Counselling and Psychotherapy Research
2010, 1–8, iFirst article

Dialogical mindfulness in supervision role-play

LARS ANDERSSON[1]*, ROBERT KING[1], & LLOYD LALANDE[2]

[1]*School of Medicine, University of Queensland, Brisbane &* [2]*School of Psychology and Counselling, Queensland University of Technology, Brisbane, Australia*

Abstract
Aims: This exploratory pilot study investigated Mindfulness-based Role-play (MBRP) supervision to find out how therapists would experience the approach, and to what extent they would find it useful, particularly in relation to empathy toward clients. *Method:* Thirteen therapists participated in a workshop, introducing mindfulness and MBRP supervision, and subsequently had one individual MBRP supervision session. *Data collection and analysis:* Qualitative data were collected by means of semi-structured interviews and analysed with regard to participants' supervision experiences by means of a modified version of the Consensual Qualitative Research method. *Findings:* Participants predominantly had positive emotional and cognitive responses to their supervision experiences. The main supervision outcomes were empathy with the client's emotional experience, enhanced awareness of functioning as a therapist, and thoughts about how to proceed in therapy. A subset of participants also reported observed effects in therapy with clients. *Conclusions:* Even taking into account the methodological limitations of the study, these findings are promising and suggest that further research into the MBRP supervision approach is warranted.

Keywords: empathy; mindfulness; role-play; qualitative research; supervision

Introduction

While therapist empathy is a potent predictor of therapy outcome, it is nevertheless a skill that can be difficult to enhance with conventional approaches to training and supervision. This paper reports on a small-scale pilot study, which investigated a supervision approach based on mindfulness and role-play. The objective of the study was to find out how therapists would experience the approach and what they would get out of the supervision, particularly in regard to empathy toward clients.

Background

Clinical psychotherapy supervision is highly rated, both by trainees and practising therapists, as a procedure for developing treatment skills and professional competency (King & Mullen, 2008), and there is evidence that clinical supervision has a positive impact on client response to therapy (Bambling, King, Raue, Schweitzer, & Lambert, 2006). Supervisees see supervision as a crucial element of training, as it increases the development both of self-awareness and therapeutic awareness (Bernard & Goodyear, 1992). However, the relationship between supervision and therapists' skills is multifaceted. Bambling and King (2000) suggested that while supervision enhances basic counselling skills, it may have less impact on complex interpersonal processes like empathy. Fulton (2005) suggests that there is relatively little evidence that empathy can be taught to psychotherapists for improving their performance.

Empathy

Watson (2002) reviewed six decades of empathy research since 1940, and found that the majority of the studies indicated a positive relationship between empathy and outcome, and none showed a negative relationship. Similarly, a meta-analysis by Bohart, Elliott, Greenberg, and Watson (2002) found that 'overall, empathy accounts for as much and probably more outcome variance than does specific intervention' (p. 96). Understandably then, suggestions for

*Corresponding author: Email: awarenet@intawa.com.au

ISSN 1473-3145 print/1746-1405 online
DOI: 10.1080/14733141003599500

how therapist empathy may be enhanced are of great interest.

One such suggestion is that supervision role-play, with the supervisee assuming the client's position, may enhance the supervisee's empathic understanding of the client (Borders & Brown, 2005). Through role-play the supervisee may reach beyond purely intellectual understanding and toward an experiential understanding of the client.

Another avenue for developing therapists empathy can be surmised from the growing body of literature on using meditation and mindfulness to cultivate empathy (Morgan & Morgan, 2005). A review by Block-Lerner, Adair, Plumb, Rhatigan, and Orsillo (2007) identified facets of mindfulness practice which may foster empathic responding (e.g. nonjudgmental awareness, and present-moment focus), and concluded that 'mindfulness and experiential acceptance-based approaches appear to be a viable means for cultivating levels of empathy' (p. 513).

Mindfulness

The practice of mindfulness is thought to originate in Buddhist psychology, from 2500 years ago (Germer, 2005). Only recently have applications of mindfulness practices made inroads into Western psychotherapy, through approaches like Mindfulness-Based Stress Reduction (Kabat-Zinn, 1990), Dialectical Behaviour Therapy (Linehan, 1993), Mindfulness-Based Cognitive Therapy (Teasdale et al., 2000), and Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 1999).

Essentially, mindfulness practice refers to the cultivation of conscious awareness and attention on a moment-to-moment basis, where the quality of awareness includes openness, curiosity and a nonjudgmental attitude (Allen, Blashki, & Gullone, 2006). However, as emphasised by many authors on the subject (e.g. Kabat-Zinn, 1990), the true meaning of mindfulness cannot be fully grasped without experiential practice. To make way for mindfulness' potential contribution toward development of therapist empathy therefore, experiential mindfulness practices need to be incorporated in therapists' training and supervision.

Dialogical mindfulness

While mindfulness practice may involve any of the senses, as well as thoughts and feelings, and be employed in any life situation, it is nevertheless customarily considered an individual enterprise (Surrey, 2005).

'Dialogical mindfulness' refers to the application of mindfulness in a dialogue between two people, either when they are both present or when one of them is only imagined to be present, as in a role-play. Dialogical mindfulness involves all aspects of phenomenologically observable data in the total field of awareness during the dialogue; the visual, auditory, kinaesthetic, olfactory & gustatory, emotional and cognitive.

Mindfulness-based Role-play supervision

The present study was an exploratory, qualitative pilot study investigating the viability of using Mindfulness-based Role-play (MBRP) in supervision as a means to enhance therapists' empathic understanding of clients.

MBRP has similarities with the 'empty chair' technique traditionally used in Gestalt therapy, as well as with techniques used in other mindfulness-based psychotherapy approaches. Yet, MBRP supervision is a unique operationalisation of role-play in integration with dialogical mindfulness, which offers the supervisee an opportunity to access subtle details of information about the client (and also about the therapist, and the relational dynamics between them); information that is already present, but not readily available to the supervisee's awareness.

Method

Participants

The 13 participants consisted of four psychologists, four counsellors, one psychotherapist, one social worker, one mental health nurse, one art therapist and one psychiatrist, with an average of nine years (ranging from 2–26 years) professional experience, working with a broad range of client groups, from children and adolescents, to couples and families, to adults suffering from serious mental illnesses. Previous experience of mindfulness practices and role-play exercises amongst the participants ranged in an even distribution, from 'never' to 'lots of times'.

Intervention

The MBRP supervision approach investigated in this study consisted of an introductory workshop followed by one or more supervision sessions.

The workshop

The introductory workshop was an interactive presentation consisting of a mix of theoretical and practical segments, acquainting the participants with various mindfulness practices, and providing them with a conceptual framework for and practical experience of MBRP.

In the practical segments of the workshop participants practised various individual mindfulness meditation practices, such as mindfulness of the breathing process and mindfulness of phenomenological body experiences. Participants also practised 'dialogical mindfulness', both in conversational dialogue with one another and in role-playing a meeting between therapist and client. The workshop also included a sample demonstration of an MBRP supervision session.

Supervision sessions

The subsequent individual supervision session was conducted according to the MBRP supervision manual, which was developed as part of this study.

In the supervision session the supervisee role-played an interaction between herself (as therapist) and her client, taking turns playing both roles of the interaction, as facilitated by the supervisor.

The supervision session involved three stages:

(1) The Acquainting stage, where the supervisee role-played herself and client engaging in general 'therapy conversation', without focusing on any specific themes or difficulties in the therapy;
(2) The Theme stage, where the role-play focused on a 'theme', i.e. an area of difficulty in therapy (for therapist and/or client); and
(3) The Sharing stage, where the role-played interaction between therapist and client was guided toward an imaginary sharing by the two interactants of how it was for them each to be with one another, and how they felt about each other.

During the supervision process participants might revisit the Theme stage, followed by a Sharing stage, several times, with focus on different themes or difficulties each time.

Throughout the role-play the supervisor guided the supervisee toward 'dialogical mindfulness', i.e. being mindfully aware of her phenomenological experience in each of the respective roles of the dialogue. The following sample vignette illustrates the process of MBRP supervision.

Supervisee as therapist [SasT]: 'What about when you are with friends, Jeff, or with your partner, do you worry then too?'
<Supervisee switches chairs, to sit in Client Chair [CC]>
Supervisee as client [SasC]: 'I don't know.'
<Supervisee [S'ee] begins to move toward Therapist Chair [TC] to switch roles>
Supervisor [S'or]: 'Wait a moment, Alison. Can you do that again; be Jeff, and imagine that your therapist has just asked you about worrying with friends or partner. Try and get a feel for being Jeff; sit the way he would sit, look in the direction he would look, speak the way he would speak, when he answers.'
<S'ee adjusts her posture to a more slumped position, looks past TC to the side>
SasC (now with a quieter voice): 'I don't know.'
S'or: 'Notice now how you feel, as Jeff. Notice anything going on in your body for example, any tensions or movements, that seem to be present, when you pretend to be Jeff at that moment.'
S'ee: 'Well, I don't know if this has anything to do with Jeff, but how I feel when I do that is a bit self-conscious, shy perhaps . . . '
S'or: 'And what do you feel in your body?'
S'ee: 'A bit of tension around my chest, and for some reason my legs feel really heavy.'
S'or: 'Okay, just notice how that feels, without doing anything with it other than simply being aware of it.' <pauses for a few moments> 'Also, notice any emotions occurring and whatever happens to go through your mind, whether you can make any sense of it or not. Let everything be as it is, and just be aware of it, whatever it is like.' <pauses for a few moments> 'Now, move to the other chair.'

Procedures

Participants were recruited by email invitations sent to various counselling organisations and to relevant departments at local universities. No reimbursements of any kind were offered, and no particular selection amongst applicants was made.

The workshop was facilitated at two occasions by the principal researcher of the study. Within two weeks of their workshop each participant had one

individual, one-hour session of MBRP supervision, also facilitated by the principal researcher.

Qualitative data regarding participants' supervision experiences were collected in semi-structured interviews. Twelve of the 13 participants were interviewed. One participant withdrew from participation for personal reasons before being interviewed. Interviews were conducted over the phone, electronically recorded and then transcribed into written form. To reduce the influence of demand characteristics on interview responses, interviews were *not* conducted by the principal researcher.

Procedure for data analysis

Interview data were analysed using a modified version of the Consensual Qualitative Research (CQR) method developed by Hill, Thompson and Williams (1997). In CQR the data constructs are determined through a consensus process involving a team of researchers, and are described with words rather than numbers. A research team typically consists of three to five members, whose consensus judgements are checked by one or two auditors. Constructing meaning from the data is an iterative process, where the raw data are continually revisited, to ensure that all interpretations and conclusions are consistent with the data.

Procedurally, CQR consists of three steps. First, interview data are segmented into 'Domains', i.e. broad topics, used to cluster data. Second, 'Core Ideas' are constructed for all responses within each domain. Third, core ideas are clustered into Categories, which describe Themes that have emerged in the core ideas within each domain. These are then 'cross-analysed', and assigned frequency labels, such as 'general', 'typical', 'variant' or 'rare' (Hill et al., 1997).

Due to the nature of the present study – a small-scale project with limited resources – a modified version of the standard CQR method was used, where the research team consisted of only two members; the principal researcher and a PhD student. Auditing of the CQR analysis was performed by the research supervisor.

Domains, core ideas, categories and themes were identified by the research team, and audited by the research supervisor, according to a consensus, iterative CQR procedure. The categories and themes were subsequently cross-analysed by the principal researcher.

Ethics

The study did not involve clients in therapy, only therapists in supervision. Therapists volunteered for participation in the study, after having been informed of the nature the study, and could withdraw from participation at any point without any penalties or repercussions. Confidentiality of clients discussed in supervision sessions was assured by means of customary supervision protocols, such as substituting client name with a generic name, and omitting other client identifying data. The research was approved by an ethics committee of The University of Queensland.

Findings

Analysis of the interview data identified five domains: Emotional responses to the supervision; Cognitive reflections on the supervision; Supervision outcomes related to client; Supervision outcomes related to self; and Supervision outcomes related to the therapy process.

Within each domain a set of one or more domain categories were identified, which in turn consist of one or more themes. Through cross-analysis of categories and themes, frequency labels were assigned, according to the number of interviews where they occurred. The main findings of the cross-analysis are commented upon for each domain below, and summarised in Table I.

Emotional responses to the supervision

More than half of the participants offered positive emotional responses to the supervision, expressed in terms such as 'enjoyed', 'felt safe' and 'felt comfortable.'

Cognitive reflections on the supervision

All participants offered positive cognitive reflections on their supervision experience. No one offered any negative reflections. Most commonly these reflections related to specific dimensions of the process: 'The two-chair intervention was quite helpful for me', or to aspects of the facilitation: 'The facilitation made it very, very easy, by using terms like "let all of this happen", "let's just play with it, let's just see where we go with it"'.

While a few participants noted similarities with other approaches, like Gestalt therapy, almost everyone commented on the difference between MBRP and other supervision. Most comments referred to

Table I. Summary of the domains and main categories/themes.

Domain	Category/Theme	Frequency*	Illustrative quote
Emotional responses	Positive responses	Typical	'It felt safe, knowing that you weren't going to be judged or evaluated.'
Cognitive reflections	Positive reflections	General	'The two-chair intervention was quite helpful for me.'
	More experiential than other supervision	Typical	'Usually you talk about situations etc. but you don't get to experience…'
Outcomes, related to client	Empathy with client's emotional experience	General	'There was certainly a feeling of compassion for how difficult it is to be that client.'
Outcomes, related to self	Enhanced awareness of functioning as a therapist	General	'It taught me perhaps to be less inclined on my own style, and more getting into what the client really wants.'
Outcomes, related to therapy process	Thoughts about how to proceed in therapy with the client	Typical	'I've got a lot more ideas, and I know where to go with the session.'
	Observed effects in therapy with the client	General**	'I felt that there was a definite change on my part, in the sense that I was more patient with him.'

*Frequency labels: *'general'* indicates occurrence in *all or all but one* of the interviews; *'typical'* indicates occurrence in *more than half* of the interviews

**Note: This frequency label refers to the subset of 8 cases (as explained in text).

MBRP being more experiential: 'Usually you talk about situations etc. but you don't get to experience, and you don't get to get the perspective of the client into the situation, and to how *you* may be acting'. A couple also mentioned that they felt less judged or criticised than in other supervision experiences.

Supervision outcomes related to client

Empathy with the client's emotional experience was an outcome of the supervision for almost every participant. Three quarters of the participants expressed this in terms of empathic understanding: 'I'm more understanding of her whole situation, of why she is resistant'. A third of the participants expressed feelings of 'compassion' for the client.

Almost half of the participants also reported empathic understanding of what the client may experience in their body in the therapy situation: 'My perception of what it would be like in her body, it was a shock and surprise to me'.

Supervision outcomes related to self

All participants except one reported enhanced awareness of their functioning as therapists. In some instances this entailed affirmation of their functioning, in others awareness of deficits, and in others again an enhanced general awareness of their functioning as therapists: 'It gave me a lot of food for thought about my own style of working'.

Supervision outcomes related to the therapy process

A majority of the participants reported that the supervision had led to thoughts about how to proceed in therapy with the client.

Under this domain also emerged responses that reflected actual, observed effects in therapy with the client whom the supervision session addressed. While it was not part of this study to collect information regarding actual effects in therapy, and hence it was not required of the participants to see the client between supervision and interview, at least eight of the participants did so. All of those eight participants made observations in therapy which they related to their supervision experience, e.g. an art therapist reported being 'much more aware of her body and her non-verbals, not just the art making.'

Discussion

How supervisees experienced MBRP supervision

Responses from participants that they felt safe and that they felt less judged or criticised in the MBRP supervision than in other supervision experiences are noteworthy. Performance anxiety is common amongst therapists when they are under observation, and fear of exposure as a poor clinician is one of the obstacles to successful supervision, as Gold (2006) points out. Such responses may be seen, at least in part, to reflect a fundamental aim of MBRP supervision; to encourage the supervisee to approach the

supervision with a light-hearted attitude, allowing the role-play to be playful and explorative.

Furthermore, it should not be surprising that participants' experiences of an approach that bases itself on mindfulness practice are in the range of diametrical opposites to 'stressful', considering that mindfulness-based approaches are commonly utilised for the very purpose of dealing with stress, tension and anxieties in various forms (e.g. Kabat-Zinn, 1990).

Equally noteworthy, in the context of investigating an approach to enhancing empathy, are the many reports that the MBRP supervision experience was *more experiential* than other supervision experiences. As Watson (2002) suggests, true empathy requires going beyond purely intellectual understanding and entering the realm of experience.

How supervisees benefitted from MBRP supervision

This study aimed to investigate the viability for using MBRP supervision as a means to enhance therapists' empathic understanding of their clients. The great number of participant reports of empathy with the client's emotional and physical experiences is therefore particularly encouraging, and can be seen to verify earlier findings and suggestions for how empathy may be enhanced with mindfulness and role-play (e.g. Block-Lerner et al., 2007; Borders & Brown, 2005).

That all participants except one reported enhanced awareness of their functioning as therapists indicates that, not only did the MBRP supervision lead to enhanced therapist empathy, but it also, concurrently, fulfilled the more traditional expectation of supervision – of providing the supervisees with insights into their functioning as a therapist.

Another traditional expectation of supervision, that appears to have been fulfilled for the majority of the participants, was ideas about how to proceed in therapy with the client. Since the MBRP supervisor does not offer suggestions of this kind, the emergence of such ideas in the supervision session can most likely be attributed to the MBRP supervision process itself.

While observed effects in therapy were reported by the eight therapists who saw their client between supervision and interview, it should be noted that it was outside of the scope of this study to determine whether these effects in any way affected therapy outcome.

Limitations of the study

The results from this small-scale study are encouraging. However, several limitations to their generalisability must be recognised. The small sample of participating therapists were self-selected, and would hence have had an interest in mindfulness-based interventions, which may have contributed to the favourable results. The small size of the research team also allows individual researcher biases to have greater effects than is the case with a bigger team, e.g. in the CQR analysis process, a small team size means that there is a greater risk that one member has undue influence on the outcome of the consensus process.

Since adherence to the MBRP supervision manual was not monitored in the study, it is unknown to what degree the results are an outcome of the approach as specified by the manual, and to what degree they are an outcome of a personalised delivery of the approach. Furthermore, since the person who provided the supervision also had developed the supervision approach, 'positive supervisor allegiance' would have had some effect on the supervision outcomes.

Some influence of demand characteristics on the data must also be expected, since the participants were aware that interview feedback would go back to the supervisor, being the principal researcher in the study. While this study enabled investigation of the impact of MBRP supervision on participating therapists, it did not yield data regarding medium to long-term effects of this approach on empathy in clinical practice.

Finally, while the CQR approach to qualitative research was adopted for this study, additional valuable information might have been obtained using an action research approach.

Implications for future research

Further research is needed to verify the viability of MBRP supervision as a means to enhance therapist empathy. Research involving larger samples of therapists, who are unbiased with regard to their interest in mindfulness practices, is required for investigating whether the present study's effects can be generalised to psychotherapists of all inclinations. Supervisors, who are not part of the research team, should then facilitate the supervision with adherence to the MBRP supervision manual being monitored.

While therapist empathy has been established as a strong predictor of therapy outcome, previous research indicates that client-ratings of therapist

empathy are a more accurate predictor of outcome than therapist-ratings (Greenberg, Elliott, Watson, & Bohart, 2001). Hence, further investigations into the usefulness of MBRP supervision need to include client-ratings of therapist empathy.

Further investigations, using at least one control group of participants who are subjected to other forms of supervision, are also needed in order to establish whether MBRP supervision produces results different from other supervision approaches.

Conclusion

This has been an exploratory pilot-study into the viability of MBRP supervision as a means to enhance therapist empathy, with a view to improving therapy outcomes. Being a pilot-study, the research has inherent limitations, which have been discussed above. All the same, the findings of this study indicate that MBRP supervision is an approach that may enhance therapists' empathy with their clients' emotional experiences.

While practice implications should be viewed with caution at this stage, these findings nevertheless suggest that when MBRP supervision is facilitated by a supervisor who is experienced in the approach, it can be considered as a viable complement or alternative to conventional approaches to clinical supervision.

Acknowledgements

We would like to acknowledge the contributions of time and feedback from the participating therapists, and also the clients who indirectly provided material for the supervision sessions in this study.

References

Allen, N.B., Blashki, G., & Gullone, E. (2006). Mindfulness-based psychotherapies: A review of conceptual foundations, empirical evidence and practical considerations. *Australian and New Zealand Journal of Psychiatry*, *40* (4), 285–294.

Bambling, M., & King, R. (2000). The effect of clinical supervision on the development of counsellor competency. *Psychotherapy in Australia*, *6* (4), 58–63.

Bambling, M., King, R., Raue, P., Schweitzer, R., & Lambert, W. (2006). Clinical supervision: Its influence on client-rated working alliance and client symptom reduction in the brief treatment of major depression. *Psychotherapy Research*, *16* (3), 317–331.

Bernard, J.M., & Goodyear, R.K. (1992). *Fundamentals of clinical supervision*. Boston: Allyn and Bacon.

Block-Lerner, J., Adair, C., Plumb, J.C., Rhatigan, D.L., & Orsillo, S.M. (2007). The case for mindfulness-based approaches in the cultivation of empathy: Does nonjudgemental present-moment awareness increase capacity for perspective-taking and empathic concern? *Journal of Marital and Family Therapy*, *33* (4), 501–516.

Bohart, A.C., Elliott, R., Greenberg, L.S., & Watson, J.C. (2002). Empathy. In J. Norcross (Ed.), *Psychotherapy relationships that work* (pp. 89–108). New York: Oxford University Press.

Borders, L.D., & Brown, L.L. (2005). *The new handbook of counseling supervision*. Mahwah, NJ: Lawrence Erlbaum Associates.

Fulton, P.R. (2005). Mindfulness as clinical training. In C. K. Germer, R. D. Siegel & P. R. Fulton (Eds.), *Mindfulness and Psychotherapy* (pp. 55–72). New York: Guilford Press.

Germer, C.K. (2005). Mindfulness: What is it? What does it matter? In C. K. Germer, R. D. Siegel & P. R. Fulton (Eds.), *Mindfulness and psychotherapy* (pp. 3–27). New York: Guilford Press.

Gold, J.H. (2006). Why psychotherapy supervision is essential for mental health professionals. In J. H. Gold (Ed.), *Psychotherapy supervision and consultation in clinical practice* (pp. 7–20). Lanham, MD: Jason Aronson.

Greenberg, L.S., Elliott, R., Watson, J.C., & Bohart, A.C. (2001). Empathy. *Psychotherapy*, *38* (4), 380–384.

Hayes, S.C., Strosahl, K.D., & Wilson, K.G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: Guilford Press.

Hill, C.E., Thompson, B.J., & Williams, E.N. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist*, *25* (4), 517–572.

Kabat-Zinn, J. (1990). *Full catastrophe living*. New York: Dell.

King, R., & Mullen, G. (2008). Clinical supervision. In C. Lloyd, R. King, F. Deane & K. Gournay (Eds.), *Clinical management in mental health services* (pp. 115–127). Oxford: Wiley-Blackwell.

Linehan, M.M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

Morgan, W.D., & Morgan, S.T. (2005). Cultivating attention and empathy. In C. K. Germer, R. D. Siegel & P. R. Fulton (Eds.), *Mindfulness and psychotherapy* (pp. 73–90). New York: Guilford Press.

Surrey, J.L. (2005). Relational psychotherapy, relational mindfulness. In C. K. Germer, R. D. Siegel & P. R. Fulton (Eds.), *Mindfulness and psychotherapy* (pp. 91–110). New York: Guilford Press.

Teasdale, J.D., Segal, Z.V., Williams, J.M.G., Ridgeway, V.A., Soulsby, J.M., & Lau, M.A. (2000). Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *Journal of Consulting and Clinical Psychology*, *68* (4), 615–623.

Watson, J.C. (2002). Re-visioning empathy. In D. J. Cain & J. Seeman (Eds.), *Humanistic psychotherapies: Handbook of research and practice* (pp. 445–471). Washington, DC: American Psychological Association.

Biographies

Lars Andersson is in private practice as a psychotherapist, psychotherapy supervisor, and mindfulness meditation teacher in Brisbane, Australia. While originally trained as a Gestalt therapist, his approach to psychotherapy has over the last 20 years

evolved into an eclectic integration of humanistic-existential therapies with specific emphasis on mindfulness. The presented study was done as part of a Master of Mental Health degree, at The University of Queensland.

Robert King is a clinical psychologist and associate professor in the School of Medicine at The University of Queensland where he coordinates a multidisciplinary postgraduate mental health program.

Lloyd Lalande is a psychotherapist in private practice, specialising in somatic mindfulness approaches, currently completing a PhD focusing on breathwork as a clinical intervention, at The Queensland University of Technology.