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Female Mental Health Professionals' Perspectives on Mindfulness Practice After a 10-Week Training: An Analysis of Final Essays

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Mindfulness-based interventions (MBIs) seem to benefit mental health professionals. However, their perspectives have been studied rarely in cultural contexts where mindfulness is still little known. The objective of this study was to analyze the perceptions of change and experiences associated with the mindfulness meditation practice of Cuban mental health professionals who participated for the first time in a MBI. A total of 26 female participants were included in this study. Data were collected using the final essays written after completing the intervention. Content analysis was used for analyzing the data, carried out independently by two researchers. Six main categories were identified: (a) intrapersonal changes, including subcategories such as stress reduction and increase in self-awareness; (b) interpersonal changes, including subcategories related to family and social relationships; (c) changes at work, including empathy and improvement in interpersonal communication; (d) use of different types of practices, including informal practices and mindful movements; (e) negative aspects of practice, including difficulties during learning and unpleasant experiences; and (f) other aspects not related to practice, including subcategories related to the facilitator's influence and group empathy. The outcomes suggest that mindfulness practices can be a beneficial complementary training for mental health professionals in Cuba.

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Public Significance Statement
This study highlights how mindfulness-based interventions could be relevant for mental health professionals to apply in their practice but also to improve their personal and professional well-being. The results identify how mindfulness practices could be applied in Cuba, where this approach is new, and the main physical, social, and psychological benefits of this approach. We have indicated which exercises are preferred by participants as well as difficulties and unpleasant experiences encountered during the training.

Keywords: mindfulness, meditation, mental health professionals, psychological practice, content analysis

Mindfulness practice consists of focusing attention on the present moment while observing the flow of sensations or the stream of thoughts, accepting what arises nonjudgmentally (Kabat-Zinn, 2003). In the health field, mindfulness-based interventions (MBIs) are being used for a wide variety of clinical populations with physical (Crowe et al., 2016) or mental (Goldberg et al., 2018) disorders. MBIs have also been investigated for use in health professionals. A recent meta-analysis of 38 randomized controlled trials (RCTs) for health care professionals and trainees concluded that mindfulness training had a significant moderating effect on stress, anxiety, depression, and psychological distress (Spinelli et al., 2019). Thus, MBIs are of particular interest to mental health professionals.

MBIs differ from most therapeutic interventions because the therapist must have a certain mindfulness trait to carry them out (Razzaque & Wood, 2016). Mindfulness should not be seen as a technique that the therapist "does" to the patient but as a mutual involvement in which both benefit. In this regard, a systematic review of 24 RCTs with a focus on mental health professionals showed improvements in self-compassion, stress, burnout, and psychological flexibility, among other areas (Rudaz et al., 2017). These results not only represent benefits on a personal level but also indirectly benefit patients through improvement in the therapeutic alliance (McCollum & Gehart, 2010; Razzaque et al., 2015). It must be highlighted that a therapeutic alliance is a significant predictor of the user's recovery (Priebe et al., 2011) and could be more effective than the type of intervention in any psychotherapy model (Norcross & Wampold, 2018).

According to Demarzo et al. (2015), MBIs are defined as complex interventions in which quantitative research is limited to understanding. Therefore, to understand the complexity of these interventions, qualitative and mixed methods research is necessary (Thirsk & Clark, 2017). Fostering qualitative studies in mindfulness research could allow the construct and the psychological processes involved to be explored in-depth (Cigolla & Brown, 2011; Proulx, 2003). Moreover, there could be therapeutic aspects of MBIs not related to the practice of mindfulness itself (Himelstein et al., 2012; Wyatt et al., 2014) in which qualitative studies could clarify the impact of the interventions.

Regarding studies to date that focused on analyzing the perspectives of mental health professionals, Christopher et al. (2011) interviewed 16 students who were practicing counselors; participants described how mindfulness training had influenced both their personal and professional lives. In a sample of 13 therapists in training, McCollum and Gehart (2010) investigated how to learn mindfulness, develop the capacity to be present, and achieve acceptance and compassion for themselves and their clients through thematic analysis. Cigolla and Brown (2011) employed interpretative phenomenological analysis to explore the impact of mindfulness in six therapists with 4–20 years of personal mindfulness practice and how they brought this into their therapeutic work. Finally, Horst et al. (2013) studied the experiences of both members of the therapeutic dyad (client and therapist) when using mindfulness in therapy. Ten interviews were analyzed, and the results indicated that both felt a positive impact of mindfulness practice on their relationship.

Mindfulness is practiced in dozens of countries, although most of them are Anglo-Saxon. The claim that MBIs operate similarly across cultures is a relatively unproven assumption (Ghorbani et al., 2009). It is important to investigate how mindfulness can be integrated into health systems that still do not have any type of experience with this practice, as is the case in many Latin American countries (Tovar García & García-Campayo, 2017). Specifically, in Cuba, mindfulness training has begun to be present in the field of health, mainly in scientific events and congresses. Thus, introductory workshops have been held on the practice of mindfulness (Ruiz-Íñiguez, 2017a), and conferences about scientific evidence of mindfulness in the health field (Santed, 2018) or MBIs for depression (Ruiz-Íñiguez, 2017b) have been presented. However, regulated training has not yet been developed.

Some specifications must be considered when discussing the integration of MBIs in the Cuban health system. First, Cuba has a widely eclectic, practical, and pragmatic tradition of psychotherapeutic resources in the training of its professionals, understood as an integration of the different psychological models and schools (Morales, 2011). Second, MBIs arose in a private health care system for White, middle to upper class populations (Olano et al., 2015), which contrasts deeply with Cuban characteristics. Third, Cuba has a free public health system, with scarce material and structural resources, based on a community care model. Finally, Cubanness is a peculiar quality of Cuban culture formed by a complex set of emotional, intellectual, and volitional elements (Ortiz, 1964). In contrast to masculine and individualistic American culture (Hofstede, 2001), Cuba is a collectivist country, with a strong group orientation and feminine culture, which leads Cubans to have a more intense experience and verbal expression of positive emotions than negative ones (Fernández et al., 2000).

Considering all of the above, there is a growing interest in achieving a deep understanding of the impact of mindfulness practice on mental health professionals in new cultural contexts. In addition, understanding the experience of Cuban professionals could elucidate how to promote and incorporate MBIs in Cuba.

Thus, this study focused on understanding the perceptions and experiences of Cuban mental health professionals with mindfulness practice, based on their reflections after participating in their first MBI. The purpose of this study was to analyze (a) the impact of mindfulness practice and the intrapersonal and interpersonal changes associated with it; (b) use of the different types of mindfulness exercises proposed; and (c) the possible existence of negative aspects related to the mindfulness practice and other aspects of interest.

Method

This research was part of a large study in which an RCT on mindfulness was carried out involving Cuban mental health professionals, focused on the reduction of stress, anxiety, and burnout. The RCT, with a crossover design, included two experimental groups. Training consisted of two blocks of exercises so that each group received the same training but with the blocks in reverse order. One block (5 weeks) consisted of body scan practices (becoming aware of one's bodily sensations) and mindful movement (hatha yoga exercises in a mindful way). The other block (5 weeks) consisted of focused attention meditation practice (focusing one's attention on a single object, such as one's breath or a sound) and open awareness meditation (open monitoring, becoming aware of everything that is happening in one's mind and body).

Each face-to-face session started with a review of home practice (starting with the welcome in the first session) and a reminder of the importance of compliance. Next, theories and explanations of the practice were developed. Practical exercises were then performed. Practice increased over the weeks, from 15–20 min in the first sessions to 40–45 min in the final sessions. There were two exercises per session, with a break between them. Finally, a group reflection on personal experiences related to the practice was conducted.

Thus, participants received 10 weeks of mindfulness training comprising weekly face-to-face sessions lasting 2.5 hr each and the recommendation of daily practice (20 min for 6 days a week) using audio guides. Informal practice (mindfulness in daily life activities) was also performed throughout the 10-week period. In this context, a qualitative study was conducted.

Research Team

The research team comprised five members. RRI is an expert in mindfulness and trained in qualitative analysis, whereas RPD is an expert in qualitative analysis and trained in mindfulness. ACM is a researcher trained in both qualitative analysis and mindfulness. RRI and RPD led the data analysis. In case of disagreement in the analysis, ACM intervened as a mediator and performed a critical audit of the identification of categories and patterns of meaning. AMG is an expert in qualitative research. MAS is the research dissertation director of RRI, with high qualifications and training in meditative techniques. Both AMG and MAS conducted a general review of the analysis.

Participants

In the RCT, 104 mental health professionals participated from different primary and hospital care centers in Havana Province. Regarding the selection criteria for inclusion in the RCT, participants had to be active professionals with regular patient contact and commitment to attendance during the intervention. Participants with particular medical conditions that discouraged their participation were excluded.

Subsequently, the participants in this qualitative study completed the RCT. Of the 104 professionals who started the mindfulness training, 77 completed the training. All participants were invited to participate in this study, and 26 female mental health professionals agreed to participate. The sociodemographic and employment data for the sample are presented in Table 1.

Data Collection

Researchers collected data from the final essays written by the participants. They were to explain the experience of practicing mindfulness, addressing the following aspects: (a) personal and interpersonal (i.e., family, friends, workmates, or patients) changes related to practice; (b) difficulties encountered in mindfulness practice and their experience with the different types of exercises proposed; and (c) general assessment of the effects achieved and any other aspect of interest that they wanted to point out related to the

Table 1
Sociodemographic and Employment Data

Data	Option	N[a]	%	M	SD	Range
Age (years)				38.65	11.66	26–62
Gender	Female	23	100			
	Male	0	0			
Profession	Psychologist	12	52.2			
	Psychiatrist	6	26			
	Other[b]	5	21.8			
Workplace	Clinical-surgical hospital	7	30.4			
	Psychiatric hospital	1	4.3			
	Polyclinic	6	26.1			
	Mental health center	5	21.7			
	Other	4	17.4			

[a] Sociodemographic and employment data were not obtained from three participants (they did not attach their personal password when submitting the essays, so the password could not be compared with these data), therefore $N = 23$, although the study considers $N = 26$. [b] One third-year psychiatry resident, one defectologist, one nurse, one general doctor specializing in addictions, and one rehabilitator.

mindfulness practice process. On average, participants wrote between three and five pages per essay.

In addition, an email follow-up was sent 6 months after the essay was written to collect information about the maintenance of personal practice and its incorporation into clinical practice. In this email, participants were asked (a) if they maintained their personal practice, what was the frequency, and what were the types of exercises they practiced and (b) whether they had incorporated any mindfulness technique into their care practice, with four possible answers: (a) "no, I do not consider it"; (b) "no, but I will consider it in the future"; (c) "occasionally"; and (d) "habitually."

Ethical Considerations

This study was part of an RCT registered in Clinicaltrials.gov that was approved by the Ethics Committee at General Calixto García University Hospital in Havana (2018, p. 168). Informed consent was obtained from the participants for analysis of their essays. The writing of the essays was voluntary and was not a requirement for course accreditation. Participants were informed that all identifying information would be removed before the analysis and that the essays were tagged with the personal alphanumeric code used in the RCT to preserve anonymity and to be able to compare the available sociodemographic data.

Data Analysis

Essays were anonymized and analyzed using content analysis, which is an accessible and flexible research approach for analyzing qualitative data (Braun & Clarke, 2006). Content analysis can be defined as a method for subjective interpretation of the content of a text through a process of systematic classification (coding) and identification of themes (Columbia Public Health, 2019). Only reflections of the essays focused on the participants' experience were used, discarding any other information described in the analysis (e.g., general reflections on theoretical aspects of mindfulness, advice for others, gratitude for having been able to attend the training).

Following the different approaches proposed by Hsieh and Shannon (2005) for content analysis, a conventional method was used (i.e., the categories were created inductively from the text, avoiding the use of preconceived categories). Two authors of this study (RRI and RPD) independently performed the analysis. They started with a comprehensive reading repeatedly to familiarize themselves with the data, highlighting words in the text that seemed to refer to key concepts. Next, they made notes of their first impressions, and it was in this process that the initial analysis and labels for codes emerged. Subsequently, the codes were ordered into subcategories based on their similarities and differences. Finally, both authors conducted a review to compare the codes that emerged and the subcategories created. In case of discrepancies, a consensus approach was used. They both worked together to organize all subcategories into a few manageable categories.

Results

The categories and subcategories are listed in Table 2. The information described in the sections below is taken from the analysis of the essays and is accompanied by verbatim excerpts. When data obtained at follow-up are referred to, this is indicated.

Intrapersonal Changes

This category included the most relevant aspects related to personal well-being. The main changes indicated by the participants were stress reduction and increased self-awareness about emotions, thoughts, and behaviors: "I am learning to identify what feelings or thoughts I have when, for example, I am not concentrating at work or because of anxiety [. . .] it is helping me to treat and understand how my head works" (p. 9).

Participants also indicated other effects such as feeling present-moment awareness, a greater capacity to accept themselves and the events around them, and feeling able to incorporate a nonjudgmental position:

> I realized that I rarely enjoy the present, and that is why I always want more. [. . .] I am an extremely angry person . . . Mindfulness has made it possible [. . .] to realize that this way of life is not the best [. . .] I have learned to live the moment, [. . .] understand that everything that happens around cannot be a problem because, in the end, I will be the one affected. (p. 14)

Likewise, some participants indicated an improvement in cognitive processes, especially in concentration, sensory perception, memory, and language: "My ability to concentrate improved a lot, and ideas flowed more easily" (p. 7).

Participants also assessed other positive changes related to physical well-being, mainly pain and other symptoms related to chronic diseases, and surgical operations. One participant also referred to improvement in her sexual relations:

> I have suffered a lot of dryness in the vagina, which has contributed to the decrease in sexual desire because I have even experienced pain. After the course, where I have managed to concentrate more on what I am living and not what may happen, we [her partner and her] have achieved a fuller sexual relationship. (p. 16)

Mindfulness also contributed to an increase in personal growth and self-confidence: "I noticed changes . . . in terms of the perception of myself, my body, my body posture, in a certain way, my self-esteem . . . it increased, and I began to look at myself and my appearance again" (p. 2). Participants also evaluated other changes in their health, such as improvements in sleep and mood, but mainly felt less sad.

Interpersonal Changes

A group of participants identified positive changes in family and social relationships. They associated mindfulness with better interpersonal communication, both in verbal and nonverbal language: "I listen more carefully to everything, to my patients, family members, and students" (p. 3).

Participants also related mindfulness to certain intrapersonal changes focused on increased personal self-awareness, nonjudgmental acceptance, and self-confidence. They reported better management of emotions, thoughts, and behaviors in interaction with others:

> In the couple relationship, it has helped me to see myself when I get angry and to observe myself [. . .] accepting other situations that I do

Table 2
Categories and Subcategories Developed From Content Analysis

Category	Subcategory	Reference[a]	
		%	*n*
Intrapersonal changes	Stress reduction	65.4	17
	Self-awareness increase	61.5	16
	Greater awareness in the present	50	13
	Acceptance without judgment	42.3	11
	Improvement in cognitive processes	38.5	10
	Improvement in physical well-being	34.5	9
	Personal growth	26.9	7
	Greater self-confidence	15.4	4
	Reduction of negative mood	11.5	3
	Improvement in sleep	11.5	3
Interpersonal changes	Improvement in family relationships	38.5	10
	Improvement in social relationships	11.5	3
	Meditation with others	15.4	4
Changes at work	Increase of empathy with patients	38.5	10
	Improvement in professional performance	30.8	8
	Improvement in coworker relationships	23	6
	Incorporation into clinical practice	23	6
Use of different types of exercises	Informal practices	50	13
	Mindful movements	46.1	12
	Mindfulness of breath meditation	38.5	10
	Mindfulness of sound meditation	23	6
	Open awareness meditation	23	6
	Body scan	23	6
Negative aspects of practice	Learning: lack of competence for concentration	23	6
	Unpleasant experiences (frustration, discomfort, boredom, sleepiness, fatigue, anxiety, and dizziness)	26.9	7
	Maintenance: lack of time and constancy	34.7	9
Other relevant aspects	Facilitator's influence	57.7	15
	Group cohesion	11.5	3

[a] Participants (percentage and number) who identified the category.

> not like about my husband [. . .] It has also helped me to control my anger at my son's disobedience. (p. 10)

The participants also related these changes to increased tolerance and understanding in their interpersonal interactions: "Before, the presence or the voice of certain people made me irritable and generated discomfort; now, I just let it go" (p. 14). Finally, some reported the incorporation into the mindfulness practice of people from their surroundings (family, professional, or social). They noted that practicing with people around them was easier and more rewarding.

Changes at Work

In addition to the improvement in the relationship with their peers, the participants alluded to an increase in empathy with the patients and greater attention, tolerance, and acceptance. Some professionals reported feeling more effective and with more ability to manage work pressures:

> Before [. . .] for example, I interviewed a patient, but at the same time, I was thinking that another patient was already waiting for me to be treated [. . .] Mindfulness taught me to dedicate all my attention and time to the person or activity that needed it, [. . .] doing it this way was the only way to do it really well and to feel satisfied with the results. (p. 11)

Participants referred to the use of mindfulness in clinical practice, considering that their patients could also benefit from it. Most of them indicated that they needed more personal experience and training to practice with their patients, although there were limited experiences related to the explanation of some relevant concepts and the use of practices, mainly breath meditation and informal meditation: "I explain it a lot in my consultations to remind patients that we are not the emotions we feel" (p. 10).

Participants also reported that practicing mindfulness personally was a way of incorporating mindfulness into their clinical practice, as it indirectly benefitted the patient. This was related to the improvement in professional performance and to the intrapersonal changes observed: "It helps me to take a break and be able to see clearly what I am doing, saying, and how I am feeling when interacting with my patients. [. . .] This also works for my patients" (p. 5).

Seven out of the 15 participants (57.7%) who responded at the 6-month follow-up indicated that they had occasionally incorporated mindfulness into their clinical practice (teaching some mindfulness exercises to the patients) when asked about it; no one included it regularly. Six said they would consider it in the future.

Use of Different Types of Exercises

This section collected the assessment made by the participants about the mindfulness exercises. Half of them highlighted informal practices, mainly related to domestic tasks (washing, cooking, and

cleaning being among the most relevant). Participants referred to their preference for such practices to take place anywhere and at any time: "I identified a lot with the informal meditation especially when I had that first coffee in the morning, that is, and it will continue to be important to me, so then I dedicated that little time to meditate" (p. 19).

However, one participant pointed out that informal practices were the ones that he did the least of because they seemed the most complex:

> It was really difficult for me to do this practice; it is the one I felt least comfortable with [...] I prefer to dedicate a specific time in which I know that I am going to do some mindfulness practice, rather than doing it in conjunction with another activity. (p. 7)

With regard to formal practices, participants positively highlighted some exercises, especially mindful movements and mindfulness of breath meditation. Breathing was also used informally as a short pause in difficult or stressful situations in daily life. The remaining exercises were less frequently practiced, but one participant highlighted the body scan:

> Body scan was a deep and rewarding experience, because, strangely, I got to know every beat of my body. The way to discover it, feel it, and touch it was wonderful and in a conscious way. Feel my hands, my feet, fingers, and body. Discovering how I feel my body, through every sensation of tingling, cramping, or simply pleasure is extraordinary. (p. 17)

Regarding the data at follow-up, the exercises that participants still practiced after 6 months were informal practice (92.9% of the participants), mindfulness of breath meditation (85.7%), open awareness meditation (57.1%), mindfulness of sound meditation (42.9%), mindfulness movements (7.1%), and body scans (7.1%).

Negative Aspects of the Practice

Some participants made different allusions to learning difficulties, referring to a lack of concentration. These questions mainly referred to the first weeks. When participants first started practicing mindfulness, they realized that their minds could not stop thinking; although the mindfulness trainer pointed out as usual when starting to practice, practitioners felt frustrated. Reference to the difficulty in concentration also occurred when participants started open awareness practices, after a few weeks of practicing focused attention, related to the difficulty of going from focusing on one thing at a time to opening the mind to the entirety of the environment. These difficulties led to negative self-judgment in this regard, indicating a lack of personal competence:

> At first it was somewhat annoying because thoughts of all kinds mixed in my mind making a lot of noise, and it was difficult for me to return my attention to my breathing. I continually told myself that I was doing it wrong. (p. 15)

Some unpleasant physical and emotional experiences were reported to be related to learning difficulties, especially during the first moments of training. Participants mainly reported frustration, discomfort, boredom, sleepiness, fatigue, anxiety, and dizziness. Some participants related these discomforts to specific practices (body scan and mindfulness of breath meditation), reporting that connecting with their body or the slowness of the exercise generated anxiety: "What the fact of being consciously breathing generated in me was more anxiety and to a certain point discomfort" (p. 24) and "In the body scan [...] I went away easily, and when I returned, I felt dizzy, I had anxiety while waiting for the other order" (p. 1).

The participants indicated that the greatest difficulties in maintaining daily practice were lack of time and the need for constancy. Regarding the data at the 6-month follow-up, all participants indicated that they continued to practice mindfulness on a personal level, although only six participants did so regularly (at least 2–3 times/week).

Other Relevant Aspects

Among the positive aspects identified by the participants, but not related to the practice itself, the importance given to the relationship generated with the trainer stands out. Thus, expressions of gratitude, emphasizing her empathy and availability, made the influence of this aspect visible. The other aspect to be highlighted was the group cohesion, the sense of belonging, and the importance given to sharing the experience with others, seeing the value of the group as a strengthening the practice of mindfulness: "Keeping practice is what I know that it will be more difficult for me because having a group that shares experiences ... helps a lot" (p. 21).

Discussion

This study contributes to the literature by illuminating mental health professionals' perspectives on practicing mindfulness after mindfulness training in a context in which mindfulness is still little known, as it is in Cuba. Participants reported improvements in physical well-being, stress levels, cognitive aspects, self-awareness, capacity for acceptance, personal growth, and self-confidence. Participants also identified changes in their family, work, and family relationships, as well as enhanced professional performance, considering that their patients had received the benefits indirectly. Satisfaction with the different types of exercises was unequal. Specifically, informal practices, mindful movements, and breath meditation were the most valued. Participants also suggested negative aspects related to mindfulness practice, reporting difficulties in learning, and maintaining the practice and unpleasant experiences when practicing, such as frustration, discomfort, or boredom. Finally, the trainer's influence and group cohesion were other relevant aspects highlighted.

Considering the eclectic approach of most Cuban psychotherapists practice, the most natural way to integrate mindfulness into clinical practice would be informally (not through a standardized protocol). Germer (2005) referred to three different ways of incorporating mindfulness informally: an indirect approach, through benefits in the professionals themselves; a theoretical direct approach, incorporating ideas and concepts related to mindfulness; and a practical direct approach, teaching mindfulness exercises to patients. This study focused on the indirect approach, as participants attended mindfulness training to reduce stress levels and other related constructs.

The mental health professionals in this study reported personal benefits that are consistent with those indicated for nonclinical populations and health professionals in other studies. Thus, several mindfulness reviews and meta-analysis noted a decrease in stress

(Rudaz et al., 2017), improvement in self-awareness and nonjudgmental acceptance (Morgan et al., 2015; Wyatt et al., 2014), improvement in cognitive processes (Chiesa et al., 2011) and concentration (Morgan et al., 2015), improvement in such aspects of physical well-being as physical pain or symptoms of illness (Morgan et al., 2015), personal growth (Beckman et al., 2012), greater self-confidence (Morgan et al., 2015), improvement in mood (Eberth & Sedlmeier, 2012), and improvement in sleep (Morgan et al., 2015). Closely related to intrapersonal changes, mindfulness practice produced interpersonal changes. In fact, some participants seemed to perceive more clearly how mindfulness had affected them personally when talking about their interpersonal relationships. The relationship with others was one of the key categories indicated in the reviews, both in clinical populations (Wyatt et al., 2014) and among health professionals (Morgan et al., 2015). Specifically, improvements in family and coworker relationships were also reported in other studies with health professionals (Cohen-Katz et al., 2005; Razzaque & Wood, 2016). However, the compassion reported by other studies (Morgan et al., 2015; Razzaque & Wood, 2016) did not appear in our study. According to Hofstede's (2001) theory, the feminine Cuban culture would be more related to compassion than other masculine cultures, as in the case American culture. We can hypothesize that the more compassionate nature of Cuban culture would explain why the participants did not refer to this aspect as something that the practice of mindfulness had brought them, in contrast to masculine-based culture.

Regarding the type of practice, participants in this study highlighted informal practices, both immediately after training and at follow-up. However, one participant encountered difficulties because they did not have a specific time to practice. This aspect was already pointed out (Morgan et al., 2015), indicating that it can be difficult to identify mindfulness because it is complex to determine when one is informally meditating. The use of informal practice during housework stood out, which surely was related to the gender of the sample, as was the case in a study with nurses (Cohen-Katz et al., 2005).

Regarding the negative aspects, the reasons identified in this study as barriers to learning and practice (difficulty in concentrating and lack of time and constancy) were reported both in the clinical population (Wyatt et al., 2014) and among the professionals (Morgan et al., 2015). The unpleasant experiences referred to in this study were also noted in health care workers (Morgan et al., 2015). However, Cebolla et al. (2017) pointed out that very few experiences are universally classified as negative, with the same effects being interpreted very differently between people; discomfort can be experienced as something minimal and transitory, as was the case in our study, or it can be experienced as something severe and persistent. Thus, in the Buddhism tradition (Theravada, Tibetan, or Zen), the unpleasant experiences related to meditation are not seen as negative but as part of the experience and the path (Sayadaw, 2016; Wallace, 2011).

Other studies indicated that incorporating a greater state of presence influenced the improvement of communication and greater tolerance, understanding, acceptance, and empathy in the professional sphere among therapists in training (McCollum & Gehart, 2010; Rimes & Wingrove, 2011), aspects similar to those emerging in this study. Nonjudgment is fundamental in the helping professions, and mindfulness can improve therapeutic skills. The use of mindfulness would be a way of being present in therapy and of being connected with each other through a conscious and present disposition. It would allow one to be compassionate, without judging the other, with which it is possible to be in tune (state of mental resonance). There is a positive correlation between the therapist's mindfulness skills and the quality of the therapeutic alliance (Wexler, 2006).

The participants in this study also reflected on the direct approach to integrate mindfulness informally in clinical practice (teaching mindfulness to patients). Most studies with professionals/therapists in mindfulness training showed the intention of applying mindfulness in clinical practice, even if the objective of training was to apply it to professionals' personal lives (Christopher et al., 2011; de Zoysa et al., 2014). It has been hypothesized that the degree of use of mindfulness in therapy depends on the comfort level of the therapist (those who maintain personal practice being more confident) and the patient's comfort level in the use of mindfulness (Christopher et al., 2011), which is in line with our findings.

There are no rules on what is required of the professional who applies it informally (Steiner, 2014), but it has been pointed out that patients feel more comfortable when professionals are using mindfulness on themselves (Horst et al., 2013). Moreover, authors who introduced MBIs in Western cultures have also emphasized the importance of the therapist as a practitioner (Kabat-Zinn, 2005; Segal et al., 2002). In some studies, the therapists noted the need for further training before using mindfulness with patients (Christopher et al., 2011; de Zoysa et al., 2014), as indicated in our study. However, Pollak (2013) maintained that including mindfulness informally in therapy does not require excessive training but only basic training for the use of breaths and simple meditations. He particularly referred to this when the therapist is interested in exploring the technique. Finally, scholars have warned that professionals who focus on learning techniques for their patients are less motivated to overcome barriers to practice than those who focus on self-care; thus, a key aspect in the training of professionals may be in the analysis of initial motivation, communicating the need to develop an experimental personal understanding of mindfulness (Morgan et al., 2015).

Implications for Training and Clinical Practice

Considering that all the benefits, difficulties, and reflections indicated in this study were common to other similar studies carried out in other cultural contexts, it could be pointed out that MBIs seem adequate for implementation in Cuba. However, there were unique aspects related to the Cuban context that are worth highlighting.

The first such aspect concerned the role of family and groups. Latino families tend to be large, with strong communication among their members and frequent contact (García-Campayo & Demarzo, 2014). In Cuba, it is common for different generations of the same family to share the same home, and Cuba is a collectivist country (Fernández et al., 2000). Thus, although professionals from other cultures indicated that they had practiced with family members and people around them (Morgan et al., 2015), the family and groups were able to play a crucial role in Cuba. In this study, participants noted that practicing in a group was easier. Therefore, encouraging participants to include other people around them, such as family members or coworkers, in their regular practice, to establish a practice group, or to carry out periodic follow-up group sessions once training had finished should promote long-term continuity in

mindfulness practice. It should be noted in the review by Proulx (2003) that of the 21 studies analyzed, the 2 with no significant decrease in anxiety were those in which the intervention had been individual.

The second such aspect concerned the role of the body. Latin population is usually less reserved in showing the body and make direct physical contact more easily; therefore, the practice of body scan and mindful movements would be the most comfortable exercises for this population (García-Campayo & Demarzo, 2014). The ease and naturalness with which one of the participants spoke about mindfulness in sexuality would be consistent with this line of thought. However, contrary to these indications, breath meditation was the most successful formal practice, and body scans were not specially practiced. The practice of mindful movements, although the second most practiced exercise during training, was one of the least practiced at the 6-month follow-up, which could be related to the need to have a specific physical space. The lack of sufficient physical space to practice these exercises at home is due to the high number of people sharing the same house, caused by the existing housing deficit in Cuba (García Vázquez, 2018). Therefore, providing a place in the community area to implement structured or informal mindfulness activity like dance would be essential.

The third aspect concerned the influence of religion. It has been pointed out that Christian influences in Latin American countries must be considered, since certain practices emerging from Buddhism and Hinduism could be incompatible with religious beliefs (García-Campayo et al., 2017). However, aspects related to spirituality and religious beliefs were not made explicit in this study. One reason may be that participants were not specifically asked about such beliefs. Another reason could be that the experience of religiosity in Cuba is quite different from that in other Latin American countries. Cuba has a political singularity, a multiracial identity, and a religious life not marked by religious orthodoxy (Pérez Cruz, 2000).

The fourth aspect concerned the expression of negative feelings. Cultural, racial, and ethnic factors affect the experience and expression of emotions (Hofmann & Hinton, 2014); Cuban culture is marked by more intense verbal expression of positive than of negative emotions (Fernández et al., 2000). Perhaps the participants only pointed out aspects of difficulty in practice because they were specifically asked about it. Considering that more than 75% of the studies on meditation do not actively evaluate the adverse effects (Lindahl et al., 2017), but rather are the result of spontaneity, it is unlikely that Cuban people report negative effects if not expressly asked. Therefore, the importance of working on negative initial experiences and obstacles to practice is critical for understanding and maintaining practice. In fact, in this study, although body scans were very beneficial for some participants, others associated them with unpleasant effects, and they stopped practicing the exercise possibly for this reason. The most highly valued exercises were those that continued to be performed 6 months after the end of training. Conversely, open awareness meditation practice had increased at follow-up, which was possibly related to reduced difficulty in concentrating, referred to at the beginning of training and mainly linked to this meditation.

Therefore, in clinical practice in Cuba, it would be essential to be able to talk about negative aspects connected with the practice, in which the role of the instructor is fundamental. Thus, many of the participants' comments about what they liked the most in training referred to the instructor (attitude, availability, presence, and way of teaching). When starting to practice mindfulness in general or trying a new particular exercise, it is essential that the instructor indicates different ways to stay grounded to the practitioner, and the practitioner must try to feel confident in the practice. However, it seems inevitable that a person tends to self-judge in the first steps of mindfulness practice. Weber (2017) pointed out that judgment is closely attuned to ignorance and argued against the capacity for nonjudgment.

Limitations and Future Research

This study has several limitations. First, the participants were self-selected, so they were people with a preexisting interest in the topic, which may have affected their responses. Similarly, the 6-month follow-up data referred only to professionals who wanted to respond to the study, who were presumably the most motivated, and those who continued to practice. Second, the final essays were held at the end of the long extension course. Many of the statements in the sample were retrospective in nature, so the temporal relationship was difficult to assess, and information bias may have occurred. Third, the participants' responses could have been affected by what they felt they had to say in gratitude to the course and to meet the instructor's expectations. The type of analysis performed did not allow the content to be clarified with the participants, as there was no interaction with the investigator. Asking about specific aspects in a certain way could have forced answers that otherwise would not have been given. Fourth, the sample was made up entirely of women, although it was a diverse sample in other aspects (such as age and work experience). All these limitations and potential biases make it necessary to treat the results with caution.

It would be interesting to conduct longitudinal measurements of weekly reflections during training and follow-up in future research. In relation to the differentiation that Lutz et al. (2002) indicated regarding measurements in research on the nature of the mind, it would be of interest to contemplate second-person perspectives (i.e., measures based on reports made by people close to the patient, as spouse, or coworkers). To fully understand the effects of mindfulness training on the clinical practice of mental health professionals, patient feedback is essential. It would be interesting to investigate the experiences and therapeutic alliance perceived by patients from three groups: nonpracticing professionals, practicing professionals who do not instruct their patients in mindfulness, and practicing professionals who do. In addition, patients were blinded to the first and second groups. Furthermore, conducting in-depth interviews or focus groups could achieve a better understanding of the perceived results and more spontaneous reflections, allowing certain aspects to be clarified (e.g., incorporation of mindfulness meditation with other family members or how to deal with barriers to practice and unpleasant experiences).

How to motivate people to maintain regular practice is a challenging aspect that would benefit from further analysis of, among others, the question of which kinds of people prefer what type of exercises and the influence of group cohesion in maintaining the practice. The identification of preferences in regard to practices in different cultural contexts could be key to maintaining the practice and its cultural adaptation in the professional field. Specifically, in the Cuban context, it would be necessary to deepen future research

on the aspects indicated in this study, such as the importance of the body or the impact of religion, including male samples.

Conclusion

It is essential to consider professionals' perspectives in the field of mental health to reflect on the training process in mindfulness. This study provides preliminary insight into the perspective of a sample of Cuban female mental health professionals on their experience of practicing mindfulness after participating in mindfulness training.

Similar to other cultural contexts, participants in this study found benefits in terms of stress level, self-awareness, acceptance, cognition, physical well-being, personal growth, and self-confidence. In the same way, they reported improvements in relationships, including personal and work relationships. In addition, mindfulness practice was indicated as a facilitator to improve professional performance by improving tolerance, understanding, acceptance, and empathy, which in turn could be related to a better therapeutic alliance.

In Cuba, an informal approach (not based on a standardized protocol) is the suitable approach for the clinical application of mindfulness. The aspects of the Cuban cultural environment that we suggest for consideration are the important role of the family and social relationships, aspects related to corporality and physical contact, as well as the possible difficulty in talking about negative aspects in comparison with other cultural contexts.

The development of mindfulness training in Cuba has a series of keys to be specified. There is a potential role of family and other social groups as facilitators to keep the home practice (doing it in group and not individually). It does not seem necessary to consider aspects related to Catholicism and Christianity in the trainings, given the lesser religious influence compared with other Latin American countries. Finally, it is crucial to facilitate the expression of negative experiences and obstacles related to mindfulness practice due to the less intense verbal expression of negative emotions in Cuban population.

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