THE JOURNAL OF ALTERNATIVE AND COMPLEMENTARY MEDICINE
Volume 10, Supplement 1, 2004, pp. S-7–S-14
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Mindfulness and Healing Intention: Concepts, Practice, and Research Evaluation

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ABSTRACT

This paper deals with the role of the health care professional in creating an optimal healing environment (OHE), with a special focus on which inner state and way of being in the world can create a healing intention. A core thesis is that every healing effort and every healing intention starts within the health care professional. An accepting, mindful, and warm-hearted relationship with self is primary to any healing intention. Important concepts to develop such an attitude are mindfulness, love, compassion, and awareness. The concept of a healing attitude toward the self is described, as is the mirror principle that states there is symmetry between someone's relationship with the outer world and his or her inner world. The mindfulness concept is outlined through a set of mental and heart qualities. Mindfulness is strongly related to compassion, and it is compassion that serves as a source for all healing intentionality. Compassion connects the suffering of the patient with the healer's own suffering, and this emotional connection instantiates a healing relationship. The power and importance of mindfulness and compassion for healing are explored along the Frank model of nonspecific therapeutic components. This is the approach whereby a health care professional can elicit self-healing powers in patients through his or her inner attitudes. Finally, a research program and some hypotheses on how to implement and research this specific approach toward the creation of an OHE are outlined.

INTRODUCTION

This paper deals with the question of what might be necessary for a health care professional to create self-awareness and a relationship with the goal of creating wholeness and growth. It explores why this approach can elicit self-healing capacities in the healer himself or herself, and why this ability is crucial for any (healing) relationships with patients.

The focus of the paper is on the concept of mindfulness and on the notions of awareness, love, and compassion as key for the creation of an optimal healing environment (OHE) through healing intentions. A core thesis is that every healing effort and every healing intention starts within the health care professional him or herself. Thus, an accepting, mindful and warm-hearted relationship with the self is primary to any healing intention. This thesis is subsumed under the headline healing the healer.

BASIC IDEAS AND CONCEPTS

To be and to do

A basic distinction must be made between "to be" and "to do." The question "how to be?" addresses the issue of "how am I in the world?" or in other words "what is my basic attitude toward everything I experience (including myself)?" The question "what to do?" addresses our behavior including verbal behavior. The same behavior can be displayed with different inner attitudes. For instance, one of the most common interactions between a health care profes-

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sional and a patient is the question "How are you today?" This can be asked in an annoyed and neglectful way, but also with compassion, acceptance, and respect.

Relationships: Inner and outer

All questions regarding "How am I in the world?" are questions about relationship. Questions regarding basic attitudes are questions about relationships with others including: humans, animals, plants, material objects, and immaterial things such as ideas and concepts. Relationships can differ widely on various aspects. But, there are not only relationships with others or the outside world; everyone also has a relationship with him or herself as the relationship toward ones inner world.[1]

Mirror principle

There is symmetry between someone's relationship with the outer world and his or her inner world. All the qualities of the inner relationship with the self will also be reflected in outer relationships. The inner relationship is the basic template for any encounter with the world, and as such is the starting point for all encounters. If one is able to acknowledge herself, she will also have the capacity to acknowledge others. If someone cannot accept himself as a whole and has to neglect some aspects of his personality, then he will not be able to accept others for what they completely are. I call this symmetry the mirror principle because it reflects in both directions. In transforming the attitudes toward the self, one can start to encounter the world in a different way.

I believe all healing relationships start in the person of the health care professional. To the Western mind this sounds unexpected because one of the basic assumptions of the Western medical philosophy is the idea that something has to be done for the patient. This often includes the idea that the health care professional has to hold back his or her own personality in a medical context because the patient comes first. The concept that every healing intention starts from a healthy attitude towards the self, or in other words, healing starts by healing the healer challenges that assumption.

Acceptance

One of the basic qualities in a healing and holistic encounter with a patient is unconditional acceptance and positive regard. But this cannot be achieved without self-acceptance and self-respect. A basic feature of the Western culture is to evaluate people according to what they achieve. Most people do the same with their selves. Self-acceptance and self-respect are often tied to achievement and success or, in other words, to things that are done. People act in order to achieve acceptance and respect for what they do.

However, unconditional acceptance means to accept and to respect ourselves for what we are. The fact that we are alive is sufficient to spend life respectful and to accept it. We do so with newborns and also with old people, and we can do so with ourselves as well.[2]

A healing attitude toward the self

A healing attitude is a way to approach wholeness and well-being in one's own self in a way that creates a foundation for a healing relationship. Holmes[1] in a book written with several coauthors described it as "connecting with our inner selves." According to this approach, there are many components and inner voices "that make up the completeness of who we are."[1] They are known in psychology by a variety of different labels such as "archetypal patterns," "schemes," or "subpersonalities." All of these inner voices have their own positive function for the whole system. Sometimes this positive function may be obscured and cannot initially be seen. A "healthy" system is characterized by the possibility to move from one position to another as required (e.g., by changing from the "business" mode to a "playful" mode).

But if the system is out of balance, a person might be locked in the ever critical or ever-devaluing mode. According to Holmes' concept, there is a center in this inner system of a different quality from which the parts or subpersonalities can be observed. This center might be called "observing ego," "witness," or "self." Observing all these parts without being identified with one of them increases the sense of who we are. The concept of mindfulness introduced in the next section deals with this kind of observation. Through the capability to observe the inner self from this nonidentified position, a more self-centered attitude will be developed. In this state, one is better "able to experience feelings of compassion, calm, and competence, along with a deeper understanding of other people."[1]

MINDFULNESS

Mindfulness is one of the key methods and competences required to connect with the inner selves and to develop compassion for the feelings of other people. It is often described and explained in terms of the practice of mindfulness meditation. Another approach is to describe some of the attitudinal qualities that are integral to a mindful approach.[2–6]

A first definition and the Buddhist origin of mindfulness

Kabat-Zinn described mindfulness as a "consciousness discipline" that can be explained "as the intentional cultivation of non-judgemental moment-to-moment awareness."[7] The concept has its origin in the teachings of Buddha. It is the

core principle of the Buddhist *Theravada* tradition (i.e., the way of the elders).[8] *Vipassana* is a Pali word that is often used synonymously for mindfulness, although the meaning is slightly different. It means insight and stands for the intention of the mindfulness practice, while mindfulness itself stands for the attitudinal qualities of that intention.

Mindfulness meditation: The formal practice

Mindfulness is a bare and continuous moment-to-moment awareness of our experiences. This means in meditation that the pure awareness of the experience of the present moment is the object of the meditation. The mind in this process focuses on the present experience without the slightest reaction toward this experience. These might be sensual, bodily, emotional, or mental experiences. This kind of attention is not easy to maintain. Often the mind engages in past experiences or in planning future activities rather than being at present. Also strong emotions are frequently a source of distraction.

Mindfulness qualities

As described, the focus of observation is on the experience. The attitudinal qualities involved in this observation can be described by the mindfulness qualities.[6,9–11] There are two groups of qualities related to two intentions linked with mindfulness practice. One intention is to gain insight. The other intention is to encounter ourselves and the world with an attitude of love and compassion. Thus, the two basic qualities of mindfulness are the mental quality of clear insight and the heart quality of loving kindness.[12]

Nonjudging. This quality represents bare observation. It means that one should not infer from what one is observing, and should not evaluate the observations in any way. One should just observe with equanimity the immediate experiences as they are.

Acceptance. Nonjudging is the basis for this quality. The acceptance is holistic and unconditional. This is also a quality serving the acknowledgement of the experiences as they are.

Nonattachment. This quality stands for the nonidentification with the object of our attention. It stands for not getting carried away by thoughts or feelings and not holding on to experiences. The observation is detached from the object.

Beginner's mind. This quality stands for the openness with which the experiences are observed. It is the quality of seeing things "as if for the first time." It is an observation full of curiosity, interest, and joy.

Nonstriving. The observation is not goal-oriented. There is no intention to change experiences by the process of observing them.

Gentleness. A detached and nonevaluative observation is not necessarily cold hearted. Mindful awareness is warm, gentle, soft, and tender.

Kindness. Kindness or loving kindness is the core heart quality of mindfulness. It stands for a cherishing, benevolent, and loving attitude toward all our experiences. This loving kindness is unconditioned and holistic. This kindness has its origin not in a desiring ego, but in a void that is selfless and sharing.[13]

Informal practice

Mindfulness is not a meditation technique. Mindfulness meditation is a means to practice and by which to learn mindfulness. Mindfulness is a way of being.[8] Mindfulness can be practiced in all aspects of daily life. One can bring moment-to-moment awareness to all activities and to all experiences. Mindfulness in daily life simply means "to be present" in all of one's activities and interactions.

Baime[14] described the difference it makes whether a doctor simply encounters a patient in a medical and technological mode or with his full presence. In the former, the doctor is mentally preoccupied with the patient's medical history and with choosing a possible diagnosis, while he or she is, at the same time, listening to the patient. His mind is not with the patient but elsewhere, the doctor is busy thinking in the past (medical history) or future (therapy to be described). In the latter, the doctor brings not only his technology or knowledge, but his or her whole human presence into this clinical encounter. Here, it is more likely that the patient will have the feeling that someone is listening and that he or she is being accepted for what he or she is. Equally, the doctor will gain a better understanding of the specific problems of the patient when really listening rather than being busy with other cognitive activities. The patient feeling accepted, will more likely describe directly his or her true complaints and problems, again facilitating the communication process between them.

Practicing mindfulness may lead to insight, detachment and equanimity. Insight may result from a continuous process of pure and nonattached observation. Detachment and equanimity may result from the practice of nonstriving and nonattachment. Mindfulness practice may also lead to compassion and love because mindfulness also involves qualities of heart.

Love and compassion

There are 40 objects on which one can concentrate in Buddhist meditation. Four of these have been linked to the development of moral and spiritual qualities. They are the "Four Divine Abodes" (in Pali, *brama vihāra*) and they are also often called the cardinal virtues of Buddhism.[8] They translate into English as the notions of loving kindness (*mettā*), compassion (*karunā*), sympathetic joy (*muditā*), and

equanimity (*upekhā*). A balanced state of mind, a self-centered position that is neither affected by attachment or aversion, is subsumed under the term equanimity. It is the basis for all self-less love, for true altruism.[8]

Loving kindness, compassion, and sympathetic joy are strongly related to each other and are all different aspects of the same quality: love. This kind of love is egoless and unconditional. It is charity, the ability to encounter others with a benevolent and open heart. Loving kindness is not just a friendly behavior, achieved by holding back negative emotions. It is the spontaneous act of a balanced mind, that aims for the happiness of the other unconditionally.[8,13]

The practice of mindfulness meditation as briefly described above supports all four abodes in the meditator. But there are also formal meditation exercises for each of them (often referred to as merrā-meditation as described by Kornfield,[7] Mitchell,[10] and Solé-Leris.[8] They all start with practicing love toward the self as an example of a sensitive being. The next step involves practicing love toward others. Thus, the core principle of any healing process is to start with one's self.

In conclusion, and according to Buddhist wisdom, two qualities are necessary for someone's inner potential to unfold, and both are necessary to initiate self-healing powers integral to every living system. It is the practice of mindful awareness, observing the very moment in a nonevaluative way on one hand, and it is an attitude that comprises loving kindness and compassion on the other.[2] Loving kindness can be practiced in meditation in the same way that observing in a nonjudging way can be practiced.

Applied mindfulness: A nonesoteric approach

So while the mindfulness concept has an Eastern and somewhat religious background, this origin is not necessarily relevant for its application. Kabat-Zinn[6,9] demonstrated that mindfulness can be taught in a completely nonesoteric and nonreligious way. He developed a health program termed mindfulness-based stress reduction (MBSR). This 8-week program is suitable for chronically ill patients as well as for healthy individuals who want to improve their abilities to cope with stress. A meta-analysis of the controlled studies from the last 20 years has concluded this intervention to have a significant impact.[15] For both, standardized mental health and physical health scales the patients receiving MBSR scored more than half a standard deviation better than participants in the control condition (/N/ = 771 participants, /k/ = 10 studies, mean effect size mental health scales Cohen's /d/ = 0.54, $p < 0.0004$; physical health scales: N = 203; k = 5; d = 0.53; $p < 0.0004$).

So while it might be of interest for people working with the mindfulness concept to understand its background and origin, it is not essential. Mindfulness can be learned and practiced without referring to this background, and it has been shown that it is an approach resulting in significant health benefits.

HEALING INTENTION: HEALING IN AN INTERPERSONAL RELATIONSHIP

Healing intention

So far, only the inner relationship has been considered as a foundation for healing interaction, and the basis from which to practice loving kindness and compassion towards the self to develop these qualities in relationships with others. This loving and compassionate attitude toward others is the foundation for any healing intention. It is compassion in particular that serves as a source for all healing intentionality. Compassion connects the suffering of the patient with the healer's own suffering. The patient's suffering reminds and points the healer to his or her own distress. This emotional connection often referred to as empathy instantiates a healing relationship. From the Buddhist perspective, the deeper connection in this process is insight into the truth of suffering (*dukhka*), which is one of the Four Noble Truths.

Other qualities that arise from this connection are unconditional love, acceptance, and hope. They are all essential qualities in any healing process. Positive expectation and hope communicated by a trustworthy health care provider especially can elicit strong self-healing powers. How these qualities are effective in the interaction with the patient can be excellently studied in the framework of non-specific healing factors presented by Frank.[16]

Nonspecific healing factors

Without referring to any kind of specific therapy, intervention or treatment, Frank identified nonspecific therapeutic components in answer to the question "What heals?" These nonspecific components are only about the relationship between the healer/doctor/therapist and the healee/patient, and about the *meaning* that is created in this relationship by the means of rituals and language. Frank[16] identified four key principles:

1. An emotionally charged, confiding relationship with a helping person:

   There are two components that are important to form such a relationship. They are "the adherence of therapist and patient to the same therapeutic myth"[16] (i.e., a shared belief system), and "the therapist's continued acceptance." Applying the ideas derived from the Buddhist mindfulness concept as outlined above, it is possible to add that an emotionally charged relationship can be established if the healer/therapist encounters the patient with his or her full awareness and presence. This means that the therapist is not hiding behind a professional stance, but shows his or her full personality in a genuine human way. Moreover, a therapist or healer who is practicing mindfulness toward his own person is likely to display an unconditionally accepting and compassionate healing intention toward the patient.

2. A healing setting with three functions: Symbolizing the therapist as a healer, raising the patient's expectations and providing safety:

   The healing setting is created by the relationship that is established. But to raise the patient's self-healing capacities, the necessary expectations such as hope for improvement have to be generated. This can be achieved by three means that are mutually interdependent: (1) by the therapeutic rationale; (2) by symbolized significance of the therapist as healer; and (3) by providing safety.

   This approach entails two aspects that are essential and crucial to any healing process. On the relationship side there has to be closeness, similarity, and a close bond to enable expectations and safety and to communicate love and compassion. The opposite is needed on the meaning side. Here differences in the mental concepts between therapist and patient are needed. A "difference that makes a difference"[17] has to be introduced to create a new meaning on the side of the patient. If the patient creates new meaning then he or she makes a different sense out of his or her situation. He or she will then look at his or her own life from a different perspective, maybe even with a different mindset, and this change is one of the most important sources for the activation of self-healing powers. That is why there is a large healing power to every new treatment that comes with a powerful myth even if it appears inert from a causal perspective.

3. A rationale, conceptual scheme, or myth:

   The therapeutic rationale has a similar function in serving to develop an alternative perspective of oneself, and to that symbolizing the therapist as a healer. The important step is the difference between the way one usually looks at oneself, and the way that is implied by the therapist and the healing myth he or she is communicating. It is not important whether the myth is a shamanic or esoteric one on the one hand, or a rational scientific Western one on the other hand. The important factor is whether it is able to create a new meaning[18] that introduces a difference.

   The power of this therapeutic rationale is critically dependent on the way it is presented by the therapist or health care provider. If the rationale is communicated with enthusiasm by a person who is obviously convinced and who is passionately living his medical work, it will have a strong impact. This is the point at which the motivational aspects of the health care provider enter the equation. The motivation to engage in work with patients also determines the attitudinal qualities that can be developed in the healer–healee relationship. Here again the mirror principle applies. The therapeutic rationale or myth can only make sense to the patient if it also makes sense to the person who is communicating it to the patient. Thus, the healer should have a strong belief system (not necessarily a fixed one), and the motivation to do the work should be something that is under continuous reflection or consideration. The healer can apply mindfulness to the study of his or her own intention and to correct it if hostile or halfhearted.

4. A ritual that requires active participation of both patient and therapist:

   A ritual serves the function of creating new meaning. It also activates the patient. This kind of intervention is even more powerful if the patient is advised to perform some ritual continuously in his or her daily life. This might be taking a pill three times per day 1 hour before mealtimes, or practicing yoga exercises for 20 minutes each morning. The important difference that is introduced here is that the patient can actively do something to improve his or her health. This generates a sense of control over one's own health, and can lead to improved responsibility for one's own well-being, rather than delegating it to the medical system. Both are essential components in raising self-healing capacities. Often they serve to create a coherent meaning for health and disease that makes sense to the patient. In the terms of Antonovsky's[19] salutogenesis model, this ritual yields a larger sense of coherence.

The development of healing intentions

The development of insight and especially insight into one's own suffering as the full acceptance of all the parts of one's self is a necessary condition for the development of true healing intention. However, people working in health care have various motivations to do so, and often it is this motivational background that matters. For example, an inability to cope with one's own history can result in activities to help others instead. Unfortunately, such a motivation does not necessarily benefit the other person. With this motivational background, the healee has to fulfill the unfulfilled needs of the healer and not all his or her behaviors will fit these needs. Thus, this cannot result in a healing intention comprised of unconditional acceptance.

Therefore, the development of true healing intention is linked to the process of self-acceptance, and to the process of scrutinizing the motivational background for an engagement in health care. Both processes are never complete, but are a continuous companion for the healer. They can be achieved through mindfulness, but it might be that mindfulness alone is not enough and that it is necessary to seek assistance from other professionals. This might be true for a deeper understanding of one's own history, especially in cases of severe trauma or persistent "blockage" that resist change even though addressed. It is not realistic to assume that every health care professional is free of any self-neglecting aspects or full of true unconditional healing intention. But the important point is that these motivational aspects are continuously addressed rather than ignored. The repeated questions "why do I want to work in this profession?" and "what is the aim of my engagement in this profession?" will serve to establish continuous growth to be-

coming a more powerful and a more compassionate therapist.

Another important source for the development of healing intention can be a spiritual background or tradition. The notion of mindfulness, although discussed here as a Buddhist concept, is in various forms at the basis of almost every spiritual tradition. Thus, mindfulness can be seen as the entry point to powers that transcend the self. Spiritual belief systems may benefit the development of healing intentions in a twofold way. As part of the therapeutic myth, they may provide a therapeutic-medical belief system that places the healer in a powerful tradition which is perceived to go beyond his or her own capabilities. They may also serve as a guide for the healer on how to develop love, compassion, and healing intention through spiritual growth.

Communication of (healing) intentions. The standard psychological answer to communication of healing questions is they are exchanged through all known communication channels, such as speech with its verbal and nonverbal components, body language and so forth. But from its very definition, an intention is a "mental state directed toward achieving a goal."[20] Moreover, science does not exactly know how mental states are transferred through physical behavior to another person. Recent research on so-called distant healing intentions indicates that they might also have an effect on another person even if there is no direct contact between them.[21] Therefore, a prayer for an absent person or a healing ritual conducted somewhere else might also introduce changes in the person for whom it is aimed. Thus, healing intentions are not necessarily bound to local interactions, but may transcend physical space by so far unknown mechanism(s).

The compassionate teacher

Reviewing the essential elements of this approach and again asking the question, "What is needed in the health care professional to obtain pure healing intention?," we arrive at the following answer: compassion, loving kindness and acceptance in the relationship, and being able to introduce a difference in the process of meaning construction between the patient and the health care professional. The latter can be attained through rituals, knowledge and experience. The combination of these two features can be characterized as the compassionate teacher.

The teacher is not trying to merge with the patient in a healing partnership with an emphasis on the sameness of all humans. The teacher knows that there is a difference between herself and the patient. He or she also knows that this difference is crucial to the introduction of any change. As a teacher he or she has a certain belief system that serves as a guide, and thus, he or she also has a strong motivation to work in this profession. But the teacher in this picture is also full of compassion. He or she does not avoid the patient and his or her feelings however unpleasant they are. The teacher is fully aware, and present, and empathizes with the patient. The suffering of the patient reminds the teacher of his or her own suffering. Compassion is the foundation for any healing intention.

RESEARCH PROGRAMS AND HYPOTHESES

Neither mindfulness, love, or compassion are qualities included in the current Western medical system. The rising economic pressure and the growing impact of technologies and quantitative outcome criteria restrict the space for these healing qualities. On the other hand, we are facing dissatisfied patients seeking complementary and alternative medicine (CAM) therapies and alternative healing environments, and this offers a opportunity to (re-)introduce the qualities of mindfulness, love and compassion into these medical contexts.

Mindfulness has not only healing qualities, but also research qualities. However, any research into mindfulness should also be conducted in a mindful way. A quick proposal seeking large effect sizes with just one or two outcome criteria within a short time period, in order to produce a high-impact publication before moving on to the next topic, will hardly benefit mindfulness. This kind of research culture produces scattered and unlinked results without any deeper understanding of the investigated phenomena. It is the attitude of the people involved in the research that makes the difference. The mindfulness qualities in the context of science and research fit excellently with the stereotype of the Western scientist: curious, open-minded, observing, detached, warm-hearted, and interested.

The healing concept discussed above is based on the ideas that mindfulness, awareness, love and compassion serve as the foundation for healing intention and healing expectations in health care providers. These healing intentions and expectations will elicit self-healing in the patient. The basic idea is to heal the healer. Two main questions arise, namely: (1) How can these concepts be implemented into our Western medical system? (2) How can the benefits of these implementations be evaluated? There are at least three possible implementation strategies that can be briefly outlined as examples for a larger variety of possible interventions.

Teaching mindfulness to health care providers

All of the staff of a clinical unit or a general practitioner's surgery can be acquainted with the concept of mindfulness. The easiest way to do so is the 8-week program for mindfulness-based stress reduction (MBSR) by Kabat-Zinn[6,9] (see also section entitled Applied mindfulness: A nonesoteric approach), which teaches mindfulness and awareness in various forms (sitting meditation, informal practice of mindfulness in daily life, body-awareness through yoga and

the body scan). This program puts a strong impact on the responsibility for one's own health.

Approaches like this are already being conducted in Philadelphia, PA (www.uphs.upenn.edu/stress/healthcare.shtml), and at the Stress Reduction Clinic at the University of Massachusetts Memorial Medical Center in Worcester, MA.[22] The effects of such a program for health care providers have to be evaluated from two perspectives: changes in the providers and changes in their patients. From the perspective of the health care providers, important criteria might be: physical and psychologic well-being (e.g., generic quality of life, symptom lists, depression, and mood), but also work-related parameters (e.g., job satisfaction, perceived stress, perceived control, perceived effectiveness and quality of patient relationship).[23] Moreover, it is also important to investigate whether the program really results in a change for the participants. Thus, mindfulness and awareness scales[11,24] and implementation controls have to be added.

On the side of the patient, the same global health care variables should be evaluated. If the project is taking place at a specific unit or with a specific patient population, the appropriate specific health variables should be added to the investigation. Furthermore, it is necessary to evaluate the quality of the health care given from the perspective of the patients (patient satisfaction, perceived empathy, quality of relationships). Ideally such an intervention should be compared to a control group. This could be a similar clinical unit or general practitioner's or outpatient department, where the staff have either had no training at all or a training program focusing on some medical skills.

Healing supervision

The next logical step to an 8-week program would be a structural change within the health care environment. This would guarantee that not only will the concept of healing the healer be introduced, but that its continuous presence in the medical system would be ensured. Expanding on the already existing and often well-embedded supervision concept with a spiritual or healing supervision model could include the following topics:

- Reflection on one's own motivation
- Reflection on one's own belief system
- Reflection on one's own limits
- Mindfulness and mettā meditation
- Reflection on the role of spirituality in one's own life and in the work context
- Social skills.

This program also reaches further because it takes into account that in order for a health care professional to develop healing capacities, several aspects of his or her own life and biography, as well as how to relate to patients, have to be addressed. The impact of such a program can be evaluated in a similar way to that outlined above for the MBSR concept.

Creating an optimal healing environment

The third proposal addresses not only the staff within a specific organizational structure, but also the structure itself. The ways in which organizations are designed and proceed may be either conducive or inhibitory for the goal of creating an OHE. Speaking more specifically for the health care providers that are addressed in this paper, there may be clinical environments that are designed in such a way as to facilitate a mindful and compassionate encounter with patients or, on the other hand, are more likely to produce mindless and scattered interactions.

The proposal is to restructure the clinical organization, such as a rehabilitation clinic, with the aid of professional organizational developers to introduce the idea of an OHE as a key organizational concept. Similar to the procedures of quality management systems or cost reducing systems, every detailed element, procedure and facility of the organization as well as the organizational structure as a whole will be evaluated and improved in order to reach an OHE. This could be done by small groups consisting of staff members on all levels and professional external counsellors.

The evaluation of such a complex project is of similar complexity. Ideally, the researchers would already be taking part in the process of restructuring the organization (formative evaluation).[25] Changes have to be assessed using a multitude of variables from different perspectives ranging from patient satisfaction to cost effectiveness. Evaluation concepts and methods for such an enterprise can be found in the relevant literature.[26]

ACKNOWLEDGMENTS

I am grateful to Helmut Wetzel for his inspiring input to this paper. I am also grateful to Harald Walach for helping comments and to Deborah Lawrie for her assistance in improving the language of the manuscript.

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