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Buddhist Moments in Psychotherapy

by

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## ABSTRACT

This exploratory study was conceived with an aim to fill gaps in the fields of psychotherapy integration and multicultural counselling. A discovery oriented approach was implemented to examining the presence of Buddhist Principles when Good Moments were occurring for clients in psychotherapy. The aim was to determine whether there is empirical support for the integration of Buddhist Principles and Western psychotherapy. The data consisted of twelve sessions of psychotherapy with twelve clients and six therapists. The responses to the Important Event Questionnaire and Therapist Identified Important Event Questionnaire also served as data. Seventeen different types of Good Moments emerged from the tape analysis and questionnaires. The Category System of Buddhist Principles, a measure of six core Buddhist Principles, was implemented to determine the presence of Buddhist principles during clients' Good Moments. Eighty-eight percent of the Good Moments were found to be associated with Buddhist principles. Two Buddhist principles, Openness in the Present Moment and Compassion were identified as possible universal change processes. Four others, Flexibility of Self, Experiencing without Evaluation, Interconnectedness, and Sitting with Suffering were identified as possible unique change processes. Agreement between judges', therapists', and clients' perspectives are discussed.

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*"We shall not cease from exploration and the end of all exploring will be to  
Arrive where we started and see the place for the first time"*

T. S. Elliott

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## CHAPTER 1 – INTRODUCTION

The integration of Eastern and Western principles of psychology has the potential to move the field of psychotherapy interventions to a new level of responsiveness. Over the past 60 years theoretical discussions of the integration of Buddhist psychology and Western psychotherapy have ensued. This study is the first to move past the theoretical discussions and into the realm of practical application. This is done by examining the principles of Buddhist psychology as they appear in Western psychotherapy. Support for such an integration is drawn from multicultural counselling, psychotherapy integration, common factors in psychotherapy, and psychotherapy process research.

### Multicultural Counselling

The field of multicultural counselling has called to attention the ethnocentricity of Western theories of psychotherapy. Many authors have asserted that theories and corresponding techniques that are based upon Western assumptions fail to provide responsive treatment to the culturally or ethnically diverse client (Ibrahim, 1991; Jalali, 1988). The initial focus in multicultural counselling was on ethnically diverse clients. However, as the field has grown, emphasis has been placed on the premise that all counselling occurs in a cultural context (Sue, et al., 1998). In fact, counselling and psychology have most recently been deemed a 'culture inclusive science' (Pedersen, 2001, p.15). If all counselling is considered to include a cultural component, counsellors must be equipped to provide professional services to individuals with diverse cultural backgrounds.

Research indicates variation among cultures regarding assumptions in theories of mind and psychology (Lillard, 1998). The flexible therapist is well versed in different theories of psychology so as to be able to work with culturally diverse clientele. In order to broaden one's

frame of reference, it is necessary to understand not only the theory, but also the application of theoretical perspectives. A natural expansion of ones' repertoire of theoretical understanding would be to consider Eastern perspectives. Examination of the theory and application of Buddhist psychology promises to serve the flexible and responsive counselor well.

Understanding Buddhist ideas of mind, mental states, and psychology provides the counselor with an alternative approach to diverse cultural professional practice. Buddhist psychology also has much to offer the field of psychotherapy integration.

### Psychotherapy Integration

Psychotherapy has traditionally been fraught with intellectual battles between psychotherapists from various theoretical perspectives, asserting their understanding of human nature and change as more accurate than others. The last 30 years have witnessed a general decline in ideological struggles and increased openness to the integration of theories of psychotherapy (Norcross & Goldfried, 1992). Openness and interest in psychotherapy integration are reflected in the burgeoning organizations and international publications devoted to integration.

One of the major sources of empirical support for psychotherapy integration are findings of surprisingly few significant differences in outcome among different therapies (Lambert & Bergin, 1994; Stiles, Shapiro, & Elliott, 1986). Similar outcomes have supported the belief that there may be some common 'curative' elements disguised in different forms, present in all therapies (Grencavage & Norcross, 1990). These curative elements have been called common factors (Frank, 1961). Common factors among Western psychotherapies have been examined and articulated (Grencavage & Norcross, 1990). New theories of change have even been built on

what different authors have deemed to be common factors (Arkowitz, 1992; Prochaska & DiClemente, 1992).

Goldfried (1980) suggested that three levels of abstraction exist when looking for commonalities among therapies. The highest level of abstraction is the theoretical framework. Integration at this level is unlikely to occur because of philosophical differences between therapies. The lowest level of abstraction is at the interventions level and integration at this level is somewhat superficial. The most meaningful consensus could exist at the clinical strategies level that exists somewhere between theory and technique. Goldfried further suggested that empirical support for clinical strategies would deem them principles of change.

Though different common factors, such as the therapeutic relationship, therapist qualities, the opportunity for catharsis, and others have been identified as common to all therapies, all examinations to date have considered only Western therapeutic systems. Surely, for a factor to be 'common' and for integration to truly integrate, both Eastern and Western systems must be considered. It seems that the only way a therapeutic system can result in responsive practice in the current cultural milieu is if it includes both Eastern and Western philosophies. This integration may be best performed through psychotherapy process research.

### Psychotherapy Process Research

Psychotherapy process research is the examination of the helping process in counselling psychology (Hill & Corbett, 1993). Process generally refers to what happens in psychotherapy, specifically, therapist methods or operations, client behaviours, and the interaction between therapists and clients are examined (Hill & Corbett, 1993). The biggest and earliest influence on process research was the advent of audio recording, which enabled researchers to obtain a moment-by-moment representation of counselling events (Keisler, 1973).

Early psychotherapy process research commenced with analogue designs. However, with problems such as lack of generalizability, impossibility of controlling extraneous variables, and difficulty in simulating clinically important events, the popularity of analogue designs has decreased (Speigel & Hill, 1989). It is preferable to examine real therapy sessions. Steps toward improving process research included examining significant in-session events (Greenberg, 1986) and implementing discovery oriented or exploratory approaches. Discovery oriented approaches to research examine process without preconceived notions about what one expects to find (Elliott, 1984; Hill, 1990; Mahrer & Boulet, 1999). In contrast with discovery oriented approaches, in hypothesis-testing approaches, researchers test hypothesis about psychotherapy that is derived from clinical theory (Luborsky, Barber, & Crits-Cristoph, 1990).

The current study implements a discovery oriented approach to the examination of Buddhist principles of change in psychotherapy. Twelve sessions are analyzed and rated by 3 judges for in-session client Good Moments (i.e., moments of significant process, progress, movement, or change). Therapist operations or methods preceding the identified good client moments are analyzed for the presence of Buddhist Principles of Change. As suggested by Hill and Corbett (1993), the effective components of a treatment system (i.e. Buddhist psychology) are being determined in the present study. They suggested that it is necessary to determine what the effective components of a treatment system are before building a treatment approach.

#### Summary

By considering the history of multicultural counselling research and literature, the current study simultaneously fills a gap in both areas of counselling psychology by examining how a traditional Eastern psychological system may be integrated with Western psychotherapy. Consequently, Western clinicians can become well versed in the practical implementation and

application of Buddhist psychology in their professional practices. For theorists, the field of psychotherapy integration moves forward with the examination of principles of psychotherapy that may be common between East and West. For researchers, the present study implements an important process research suggestion by examining the effective components of Buddhist psychology before creating a treatment approach. The next chapter provides a detailed examination of the literature in multicultural counselling, psychotherapy integration, and Buddhist psychology.

## CHAPTER II- LITERATURE REVIEW

The population in Canada is culturally and ethnically diverse and becoming increasingly so due to shifting patterns in immigration and expanding source countries (Arthur & Stewart, 2001). Additionally, the number of people with multiple ethnic origins is growing (Statistics Canada, 1996). Consequently, psychotherapists need to be prepared for professional practice with diverse clients having diverse needs (Arthur, 1998; Iijima Hall, 1997). Both the Canadian Psychological Association (CPA) (1996) and the American Psychological Association (APA) (1990) have recently set guidelines for non-discriminatory practice and standards of training for working with culturally diverse populations, emphasizing issues pertinent to therapeutic conduct with culturally diverse populations.

These demographic changes must be accompanied by fundamental changes in the way we think about counselling services (Arthur & Stewart, 2001). Some of the fundamental changes are based on the premise that *all helping* occurs in a cultural context (Sue, et al., 1998) (emphasis added). More recently however, Pedersen (2001) asserted that psychology and counselling are becoming a 'culture inclusive science' (p.15), consequently cultural variables are becoming routinely included. Others stated that cross-cultural psychology will not be spoken of, but rather, all human behaviour will be understood in the cultural context where that behaviour was learned and is displayed (Segall, Dasan, Berry, & Poortinga, 1990).

In addition to involvement by APA and CPA, there has been unprecedented growth in the number of professionals writing about diversity and competency with diverse groups (Jackson, 1995). Researchers have addressed and articulated professional standards for multicultural counselling competencies (Arredondo, et al., 1992) as well as developed training models for multicultural counselling (e.g., Reynolds, 1995). Many writers (Arthur & Januskowski, 2001;

D'Andrea & Daniels, 1997) have emphasized the need for graduate training and continued professional development in the field of multicultural counselling.

It is necessary to present and relate the developments in a number of different areas in psychology and counselling in order to understand the basis for the present study. This literature review will be divided into seven parts. The first part will outline two of the main debates in multicultural counselling – definitions of culture and approaches to multicultural counselling. Second, the common factors perspective will be introduced as a first step to moving beyond the divisive debates in multicultural counselling. Third, the principles of change approach to counseling is described as a way to address the criticisms of the common factors perspective. The principles of change approach stems from the position that the processes of change are universal regardless of the cultural identity and worldview of the client and therapist. The fourth section provides a brief history of psychotherapy process research and the benefits of using it as a way to identify effective change processes from both Western and Eastern frameworks of psychology. The fifth section, entitled 'principles of change – East and West' outlines the limits of Western approaches to counseling and presents the benefits of diversification of Western frameworks of psychology and psychotherapy. In the sixth section, Buddhist psychology is reviewed as well as ways that the philosophy has been linked to Western psychotherapy. Limitations of linkages will be provided. Lastly, the objectives of the present study and the research questions will be introduced.

### Definitions of Culture

It has been stated that the field is "moving toward a generic theory of multicultural counselling as a 'fourth force' position, complementary to the other three forces of psychodynamic, behavioural, and humanistic explanations of human behaviour" (Pedersen,

1991, p.7). The view that multicultural counselling is a fourth force has been shared and endorsed by many researchers (Ibrahim, 1991; Ivey, Ivey, & Semek-Morgan, 1993). Despite this bold position, multicultural counselling is fraught with theoretical ambiguities and tensions. During the past two decades a dialogue about diversity-sensitive counselling has ensued within the counselling profession. The current status of this dialogue represents a postmodern clash of values (Thomas & Weinrach, 1998). Two popular positions are the culture specific position (emic) and the universal position (etic). They essentially disagree as to the definition of the term 'culture'. Central to the disarray within the field, is the dispute over the meaning of culture. The term 'culture' has been defined both broadly (inclusive definition) and narrowly (exclusive definition).

#### Inclusive Definition

When broadly defined, culture is a frame of reference from which we encounter ourselves, our lives, and the world around us (Draguns, 1996; Pedersen, 1985). Poortinga (1990), defined culture as "shared constraints that limit the behavior repertoire available to members of a certain socio-cultural group in a way different from individuals belonging to some other group" (p. 6). This definition of culture includes values, norms, beliefs, attitudes, behaviours, and traditions that link the individuals of the groups to one another (Leighton, 1982). It may also include demographic variables, status variables, affiliation, and ethnographic variables (Pedersen, 1991). When culture is defined broadly, all counselling is multicultural to some extent (Pedersen, 1988). Recognizing all counseling as multicultural provides a conceptual framework that recognizes the complex diversity of a plural society (Pederson, 1991).

### Exclusionary Definition

A narrow definition of culture limits the variables to ethnicity or nationality (Pedersen, 1991). From this perspective an individual is culturally diverse only if he/she is of different ethnicity or nationality than the majority group. The proponents of an exclusionary definition fear that if a broad definition of culture is employed the effects of racism against the minority group member will be overlooked (Essandoh, 1996). Disenfranchised populations will not receive the attention required to better their social, economic, and political situations/circumstances.

### Internalized Culture

The resolution to this debate may be found by changing the focus of attention from external culture to the internalized culture of the individual. Ho (1995) argued that the conception of culture most relevant to counselling "pertains not to the culture external to the individual but to the culture internalized by the individual through enculturation" (p. 5). This approach places the individual at the centre of the debate by allowing for the possibility that culture can mean different things to each person. To understand the individual, the focus must be on his/her internalized culture versus his/her cultural group membership. From this perspective, theory and technique in psychotherapy may be derived from many cultural sources, including Eastern and Western ideas. The important thing is making the link with the client's internalized culture. Ho (1995) likened this to focusing on psychological maturity, gender, and class identification instead of age, sex, and socioeconomic status. Suggesting that the focus be on the culture internalized by the client moves the discussion to a different realm. Instead of searching for a static definition of culture as suggested by both the inclusive and exclusionary positions, culture may be variably and flexibly defined to allow for each client's perspective.

## The Etic/Emic Debate

Disputes about the definition of culture set the stage for a more pervasive tension within the field – one dealing with approaches to multicultural counselling. A number of authors have suggested that multicultural counselling is a new paradigm in counselling (Ivey, et al., 1993; Pedersen, 1991). According to Essandoh (1996) a new paradigm should “function as a focal point for the consensus of the scientific community” (p. 129). Multicultural counselling is faced with the problem of searching for a unifying focal point. At the moment two opposing forces divide the field. Some theorists hold that multicultural counselling should be approached from a universal perspective (etic), while others believe that the specifics of culture (emic) should be the starting point.

### The Etic Position

The universalistic position rests upon the inclusive definition of culture holding that “to some extent all mental health counselling is multicultural!” (Pedersen, 1990, p. 94). When culture is broadly defined, each person is considered to hold a unique cultural composition which means that all forms of helping relationships must necessarily be defined as multicultural (Speight, Thomas, Kennel, & Anderson, 1995). Even within a given cultural group (e.g., women of colour), people carry their own version of that culture making individuals unique in their sense of cultural identity. As was emphasized by Ho (1995), it is the internalized culture that is most significant in understanding diverse individuals. The etic position emphasizes the internalized culture by asserting that each person, not just those individuals belonging to ethnic minority groups, holds a unique culture. Consequently, people are believed to be distinct in their counselling needs.

Advocates of the etic position believe that it is important to look beyond stereotypes and differences in order to develop an authentic counselling relationship with each client (Vontress, 1988). The proponents of this position emphasize that the most basic element of counselling is the interpersonal relationship (Patterson, 1996; Sue & Zane, 1987). The problem with emphasizing culturally specific techniques in professional practice with diverse clients is the risk that the cultural characteristics of the client may be over emphasized or, alternatively, under emphasized. The counsellor may fail to notice and experience the personal characteristics of the client, and thus fail to develop an authentic therapeutic relationship.

Pedersen (1996) stressed that saying that all counselling is multicultural is not the same as advocating a single universal system of counselling. From his perspective, emphasizing the generic dimension of multiculturalism in all counselling, reminds the therapist that all behaviour is culturally learned and that it is important to pay attention to the client's cultural context. This approach reminds counsellors that they have cultural perspectives just as the clients do. When culture is defined narrowly and only culture specific techniques are employed there is the fear that counsellors will view clients as the only one's in the therapeutic encounter who come from a cultural context. In that case, it becomes easy for therapists to encourage clients to shed their cultural context and become like 'everyone else'. Instead, Pedersen's (1991) position that multicultural counselling is a generic approach to counselling encourages counsellors to be aware of themselves and their clients as cultural beings placed in the context of larger cultures. With this belief in mind counsellors become able to see their clients' cultural milieu changing from moment to moment. Counsellors learn to appreciate the complexity of individual clients in constant struggle to balance the ever-changing salience of each aspect of him/herself.

### The Emic Position

Supporters of the emic position espouse that to provide effective mental health service to culturally diverse clients, therapists must have knowledge specific to the client's culture. When counsellors have conceptualized all of the characteristics of a variety of cultural, racial, and ethnic groups, they will be skillful and effective counsellors (Speight, et al. 1995).

The emic position is founded upon recommendations of investigators for improving the relationship between therapists and ethnic minority clients. Recommendations typically suggest that therapists improve their knowledge of various cultures and the specific techniques based on their knowledge (Sue & Zane, 1987). Inherent to these recommendations is the assumption that culturally diverse clients receive an inferior quality of care because counsellors are unfamiliar with the cultural backgrounds of their ethnically diverse clients. Lack of knowledge of the client's cultural background means that therapists are unable to devise culturally appropriate treatment (Sue & Zane, 1987).

Another premise of the emic position is the belief that most prominent theories of counselling (e.g. behavioural, client-centred, psychodynamic) start from Euro-North American cultural frameworks. These theories reflect the values, mores, customs, philosophies, and language of the culture from which they have originated (Nwachuku, & Ivey, 1991). Often the theory is adapted for use with the culturally diverse client. It is argued that adaptation is ineffective because the values implicit to the theory are often antagonistic to the values and experiences of members of the culturally different group (Sue, Ivey, & Pedersen, 1996). Adapting the theory does not remove or negate the effect of the implicit values represented by the theory.

An example provided by Sue, et al. (1996), illustrated the problematic nature of merely adapting established theories. They reported that most Western theories emphasize individualism and the development of a separate sense of self. However, the majority of societies and cultures in the world have a more collective notion of identity. These cultures do not define the psychosocial unit of operation as the individual but instead focus on groups as the most important unit of operation. Thus with clients coming from collective cultures it may be more helpful to focus on relationships or the family unit than on the internal intrapsychic dimension that is most often emphasized in Western frameworks.

Instead of adapting existing Euro-North American based theories, the culture-specific approach asserts that counselling theory would be enriched if theorizing began from the point of view of another culture (Nwachuku & Ivey, 1991). Attempts to do this have been made by Nwachuku and Ivey (1991) who have developed a step model for generating a culture specific theory. Similarly, Lee, Oh, and Mountcastle (1992) identified methods used by other cultures for dealing with psychological distress and behavioural deviance. Instead of developing different theories and approaches based on each and every culture as suggested by Nwachuku and Ivey (1991), Lee et al. (1992) believed that the principles of various indigenous healing systems could be consolidated. They developed the Universal Shamanic Tradition (UST), which consolidated the mental health practices found in Korea, Nigeria, Pakistan, Singapore, Sudan, and Zambia. The salient features of the UST are a holistic view of the person, an emphasis on a non-ordinary reality, and on the psycho-spiritual realm of the personality.

In sum, the emic approach to multicultural counselling emphasizes that theory and techniques best serve the culturally diverse client when they are developed from a culture specific framework, which holds that ethnicity and nationality are the most significant

dimensions of culture. The development of these theories can be done through the use of indigenous systems of healing. The resolution of the emic/etic debate can be found in the culture-centred perspective

### The Culture-Centred Perspective

The 'culture-centred' perspective proposed by Pedersen and Ivey (1993), proposed a way to step out of the emic/etic debate. The culture-centred perspective focuses on the culture in the person, or the internalized culture (Ho, 1995). By focusing on the culture in the person, counsellors can better identify the social variables that are relevant to and influential on the client's behaviour (Arthur & Stewart, 2001). Pedersen (2001) asserted that the culture-centred perspective enables both the universal and the specific perspective to be valid at the same time. The common factors perspective in psychotherapy supports the culture-centred perspective.

### The Common Factors Perspective

Common factors theorists propose that the curative properties of any psychotherapy lie not in its theoretically unique components, but in the components common to all psychotherapies (Garfield, 1992). The rationale for this assumption is the consistent finding of psychotherapy outcome studies that no psychotherapy is superior to any other (Lambert & Bergin, 1994; Stiles, Shapiro, & Elliott, 1986). It follows from this that if the many systems of psychotherapy claim equal success then perhaps they are not as diverse as they first appear (Grencavage & Norcross, 1990). Perhaps there are some common 'curative' elements disguised in different forms present in all therapies.

The idea of common curative elements was first introduced to counselling in the 1930's (Rosenzweig, 1936). Rosenzweig identified the therapeutic relationship, provision of a rationale explaining the patient's condition, initiating change from any number of starting points, and the

therapist's personality as important factors that cut across the various schools of therapy. Though Rosenzweig was the first to write about common factors, Frank (1961; 1973) is often credited as the father of the movement. Frank's (1961) landmark book, *Persuasion and Healing*, identified four shared features of therapy. The first is a particular type of relationship in which the patient is confident in the therapist's ability to help. Second, there is the idea of a place that the community at large has designated as a place of healing. Third is the therapist's provision of a credible rationale for the patient's difficulties and a method for relieving it. Lastly, the healing consists of prescribed 'rituals' or treatments for alleviating the patient's difficulty.

After Frank's work, little more was written or researched in the common factors area until recently. Recently, common factors have been conceptualized in two slightly different ways. When Frank initially wrote about common factors he was focusing on the factors as universal elements found to be operating in all psychological and spiritual healing systems (Fischer, Jome, & Atkinson, 1998). His interest stemmed from a position of curiously wondering what it was that occurred in healing settings such that consistent phenomenon could exist across time and place.

More recent interest in common factors is characterized by the goal of psychotherapy integration. Renewed interest in common factors is marked by Goldfried's (1980) pivotal article which has provided direction for therapists and researchers alike for uncovering the elements that are common to all Western therapeutic systems. Goldfried suggested that in looking for commonalities it might be helpful to conceptualize the therapeutic enterprise in terms of levels of abstraction from what is directly observable. He proposed that three levels of abstraction exist. Most removed from what is actually observed in therapy is the theoretical framework that explains how and why change occurs as well as an accompanying philosophical stance on the

nature of human functioning. Goldfried concluded that rapprochement at this level is unlikely to ever be possible because there will always be differences of opinion at philosophical levels.

At the lowest level of abstraction, that which is most observable in therapy, is therapeutic techniques or interventions that are employed in treatment. Though similarities are likely to be found at this level, Goldfried concluded that these similarities are superficial and trivial in nature. This position was supported by later reviews of outcome studies that suggest that techniques account for less than 15% of outcome variance in psychotherapy (Beutler, Mohr, Grawe, Engle, & MacDonald, 1991; Lambert, 1989).

Goldfried suggested that the possibility of finding meaningful consensus exists at a level of abstraction between theory and technique, which he termed *clinical strategies*. Upon uncovering empirical support for these clinical strategies they would be better termed *principles of change*. Goldfried identified (a) providing the client with new, corrective experiences, and (b) offering the client direct feedback as two examples of clinical strategies that are common to all theoretical orientations.

Conceptualization of common factors in terms of clinical strategies opened the door for many authors to develop their own lists of the factors they observed to be present in all Western psychotherapies (Garfield, 1992; Orlinsky & Howard, 1987; Prochaska, Rossi, & Wilcox, 1991; Stiles, Shapiro, & Elliott, 1986; Weinberger, 1995). From the number of lists and diversity of factors within them, it seems that there is more agreement about the importance of common factors than on defining what they are. Further, most of the lists are based on clinical observations and theoretical analyses as opposed to empirical studies.

In an attempt to consolidate the literature and turn the attention of authors toward finding empirical support for common factors, Grencavage and Norcross (1990) performed a meta-

analysis of all published lists of common factors. They reviewed and consolidated the lists found in 50 publications to answer the question, "Where are the commonalities among the therapeutic common factors?" They organized their findings into two levels; the category level which refers to common factors that can be clustered together because of a similarity between them and the factor level which refers to the specific common factors that were articulated in the literature reviewed by the researchers. They developed five categories of factors from the literature. They are: (a) Client characteristics (e.g. positive expectations), (b) Therapist qualities (e.g. ability to cultivate hope, empathic understanding), (c) Change processes (e.g. opportunity for catharsis, acquisition and practice of new behaviours), (d) Treatment structure (e.g. use of techniques or rituals), and (e) Relationship element (e.g. development of alliance).

At the category level, change processes were the most frequent types of common factor mentioned. Interestingly, this is consistent with Goldfried's suggestion that the intermediate level of clinical strategies of principles of change is the most promising starting point for determining the common factors.

At the factor level, the development of a collaborative therapeutic relationship or alliance was identified as the most frequent commonality across orientations. This has been supported at both a theoretical and empirical level in the literature. Strupp (1995) has consistently asserted that therapeutic techniques are inextricably embedded within the relationship. The working alliance has received a great deal of empirical attention. Research findings lend support to the idea that the strength of the therapeutic relationship is positively related to the outcome of therapy (Gaston, Marmar, Gallagher, & Thompson, 1991; Luborsky, Barber, Crits-Christoph, 1990). A meta-analysis conducted by Horvath and Symonds (1991) evidenced the importance of the therapeutic relationship most clearly. They reviewed 24 studies and found a reliable effect of

the working alliance on therapeutic outcome. More significantly, the effect of the working alliance was similar in psychodynamic, cognitive, and eclectic therapies and across a wide range of diagnostic categories.

### Common Factors and the Culture-Centred Approach to Counselling

The common factors perspective has only recently received attention in the multicultural counselling literature (Fischer, et al., 1998; Sue & Zane, 1987). Sue and Zane (1987) were among the first to move in this direction with their assertion that therapist credibility and giving (the client's belief that something has been received from the encounter) in the therapeutic relationship are crucial to effective therapy with culturally diverse clients. They believed that if these two qualities are present in the therapist-client relationship, a solid basis for therapeutic work has been established.

More recently Fischer, et al. (1998), have been instrumental in developing the common factors paradigm in the field of multicultural counselling. Though a multitude of common factors can be found in the literature as noted above, Fischer, et al. determined that the therapeutic relationship, a shared worldview between client and counsellor, client expectations for successful outcome, and interventions believed by both the therapist and the client are the common factors of psychotherapy that are the most relevant to multicultural counselling.

As multicultural counselling becomes a reality of the professional practice of most counsellors and psychologists, the research and literature in this area continues to grow exponentially. It is common for writers to assert their commitment to either the etic or the emic position. This kind of rivalry has masked more important issues and has unfortunately impacted the credibility of the movement (Weinrach & Thomas, 1996). Initially the culture-centred position, and more recently the common factors approach proposed by Fischer et al. (1998), have

been bold and powerful steps to moving beyond the divisive debate to a more fruitful and unifying road for multicultural counselling scholars and practitioners.

A review of the multicultural counselling literature might lead some psychologists to the conclusion that they must choose between two camps, one that says that techniques or rituals associated with their theoretical approach can be applied across all cultures and one that says that psychologists must apply only those techniques from the client's indigenous culture. Instead of choosing between these etic and emic approaches, we suggest that counsellors can use a common factors approach as a guiding framework for counselling, especially with culturally different clients (Fischer, et al. 1998, p. 566).

Fischer et al. (1998), have taken an important step in bridging multicultural counseling with the psychotherapy process area. It is necessary to consider the criticisms of the common factors approach.

#### Criticisms of the Common Factors Approach

The common factors position has been criticized for being overly general and ambiguous in the differentiation of factors. This results in abstract ideas that have little practical value (Sue, et al., 1996). An examination of the common factors articulated by Fischer et al. (1998) substantiates the validity of this criticism. Though the common factors approach meets its goal of providing an organizational framework for the multicultural counselling literature, it gives little direction to therapists who want to know what they can do to meet the needs of the diverse client.

The criticism of applicability is also relevant to etic and emic approaches. The etic approach stresses the multicultural nature of all counselling relationships, but says little about what to do within that relationship. The emic approach emphasizes the importance of understanding the client's ethnic background and using techniques derived from that knowledge. It has been criticized on the basis that culture specific knowledge and techniques seem to have no

relationship to general therapeutic techniques and processes. Sue and Zane (1987) stated that “the major problem with approaches emphasizing either cultural knowledge or culture specific techniques is that neither is linked to *particular processes* that result in effective therapy” (p.39) (emphasis added). The emphasis here is on the need to link theory and techniques to psychological processes so that they can be appropriately utilized in the therapeutic encounter. What is needed is a way for therapist to move beyond the basic debate and into *responsive* professional practice. In this vein, the principles of change approach is presented next.

### The Principles of Change Approach

Goldfried’s (1980) pivotal article drew attention to the middle level of abstraction in psychotherapy, namely clinical strategies or principles of change. His article, written in the midst of the psychotherapy integration movement, responded to two general conclusions of outcome evaluation literature: (1) psychotherapy is effective; and (2) different types of psychotherapy do not produce significantly different degrees of benefit. The combination of these forces has led to a re-examination of the psychotherapeutic process in hopes of understanding *how* change occurs in therapy (Castonguay & Goldfried, 1994). The rationale for proposing an approach that is based on common principles of change stems from the position that the processes of change are universal. That is, regardless of the cultural identity and worldview of the client and therapist, the mechanisms of change are consistent. Steenbarger and Pels (1997) asserted that “the process of change is universal, even as its thematic content is derived from diverse individual, social, and cultural sources” (p. 112).

The principles of change perspective is similar to the common factors approach in that they both seek out similarities as the starting points. Where a common factors approach highlights the factors that are common to all healing relationships, the principles of change

perspective highlights the psychological processes that are common to people in general and useful in the therapeutic relationship. An example of this is co-constructing problems in a novel and useful way (Steenbarger & Pels, 1997). Through this process the client may be relieved of feelings of blame and inferiority while simultaneously becoming invested with a sense of responsibility for alleviating his/her suffering. How this principle of change (i.e., co-constructing problems in a novel and useful way) is implemented by the therapist in specific therapeutic contexts, with the diverse client, will depend on the therapist's assessment of which techniques are most appropriate with the specific client, holding a specific worldview, at the present time (Paul, 1967). The detailed study of the uses and implementation of principles of change is best done through psychotherapy process research.

#### Principles of Change and Psychotherapy Process Research

The study of the psychotherapeutic process is a relatively new discipline (Marmar, 1990). Process refers to what happens in psychotherapy sessions, specifically in terms of therapist behaviours, client behaviours and interaction between therapists and clients (Hill & Corbett, 1993). In terms of the process of multicultural counselling, research investigating racial and ethnic variables in psychotherapy has linked racial identity attitudes to preferences for counsellors (Helms & Carter, 1991; Parham & Helms, 1981), client satisfaction (Bradby & Helms, 1990), and counsellor interventions and client reactions (Carter, 1990).

There are several reasons for studying change processes. Greenberg (1994) observed that science proceeds by observation, measurement, explanation, and prediction. Psychotherapy research to date has paid limited attention to the first three, especially observation and explanation (Greenberg, 1994; Stiles, Shapiro, & Harper, 1994). To compensate, it is crucial that researchers in psychotherapy begin to observe the process of change, and find ways to

understand and explain what occurs. Paying attention to observation and explanation will give psychotherapy rank among other sciences (Greenberg, 1994). This new focus on understanding change processes has led to the investigation of change episodes in therapy and to the development of 'micro theory' which explains how change takes place (Greenberg, Rice, & Elliott, 1993).

According to Greenberg (1994), the study of psychotherapy process will eventually allow researchers to specify the determinants of different disorders that need to be changed as well as define the processes involved in changing those disorders. Once appropriate change processes have been articulated, their application to certain disorders, as well as different populations of people, could be verified by outcome studies. Overall, the quality of treatment will improve because uncovering the process of change will allow clinicians to be more precise in their therapeutic strategies. Some researchers have examined the change process of clients receiving therapy from a Western pan-theoretical model of psychotherapy (Cummings, Hallberg, & Sleman, 1994; Prochaska & DiClemente, 1992).

In 1977, Prochaska sought to find the commonalities across the boundaries of the most popular theories of psychotherapy. He identified ten separate processes of change: (a) Consciousness raising, (b) Social liberation, (c) Self-liberation, (d) Counter conditioning, (e) Stimulus control, (f) Self-revelation, (g) Environmental reevaluation, (h) Contingency management, (i) Dramatic relief, (j) Helping relationships (Prochaska, 1984). Prochaska and DiClemente (1983), also discovered that particular processes of change are emphasized during particular stages of change (see Table 1).

Table 1:

## Prochaska's Model

Precontemplation	Contemplation	Preparation	Action	Maintenance
Consciousness raising				
Dramatic relief				
Environmental reevaluation				
	Self-reevaluation			
		Self-liberation		
				Contingency management
				Helping relationship
				Counterconditioning
				Stimulus control

A considerable amount of research has validated that Prochaska's stages of change with a range of issues, alcoholism (DiClemente & Hughes, 1990), obesity (Prochaska, Norcross, Fowler, Follick, & Abrams, 1992), smoking (Prochaska, Velicer, DiClemente, & Fava, 1988), and weight control (Prochaska & DiClemente, 1985). Apparently, Prochaska's 'Transtheoretical Approach' appears to have been widely used with addiction issues.

Another model based on common factors is Arkowitz's (1992) 'Common Factors Therapy' for depression. Arkowitz combined Frank's (1961, 1973) four common components of psychotherapy with social support literature to develop a common factors therapy manual. The common factors model for depression has not been empirically tested.

Garfield (1992) took a common factors approach to eclectic psychotherapy. He identified the common mechanisms of change as relationship, reinforcement, desensitization, facing or confronting a problem, information, skills training, and time. Garfield explained why his approach had not been empirically tested, stating that "it is difficult to provide systematic research data on 'an eclectic approach'" (p. 195).

The main thing that all of these approaches have in common is their reliance on Euro-American traditions. Though each perspective takes a broader approach than all of the theoretical traditions that each is integrating, the authors continue to make the assumption that Western approaches encompass and include all universal change processes. A further assumption is that the Euro-American change processes identified and articulated are universal.

Many authors (Frank, 1974; Fischer, et al., 1998) have asserted that some change processes are universal, but research has not been conducted to verify this belief. Researchers have found that the opportunity and process of catharsis and ventilation, the acquisition and practice of new behaviours, the process of receiving a rationale, and the process of emotional and interpersonal learning are among the most helpful and common change processes among Western schools of psychotherapy (Grencavage & Norcross, 1990). The universality of these change processes has not been tested.

### Responsive Professional Practice

Psychotherapy integration, through identifying and implementing common principles of change, can lead to increased therapist responsiveness in psychotherapy (Stiles, et al., 1994). Responsive matching is defined as using techniques as called forth by the circumstances during treatment (Stiles, Shapiro, and Barkham, in Norcross (1993) roundtable). It is contrasted with deciding in advance of treatment which client goes with which treatment.

Stiles, et al. (1993) notes that historically, responsive matching has received less attention, but that it holds promise. It is often done intuitively as practitioners draw techniques from their repertoire to fit their momentary understanding of their clients' needs. This combined with understanding change processes may be the key to a responsive therapeutic system.

Greenberg, et al. (1993) have developed a comparable system of different therapist responses organized according to their primary functions in the treatment modality. This system provides various types of responses for therapists to implement based on the needs of the client.

It has been acknowledged that no comprehensive or exhaustive integrative theory is possible (Neimeyer, 1993), but a coming together for the purpose of growth and dialogue is both possible and desirable and has begun to occur. Consequently, therapeutic perspectives have begun to broaden at both conceptual and practical levels. One of the great benefits of the psychotherapy integration movement is increased interest in psychotherapy process research. Articulating what occurs in psychotherapy and how it occurs holds much promise for more effective and responsive therapeutic practice for all clients. The next section provides a rationale for psychotherapy integration to cross boundaries between Eastern and Western approaches to psychotherapy.

#### Principles of change – East and West

The limits of Western counselling have recently received attention because of its reliance upon a Eurocentric system that cannot be applied to all clients (Ibrahim, 1991; Jalali, 1988). A first step to inclusive practice and training may be diversification of Western frameworks of psychology and psychotherapy in order to encourage therapists to look beyond their own cultural backgrounds for theories of understanding human nature. The benefits of psychotherapy integration of both Eastern and Western systems are far reaching for the field of psychotherapy.

Ho (1995) suggested that theorizing from another perspective may give momentum toward a major breakthrough from the present perspective of psychology. Research indicates cultural variation in theories of mind and psychology (Lillard, 1998). Thus the flexible therapist is well versed in different theories of mind, mental states, and psychology such that he/she can work with any client. To meet the goal of broadening one's frame of reference it is necessary to review Eastern perspectives in psychology. For example, an Eastern systems of psychology that has been implemented to some degree in the West is Morita therapy. Morita therapy is a Japanese system of psychotherapy that has been used for treating phobias, obsessions, and other anxiety-related problems (Ishiyama, 2000). It is an experiential approach that is primarily activity focused as opposed to being verbally focused. The assumption of Morita therapy is that anxiety is a great problem for clients because of their adversarial relationship with it. Through a planned regiment, the person develops a different relationship and more peaceful relationship with the anxiety and consequently space is made for other changes to also occur for the person (Ishuyama, 2000).

In recent years, Western psychologists have been writing about the parallels and uses of Buddhist psychology in Western psychotherapy. Buddhist psychology is an ancient and highly developed system in the East for understanding human nature. It is a system that is relational in nature, making it a useful compliment to Western approaches. The first look at Buddhist theory from a psychological perspective was performed by Franz Alexander in 1931, but it was Alan Watts (1961) and D. T. Suzuki (1960) who were instrumental in popularizing it as part of the 'counterculture' of the 1960's (Molino, 1998). Since the 1960's the dialogue has become more mainstream with more articles and books being published each year.

The dialogue between Buddhist and Western psychology is important and useful in the context of the current cultural composition of North America. With increased globalization both people and ideas are able to travel with high rates of speed. Consequently, the interest of lay-people (i.e. consumers of psychological services) and practitioners (i.e. providers of psychological services) in Buddhism as a religion and/or philosophy for living is at a current all time high (Molino, 1998).

Over the past 40-50 years, the dialogue between Buddhism and psychotherapy has primarily focused in three areas – theoretical discussions about the similarities and differences between psychoanalytic theory and Buddhism, general discussion of Buddhist ideas for living, and the uses of Buddhist meditation in professional practices. A number of books focusing on the similarities and differences between psychoanalytic theory and Buddhist psychology have recently been published (Epstein, 1995; Molino, 1998; Rubin, 1996; Suler, 1993). Though useful for the psychoanalytic practitioner, clinicians identified with other approaches, or integrative approaches are excluded from the dialogue. In addition, much of the writing occurs at abstract and theoretical levels leaving the clinician wondering what the integration of East and West means at a practical level. Incorporating Buddhist meditation has been a positive contribution to professional practice, but many practitioners are again excluded from the dialogue.

The remainder of this chapter will review the essence of Buddhist philosophy in order to provide an understanding of the core of the philosophy. Contributions of the current approaches to linking Buddhist psychology and Western psychotherapy through meditation will be acknowledged, while providing a critical analysis of the limitations of such an approach. The results of research with Buddhist psychology will be presented. Finally, the objective of this study will be introduced along with the research questions.

## Buddhist Psychology

Buddhism was established as a unique and separate psychological system when Siddhartha, the prince of the Sakya clan sat under the Bo tree to resolve his human situation of suffering. Buddhism, like other theories of psychology, is the codification of one person's insights about human psychology developed in the course of that person's self-investigations (Rubin, 1996). Buddhist psychological methods of observation are concerned with a study of human potentials as they now exist and how to develop them into the future (Guenther & Kawamura, 1975). Buddhist philosophy is often oriented around the four Noble Truths.

### The Four Noble Truths

The central principles of Buddhist psychology lie in the four Noble Truths. The symptom, diagnosis, prognosis, and treatment plan for human suffering are addressed in these Noble Truths (Ramaswami & Sheikh, 1989).

The first Noble Truth. The first principle is that life consists of '*dukkha*'. The literal translation of this term is that the "wheel of life" does not run well (Miyuki, 1994). The term *dukkha* is often translated as 'suffering'. This translation is misleading as it suggests that the experience is a subjective one as opposed to a general condition of life that exists for each person (Miyuki, 1994). The term 'dis-ease' would be more reflective of the true meaning as it better reflects a basic condition (L. S. Kawamura, personal communication, March 31, 1998). Thus, Buddha is speaking of the basic human condition when he stated that life consists of suffering or 'dis-ease'. This principle encompasses the dissatisfactions present in human existence. Life is filled with a sense of dis-ease stemming from at least two sources (Claxton, 1986). First is the pain that inevitably occurs with life. Inevitabilities of life are old age, sickness, and death

(Epstein, 1995). The pain that accompanies aging, sickness, and death are necessarily encountered through the inescapability of the events. Second, the individual's own likes and dislikes cause dis-ease. Not to obtain what one desires causes dissatisfaction, being stuck with what one does not desire causes dissatisfaction, and being separate from that which is cherished causes dissatisfaction (Epstein, 1995).

The second Noble Truth. The cause of suffering and dissatisfaction is addressed by the second principle. The second principle is the Doctrine of Dependent Origination. An understanding of the second truth requires a discussion of the nature of concepts and perception. Generally, an individual divides an experience into small pieces and interprets those pieces as evidence supporting or denying the presence of a concept. Collins and Quillian's (1969), discussion of the concept 'canary' illustrates this point. A canary cannot be seen as possessing attributes without at the same time being given the status of an entity. The evidence becomes circular in that an implicit decision has been made that the concept has its' own existence before a true discussion of it occurs.

The doctrine of dependent origination posits that concepts are simply ideas or labels. They are nothing other than a recurrent conglomeration of experiences, reactions, feelings, thoughts, descriptions, and impulses woven together. Claxton (1987), states:

Any concept is irreducibly composed of, and dependent upon other concepts, and if we forget the seamlessness that underlies our notations and allow that amnesia to percolate our perception, then we are apt to confer on these notations and conventions an ontological status that they do not deserve. (p.28)

Simply put, each phenomena depends upon another to exist (Bowman & Baylen, 1994).

The second Noble Truth becomes most meaningful when it is applied to the individual.

Buddhism states that the doctrine of dependent origination applies to the concept of self. Thus,

qualities and characteristics of self cannot be simultaneously used as evidence for the existence of self.

The core of the second principle is that suffering is caused by the individual's belief in a persistent, unchanging self. Just as other concepts or constructs in the world do not hold a permanent identity, the individual, too, is impermanent. Dis-ease arises when the individual clings to ideas, things, people, and a single constant self as permanent (Rubin, 1996). As mentioned, the fallacy of giving attributes to concepts reifies their existence. At a personal level, giving attributes to the self reifies the existence of a stable unchanging self. Misconceiving one's identity as stable and consistent causes dis-ease. As stated by Claxton (1987), an individual, having identified him/herself as separate and bounded, persisting in essence through space and time, partially autonomous, has adopted a stance toward life which makes unintended, unanticipated change grave. Whatever people write into their definition of self, they are thereby required to search for, cling to, or defend.

In sum, the world as presented in a human situation is an interdependently originating process to which one can bring meaning, but in which meaning is not inherent. The conceptualization process by which the individual concretizes reality is the foundation on which pervasive unsatisfactoriness and dis-ease arise (Kawamura, 1990).

The third Noble Truth. The third Noble Truth is that release from the second type of dis-ease and serenity in the face of the first type is a real possibility (Claxton, 1986). It is seeing things as they really are or seeing 'reality as-it-is' that releases one from dis-ease (Kawamura, 1990). Seeing 'reality-as-it-is' requires that the person sees the divisions or boundaries placed around people, things, and ideas as being just that - placed there versus belonging to those people, things, and ideas. What is important about the process of deconstructing boundaries, is

that in truly doing so, the individual neither judges, evaluates, nor concretizes the perceptual process or the object of perception as holding a particular existence (Kawamura, 1990).

The fourth Noble Truth. The fourth Noble Truth is the path through which one can alleviate pervasive unsatisfactoriness or dis-ease. This essentially occurs by giving up clinging to ideas and concepts as realities of experience. According to Buddha, it requires the alignment of eight specific factors: understanding, thought, speech, action, livelihood, effort, mindfulness, and concentration (Epstein, 1995). These factors comprise the eight-fold path to enlightenment. Each of these factors of being can be developed so that the individual is following the 'right' path (i.e. the path to enlightenment). Much like the idea of self-actualization discussed by some Western schools of psychology, the process of enlightenment is the developing of one's potentials. Easwaran (1985) has translated and interpreted the eight-fold path as follows: right understanding is seeing life as it is, this is the knowledge that all things that come into being have to pass away. Right purpose means the ability to think about life in a way that is consistent with the way life is, essentially, it is realizing that life is about learning to live. Right speech, right action, and right occupation mean living in harmony with the unity of life, speaking kindly, and earning livelihood in a way that is not harmful or at the expense of others. The last three components deal with developing the mind, right effort is the constant endeavour to train one's self in thought, word and action (normally through meditative practices). Right attention means keeping the mind focused on the present so as to be mindful; right meditation is the means of training the mind.

At the root of these eight is mindfulness. Mindfulness is awareness without judgment, attachment, or aversion to what is happening in the present moment (Rubin, 1996). The development of mindfulness is to happen in four areas: (i) bodily phenomena such as physical

sensations; (ii) feelings, which are not emotions, but rather reactions to things which we classify as 'pleasant', 'unpleasant', or 'neutral'; (iii) mental phenomena; and (iv) to observe whether the mental state is wholesome or unwholesome (Khema, 1987; Rubin, 1993). A discussion of wholesomeness of thought can be found in the 'health and dis-ease' section. The development of mindfulness requires the individual to be fully experiencing the present and to begin to be free of illusions. It is clear and single-minded awareness of what actually happens to and in the individual at successive moments of perception. It requires the individual to attend, without selection or judgment, to the experience of whatever mental or physical phenomena, for example, thoughts, feelings, sensations, or fantasies are predominant in his/her field of awareness (Rubin, 1996). Central to the practice of mindfulness is an understanding of the Buddhist view of self.

### Self

Buddhist theory states that a separate, permanent, and distinct self does not exist. This distinction is an illusion which gives rise to dissatisfaction (Parry & Jones, 1986). Interestingly, the illusion is one that each person experiences. The focus of this section of this paper is to explain how the illusion of self is constituted and how it functions.

The development of a psychophysical self is explained by the *skhandas*, which are the physical, and mental factors that compose the psychophysical personality. There are five *skhandas* as follows:

- (i) form – this includes the material body with its sense organs;
- (ii) feelings and sensations;
- (iii) perceptions
- (iv) mental formations (or volitional attitudes) including habits and dispositions

- (v) consciousness (consciousness of the six senses-the five traditional one's plus mental events)

It is important to note that though these five components comprise the self they do not constitute the self, their interaction is what creates the illusion of self (Loy, 1992), through the arising mental states. Mental states in Buddhist psychology are only thoughts, emotions, memories, sensations, and perceptions (Ramaswami & Sheikh, 1989). There is no self or 'I' behind them and without them there is no sense of self or sense of 'I'. The relationship between mental states and the sense of self is where the illusion begins. The self regards mental states as objects that belong to it. Dividing mental contents into a subjective self and objective mental states gives rise to the sense of a permanent and stable sense of self with only the mental states being considered transient. Since the self is but a series of mental states, all mental states are subjective, not objects of a subject (Ramaswami & Sheikh, 1989). Once the illusion of self is created, the individual begins to identify with this illusion. The self is illusive because, like everything else, it is a temporary, ever changing manifestation arising out of the interaction of the five *skhandas*, yet it feels separate from the rest of the world. The basic difficulty is that insofar as the self feels separate, or autonomous, it also feels uncomfortable, because of the insecurity of an illusory separateness (Epstein, 1989). Ironically, the sense of self becomes pre-occupied with trying to make itself self-existing. Often the result is the creation of a boundary between 'me' and 'not-me' (Claxton, 1986). Such a boundary makes the individual vulnerable. Whatever the individual identifies with as self, becomes a point of vulnerability for the self. For example, if the individual identifies with wealth, poverty is a threat. Buddhism states that the act of seeing oneself as separate (i.e. as this and not that), is what creates dis-ease (Claxton, 1986).

When the individual sees the world as-it-is, and in doing so realizes that adaptations of self and strivings for security are worthless, he/she is moving away from dis-ease (Walley, 1987).

### Health and Dis-ease

The Buddha stated that physical illness is often the consequence of or associated with unhealthy mental states (Ramaswami & Sheikh, 1989). As mentioned, mental states refer to thoughts, emotions, memories, sensations, and perception. Integral to a healthy mental state is the wholesomeness of one's thoughts. The wholesomeness of one's thoughts is measured by the presence or absence of the five hindrances (Kawamura, 1990). The five hindrances refer to five emotional states that make thoughts unwholesome. The five hindrances prevent the individual from experiencing reality as-it-is. They are:

- i) Overexuberance and remorse because when overly excited or remorseful the individual becomes further attached or identified with the object;
- ii) Vindictiveness as this deepens the illusion of self because this often stems from a perceived transgression against the self;
- iii) Gloominess and drowsiness because this dulls the perceptual organs;
- iv) Attachment because this is based purely on illusion;
- v) Indecision because the mind is inescapable of seeing reality as-it-is (Kawamura, 1990).

Goldstein (1976, p.53) provides a simile to describe the impact of these hindrances:

Imagine a pond of clear water. Sense desire [attachments] is like the water becoming colored with pretty dyes. We become entranced with the beauty and intricacy of the color and so do not penetrate to the depths. Anger, ill will, aversion, [vindictiveness], is like boiling water. Water that is boiling is very turbulent. You can't see the bottom... Sloth and torpor [gloominess and drowsiness] is the pond of water covered with algae, very dense. One cannot possibly penetrate to the bottom because you can't see through the algae... Restlessness and worry [overexuberance and remorse] are like a pond when wind-swept. The surface is agitated by strong winds... Doubt [indecision] is like the water when muddied; wisdom is

obscured by murkiness and cloudiness.

By cultivating mindfulness, the five hinderances can be counteracted and the three defining characteristics of reality, namely, that all is dis-ease, all is transitory, and all is nonsubstantive can be experienced (Kawamura, 1990). The practice of mindfulness, or refined nonjudgmental and nonselective awareness of whatever is coming leads to highly refined perceptual acuity and attentiveness, increased control of apparently voluntary processes, deepened insight into the nature of mental and physical processes, selfhood and reality, and the development of compassion (Rubin, 1996). Mindfulness strips away illusion, and the individual who presently fears nothingness or emptiness because of his/her illusioned identity, is instead left with pure potentials. Pure potentials are no longer constricted by the boundaries created by illusion (L. S. Kawamura, personal communication, March 31, 1998). When individuals stop trying to be that which they have identified with, they can become no-thing and discover that they are every-thing, or more precisely, that they can be anything (Loy, 1992).

The essence of Buddhist psychology can be found in its emphasis on impermanence, transience, process, and change. These constructs are repeatedly expressed in discussions of self, health, and dis-ease. The emphasis on process and change make Buddhist psychology relevant to psychotherapy and specifically relevant to the principles of change approach to bridging Eastern and Western systems. Further, Buddhist psychology can play a role in unifying the field of psychotherapy in general.

#### Application to Psychotherapy

The goal of theories of psychology is to explain how the human mind functions. Theories are most helpful to clinicians when abstract ways of understanding people are brought to a concrete level. Thus, it is important for each theory of psychotherapy to discuss applications

to the practice of psychotherapy. This section will discuss the current literature on the utility of Buddhist Principles to psychotherapists.

### First and Second Order Change

The most recent trends in psychotherapy are focused on an inquiry into the nature of change (Lyddon, 1990). As part of this inquiry a distinction has been made between first order change and second order change (Watzlawick, Weakland, & Fisch, 1974). First order change refers to a change that can occur within a system which itself stays invariant (Bowman & Baylen, 1994). That is, the structure of the system remains intact despite a change that occurs within it.

Second order change offers a framework for considering the relationship between member and system. In second order change there is a breaking free from the system to another level (Bowman & Baylen, 1994). When this type of change occurs the fundamental structure of the system is altered. In the case of Buddhist psychology, the application of Buddhist Principles requires a systematic examination of the hindrances to developing the wholesome states of mind such that the individual begins to see the illusions of self that are socially and personally created. The method for alleviating suffering does not lie in helping clients better adapt to their environment or become more adept at getting what they want as would be the case with a system that implements first order change. In the case of second order change described here, the individual gradually begins to see beyond the illusions (Bowman & Baylen, 1994). Seeing beyond illusions alters the fundamental structure of the self-system as opposed to finding another way to function within the system. Buddhist philosophy emphasizes seeing through the illusions of self by practicing meditation, and thereby changing the fundamental structure of the self-system. in a second order change system.

### Buddhism and the Self

Many authors have written about Buddhist perspectives of the self. Hayward (1999) presents an interpretation of the sense of self as egoless and discontinuous. Others have written about the lack of self in Buddhism (Loy, 1992) as well as the role of consciousness (Laycock, 1999). Selfhood and identity in Buddhism had been contrasted with the West (Ho, 1995; Chang & Page, 1991). Theorizing about the components of the self or lack of self is an area that is difficult to study empirically. A great deal of the literature about self in Buddhism also speaks of meditation which has been both theorized and researched.

### Buddhism and Meditation

Meditation is the careful and detailed non-judgmental observation of proximate dimensions of consciousness (Rubin, 1993). The purpose of meditation is the acquisition of self-knowledge, which can only be accomplished by direct self-study of the mind (Suzuki, 1960). Meditation yields self-knowledge by focusing one's attention on the immediacy of experience. The meditator is instructed to notice whatever is experienced at each moment.

Through the process of noticing, the meditator begins to develop the awareness that the mind is not still, but is, rather in a constant state of activity. Until the individual stops to observe the mind, there is a lack of awareness of its incessant activity.

Effects of meditation. A major obstacle to achieving being in the present is that people often assess a current situation on the basis of events that have occurred in the past (Epstein, 1998). Using the past as a frame of reference makes it difficult for the individual to have a new and unanticipated experience. Through meditation, the individual is able to understand reactions as belonging to incidents of the past. Consequently, he/she enters the present; engages in moment-to-moment observation of thoughts. Entering the present by noticing one's thoughts is a

process of de-automatization – the undoing of automated, habitual thought and action (Deikman, 1982). In cultivating perceptual acuity and attentiveness, meditation fosters awareness of and de-automatization from, previously habitual reactions (Rubin, 1993).

In a similar vein, the practice of meditation diminishes the individual's reactivity. The individual often automatically identifies with his/her reactions. Through meditation the individual develops a detached relationship to the reactions. Thus, the person is able to make space for the existence of the reaction, but does not completely identify with it because of the concomitant presence of non-judgmental awareness (Epstein, 1995).

A detached relationship is not to be confused with a withdrawal or disengagement from life. The meditator is detached from agitation; but not detached from the activities of the world. Without the distraction of the restless mind, the individual is better able to participate in the world (Suzuki, 1960).

The most profound effect of meditation is that the individual begins to fully experience. The restless mind is constantly reminding the individual of its separateness (illusory), and thereby preventing the person from fully connecting with the surrounding world around (Epstein, 1998). The Buddha stated that everything is always changing or transient. When a person feels love toward an object he/she hopes or expects to have that object forever. Incorrectly believing in the permanence of objects and one's relationship with them postpone's the inevitable grief associated with the transience of one's self, the transient feeling one holds toward the object, and the temporary existence of the object itself. The solution is not to deny attachment, but for the person to become more open to the temporary nature of experiences by removing the demands of permanence that are often placed on experiences. Meditation assists the person in developing a

relationship to transience that is not adversarial, in which the ability to embrace the moment takes precedence over fear of its passing.

Meditation and psychotherapy. Meditation is at the core of Buddhist practice and has been shown to be effective in the alleviation of one's suffering. Consequently, much of the literature linking Buddhist practice with psychotherapy emphasizes the use of meditative techniques in psychotherapy.

Epstein (1995) outlined how meditation facilitates remembering, repeating, and working through in psychotherapy. In his recent work, *Falling Apart without Going to Pieces*, Epstein (1998), provided many examples of successfully using meditation practices with clients. Odajnyk (1998) discussed Zen meditation as a way of individuation and healing. The implementation of meditation has been encouraged to enhance empathy (Sweet & Johnson, 1990). Rubin has written about meditation and psychoanalytic listening (1985), as well as resistance in meditation (1996). West (1987) edited an entire book entitled 'The Psychology of Meditation'. The influence of meditation on physiological arousal (Holmes, 1987), and EEG (Fenwick, 1987), and personality (Delmonte, 1987) have been researched. Others have written about using and managing meditation in clinical practice (Smith, 1987; Carrington, 1987). In recent times meditation research has been called state of the art (Walsh, 1996).

Limitations of meditation and psychotherapy. The link that has been made between Buddhist meditation and psychotherapy is an important one. Although meditation is central to Buddhist practices, it would be unfortunate for the dialogue between Buddhist psychology and Western psychotherapy to stop at conversation only focused on meditation for a few reasons. First, meditative approaches do not fit every therapist or every client (Kelly, 1996). Consequently, many therapist and clients who could benefit from the principles of Buddhist

philosophy in ways other than the implementation of meditation into their lives are not given that opportunity. It is important for techniques of inner exploration to fit the culture and social contexts in which the psychotherapist works (Kelly, 1996). This means that it is inappropriate to introduce meditation as an intervention when it does not fit the client's culture and social context. Secondly, despite meditation being an important Buddhist practice, the principles of Buddhism are larger than meditation. It is a rich philosophical and spiritual tradition with much to say about living life with inner peace. Though meditation is an important part of the philosophy, it is asserted that relying on it as the only bridge to psychotherapy is limiting. The process focus of Buddhist psychology is where the promise of its' contribution to psychotherapy lies.

#### Buddhism and Psychotherapy in General

The relevance of Buddhism to counselling is emphasized by a number of authors approaching its' value from different perspectives. The four noble truths have been considered as a way to consider problems (Vassallo, 1984), and Buddhism has been considered from the perspective of motivation and happiness (Gaskins, 1999). Most of the literature considers the implications of Buddhist thought for Western psychotherapy (de Silva, 1993; Fenner, 1987; Muramoto, 1985; Tart, 1990a, Tart, 1990b, Walsh, 1988). Comparisons have even been made between self-realized persons from the East and West (Chang & Page, 1991). Many others have focused on theoretical comparisons and at times integration between Buddhism and psychoanalysis (Cooper, 1998; Finn, 1998; Fromm, 1960; Kelman, 1960; Phillips, 1998; Rubin, 1996).

Much has been written about the importance of integrating Buddhist and Western psychology. Although previous writing provides ideas for integration, no literature could be found that addresses how to integrate Buddhism and psychotherapy.

#### Process Focus of Buddhist Psychology

Buddhist psychology is essentially a philosophy emphasizing impermanence, transience, or *process*. The Buddhist discussion of process may be its most useful contribution to therapeutic systems. As stated earlier, the most recent trends in psychotherapy focus on the investigation into the nature of change (Lyddon, 1990). Buddhist psychology, a 2500-year-old system, focuses on change. At present there is no literature that conceptualizes the Buddhist system from a principles of change perspective.

Only recently have researchers and practitioners begun to conceptualize and understand psychotherapy by looking at the change mechanisms that may be occurring in the client and between the client and therapist. Little has been said about the universality in terms of the presence and application of the various change mechanisms articulated earlier in this chapter. A complete system of change would include processes and principles of change that are derived from both Eastern and Western systems of psychology. If they are found to be universal, that is if they are equally valid and applicable to all clients regardless of cultural background, then it is important that the therapeutic environment provide the client with the opportunity to experience them. In order to do this each therapist must have an understanding of each of these processes and a broad repertoire of skills that would enable him/her to effect them and thus provide responsive therapy.

Review of research has drawn attention to the usefulness of careful, intensive examination of how in-session client change events are brought about by therapists (Elliott,

1983; Gendlin, 1986; Greenberg, 1986; Hill, 1990; Luborsky, 1990). General psychotherapeutic research questions have been asked such as "Given certain in-session patient condition or states, what therapist operation or methods are useful in helping to bring about what kinds of Good Moments of in-session client change, improvement, movement, progress, or process?" (Mahrer, White, Howard, Gagnon, MacPhee, 1992, p. 252).

There are three elements to these research questions. Some studies investigated the relationship between in-session client conditions and subsequent therapist operations (the first two elements). Wampold and Kim (1989), studied therapist operations when clients are describing events. Others looked at therapist operations when clients are being dominant or controlling (Litchneberg & Barke, 1981). Other studies have examined the relationship between therapist operations and in-session client events (the second two elements). Client in-session events following therapist interpretation and confrontation have been studied (Elliott, James, Reimschuessel, Cislo, & Sacks, 1985) as well as therapists open questions (Martin, Martin, & Slemon, 1989). Other studies chose the client event and studied the preceding therapist operations, such as heightened personal description (Hill & O'Grady, 1985), client defensiveness, (Waldron, Turner, Barton, Alexander, & Cline, 1997), and topic shifts (Friedlander & Phillips, 1984).

A sensitive research strategy with this kind of process research is to focus on the in-session client change or progress event and to work backward to identify the antecedent therapist operation (Barkham & Shapiro, 1986; Hill, Helms, Tichenor, Spiegel, O'Grady, & Perry, 1988; Mahrer White, Souliere, MacPhee, & Boulet, 1991). An examination of in-session change events and Buddhist psychology can be done by seeking to answer the question: What Buddhist Principles implemented or operationalized by therapists are useful in helping bring about what

kinds of Good Moments of in-session client change, improvement, movement, progress, or process?

### The Current Study and Summary

The purpose of the present study is to examine a number of sessions in order to identify exceptional, noteworthy moments of client change, or progress, and to determine whether the antecedent therapist operations and methods, judged as instrumental in bringing about the Good Moments, were similar to Buddhist Principles. This chapter has outlined the current debates in multicultural counselling and arrived at the conclusion that resolution of the debates may be found by approaching the field from a common principles of change approach. In order to broaden therapists' frames of reference, in which psychotherapy may be approached from a culture-centred perspective, it is necessary to review Eastern perspectives in psychology in addition to the much researched Western perspectives. It is suggested that by understanding principles of change from both Eastern and Western traditions the counsellor is in a better position to work with the client from the perspective of his/her internalized culture. Buddhist psychology was introduced as the oldest and most highly developed system in the East for understanding human nature.

Though Buddhist philosophy and Western psychotherapy have been linked through theoretical discussion and the practice of meditation, this study suggests a unique way of bridging them through principles of change. The study of principles of change is essentially the study of psychotherapy process – looking at change processes in psychotherapy. Though this has been done to some degree, effective change processes have never been identified in perspectives outside of Euro-American traditions.

Hill and Corbett (1993) stated that the science of psychotherapy has lagged behind the practice of psychotherapy as researchers are often testing theories that are already in practice. They believe that an overall goal of psychotherapy process and outcome research should be to develop new theories of psychotherapy. By bringing together principles of change, Buddhist psychology, and psychotherapy process research the present study filled that gap by investigating whether the principles of Buddhist psychology exist in psychotherapy as known in the West by answering the following questions:

1. What is occurring for the clients when there is a moment of clear and definite movement or change (Good Moment) in the twelve therapy sessions studied?
2. Are the therapists' operations or methods preceding the clients' Good Moments consistent with any of the Buddhist Principles of change?
3. If #2 is occurring, how certain is the research team that the therapists' operations or methods are similar to the Buddhist Principles identified as present?
4. What is the level of agreement between judges' identification of Good Moments, clients' articulation of Good Moments, and therapists' articulation of Good Moments?

Chapter three outlines the methodology used to study the presence of Buddhist Principles with Good Moments in psychotherapy.

### CHAPTER III - METHOD

The chapter is organized as follows to describe the methodology used for the present exploratory study. First, a brief rationale for employing the discovery-oriented approach is presented. Second, a description of the participants is provided. Third, a detailed description of the instruments as well as the method by which the Category System of Buddhist Principles was developed is provided. The fourth section outlines the procedures used for obtaining participants, data, and training the judges. This chapter concludes with details of data rating and analysis.

Twelve therapy sessions were rated and interpreted by three judges in this study. The sessions were qualitatively interpreted using the Category System of Good Moments (CSGM) (Mahrer, 1988) as a guide for uncovering moments of clear and definite moment or change (Good Moment). The Category System of Buddhist Principles (CSBP) (a measure developed by the researcher) was used to rate and categorize the therapists' participation in Good Moments. Two other instruments, the Important Events Questionnaire (IEQ)(Cummings, Martin, Halberg, & Slemons, 1992) and the Therapist Identified Important Events Questionnaire (TIEQ), a measure created by modifying the IEQ, were also used to obtain perspectives of clients and therapists, respectively.

Once the qualitative analysis was accomplished, statistical analyses were applied to the data. Traditionally, research studies did not combine qualitative and quantitative procedures. More recently however, Greene, Caracelli, and Graham (1989) advanced a number of purposes for combining methods in a single study. In the case of the present study, the combination of methods is developmental, wherein the first method is used sequentially to help inform the second method (Greene, et. al, 1989). Specifically, the results of the qualitative interpretation are the data for the quantitative analysis.

### Rationale for Employing the Discovery-Oriented Approach

In the last chapter, psychotherapy process research was introduced as a way to study principles of change. The two possible ways of approaching psychotherapy process research are 'hypothesis testing' and taking a 'discovery-oriented' approach (Mahrer & Boulet, 1999). The foundation of the hypothesis testing approach is to begin by stating the questions that the research question attempts to answer. Discovery-oriented research is aimed at discovering new things about psychotherapy (Mahrer, 1999). In recent times it has been asserted that the discovery-oriented approach offers a careful and sensitive way of finding and describing in-session events and changes (Gendlin, 1986; Greenberg, 1986; Mahrer & Boulet, 1999; Marmar, 1990; Stiles, Shapiro, Elliott, 1986). In the case of the current study the discovery-oriented approach is considered appropriate because it allows for (a) the continual testing of hypotheses, (b) the actual trying out of what was discovered, and (c) the continual study of further instances (Mahrer & Boulet, 1999).

In light of the benefits of using the discovery-oriented approach when studying psychotherapy process, the methodology employed addressed answered the following questions:

1. What is occurring for clients when there is a moment of clear and definite movement or change (Good Moment) in the twelve therapy sessions studied?
2. Are the therapists' operations or methods preceding the clients' Good Moments consistent with any of the Buddhist Principles of change?
3. If #2 is occurring, how certain is the research team (on a Likert scale of 1-3) that what the therapists' operations or methods are similar to the Buddhist Principles identified as present?

4. What is the level of agreement between judges' identification of Good Moments, clients' articulation of Good Moments, and therapists' articulation of Good Moments?

### Participants

#### Therapists

Six therapists participated in this study. One therapist services clients through his private practice, one works in a community service agency, one works in a college counselling center, and three therapists service clients through an employee assistance program provider. Four of the participating therapists are male and two are female. The therapists represent a variety of theoretical orientations: Solution Focused, Integrative Body Psychotherapy, Humanistic, Interpersonal, and Cognitive-Behavioural psychotherapy

In terms of training and education, one therapist has a Masters of Social Work degree, four are Chartered Psychologists, two are trained at the Masters level, one is a Ph.D. candidate, and two have obtained Ph.D. degrees. The age range of the counsellors was 28 years to 46 years, with a mean of 37 years. The range of years of experience counseling was 2 to 18, with a mean of 10.5 years. Four of the therapists are Euro-Canadian, one is Asian-Canadian, and one is Jamaican-Canadian.

#### Clients

Twelve clients participated in this study. Four of the client participants are male and eight are female. The age range of the clients is 20 years to 46 years, with a mean of 34 years. Five of the clients are married, one is co-habiting with her partner, and six are single. Eleven of the clients are Caucasian and one is East Indian.

## Judges

One male Masters level counsellor, one female Masters student in counseling psychology, and myself, a Ph.D. candidate in counseling psychology, served as judges. Judges were selected on the basis of their interest and enthusiasm for the project and their unique contributions to the team. One judge practices and conceptualizes from a Cognitive-Behavioural perspective, one practices from Experiential perspective and the other practices from an Integrative perspective. With these different theoretical perspectives a richer analysis of the counselling session tapes could be completed (Mahrer & Boulet, 1999).

## Instruments

### The Category System of Good Moments

The Category System of Good Moments (CSGM) (Mahrer, 1988) consists of 12 nominal categories of client change events. It was used to identify moments of clear and definite movement or change based on the spoken words of the client. Though the focus is on client statements, the therapeutic context is considered (Mahrer, personal communication, April 12, 2000). The method of derivation and refinement of the Good Moments was designed to enable the list as a whole to incorporate the Good Moments of therapeutic process (Mahrer, Lawson, Stalikas, & Schachter, 1990). The categories of Good Moments may be summarized as follows:

- 1) Provision of Significant Material about Self and/or Interpersonal Relationships. The client is providing (reporting, describing, expressing) material that is significant (important, revealing, special, meaningful) and that pertains to the client's personal self and/or interpersonal relationships.

- 2) **Description-Exploration of the Personal Nature and Meaning of Feelings.** The client is describing-exploring the personal nature and meaning of feelings that are immediate and ongoing.
- 3) **Emergence of Previously Warded-off Material.** The client is expressing, manifesting, recollecting, or exploring material that is meaningful and significant, but has been avoided, defended against, blocked, and unavailable.
- 4) **Expression of Insight/Understanding.** The client is expressing, demonstrating, or acquiring a significant degree of insight/understanding that is therapeutically meaningful in that: (a) its expression is accompanied with feelings of emotional arousal; (b) it indicates a substantial change in the way the client sees (recognizes, construes, sustains and maintains) him/herself and his/her world; and (c) it has significant implications in the client's determining role in effecting well being, personal and interpersonal behaviour.
- 5) **Expressive Communication.** The client is communicating in a way that is significantly expressive: (a) the voice quality is active, alive, energetic, fresh, spontaneous, and vibrant, with energy turned outward or inward. (b) the expression includes vividness, and richness and in the spoken words: figures of speech, colourful use of imagery, a strong sensual quality that draws upon visual, auditory, and/or kinesthetic qualities.
- 6) **Expression of Good Working Relationship.** This includes expression of a high level of trust in the therapist, reliance and confidence in the helping intent and motivation of the therapist, a valuing of the patient-therapist working bond and alliance, active cooperation in the search for meaningful material, and acceptance of a significant responsibility for effecting personal change.

- 7) **Expression of Strong Feeling Toward the Therapist.** The client is expressing feelings that are strong, may be positive or negative, and are expressing directly toward the therapist.
- 8) **Expression of Strong Feeling in Personal Life Situation.** The client is predominantly being (living, existing) in a personal life situation and is expressing (having, undergoing) strong feelings within the context of the personal life situation.
- 9) **Manifest Presence of Substantively New Personality State.** The client is manifesting a substantively new personality state, a radical shift or transformation with the critical feature that of a substantively new personality state, qualitatively different from the ordinary, continuing person and /or personality state.
- 10) **Undertaking New Ways of Being and Behaving in the Imminent Extratherapy Life Situation.** The client is undertaking (expressing, manifesting, carrying out, undergoing) new ways of being and behaving in the context of the imminent extratherapy life situation.
- 11) **Expression or Report of Changes in Target Behaviours.** The client is expressing (showing, manifesting) or reporting the increased or decreased occurrence of behaviours (actions, symptoms, thoughts, feelings) that have been targeted as change markers.
- 12) **Expression of a Welcomed General State of Well- Being.** The client is expressing (indicating, manifesting, reporting) a general state of well being (good feelings, soundness, pleasure, happiness).

The psychometric properties of the scale have been reported to be satisfactory with inter-rater Kappa reliabilities (Cohen, 1960) ranging between .72 and .77 (Martin, Martin, & Slemon, 1987; Martin & Stelmazonek, 1988). There are a number of problems with using a list such as the CSGM to identify moments of clear and definite movement or change in psychotherapy. One

such problem is that using a list makes it difficult for new items, to be discovered that are beyond that list (Mahrer & Boulet, 1999). Another problem is that the description of the impressive or valued in-session event was determined before the event was studied in the actual session (Mahrer & Boulet, 1999). A critical issue is that searching for and identifying Good Moments based solely on a list is restrictive to the data. It is like forcing the events of the session into categories that may not be completely accurate descriptions of the data.

To prevent these problems from interfering with the coding or understanding of the data, the CSGM was used as a guide for identifying moments of clear and definite movement or change instead of using it as a template. The CSGM is best used as a guide with helpful suggestions, but judges are free to go well beyond these categories (Mahrer, personal communication, April 17, 2000).

#### The Category System of Buddhist Principles

The Category System of Buddhist Principles (CSBP) consists of six nominal categories of Buddhist Principles. This measure was developed for the purposes of this study. Hill (1991) provided guidelines for developing a process measure. She suggested several sources for gaining information about the measure. Some important sources are literature, expert opinion, and the researchers experience in therapy (Hill, 1991). For the development of the CSBP, the aide and assistance of Barber, an expert in Buddhist psychology and a professor in the department of Religious studies at the University of Calgary was enlisted. Barber provided assistance from the commencement of the creation of the measure by suggesting literature to read and discussing Buddhist concepts. As I read the literature and developed a better understanding of Buddhist psychology and ideas about change, a first draft of the CSBP was developed. Over the course of one and a half years, through deeper understanding of the literature, travel to and emergence in a

Buddhist culture, participation in Buddhist meditation, and extensive communication and consultation with Barber, the CSBP was finalized for the purpose of this study. These categories are neither exhaustive nor do they comprehensively capture the complexities of Buddhist philosophy. They are an attempt to simplify the main principles and articulate them in a way that may facilitate their bridging into the practice of psychotherapy.

When creating a measure it is important that a good definition be written for each item and that the definitions be as operational as possible, requiring minimal inference (Hill, 1991). For this reason the items have been written in the most concrete manner as is possible. They are written to reflect counselling interactions in order for the category system of Buddhist Principles to be relevant to counselling or psychotherapy. Each of the categories is accompanied with an explanation to facilitate the understanding and application of it. Just as the CSGM attended to client statements, the CSBP was used to attend to therapist statements. The Buddhist Principles are organized into six distinct categories. A section entitled 'additional information' follows the description of each category. The added information is intended to provide a more complete picture and understanding of that category. The Category System of Buddhist Principles follows:

1. Flexibility of self. The therapist facilitates the experience of a self that is flexible. The individual is considered as having the ability to express a variety of qualities/characteristics (sometimes they may seem contradictory). The therapist assists the client in loosening his/her grasp on the qualities and characteristics that are deemed essential to self. One's qualities are encouraged to be held loosely, as if resting upon an open palm instead of squeezed in a tight fist. This loosening is a freeing experience as it enables the client to begin seeing/experiencing him/herself as in process and with unlimited potentials to be both/and instead of either/or.

Additional information: Western psychology values a coherent self-image and high self esteem. It is healthy to have a clear sense of one's own identity and a feeling of autonomy and to value one's self and one's achievements (Ray, 1987).

The Buddhist belief is that suffering is caused by the individual's belief in a persistent and unchanging self. Suffering occurs when the individual clings to ideas, things, people, and considers a single constant self as permanent. The individual is continually and rigidly categorizing things/qualities/characteristics into either-or categories, helping him/her decide what is me and not-me (Fontana, 1997). Hence, when things are categorized as not me they are points of vulnerability and threat and being such, a source of suffering (Claxton, 1987). Flexibility of self recognizes and encourages a more flexible 'both-and' way of approaching one's self.

The emphasis is on experiencing the self as a function, not as a discrete, knowable, permanent thing. Young-Eisendrath (1996) used the metaphor of a pancreas to illustrate. The pancreas changes all of its cells every 24 hours. So in a day, the pancreas is completely new. Yet everyday the pancreas carries out roughly the same functions, although it is affected by what goes through it, what it absorbs. Similarly, the self is reconstituted from moment to moment as anew and yet its' functions are the same: to help us integrate complexity into unity, to feel that we exist over time, and to provide us with the basic ego functions of willing, choosing, and taking initiative (Young-Eisendrath, 1996).

2. Openness in the present moment. This item has two essential components: openness and being in the here and now. Openness to one's experiences means that the client ceases to block, limit, or ward off the experience. It requires the client to let go of the boundary between the acceptable and unacceptable parts of the experience. The therapist facilitates

the client to open up to the immediate experience of the present moment. This assists the client in being fully in the moment without the usual boundaries or limits that cut off parts of the experience. The therapist, by staying in the moment, without the boundaries, limits, or expectations that he/she places on the client, then makes room for the client to be free of the same. Often one's limitations or boundaries are influenced by experiences in the past and expectations of the future. The therapist, by drawing the client's attention to the 'now' and focusing on the client's experiences in the now, facilitates the letting go of client's self-imposed barriers.

Additional information: Too often we are lost in thoughts of the past or future and unable to simply be with our immediate experience. As a result, we bring our suffering into the present moment. The present moment, free from association with the past or future, does not hold suffering. It is a matter of opening one's self to it. The Buddhist philosophy emphasizes opening one's self to all aspects of one's experience, both internal and external. It is a type of openness that is not interfering (Epstein, 1995). This implicitly requires that the therapist be open him/herself to whatever thought, feelings, experiences, wishes, dreams, desires the client has. Often the therapist too puts boundaries around the client through imposing personal expectations of what the client should be like. Without these boundaries from the therapist, the client is freer to enter his/her own experience.

3. Experiencing without evaluation. The therapist moves the client away from intellectualizing the experience and trying to understand why the experience is as it is. Experiencing encompasses emotions, thoughts, senses, physiology, etc. The therapist facilitates the client in staying with his/her experience at the level at which it occurs. This may be an emotional state, a sense experience, an experience of physiology, or anything

else. The therapist will discourage intellectualizing or theorizing or understanding why he/she is having this experience, whether it is positive or negative, what it means, etc.

This is not managing or ignoring one's experience, but instead learning how to be with it.

Additional information: Western models emphasize the importance of predictability and control in one's life (Ray, 1987). The well-adjusted person develops realistic expectations of outcomes and has a sense of self-efficacy in achieving them (Bandura, 1977). It follows that clients are used to evaluating things as good, bad, or neutral. be it an emotion, a bodily sensation, an event, or all the other incidents of life (Epstein, 1995). This often happens at a habitual level. These interventions assist the client in attending to the experience with dispassionate interest. That is, transcending the attachment or aversion (judgment of some kind). By transcending the attachment or aversion to the experience, it is able to exist without an evaluation of it.

Consequently, the client becomes free to act instead of react.

The movement away from intellectualizing is particularly important because from a Buddhist perspective intellectual understanding can become a defense serving to distance one's self from suffering.

4. Compassion. The therapist treats the client gently, tenderly, with kindness and/or firmness or alternatively assists the client in treating him/herself this way. Compassion is not to be confused with pity or sympathy. Pity or sympathy serves to amplify space and distance between the giver and the recipient. Compassion, associated with warmth, acceptance, humility, tenderness, and kindness is a way of 'suffering-with' the other thereby closing the distance between self and other. Compassion may not always appear as loving/caring in the traditional sense. It can at times be firm and confrontational, but maintains the quality of joining with the person.

Additional information: This is a state of mind that is nonviolent, nonharming, and non-aggressive. It is a mental attitude based on the wish for others and one's self to be free of suffering (Lama & Cutler, 1999). Part of the process means avoiding treating ourselves more harshly than we do others (Walley, 1987). Compassion can be likened to the acceptance, warmth, and tenderness a mother would feel towards her newborn child. The idea is to use compassion as a therapeutic intervention in which the client either receives the experience from the therapist or begins to experience compassion him/herself.

5. Interconnectedness. The therapist emphasizes that the client is in relation to his/her surrounding and encourages the client to examine the connections. This facilitates a cognitive understanding of interconnections.

Additional information: Very often clients come to therapy because they want to change one thing in their lives (eg. improve communication in relationship, stop smoking). They often believe that this one thing can be changed while keeping all other things in their lives the same. These interventions highlight that things in the client's life do not exist in isolation from each other, just as the client does not exist in isolation from all the relationships around him/her. Everything is related to everything else.

This gives the client a sense of embeddedness in all that is around him/her. The key, for the therapist, is to create an environment in which the client can candidly and accurately examine how things are interconnected both inside and outside him/herself. Consequently, the nature of the connections may begin to change.

6. Sitting with suffering. Suffering is considered to be all uncomfortable feelings, ranging from emotional pain such as fear, anger, anxiety, sadness, etc. to any kind of physical pain. Through these interventions the therapist demonstrates a level of comfort with the

client's suffering by being able to be present with it. The key is being with the suffering without rushing to change it. The client experientially learns that suffering is not 'bad'; it simply is part of our experience.

Additional information: From the Buddhist perspective, working through a problem means that the person is able to be present in his/her pain without trying to fight it. Clients are used to reacting to their pain by finding ways to assuage it. Many therapists assist clients by providing alternative or additional techniques to avoid one's pain. These interventions assist the client in staying with the pain – not being adversarial with it.

Traditionally psychotherapists struggle with their clients to take uncomfortable feelings away. They try to solve problems, uncover hidden dynamics and come up with explanations for feelings (Epstein, 1998). All of these approaches distance the person from the uncomfortable feelings. According to Buddhist philosophy, it is necessary to find a way to 'look at' and 'be with' one's uncomfortable feelings.

Both the CSGM and the CSBP were used to convert the useful content of the tapes and transcripts to data that could then be coded and analyzed. The conversion from session content to research data occurred with the judgment and consensus of the three judges. "The purpose of data production in qualitative designs is to accumulate sufficient depictions of instances of the phenomenon under study to permit construction of a pattern that fully describes the diverse qualities of the phenomenon" (Polkinghorne, 1991, p. 115).

A study using a qualitative design typically assembles data from a variety of sources (Polkinghorne, 1991). In addition to judges' perspectives, the perspectives of the clients and therapists respectively, are considered through the following two instruments: the Important Events Questionnaire and the Therapist Identified Important Events Questionnaire.

### The Important Events Questionnaire

The Important Events Questionnaire (IEQ) (Cummings, Hallberg, Martin, & Slemon, 1992) has been used in numerous studies (Cummings, Hallberg, Martin, & Slemon, 1992; Cummings, Hallberg, & Slemon, 1994; Cummings, Slemon, & Hallberg, 1993; Kavanagh, Multan, Patton, 2000). It contains five questions: (a) What was the most important thing that happened in this session (i.e. what stood out for you)? Please be as specific as you can. (b) Why was it important and how was it helpful or not helpful? (c) What thoughts and feelings do you recall experiencing/having during this time in the session? (d) What did you find yourself thinking about or doing during the time in between sessions that related in any way to the last session? (e) Are you experiencing any change in yourself? If so, what? In the current study the first three questions were repeated for the second most important event in the session.

In total there were eight questions. The first six questions are session specific, while the last two elicit processes and experiences of the client outside of counseling (Cummings, & Hallberg, 1995).

### The Therapist Identified Important Events Questionnaire

Using the Therapist Identified Important Event Questionnaire (TIIEQ) therapists were asked to complete a modified version of the IEQ. It contains four questions: (a) What was the most important thing that happened in this session? Please be as specific as you can. (b) Why was it important? (c) What was helpful or hindering about this event? (d) How does this event fit or not fit into your conceptualization of the client's issues?

## Procedure

One hundred and thirteen therapists were introduced to this study by the researcher. Fifty-one of these therapists were contacted by telephone and sixty-two of them received a presentation of the study at their respective counseling centers.

All of the therapists were sent/given a package containing: a) introduction letter to the therapist (Appendix A), b) informed consent form (Appendix B), c) introduction letter to the client (Appendix C), d) informed consent form for the client (Appendix D), e) a demographic information form for the client (Appendix E), f) samples of the questionnaires to be completed by the therapist and client (Appendix F), g) statement of procedure (Appendix G), and h) statement of ethical compliance were mailed to the therapists (Appendix H). The therapists were advised that the researcher would make a follow-up telephone call to them approximately seven to ten days after receipt of the package.

Of the one hundred and thirteen therapists contacted 20 (17.7%) agreed to participate in the study. Ultimately 6 therapists (5%) of all the therapists contacted actually provided tapes. This low percentage of participation is consistent with research examining the response rate of therapist participation in psychotherapy process studies. Finding a sample of psychotherapists to participate in field based process research has been identified as a major challenge (Vachon, Susman, Wynne, Birringer, Olshefsky, & Cox, 1995). In a study performed by Bednar and Shapiro (1970), a one percent response rate was found. Therapists have stated the main reasons for their refusal to participate as taping concerns, and time constraints (Vachon et al., 1995).

The provision of tapes per therapist is presented in Table 2.

Table 2:

Therapist Demographics

Therapist	Place of work	Gender	Ethnicity	Level of education	Age	Years of experience	Number of tapes provided
1	Community agency	Male	Euro-Canadian	M.S.W.	40	14	4
2	Private practice	Male	Asian-Canadian	M.A. Chartered psychologist	42	18	1
3	EAP provider	Male	Euro-Canadian	Ph.D. Cand. Chartered psychologist	28	2	2
4	EAP provider	Female	Euro-Canadian	M.Ed. Chartered psychologist	35	6	1
5	College counseling center	Female	Euro-Canadian	Ph.D. Chartered psychologist	32	5	2
6	EAP provider	Male	Jamaican-Canadian	Ph.D. Chartered psychologist	46	18	2

The therapists were asked to introduce the study to potential client participants in the first or second session. A potential client-participant is an adult client engaged in individual counselling. Therapists were asked to introduce the study as looking at common factors of client change across different therapies. Participation for clients involved consenting to the audio tape recording of the third session of therapy and completing the necessary questionnaire immediately following the third session. Therapists were asked to assure clients that participation was completely voluntary and not a condition for continued therapy. They were also assured that the type of therapy they received would not be affected in any way by participation. Therapists assured clients that they would never see their completed questionnaire. The clients were given a package containing: a) a letter introducing the researcher, describing the study, and how to

contact the researcher (Appendix C), b) an informed consent form (Appendix D), c) a demographic information form (Appendix E), and d) a copy of the questionnaire they would be asked to complete (Appendix F).

#### Procedure for Obtaining the Data

If a client was interested in participating, the therapist reviewed the informed consent form with him/her immediately before the third session of therapy. The third sessions of therapy were the data for this study. It has become generally accepted in psychotherapy process research that the processes of psychotherapy are well underway by the third session and therefore the third session is considered a good reflection of therapeutic process (Cramer, 1993; Hampson & Beaver, 1996; Mallinckrodt, 1996; Safran & Wallner, 1991; Waldron, Turner, Barton, Alexander, & Cline, 1997).

Immediately following the third session, the client was given a demographic information form along with the questionnaire requiring completion and an envelope in which to seal the completed forms. The client was asked to complete the form and questionnaire, seal it in the envelope and return it to the therapist or receptionist depending on the office set up.

Therapists were also asked to complete the TIEQ immediately following the third session of therapy, and seal it in the envelope provided. The therapist contacted the researcher, and the researcher picked up the audio tape and sealed envelopes within twenty-four hours of the session.

The audio tapes and completed questionnaires were stored in a locked filing cabinet in the researchers home. The researcher kept the only copy of the key. The tapes, completed questionnaires, and demographic information form were given a code and kept separate from the informed consent forms. This was to ensure that the client's name was kept confidential and

known only by the researcher. Upon provision of the code, tapes and questionnaires were identified only by code. The audio tapes were transcribed and all the identifying information in the tapes was blocked out so that the tapes and transcripts were free of identifying information.

#### Procedure for Training the Judges

Training for use of the CSGM: During approximately 5 hours of training the judges independently studied the CSGM and met to discuss their understanding of the qualities of Good Moments of therapy in general and the specifics of each of the twelve categories in the CSGM. The judges were encouraged to rely on their own personal understanding, with as few restrictions as possible and to use the CSGM only as a helpful guide (Mahrer & Boulet, 1999).

The judges practiced the process by independently identifying and describing Good Moments on two practice sessions. The transcripts of the practice sessions were divided in half based on the total number of client statements in each practice session. This resulted in four separate blocks of practice statements.

Judges were to determine where the Good Moments began and ended and in their own words describe what they believed was occurring for the client during this part of the session. Judges were asked to answer the questions: "Is this a significant, valued, impressive moment?"; "If so, how would you describe what is happening and what do you believe qualifies it as impressive, significant, or valued?" Each judge handed his/her answers to myself. I reviewed the answers. Where there was agreement, the descriptions were organized into a single composite. That single composite was presented to the entire team at the next research meeting for a final team approved composite.

Those Good Moments that were identified by only one or two of the team members were also discussed at the next meeting. The judge(s) who identified it were given the opportunity to

provide a rationale for the selection of that particular segment as a Good Moment. If consensus was reached, the discussion proceeded to describing the event and what made it significant, important, or valued. If consensus could not be reached, the statement/segment of the tape did not qualify as a Good Moment. These procedures were repeated for the four training sessions so that the judges could practice the process.

After all of the tapes had been judged for the presence of Good Moments, the judges were introduced to the CSBP. Approximately 4 hours were spent discussing what each of the categories mean and examples of what the manifestation of the principles could sound like in sessions. Judges were then asked to return to the practice sessions that had been used for training with the CSGM. The Good Moments had been identified during earlier training. Judges were asked to independently determine where the Good Moment began from the perspectives of the therapists' intervention. Specifically, judges were asked to answer the following question: "At what point in the session did the therapist seem to be involved in this impressive change?" (Mahrer & Boulet, 1999). The therapist statement sometimes directly preceded the clients' Good Moment, sometimes it was four or five statements earlier, and other times the therapist had not made a statement related to the Good Moment.

The judges had to reach consensus regarding the question of where the therapist intervention began before they went on to the next step. The next step required that each judge examine all of the therapist's statements up to the Good Moment and independently determine a) whether or not any of the Buddhist Principles in the CSBP were present in the therapist statements, and b) when Buddhist Principles were found to be present judges were required to independently decide how certain they were, on a Likert scale of 1 to 3, that particular Good

Moment was present. The Likert scale measure indicators follow: 1 represents 'not too sure', 2 represents 'somewhat sure', and 3 represents 'certain'.

### Data Analysis

#### Rating the Data

Once judges were trained for use of the CSGM, actual tapes were rated. After six tapes had been rated, Mahrer, the creator of the CSGM, was consulted (personal communication June 12, 2000). During this consultation it was determined that the judges had been implementing somewhat broad criteria in identifying 'significant, valued, impressive movement' (personal communication, June 12, 2000). It was suggested that implementing more stringent criteria would perhaps result in the identification and analysis of Good Moments that were more clearly significant (personal communication, June 12, 2000). The research team decided to add the criteria of 'clear and definite movement or change' to the requirements for a Good Moment. The remaining six sessions were analyzed using more the stringent perspective. As was expected, fewer Good Moments were found.

The judges independently reviewed the six tapes that had already been rated and removed the Good Moments that fell short of the more stringent criteria. When there was disagreement a discussion ensued to decide whether to keep/discard the Good Moment under debate.

When all of the twelve tapes had been analyzed for Good Moments, the judges began analyzing tapes for the presence of Buddhist Principles. The procedure used was consistent with the training procedure described above.

Rater bias. When using raters in a study it is necessary to address the issues of rater bias. Researchers on rater bias suggest that it is not found on scales that were highly operationalized, however evidence of bias was found with ratings of therapists' facilitative conditions (Hill,

O'Grady, & Price, 1988). It seems that raters have difficulty rating items about global therapeutic conditions such as facilitative conditions or affiliation, perhaps because their personal feelings interfere with the judgment process (Hill et al., 1989). Because the current study required raters to identify and describe Good Moments and therapists involvement, bias is possible and may compromise the validity of the ratings.

Hill (1991) suggested solving this problem by choosing a group of raters who represent a wide range of theoretical orientations. This is reflected in this study by one judge representing a strong Cognitive orientation, another being Experiential with an emphasis on bodily experience, and the third being Integrative. At times these different orientations were evident in terms of the different moments identified by each judge. It is hoped that any negative effects of rater bias were compensated by the fact that consensus was required at all stages in the qualitative analysis. Consensus was required for a moment to be identified as good/significant, to determine the place of therapist involvement, to determine the presence of Buddhist Principles, and to determine the certainty of that presence.

#### Data Analysis of Client and Therapist Identified Good Moments

The IEQ and TIEQ required both clients and therapists to identify the most important/significant moments in the session from their own perspectives respectively. I read the descriptions of these moments and identified them on the tapes and transcripts. This was done only after all the ratings of the tapes and transcripts were completed. Since clients and therapists provided information regarding what made the chosen moments important/significant, the only task left for the judges was to determine where the therapist's intervention began, whether any Buddhist Principles were present, and if so, decide on the level of certainty. This was all done in accordance with the protocol described above.

### Organizing the Data

Once all the data had been interpreted, I sorted all the Good Moments. The Good Moments were sorted according to the way they had been described by the consensus of the research team. Descriptive analyses, contingency analyses, and Kendall's Tau correlations were performed on the data.

### Summary

In Sum, a discovery-oriented approach was taken to uncover the presence of Buddhist Principles with client Good Moments. Twelve therapy sessions of therapists, representing various theoretical orientations, with their respective clients were examined. The CSGM was implemented to determine the location and types of therapeutic events that were considered Good Moments. The CSBP was then implemented to determine the presence of Buddhist Principles in therapist interventions preceding the Good Moments. Client and therapist perspectives were considered through the implementation of the IEQ and TIEQ respectively.

## CHAPTER IV– RESULTS

This chapter outlines the results of the study and is organized into seven sections. The first section describes the number and percentage of Good Moments that were discarded upon implementation of the stringent criteria of ‘moments of clear and definite movement or change’ (Good Moments). The second section provides background information about frequencies of Good Moments of each of the therapists and clients. The information serves as a backdrop for addressing the research questions

The remainder of the chapter addresses each of the research questions in turn. The third section reports what is occurring for clients during Good Moments. A synopsis of the sixteen types of Good Moments is provided as well as the frequency of each one. The fifth section addresses what therapists are doing when Good Moments are occurring for clients. The frequency of Buddhist Principles is provided. The sixth section provides an overview of the presence of Buddhist Principles with each of the different Good Moments. The general overview is followed by a breakdown of the presence of each Buddhist Principle with each of the sixteen Good Moments illustrated by figures. The figures also indicate the judges’ level of certainty with respect to the presence of each of the Buddhist Principles. The issue of distinctness of each of the categories of Buddhist Principles is addressed in the next section. The last section respectively reports clients’ and therapists’ perceptions of significant in-session events. Percentages of agreement with respect to identifying Good Moments is provided.

### Results of the Application of Stringent Good Moment Criteria

As discussed in the previous chapter, it became necessary to apply rather stringent criteria when examining the therapy sessions. As noted, the first six tapes were analyzed for the presence of the clients’ Good Moments. One hundred and sixteen Good Moments were identified and

given consensus by the judges. Upon further and more stringent analysis sixty-two Good Moments (53%) of those Good Moments were discarded. Fifty-four Good Moments (47%) met the more stringent criteria.

The remaining six tapes were analyzed with stringent criteria. When the twelve sessions were analyzed according to stringent criteria one hundred and twenty-two Good Moments emerged. The themes in terms of the types and frequencies of types of Good Moments will be reported in section three of this chapter.

### Frequencies

In order to provide a complete description of the data, frequency analyses were conducted. This section will report the frequencies of each of the six therapists (Table 3) and the twelve clients (Table 4). Frequencies of the Good Moments can be found in Table 5, in the next section of this chapter. Frequencies of the Buddhist Principles can be found in Table 6, in section five of this chapter.

Table 3:

Frequency of Therapists' Good Moments

Therapist	Frequency of Good Moments	Percent of frequency of Good Moments	Number of sessions contributed (out of 12)
1	81	66.4	4 (33%)
2	7	5.7	1 (8%)
3	15	12.3	2 (17%)
4	1	0.8	1(8%)
5	15	12.3	2 (17%)
6	3	2.5	2 (17%)

It is important to note that therapist 1 contributed 66% of the Good Moments. Also notable is that this therapist contributed 33% of the tapes interpreted while the remaining 67% of the tapes are shared among five therapists. The mean number of Good Moments in therapist 1's tapes is approximately twenty Good Moments per session. The mean number of Good Moments found in the tapes of the other five therapists is approximately five Good Moments per session. Therapist 1 had on average four times as many Good Moments in any given session as any of the other five therapists participating in the study. The mean number of Good Moments per session in the twelve sessions used in this study is approximately 10.

Table 4

Frequency of Clients' Good Moments

Client	Frequency of Good Moments	Percentage of frequency of Good Moments	Therapist
1	29	23.8	1
2	27	22.1	1
3	7	5.7	1
4	12	9.8	1
5	12	9.8	2
6	3	2.5	3
7	16	13.1	3
8	9	7.4	4
9	3	2.5	5
10	1	0.8	5
11	3	2.5	6
12	0	0	6

The frequency of clients' Good Moments chart indicates that clients 1 and 2 combined, contribute 45% of the Good Moments.

## The Research Questions

The following sections address each of the research questions in turn.

### **What is occurring for the client when there is a moment of clear and definite movement or change (Good Moment) in the twelve therapy sessions studied?**

The process of discovering the moments of clear and definite movement or change required that each judge not only identify the moments but describe what he/she believed was occurring that comprised the movement/change. Consensus was required regarding both identification and description of the Good Moment.

Once all one hundred and twenty-two Good Moments were discovered and described they were then sorted for themes. The sorting of the moments into themes did not pose any difficulty because the descriptions of the Good Moments were clear and concise. Sixteen themes emerged. The frequency of each of the types of Good Moments is reported in Table 4.

#### Types of Moments

1. Description and/or exploration of the personal nature and meaning of feelings
2. Provision of significant information about self and/or interpersonal relationship
3. New level of awareness regarding the possibility for change
4. Experience of bodily felt sense in the moment
5. Expressive communication
6. Expression of insight
7. Expression of strong feeling toward the therapist
8. Expression of desire for change
9. Undertaking/exploration of new ways of being in the moment
10. New level of honesty in the therapeutic situation

11. Confrontation/disagreement with the therapist
12. Description of significant impact of therapy session
13. Expression of welcomed general state of well-being
14. Movement to the core of the issue
15. Experiencing in the moment
16. Openness to emergence of previously warded off material

Table 5

Frequency of Good Moments

Type of Good Moment	Frequency	Percentage of frequency
1-Description of feeling	7	5.7
2-Provision of significant information	26	21.3
3-Awareness of the possibility for change	1	0.8
4-Expression body felt sense	9	7.4
5-Expressive communication	12	9.8
6-Insight	11	9
7-Strong feeling toward therapist	2	1.6
8-Desire for change	1	0.8
9-New way of being	4	3.3
10-New level of hone'sty	2	1.6
11-Disagreement with therapist	4	3.3
12-Sig impact of therapy	1	0.8
13-Welcomed state of well-being	1	0.8
14-movement to core of issue	1	0.8
15-Experiencing in the moment	25	20.5
16-Openness to previously warded off material	15	12.3

The frequency of five of the sixteen types of Good Moments is very low, only presenting themselves one time each. The five types of Good Moments are Awareness of the Possibility for Change, Desire for Change, Significant Impact of Therapy, Welcomed State of Well Being, and Movement to the Core of the Issue. Despite the low frequency of occurrence for each of these Good Moments it is necessary to include them in the list because they describe what was found in the sessions. Another important finding is that only two types of Good Moments, Provision of

Significant Information about Self and/or Interpersonal Relationship and Experiencing in the Moment, account for 42% of all the moments.

**Are the therapists' operations or methods preceding the clients' Good Moments consistent with any of the Buddhist Principles of change and how certain is the research team of this?**

A report of the frequency of Buddhist Principles provides a complete picture before specifically addressing this research question. Frequency of Buddhist Principles can be found in Table 6.

Table 6

Frequency of Buddhist Principles

Buddhist Principle	Frequency	Percentage of frequency
1-Flexibility of self	7	5.7
2-Openness to the present moment	68	55.7
3-Experiencing without evaluation	14	11.5
4-Compassion	23	18.9
5-Interconnectedness	11	9.0
6-Sitting with suffering	14	11.5

'Openness in the Present Moment' was found close to 56% of the time. All the other Buddhist Principles were found to be present between 5% and 19% of the time.

In order to answer the specific question of whether the therapists' operation or methods were consistent with the Buddhist Principles preceding the clients' Good Moments crosstabulations were performed. Figure 1 presents what percentage of the time Buddhist Principles appear when each category of Good Moment is present.

Figure 1. Presence of Buddhist Principles with Each Type of Good Moment

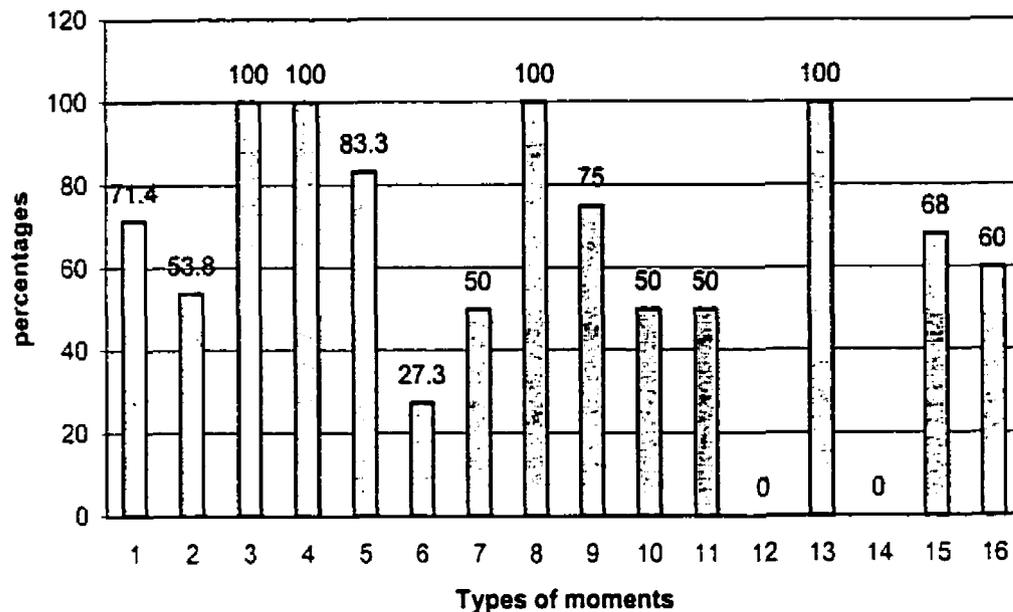


Figure 1 clearly indicates a strong association between the Good Moments and Buddhist Principles. Of the sixteen types of Good Moments discovered in the data ten (63%) are more often present with Buddhist Principles than not. Three (19%) are equally present with Buddhist Principles and no Buddhist Principles, and another three (19%) are more highly present with no Buddhist Principles than with Buddhist Principles.

The question that emerged from the above results is "Specifically, which Buddhist Principles are present when each type of Good Moment occurs?" The following figures each illustrate the presence of each Buddhist Principle as well as the judges' level of certainty when each of the sixteen types of Good Moments are present. Results are first reported in Table 6.

Table 7

Percentage of Frequency Between Types of Good Moments and Buddhist Principles

Types of Good Moments	Buddhist Principles					
	Flexibility of self	Openness in the present moment	Experiencing without evaluation	Compassion	Inter-Connectedness	Sitting with suffering
Desc. of feeling	0	57.1	14.3	28.6	14.3	0
Sig. Info.	0	46.2	7.7	19.2	7.7	15.4
Aware of change	0	100	0	0	100	0
Bodily felt sense	11.1	100	22.2	11.1	11.1	22.2
Expressive com.	8.3	66.7	16.7	8.3	16.7	8.3
Insight	0	27.3	0	9.1	0	9.1
Strong feeling toward therapist	0	50	0	0	0	0
Desire for change	0	0	0	100	0	0
New way of being	75	50	0	0	0	0
New level of honesty	50	50	0	0	0	0
Disagreement with therapist	25	50	0	0	0	0
Sig. Impact of therapy	0	0	0	0	0	0
State of well being	0	100	0	0	0	0
Move to core of issue	0	0	0	0	0	0
Experiencing in the moment	0	64	16	32	8	16
Openness to warded off info.	0	53.3	20	26.7	13.3	13.3

**Figure 2.** Percentage of Frequency and Certainty of Buddhist Principles with Good Moment One (Description and/or Exploration of the Personal Nature and Meaning of Feelings)

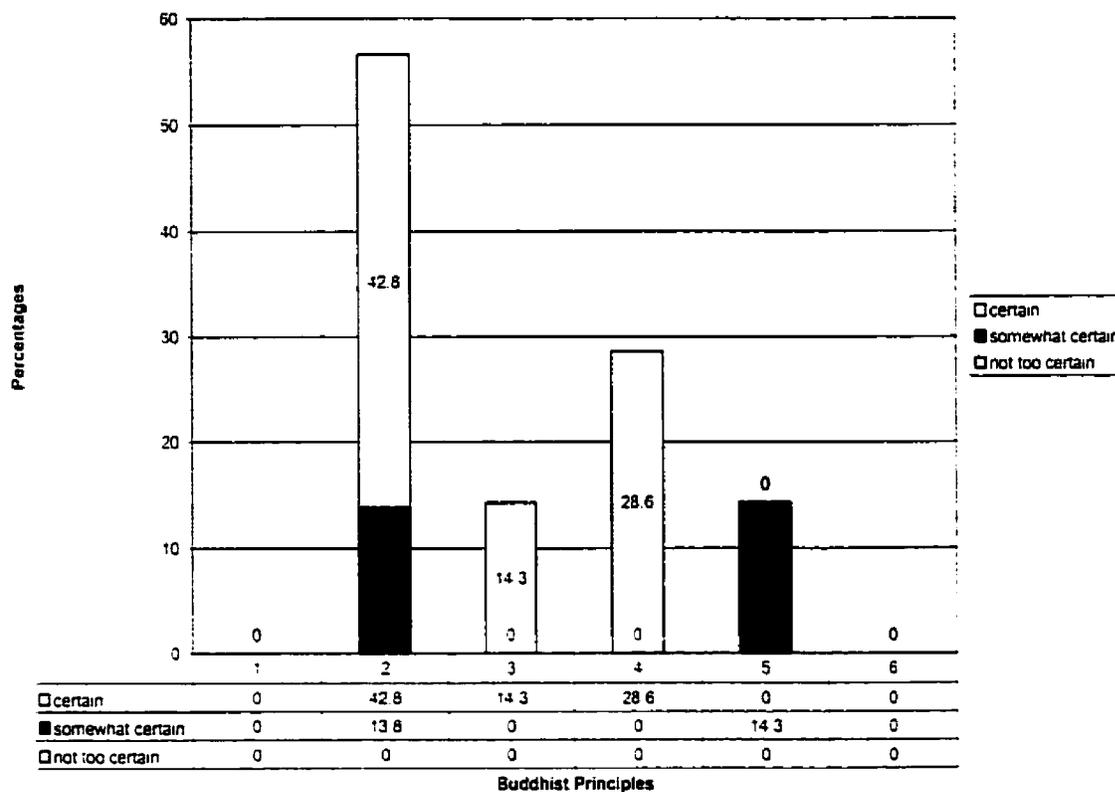


Figure 1 indicated that when Description and/or Exploration of the Personal Nature and Meaning of Feeling was identified in the sessions, 71% of the time Buddhist Principles were also present. Figure 2 provides an analysis of the presence of the Buddhist Principles. Clearly Buddhist Principle 2, Openness in the Present Moment, is associated with Description and/or Exploration of Feelings being present 57% of the time. The judges were certain of its' presence 42% of the time. Other Buddhist Principles also appeared, Compassion (4), 28%, and Experiencing without Evaluation (3), 14%, both with the judges' certainty. Interconnectedness (5) appeared 14% of the time with moderate certainty from the judges.

**Figure 3. Percentage of Frequency and Certainty of Buddhist Principles with Good Moment Two (Provision of Significant Information about Self and/or Interpersonal Relationship)**

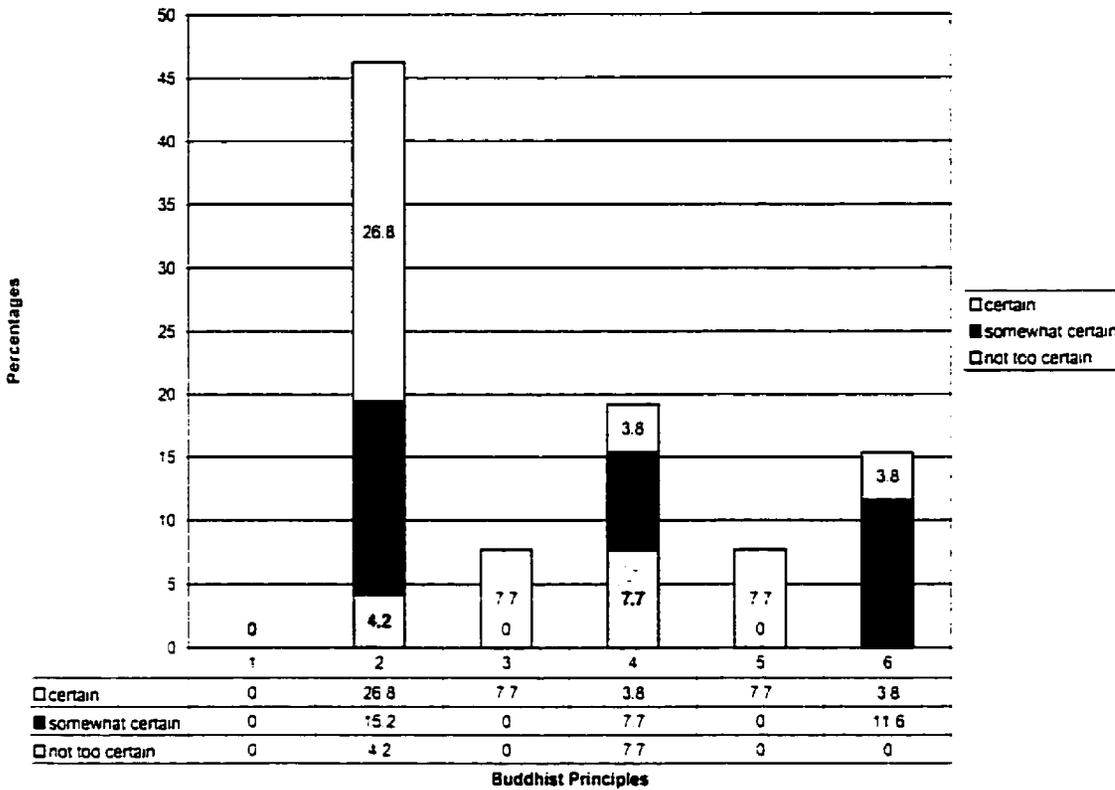


Figure 1 indicated that when Provision of Significant Information about Self and/or Interpersonal Relationship was identified in the sessions, 54% of the time Buddhist Principles were also present. Figure 3 provides an analysis of the presence of the Buddhist Principles. Buddhist Principle 2, Openness in the Present Moment, appears to be somewhat associated with Provision of Significant Information about Self and/or Interpersonal Relationship being present 46% of the time. The judges were certain of its' presence 27% of the time, somewhat certain 15% and not too certain 4% of the time. Other Buddhist Principles also appeared, Compassion (4), 19% but with differing levels of certainty and Experiencing without Evaluation (3) and Interconnectedness (5) both 8% of the time and with the judges' certainty. Sitting with Suffering (6) appeared 15% of the time with moderate and high certainty from the judges.

**Figure 4. Percentage of Frequency and Certainty of Buddhist Principles with Good Moment Three (New Level of Awareness Regarding the Possibility for Change)**

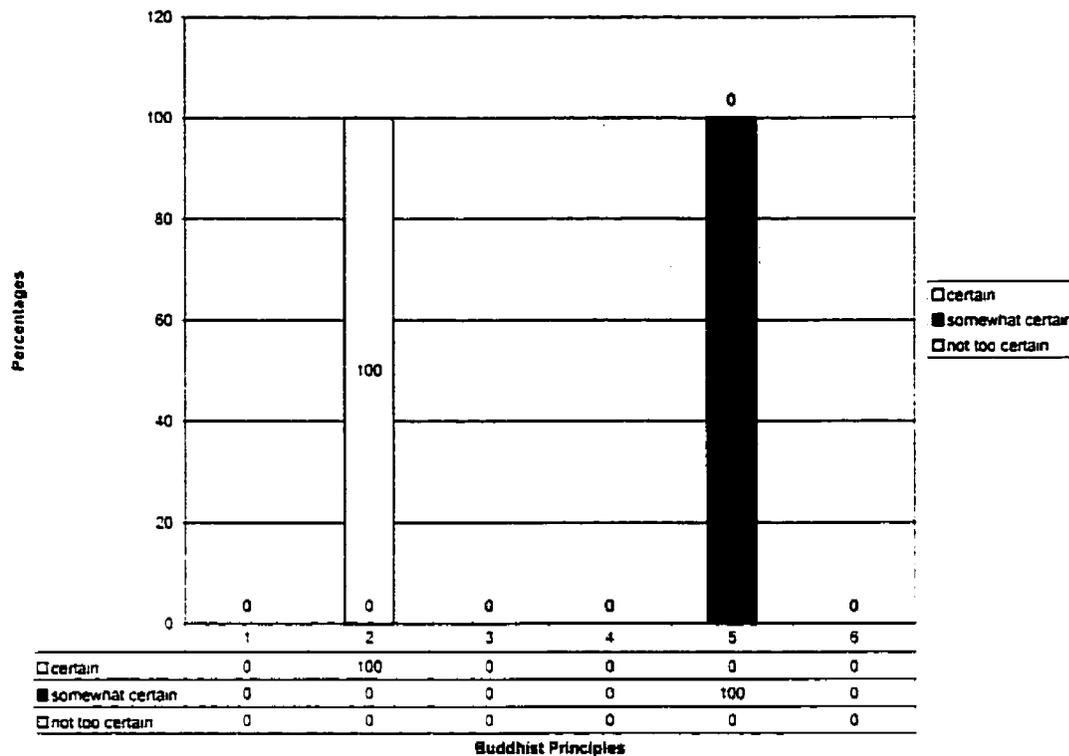


Figure 1 indicated that when New Level of Awareness Regarding the Possibility of Change was identified in the sessions, 100% of the time Buddhist Principles were also present. Figure 4 provides an analysis of the presence of the Buddhist Principles. Clearly Buddhist Principle 2, Openness in the Present Moment, is associated with New Level of Awareness Regarding the Possibility of Change being present 100% of the time with the judges' certainty. Interconnectedness (5) also appeared 100% of the time with low certainty from the judges.

**Figure 5. Percentage of Frequency and Certainty of Buddhist Principles with Good Moment Four (Experience of Bodily Felt Sense in the Moment)**

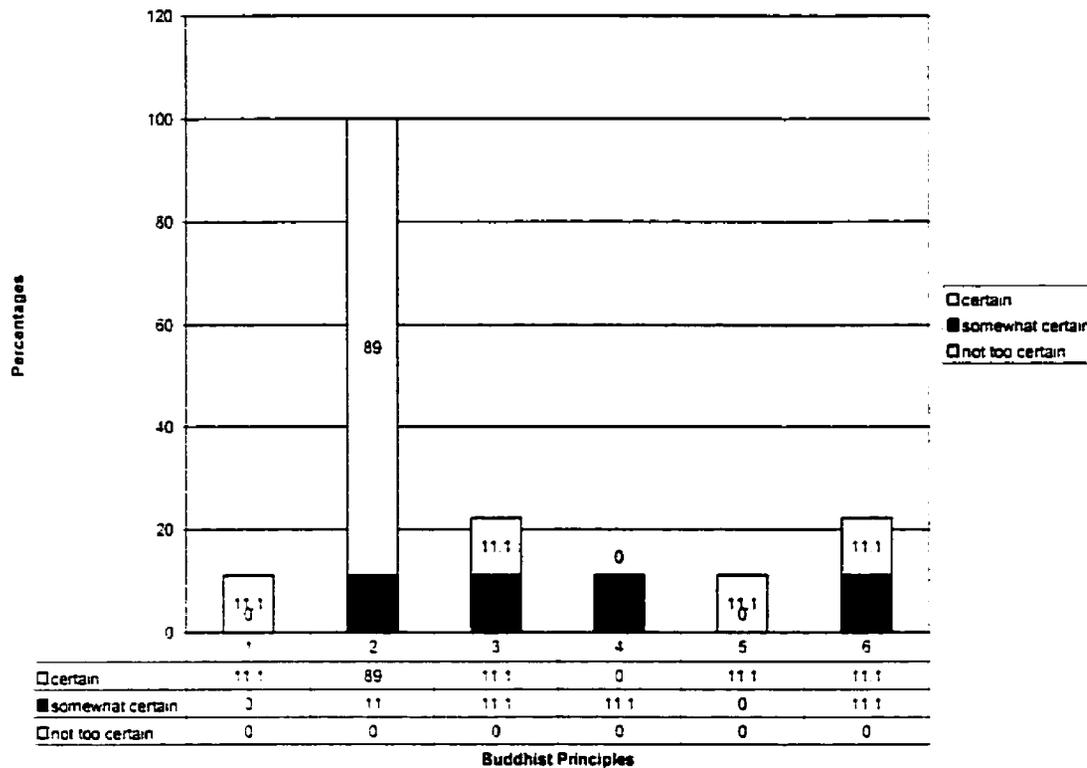


Figure 1 indicated that when Experience of Bodily Felt Sense was identified in the sessions, 100% of the time Buddhist Principles were also present. Figure 5 provides an analysis of the presence of the Buddhist Principles. Clearly Buddhist Principle 2, Openness in the Present Moment, is associated with Description and/or Exploration of Feelings being present 100% of the time. The judges were certain of its' presence 89% of the time. All the other Buddhist Principles also appeared. Flexibility of Self (1) and Interconnectedness (5) appeared 11% of the time with the judges' certainty. Compassion (4), appeared 11% of the time as well, but with moderate certainty. Experiencing without Evaluation (3), and Sitting with Suffering (6) both appeared 22% of the time, both with divided certainty from the judges.

**Figure 6.** Percentage of Frequency and Certainty of Buddhist Principles with Good Moment Five (Expressive Communication)

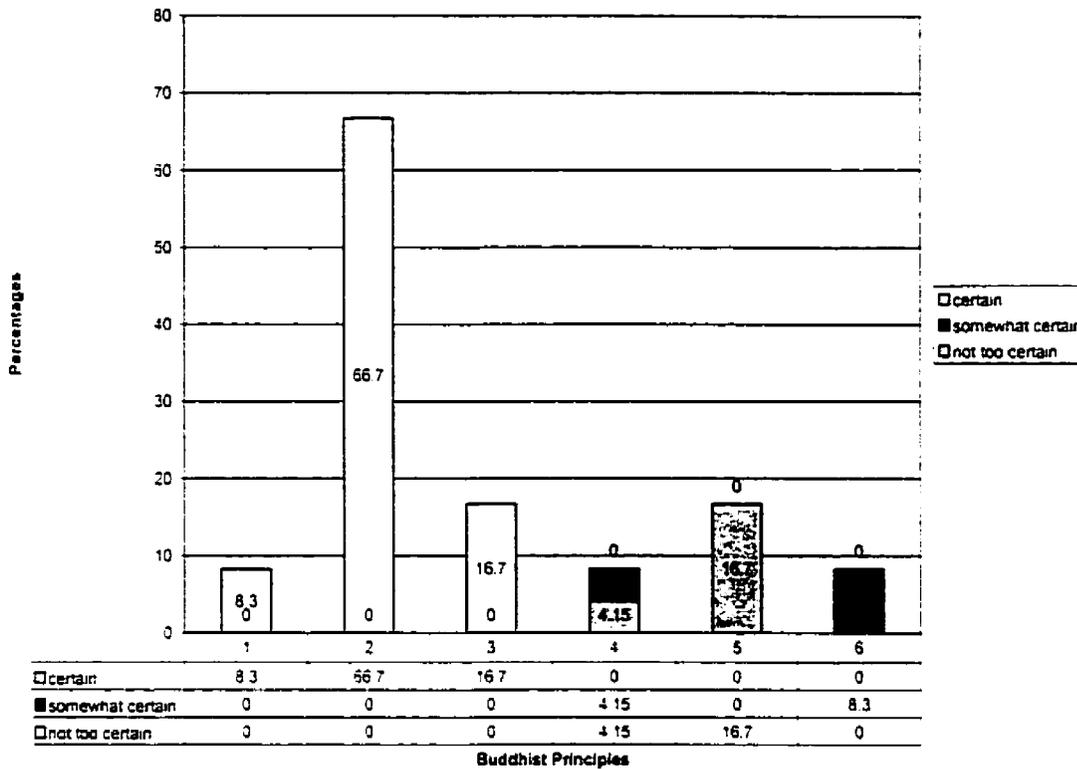


Figure 1 indicated that when Expressive Communication was identified in the sessions, 83% of the time Buddhist Principles were also present. Figure 6 provides an analysis of the presence of the Buddhist Principles. Clearly Buddhist Principle 2, Openness in the Present Moment, is associated with Expressive Communication being present 67% of the time, with complete certainty from the judges. All the other Buddhist Principles also appeared. Flexibility of Self (1) and Interconnectedness (5) appeared 8% and 17% of the time respectively, both with the judges' certainty. Compassion (4), appeared 8% of the time as well, but with moderate and low certainty. Experiencing without Evaluation (3), appeared 17% of the time with moderate certainty and sitting with suffering (6) appeared 8% of the time, with low certainty from the judges.

**Figure 7.** Percentage of Frequency and Certainty of Buddhist Principles with Good Moment Six (Expression of Insight)

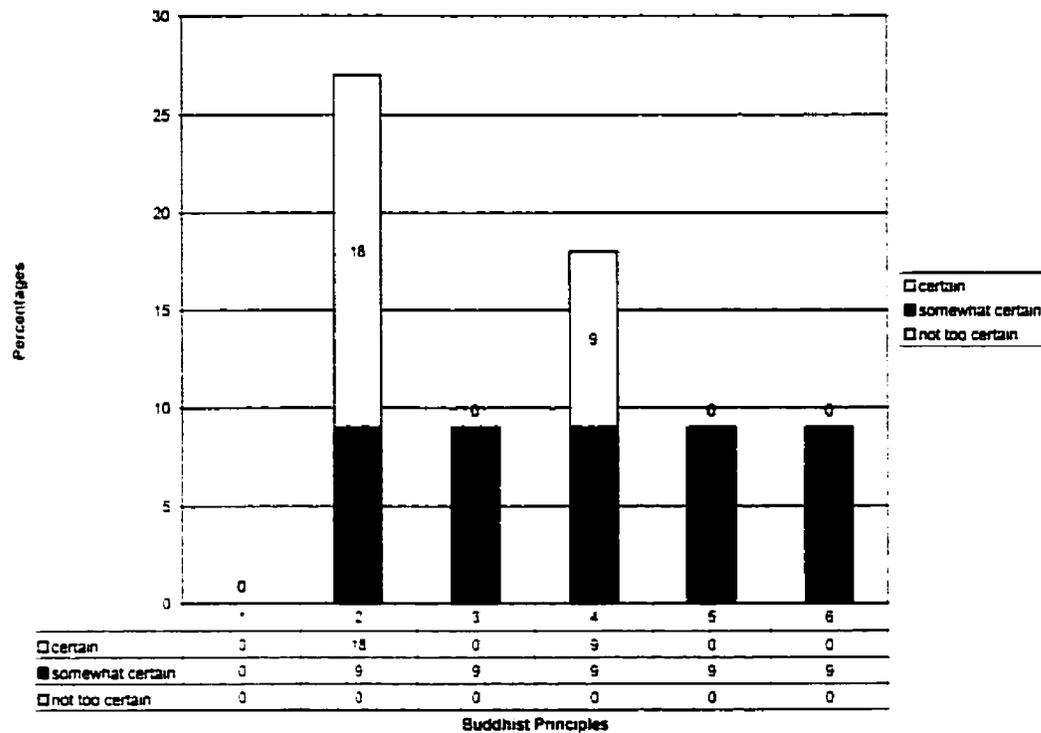


Figure 1 indicated that when Expression of Insight was identified in the sessions, 27% of the time Buddhist Principles were also present. Figure 7 provides an analysis of the presence of the Buddhist Principles. Buddhist Principle 2, Openness in the Present Moment, has limited presence with Expression of Insight being present 27% of the time, with the judges being certain 18% of the time and somewhat certain 9% of the time. Other Buddhist Principles also appeared. Experiencing without Evaluation (3), Interconnectedness (5), and Sitting with Suffering (6) each appeared 9% of the time respectively, all with moderate certainty. Compassion (4), appeared 18% of the time as well, but with moderate and high certainty.

**Figure 8.** Percentage of Frequency and Certainty of Buddhist Principles with Good Moment Seven (Expression of Strong Feeling Towards Therapist)

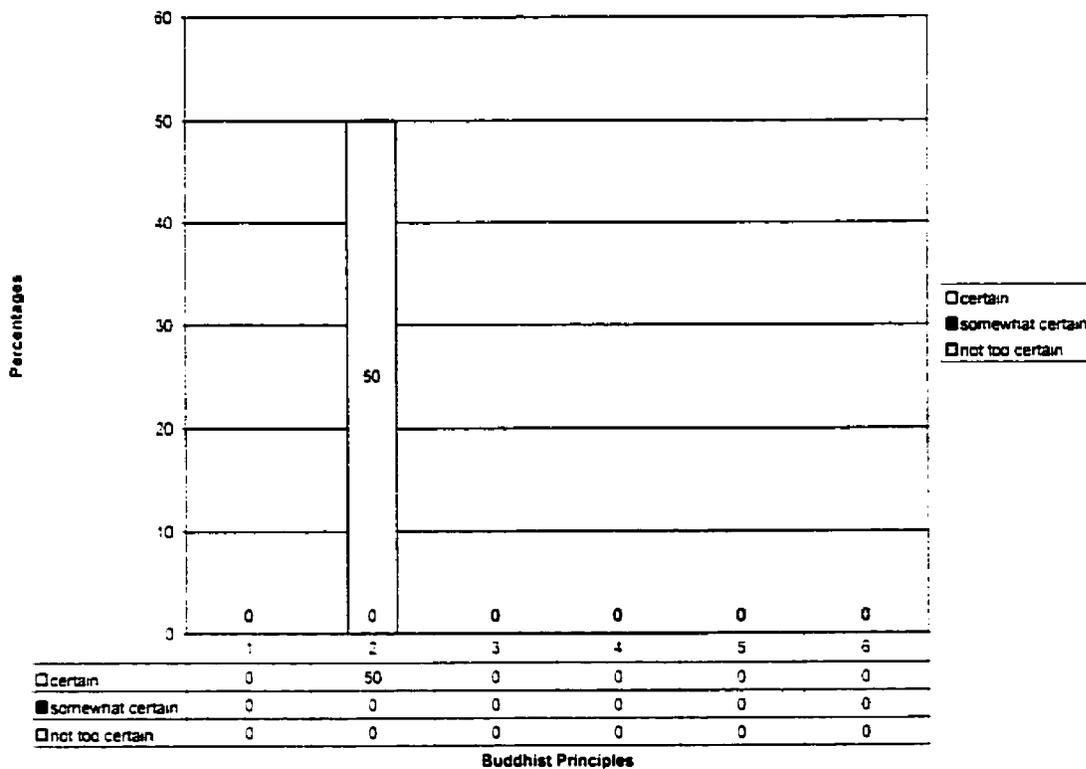


Figure 1 indicated that when Expression of Strong Feeling Towards the Therapist was identified in the sessions, 50% of the time Buddhist Principles were also present. Figure 8 provides an analysis of the presence of the Buddhist Principles. Buddhist Principle 2, Openness in the Present Moment, appears to be somewhat associated with expression of strong feeling towards the therapist being present with certainty 50% of the time.

**Figure 9.** Percentage of Frequency and Certainty of Buddhist Principles with Good Moment Eight (Expression of Desire for Change)

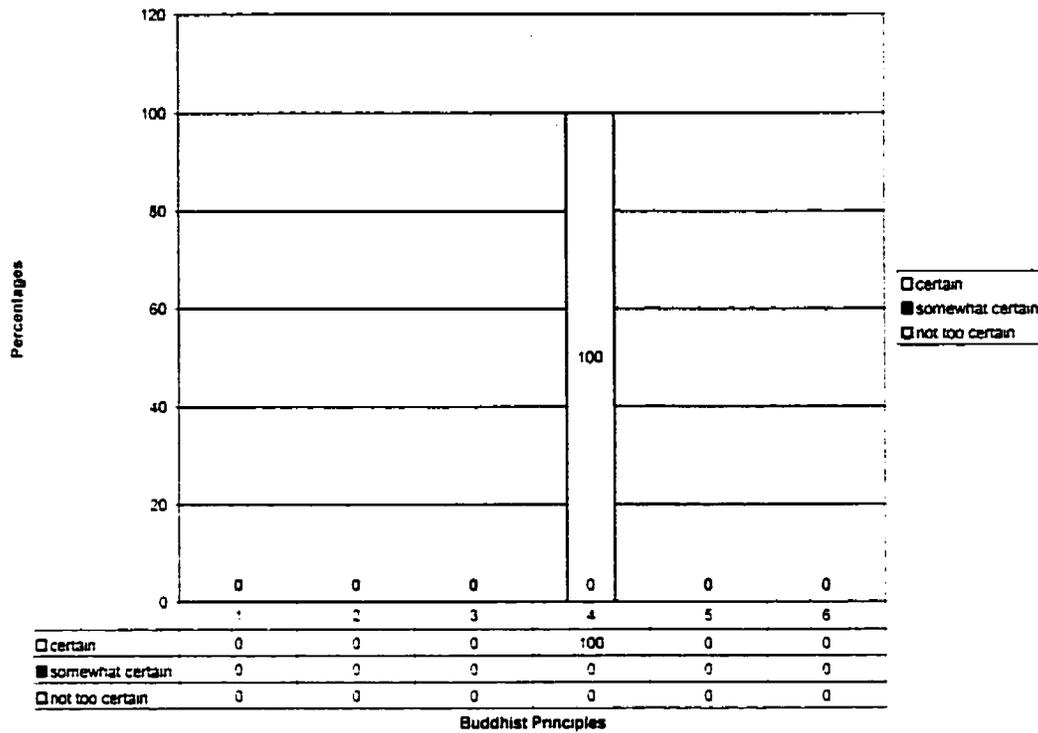


Figure 1 indicated that when Expression of Desire for Change was identified in the sessions, 100% of the time Buddhist Principles were also present. Figure 9 provides an analysis of the presence of the Buddhist Principles. Clearly, Buddhist Principle 2, Openness in the Present Moment, is associated with expression of Desire for Change being present with certainty 100% of the time.

**Figure 10.** Percentage of Frequency and Certainty of Buddhist Principles with Good Moment Nine (Understanding/Exploration of a New Way of Being in the Moment)

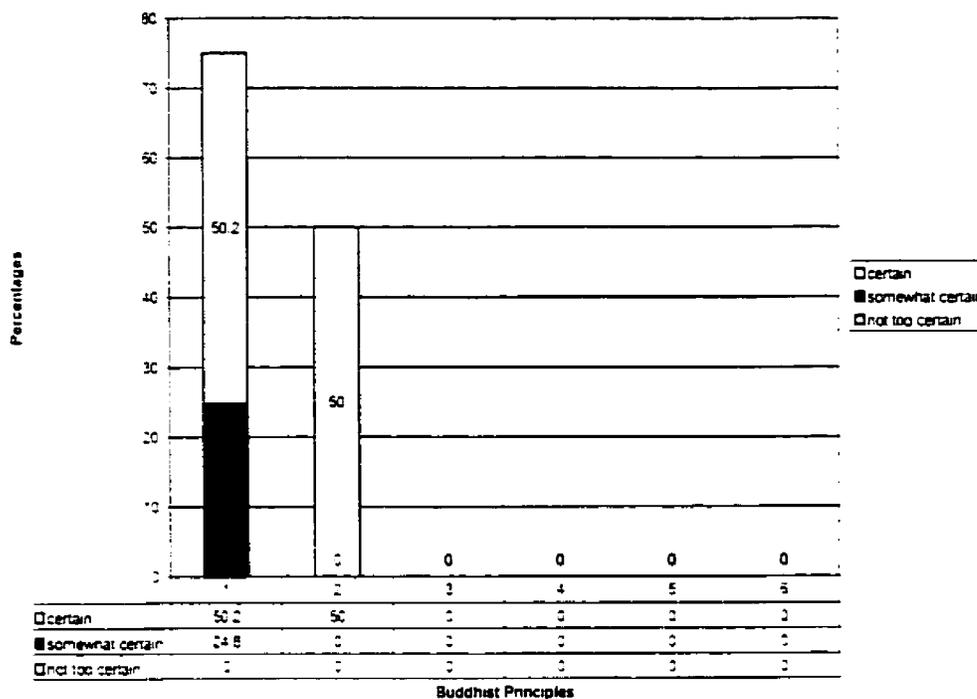


Figure 1 indicated that when Undertaking/Exploration of New Ways of Being in the Moment was identified in the sessions, 75% of the time Buddhist Principles were also present. Figure 10 provides an analysis of the presence of the Buddhist Principles. Clearly Buddhist Principle 1, Flexibility of Self, is associated with Undertaking/Exploration of New Ways of Being in the Moment present 75% of the time. 50% of the time the judges were sure of its presence and 25% moderately sure. Buddhist Principle 2, Openness in the Present Moment, was present with certainty 50% of the time.

**Figure 11.** Percentage of Frequency and Certainty of Buddhist Principles with Good Moment Ten (New Level of Hone'sty in the Therapeutic Situation)

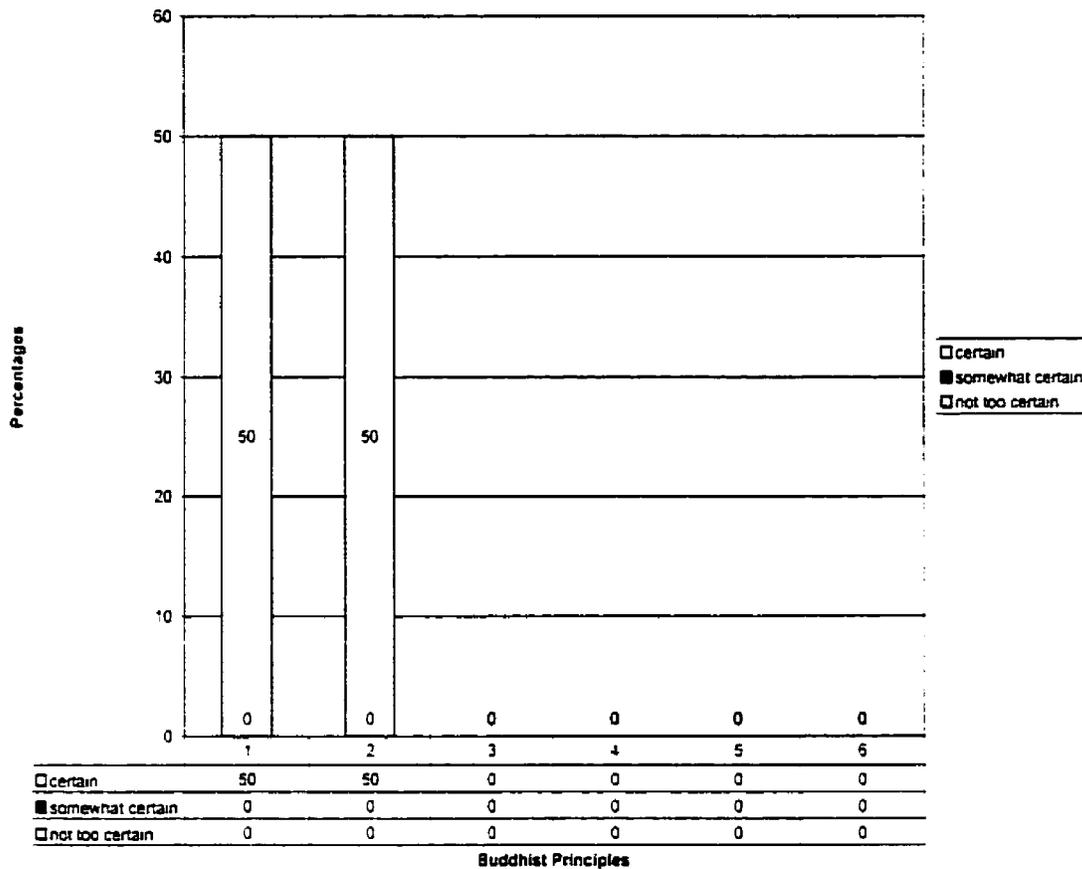


Figure 1 indicated that when a New Level of Hone'sty in the Therapeutic Situation was identified in the sessions, 50% of the time Buddhist Principles were also present. Figure 11 provides an analysis of the presence of the Buddhist Principles. Buddhist Principles 1, Flexibility of Self, and 2, Openness in the Present Moment, appear to be associated with a New Level of Hone'sty in the Therapeutic Situation being present, with certainty, 50% of the time.

**Figure 12.** Percentage of Frequency and Certainty of Buddhist Principles with Good Moment Eleven (Confrontation/Disagreement with the Therapist)

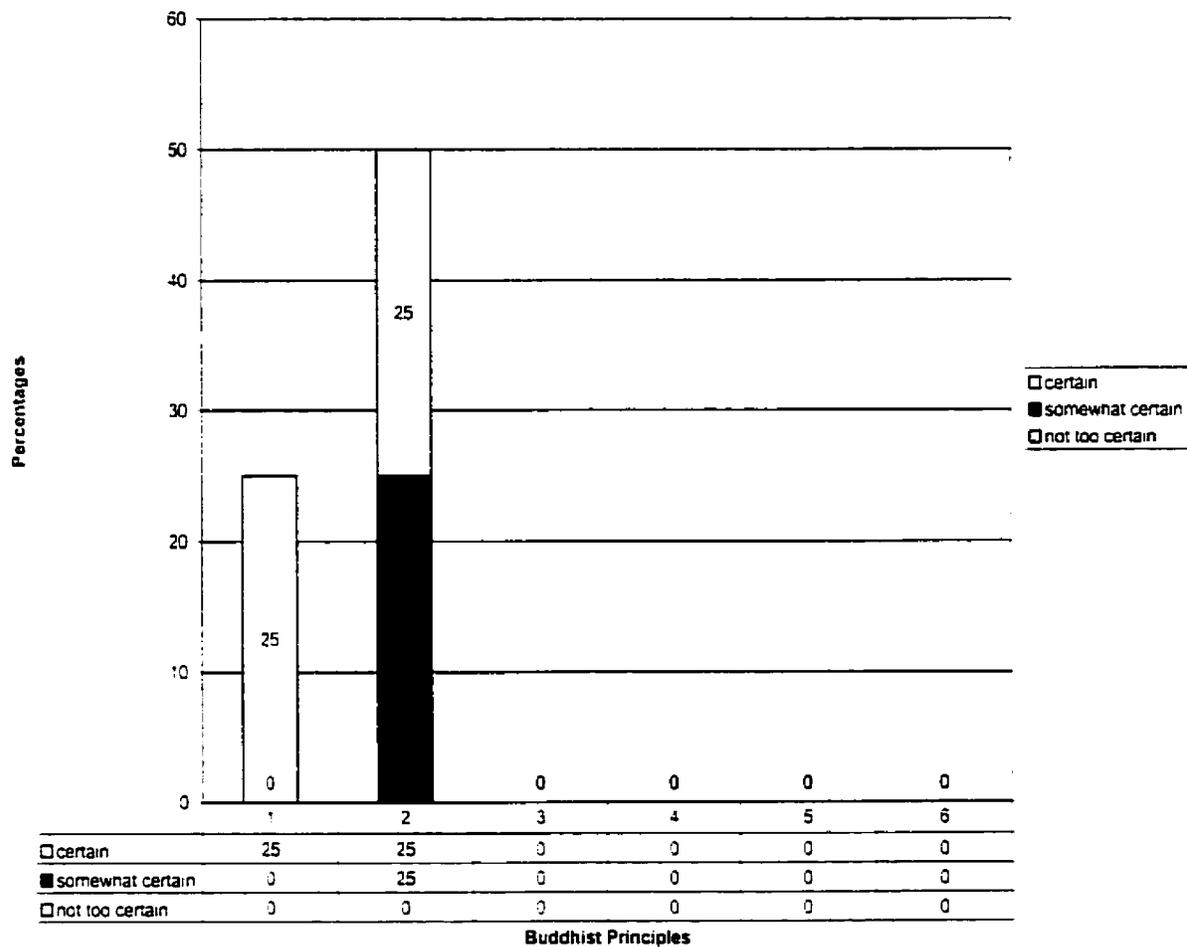


Figure 1 indicated that when Confrontation/Disagreement with the Therapist was identified in the sessions 50% of the time Buddhist Principles were also present. Figure 12 provides an analysis of the presence of the Buddhist Principles. Buddhist Principles 1. Flexibility of Self, and 2. Openness in the Present Moment, appear to be associated with Confrontation/Disagreement with the Therapist. Flexibility of Self is present, with certainty, 25% of the time and Openness in the Present Moment present 50% of the time with moderate to high certainty.

**Percentage of Frequency and Certainty of Buddhist Principles with Good Moment Twelve  
(Description of Significant Impact of Therapy Session)**

Figure 1 indicated that when Description of Significant Impact of Therapy Session was identified in the sessions, Buddhist Principles were never present. Consequently a figure is not indicated.

**Figure 13. Percentage of Frequency and Certainty of Buddhist Principles with Good Moment Thirteen (Expression of Welcomed General State of Well Being)**

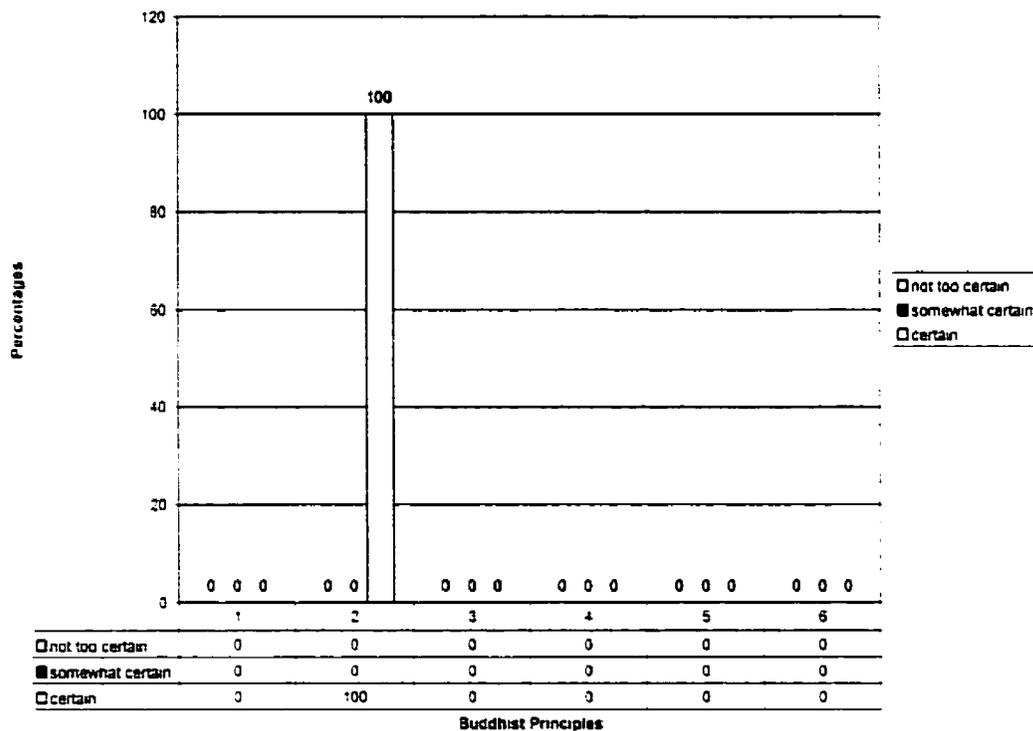


Figure 1 indicated that when Expression of Welcomed General State of Well Being was identified in the sessions, 100% of the time Buddhist Principles were also present. Figure 13 provides an analysis of the presence of the Buddhist Principles. Clearly Buddhist Principle 2, Openness in the Present Moment, is associated with Expression of Welcomed General State of Well Being. It was present, with certainty, 100% of the time.

Percentage of Frequency and Certainty of Buddhist Principles with Good Moment Fourteen  
(Movement to the Core of the Issue)

Figure 1 indicated that when Movement to the Core of the Issue was identified in the sessions, Buddhist Principles were never present. Consequently a figure is not indicated.

**Figure 14.** Percentage of Frequency and Certainty of Buddhist Principles with Good Moment Fifteen (Experiencing in the Moment)

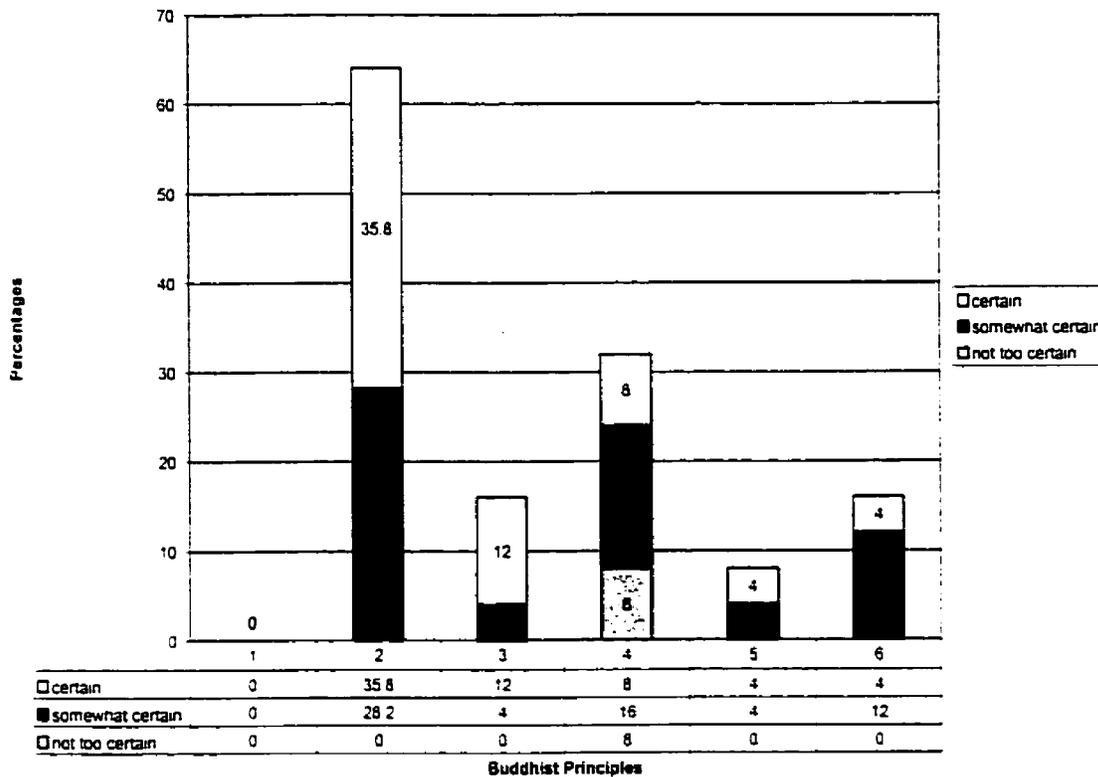


Figure 1 indicated that when Experiencing in the Moment was identified in the sessions, 68% of the time Buddhist Principles were also present. Figure 14 provides an analysis of the presence of the Buddhist Principles. Clearly Buddhist Principle 2, Openness in the Present Moment, is associated with Experiencing in the Moment being present 64% of the time, with moderate and high certainty from the judges. Other Buddhist Principles also appeared. compassion (4) appeared 32% of the time, Experiencing without Evaluation (3) Sitting with

Suffering (6) appeared 16% of the time and Interconnectedness (5) appeared 8% of the time. All appeared with variable levels of certainty.

**Figure 15. Percentage of Frequency and Certainty of Buddhist Principles with Good Moment Sixteen (Openness to the Emergence of Previously Warded off Material)**

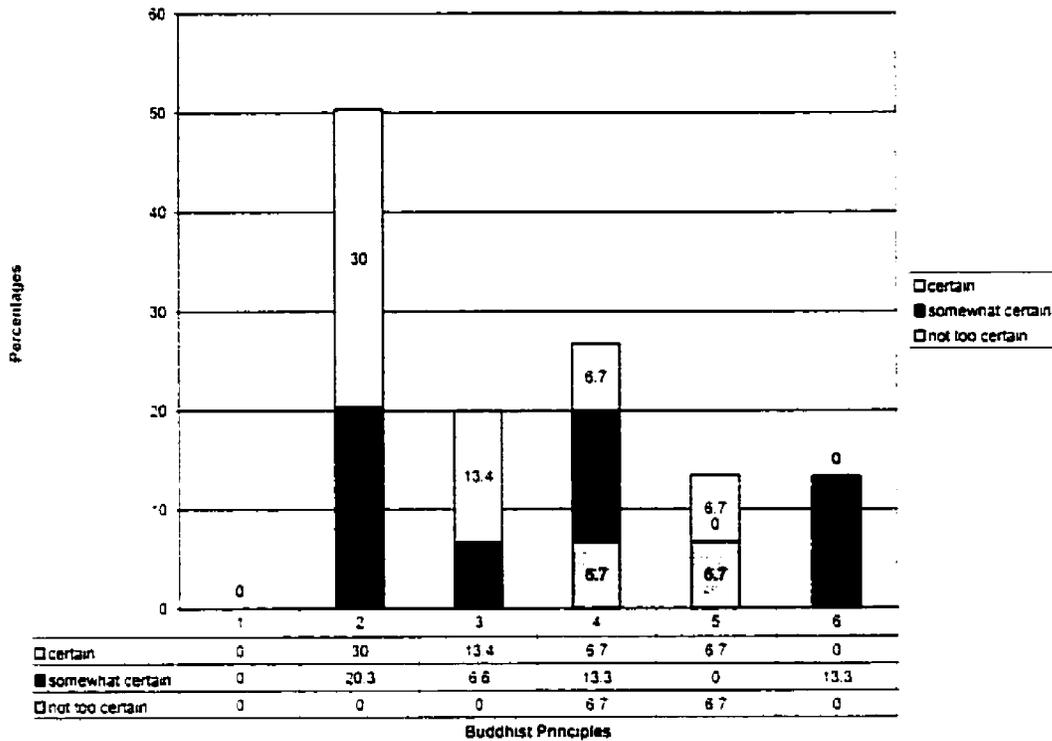


Figure 1 indicated that when Openness to the Emergence of Previously Warded off Material was identified in the sessions, 60% of the time Buddhist Principles were also present. Figure 15 provides an analysis of the presence of the Buddhist Principles. Buddhist Principle 2, Openness in the Present Moment, appears to be associated with Openness to the Emergence of Previously Warded off Material being present 53% of the time, with moderate and high certainty from the judges. Other Buddhist Principles also appeared. Compassion (4) appeared 27% of the time. Experiencing without Evaluation (3) appeared 20% of the time and Sitting with Suffering (6) and Interconnectedness (5) each appeared 13% of the time. All appeared with variable levels of certainty.

Each Buddhist Principle is meant to be a distinct category. As was found during the qualitative analysis of the session however, the judges at times found more than one Buddhist Principle to be present during some segments. This raised the question ‘How distinct are the categories of Buddhist Principles?’. In other words, it is possible that if a particular Buddhist Principle was always present with another Buddhist Principle, then those two may not be distinct, but instead manifestations of the same phenomenon. In order to address the question of distinctness of categories of Buddhist Principles, coefficients of concordance were calculated using Kendall’s Tau (Norman & Streiner, 1997). One aim of the present study was to determine the percentage of frequency of Buddhist Principles with types of Good Moments. Kendall’s Tau, being a nonparametric measure of association, was an appropriate statistical tool for the present study.

Table 8

Coefficients of Concordance of Buddhist Principles

Buddhist Principles	1	2	3	4	5	6
1	1.0					
2	.149	1.0				
3	-.089	.217*	1.0			
4	-.119	.261*	.221*	1.0		
5	-.078	.108	-.024	-.005	1.0	
6	-.089	.166	.112	.615*	-.113	1.0

The coefficient of concordance of the Buddhist Principles indicates that most Buddhist Principles are independent of one another and also that some are correlated. Kendall’s Tau

correlations indicate that Buddhist Principle 2, Openness in the Present Moment, is significantly correlated with Experiencing without Evaluation (3) and Compassion (4). Further Experiencing without Evaluation and Compassion (4) are correlated with one another. Lastly, Compassion (4) and Sitting with Suffering (6) are significantly correlated with one another. Flexibility of Self (1) and Interconnectedness (5) are not correlated with any other Buddhist Principles.

**What is the level of agreement between judges' identification of Good Moments, clients articulation of Good Moments, and therapists' articulation of Good Moments?**

Including different perspectives and sources of data is valuable to a research project. Each client was asked to identify two significant in-session events. With twelve clients, twenty-four Good Moments were anticipated. Two problems emerged with the questionnaire data: clients did not answer all the questions, and clients misinterpreted the questions by providing a summary of the session instead of good in-session moments. Consequently the twelve clients identified twenty Good Moments.

Of the twenty moments identified by the clients, nine of them were also identified by the judges. There was a 45% agreement rate between clients and judges. Most of the remaining eleven Good Moments categorized into the sixteen types of Good Moments already articulated. Three Good Moments did not previously appear and conformed to create a seventeenth category of Good Moments labeled "Client is Uncovering a Way to Combat the Problem".

Therapists were also asked to identify important in-session events. Each therapist was asked to identify one event per session. Since twelve sessions comprised the data, twelve therapist identified Good Moments were anticipated. Due to similar problems with the therapist questionnaire data, eleven Good Moments were identified.

Of the eleven Good Moments identified by the therapists, the judges also identified five of them. There was a 45% agreement rate between therapists and judges. All of the remaining six Good Moments categorized into the sixteen types of Good Moments already articulated.

An agreement rate of 27% was found between the clients and therapist. An agreement rate of 9% was found between clients, therapist, and judges.

This chapter provided the results of the present study. In sum, sixteen different types of Good Moments emerged for the twelve therapy session. An additional Good Moment was identified in the client responses to the IEQ. Fourteen of the sixteen types of Good Moments were found to be associated with various Buddhist Principles. The next chapter will discuss the meaning of the Good Moments and their associations with Buddhist Principles.

## CHAPTER V– DISCUSSION

The purpose of the present study was to determine whether Western approaches to psychotherapy could be informed by Buddhist psychology. This was done through an exploratory study examining whether in-session Good Moments occurred alongside Buddhist Principles in therapist methods or operations. The main findings of the present study are as follows: a) 16 different types of Good Moments emerged from coding the twelve therapy sessions and an additional type of Good Moment emerged from client responses to questionnaires, b) some of the Buddhist Principles of Change were found to be significantly correlated with one another, c) the six Buddhist Principles were found to have different percentages of frequency with each of the different types of Good Moments, with Openness in the Present Moment having presence with nearly all of the different types of Good Moments, d) there was a 45% agreement rate between clients and judges, a 45% agreement rate between therapists and judges, and a 27% agreement rate between clients and therapists.

This chapter will discuss each of the findings in turn. Sections follow that outline the limitations of the current study, implications for counselling practice, implications for counsellor education, and recommendations for future research.

### Good Moments in Therapy

A number of studies have implemented the Category System of Good Moments (Boulet, Souliere, & Sterner, 1993; Fitzpatrick, Peternelli, Stalikas, & Iwakabe, 1999; Mahrer, Boulet, & Stalikas, 1987; Mahrer, Lawson, Stalikas, & Schachter, 1990; Mahrer, Stalikas, Fairweather, & Scott, 1989; Mahrer, White, Howard, Gagnon, & MacPhee, 1992; Stalikas, DeStefano, & Bernadelli, 1997). Good Moments have previously generally been defined as exceptional, noteworthy, significant, impressive client change process, improvement, progress, or movement.

In the present study the idea of clear and definite movement or change was added to the definition in order to provide additional focus and clarity for the research team.

The increased focus within the psychotherapy research literature on the study of in-therapy change led to the development of the Category System of Good Moments (Mahrer, 1985; Mahrer & Nadler, 1986). The instrument has been used to identify the kinds of in-therapy moments indicated by a wide range of therapeutic approaches as reflective of significant client change or process that facilitates progress or movement in therapy (Boulet et al., 1992). The number of studies that have implemented the idea of examining in-session client Good Moments lend credibility to the value of this approach to psychotherapy process research. Studies to date fall into two groups. One group examines Good Moments found in sessions of therapist representing therapeutic disciplines, specifically Gestalt therapy (Boulet et al., 1993; Stalikas & Fitzpatrick, 1995; Mahrer et al., 1992), Rational-Emotive psychotherapy (Mahrer et al., 1987), and Experiential psychotherapy (Mahrer et al., 1987). The other group of studies examined the relationship between clients' strength of feeling or feeling level and the occurrence of in-session Good Moments (Fitzpatrick et al., 1999; Mahrer et al., 1989). All of these studies implemented the Category System of Good Moments to identify in-session Good Moments, but none of them added categories of Good Moments to the already existing measure. Additionally, all of these studies included only the perspectives of trained judges in identifying Good Moments. One study, using the perspective of trained judges, developed a category system of Good Moments specifically relevant to Gestalt therapy (Boulet, Souliere, Sterner, & Nadler, 1992).

Studying in-session client Good Moments is an effective way to begin examining helpful psychotherapy process for two reasons. First, it identifies and articulates what is considered good client process, providing clinicians with an idea of sought after client processes. Secondly, it

identifies a place to begin examining therapist method or operation in order to assist clinicians with how to bring about good client change processes.

### Common Good Moments

The Category System of Good Moments is comprised of twelve nominal categories. One of the purposes of this study was to identify whatever kinds of Good Moments were judged to be present in the twelve sessions studied. Consequently, this study identified some of the twelve items in the Category System of Good Moments, and identified some items not articulated by the measure. Nine of the twelve types of Good Moments articulated in the measure were also found in the present study. They are:

- 1) Provision of significant information about self and/or interpersonal relationship.
- 2) Description/exploration of the personal nature and meaning of feeling.
- 3) Emergence of previously warded off material.
- 4) Expression of insight.
- 5) Expressive communication.
- 6) Expression of strong feeling toward therapist.
- 7) Undertaking new way of being and behaving in the imminent extratherapy life situation.
- 8) Description of significant impact of therapy session or Expression of reported changes in target behaviours. and.
- 9) Expression of a welcomed general state of well-being.

### New Good Moments

The present study identified sixteen types of Good Moments, seven other than those identified by the Category System of Good Moments. They are:

- 1) New level of awareness regarding the possibility for change,

- 2) Experience of bodily felt sense in the moment,
- 3) New level of honesty in the therapeutic situation,
- 4) Expression of desire for change,
- 5) Confrontation/disagreement with therapist,
- 6) Movement to the core of the issue. and,
- 7) Experiencing in the moment.

Four of the seven new categories. Awareness of the Possibility of Change, Expression of Desire for Change, Movement to the Core of the Issue, and New Level of Honesty in the Therapeutic Situation only appeared one or two times in the twelve sessions. Despite their low frequency they are reflective of good client change process.

Experiencing in the Moment had the second highest level of frequency of the categories of Good Moments identified. It is noteworthy that Experiencing in the Moment occurred with such high frequency (20.5%), and was not previously articulated by the Category System of Good Moments.

Explanations for the emergence of new Good Moments. There are a few explanations for the emergence of seven new categories. The Category System of Good Moments and all subsequent research implementing the measure used sessions of therapy found in the American Academy of Psychotherapists Tape Library. This means that old sessions with well-known therapists reflecting specific traditions were used to create the measure. Subsequent implementation of the measure was also performed on the same kinds of tapes. The measure is pan-theoretical and was developed from studying sessions by Client-Centered, Gestalt, Rational-Emotive, and Experiential psychotherapists. The current study is the first to implement the measure on sessions with current therapists practicing in the present day community. Also a

fuller range of therapeutic traditions were represented in the current study, including Solution Focused, Integrative Body Psychotherapy, Humanistic, Interpersonal, and Cognitive-Behavioural orientations.

The present study also implemented the Category System of Good Moments as a guide to understanding and identifying Good Moments. Some other studies seem to have approached the measure as a static and complete measure of good client process. Approaching a measure as a guide allows for flexibility and growth of it as a research tool (Mahrer, 1999).

In addition to judges' perspectives of Good Moments, the present study also asked clients and therapists to identify what they believed to be meaningful in-session events. As past studies analyzed old library tapes, therapist and client perspectives could not be considered. In the present study, results indicate that therapists' perspectives did not add anything to the data in terms of types of client Good Moments. However clients' perspectives provided additional information. Three different clients identified a good in-session moment as "Uncovering a Way to Combat the Problem". Uncovering a Way to Combat the Problem indicates that clients experience therapy as helpful when they feel that they have developed a tool or plan for addressing approaching the issue that led them to seek counselling. It seems logical to include clients' perspectives when trying to identify in-session Good Moments for clients. This result indicates that client perspectives are valuable to process research because valuable information can get lost when researchers do not include their perspectives.

In Sum, seven new categories of Good Moments emerged in this study. An eighth category emerged when clients' perspectives were considered, lending credibility to the idea that clients' perspectives provide valuable information in the study of psychotherapy process. The next section will discuss the results of the findings of Buddhist Principles in therapy.

## Buddhist Principles in Therapy

### Compassion

In order for a measure of nominal categories to be useful, the items should be distinct, measuring different things. The coefficients of concordance of Buddhist Principles illustrated in Table 8, provided information regarding the correlation of the six Buddhist Principles with one another. Compassion (Buddhist Principle four) is the idea of the therapist treating the client gently, tenderly, with kindness, and/or with firmness, or alternatively assisting the client in treating him/herself this way. It effectively closes the distance between self and other. Implementing the Category System of Buddhist Principles resulted in Compassion being correlated with three other Buddhist Principles. It was moderately correlated with Sitting with Suffering (Buddhist Principle six) at a level of 0.615. The key to Sitting with Suffering is in the therapist's ability to be comfortable with the client's suffering without rushing to change it. Though two different ideas, Compassion and Sitting with Suffering, are similar in that both interventions are about closing the gap between individuals – being together in the experience. The difference between the items is that Sitting with Suffering requires that the therapist be present with the client's pain, that is, the object holding the illusion of belonging to the client. Compassion is a way of treating the client directly, not through an object.

Compassion had a weak correlation with Openness in the Present moment (Buddhist Principle two) at a level of 0.261. Openness in the Present Moment is essentially assisting the client in being in the here and now and enabling the person to let go of boundaries, limits, or expectations that he/she normally places on his/her experience of self. The relationship between Compassion and Openness in the Present Moment may be reciprocal. In order to assist the client

to be open in the present moment, it is helpful to also feel and express compassion for and to that person. The attitude of compassion assists the therapist in also being open in the present moment.

Compassion also had a weak correlation with Experiencing without Evaluation (Buddhist Principle three) at a level of 0.221. Experiencing without Evaluation is an emphasis on pure experience without trying to understand or intellectualize about the experience. Like Experiencing without Evaluation, Compassion may assist the therapist in helping the client to accept the experience. Compassion occurs at an experiential level and as such it may mean that the therapist is involved at an experiential versus intellectual level.

The correlation of Compassion with three other items on the category system of Buddhist Principles suggests that it may be best described as a way of being, and not solely as an intervention. It is speculative that it should not be listed as a distinct category, rather, it may be that other items should be expanded so as to include a component of Compassion in each of them.

In order to consider the feasibility of the suggestion that Compassion be considered as a way of being, it is necessary to consider the general and overall presence of the item. Results (Table 7) indicate that Compassion was rated as present with only eight of the sixteen types of Good Moments. Further, with the vast majority of the types of Good Moments, Compassion had a low percentage of frequency. These results are counter-intuitive to the possibility that Compassion should be considered more as a way of being and less as an intervention.

The arguments against removing Compassion as a category are strong. Though correlated with other Buddhist Principles, the correlations are moderate to weak and Compassion continues to have components to it that are unique and distinct. The idea of it being used as an intervention to join with the experience of another whether through gently kindness or firm confrontation

makes it a unique and distinct category. It is also the only category that reflects a feeling and/or attitude toward the other person. All the other categories are about assisting clients either to approach themselves or their current circumstance differently. Despite the correlations of Compassion with other Buddhist Principles, it is asserted that the Category System of Buddhist Principles is a more complete presentation and measure of Buddhist Principles when Compassion is included in it as a separate and distinct item.

Compassion as universal principle of change. Compassion has some components that are similar to Roger's (1980) unconditional positive regard as espoused by Person-Centred psychotherapies. Unconditional positive regard has also been called 'acceptance', 'respect', 'liking', or 'prizing'. The quality is a basic attitude of liking or respecting directed at the client as a whole person (Bohart, 1995). The belief is that when clients feel liked and prized as people, they begin to feel safe to explore their experience and take a more objective look at their behaviour (Bohart, 1995). This assists clients in distinguishing between their intrinsic worth as persons and their dysfunctional ways of currently experiencing and behaving. Like unconditional positive regard, Compassion may sometimes be firm and/or confrontational. It is necessary to note that the therapist-participants were implementing methods or operations as they normally would with no knowledge that this study would be looking at Compassion. Therefore, it is likely that they were operating from the principle of unconditional positive regard.

Compassion involves unconditional acceptance, espoused by Rogers as being intrinsically therapeutic (1980). He wrote, "To be with another in this way means that for the time being, you lay aside your own views and values in order to enter another's world without prejudice. In some sense it means to lay aside your self" (Rogers, 1980, p.143). One purpose of this study was to determine whether Western psychologies and psychotherapies could be

informed by Buddhist psychology. Secondary to that purpose, the results seem also to have helped identify change processes that may be now deemed universal because of their support from both Eastern and Western perspectives.

Compassion is a fundamental principle, at the core of Buddhist philosophy, about the kind of attitude and approach one benefits from fostering toward self and other. Compassion provides one with a bridge to the outside world (Trungpa, 1973). Compassion, though warm and loving, is also ruthless in its honesty because the purpose of it is not to protect one's unhelpful ego, but promote and bring honest reflection of it. It is the basic and primary role and purpose of compassion in the complete Buddhist philosophy that supports its inclusion in the Category System of Buddhist Principles. The common themes between Compassion and Humanistic unconditional positive regard suggest that compassion may be a universal change process.

Compassion and the therapeutic alliance. The therapeutic alliance has been deemed to be a quintessential integrative variable in the area of psychotherapy integration because its importance does not lie within one school of thought (Wolfe & Goldfried, 1988). The working alliance has been considered essential to the therapeutic relationship. It was first enunciated by Freud (1910) as having two complementary aspects: the therapist's understanding and feeling well-disposed toward the patient and the therapist's encouragement of the patient's warm feelings toward the therapist. There has been a great deal of empirical data strongly supporting the therapeutic efficacy of the working alliance (Dierick & Lietaer, 1990; Gaston, Marmer, Gallagher, & Thompson, 1991; Luborsky, Barber, & Crits-Cristoph, 1990; Orlinsky & Howard, 1986). Horvath and Symonds (1991) most clearly evidenced support for the working alliance in a meta-analysis of twenty-four studies. They found a small, but reliable effect that was similar across different schools of psychotherapy and across a wide range of diagnostic categories. In

spite of knowing that the working alliance is a carrier of therapeutic effects, what constitutes the best working alliance and how to best achieve it is unknown (Weinberger, 1995). Much has been written theoretically, but none with empirical support.

Though the present study had no intention of examining the therapeutic relationship, it may have inadvertently uncovered Buddhist Compassion as a change process that exists within the therapeutic relationship and working alliance. Support for Compassion as a universal principle of change comes from the fact that it was found in the methods and operations of Western psychotherapists and that it has theoretical origins rooted in Eastern philosophy.

Of all the Buddhist Principles, it is the only one that focuses on the therapist's attitudes toward the client. Moreover, it was judged as being present with half of the different types of Good Moments identified, clearly signifying that Compassion is a helpful component of good client process.

#### Openness in the Present Moment

Openness in the Present Moment (Buddhist Principle two) was also correlated with two other Buddhist Principles, Compassion as discussed, and Experiencing without Evaluation (Buddhist Principle three) at a level of .217. Though two different principles, upon close examination it is not difficult to see the relationship between Openness in the Present Moment and Experiencing without Evaluation. Openness in the Present Moment requires that the therapist assist the clients in allowing themselves (open) to experience in the here and now (present moment). It logically follows that once people open to the experience, that they may then allow the experience of it to exist without putting judgments (evaluations) on it. The connection between these two principles seems to be that the experience of one can at times follow the other. That is, sometimes Experiencing without Evaluation follows Openness in the

Present Moment. In spite of this, it is important to maintain them as separate and distinct categories because often each of the principles exist on their own. Openness in the Present Moment was clearly identified a number of times when Experiencing without Evaluation was not. Further, when both principles were present with some types of Good Moments, Openness in the Present Moment always had a higher percentage of frequency of presence than did Experiencing without Evaluation.

Despite both being about one's' experience, the two items are distinguished by what is emphasized in each. Item two, Openness in the Present Moment emphasizes the therapist's ability to be open and not shut down the client's experience. Item three, Experiencing without Evaluation, emphasizes the therapist's neutrality or absence of evaluative judgment in relation to the experience. The distinction of focus is important because it indicates where the attention is placed in relation to the experience and thus necessitates that the items be regarded as distinct categories.

Though all six of the Buddhist Principles were articulated and described as specific therapeutic interventions, one possible explanation for the vast presence of Openness in the Present Moment is that it is actually a therapist quality as opposed to a therapist intervention – that is, it is more a question of how the therapist is than what the therapist does. It seems that by the therapist being open and in the experience of the here and now, the client is both guided to and given permission to be open to the present moment as well.

Openness in the Present Moment as a universal principle of change. Openness in the Present Moment is similar to Person-Centred, Gestalt, and Existential-Humanistic ideas of moment-by-moment living, here and now experiencing, and presence respectively. All four perspectives emphasize the importance of being aware and participating as fully as one can in the

moment. From the Gestalt perspective people can best be self-supportive by being present-centred. Present-centredness means knowing with one's whole being what one is doing and what is need is being addressed in the present organismic-environment field (Yontef, 1995). The centrality of openness in the present moment in Buddhism is clear as a way of approaching one's self in one's life. The belief is that through opening one's self, the illusions of solidity fall away and the person becomes free to truly be present. It is an important and necessary development in the release of one's suffering. Like Compassion, Openness in the Present Moment, may also be a universal change process.

More powerful support for considering Openness in the Present Moment as a universal change principle comes from its' presence in the data. Openness in the Present Moment appeared with thirteen of the sixteen different types of Good Moments and in most cases was present fifty percent or more of the time. Such strong presence of a therapist operation, coupled with its' similarity to Western theories lends strong support to it being a universal change process.

#### Distinctness of the Categories

Though some Buddhist Principles were significantly correlated with one another, Flexibility of Self (Buddhist Principle one) and Interconnectedness (Buddhist Principle five) were not significantly correlated with any other Buddhist Principles. Overall, despite the significant correlation between different Buddhist Principles, the categories are unique enough to continue being considered distinct categories. The results of this first study implementing the Category System of Buddhist Principles, suggest that further investigation using this measure could provide useful information about the distinctness of the different items. If significant correlations continue to exist it may become necessary to find ways to further differentiate the categories. For the purposes of the present study, the Category System of Buddhist Principles

provided categories that were sufficiently distinct for the preliminary investigations into this area. The next section will consider the Buddhist Principles in terms of psychotherapy integration.

### Buddhist Psychology and Psychotherapy Integration

The larger goal in examining whether Buddhist psychology can inform Western approaches to psychology, is psychotherapy integration. As was done in the present study, investigating psychotherapy process is a major vehicle for psychotherapy integration (Wolfe & Goldfried, 1988). The goal of this type of research is to develop a cumulative body of knowledge regarding the process of change, that is, how the behaviour of the therapist facilitates change in the client (Wolfe & Goldfried, 1988). Wolfe and Goldfried (1988), in summarizing the recommendations and conclusions from a National Institute of Mental Health workshop on researching psychotherapy integration, provided strategies of investigation. Both were implemented in this study. First, they suggested that rather than studying entire theories of therapeutic change, investigators should study the key theoretical concepts that are believed to be effective. The Category System of Buddhist Principles is an abstraction of the key theoretical concepts from Buddhist psychology believed to be effective. The second suggestion was to isolate significant events in the therapy session that correlated with change and study those instead of whole sessions. The implementation of the Category System of Good Moments was used specifically for the purpose of identifying important in-session change events and considering the question of therapist intervention from that important perspective.

Wolfe and Goldfried (1988) also emphasized that research needs to elucidate common and unique factors among the various schools of psychotherapy. Identifying unique factors that are related to in-session client change will suggest the procedures and theoretical constructs that

might be integrated to enhance therapeutic effectiveness. What follows is a discussion of the presence of some Buddhist Principles of change that may be common and unique to Buddhist psychology.

#### Common Factors in Psychotherapy Integration

Table 7 provided a breakdown of the percentage of frequency between types of Buddhist Principles and the different Good Moments. The figures that followed. (Figures 2-15), provided a visual breakdown of the percentages of frequency and certainty of the Buddhist Principles with each of the different types of Good Moments. From a common and unique factors perspective to psychotherapy integration, Openness in the Present Moment and Compassion are the only two Buddhist Principles that are similar to Western ideas about mechanisms of therapeutic change. Thus, they may be deemed universal change mechanisms.

Openness in the Present Moment. There is an additional explanation for the vast presence of Openness in the Present Moment. It may be that Openness in the Present Moment is a therapist quality in addition to being a therapist operation or method – that is, it may be a question of how the therapist is in addition to what the therapist does. Close examination of Openness in the Present Moment lends some credibility to the idea that it is a therapist quality. The description of Openness in the Present Moment says specifically that it ‘implicitly requires that the therapist be open him/herself to whatever thoughts, feelings, experiences, wishes, dreams, desires the client has’.

Conceptualizing openness in the present moment more like a quality and less like an operation, method, or intervention has important implications for the Category System of Buddhist Principles as a measure. It means that the six items are measuring different things about the therapist. Five of them would be measuring therapist operations, and one would be measuring

the therapists' personal quality. Perhaps, if this were the case, it would not pose a significant problem as long as the distinction was indicated in describing the measure.

### Unique Factors in Psychotherapy Integration

Having identified Openness in the Present Moment and Compassion as universal change mechanisms, there are four other Buddhist Principles to consider as possible unique change mechanisms.

Flexibility of Self. Buddhist Principle one, Flexibility of Self, was present with five different types of Good Moments. With the exception of two types of Good Moments, its' presence was negligible. Interestingly, Flexibility of Self was present 75% of the time when the client was Undertaking or Exploring a New Way of Being and 50% of the time when the client arrived at a New Level of Honesty in the therapeutic situation. Though the data analysis does not allow for abstraction of a causal relationship, the link between the Buddhist Principle and Good Moments is logical. When implementing Flexibility of Self, the therapist assists clients in loosening their grasp on qualities that are deemed essential to self. The belief is that clinging to a permanent and unchanging sense of self, leads to suffering as it does not allow for movement, flexibility, and a new way of being. It is likely that when clients were Undertaking or Exploring New Ways of Being they were responding to the therapist intervention of assisting in experiencing a more flexible self. Similarly, in order for clients to arrive at a new level of honesty in the therapeutic situation they would likely be less rigid about who they are or should be.

Results of this study suggest that Flexibility of Self may be a unique change process that should be examined further for its place in the integration of psychotherapies. It seems that it would not be an appropriate intervention to use with all clients in relation to all issues. For

instance, it would be contra-indicated for clients meeting the criteria for borderline personality disorder because of the difficulty these clients have with boundaries between self and other. With other types of clients, perhaps those struggling predominantly because of a rigid sense of self, implementing flexibility of self as a change mechanism may facilitate the development of a healthier and more flexible self of self.

Experiencing without Evaluation. Experiencing without evaluation was present with six types of Good Moments. In each case its' presence of frequency was less than 22% of the time. In each case a number of other Buddhist Principles were present when Experiencing without Evaluation was present. Results suggest that Experiencing without Evaluation does not play a significant role in facilitating in-session change and would not be helpful to include or examine as a unique change process. One explanation for this is lack of knowledge about this construct by Western therapists. It may simply be that it was not implemented because many Western therapists have no knowledge or comfort with the idea. Evidence for the value of Experiencing without Evaluation as a unique process of change comes from its' position as a core Buddhist principle and its' presence in Morita therapy. At the essence of Morita therapy is the clients' ability to change his/her own negative attitude toward the distress, usually anxiety. By doing so, the client develops a different, less adversarial relationship with the distress. Consequently the impact of the anxiety on the person also changes. It is asserted that Experiencing without Evaluation is an important Buddhist Principle that requires further study.

Interconnectedness. Interconnectedness, Buddhist Principle five, was present with seven types of Good Moments. All but one had a very low percentage of frequency. Interconnectedness was always present when the client had attained a New Level of Awareness Regarding the Possibility of Change. When implementing Interconnectedness the therapist emphasizes that the

client is in relation to his/her surrounding and encourages the client to examine the connections. Logically, such an intervention would facilitate the client in becoming aware of the possibility of change. Through the process of examining the relationships between people, things, events, and other components of life, clients may become aware of their own role in change or become aware of something that had gone unnoticed earlier.

Interconnectedness is an important change mechanism that demands further investigation. The strong presence of Interconnectedness with the Good Moment suggests that it may be a unique mechanism of change that would be a valuable contribution to psychotherapy integration.

Sitting with Suffering. The last Buddhist Principle, Sitting with Suffering, was present with six types of Good Moments. Both its' percentage of frequency and certainty were low each time, suggesting that, like Experiencing without Evaluation, it would not be a valuable addition to psychotherapy integration. A different explanation however, is presented for its low percentage of frequency of presence. It may be possible that Sitting with Suffering did not appear, not because it is a less valuable change process, but because the Western trained therapist-participants did not implement it as a therapist method or operation. This cannot be ascertained because whole sessions were not analyzed for the presence of Buddhist Principles, only the sections relevant to client Good Moments were considered and Sitting with Suffering did not have a notable presence in these parts.

Support for the suggestion that the absence of Sitting with Suffering is explained by therapist ignorance of the concept comes from the lack of literature about such a concept in Western theories of psychotherapy. An examination of most major western theories of psychotherapy found that none spoke of the idea of sitting with one's suffering. To exemplify this point, Gurman and Messer (1995) edited a text on the various theories of psychotherapy. The

expert authors were required to include a section entitled 'curative factors or mechanism of change'. Traditional Psychoanalysis relayed insight and the relationship as the mechanisms of change (Wolitzky, 1995). Person-Centred approached emphasized the therapist's expertise with process, creativity, and relationship (Bohart, 1995). Behaviour therapists emphasized operant conditioning and verbal control (Hayes, Follette, & Follette, 1995). Cognitive therapy focused on correcting cognitive distortions and their underlying schemata (Freeman & Reinecke, 1995). Existential-Humanistic psychotherapy emphasized being in the present and changes in perception through insight (Bugenthal & Sterling, 1995). Finally, Gestalt therapy focused on contact, being in the present and the therapist-client relationship (Yontef, 1995). Sitting with Suffering appears to be more foreign than unhelpful. From this perspective it seems more valuable to further investigate whether sitting with suffering can be a valuable and unique mechanism of change than to discard it as unhelpful.

Common and unique factors have been discussed from a Buddhist perspective of psychotherapy integration. The implications of this discussion in terms of counselling interventions, counsellor education, and future research will be discussed in a later section. The next section discusses the agreement between judges, clients, and therapists.

#### Agreement between Judges, Clients, and Therapists

The Important Events Questionnaire (IEQ) was administered to clients to gain an understanding of what they felt was important in the therapy session. This questionnaire has been used a number of times in previous studies. It has been used for one of two purposes in the past. One set of studies employed the IEQ in order to map client change processes (Cummings & Hallberg, 1995; Cummings, et al., 1994) These researchers found two or three patterns of

change, which they named consistent change, interrupted change, and minimal change. In both of the studies all of the responses to the IEQ were analyzed to map the changes.

The second type of study implementing the IEQ used it as a secondary source of data (Cummings, Martin, Hallberg, & Slemon, 1992; Cummings, Slemon, & Hallberg, 1993) In both studies only answers to the first question were examined as important event data. Similarly, in the present study only answers to questions one, two, four and five were examined as important events data. Specifically, the questions were:

(1) What was the most important thing that happened in this session (i.e. what stood out for you)? Please be as specific as you can.

(2) Why was it important and how was it helpful or not helpful?

(4) What was the second most important thing that happened in this session (i.e. what stood out for you)? Please be as specific as you can.

(5) Why was it important and how was it helpful or not helpful?

Unlike other studies that employed the IEQ, the purpose of asking clients to identify important in-session events was to determine the level of agreement between what the judges felt were Good Moments, what the clients felt were Good Moments, and what the therapists felt were Good Moments. The client data was not analyzed for maps of change processes or themes of client change.

As reported in the results, there was a 45% agreement rate between clients and judges. Specifically, of the twenty important events identified by the clients, nine of the important events were also identified by the judges. The implications of this result for research are important. Most of psychotherapy process research relies on the observations of trained judges. Though judges provide a useful perspective, they also provide a limited perspective. Finding a 45%

agreement rate advises that a great deal of important information regarding good client process is not considered when researchers employ only judges perspectives in psychotherapy process research. In light of the fact that the purpose of studying psychotherapy process is to understand and improve therapist ability to facilitate good process it seems logical to ask clients what they consider to be important in-session events and why. It is not only logical, but scientifically useful.

It was encouraging to discover that though judges did not identify 55% of the events that the clients considered important, both agreed for the most part about the kinds of events that are considered Good Moments. Fifteen percent of clients' responses resulted in a new category of Good Moments entitled 'Client Uncovered a Way to Combat the Problem'.

Like the current study, some previous studies have examined the percentage of matching between therapists and clients. Therapists were asked to identify the single most important in-session event from their perspective. The level of agreement between therapists and clients was 27%. Other studies examining memory have found a relatively consistent match rate of between 33% (Cummings et al. 1992; Martin & Stemaczonek, 1988) and 39% (Cummings et al., 1993). The relationship between therapist and client match of recall of therapeutic events has the potential to be an important finding for counsellors. When therapists and clients select the same event as important, it is an indication that they are valuing the same information from the session (Cummings et al., 1992).

Interestingly, like the client-judge match, there was also a 45% agreement rate between therapists and judges. Of the eleven important events identified by the therapists, Judges also identified five of them. Conclusions about the implications of this, parallel conclusions and

suggestions regarding client-judge match. Simply put, it is necessary to consider all perspectives when doing psychotherapy process research.

Another study could not be found that considered client, therapist, and judges' perspectives, thus this can be considered a unique contribution to psychotherapy process research. Including all perspectives resulted in contributions to both the content and process of the research.

The results of including client, therapist, and judges perspectives are relevant for the following reasons: (a) the low match rate between judges and clients advises researchers that information is lost when client perspectives are not considered. (b) the low match rate between judges and therapists advises researchers that information is lost when therapist perspectives are not considered. (c) asking judges, clients, and therapists about what they felt was important advised that for the most part all three agree on the kinds of things that are considered Good Moments. (d) asking clients advised researchers that clients believe that finding a way to combat the problem is an important in-session event. The following section discusses the implication of the findings for counselling

#### Implications of the Results for Counselling

##### Good Moments

This section summarizes the implications of the findings of the current study for counselling. First, the Category System of Good Moments is a measure that is directly relevant to counselling because it identifies good in-session client processes. The major implication from the present study is the identification of eight new types of Good Moments, one of which was directly identified by clients. Adding items to the measure adds to the repertoire of knowledge that therapists have about the kinds of things that they want to facilitate happen for the client. In

addition, continued study of client processes heightens awareness of the importance of therapist attunement to psychotherapy process and client process.

### Client and Therapist Agreement

Including both client and therapist perspectives in this study has an important implication for counselling because there was only a 27% match rate between them. This suggests that therapists need to be more aware of client processes as they are occurring so that therapists and clients can be emphasizing the same material. In order to do this it may be helpful for therapists to informally ask clients at the end of each session what they felt was the most important event that session and check about clients' reactions between sessions. This way the therapist can learn more about the client and can hone skills to become more aware of ongoing therapeutic process.

### Buddhist Principles

This is the first study to articulate Buddhist Principles in the form of a category system and consider their presence in psychotherapy both conceptually and empirically. A number of results have important implications for counselling. First, the categories provide a way for therapist to consider Buddhist psychology beyond theorizing and from the perspective of implementation in therapy. As noted in the literature review, Buddhist psychology has been written about for many years. To date, all of the discussion has been at a theoretical level. The Category System of Buddhist Principles provides something concrete for therapists to work with at an applied level. Second, results indicate that two of the Buddhist Principles may be considered universal mechanisms of change. This suggests that regardless of the theoretical orientation of the therapist, it would be useful to implement Compassion and Openness in the Present Moment into their therapeutic work. In terms of the principles of change, specific and, albeit unique, Buddhist Principles have been linked to different kinds of Good Moments. Thus, if

the therapist believes that the client may be served by undertaking or exploring a new way of being or by being more honest in the therapeutic encounter, he/she may implement the Buddhist Principle Flexibility of Self in order to facilitate therapeutic goals. Likewise, when the therapist assesses that the client would be served by arriving at a new level of awareness regarding the possibility of change, he/she may implement the Buddhist Principle Interconnectedness. In sum, it seems that the results have powerful implications for counsellors who are interested in integrating ideas and processes of change into their therapeutic work.

#### Implications of the Results for Counsellor Education

The results of this study suggest that counsellor education should include theoretical exploration of Eastern approaches to psychotherapy. Whether the aspiring student eventually finds practical value in one specific school of thought or from the integrative approach it is valuable for the student to be exposed to as many diverse theoretical perspectives as possible. Additionally, education of common Western principles of change and universal principles of change assists the student in thinking of the different levels of therapeutic integration. In order to provide respectful and responsive psychotherapy to clients the student must learn to become aware of content and process levels in the therapeutic interaction.

As noted in the literature review, it is necessary to educate counsellors to meet the needs of clients from diverse backgrounds. Part of the process of doing this is to teach students to think outside of their generally accepted paradigms. Introducing Buddhist Psychology into the curriculum of counsellor education forces students to consider the dilemmas of human nature and suffering from an Eastern paradigm, both forcing them to think other than their usual way and familiarizing them with the possible world view of Eastern clients.

Counsellor education should also open students' minds to what researchers have considered as Good Moments in psychotherapy. Background knowledge of this information can assist novice and experienced therapist with an understanding of clients' processes that are considered valuable. Armed with an understanding of scientifically validated good client process in addition to theoretical understanding can support the therapist in creating the conditions for meeting therapeutic goals.

#### Contributions of the Study to Research and Future Research Directions

The results of this study have many implications for psychotherapy process research and research of psychotherapy integration. This was the first study to use the Category System of Good Moments more as a guide than as a static, established measure. Seven new types of Good Moments emerged. Investigation of the new Good Moments is warranted. Further research could determine whether they are unique to this investigation or is whether there is ground to consider expanding the Category System of Good Moments to include them and/or others that may emerge.

This is the first study to consider Eastern and Western perspectives through empirically identifying universal variables of psychotherapy at the principles of change level. Others have identified common factors in psychotherapy from Western perspectives (Prochaska & DiClemente, 1992) or common factors from multicultural counselling perspectives (Fischer, et al., 1998) and still others have identified common factors of nonwestern perspectives (i.e. universal Shamanic tradition) (Lee, et al., 1992). Now that empirically validating universal change processes have been identified it is necessary for researchers to explore in more depth how these principles facilitate client change. It is necessary to explore the presence of Buddhist principles with different client presenting problems. Do the principles appear differently with

different kinds of clients? Should they be implemented differently depending on the client's cultural group membership? It is possible that the principles should be implemented differently with different presenting problems. How can therapists best implement universal change processes? There are many questions pertaining to ways that therapists can implement our knowledge about universal change processes.

This study has identified three unique principles of change. Two of them have already been connected to specific types of Good Moments. Future research could examine the relationship between these Buddhist Principles of change and the types of Good Moments to which they have been connected. Is the co-presence stronger with some kinds of clients and not with other kinds of clients? Are the unique Buddhist Principles more present with clients from particular cultural groups?

Sitting with Suffering was introduced as a unique Buddhist Principle of change that had little presence among the Good Moments. Further investigation of its lack of presence may be helpful in determining whether it is a principle of therapeutic value for psychotherapy integration.

This study included the perspectives of judges, clients, and therapist, and found therapist and client perspectives added valuable information to the results. It follows in the continued unfolding of psychotherapy process research that inclusion of client and therapist perspectives can only be a useful addition.

These directions suggest a number of ways that the results of the current study can be used to inform future research. However, despite these potential assets of the research, the limitations of this study must be acknowledged.

### Limitations of the Study

There are a number of limitations of this study. First, a small sample of therapist and client-participants were employed for the study. Additionally, there was an uneven contribution of tapes from the therapist-participants. One therapist contributed four tapes, while another contributed one. Because only twelve tapes were analyzed, a contribution of twenty-five percent by one therapist has an impact on the data. These limitations raise the question of generalizability of the results. Thus the implications for counselling, counsellor education, and research should be read with the issue of generalizability in mind.

The small sample size of only twelve tapes raised some limitations with respect to the type of statistical analysis that could be performed on the data. The data and the exploratory approach taken by this study warranted a percentage of frequency analysis to be taken. A more powerful analysis would be to perform correlations between Buddhist Principles and Good Moments allowing for a stronger discussion of relationship between the items.

This was the first study to employ the Category System of Buddhist Principles. Though the development of the measure makes original contribution to the area of integration of Buddhist psychology and Western psychotherapy, the validity of the measure has not been determined.

Often psychotherapy process research teams are comprised of at least five team members. Because of limited resources the research team employed in this study was comprised of three members. Having more members suggests that a broader outlook will be taken by the mere introduction of more perspectives. It may be possible that fewer members, as in this case, resulted in overlooking some Good Moments and/or less complete descriptions of the Good Moments identified.

## Summary

This chapter has discussed the meaning of the results presented in chapter four. The addition of the seven types of Good Moments suggests that further research is needed to investigate whether or not the list should expand to include new additions. An in-depth analysis of the Buddhist Principles was provided, labeling two as possible universal principles of change and identifying three others as specific principles of change to be considered in psychotherapy integration. The implications of low levels of agreement between judges, clients, and therapists were considered. The chapter summarized the implications of the research findings for counselling, counsellor education, and future research.

In sum, this study, *Buddhist Moments in Psychotherapy*, has provided the fields of multicultural counselling, common factors, and psychotherapy integration with some important findings. It is the first study to step beyond theorizing about the integration of Buddhist Psychology and Western psychotherapy. Through articulating six core Buddhist Principles and examining their presence in therapy, this study applies Buddhist Principles in Western psychotherapy. Two universal change processes were identified, Compassion and Openness in the Present Moment. Three unique change processes have been opened up for consideration, Flexibility of self, Interconnectedness, and Sitting with Suffering.

The consideration of diversity issues in counselling has highlighted the importance of understanding clients from their own worldview. This study provides an alternative worldview at both a theoretical and practical level and discusses ways to incorporate Buddhist Principles into professional counselling practice. As we attempt to better understand issues of diversity and psychotherapy, the incorporation of Buddhist Principles appears as a promising direction for future research.

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APPENDIX "A"  
INTRODUCTION LETTER TO THE THERAPIST

Dear \_\_\_\_\_,

I am sending you this package as a follow up to our telephone conversation on \_\_\_\_\_. As I mentioned at that time, I am conducting a research study for my Ph.D. dissertation. My supervisor is Dr. Nancy Arthur. This letter provides you with information regarding my research project entitled Non-Western Psychology and Common Factors in Psychotherapy. It is my hope that this information can assist you in making an informed decision regarding your participation.

The purpose of this study is to determine whether there are some factors in common across Western-based psychotherapies and whether those factors are also consistent with non-Western ideas or principles of psychology.

If you agree to participate in this study you will be asked to:

- (1) Introduce the study to some of your new clients using the script that I will provide. I will need four of your clients to agree to participate.
- (2) Complete a short questionnaire immediately following your third session of counselling. This questionnaire will take approximately 10-15 minutes to complete. Your responses to this questionnaire will be confidential.
- (3) Consent to the audio taping your third session with each of the four clients who have also agreed to participate in this study. . The audio taped recordings will be transcribed so that they may be analyzed. All names, places and other identifying information will be replaced with a letter code. Only I will have access to the identifying information and its corresponding codes.

All this confidential information will be kept in a locked filing cabinet to which only I will have the key. The original tapes, the transcriptions, and the questionnaires will all be destroyed two years after I complete my program of study at The University of Calgary.

It is important for you to be aware that even if you agree to participate in this study you are free to withdraw at any time for any reason and without penalty. Participation in this study will involve no greater risks than those ordinarily associated with providing psychotherapy to clients.

If you have any questions please feel free to contact me at (403) 262-3897, my supervisor, Dr. Nancy Arthur at 220-3585. You may also call the Office of the Chair, Faculty of Education Joint Ethics Review Committee at 220-5626, or the Office of the Vice-President Research at 220-3381. Two copies of the consent form are provided. Please return one signed copy to your me and keep the other copy for your records.

I will contact you in a few days to answer any questions you may have and/or review and discuss the enclosed consent form if that is appropriate.

Thank you for your interest.

Sincerely,

Roshni Daya

## APPENDIX "B"

## THERAPIST INFORMED CONSENT FOR PARTICIPATION

I, the undersigned, hereby give my consent to participate in a research project entitled Non-Western Psychology and Common Factors in Psychotherapy.

I understand that such consent means that I will allow the third session of psychotherapy with a client whom has also agreed to participate in this study to be audio taped. I also agree to complete a short questionnaire following this third session. This questionnaire will take me approximately 10-15 minutes to complete.

I understand that participation in this study may be terminated at any time by my request or at the request of the researcher. Participation and/or withdrawal from this project will not adversely affect me in any way. I understand that I will be providing the same type of psychotherapy whether I agree to participate in this study or not.

I understand that this study will not involve any greater risks that those ordinarily occurring in the course of providing psychotherapy.

I understand that identifying information in the taped session will be coded and kept in the strictest of confidence.

I understand that some of my specific interventions may be reported in any published articles.

I have been given a copy of this consent form for my records. I understand that if I have any questions I can contact the researcher, Roshni Daya, at 262-3897, her supervisor, Dr. Nancy Arthur, at 220-3585. I may also contact the Office of the Chair, Faculty of Education Joint Ethics Review Committee at 220-5626, or the Office of the Vice-President (Research) at 220-2281.

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
Therapist's Printed Name

## APPENDIX "C"

## INTRODUCTION LETTER TO THE CLIENT

Dear Participant,

Hello, my name is Roshni Daya. I am a graduate student in the Department of Educational Psychology at the University of Calgary. As part of the requirements towards my Ph.D. degree I am conducting a research project under the supervision of Dr. Nancy Arthur. This letter provides you with information regarding my research project entitled Non-Western Psychology and Common Factors in Psychotherapy. It is my hope that this information can assist you in making an informed decision regarding your participation.

The purpose of this study is to determine whether there are some factors in common across Western-based psychotherapies and whether those factors are also consistent with non-Western ideas or principles of psychology. You will be receiving the same type of psychotherapy whether you agree to participate in this study or not.

As part of the study you will be asked to:

- (4) Complete a short questionnaire immediately following your third session of counselling. This questionnaire will take approximately 10-15 minutes to complete. Your responses to this questionnaire will be confidential. Your therapist will not have access to them
- (5) Consent to the audiotaping of your third session of therapy. The audio taped recordings will be transcribed so that they may be analyzed. All names, places and other identifying information will be replaced with a letter code. Only I will have access to the identifying information and its corresponding codes.

All this confidential information will be kept in a locked filing cabinet to which only I will have the key. The original tapes, the transcriptions, and the questionnaires will all be destroyed two years after I complete my program of study at The University of Calgary.

It is important for you to be aware that even if you agree to participate in this study you are free to withdraw at any time for any reason and without penalty. Also, the therapy you receive will not be influenced or effected by your decision with respect to participation in this study. Participation in this study will involve no greater risks than those ordinarily associated with participating in counselling.

If you have any questions please feel free to contact me at (403) 262-3897, my supervisor, Dr. Nancy Arthur at 220-3585. You may also call the Office of the Chair, Faculty of Education Joint Ethics Review Committee at 220-5626 or the Office of the Vice-President Research at 220-3381.

If you are interested in participating, please contact me directly, or sign the enclosed form indicating your interest in the study and return it to the receptionist at your therapist's office in the envelope provided. If you feel more comfortable dealing only with your therapist, you may review and sign the informed consent form with him/her.

Thank you for your interest.

Sincerely,

Roshni Daya

## APPENDIX "D"

## CLIENT INFORMED CONSENT FOR PARTICPATION

I, the undersigned, hereby give my consent to participate in a research project entitled Non-Western Psychology and Common Factors in Psychotherapy.

I understand that such consent means that I will allow the third session of my counselling with Dr. \_\_\_\_\_ to be audio taped. I also agree to complete a short questionnaire immediately following this third session. This questionnaire will take me approximately 10-15 minutes to complete.

I understand that participation in this study may be terminated at any time by my request or at the request of the researcher. Participation and/or withdrawal from this project will not adversely affect me in any way. I understand that participation in this study is not a condition for continued treatment. I understand that I will be receiving the same type of psychotherapy whether I agree to participate in this study or not.

I understand that this study will not involve any greater risks that those ordinarily occurring in the course of psychotherapy.

I understand that identifying information in the taped session will be coded and kept in the strictest of confidence.

I understand that only group data will be reported in any published reports.

I have been given a copy of this consent form for my records. I understand that if I have any questions I can contact the researcher, Roshni Daya, at 262-3897, her supervisor, Dr. Nancy Arthur at 220-3585. I may also contact the Office of the Chair, Faculty of Education Joint Ethics Review Committee at 220-5626, or the Office of the Vice-President (Research) at 220-2281.

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
Participant's Printed Name

## APPENDIX "E"

## CLIENT DEMOGRAPHIC INFORMATION FORM

Age: \_\_\_\_\_

Status:     Single

Married

Common-Law

Ethnicity: \_\_\_\_\_

## APPENDIX "F"

## SAMPLES OF THERAPIST AND CLIENT QUESTIONNAIRES

## Questionnaire to be Completed by Therapist following Third Session

## Therapist Identified Important Events Questionnaire

- (a) What was the most important thing that happened in this session? Please be as specific as you can.
- (b) Why was it important?
- (c) What was helpful or hindering about this event?
- (d) How does this event fit or not fit into your conceptualization of the client's issues?

Questionnaire to be completed by client following third session

Important Events Questionnaire (IEQ)

- (a) What was the most important thing that happened this session (i.e. what stood out for you)?  
Please be as specific as you can.
- (b) Why was it important and how was it helpful or not helpful?
- (c) What thoughts and feelings do you recall experiencing/having during this time in the session?
- (d) What was the second most important thing that happened this session (i.e. what stood out for you)? Please be as specific as you can.
- (e) Why was it important and how was it helpful or not helpful?
- (f) What thoughts and feelings do you recall experiencing/having during this time in the session?
- (g) What did you find yourself thinking about or doing during the time between sessions that related in any way to the last session?
- (h) Are you experiencing any change in yourself? If so, what?

## APPENDIX "G"

## STATEMENT OF PROCEDURE

The researcher will contact a number of therapists in the Calgary area to introduce the study. Those therapists who show interest will be mailed a package containing: (i) a cover letter and (ii) an informed consent form. The researcher will follow up this package with a telephone call and arrange to meet with those therapist who show are interested in participating. The purpose of this meeting will be to review and discuss the informed consent form and to give the therapist the opportunity to ask the researcher any questions he/she may have.

At the end of the first therapy session the therapist will read the attached script which introduces the study to the client. The client will be given an envelope containing: (i) a letter introducing the researcher and describing the study and how to contact the researcher. (ii) a form for the client to complete if he/she is interested in participating in the study and envelope in which to return the signed form, and (iii) an informed consent form.

If the client is interested in participating in the study, he/she will be instructed to complete the form of interest and give it, in a sealed envelope, to the receptionist at the therapist's office. Upon receipt of the sealed envelope, the receptionist will contact the researcher who will pick up the envelope from the therapist's office. The researcher will then call the client and meet with him/her to review and discuss the informed consent form. This is done to create a distance between the research and the therapy. If the client is still interested in participating in the study, he/she will be required to sign the informed consent form and return it to the receptionist in the envelop provided.

Both the letter and the therapist will advise the client that participation in the study is not a condition for continued therapy, nor will the type of therapy received be affected by participation.

The third session of psychotherapy with each of the clients will be audio taped and subsequently transcribed. Each transcript will be broken into speaking turns representing individual client and therapist statements. A client statement is defined as all the words spoken by the client, preceded and followed by words spoken by the therapist. When the sessions are transcribed codes will be inserted to replace the names of people and places referred to in the session. Once transcribed the transcript itself will be given a code that will correspond to the client. The list of corresponding codes and the tapes will be stored in a locked cabinet. Only the primary researcher will have a key to the cabinet which will be kept locked at all times.

The receptionist will give the client a questionnaire to be completed immediately following the third session of therapy. The client will be informed that the therapist will never see the completed form and that he/she is to seal the completed questionnaire in the envelope provided and give it to the receptionist. The therapist will be required to complete the TIEQ immediately following the third session. The therapist will also seal the completed questionnaire in the envelope provided and give it to the receptionist. The receptionist will be responsible for securing the two envelopes and audio-tapes in a locked cabinet at the therapist's office. The receptionist will notify the researcher that said documents are ready to be picked up. The researcher will pick up the documents within 48 hours.

## APPENDIX "H"

## STATEMENT OF COMPLIANCE WITH ETHICAL STANDARDS

Information on the Subjects: There will be two groups of participants in this study. The first group consists of three psychologists practicing psychotherapy (therapist). One therapist will represent each of the three major school of psychology in the West.

The second group of participants will consist of twelve clients (clients). The clients will all be adults, eighteen years of age or older. Each therapist will engage in therapy with four clients.

At the end of the first therapy session the therapist will read the attached script which introduces the study to the client. The client will be given an envelope containing: (i) a letter introducing the researcher and describing the study and how to contact the researcher; (ii) a form for the client to complete if he/she is interested in participating in the study and envelope in which to return the signed form ; (iii) an informed consent form. If the client is interested in participating in the study, he/she will be instructed to complete the form of interest and give it, in a sealed envelope, to the receptionist at the therapist's office. Upon receipt of the sealed envelope, the receptionist will contact the researcher who will pick up the envelope from the therapist's office.

All potential participants will be assured that participation in the study is not a condition for continued therapy, nor will the type of therapy received be effected by participation.

Neither participants nor therapists will be remunerated.

Informed Consent: The researcher will call any client who completes the form of interest and meet with him/her to review and discuss the informed consent form. This is done to create a distance between the research and the therapy. If the client is still interested in participating in

the study, he/she will be required to sign the informed consent form and return it to the receptionist in the envelop provided.

The researcher will meet with the therapist at the time of introducing the study and discuss the informed consent form at the time.

Precautions to be Taken to Ensure Anonymity of Participants: When the sessions are transcribed codes will be inserted to replace the names of people and places referred to in the session. Once transcribed the transcript itself will be given a code that will correspond to the participant. The list of corresponding codes and the tapes will be stored in a locked cabinet. Only the primary researcher will have a key to the cabinet which will be kept locked at all times. Original tapes will be destroyed two years after the researcher completes her program at the University of Calgary.

This process ensures that no names can be released with respect to the results of the study so the participants are assured of anonymity.

Ultimate Disposal of the Records: When the sessions are transcribed codes will be inserted to replace the names of people and places referred to in the session. Once transcribed the transcript itself will be given a code that will correspond to the participant. The list of corresponding codes and the tapes will be stored in a locked cabinet. Only the primary researcher will have a key to the cabinet which will be kept locked at all times. Original tapes and transcribed copies will be destroyed two years after the researcher completes her program at the University of Calgary.