cited above, via a 10 to 20 minute pre-interview conversation arranged in person, by phone, or via email. Person-to-person, phone, and Skype interviews were conducted and recorded with these clinicians, from different parts of the country and the world, gathering relevant data by focusing on the bracketed topic and question.

Data collection methods and instruments:

Prior to interviewing participants, a description of the researcher's own experience and understanding of the impact of mindfulness on her listening stance in the clinical setting was audio-recorded to set aside her mindset. This recording was transcribed into a smooth verbatim (i.e., eliminating the uhm's, ah's, stutters and verbal tics) and stored for review, following determination of findings.

The researcher has been immersed in the study of Buddhism for more than 25 years, during which mindfulness has been sought as way of being, however imperfect.

This includes a period of eight years in which she was ordained within a Buddhist monastery, living within this environment of routine practice of mindfulness meditation. After she obtained her Masters in Pastoral Counseling, the researcher attended a Buddhist seminary, whose primary focus was study of Buddhist Sutras, with the hope of integrating Buddha's teaching with psychotherapy. Both of these experiences involved regular, intensive periods of meditation and mindfulness practice. For the past 17 years, the researcher has been an avid student in the psychodynamic tradition; and, since the early 1990s, integrating Buddhism and the way of mindfulness with psychodynamic practice has been a continual interest for the researcher.

As the years have gone by, experience in the practice of therapy has taught the researcher not to assume the role of "knowing" what the patient will say or do, or how the patient should act. Her mindfulness practice has helped her to stay more keenly observant of what goes on internally in response to the patient's total self-presentation and to her relationship with the patient, while, at the same time, to contain reactions to whatever that has been stirred up. The researcher has been told in supervision time-and-time-again that to manage effectively and to become proficient in this craft requires time and practice, and then more practice. Though I do not doubt this wisdom that "patience and practice makes perfect," I wonder whether mindfulness practice, prescribed by the Buddha, might offer *more concrete steps* to train the mind of the therapist to master the patient-therapist dance effectually. The researcher personally believes that mindfulness has a profound impact in regards to her presence, her sensitivity, her attunement to what's in the room (verbal and non-verbal), her capacity to contain reactivity in herself and from the patient,

and her compassion for the patient. But how do other psychodynamic clinicians, coming from many different psychodynamic traditions, experience how their mindfulness affects their therapy practice and how they listen to their patients? In part, due to the researcher's mindfulness practice, she felt able to set aside her preconceived notions, experience and understanding about mindfulness and psychodynamic listening to conduct interviews with 15 psychodynamic clinicians with a curious and open mind.

Each interview had its unique requirements in terms of preparing the setting so that technical aspects of the recording equipment did not distract from creating a relaxed, informal and interactive process. During a brief introductory period to get comfortable and focused, each participant was asked to describe the growth of their psychodynamic listening stance and their mindful awareness:

1. How would they describe the development of their listening stance as a psychodynamic clinician?
2. What motivated their growth in mindful awareness?
3. Was their motivation to impact their listening stance or increase their capacity for evenly suspended attention as a psychodynamic clinician?
4. How did they develop their capacity for evenly suspended attention?
5. What they have found helpful or unhelpful in developing their current capacity for mindful awareness?

Then, participants were asked to focus upon their experience of mindful awareness in their clinical work and describe their experience. Since the interview process was intended to facilitate honest and comprehensive responses, adherence to the

participants' exploration of their experience and avoidance of a routine series of questions was a priority. To enhance participants' exploration, at appropriate times, the following questions facilitated the process:

1. How does your mindful awareness affect you, your client and/or a clinical session?
2. How does your mindful awareness affect your listening stance in-session?
3. Is there a difference between mindfulness awareness and evenly suspended attention in your experience? If so, how are they different? If not, how are they the same?
4. Do you associate any changes in attention with mindful awareness during a clinical session?
5. Do you associate any positive or negative effects of mindful awareness on your attention during a clinical session?
6. How does mindful awareness affect your listening to a patient's conscious communications?
7. How does mindful awareness affect your listening to a patient's *unconscious* meanings and processes?
8. Do you experience your mindfulness awareness having an influence on the patient's free associations?
9. Have you shared all that is significant about your experience of mindful awareness with reference to evenly suspended attention?

Again, these questions were formulated and presented for the purpose of facilitating participants' exploration of their experience, not shaping their comments to concur with preconceived ideas. Participants were able to elaborate their experience by addressing the dissertation question via their own network of associations.

Following each interview, the audio-recording was transcribed to form a smooth verbatim text of each interview, whose statements were carefully considered in terms of their significance for the description of how mindful awareness impacts psychodynamic listening in-session.

Data analysis

As outlined in the formulation of the problem (p. 2-4), this study intended to provide descriptive findings to the clinical field about its practice of psychodynamic psychotherapy, to clarify the potential for integrating mindfulness in psychodynamic therapy and to contribute to clinical process theory. The analysis of the data was informed by a version of the Stevick-Colaizzi-Keen method discussed by Moustakas (1994).

Before the first interview took place, the researcher bracketed her own mindset by interviewing herself with the same set of questions, to which the participants would be asked to respond and which described their experience and understanding of the impact of mindfulness on their listening stance in the clinical setting. All interviews were digitally recorded and each recording was transcribed into a word document to form a smooth verbatim transcript. Throughout the interview process, the researcher was

mindful to respect the participants' views on the topic addressed. Thus, ongoing bracketing was employed in order to make sure the researcher's own views were set aside.

Each transcript was studied to examine each statement for its potential description of the impact of mindful awareness on psychodynamic listening. All participant interviews were listened to and read many times to become completely familiar with each participant's experience and perspective. All statements relevant to the experience studied were highlighted in bold font in each interview document. This implemented "horizontalization," which treats every participant statement equally (Moustakas, 1994, p. 180). Statements highlighted in bold font were simplified or eliminated to determine "invariant constituents," using two screening questions (Moustakas, 1994, p. 121):

1. Does the statement contain a moment of the experience that is a necessary and sufficient constituent for understanding it?
2. Is it possible to abstract and label it?

Using the MS Word comment function, a description of the content of each participant's experience was attached to statements in *italics*. These *descriptive comments* subsequently contributed to a Composite Textural Description. Next, using the MS Word comment function, statements that focused upon raising questions and formulating the material at a conceptual level were added and designated with underline. These conceptual comments subsequently contributed to a Composite Structural Description.

Using MAXQDA 11, a qualitative research data analysis software application, relevant statements, now invariant constituents, were coded with multiple categories to

identify easily what subjects they addressed. Descriptive and structural comments were added as “memos” to manage effectively the volume of interview data with commentary.

Categories were then evaluated with three outcomes in mind: 1) they explicitly express what was in the transcripts; 2) they were compatible, but not explicitly expressed in the transcripts; 3) they were not compatible or expressed, so discarded (Moustakas, 1994, p. 121). Explicit or compatible categories were reduced to five workable themes, which allowed for further study of invariant constituents or relevant statements. These fundamental themes were further articulated in the “Findings” of this dissertation, which were submitted to participants for review and to elicit feedback from participant group members. These findings were illustrated, using verbatim examples, to amplify the meaning of individual findings.

Composite textural and structural descriptions of the experience of mindfulness’ impact on psychodynamic listening were formulated, based on descriptive comments and conceptual comments, viewed within in the context of themes and findings. Finally, a synthesis of textural and structural descriptions was formulated to articulate the essence of the experience of mindful awareness as it influences the clinician’s listening stance in psychodynamic psychotherapy. This synthesis of the participant group’s experiences constitutes the textural-structural composite below. Once the analysis was complete, findings were compared to the researcher’s review of literature and were studied for their theoretical impact and implications for clinical social work.

Limitations of the Study

This study drew upon a limited number of 15 participants. Such a small population limits the ability to generalize to a larger population. Although the sampling techniques for gathering participants encouraged voluntary participation and avoided shaping the data sample through potential coercion of participants, it was nonetheless a non-probability sampling method, which further undermined the generalizability of the study's conclusions. Also, one 90-minute interview is a brief time period for discussion of such subtle, yet complex questions. Nonetheless, even when qualitative studies, such as this one, cannot be considered conclusive, they can identify ideas or themes that lead to further clarification or study.

I am one who practices mindfulness. Despite the efforts to bracket my own experience in the methodology of this study, this factor can be acknowledged as a potential limitation. My personal experience could lead to assumptions regarding what I heard or expected to hear in the experience of the participant population. The bracketing methodology, outlined above (pp. 56-57), was embraced precisely to minimize the potential for biasing the data with my own preconceived ideas. Giving more attention to my own views could have increased the rigor of bracketing. Considering carefully any parallels between my bracketed views and those of my research will minimize this limitation. Parallels with the findings will be carefully considered in the comparative discussion in Chapter VII.

CHAPTER V

PARTICIPANTS

In the beginner's mind there are many possibilities,
But in the expert's there are few.

~Shunryu Suzuki (1970, p. 21)

Selection

Participants in this phenomenological study were chosen because they were believed to have rich experience regarding the topic being studied. Initially, the researcher tried to recruit people by distributing flyers at an international conference as well as at local psychotherapy workshops, and by advertising the research project in a quarterly therapy journal. These recruitment efforts made the research project public; however, only one participant responded to this method. So, rather than passively waiting for more volunteers, the researcher chose a more active approach to solicit participants. People who were known to be seasoned clinicians and mindfulness practitioners in the psychotherapy community were contacted directly (in person, via email or by phone) and asked whether they would consider participation in the research project. Some readily responded to the request for interview; some did not respond; and some were encouraging in their reply, but too busy to participate. A couple of people, who were contacted but unable to participate, offered to help spread the word of this research

project among their circle of clinicians. Through these referrals, a few is volunteered to be participants.

Demographics

Eight participants were located in Washington State, where the researcher resides. Three participants were located in California. One participant was interviewed from each of the following locations: Oregon, New York, England and Taiwan. All participants were seasoned clinicians with rich life histories and abundant clinical experience. The extent of their clinical experience ranged from 10 to more than 40 years. The majority of the participants had been practicing psychotherapy for over 30 years and had undergone many different phases of development in their lives. Participants consisted of four females and eleven males. Six out of the fifteen participants were psychoanalysts. Five of the participants were practicing Buddhists, two of which were Roshis (i.e., Zen Buddhist teachers). Six of the participants were practicing Christians, five of which were active, ordained ministers. Although some of the participants were acquainted with the researcher and one participated in a monthly group consultation, no other on-going social or professional relationship existed between the researcher and anyone who participated in the study.

Procedures

All participants were informed of their right to terminate the interview at any time if they so desired, but none dropped out of the study. All of the interviews were

conducted in English, except one (which was conducted in Chinese, mixed with some English). Each interview lasted approximately 90 minutes. Due to geographic distances, most interviews (eight) could be conducted face-to-face; however, some interviews were conducted via phone (six) or Skype (one). All 15 interviews were digitally recorded and transcribed into smooth verbatim by a professional transcribing company, except one (which the researcher translated from Chinese and transcribed). Audio-file numbers were used to identify individual participants, which have been added in parenthesis, following quotation, to identify the speaking participant. During the interviews, generic open-ended questions were employed to help participants engage with the research topic and prompt reflection on their experience. Participants were given the freedom to associate freely and elaborate, as they saw fit, their experience with mindfulness and psychodynamic listening.

Responses

All participants appeared to be fully engaged in the opportunity to reflect about their experience of mindfulness and psychodynamic listening. Most expressed appreciation for the research topic and the challenge to investigate their own experience during the interview. However, two emotional experiences of participant responses to the topic stood out. First, one of the participants disclosed that she regularly got contacted to participate in research relating to topic with mindfulness and mostly would say ‘no’ to the requests. However, the research topic here intrigued her to a degree that she wanted to know more about the research and about the researcher. This unexpected reaction was

heartening. Second, another participant, a long time yoga and Buddhist practitioner, had a strong reaction to what he called “the mindfulness craze.” Early on during the interview, before discussing how his own mindfulness practice affected his therapy practice, he appeared to be reactive to a popularized misunderstanding of “mindfulness” (i.e., an idea that mindfulness would be an easy fix to personal change or for psychodynamic psychotherapy training). Apart from the legitimacy of his protest, I had not anticipated that the research topic could be viewed as searching for “a magic pill.”

After completing the data analysis, a formulation of findings was presented to participants for their feedback. Five responses were received back. All five were in basic agreement with the findings. Two offered rewordings of Findings 4 and 6; these have been incorporated into the presentation of findings. A third respondent felt that Findings 6 and 7 were too broadly stated (but did not specify how this was so).

Backgrounds

Background stories of how participants recognized the importance of mindful awareness were highly individual, as one might expect. Some began in childhood with a sense of wonder or a quiet contemplative personality, which got lost, found and developed in their process of healing as an adult. Typically, participants reported a path of personal growth, shaped by key people and experiences, which fostered their recognition of and investment in mindful or contemplative practice as an adult Important experiences were reported from personal therapy, spiritual practice or clinical supervision, in which participants realized that they were not “hearing what others were

saying" (326, 336)[1], or in which participants struggled with "learning to count breaths" for an extended period (340, 343), or in which participants recognized "how much my experience was my own projection" (349, 355). "Learning to pay attention to my body" (325, 330, 355) enlarged awareness, but also settled participants to remain in the present moment.

Likewise, key people were met in personal life, spiritual practice and clinical training, who influenced participants' direction or provided critical opportunities for transformation of the meaning of "life," "health," "suffering," or "psychodynamic practice." Experiences with a mentor, a personal therapist, or a supervisor (326; 330; 336; 340; 342; 358; 366; 375) appear commonly in participant interviews as each one reports struggles with the limits of their understandings of self and others. Personal suffering provided a compelling motive (i.e., self-healing) to find a spiritual or healing tradition, which both mindfulness and psychotherapy practice offer.

East and West

For most participants, the path to mindfulness practice came after they had practiced psychotherapy for quite some time. These found the practice of mindfulness so compatible with psychodynamic listening that they began practicing to incorporate its practical benefits without regard for theoretical tensions implicit in blending East and West (336). These participants could adopt and apply mindfulness practice within the

[1] Numbers in parenthesis represent codes assigned to individual participants.

context of their clinical experience and let it grow, relying on principle that the truth is valuable no matter where it comes from.

However, three participants had been immersed in mindfulness practice before they actually became a psychotherapist. These participants were immersed in a spiritual tradition and pursued their clinical training regardless of its congruence or dissonance with their mindfulness training. Some participants describe how their management of the two traditions (Buddhist; psychodynamic) changed from being kept totally separate, to adding some Buddhist elements to the psychodynamic (e.g., view of self), to translating concepts (e.g., evenly suspended attention ~ mindfulness), to attempting a full collaboration between the two healing traditions (341, 343, 349). This type of integrative effort could also be seen among those with Christian backgrounds, who had been involved in the pastoral counseling movement for years (325, 326, 334, 342, 358). Envisioning their "mindfulness" from the perspective of the mystical tradition of Christianity, they could translate the effects of contemplative practice on their psychodynamic experience.

Only those who had engaged in dedicated Buddhist practice appeared to be conscious of the dilemmas of blending Eastern and Western traditions. Perhaps only those who are deeply embedded in Buddhist culture with all its associations can feel this tension. But one participant describes her synthesis eloquently as she says:

> I've always been aware of consciousness and I think that's connected in me to a quest for a certain kind of freedom that I would describe as freedom from my thinking mind and that Dharma helped to clarify for me the difference between my awareness and my cognitive structure. And so, it just seemed so obviously true to me and it was also liberating at a very profound level because I've always been so intellectual. So, it gave me a sense of being returned to some basic aspect

of my authentic being (341).

In their training histories, participants of this study uniformly espoused and exemplified the dedication to training and devotion to personal growth required to develop their mindfulness within psychodynamic psychotherapy; so they provided absolutely no evidence for a view that mindfulness training could replace the rigors of personal therapy, clinical supervision or theoretical training. And even though participants came from different spiritual disciplines and had diverse theoretical backgrounds, their experience of the essence of mindful awareness and psychodynamic listening appeared to be similar.

Participant histories exemplified a life-long effort toward emotional and spiritual growth and integration. To some extent, this retrospective view of participant histories allows for connecting choices and events that were not anticipated by an over-arching plan. However, all participants had set intentions to complete extended programs and had fulfilled lengthy commitments fostering their inclination to become a healing presence. None of the participants felt their mindfulness or contemplative training was a substitute for some element of psychodynamic training, but felt that developing mindfulness via a meditative, spiritual or contemplative practice addressed their own suffering and stabilized their attention to others' suffering.

Not all participants were fully engaged in an integration of East and West; only a third (five). But these, who were so engaged, were deeply identified with Buddhism and psychoanalytic psychotherapy. These had devoted years to regular meditative practice, sesshins (retreats) and/or work with a Buddhist master. This group had studied and

practiced traditional mindfulness and could speak from this Eastern experience as well as their experience of psychoanalytic practice. One participant aptly articulates what each one's history supports in their own way:

> What propelled the choice of both becoming a psychotherapist and a psychoanalyst and practicing Buddhism was the reality of both my own personal suffering and my awareness of the suffering of other people around me. And the psychotherapy addresses suffering from one point of view and Buddhism addresses it from another, superficially. . . . in what Buddhism would call the reification of the self or the suffering generated by attachments and diversions. And in psychoanalysis, we would think about that perhaps as the problem of narcissism in an overemphasis (becoming trapped) in the needs of the self. So both of those are misperceptions or mistaken investments that create an enormous amount of blind spots in the way that you actually perceive the world (330).

Another rough third (four) of participants had trained in Hakomi therapy, which was formulated as an integration of Eastern (Taoist) thinking by Ron Kurtz, the founder. These participants found the Hakomi integration more balanced than other psychotherapies, for which they had trained. The final rough third (six) were translating their notions of Christian contemplative life to therapeutic (Western) mindfulness and appeared motivated by the need to balance emotional and spiritual dimensions of human life.

CHAPTER VI

FINDINGS

> *We can make our minds so like still water that beings gather about us, that they may see, it may be, their own images, and so live for a moment with a clearer, perhaps even with a fiercer life because of our quiet.*
> ~William Bulter Yeats, cited in Didonna (2009, p. 17)

Prologue

Analysis of participant interviews extracted eight findings that represent the invariant constituents of data gathered during this research project. In summary form, these findings are: 1) Development and integration of mindfulness complements clinical theory and grounds clinical work. 2) Mindfulness is a state of mind that is calm, receptive, open, non-judgmental, and curious, more like a way of being than a technique. 3) Mindfulness helps the therapist remain clearer about her own associations and manage her reactivity to the patient's processes. 4) Mindfulness helps both therapist and patient observe: the therapist to sustain attention to mind/body communications of the patient and the patient to regulate her emotional and physical experiences. 5) Mindfulness contributes to the creation of a safe emotional space for the patient's exploration of their experience. 6) Mindful awareness helps the therapist focus on the patient as person and the relational process, not solely the content of the patient's story, helping elicit deep

inner resources from within the client to transcend their presenting difficulties. 7) Mindful awareness increases the capacity for psychodynamically-informed listening in-session and sustains the therapist's attention to her own mind/body experiences, enhancing recognition of unconscious communication from the patient. 8) Good psychodynamic psychotherapy is inherently mindful; mindfulness is an integral part of psychodynamic listening. The meaning of each finding is illustrated below, followed by a synthesis of composite descriptions of participant experiences. This chapter concludes with evaluation of potential influence from this researcher's bracketed mindset.

Finding 1

Development and integration of mindfulness complements clinical theory and grounds clinical work.

Participants describe the function of mindfulness in psychodynamic listening with a variety of metaphors: a "bridge" from conscious to unconscious communications and a sensitivity to recognize the "clues" to or "echoes" of unconscious communications. Although participants represented several spiritual traditions, all affirmed the need for mindfulness in the practice of psychodynamic psychotherapy and all observed that individuals develop competency in mindfulness within psychotherapy through a variety of approaches, not one single path. The variety of paths, represented in participants' stories of development of mindful awareness in their clinical practice and reported above (pp. 67-71), illustrates this fact. In a nutshell, awareness is a part of human nature and no single tradition (spiritual or scientific) has restricted access to awakened awareness.

Given these basic attitudes, participants advocate for the development of mindfulness in the clinician because there are many similarities and overlaps between mindful awareness and quality psychodynamic listening.

> Ordinary consciousness, generally speaking, is trying to understand and so it seeks to categorize and to know something. . . . Mindfulness is much more willing to just allow mysteriousness and not knowing and that's an important thing in terms of being open and receptive, and especially for therapy, for going deeper, for discovering something you don't know. . . .Well, I mean, in terms of therapy or any kind of learning, you don't learn from what you already know, you learn from what you don't know. And so, in a mindful state of consciousness, you have to allow and be willing to allow more of the mysterious, the darkness, the not knowing (358).

Participants, like the one above, say that mindfulness and psychodynamic listening depend on each other and are equivalent as far as attention goes. Thus, psychodynamic ideals such as "evenly suspended attention" and "listening without memory, desire or understanding" find support in mindful awareness:

> Yes! Theory is important. But then, like Carl Jung said, "When you go into the office, throw all your theories out the window and just be with the person in the present moment." Trust that whatever you've learned is going to come through, but you don't want to be splitting by thinking while you're with somebody. You want to let thoughts come in and intuitions come in. But you also want to be with the present, be in the present with the client (355).

Mindfulness provides a strong support to this ideal of being in the present moment. However, other participants characterize psychodynamic listening and mindfulness as distinctly different, even if mutually supportive. Even though he believes psychodynamic listening and mindfulness corroborate each other at a deeper level of listening, one participant comments from his experience in the Zen tradition:

> I think they overlap. Obviously, there are similarities in the style of attention. There are similarities in the goal, which is healing and transforming suffering. There are many similarities. In the Zen tradition, there's a use of dialogue

> between teacher and student. In psychotherapy, dialogue is at the heart of things. So, there are many, many overlaps (349).

Here, this participant identifies three similarities (or "overlaps") between Zen tradition and psychodynamic tradition:

1. Style of attention;

2. Goal = healing, transforming suffering;

3. Method = use of a dialogue between teacher/therapist and student/patient.

An explanation of these three similarities follows as responses to each respective question (in italics).

What can be said of the overlap in "style of attention" between Zen and psychotherapy? Zen develops attention to the present experience, accepting whatever occurs without clinging or aversion. Psychodynamic psychotherapy develops attention to unconscious-to-unconscious communications, listening to oneself-listening-to-the-other. Both value and develop attention and awareness in the present moment. Zen is highly focused on the transient nature of one's way of constructing meaning from experience and one's interdependence upon all things. Psychodynamic psychotherapy is highly focused on the patient's experience and listens to oneself-listening-to-the patient as a mode of access to unconscious communications. At a very deep level, the attentional capacities developed in mindfulness training can become assets when combined with psychodynamic training to include attention to the subtleties and possibilities of unconscious-to-unconscious communications.

What can be said of the overlap regarding the goal of healing between Zen and psychotherapy? Zen's ultimate goal is liberation of all things; Zen's proximate goal is

liberation of the individual from the illusion of "self," which amounts to spiritual freedom. Psychodynamic psychotherapy's ultimate goal is freedom for the patient to love and work (Freud) or to know the truth (Bion); psychodynamic psychotherapy's proximate goal is to help a patient discover and undo unhealthy, unconscious patterns, which amounts to emotional freedom. Both are seeking freedom from the constraint of self-constructions. Zen presumes that awareness of No Self (or "emptiness," a recognition of the self as dependent on other conditions, not existing on its own) as is an ultimate goal. Psychodynamic psychotherapy presumes a healthy, animated, constructed self to be an ultimate goal. When developed at a deeper level, integration of Zen and psychodynamic psychotherapy can lead to a spiritual grounding of the latter and an emotional grounding of the former.

What can be said of the overlap in the dialogues of Zen and psychotherapy? Zen (teacher/student) dialogues are focused on difficulties with maintaining the discipline of Zen sitting (focus = spiritual growth). Psychodynamic psychotherapy (therapist/patient) dialogues are focused on patient's free associations, presumably related to emotional expression (focus = emotional growth) and recognition of unconscious communications. Both exemplify an ordinate/subordinate structure; both exemplify a relationship of dependency; both are helping, mentoring relationships. At a deeper level, the nature of the dialogue coalesces in the form of relief from suffering as the teacher/therapist and student/patient awaken or realize what is true, passing beyond the limits of their ephemeral emotional or spiritual constructs.

One participant advocates developing one's competence in psychodynamic

psychotherapy by getting a good analyst.

> Study not one, but several different approaches to psychoanalytic thinking. Get on-going and consistently good supervision, which is required if you're doing psychoanalysis, and train yourself in mindfulness. Q: I see. So, that piece is just as important as the.... A. I think the mindfulness is. If you take the elements apart, you can notice that these are parallel tracks and they have a tremendous amount in common. They do a lot of the same stuff; but they've got different names for that. Free-floating attention is what Freud called [mindfulness]: what "later" Buddhists were calling, long before Freud, mindfulness. Although, mindfulness is a recent term, isn't it, in [Western] Buddhism? I don't think that ["mindfulness"] was used until the psychologists got a hold of it (336; brackets mine).

Participants of this study uniformly endorsed the value of mindfulness in psychodynamic listening as well as the legitimacy of developing mindfulness in a variety of ways. Even those, whose Buddhist background was unmistakable, did not claim that traditional mindfulness practice is the only method of training attention to be considered. Yet, all participants were persuaded that developing mindfulness in their therapeutic listening stance required continual, devoted practice. The notion of always practicing, perfecting one's practice, builds upon a realization that one must be paying attention in the present moment and that conditions or influences (e.g., sensations, memories, desires, fears, thoughts), which can take attention away from experience of the present moment, will always be potential distractions. Practicing one's ability to be aware of one's experience, again and again, in order to develop one's capacity to be welcoming, compassionate and non-judgmental to whatever arises from the patient, becomes a life-long endeavor because "perfection" (even when achieved in one moment) cannot be preserved, as if to be applied for the next moment without a residue of being past, not present. Training to sustain a stable, open awareness requires repeated efforts over an extended period of time so that reliable habits of mind and heart develop.

Finding 2

Mindfulness is a state of mind that is calm, receptive, open, non-judgmental, and curious, more like a way of being than a technique.

As I listened to participants respond to my questions regarding their experience of mindfulness during psychotherapy, I heard them speaking of a particular experience, a valuable experience. One participant called it “a special state of consciousness, a special quality of consciousness that stands in contrast to ordinary consciousness” (358). Their experiences require awareness of their body and emotions as well as their mind, so that mindfulness is not being understood simply as a cognitive skill or mental exercise. Mindfulness is a way of being in which awareness of bodily, emotional, and cognitive experience is available to attention. “Mindfulness is the ability to slow down, be in the present moment, and witness . . . observe what's taking place in sensation, thought and feeling without judgment” (355). By way of contrast, “mindlessness” occurs when one is immersed in bodily, emotional, and cognitive experiences without the awareness that is capable of observing these experiences.

Participants contributed a kaleidoscope of words to describe mindfulness, which in concert color and allow for the meaning of mindful awareness to come through. Simply put, the mindful attitude is curious, open, accepting and deeply caring. The mindful person is present to the other and the environment, transmitted by the degree of their awareness. Participants developed aspects of mindfulness in reference to a) view of one’s self, b) range of sensory experience, c) range of emotional experience, d)

movement of discursive thought, e) quality of attention, f) time and place, g) judgment, h) empathy, and i) compassion. An overview of how participants' choices of words enrich and amplify the meaning of mindfulness yields the following:

A) View of one's self - "getting away from the habitual ways you organize yourself" (358) or just "getting away from yourself" (336); "allows you to take yourself, your experience under observation" (358); the quality of attention which "notices what's happening without preference;" sometimes, it's called "witness consciousness" because it is "the ability to watch what's happening" (355).

B) Range of sensory experience – "an awareness of looking, at the same time you're listening" (350); "a strong mind-body connection in the understanding of mindfulness because mind/body process is fundamental to awareness" (350); "awareness of internal processes; the ability to slow down, . . . be in the present moment, and witness . . . observe what's taking place in sensation, thought and feeling without judgment" (358).

C) Range of emotional experience – the capacity to be totally present in and aware of the mind/body unity (350; paraphrase mine); "very quiet, peaceful, focused on the present sensations, paying attention to feelings . . . in a non-analytical way" (375).

D) Movement of discursive thought – "an awareness that starts with not-knowing, that is, releasing our predilection for certain theoretical stances. By renouncing expertise and just devoting the full attention to taking-in-what-is-being-presented, both by [the patient] . . . and within myself and in the interpersonal field between us, these

three ‘levels’ of attention then lead to being engaged, but in a non-dualistic fashion” (343; brackets mine).

E) Quality of attention – “curiosity” (326); “the quality of attention that notices what’s happening without preference” (355); “being non-judgmental, being a witness, without judging, being patient, letting things move in their own time, having a beginner’s mind where you’re free of expectations from the past, when you’re trusting in the present moment, in yourself, in your feelings. . . . You’re not having a goal other than to be yourself. We look at what’s pleasant and what’s unpleasant, and we’re willing to stay present for both.” (355); “has a much more open focus: soft eyes so that you have more peripheral vision, you’re taking in more information, you’re not just overly focused on trying to accomplish any particular thing.” (358).

F) Time and space – “creating a space in which all mental phenomena can arise” (330); “embody the awareness of the present moment-by-moment” that has a depth dimension (341; paraphrase mine); “awareness of the present moment of experience as it is arising” (341); “awareness is more turned inward toward felt present experience” (358).

G) Judgment – awareness in present moment without judgment and with a compassionate experience-friendly attitude. The body is included because it is in the present moment. ’Without judgment’ suggests acceptance of what ever comes up internally or externally (366; paraphrase mine);

> mindfulness is much more willing to just allow mysteriousness and not-knowing, and that’s an important thing in terms of being open and receptive, and especially for therapy, for going deeper, for discovering something you don’t know -- well, I mean, in terms of therapy or any kind of learning, you don’t learn from what you

> already know, you learn from what you don't know. And so, in mindful state of consciousness, you have to allow and be willing to allow more of the mysterious, the darkness, the not-knowing (358);

"willfully passive where we invoke the witnessing aspect of our ability to be the witness to what comes up. . . . We try to suspend normal judgments and habits and simply bring awareness to what is" (358).

H) Empathy – "an intentional focusing of my heart upon the heart or the core of the other person" (342); "just being curious and open, and again, receptive. . . . it has more to do with befriending, just befriending something without trying to change it, just getting to know it, just bringing, again -- bearing awareness to what is, just in a curious way" (358).

I) Compassion – "the passion in a moment that allows one to go on" (350); "involves resting in the larger consciousness, compassion and healing, knowing that it's okay and fine, no matter what's happening" (358; italics mine).

On the one hand, mindfulness is easily accessible, immediately available, so that moments of mindfulness can be noticed with patients through a simple effort toward empathic listening. On the other hand, sustaining mindfulness for any length of time is *not* easily accessible or immediately available. Sustained mindfulness takes years of dedicated practice and occupies a significant effort over a lifetime, developing in concert a capacity for focused concentration and de-centered awareness, developing a habitual way of being. One participant described the results of her mindfulness practice on her clinical experience:

> I would say that I regard my hours that I spend in the consulting room as hours not only in psychotherapy practice but a good part of it hours of meditation

> practice because I am in a quasi-meditative state when I work most of the time or a lot of the time -- as much as I can (341).

Another participant summarized his understanding of mindfulness as:

> So we direct attention towards the internal organization of experience. A mindfulness is used to be in the present rather than in the past or the future. And we also want to remain curious and interested when we're in mindfulness rather than being interpretive or judgmental. It's the quality of attention that notices what's happening without preference. So mindfulness is sort of like a choice-less awareness, like the sun that shines on all things. In terms of a mindfulness practice, what could be considered in mindfulness . . . is one being non-judgmental, being a witness, without judging, being patient, letting things move in their own time, having a beginner's mind where you're free of expectations from the past, where you're trusting in the present moment, in yourself, in your feelings. And in mindfulness you're not having a goal other than to be yourself. So you're not goal-directed like we are in our society. And there's an acceptance in mindfulness, a willingness to see things the way they are. And in mindfulness we also look at what's pleasant and what's unpleasant, and we're willing to stay present for both (355).

An assumption that a natural capacity to be mindful exists in humans runs throughout participant comments. One participant comments on the importance for her of discovering this in her process of Hakomi training. “So, in Hakomi, you come to see early on that you have the capacity to observe and discover yourself. This capacity comes from oneself” (375).

Finding 3

Mindfulness helps the therapist remain clearer about her own associations and manage her reactivity to the patient’s processes.

Repeatedly, participants brought up the calming, spacious effect of a capacity for mindfulness in their clinical experience. They were well aware of experiences without mindfulness in which they felt so impacted by the emotional field that they became part

of an enactment with the patient, losing the opportunity to collect what was happening and reflect upon its meaning. For example, with mindfulness,

> I'm less fearful when people talk about catastrophic things or horrific things or violent things. I'm less reactive so that I can think about why it is they might be wanting to tell me this. Whereas, in the past, I would be more reactive, I would say □□ I'd be more instructive, I would give them instructions, basic instructions □□ I wouldn't say "Calm down!" but that would be the inference. But how are they ever going to experience violence unless they experience it with me safely (340)?

Building the strength of one's awareness to remain calm, receptive, observant and present while listening to a patient is considered fundamental to psychodynamic listening and this is what participants found valuable about access to mindful awareness. It endowed them with a capacity for "non-reactive listening" (334), ridding them of the "usual ways of seeing, talking and being smart" (336). They could listen "without privileging one feeling over another" or believing that a "bad feeling is something that we have to get rid of and a good feeling is something that we have to accumulate" (340). Mindfulness allows the therapist to be clearer, "less hung up on her own associations," more able to listen to her own mind as well as that of the patient (336).

> So, if I feel, "Wow, this is really interesting, and I could talk about this forever," or, "Wow, that person really did you wrong and I'm going to call up the board of professional standards and report that person," suddenly, I become aware of the feeling and use that. And then, have the discipline to not act □□ although, I act in little ways. I might engage myself before I'm aware, just like with any other emotion. The hope is. . . to have the gap of awareness be shorter between the action and the awareness of it (340).

This impulse to act on emotion is built into the nature of affect and emotion, of course; but slowing the process down with awareness enhances the possibility of observing and

attending to what is happening habitually, unconsciously, and without thoughtful consideration.

> Now, I have the same struggles that all of us have. There are days where I'm going to be triggered by what's being presented or what's being expected of me or demanded of me, and I have to, again, pay mindful attention to what's happening to me, that's happening, my push to scratch the itch instead of attending to that, and then shifting the focus. I have to slow down. I can rev up and I have to say to myself, "This is not going to be helpful to him or her or them. I just need to slow down" (342).

This capacity to "slow down" in mindfulness, to patiently give attention to an impulse rather than act on it (342), is equated by some with a freedom of mind to

> follow the flow of . . . associations, slowing down the mind, so we can see frame-by-frame what the patient says and how we are responding, a kind of leisurely quality to listening where we're not compelled to do anything, to solve any problem, but just to observe for the sheer pleasure of observing our responses to the patient (349).

Mindfulness allows the clinician simply to observe and wait for the patient's communication (conscious and unconscious) to surface. "I think there's less distractibility and less identification with transient affective states, like counter transference. The counter-transference still occurs, but it stands out in bold relief rather than being insidious and sucking one into it" (343).

Mindfulness encompasses awareness of one's actions and reactions and permits a degree of chaos, trusting that an organizing principle operates amidst the complexity. "Comfort with uncertainty, comfort with confusion, ease, stability, honesty" (349) develops from assuming a perspective aligned with being present, non-judgmental and aware (i.e., not identified with sensation, imagination or discursive thinking).

> All of this is done in mindfulness, so the therapist has to be mindful of one's self. It's not mindfulness like in meditation; it's relational mindfulness. You are being

> mindful while you're interacting with another person. And if you're not observing yourself, you're going to get into trouble because you're going to be projecting your own feelings. You're going to be leading. So, you have to kind of know what your own state is. If you start to feel frustrated and tight and heavy, it's a good idea to look to see what's going on with you because you're probably trying to force things (366).

The field of awareness is wide, if one chooses not to limit one's focus in some particular direction. Some label such undifferentiated awareness as "choice-less awareness"; it is the root of awareness, which can be directed by attention to specific sources of experience. Participants associated mindful awareness with their ability to observe their experiences with patients:

> There's also a greater awareness of one's own body, the musculature of the muscle tonus, of facial muscles, of the visceral muscle tone and blush response. One becomes very aware of one's own bodily responses but they serve as channels of communication rather than as distractions (343).

One can see this in a participant's description of a variety of sensations, felt in-session with a patient, which could be overlooked, discarded or ignored as irrelevant to the patient's communication. Mindfulness increases one's acceptance, recognition, and tolerance for such somatic experiences as meaningful cues in the context of patient-therapist relationship, allowing the therapist to preserve neutrality:

> If I feel the patient is extraordinarily angry, my chest will start to burn and . . . it's not a metaphor; I feel this burning in my chest . . . I think to myself there's anger in the field . . . I need to be aware of that. . . . If I feel a kind of goose bumps or iciness flush down my back, then I feel I'm really in trouble because that's like a predatory aggression that's somehow in the field. If I feel that my legs and . . . my belly start to just shudder, then I know that I've fallen into some very primitive memory of my own infantile distress. It may be triggered by something going on in the patient, but that's when I really need to pay attention to regulate myself, because that's a little . . . like physiological, it's like a trembling and a falling of the heart. So all of these are somatic states that are anything but calm, (and) . . . instead of getting freaked out by it, I have to become curious and attentive and compassionate about it, so that I can bring that curiosity and that attention to those

> states so that I can regain my calm alert state. And then, the fact that it's-happening-in-the-moment-with-the-patient makes me think that my state is somehow related; it's part of how I listen. This is embodied listening, it's like the patient -- the impact of not only what the patient's saying, but how they're saying it, is being registered somatically which gives me a clue to something, even though it doesn't tell me exactly what's going on (330).

Not knowing the meaning of these clues (or where they might lead) typically creates a tension, which must be tolerated for true discovery to emerge. One can easily formulate a story that prematurely confuses or diverts the truth on its way to creation. Mindfulness recognizes the artificiality of any story or self-construction, even though it might be legitimate from some point of view (340) and can temporarily hold the tension for true discovery.

Another participant gives several instances of how mindfulness might function in directing her attention within psychotherapy sessions toward a) recalling; b) wondering, c) noticing, d) imagining a relevant story, e) exploring, f) asking, and g) reflecting.

> Sometimes, I say, "You *told me about* what happened this week with your husband and I'm *reminded* of what you told me about that particular incident that happened with your father when you were five or I *wonder* if that's similar to the way you feel about your sister or I wonder if that wasn't something like *how you felt with me* a month ago when we talked about such and such." Or I just *associate*. It might be with my own experience and I just talk to the person in the way that I do or I ask questions or sometimes I'll say, "I think it's hard for you to tell the difference between this and this." Sometimes, I'll *tell a Dharma story*, if it's relevant to what we're talking about. So, there's a whole range of things that I do in a session that . . . are relational; some of them are (what I would call) clinical or psychoanalytic, an *exploration* of something by *asking* questions. Sometimes, it's just *reflecting* on the quality of the moment, you know, something about how that particular moment feels (341; italics mine).

In these instances, mindfulness plays a role in discerning when one's own listening response is accurate, appropriate and timely.

> We observe in the moment what happens in ourselves. This practice is what I do almost every day because before my brain recognizes something my body will have already had some feelings. For example, my body feels anxious but my brain did not detect it yet. So with this practice I am able to sense more quickly than before, like sensing that my heart has already beating very fast, my mind might be saying, “It's okay. I can deal with it.” But in reality, my heart feels really afraid, or my muscles feel tense. This will help me when I am with my clients. Say even if I feel peaceful when I am with the client, but how the client conducts himself makes my body sense some emotions, then it alerts me to be curious about what's going on inside of the client more quickly. I will ask what made me have that feeling? It is easier to differentiate whether it is a feeling coming from what's being presented in the moment or was it from my own personal issues that got stirred up (375).

Clarity regarding the likely source of one’s feelings is a necessary asset when subtle affective and emotional processes are at work.

Finding 4

Mindfulness helps both therapist and patient observe: the therapist to sustain attention to mind/body communications of the patient and the patient to regulate her emotional and physical experiences.

Listening requires the orchestration of all our senses and imagination in order to recognize the meaning of the patient’s communication in-session. In an extended comment, one participant elaborates how inclusive attention needs to be in order to absorb all that a patient presents.

> It’s all the senses that more or less are coming together somehow. And it’s like an orchestra directed by one of the senses. But, in fact, it’s all the senses working at the same time. We are not listening only. We are using the other senses (350).

Working psychodynamically requires a therapist to develop their capacity for connecting all their senses in the process of generating meaning with the patient. Difficulties in listening correspond

to problems in connecting what the senses are taking in.

> When the other person is talking -- and I'm talking about listening and talking here because the other person is talking -- the other person is talking to you, but also is talking to someone else. That is in the dark that I'm going. I'm trying to move to this question of what I think about mindfulness, or [what I think] about this mind/body unity; in my language, mind/body unity is mind/body experience (350; brackets mine).

What becomes difficult in therapy is listening to the unpleasant "music of the patient's voice." It is the unpleasant, the suffering, in a patient's "music" that appeals for the interest of another person, who might listen to help the patient appreciate their own music or possibly to help the patient decide to make a change.

> I'm not talking about even the content because then, obviously, at some moment, if you combine that with the richness of the content of the communication, well, it's marvelous. The sync with ears and the mind/body unity, it's marvelous. But, unfortunately, you're in a situation that you have to listen to music that you don't like, and that requires a little bit of developing how important it is for the other person to have another person listening to their own music. But there are some people [therapists] that become very intolerant, they don't want to listen to what you [the patient] want to say. Every time you talk to them, they become irritated with the music of your voice; and you [the therapist] have to tolerate that. (350; brackets mine).

Developing this capacity to remain tolerant of what is unpleasant, but what is as familiar to the patient as the music of his voice, is an integral part of psychodynamic listening. Bringing a quality of awareness that allows for the unpleasant, that observes, accepts and validates how the patient suffers, requires mindfulness in the therapist.

> The intentionality for me in the psychoanalytic situation is that the listening is a component of showing interest, interest in the other person, interest in the problem; and, of course, the patient or the client or the person feels a little bit understood. And that has a tremendous therapeutic effect. It's a little bit complicated, a little bit, a little bit because his voice, or her voice, their voice kind of belongs. Someone can make an effort they're trying to understand and trying to perceive this function in the mind. (350).

Providing a welcoming interest to what "belongs" to a patient, even when the patient may not be aware of it, helps regulate "this function of the [patient's] mind" because the therapist offers him

sustained attention to help the patient observe what is his own behavior, perception, thought, emotion or affect.

> When the other person is communicating and you are listening, you are listening to the dream of other person, you are listening to the different music. And the music of the dream is fundamentally different. The music of the patient when they talk about the dream, they change the tone of voice. Why is that? Well, I was thinking quite a lot, and it's because it's a much more intimate communication and has to do with his mind/body. It's buried in the nature of the mind-body unity (350).

Interestingly, this participant now shifts his focus to how such mindfulness in psychotherapy is developed and he outlines the traditional course of psychodynamic training.

> How the analyst develops that would require a process that requires training in some institution, then your own beginning to work, and, of course, fundamentally your own analysis with your own process, supervision, and then experience of this, I mean, in a different sort of patient or people that need help, and trying not to be selective (350).

The question of mindfulness training for psychodynamic listening will be considered further in Chapter VII.

Finding 5

Mindfulness contributes to the creation of a safe emotional space for the patient's exploration of their experience.

By addressing one's own issues, those issues are less likely to affect work with patients. Because the therapist becomes such a keen observer of her own internal processes, mindfulness helps monitor and minimize countertransference, leaving more emotional space for the patient to work through his issues. The calm, open, curious, non-judgmental way of being, which is characteristic of mindful awareness, creates a secure emotional space for self-exploration. "Mindfulness is really important in terms of

creating a space in which all mental phenomena can arise" (340). One participant recognizes that his mindful presence has a "somewhat calming" influence on his patients, although this varies widely, depending on how psychologically minded the patient is and what their issues are" (343). Another participant carries this notion further to its outcome:

> If I am mindfully heart-open to them, lovingly indifferent to them, compassionate to them, that's what changes people, . . . is to have people compassionately, non-reactively, compassionately, empathically and yet, in a boundaried way, listen to them and keep their heart open, that's what changes. That's one of these things I've learned. It's not easy to be a nonreactive, empathic, lovingly-indifferent and boundaried-awake listener. Those are hard criteria. You don't learn those easily, but that's what changes people (334).

Yet another participant elaborates the dynamics of change, recalling two ways in which mindfulness sponsors change in the patient (i.e., creating a safe emotional space and modeling of mindfulness):

> Q: Does your mindful awareness help facilitate that process in your patient? A: Yeah! Well, I think there are two things going on there. The first thing is: if this container, if this space is nonjudgmental and safe enough, then they are free to emerge beyond what life has taught them is safe. They can explore feelings that they've never felt before, or needs that they've never experienced before, or actions that they dared not try before. So, if this space is safe enough, then that allows them the freedom. And if I'm present to them, that helps. There's someone here. It's not just: this space is a vacuum. There is another being here with them who deeply cares, and invests in who they are, who they are becoming, without judgment or expectation. So, that's one part of it. The second part of it, I think, is my modeling, my mindfulness of them may help them to become more mindful of themselves (326).

This participant believes that his own mindful behavior in-session teaches the client, by example, to slow down and observe his own experience. Then, learning from this in-session experience that it is safe to explore experience, the patient moves beyond an assumed threat (or an assumed limit) to learn that understanding and discovery can come from within himself.

Theories of change offer many models for understanding how change happens. One participant describes her understanding of how mindfulness influences a therapist with a "stuck" patient, utilizing intersubjective theory.

> I would say that really it's something that is happening on multiple levels in the interaction, or [that] what they call [in intersubjectivity theory] "the intersubjective intersection" is where it's happening. The "unstucking" is happening there. And it's happening as a result of the light of awareness, where [we're] focusing on a statement, a feeling. I think that there is something about narrating: . . . for the patient to speak their experience into the therapy space (into my listening). I hear the way that they speak to me; and I also hear the way that they listen to my listening; and I also try to speak to them in such a way to awaken their reflective listening; and it opens up the states of possibility to see things in a different way (341; brackets mine).

A deep capacity to accept experience whether it is pleasant or unpleasant, which is a hallmark of mature mindfulness, permits patients to report whatever is on their mind.

> I hope that people don't feel that they can only say certain things, but not others, because I'm only open to certain experiences, but not others. I hope that the more I can manifest that non-discriminating mind, the more that they feel that they can come and talk about their experiences of me, so the session has to involve a really lived experience with me. And if they feel that I am not listening, then I'm open to being appreciated as a not-listening person and I'm not going to defend myself by saying, "Of course, I'm listening," even though I'll say it to myself. I'll nonetheless identify they need me to be absent. Maybe what they're really saying is, "I am so embarrassed at being listened to that I can't tolerate it, so I have to perceive you as a non-listening person," because many people feel when they're listened to closely, it's very wrong, it's so sensitive to be felt so warmly, . . . so without criticism. That's part of the practice. That is important to bring into the clinical setting, because if you kind of mouth openness, people can say whatever they want, you can still feel from my voice or from . . . nuances of my expression, that I'm not open. So, I think mindfulness is really important in terms of creating a space in which all mental phenomena can arise (340).

> Q: So, how do you think your mindfulness affects the patient's process? A: I hope that they would feel that they have less to defend against because I am only considering certain parts of themselves as good and other parts as not good. The great happiness would be free of those considerations (340).

When the therapist can get out of the way for the patient to do his therapeutic work, the

patient no longer feels that he needs to take care of the therapist and can engage in their therapeutic process fully, without distraction. One participant reflected on this experience from his perspective as an analytic patient for many years:

> Q: What can therapists offer? A: What I'm talking about: they can offer mindfulness. They can teach by their model that they don't have to know, so you don't either. They don't have to react and try and make stuff better for -- I don't try to help my patients, that's one of the rules. The [therapists] don't try and fix it because they think you [the patient] probably can fix it better, if they can create an atmosphere for you to take your life on. They can show you, hopefully, calmness, serenity. A lot of people are just tremendously agitated, and it irritates them if the therapist doesn't get agitated, too, with all that agitation stuff they bring. But if they stick long enough, they'll begin to know, "What's going on that he's so calm? There's a war in Afghanistan, and I'm broke, and ne, ne, ne, ne..." The [patient's] hair is on fire, right? What you're offering them [as therapist] is yourself to be internalized. That's the way it works. I've got my analyst and therapist inside me, I promise you, all the time. They don't always make a lot of noise, but I have swallowed them emotionally. I've been with them long enough so I can tell you what my therapist would have said about whatever it was that I was facing. He has done with me what I'm talking about doing with you. He's absorbed me into a very healthy, open, free life that's responsible. And when I keep sticking my stuff into my analyst and he seems to be interested, but not having a fit, worried to death, or gives me advice (which I don't need, even though I ask for it all the time), then after a while, that gets in you. He's offered me mindfulness. He gives me mindfulness. . . . So after a while, I'm sounding like him. That's a risk, but it's a lot better than before I came in (336; brackets mine).

When mindfulness helps a therapist listen to patient's experiences in a way that receives and respects the needs implicit in these experiences, then the experience becomes more tolerable and the patient is able to internalize the process with the therapist. Many participants refer to this process as "reverie." In this way, mindfulness helps the therapist by giving a vision of non-reactivity, which becomes an antidote to getting lost where the patient gets lost.

> And probably this awareness, what you call mindfulness, is giving you an indication it can help at least to give somebody a vision not to get lost, not to get

> terribly lost because that is the situation with the patient that comes to therapy (350).

Finding 6

Mindful awareness helps the therapist focus on the patient as person and the relational process, not solely the content of the patient's story, helping elicit deep inner resources from within the client to transcend their presenting difficulties.

Maintaining a focus on the uniqueness and individuality of the patient becomes crucial amidst the complexity of the patient's self presentation (i.e., life history and current emotional status). "With mindful awareness, one can notice when one has gotten distracted or when one's attention has become skewed and is able to compensate for it, at least, to take it into account" (343).

One participant models mindfulness for the patient by "allowing [her] to become my meditation." He explains how he does this and how his attention includes awareness of his own reactions to the patient as a way of knowing the patient as a person.

> I allow the client to become my meditation, and so I try to slow down and become open and receptive to who this person is, and I try to allow their truth or reality to just come to me and register in my own experience, and so then I'm □□ so I'm always □□ then I'm becoming mindful myself, I'm noticing myself. Like do I start to feel competitive with this person? Or I start to feel like I want to help them and I reach into my wallet and give them some money? So, I'm always studying myself to notice how I'm experiencing the person and what they're stirring up in me. So, I'm mindful of them, I mean on many levels, as well as I'm mindful of myself, my own process while I'm with them, and so, I try to pick up the interpersonal subtleties. So, yeah. So the person themselves become our meditation as a therapist (358).

The psychotherapist's "ability to be able to attend and then engage has to do in part, at least, with your capacity to be mindful" (341). Some spoke of their listening to the patient

as listening to the "core of the person" or the "person in the patient." One participant describes how he listens to the person in therapy in terms of listening to the core of the person, the true self, hidden beneath the false self.

> The human being is pure gold at the bottom. Every human being has not only that [golden] core, but has a very well developed ME, capital M-E, and the ME is the anxious, struggling one that manifests all the symptoms, anxiety, depression, hyperactivity, manipulation, everything. The ME is constantly demanding our attention and drowns out the voice of the core. The capital M-E, ME, is like our false self. The work of therapy then has to do with helping the person to get below the level of ME, learning how to set the ME aside enough to be able to hear the core. So, when I sit with someone, I may start by hearing the ME being expressed, but I know that's not going to go anyplace. They could spend years of psychotherapy speaking from the ME, so I want to accept that, receive that, then start to ask questions to go below to the level of the core (342; brackets mine).

Another participant spoke of listening for "who's talking in the patient," recognizing a distinction between how patient presented themselves and who they really are, but also recognizing how therapist might recognize the distinction by noticing "which part of you [the therapist] has been talking."

> Listening is not only listening to one's self and listening to another, but for me it's fundamentally listening to another, and listening for who is talking in the other. And also listening, trying to listen to which part of you has been talking (350).

Listening to the relational process likewise exercises the capacity to attend to how the relationship with this particular patient affects the therapist and to what interpersonal processes need tracking.

Finding 7

Mindful awareness increases the capacity for psychodynamically-informed listening in-session and sustains the therapist's attention to her own mind/body experiences, enhancing recognition of unconscious communication from the patient.

A primary function of psychodynamic psychotherapy is to help a patient become aware of unconscious dynamics that affect their daily living and decisions. Participants recognized the importance of unconscious communications from and with the patient as fundamental to their approach to psychotherapy. For example, one participant put it this way:

> Unconscious communication is of great significance in the clinical situation. Much of the communication of the patient to the clinician and vice versa is unintentional, almost accidental but when examined more closely and in context, one begins to be able to trace associate pathways that led to the communication and enhanced or amplified its meaningfulness to the patient and to the clinician. And I think that mindful awareness is at play in all of this process (343).

Of course, then, one becomes curious and asks: how is mindful awareness "at play" in psychodynamic psychotherapy? How can one characterize a conscious process of directing attention to what is unconscious to both the patient and the therapist – or, at least initially, not available to their consciousness?

When participants address this question, their comments form a picture in which mindfulness is playing a part. Several participants describe the beginning of the unconscious becoming conscious as "noticing things that stand out" in the emotional, relational field of the therapy session. One participant put it this way:

> For me, there's not a delineation between unconscious and conscious. It's something that is completely organic to me. It's completely internalized at this point. Some of it is just noticing things that stand out to me . . . and starting to think about them over time. It's not hocus-pocus. It's being very engaged with somebody in the dialog. (I've become much more relational as I've gotten older.

> I'm not sort of sitting back there decoding the hidden means to their productions, but getting emotionally and intellectually and verbally and otherwise involved with somebody in an engaged interaction.) And then, just like the participant-observer paradigm, stepping back and then dipping in and stepping back, and realizing what I'm co-creating with the other person, and how it's affecting me and how it's affecting the other person (349).

"Noticing things that stand out" is one feature of mindfulness that prepares one for recognition of emotional patterns, of which the patient may be unaware. This same participant describes the many directions from which unconscious information (which "stands out") can register in the psycho-dynamically oriented therapist. The unconscious communication from the patient may seem "insignificant" or only an "echo" of some meaning, which can lead the therapist to be able to reconstruct the unconscious meaning of the patient's "message".

> If we're really open in this way, every once in a while, something will strike us and echo, something that the patient says or something that we feel, or something that's not being said or a bodily movement or some very insignificant element will strike us and echo, and at that moment, if we haven't been trying to figure anything out, very often that echo is the echo of the unconscious. Those are kind of two different paradigms, one of them more relational interactive, and the other more listening in a somewhat more together but also separate framework, listening to the sort of harmonics or the aftershocks of a particular interaction. One is more engaged; one is somewhat more detached. And I do a little bit of both (349).

Being open, fully engaged to hear echoes of meaning in what the patient says or does requires a high degree of awareness in the present moment, being both engaged and detached, which he calls mindfulness.

Another participant considers mindfulness as "the bridge" between the conscious and the unconscious, but also goes on to discuss how slowing down conscious attention to sensations can lead to emergence of image, emotion, thought or memory, which holds

unconscious meaning for the patient. Mindfulness enables this slowed down, bottom-up processing and thus is characterized as a bridge for both the therapist and the client.

> So mindfulness for me is the bridge between the conscious and the unconscious. And in terms of bottom-up processing, processing from sensation to emotion to thought, you might call it free association. When a client is in mindfulness, what happens is they can slow down and as you help the client stay in sensation, very often what will come from the world of sensation would be an image or an emotion or a thought or a memory. So, mindfulness really helps a client go into their own conscious and it becomes the bridge between the unconscious mind, the conscious mind, and the relationship (355).

Mindfulness is a supremely conscious activity because it heightens awareness of experience in the present moment so that automatic or habitual patterns can be slowed down enough to attend to them. Slowing down is a common attribute of the kind of listening required to hear unconscious communication. “Mindfulness is also the bridge between slowing down what we would call habit pattern, which is an instinctual habit pattern, and slowing a habit pattern down so we can understand what's underneath the habit pattern”(355).

Still another participant speaks of listening to unconscious communication as attending to the “basic organizers,” the unconscious organizers of a person’s life. Again, mindfulness is at play as attention is given to potential “indicators” of core unconscious beliefs organizing the person’s life. He includes his comparative analysis of how various (Freudian, Jungian, Body-Centered) psychodynamic orientations can approach unconscious communications differently, but can discover the same core message about the person’s mental/emotional organization.

> You want to have evenly hovering attention, you want to be mindful of all of those things and everything, and things you don’t even maybe think of, because any of those can be indicators of a core belief and any of them can become a royal

> road to the unconscious. Like Freud, psychodynamic people or psychoanalytic people tend to use relational qualities as their royal road to the unconscious. But Jungians tend to use dreams as their royal road; and body-centered psychotherapists will often use posture, or gesture, or movements, or breath as a royal road to the unconscious because . . . they're all organized by the same basic organizers. So, you can pay attention to many, many things and becoming mindful of any one of those things can be a possible way to the core where someone can study how they're organized now and open themselves to reorganizing around more □□ a larger, more fulfilling way of being in the world (358).

Mindfulness contributes to listening to unconscious communications by its enhanced awareness of the play of the sources of experience. Informed of unconscious dynamics, a deeper awareness in mindfulness offers a greater sensitivity to the evidence for unconscious-to-unconscious communication. Mindfulness can be seen at play in a participant's description of her experience of unconscious-to-unconscious communication.

> Sometimes it might be like: I sat with a woman this week (and I've been in practice for a long time now in clinical practice) and this woman walks in the room and I get agitated and I don't yet understand what that is. I don't know what it is in me and I don't know what it is in her or what it is between the two of us. So I trust my own clinical experience to know that that's extremely important in the work. So I have that. I'm mindful of that dimension. While I'm talking to her about other things, I'm mindful of my feeling of agitation and my experience of her defensiveness and I'm not sure what's going on with her. She has some dementia, but anyway I'm just very alert to my self-sense of the moment (341).

Similarly, another participant summarizes what "being mindful in psychoanalysis" means for him and how experientially mindfulness contributes to unconscious-to-unconscious communication.

> Being mindful in psychoanalysis means that you will clear your mind; [you] have free-hovering-attention; you will notice what comes up inside you, but you will not get stuck on it; and you will try and absorb in-every-way-you-can the patient that's across from you. At some point in the hour, hopefully, they'll say something that makes you think, "Hmm." Then, what you have come up in your own countertransference, in your own

> analysis, in your own life, that joins this selected fact will give you an idea about what the patient is really trying to tell you (336).

This participant's attention to the "selected fact" refers to something that gets his attention while attending to the patient's continuity of affect. Unconscious communication intends to communicate something, suggested in the comment "what the patient is really trying to tell you." Presumably, patients seek understanding of themselves at a deeper level than they consciously appreciate so that the psychodynamic psychotherapist needs to be prepared to listen deeply and carefully to realize this intent. Participants considered their capacity for mindfulness to be a major asset in this endeavor.

> Association is a potent part of the therapeutic process. The associative process is essential to take in because it's such a significant part of the session. The architecture of the session is reflected in the train of thought. The train of thought is influenced associatively. . . . The associations that most people present most of the time either cause them to go off in a direction of defense or to become self-conscious and so the association is sometimes important by its own being blocked. . . . If you notice when blockages occur, when the speech changes, when the voice changes, the bodily posture changes, the muscle tone changes, all these things are indicators of interruption or a diversion of the flow of association which is the rule rather than the exception. . . . And so I try and be aware of those patterns as well. But this is multileveled work. I tend to make note of them in people's minds as we go forward but again, I may recall something that was said in two or three sessions previously or a year ago previously and associate to it myself. And so I learn to trust my own associations and to be interested in them and to treat associations of the patient with respect and interest. And I think that in itself tends to facilitate the flow of association; being received and feeling understood (343).

Finding 8

Good psychodynamic psychotherapy is inherently mindful; mindfulness is an integral part of psychodynamic listening.

When psychotherapy is evaluated for its dependence on mindful awareness, participants speak in terms of fundamentals and depth of human relationship. Mindful awareness awakens the interconnectedness of all that comes into human experience, from which a sense of belonging and gratitude arise.

> We have to differentiate between awareness in its ordinary sense and awakened awareness, because awakened awareness is not about you or me anymore, it's just about presence or it's about whatever you want to call the animating factor . . . that's actually about the core of Buddhism. And if you get a glimpse of that or a taste of that or a feel for that, and you feel it's actually real and not theoretical, then gratitude naturally arises, and that allows you to feel -- to tolerate being alone, because you're not alone anymore, you're actually just resting in that awakened awareness (330).

Another participant sees mindfulness giving a "larger sense of consciousness that allows for awareness and compassion and the witness" and that this alone affects the quality of the therapy.

> And you can only do that from that larger sense of consciousness that allows for awareness and compassion and the witness. So, those really do affect the quality of the therapy and it takes it out of the realm of just having a therapeutic bag of tricks or something that you pull out for conditions (358).

Mindfulness contributes in this way to the building of human connection, which is fundamental to the therapist's relationship with the patient. Because the quality of relationship becomes the pathway for communication and healing, mindfulness contributes something essential to the psychotherapeutic effort. One Buddhist participant understood it this way:

> If we say that psychotherapy is a concern with the health and well being of the human mind and heart, then mindfulness is, on the face of it, the *sine qua non*. Without mindfulness, what you might do may resemble therapy, but it can't be very therapeutic in my opinion. The human connection is absolutely necessary (343).

Another participant with Christian background expressed it this way, defining psychotherapy and mindfulness as "increasing consciousness" or becoming more awake.

> I think psychotherapy is inherently a contemplative activity; if not, it doesn't create the effects that it seeks to create. Every encounter should change not only the patient, it should change me. We both should leave it more awake, more mindful, more conscious. If that hasn't happened, it hasn't been a genuine encounter (334).

However, participant comments about the fundamental value of mindfulness to psychodynamic listening eschew an attitude that mindfulness is a recent discovery that introduces a new era of psychotherapy. Even though mindfulness has been practiced in Eastern traditions for 2,500 years, its recent recognition in Western Buddhism and translation to therapeutic mindfulness within Western psychological traditions does not supersede other formative influences in psychodynamic listening. Christian participants, in particular, espoused a view of psychodynamic psychotherapy, which is at its heart spiritual, even though its tradition is now only little more than 100 years old. Two participants summarize their views as follows:

> For me, the whole thing is a psycho-spiritual whole, it [psychotherapy] can't be separated from my own belief system that the human being is at root a spiritual being with a soul, a core, that is forever seeking the presence of God, and we most tangibly experience that "divine encounter" by encounter with our own core and with loving service to other people (342; brackets mine).

> I've always seen therapy to be inherently a psycho-spiritual activity, mindfulness is a little late to the ball. I think all deep psychotherapy has been about mindfulness, has been about producing reverie (334).

These participants are saying that the psychodynamic tradition has preserved and fostered a tradition of mindfulness by recommending evenly suspended attention and reverie. The linkage between these forms of attention validates their respective importance and

enriches their meaning in the psychotherapeutic milieu. Just as one's attention to the avenues of unconscious communication can enhance one's sensitivity to and recognition of the "echoes" of unconscious communications, so one's depth of mindfulness may contribute to the enhancement of psychotherapy.

> I have some internalized appreciation of the power of emotional presence, of just being with somebody rather than doing something to somebody, of doing some protocol, some therapeutic protocol. I've developed some appreciation of the healing power of being with someone in a therapeutic way, that it has evolved not only from my therapy experience, but from my meditative spiritual practice (349).

One participant even conflates "evenly hovering attention" with mindfulness by endorsing "a kind of a hovering mindfulness that tries to pick up without being distracted" (336).

> I don't think Freud would ever say that we need to meditate before we engage in a clinical session, but how do you have evenly hovering attention where nothing is rejected and nothing is held onto? That's what neutrality is about. It's not about being stony. It's about just that, evenly hovering attention where you're kind of steady. Your mind is not perturbed, it's not rejecting, and it's not attaching, but it's still allowing for phenomenon to occur (340).

> Yes, the evenly hovering suspended attention. I would say that that's a fairly valid description with the state that I go for. Q: [Freud] spent years using evenly hovering attention, but he didn't really give any methods of how you do that. A: No, he was making it up as he went along. (Laughs) And the other thing is that he had lousy supervision. Q: So do you feel that his prescription, the evenly hovering attention, is equivalent to the mindful awareness? A: I think it depends to what degree one enters into evenly hovering attention. Ideally, theoretically, there should be no distinction between the two (343).

"Evenly hovering attention" can have "a mindful quality" to it, which again can go deeper to a point where there is "no distinction." Another participant (358) develops how "evenly hovering attention can have a mindful quality to it," expanding how mindfulness can deepen evenly hovering attention.

> Q: Is what you were saying in contrast to what Freud was prescribing? M: Well, it's not dissimilar, actually. Like evenly hovering attention can have a mindful quality to it. So, yeah. So, that's not a bad way of describing it. Yeah, he [Freud] wanted to be open to everything so you don't miss something. You don't want to categorically look for this or that. When you're a youngster, you have to make sense out of life, you have to make meaning out of life, which means you have to organize life in the way that you can function. So, you learn about life. Is it safe or is it unsafe? Can you be supported or not supported? And so, you develop core-organizing beliefs about the world. And once you have a belief, a sense about the world, once you're organized in a certain way, if you ask the question, "What is organized?" the answer is, "Everything." Like your thoughts are organized, you feelings are organized. Your sensations are organized. You posture is organized. Your movement is organized. And so, in terms of the therapist being mindful, we want to be mindful of all these things. And especially bodily-based things, gestures and eye movements and skin tone, like all these things that especially are tied to deeper structures of the brain that are hard to fake. But you want to have evenly hovering attention; you want to be mindful of all of those things and everything, and things you don't even maybe think of because any of those can be indicators of a core belief and any of them can become a royal road to the unconscious. (358).

And mindfulness in therapy differs from one's solitary mindfulness meditation. In mindfulness training, there is an element of self-acceptance and loving-kindness, but one has direct access to her subjective experience. Mindfulness in therapy requires a vicarious introspection into the subjective world of another, such as Kohut identified (Kohut,1959).

> All of this is done in mindfulness, so the therapist has to be mindful of one self. It's not mindfulness like in meditation; it's relational mindfulness. You are being mindful while you're interacting with another person. And if you're not observing yourself, you're going to get into trouble because you're going to be projecting your own feelings. You're going to be leading. So, you have to kind of know what your own state is. If you start to feel frustrated and tight and heavy, it's a good idea to look into see what's going on with you because you're probably trying to force things (366).

Among several participants, one in particular links "reverie" with his notion of mindfulness. The intention to create a context for "reverie" within the therapeutic

relationship gets physically reflected in attention to office space, which should invite and encourage "repose and reverie" as an antidote to the patient's anxiety. Both the internal (intrapsychic; relational) and external (physical) environment should help the patient "get under … the surface of things" to attend to the heart of a patient's life.

> I think all deep psychotherapy has been about mindfulness, has been about producing "reverie" (I guess would be a good word for it) to get under the very noisy and anxious surface of things. This culture lives at that very anxious surface. Every psychotherapist office should be a place that invites repose and reverie. It [psychotherapy] should try to get under that anxiety to locate the true narrative or kind of dream of being that's there all along. Psychotherapy should have always been mindful. It's always been about mindfulness activity. I appreciate that that's a more conscious awareness. In this reverie, I'm fully awake, I see the full horizon of my life, I see 360 degrees, I feel deep into myself, into every nook and cranny of myself. Reverie seems to be closer to sorrow, a redemptive sorrow. People have a chance to grieve all their losses in this world and to feel like that that grief is honored. In these moments of reverie, I'm not just witnessing, but these deeper divine elements of existence are witnessing, and people feel that witnessing, I feel it with them, I feel witnessed. That's reverie to me. It's this deep Kairos time. It's not anxious. It's non-driven. It is often filled with sorrow. There's a lot of heart to it. There's a lot of compassion. People start feeling mercy for themselves (334).

Listening in psychotherapy requires a relaxed spaciousness, which allows room for the patient to experience being and to notice a difference within himself. Mindfulness is a "flowing reverie", a "letting things evolve . . . in a body-close, thoughtful" way.

> Mindfulness is a flowing reverie and it can't be contained by a brief, short-term model. It is letting things evolve session-to-session, in a body-close, thoughtful and evolving kind of way; and the pressure of this [culture's anxiety] is inimical to mindfulness. It takes a long time for folks to find that deeper narrative in themselves that they've been cut off from in this kind of very anxious culture (334; brackets mine).

Reverie requires a bodily awareness. 'The body seems to be the best vehicle to locate genuine reverie" (334). "So when I was learning how to touch, I learned how to sense, how to have somatic empathy with a client, how to resonate, how to stay in the present

moment" (355). Being mindful of bodily sensations and emotional cues prompts one to be listening not only to the patient, but to how the therapist herself is being impacted by the patient.

> So part of it is listening to where the client is and the other part of it is listening to my intuition and my instincts. What are their intentions, why are they coming here, and why are they spending this time and energy, and what's the unmet need? So I'm always listening or thinking about what's the unmet developmental need for this client and what's the unmet biological need? . . . So I'm listening with my body, I'm listening with my soul, I'm listening with my mind, my heart, with my intuition, with my instinct. And then I'm also listening to what is it the client is coming in for, so that they feel respected by me. Trust that whatever you've learned is going to come through, but you don't want to be splitting by thinking while you're with somebody. You want to let thoughts come in and intuitions come in. But you also want to be with the present, be in the present with the client (355).

Synthesis of Textural-Structural Composites

The above findings are formulated and presented now as textural and structural descriptions of the experience in-session of mindfulness in psychodynamic listening. In phenomenology, a textural description captures and elaborates the lived experience. The thoughts, feelings, and key features of participant experiences are captured in narrative form. A structural description provides the reader with the researcher's understanding of the underlying dynamics of the experience. This is the result of not only an analysis of participants' use of language, but also the researcher's experience of mindfulness in-session of psychodynamic psychotherapy (Moustakas, 1994). I chose a synthesis of both styles of description as the richest depiction of findings for this study. So, I have formulated composite textural and structural descriptions from the Findings presented

above. A synthetic statement combining textural and structural composites concludes this chapter on Findings.

Composite Textural Description

Based on descriptive comments and extracted as invariant constituents of participant statements, the following Textural Composite describes briefly what impact mindful awareness has on listening in psychodynamic psychotherapy.

Participants experience mindfulness within psychodynamic listening as a stable quality of mind that is calm, receptive, open, non-judgmental, and curious in the present moment; it helps them remain clearer about their associations and manage their reactivity to patient behaviors and emotional processes; it helps the therapist focus on the patient as person and the relational process, not solely the content of the patient's story. Participants' mindful awareness increases their capacity for psychodynamic-informed listening in-session by sustaining attention to their mind/body experiences and by enhancing recognition of unconscious communications from the patient. Participants' mindfulness helps observe and regulate a patient's emotional and physical experiences as well as sustain therapist attention to mind/body communications from the patient, thereby contributing to creation of a safe emotional space for the patient's exploration of subjective experiences and eliciting resources from deep within patients to transcend their presenting difficulties.

Composite Structural Description

Based on conceptual comments and extracted from invariant constituents of participant statements, the following Structural Composite explains briefly what context or setting influences how the participants experience mindfulness in their psychodynamic listening.

The experience of mindfulness in psychodynamic listening embodies a therapist's relationship with time, such that she is able to remain present to the patient's experience moment-to-moment in-session. The therapist's relationship with space via the therapeutic relationship embodies a physical, emotional, cognitive, spiritual and interpersonal environment, which supports repose and reverie. The therapist's mental, emotional, and spiritual framework allows for change in both participants of the Freudian Pair through clarity of intention, awakened awareness, and a compassionate attitude. Development of a therapist's capacity for mindfulness in psychodynamic listening requires building emotional capacity as well as spiritual capacity. Emotional capacity develops through personal therapy (practicing free association in the Freudian Pair), through psychodynamic training (training the intention to help others), through clinical practice (practicing evenly suspended attention in the Freudian Pair), through on-going self-analysis and through on-going psychodynamic supervision and/or consultation. Spiritual capacity develops through training one's quality of attention (practicing mindfulness via concentration and scanning), through training awareness of attention (practicing choice-less awareness), and formation of ethical / spiritual values and conduct (practicing a compassionate attitude toward self and others).

Mindfulness within psychodynamic listening develops more as a way of being than a technique, arising from dedicated practice of both mindfulness and psychodynamic listening as well as from experience integrating one's own psychotherapy with extensive training in psychodynamic models of psychotherapy. Development of mindfulness requires the effort to develop depth of mindfulness and a mindful way of being. The therapist's psychodynamic understanding includes the unconscious dimension of communication within the context of the Freudian Pair. Experience of mindfulness in psychodynamic listening demands sufficient mastery of particular psychodynamic models to transcend any potential constraint on attention from an effort to remember or from a preoccupation with a particular model.

Synthesis of Textural-Structural Composites

Building from descriptive comments, conceptual comments and the invariant constituents extracted from participant statements, the following synthesis captures the phenomenological essence of the experience of mindful awareness as it influences the clinician's listening stance in psychodynamic psychotherapy.

Mindfulness within psychodynamic listening is a stable quality of mind that is calm, receptive, open, non-judgmental, and curious. In mindfulness, one remains clearer about her associations and manages her reactivity to patient's processes with composure. Mindfulness helps observe and regulate patient's emotional and physical experiences as well as sustain therapist's attention to mind/body communications of the patient. Mindful awareness helps the therapist focus on the patient as person and the relational process, not

solely the content of the patient's story, helping elicit deep inner resources from within the client to transcend their presenting difficulties.

Mindful awareness increases one's capacity for psychodynamic-informed listening in-session by sustaining a therapist's attention to her own mind/body experiences in the present moment and by enhancing recognition of unconscious communications from the patient. Mindfulness helps observe and regulate a patient's emotional and physical experiences, contributing to creation of a safe emotional space for the patient's exploration of his experience.

Mindfulness within psychodynamic listening develops more as a way of being than a technique, arising from dedicated mindfulness practice as well as psychodynamic listening practice, which in turn presumes experience integrating one's own psychotherapy practice with extensive training in and mastery of psychodynamic models of therapy.

Potential Influence from Researcher's View

A review of this researcher's interview, in which she bracketed her perspective, provides documentation of several parallels with participant interviews. In particular, one can find parallels between the researcher's definition of mindfulness and views of its effect on the experience of listening in-session. This is to say: within the findings, one can find a core similarity in definition of mindfulness and the other findings. However, the views of participants expand beyond and enrich these notions in ways that this researcher did not elaborate prior to participant interviews. For example, participant emphasis on mindfulness *as a way of being* elaborated and validated what she previously

knew only intuitively. This was also true regarding the importance of attending to the body in mindfulness as well as in psychodynamic listening at the level of primary process (Ucs-to-Ucs communications). Participants defined more clearly what mindfulness could do (in terms of developing awareness in the present moment), but also delineated what the psychodynamic setting and psychodynamic understanding could do (in terms of recognition of unconscious communications). To some degree, these clarifications spoke against the researcher's unconscious assumption that mindfulness (by itself) could somehow gain access to unconscious material. Clarifying how Ucs-to-Ucs communications occur and are accessed by consciousness has become a major learning in this endeavor. In terms of training attention, participants enlarged the researcher's view of how many ways are being used by clinicians to develop evenly suspended attention.

CHAPTER VII

DISCUSSIONS

Seeing forms with the whole body and mind,
One understands them intimately.

~ Dogen Kigen

Addressing the problem posed at the beginning of this dissertation (p. 4) hoped to accomplish three objectives: 1) provide information to the clinical field about its practice of psychodynamic listening, 2) clarify the potential for integrating mindfulness into psychodynamic psychotherapy and 3) contribute to clinical process theory. The following discussions consider how these objectives have been realized and what this research project contributes to the field of clinical social work. Discussion of the theoretical dimensions of the topic follows a comparison of the research findings with existing literature and leads to a statement of implications for clinical social work.

Comparative

When the findings from this study are compared to what emerged in the review of literature, several similarities are worth noting. First of all, participants' understanding of mindfulness fit with the definitions of mindfulness formulated and tested in the literature. The elements of mindfulness (intention, attention, and attitude) were uniformly

recognized. That is, all participants accepted the capacity to remember to remain aware in the present moment without judgment as the meaning of mindfulness. However, participant emphasis on the importance of developing mindfulness as a way of being for the psychotherapist is greater in my participant sample than there appeared to be in the literature review, which is mixed between viewing mindfulness as a on-going disposition (trait-like) and as a useful skill (state-like).

Second, like the meager literature studying the effect of mindfulness on the therapist effectiveness, participants spoke of mindful listening in psychodynamic psychotherapy as giving added value to the process. Several used the word “reverie” (a term used in the literature, whose psychodynamic meaning was enriched by Bion) to describe the state of mind needed for psychodynamic listening and equated reverie with mindfulness.

Third, participant comments reflected a theoretical orientation, which values the patient’s experience of emotional safety in-session as an essential ingredient of successful psychotherapy. Because therapeutic mindfulness practices acceptance, non-judgment and compassion for emotional experience, whether pleasant or unpleasant, participant reports from a conceptual and anecdotal standpoint confirmed experimental literature on the positive association of a disposition of mindfulness with increased capacity for attention to self and decreased dissociation. Bion’s suggestion that the “only point of importance in any session is the unknown. . . . Out of the darkness and formlessness something evolves” (Bion, 1967, p. 272) was reproduced in participant references of darkness. “In

mindful state of consciousness, you have to allow and be willing to allow more of the mysterious, the darkness, the not-knowing (358)."

> I previously thought that I was to be with my depressed patients in order for them to rise up out of the darkness to the light. In meditating on darkness, I have realized that they may rise up to the light, but they may just go deeper and deeper and deeper and deeper into the darkness, and I'm to ride with them all the way to the bottom. I have to give up my expectation of outcome, and not be distracted by outcome, that's what darkness is teaching me, that's another piece of the discipline, that I'm not trying to push them or nudge them or bully them or influence them in order to have my outcome, or even the outcome that they say they want. But, whatever the process brings us, that's the compassionate companionship that I owe them and I owe myself (326).

Fourth, mindfulness develops attention to scan the field of awareness and follows development of concentrated attention, which sustains a particular focus. Because mindfulness allows for multiple sources of stimulus and maintains a holistic perspective, mindfulness sponsors one's capacity for attending to the person (in the field of awareness) while listening to the content of their self-report (a particular focus amidst several strands of input) within psychodynamic psychotherapy. Participant responses confirmed the mindfulness literature, which shows a positive correlation between mindfulness and "decentering," an ability to observe one's thoughts and feelings as temporary, objective events in the mind, as opposed to reflections of the self that are necessarily true. Two participants (336, 355) describe "listening to myself" listening to the patient as descriptive of this kind of "decentered" mindful attention.

Fifth, participant responses flesh out how mindful awareness helps attend to the body and the multiple sources of the patient's experience. A mindful awareness welcomes more than hearing, more than the sounds of patient's verbal text, even more than non-verbal cues or visual, kinesthetic, olfactory/gustatory experience. Since

psychodynamic attention welcomes Ucs-to-Ucs communication, openness to the field of communication between patient and therapist demands attention to the impact on one's imagination in-session. A tendency might be to assume these explanations are suggesting that mindfulness equips the therapist's observing ego to attend in a *hyper-conscious* way, whereas participants are describing mindfulness as a *relaxed, open, welcoming* form of attention, which allows openness to the one's own indicators of the unconscious mind. Mindfulness is viewed as an asset in this regard because it can sponsor heightened awareness within the realm of psychodynamic interest. In these respects, participants amplify the meaning of Freud's prescription for the therapist to "to surrender himself to his own unconscious mental activity" (Freud, 1961c, p. 239).

Sixth, when evenly suspended attention is equated or identified with mindfulness, then by definition mindfulness becomes part of definition of psychodynamic psychotherapy. Good psychodynamic psychotherapy requires a matured mindfulness (i.e., what some participants referred to as "having depth.") Some participants explicitly identified mindfulness with evenly suspended attention; for others, mindfulness was at least similar to evenly suspended attention. Developments of Freud's original models, which paid attention to the patient without regard for the therapist's presence, have increasingly recognized the therapist's subjectivity within the Freudian Pair and encouraged awareness of the self/other field in psychodynamic psychotherapy (e.g., Bionian, Relational and Intersubjective psychotherapies). Increasing the complexity of what deserves attention in psychodynamic psychotherapy seems to have increased the challenge of developing the therapist's capacity and disposition for mindful awareness,

making therapeutic mindfulness training a timely asset for the development of practice within the Freudian Pair.

Some participants were willing to offer recommendations for including mindfulness training to enhance the growth of active or aspiring psychodynamic therapists. These complemented what appeared in the literature review, which was focused on traditions-to-follow or exercises-to-practice. Some participants were critical of the general trend in psychodynamic education, which leads trainees to concentrate on patterns for interpretation (e.g., desire, fear, resistance, defense, transference) and so develop a propensity for listening "for something." Those participants, who spoke directly about this, advocated for a psychodynamic training that encouraged learning of psychodynamic models, but then added encouragement to develop the capacity for evenly suspended attention, open to Ucs-to-Ucs communication. Even without a systematic training protocol, participants had found individualized paths to cultivate mindfulness, evenly suspended attention and their creativity with Ucs-to-Ucs communication. Perhaps, this outcome witnesses to the power of a creative intention to realize, with effort and time, the truth of its dream. These comparisons of findings with the literature provide information about how seasoned clinicians experience their practice mindfulness in psychodynamic listening as well as clarify the potential for integrating mindfulness into psychodynamic psychotherapy.

Theoretical

This study focused on participants' experiences and beliefs about how their mindfulness influences their psychodynamic listening in-session, particularly in regard to perceiving, registering and comprehending latent, unconscious meaning and process. A central feature of this study has been the quality of attention required for psychodynamic listening and the quality of attention provided by mindfulness. A therapist's evenly-suspended-attention identifies a state of mind somewhere along an attention spectrum, reaching "from the virtual absence of attention, as in sheer daydreaming and mechanically determined mental flux, to acutely active alertness" (Novak, 1990, p. 46), most likely closer to active attention than inattention. When gauged on this continuum, evenly-suspended-attention and mindfulness appear comparable.

Although *practicing* mindfulness varies in the quality of attention moment-to-moment, such practicing aims at mindfulness, which "resides at the upper end of the spectrum" of attention (Novak, 1990, p. 46). Mindfulness, when realized, embodies a sustained, non-discursive, and active attention.

> Given the fact that the deep-seated habit patterns of the psyche will repeatedly overpower an inchoate concentrative ability and assuming that the practitioner will repeatedly attempt to establish active, concentrative attention, his constant companions in all of this are impartiality, equanimity, and non-reactive witness to what has arisen. Whatever emerges in the mind is observed and allowed to pass without being elaborated upon or reacted to. Images, thoughts, and feelings arise because of the automatism of deeply embedded psychological structures, but their lure is not taken. They are not allowed to steal attention and send it floundering down a stream of associations. One establishes and reestablishes concentrated attention, but when it is interrupted one learns to dis-identify with the contents of consciousness, to maintain a choice-less, non-reactive awareness, and to quiet the ego with its preferences (Novak, 1990, p. 48).

Mindfulness is clearly different from “ordinary attention,” which is “discursive, intermittent and passive . . . not something we do, but something that happens to us,” and even more different from “inattention.” As has been noted before, mindfulness practice aims to develop an individual’s capacity for sustained attention in the present without judgment (i.e., mindfulness), which enables a person to slow down the selection of focus, observe unpleasant as well as pleasant experiences, remain non-reactive to unpleasant as well as pleasant experience, sustain focused concentration as well as scanning attention, observe other (i.e., the patient), or observe self (i.e., the therapist), or observe self-in-relation-to-other (i.e., the patient-therapist dyad or field).

As was noted in the formulation of the theoretical framework above, psychodynamic *psychotherapy* requires this kind of refined quality of attention, which is why psychodynamic *listening* aims to develop an individual capacity for sustained attention to a patient in-session. As its primary goal, psychodynamic psychotherapy (therapist/patient dyad; the Freudian Pair) aims to help a patient become conscious of unconscious patterns that restrict their freedom to love and work (Freud) or to know the truth (Bion). Consequently, psychodynamic psychotherapy is structured to encourage a patient to relax their defenses and allow the therapist to help unconscious processes or patterns to emerge into consciousness. This disciplined dyadic structure constitutes the so-called “the Freudian Pair” (Bollas, 2007) wherein psychodynamic listening is specifically designed to attend to “deep-seated habit patterns of the psyche” and “the automatism of deeply embedded psychological structures” (Bollas, 2007). Psychodynamic psychotherapy requires the therapist to pay careful attention to the

patient's self-report and self-presentation (conscious and unconscious), but also requires the therapist to "catch the drift of the patient's unconscious with his own unconscious" (Freud, 1961c, p. 239). The therapeutic relationship, if it becomes a workable one, allows the patient to relax so that derivatives of the unconscious are more likely to come to mind and become accessible to the patient's awareness, either directly or through the therapist's facilitating or interpretive responses.

In his 1915 essay "The Unconscious," Freud explained that recognizing unconscious material was difficult because both patient and therapist are not conscious of the dynamic or pattern or belief or emotion, which is of interest because of some unpleasant symptom in the patient's life (1961d). What is known and conscious (e.g., the symptom) may offer some clues or signs for what is unconscious, but, for Freud, repression kept what could not be tolerated out of consciousness. His topographical model offered a theory of how the mind was organized into the conscious (Cs) and the unconscious (Ucs) with defenses accounting for how unconscious material remains censored and so unavailable to consciousness. He also hypothesized a preconscious (Pcs) to account for how the mind can retrieve something into consciousness (i.e., remember) or discover something that was evident (e.g., to others or even to the patient at another time), but not known and accepted consciously by the patient at the moment. Even with ideas in the Pcs, Freud recognized the need to explain how consciousness accessed Pcs material when resistance typically functioned to maintain the difference between Cs and Pcs ideas.

So, to put Freud's dilemma more succinctly, if the Freudian Pair, who co-creates the therapeutic relationship, are interested in Ucs-to-Ucs communication from the patient and, by definition, Ucs-to-Ucs communications are not conscious, how can ideas move from Ucs to Pcs to Cs? Freud explains how this can happen for the patient, in a case when the therapist recognizes an unconscious pattern and gives voice to it. Then, presumably, the patient has his Ucs idea as well as the Cs idea (from what the therapist said), but the patient at this point doesn't recognize the Ucs idea as his own. But if the patient's Ucs defenses against anxiety allow the idea to move from Ucs to Pcs and the patient's Pcs resistance to the anxiety of disclosure allows the idea to move into Cs, the patient consciously discovers the validity of the formerly Ucs idea as his own. This topographical model traces the discovery process *for the patient* through a rough spacial model, in which Freud's "idea" refers to sensations, affects, emotions, feelings, images, influences and patterns of relationship, not just cognitive thoughts.

However, when Freud writes that "catching the drift of the patient's unconscious" requires the therapist to "surrender himself to his own unconscious mental activity, in a state of evenly suspended attention" (Freud, 1961d, p. 239), he is not speaking about the therapist's *conscious* recognition of something that is *unconscious* to the patient. When it comes to explaining *how the therapist receives* Ucs-to-Ucs communication from the patient, Freud begins again with Ucs communications received by the therapist. Once more, such "communications" embody a range of sensations, affects, emotions, feelings, images, ideas, influences and patterns of relationship, not just cognitive "ideas". But when the therapist's Ucs has received the patient's Ucs communication, both members of

the Freudian Pair do *not* know consciously what that communication is. In fact, probably, the therapist's own Ucs material exists (outside awareness) side-by-side or mixed-up with what she has received of the patient's Ucs material. Now, as the therapist's own defenses allow Ucs material to enter into Pcs because she is not as defended (or defended in the same way as the patient), the Ucs material becomes more accessible to consciousness. And as the therapist's practice of evenly-suspended-attention mitigates any resistance in the therapist to receiving from the Pcs, the possibility of discovering meaning regarding the patient's unconscious pattern increases. Here is where participants' mindfulness (i.e., her capacity to sustain attention in the present moment with acceptance) with patients enhances their psychodynamic task of listening.

By 1923, Freud had redesigned his map of the mind's architecture. Recognizing that the rational, reality-constrained-part of the mind is not necessarily conscious or even capable of becoming conscious (Freud, 1961e), he reconfigured his map of the mind and attributed functional properties of the system "Cs-Pcs" to the "ego," whose core functional property was the capacity for inhibition, not consciousness.

> Freud considered this capacity (the capacity to inhibit drive energies) to be the basis of all the ego's rational, reality-constrained, and executive functions. This inhibitory capacity was the basis of what Freud called "secondary-process" thinking, which he contrasted with the unconstrained mental activity that characterized the "primary process." It was this property (rather than consciousness) that gave Freud's ego . . . executive control over the otherwise automatic, biologically determined functions of the mind (Solms, 2002, pp. 99-100).

Freud's revision has been recognized as remarkably accurate, according to recent neuropsychoanalysis (Damasio, 1999), because affective neuropsychology has mapped core consciousness (or primary consciousness) as flowing from subcortical areas (i.e., the

upper brainstem region) and secondary consciousness as flowing from the cortex, which provides inhibitory control. Translated into the Freudian map, one would say that conscious energy originates from the ”id” (Solms, 2013a); and the “ego” – though participating in consciousness – provides inhibitory functions of the mind.

Affective neuroscience has shown that the development of conscious mind typically follows upon the processing of unconscious mind (Solms, 2013a, p. 9) so that recognition of Ucs-to-Ucs communication requires conscious attention to affect and its derivatives in order to begin to perceive unconscious communication. Of course, this “processing of unconscious mind” is what is happening as the healthy mother attends to her child and provides nurture, via attachment behaviors, to develop and support the child’s affective-regulation and self-realization. Similarly, the therapist’s “processing of unconscious mind” occurs while attending to the patient’s affect and cues of distress, helping formulate and interpret what the unconscious mind is evidently processing, based on the patient’s report of experience.

While current affective neuroscience confirms elements of Freud’s understanding of unconscious processing (Solms, 2013b, p. 104), Freud’s cortico-centric view has been challenged by the neurobiological evidence that consciousness flows out of the upper brainstem (i.e., from a stratum of the brain/mind which is deeply connected to the body and from what Freud called the id or “the instincts”).

> The deep structures that generate consciousness are not only responsible for the level (quantity) but also for a core quality of consciousness. The conscious states generated in the upper brainstem are inherently affective. This realization is now revolutionizing consciousness studies. Consciousness is not inherently perceptual, it is inherently affective (Solms, 2013b, p. 106).

This insight provides the reason why attention to the body becomes so important in recognition of Ucs-to-Ucs communication, which itself occurs at a level that precedes perception of external environment and follows affective consciousness of the internal environment. That "conscious awareness is grounded in emotional awareness" (Solms, 2002, p. 105) may also provide a reason why training attention and perception to access and tolerate affective consciousness can lead to developing tolerance of and insight into those cortical inhibitory patterns, originally designed to manage affective distress, but are mistaken in the present moment. The "unconscious" in this new frame of reference are those habitual patterns of affect or reactivity which once made sense, but no longer serve the present moment well.

Mindfulness offers participants a quality of attention, which embodies de-automatization (Deikman, 1966) and dis-identification through its objectification of the mind/body flow in awareness.

> Mindfulness is the practice of open, non-interfering alertness or pure, fully present attention. The meditator gives alert attention to experience without conceptualizing, judging, or controlling experience, allowing sensations, feelings, and thoughts to arise and disappear without being followed or resisted in any way. Such non-interfering attention allows the meditator to be fully present in the experience of the moment (The Wanderling, 2013).

When understanding how mindfulness contributes to perception, registration, and comprehension of latent, unconscious meaning and process, the quality of attention in mindfulness becomes important to psychodynamic clinical theory. When the therapist is listening in-session, her task is to recognize and understand Ucs-to-Ucs communication from the patient. According to participants, mindfulness makes that task more possible.

Participants explain what they are doing in mindfulness as slowing down, giving attention to cues, signals, and curiosities, which are somatic, sensory and affective, as well as to the content of what the patient is saying. Participants describe their mindful listening as a simple listening to the whole of their experience of themselves with the patient in the moment and responding with acceptance and an attempt to convey understanding. Bollas (1999) reflects upon the clinical value of slowing down and how it is built into the psychodynamic method:

> With the Freudian technique, there can be no hurry. Freudian time realizes aspects of unconscious time, limited only by the end of the hour, as the patient loses the time-keeping function of conversational mutuality and gains the temporality of the timeless. In his speech, the analysand interrupts himself as new thoughts arise to displace narrative hegemony, customarily moving with the flow of more sentient ideas that seem to arise out of nowhere. Analysands have to learn how to do this, but when they do, they find this new relation affords them the opportunity to life in past, present and future tenses, mixing the objects and psychic realities of all times in one continuous stream of consciousness (Bollas, 1999, p. 184).

Although psychodynamic theory gives more attention to the mind than the body, participants describe their first recognition of unconscious material via their bodily signals or emotional cues. Seemingly, the unconscious communication is seeking a receptor or, as Bion (1963) said, a “container” for what has not yet been thought, understood, appreciated, or responded to. The therapist’s sustained empathic attention to their bodily indications of discomfort with the patient, as several participants described, sponsors recognition of what is being felt and what can be articulated then by the therapist or facilitated in the patient’s attention and discovery of self.

Given the therapeutic context of the Freudian Pair, a therapist’s mindfulness appears to contribute to the overall goal of psychodynamic psychotherapy in several

ways: 1) sustaining attention, even in the face of distractions or anxiety; 2) attending to what the patient knows or could know and what pops up from the preconscious in a disguised way; 3) noticing connections between disparate elements in the patient's associations or noticing what is dissociated, but not repressed; 4) noticing what is not mentalized from the receptive unconscious; and 5) attending to how the patient's presence and manner affects the therapist. Each of these contributions merit the following brief discussions.

Sustaining attention, even in the face of distractions or anxiety.

In-session, the therapist faces an ever-present potential for becoming distracted from the patient. Developing one's capacity to attend, to concentrate attention on the patient and all that he is communicating to the therapist is at the core of becoming a psychodynamic psychotherapist. Distractions can come from many directions (e.g., external noises; bodily discomforts; the therapist's agenda, theory or countertransference; the patient's self protections), but an insidious distraction comes in the form of the patient's story, which can be extremely interesting or boring. One can lose sight, then, of the patient as a person and how they are presenting themselves.

For example, imagine sitting with an angry, threatening patient. A therapist's affective response could be fear, embarrassment, frustration, outrage or a host of possibilities. Can the therapist remain able to observe what is happening in herself and consider what this might mean for the patient? Leave aside for the moment what the therapist will or should do. Stay with the moment before she acts and question whether

she can be aware of her bodily responses, such as the tension rising in her shoulders and legs, her increased heart rate, or her narrowed vision. Can her awareness remain spacious enough to include how the patient's behavior is making her feel? Is she able to entertain her own associations to or the possible meanings of the patient's outburst? Answers to these and other questions would lead us to an appraisal of how mindful the therapist is in that moment.

When mindfulness helps therapist listen to patient's experiences in a way that receives and respects the needs implicit in these experiences, then the experience becomes more tolerable and the patient is able to internalize the process with the therapist. Several participants in this study refer to the therapist's process as "reverie." In this way, mindfulness helps the therapist by giving a vision of non-reactivity and a capacity for attention, which becomes an antidote to getting lost where the patient gets lost. "With mindful awareness, one can notice when one has gotten distracted or when one's attention has become skewed and is able to compensate for it, at least to take it into account" (343).

> I think freedom of mind is very important, the lack of judgment so that you can follow the flow of your associations, a very open mind, slowing down the mind so we can see frame-by-frame what the patient says and how we are responding, a kind of leisurely quality to listening where we're not compelled to do anything, to solve any problem, but just to observe for the sheer pleasure of observing our responses to the patient. What else? I think the ability to be aware of imagery, physical sensations, as well as cognitive thoughts and processes. What's called reverie, the ability to indulge in reverie, just to let responses float through and take note of them without trying to solve any problem. Comfort with uncertainty, comfort with confusion, ease, stability, honesty, I think those are some of the qualities that are necessary to be a good psychodynamic listener (349).

Attending to what the patient knows or could know

and what pops up from the preconscious in a disguised way.

Mindfulness does not give one an immediate access into the unconscious (Rubin, 2009). Such would be a contradiction in terms. Within the psychodynamically-informed therapist, mindfulness increases awareness of the potential signals or cues of a patient's unconscious communication, which can be creatively assembled by one's own unconscious and then recognized in awareness for what it is.

Mindfulness helps in recognizing what is disconnected in the patient's experience. For example, a patient reports hearing the isolated statement, "You're in trouble" when he was driving from work. Later, he heard "Traitor" as if in a waking dream. He wondered what significance these internal words could have. They didn't seem to have a meaningful context. Later, the patient discusses past frustrations *with the therapist*. When the therapist accepts and articulates appropriately the patient's expressed frustration, by linking it to feeling betrayed ("Traitor") and the threat ("You're in trouble"), the patient is able to become more conscious of his frustration and how it is manifesting in his consciousness as well as discuss his frustration with the therapist more directly.

> By definition, the unconscious is *after the fact* (and we pick up on its impacts after the fact), whereas meditation is being aware in the here-and-now. And I think there are limits of here-and-now-conscious-introspection. So, I think there are limits, but there are also important contributions it [mindfulness] can make (349; Italics and brackets mine).

This participant's comment highlights what is evident in the preceding example: the meaning of the patient's experience is not clear at the beginning, either to him or the therapist. After the fact, the therapist listens mindfully, allowing the words "traitor" and

"You're in trouble" to be without reference, the patient's frustration with the therapist becomes noticeable non-verbally and is subsequently mentioned by the patient. The therapist's awareness of the three disparate pieces of information prepares her to put them together for the patient, assuming that the patient may intuitively recognize their meaning if it is true or somehow disconfirm this meaning if it is not true.

Noticing connections between disparate elements in the patient's associations or noticing what is dissociated, but not repressed.

Jeffrey Rubin reports an application of mindfulness, beginning his article on deepening psychodynamic listening:

> "My, the lights are bright in here," a client said to me in her first session many years ago. "Where are lights bright?" I wondered to myself. As she discussed what brought her to therapy and what she was struggling with in her life—a feeling of self-contempt and never being "good-enough"— I listened on two channels, focusing on what she was consciously saying and on her suggestive image. Lights are bright in a police station, I eventually thought to myself. When I asked her if coming to therapy made her feel "grilled under the lights by the 'cops'," she smiled nervously and told me about her fears of being judged in therapy. Since she always judged herself, she assumed that a stranger would have to judge her. After my question she noticeably relaxed and spoke more freely and openly (Rubin, 2009).

The fact that such recognitions and interventions are fundamental in psychodynamic listening need not obscure the mindful capacity needed to sustain divided attention to "two channels" as well as notice the outcome of his own associations to "the lights are bright here," leading to the parallel between her self-report and with feeling "grilled under the lights," and his formulation of an emotional, unconscious meaning for the patient's associations. The vignette aptly illustrates his process of moving from what is

not-known to a joint discovery of what is true in the relationship in the moment. Rubin reports that the patient "relaxed and spoke more freely and openly," which suggests recognition of greater safety in the therapeutic relationship than she anticipated. This is a first session and it remains unclear what more the patient absorbed from this interaction.

Conceivably, given more time in therapy, Rubin's patient could discover something about her experience of life (i.e., her expectation of the therapeutic setting as critical or her pattern of self-contempt), which would allow her to retrieve her projection and feel empowered to live in the world with a sense of being "good-enough."

> Unconscious communication is of great significance in the clinical situation. Much of the communication of the patient to the clinician and vice versa is unintentional, almost accidental but when examined more closely and in context, one begins to be able to trace associate pathways that led to the communication and enhanced or amplified its meaningfulness to the patient and to the clinician. And I think that mindful awareness is at play in all of this process (343).

Noticing what is not mentalized from the receptive unconscious.

Beyond what Freud considered the repressed unconscious, he recognized the likelihood of a receptive unconscious (Freud, 1961c), but did not develop his thinking (Akhtar & O'Neil, 2013, p. 3). Subsequent to Freud, experiences that remain emotionally and mentally undigested (for a variety of reasons) have become recognized as the "unthought known," which are regarded as the material held in receptive unconsciousness. Like the repressed unconscious, this material is not accessible to consciousness and must be discovered and processed in relationship. Such unconscious material can be accessed through a psychodynamic therapy relationship, in which the

therapist's awareness allows for the potential of a patient's unmentalized experiences. Returning to one participant's description of his physical distress in-session, he then goes on to formulate his experience of transformation of the patient's unmentalized experience in Bionian terms:

> If I feel the patient is extraordinarily angry, my chest will start to burn. . . . It's not a metaphor, I feel this burning in my chest. I think to myself, "There's anger in the field; I need to be aware of that." If I feel a kind of goose bumps or iciness flush down my back, then I feel I'm really in trouble because that's like a predatory aggression that's somehow in the field. If I feel that my legs, sometimes my arms, but mostly my legs and my belly start to just shudder, then I know that I've fallen into some very primitive memory of my own infantile distress. It may be triggered by something going on in the patient, but that's when I really need to pay attention to regulate myself, because that's a little kind of like physiological, it's like a trembling and a falling of the heart. So all of these are somatic states that are anything but calm, which - instead of get freaked out by it - I have to become curious and attentive and compassionate about, so I can bring that curiosity and that attention to those states, so that I can regain my calm alert state. And then, the fact that that's happening in the moment with the patient makes me think that my state is somehow related. It's part of how I listen. This is embodied listening. It's like the patient -- the impact of not only what the patient's saying, but how they're saying, is being registered somatically, which gives me a clue to something, even though it doesn't tell me exactly what's going on. . . . Beta means raw sensation in the body, alpha function is a variety of factors that, if you can't supply it for yourself, you have to find it in another in order to make a transformation from this raw, dysregulating sensation into these building blocks that he [Bion] calls alpha elements that can gradually be part of what nowadays they call mentalization (330).

Attending to how the patient's presence / manner affects the therapist.

One participant describes her mindfulness as an instance of "listening to herself listen to another" as a way of decoding the Ucs-to-Ucs communication. She notices her physical / emotional responses to being with the patient without becoming reactive or foreclosing on this awareness. Her capacity for mindfulness allows her to remain present,

not-knowing and not-judging, allowing for a meaning of her agitation and patient's defensiveness to emerge into consciousness (rather than consciously constructing a meaning to make sense of the experience). Implicitly, she trusts and allows for unconscious processing, which is at play in the patient/therapist experience, to unfold into meaning within the patient / therapist dialogue.

> I try to live from a place of mindfulness. So, being present and mindful with my patient, I notice what I do about how they're speaking, what they're saying, how I'm feeling, how they seem to be feeling. I work in the-here-and-now of that experience in a way [that's] very natural . . . like how I'm talking to you right now. I say: "You told me about what happened this week with your husband and I'm reminded of what you told me about that particular incident that happened with your father when you were five." Or "I wonder if that's similar to the way you feel about your sister;" or "I wonder if that wasn't something like how you felt with me a month ago when we talked about such and such;" or I just associate. I "be" with my own experience and I just talk to the person in the way that I do. Or I ask questions; or sometimes I'll say, "I think it's hard for you to tell the difference between this and this." I've been in practice for a long time now and this woman walks in the room and I get agitated and I don't yet understand what that is. I don't know what it is in me and I don't know what it is in her or what it is between the two of us. So I trust my own clinical experience to know that *that's* extremely important in the work. So I have that. I'm mindful of that dimension. While I'm talking to her about other things, I'm mindful of my feeling of agitation and my experience of her defensiveness and I'm not sure what's going on with her. I'm just very alert to my self-sense of the moment (341).

Participants in this study employed mindfulness in their effort to address the unconscious, habitual, automatic patterns that emerged with their patients and found a significant benefit from doing so. They recognized how, without mindfulness, they would be drawn into problem-solving or other habitual patterns with which the patient was identified and which some participants would regard as sustaining a false self or an adaptive self. Cultivating a dis-identification from their false self and cultivating an awareness of true self requires awareness of those "automatic, ego-centric, habit-

determined patterns of thought, emotive reaction and assessment, and imaginary activity that filter and distort reality and skew behavior, according to the needs of the self-project" (Novak, 1990, p. 49). As noted above, although participants considered mindfulness a *sine qua non* of good psychodynamic psychotherapy, they also recognized that there is no *exclusive* path to development of mindfulness and evenly-suspended-attention in-session.

Determining how mindfulness is experienced in Ucs-to-Ucs communication within the Freudian Pair links theory of clinical method with the Freudian theory of latent and unconscious knowledge. As neuropsychoanalysis increases its clarity about the unconscious mind and unconscious communications, discussion of the impact of mindfulness on recognition of unconscious communications can become more grounded in modern neuroscience (Solms, 2002).

Implications for Clinical Social Work

Participants of this study uniformly endorsed the value of mindfulness in psychodynamic listening as well as the legitimacy of developing mindfulness in a variety of ways. Even those, whose Buddhist background was unmistakable, did not claim that traditional mindfulness practice is the only method to be considered. Yet, all participants were persuaded that developing mindfulness in their therapeutic listening stance required continual, devoted practice. One participant characterized his method as: "Practice! Practice! Practice!" (336). Another participant cites research on creativity to say: "The latest creativity research . . . is [that] to get good at anything (i.e., playing a cello, doing

therapy, doing a decathlon), it takes about 10,000 hours of practice to arrive at being" (334). So, he estimated that it took him about 10,000 hours of therapy practice to move from the "doing" of therapy to a state of mindful "being" in therapy (334). Despite criticism of the disjunction between this number and the required disposition and talent, this quantitative estimate of how much practice it takes to become truly mindful helps cut through all the variations in opinion about development of mindfulness. Even granting that this hourly estimate is regarded *on the low side* by some, one could make an estimate that it takes at least about 10,000 hours to develop mindfulness awareness alone (with one's own experiences and associations) and at least another 10,000 hours to develop mindful awareness in psychotherapy, listening in-session to another's associations. Of course, if the hourly estimate increases from 10,000 to 50,000 hours, as some suggest, the urgency to practice increases accordingly. The participant in this study goes on:

> I'd say go learn a contemplative technique, go to Spirit Rock [a Buddhist retreat center], or learn how to meditate, develop a technique yourself, so you experience it. Go in to depth therapy, if you've never been into it before. Go into an analytic experience if you've not been there. Experience, deepen that hunger in yourself and enter it, find your own suffering. And then, if it's transformative and you want to do more in that and your practice, go someplace where people can teach you how to do it. The places exist; there are just not many of them. There are a few of them, but have the courage to go find them and do that training. Go get mindfulness training in whatever model makes the most sense for you (334).

The notion of always practicing, perfecting one's practice, builds upon a realization that one must be paying attention in the present moment and that conditions or influences (e.g., sensations, memories, desires, fears, thoughts), which can take attention away from experience of the present moment, will always be potential distractions. Practicing one's ability to be aware of one's experience, again and again, in order to develop one's

capacity to be welcoming, compassionate and non-judgmental to whatever arises from the patient, even what is evoked in the therapist, becomes a life-long endeavor because "perfection" (even when achieved in one moment) cannot be preserved (Siegel, 2013), as if to be applied for the next moment without the residue of being past, not present. Training to sustain a stable, open awareness requires repeated efforts over an extended period of time so that reliable habits of mind and heart develop.

Perhaps an advantage, which traditional mindfulness practices offer over other general methods of training attention, are *very specific* procedures that are known to develop certain qualities of mind and heart. If one wishes to invest their time and energy into developing an attentional capacity, then having a tested and proven methodology is a valuable asset.

Psychodynamic psychotherapy is well-known for its emphasis on life-long learning as part of the profession. Initial training requires many years of practice, education and re-education, preferably accompanied with years of self-exploration in one's own psychotherapy. Mastering psychodynamic models of the mind so as to apply them accurately and skillfully; mastering awareness of one's own sensitivities and defenses; and mastering how to respond well to various forms of patient resistance, all take time to study, to practice, and to embed firmly in memory. One participant (330) commented that it had taken him twenty years to develop his capacity for mindful listening in psychotherapy. While increasing awareness and cultivating attention by mindfulness training appears to potentiate and mature an essential component of the

psychodynamic method, training to create a mindful therapeutic environment means years of devotion to this art.

For the individual clinical social worker, dedication to both personal development and professional development commends on-going mindfulness practice, more as a requirement than an option. Moreover, sustaining attention requires protracted *intention* and thus implicates development of the will, which guides attention to its focus on Ucs-to-Ucs communication and the purpose of listening to a patient. Interior emphasis on attention also requires rectification of external conduct, for which professional moral codes are designed, but which the dedicated therapist may enrich with personal spiritual development.

Likewise, for clinical training programs, careful consideration of how to encourage development of attention necessary for psychodynamic psychotherapy, as part of curriculum design, seems relevant. Already, some clinical programs require that trainees undergo personal therapy as part of their professional development, recognizing how this experience increases self-awareness and mitigates defense patterns. Curriculum design could also include course work that fosters development of theory of clinical method and the importance of sustained attention in clinical practice. Given the ready access to mindfulness training in the current milieu, mindfulness training could be incorporated or encouraged as part of the professional training experience.

Beyond this study, many questions remain for serious consideration as an outcome of this research. For example, a few participants refer to empathy in conjunction with mindfulness. If one accepts Kohut's definition of empathy as "a mode of

observation" of psychological phenomena, simply what allows a therapist to know another's subjective experience without losing objectivity (Kohut, 1959), there appears to be a similarity with mindfulness. But one must not succumb to common misinterpretations[2] of Kohut's use of empathy, such as "extra-sensory perception" or "becoming overwhelmed by the intensity of another's feelings" or by equating of empathy with an action. Kohut's practice of empathy is not to be identified with what is commonly referred to as love or compassion[3] because its intent is simply "vicarious introspection" (Kohut, 1959).

Both Kohut's empathy and mindfulness embody a capacity for careful observation and preserve objectivity. Like Kohut's empathy, mindfulness (as a state of mind) is a tool or instrument, which permits the therapist to collect her data; but mindfulness (as a way of being) makes that tool readily available for the purpose of psychodynamic psychotherapy. Kohut's empathy is simply oriented to understanding of *another's* subjective experience. Typically, mindfulness is not restricted to understanding of another's subjective experience, but in psychotherapy that intention would become important to mindfulness since it is part of the present context. A thorough exploration of whether and how to integrate mindfulness practice and Kohutian empathy would be a thought-provoking topic.

Likewise, a more narrowly defined qualitative study could seek to understand the specific qualities of mind that apply in experiences of Ucs-to-Ucs communications in-session by interviewing a group of 15 participants (experienced psychodynamic

[2] Cf. http://selfpsychologypsychoanalysis.org/empathy-mis.shtml.
[3] Cf. http://selfpsychologypsychoanalysis.org/empathy-mis.shtml.

clinicians). A set of research questions, more narrowly focused than this study, could conceivably access detailed reports, describing seasoned clinicians' reports of how such communications emerge as an experiential process into consciousness.

A study of the ethical developments around the practice of therapeutic mindfulness could explore whether they parallel the ethical context of traditional mindfulness? In other words, will ethical developments to support therapeutic mindfulness draw from other ethical traditions in the West or simulate Eastern ethical traditions?

Finally, given the comparative study of traditional Buddhist models of unconscious mental processing (Jiang, 2006a; Jiang, 2006b) and psychodynamic models of unconscious mental processing (Bobrow, 2010), a cross-cultural study of whether proficient traditional mindfulness practice leads to awareness of unconscious processing could be done; and, if so, how? Conversely, a study could be done of whether proficient psychodynamic practice leads one inevitably to states of mindful awareness; and, if so, what specifics determine how this is achieved?

Closing Remarks

Over 25 years ago, my quest to understand human suffering and to practice ways to alleviate that suffering originated in my attraction to become a Buddhist nun. While I was in college, I became interested in Buddhism. I was intrigued by Prince Siddhartha's need to renounce the world and seek the truth about life. Then, I came to learn of the compassion of Guan Yin (a boddhisattva) and felt drawn to follow in her footsteps. Soon,

I aspired to study social work in a graduate program in Taiwan. Instead, an opportunity to study psychotherapy in the United States afforded itself and I followed that path, always curious about how mindfulness might integrate with psychotherapy. As I completed my graduate training and licensed as a mental health counselor, my interests refined toward psychodynamic psychotherapy, which has become my model of choice. But I have continued my exploration of how the Four Noble Truths of Buddhism can benefit my work in psychotherapy, hopefully, drawing the best from both worlds.

No one could have foreseen how Buddhist concepts and practice (and especially mindfulness) would develop such profound influence in the Western research and Western society today. So, I feel very fortunate to have followed this heart-felt path toward understanding the impact of mindfulness on psychodynamic listening. Beginning the program at ICSW, I had some ideas about what it is like to work with patients with mindful awareness; yet, I had not anticipated a discovery of the direct link between body and mind. Perhaps, it should not have been a surprise that mindfulness starts out attending to the most basic bodily sensations, but I had not conceived of the two together. Now, it makes complete sense: when we are trying to help patients deal with emotional difficulties, a first priority is helping the person ground their attention back into the body!

Hopefully, the reflections of the 15 clinicians, participating in this research, provide individuals or clinical training programs with insight into the benefits of mindfulness training, given the many ways in which mindfulness can be fostered. Clinicians, who seek to advance their knowledge and skills to help their patients, need not wait for years to hone their skills because the concrete steps to practice mindfulness are

already available. With such clear guidance toward mindfulness, psychotherapists can help themselves follow, experience and understand fully what Freud meant by listening with evenly suspended attention!

As I conclude this study, I remain intrigued by questions about the Unconscious Mind as it is explained in psychodynamic and Buddhist theory. In particular, I am interested in a Buddhist theory of Subliminal mind (Yogacara) and how it compares with Western notions of the Unconscious mind. This could generate a further investigation at the frontiers of Buddhism and psychodynamic psychotherapy. For now, each moment holds open the chance for exploration.

We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time.

~T.S. Eliot ("Little Gidding," 1943)

APPENDIX A

COMPARISON OF MINDFUL AWARENESS AND EVENLY SUSPENDED ATTENTION

	Mindful Awareness (Shapiro and Carlson, 2009)
Intention	A value-based direction / purpose, which is related to one's personal vision; dynamic, evolving, to be held "lightly" (e.g., self-regulation, self-exploration, self-liberation, self-less service) rather than a "grasping" or "striving" toward a goal or specific outcome (2009, pp. 8-10).
Attention	A return to things themselves (Husserl), i.e., suspending (or noting) all the ways of interpreting experience and attending to experience itself as it presents in the here and now (2009, p. 10). Discerning and non-reactive, sustained and concentrated, so that we can see clearly what is arising in the present moment (including one's emotional reactions, if that is what comes up).
Attitudes <u>How</u> to pay attention	COAL (Siegel, 2007) Curious, discerning (2009, pp. 11-12) Open, equanimity, non-striving, non-grasping Accepting, non-judgmental, patient, relating to whatever is Loving, kind, gentle *Chinese character for mindfulness includes two ideograms = presence and heart (i.e., in Asian languages = heart and mind).*
Methods	*Formal practice*: systematic meditation practice geared toward cultivating mindfulness skills, such as sitting meditation, body scan meditation and walking meditation. *Informal practice*: to generalize to everyday life what is learned during the formal practice; a *central* way of bringing mindfulness into psychotherapy.
Therapeutic qualities	a-attentional capacity and therapeutic presence; b-attitudes applied during therapy c-self-compassion and self-attunement of therapists d-therapist empathy and attunement toward client e-therapist emotion regulation and handling of countertransference.

	Evenly Suspended Attention (Freud and Bollas)
Intention	To turn one's unconscious to receive unconscious communications via the patient's free associations (Freud, 1961a); Surrender to one's own unconscious mental activity (Freud, 1961b); "abandon [the observing ego] in order to surrender to one's own unconscious" (Bollas, 2008, p. 13). Enter a waking dream state (Grotstein, 2007, pp. 88, 91-92).
Attention	Without any purpose in view, allow oneself to be taken by surprise by any turn in them, open mind, free from any presuppositions, swinging over according to need from the one mental attitude to the other; not concentrated to accomplish a singular purpose (Freud, 1961a).
Attitudes <u>How</u> to pay attention	Receptive (metaphor of telephone receiver converting electrical oscillations into sound waves) (Freud, 1961a); Take patients capacities rather than his own desires as guide. (Freud, 1961a); Exclusion of all criticism of the unconscious or its derivatives (Freud, 1961a); Learn by personal experience (Freud, 1961a).
Methods	Self-Analysis (Freud, 1961a); Training Psychoanalysis (Freud, 1961a); Practice in-session (Freud, 1961a);
Therapeutic qualities	Capacity for attention to conscious and unconscious processes Attunement and reverie Empathy for patients suffering; compassion; Emotional regulation; Awareness of resistance, transference and counter-transference Awareness of projective identification and counter-transference enactments.

APPENDIX B

DEFINITIONS OF MINDFULNESS

Date / Author Components	Definition	Commentary
1994 Kabat-Zinn Three	Paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally	
2003 Baer et al. Three components	The non-judgmental observation of the ongoing stream of internal and external stimuli as they arise	Re-wording Kabat-Zinn, 1994.
2003 & 2004 Brown & Ryan MAAS One construct; Overlapping characteristics (2007): • Clarity of Awareness • Non-conceptual, Nondiscriminatory Awareness • Flexibility of Awareness and Attention • Empirical Stance Toward Reality • Present-oriented Consciousness • Stability or Continuity of Attention and Awareness	• Receptive attention to and awareness of present events and experience; • Awareness of present experience with acceptance • An enhanced attention to and awareness of current experience or present reality • The presence or absence of attention to and awareness of what is occurring in the present	Focus on attentional components rather than attitudinal components; Present-centered awareness is the foundation; The MAAS includes the attentional and awareness aspects of mindfulness, but not the attitudinal components of acceptance and non-judgment that are emphasized across mindfulness-based clinical interventions, potentially limiting the use of the MAAS in clinically related research. The MAAS does not differentiate sufficiently between awareness and attention for my purposes. Evenly suspended attention would be more like the MAAS “awareness” than the MAAS “attention”.

Date /Author Components	Definition	Commentary
2003 Kabat-Zinn Three	The awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment to moment.	Rewording of Kabat-Zinn, 1994
2004 Bishop et al. Two components • Self regulation of attention to maintain focus on immediate experience; • Orientation toward present experience with curiosity, openness and acceptance	The self-regulation of attention so that it is maintained on immediate experience, thereby allowing for increased recognition of mental events in the present moment and one's orientation to experience adopting a particular orientation towards one's experiences in the present moment, an orientation that is characterized by curiosity, openness, and acceptance.	Emphasizes the regulation of attention; Common to these definitions are four components: 1) the ability to regulate attention, 2) an orientation to present or immediate experience, 3) awareness of experience, and 4) an attitude of acceptance or non-judgment of experience.
2005 Germer Two components • Awareness • Acceptance	Awareness of present experience with acceptance	No experimental research design related to this specific definition.
2006 Baer & Krietemeyer **KIMS** Four subscales • Observing • Describing • Acting with awareness • Accepting w/o judgment	No definition, except to include four skills taught as mindfulness in DBT training for borderline patients.	Definition is shaped by requirements of DBT treatment program and may constrain its applicability to an analytic situation. The KIMS does not sufficiently differentiate attention from awareness to make it useful with my topic.

Date /Author Components	Definition	Commentary
2006 Baer, Smith et al. **FFMQ** Five elements • Observing • Describing • Acting with awareness • Nonjudging of inner experience; • Nonreactivity to inner experience	Mindfulness is usually defined to include bringing one's complete attention to the experiences occurring in the present moment, in a nonjudgmental or accepting way	Significant in that it was developed by consensus among leading researchers on mindfulness.
2006 Lau et al. **TMS**	A non-elaborative, nonjudgmental, present-centered awareness in which each thought, feeling, or sensation that arises in the attentional field is acknowledged and accepted as it is	
2006 Walach, Buchheld, et al **FMI** Five elements • Observing • Describing • Acting with awareness • Nonjudging of inner experience; • Nonreactivity to inner experience	An alert mode of perceiving all mental contents—perceptions, sensations, cognitions, Affects. Another important element is a warm and friendly, accepting and non-judgmental attitude towards those elements of our mind. Suspending categorical judgments, which normally follow every perception rather quickly, is an integral part of mindfulness.	FMI uses def of FFMQ, Bishop et al. It thus seems useful to measure mindfulness either as a target variable of clinical interventions, as a moderating variable, and perhaps even as a personality trait. The FMI is limited b/c intended for use only with individuals who already have familiarity with the principles of mindfulness. The FMI supports links between a disposition of mindfulness, increased capacity for attention to self and decreased dissociation, which suggest an influence between dispositional mindfulness and capacity for evenly suspended attention.

Date / Author Components	Definition	Commentary
2007 Thompson & Waltz Uses **FFMQ**	A way of orienting one's self to the present moment; Definitions of mindfulness commonly emphasize that it involves maintaining awareness on one's immediate experience, as opposed to being distracted by past or future oriented thoughts, or engaged in avoidance of one's experience. It also involves maintaining an attitude of ''non-judgment.''	Seek to measure overlap between everyday mindfulness and mindfulness meditation.
2007 Feldman, Hayes et al. **CAMS-R** Four components • Attention • Present focus • Awareness • Acceptance of thoughts and feelings in general daily experience	A 12-item measure of attention, present focus, awareness, and acceptance of thoughts and feelings in general daily experience	provides further confirmation that attention, present focus, awareness and acceptance of thoughts and feelings are components of mindfulness, but without sharpening the theoretical construct.
2007 Brown, Ryan & Creswell (**MAAS**) Overlapping and mutually supportive characteristics • Clarity of awareness • Nonconceptual nondiscriminatory awareness • Flexibility of awareness and attention • Empirical stance toward reality • Present-oriented consciousness • Stability or continuity of attention and awareness	• Receptive attention to and awareness of present events and experience;	

Date Author Components	Definition	Commentary
2007 Cardaciotto et al. **PHLMS** Two components • Awareness = continuous monitoring of the totality of experience • Acceptance / nonjudging	The tendency to be highly aware of one's internal and external experiences in the context of an accepting, nonjudgmental stance toward those experiences	The awareness and acceptance subscales were not correlated, suggesting that these two constructs can be examined independently. Awareness is not differentiated from attention in this study.
2009 Brown & Ryan Single factor	Mindfulness is rooted in the fundamental capacities of consciousness: attention and (meta)awareness.	Husserl's 2nd mode of processing involves a receptive state of mind wherein attention is kep to a bare registering of the facts observed
2009 Shapiro & Carlson Three components • Intention • Attention • Attitude	Mindful awareness = An abiding presence or awareness, a deep knowing that manifests as freedom of mind (e.g., freedom from reflexive conditioning and delusion) Mindfulness (as theoretical construct) = the awareness that arises through intentionally attending in an open, caring and nonjudgmental way.	A helpful model for comparing mindfulness and psychoanalytic listening.

APPENDIX C

RECRUITMENT LETTER

Call for psychodynamic psychotherapists in mindfulness research!

A doctoral candidate at Institute for Clinical Social Work in Chicago requests Volunteers

for a qualitative research project

Exploring the impact of mindful awareness

on the psychodynamic stance in listening.

Experience clinicians who utilize a practice of mindfulness

in psychodynamic psychotherapy are invited to participate.

Research participants must be willing to participate in

a 90 minute, audio-taped interview.

Anonymity assured.

Please contact: Chuan-Chuan Tsai, M.Ed.

cctsai88@gmail.com or call (253)272-4557 ext. 2

APPENDIX D

INFORMED CONSENT FORM

Individual Consent for Participation in Research

INSTITUTE FOR CLINICAL SOCIAL WORK

I,_____, acting for myself, agree to take part in the research entitled: *The Impact of Mindful Awareness on Listening in Psychodynamic Psychotherapy*.

This work will be carried out by Chuan-Chuan Tsai under the supervision of Dr. Joan DiLeonardi.

This work is conducted under the auspices of the Institute for Clinical Social Work; 400 South State Street Suite 822; Chicago, IL 60605; (312) 935-4232.

PURPOSE
The purpose of this study is to clarify how psychodynamic psychotherapists use mindful awareness to affect their listening stance.

PROCEDURES USED IN THE STUDY AND THE DURATION
Participants will be interviewed by the researcher in the participant's therapy office, in person or by phone. The interview will last no more than ninety minutes. The interview will be audio-taped in a digital format and transcribed to form a verbatim text. The data analysis and representation will follow procedures accepted in qualitative clinical studies using a phenomenological methodology described by C. Moustakas.

BENEFITS
There are no benefits that accrue directly to the participants. However, commonly, people use an opportunity to explore their own experience to their benefit in terms of self-reflection. Also, simply contributing to knowledge in this way, through participation in research, can be gratifying to the participant.

COSTS
There are no costs associated with participation, except the time each participant volunteers for an interview.

POSSIBLE RISKS AND/OR SIDE EFFECTS
Even though a substantial amount of discomfort is unlikely, an opportunity to reflect on one's practice can cause some degree of discomfort. Consequently, no known risks concerning the participation in this research study can be predicted.

PRIVACY / CONFIDENTIALITY
Each participant will be assigned a code number or letter to identify their audio-taped and transcribed interview material. Participant references to patients and places will also be disguised. Audiotapes and transcripts will be kept in separate files and stored securely in a locked file cabinet. Audiotape files will be erased when coded transcription is complete. Transcripts and data analysis will be kept for at least five years and then shredded.

SUBJECT ASSURANCES
By signing this consent form, I agree to take part in this study. I have not given up any of my rights or released this institution from responsibility of carelessness.

I may cancel my consent and refuse to continue in this study at any time without penalty or loss of benefits. My relationship with the staff of the ICSW will not be affected in any way, now or in the future, if I refuse to take part, or if I begin the study and then withdraw.

If I have any questions about the research methods, I can contact Chuan-Chuan Tsai (Principal researcher) at this phone number (253) 272-4557(day), (253) 593-3674 (evening) or Dr. Joan DiLeonardi (Dissertation Chair) at (312) 935-4232.

If I have any questions about my rights as a research subject, I may contact Daniel Rosenfeld, Chair of Institutional Review Board; ICSW; 400 South State Street Suite 822; Chicago, IL 60605; (312) 935-4232.

Signatures

I have read this consent form and I agree to take part in this study as it is explained in this consent form.

_____ _____
Signature of Participant Date

I certify that I have explained the research to _____ and believe that they understand and that they have agreed to participate freely. I agree to answer any additional questions when they arise during the research or afterward.

_____ _____
Signature of Researcher Date

APPENDIX E

MEMBER CHECKING LETTER

December 15, 2013

Dear participants,

You participated in my dissertation research on "The Impact of Mindful Awareness on Psychodynamic Listening" last year. Below are the common findings that were drawn from all 15 participants:

A. Mindfulness is a state of mind that is calm, receptive, open, non-judgmental, and curious, more like a way of being than a technique.
B. Mindfulness helps therapist remain clearer about her own associations and manage her reactivity to patient's processes. Mindful awareness increases the capacity for listening in-session and sustains therapist's attention to her own mind/body experiences.
C. Mindfulness helps observe and regulate patient's emotional and physical experiences as well as sustain therapist's attention to mind/body communications of the patient.
D. Mindfulness contributes to the creation of a safe emotional space for the patient's exploration in their experience.
E. Mindful awareness helps therapist focus on the person versus the content of the patient's story.
F. Mindfulness prepares and helps therapist for recognizing unconscious communication.
G. Good quality psychotherapy is inherently mindful; mindfulness is an integral part of therapy.
H. Development and integration of mindfulness complements clinical theory and grounds clinical work.

Please review them and give feedback on whether the findings give voice to your experience. You can reply by email to cctsai88@gmail.com or send your feedback to Chuan-Chuan Tsai, 2501 N. 8th St., Tacoma, WA 98406. Feedback received by December 30th will be incorporated into the dissertation. I look forward to hearing from you. Thank you,

Sincerely,

Chuan-Chuan Tsai

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