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Felicia Marohn
Meditation & Mindfulness in Dialectical Behavior Therapy: An Exploration of Therapists' Experiences with Personal Meditation and Mindfulness Practices

ABSTRACT

The majority of mindfulness research conducted over the past two decades has examined client improvements and far fewer studies have connected the benefits of meditation and mindfulness to skills and well-being of psychotherapists. In this exploratory study, I examined how therapists who practice Dialectical Behavior Therapy (DBT) experience a personal meditation and mindfulness practice. The goal was to explore DBT therapists' attitudes and perceptions regarding potential benefits of meditation and mindfulness, changes over time in meditation and mindfulness, and best avenues to acquire as well as maintain meditation and mindfulness skills. I drew from theories of classical Buddhism, contemporary mindfulness theories from western psychology, as well as findings from neuroscience. In their narratives, therapists emphasized numerous benefits derived from a personal meditation and mindfulness practice. Most importantly, therapists regarded a meditation practice as essential for personal well-being, professional effectiveness, and burnout prevention. The findings of my study may encourage clinical programs around the nation to systematically train psychotherapists in meditation and mindfulness practices.

MEDITATION & MINDFULNESS IN DIALECTICAL BEHAVIOR THERAPY: AN EXPLORATION OF THERAPISTS' EXPERIENCES WITH PERSONAL MEDITATION AND MINDFULNESS PRACTICES

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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CHAPTER I

Introduction

Cognitive behavioral therapy (CBT) has a longstanding history in the United States. The focus of first-generation behavioral therapy was on first-order, direct, behavioral changes without addressing non-observable phenomena, thought content, or underlying emotions. Second-generation behavioral therapy incorporated cognitive dimensions and was designed to modify dysfunctional beliefs and faulty information processing (Beck, 1993). Over the past two decades, psychotherapy in general and CBT in particular have begun to increasingly apply mindfulness training in the treatment of clients. The focus on core mindfulness skills in CBT is a paradigm shift. Researchers named this paradigm shift the third wave of CBT (Hayes, Follette & Linehan, 2004).

The purpose of the application of mindfulness in different cognitive-behavioral treatment modalities such as Mindfulness-Based Cognitive Therapy (MBCT), Acceptance and Commitment Therapy (ACT), and Dialectical Behavior Therapy (DBT) is to address that psychological phenomena are contextual and serve particular functions—functions that outweigh their explicit form, frequency or situational sensitivity (Hayes at al., 2004). DBT is based on core mindfulness skills, utilizes mindfulness exercises, and is recognized as an evidence-based practice with high rates of success (Feigenbaum, 2007; Kliem, Kröger & Kosfelder, 2010).

In this exploratory study, I will examine how DBT therapists, who professionally teach mindfulness skills to their clients, experience a personal meditation and mindfulness practice that

goes beyond the clinical setting. The goal is to explore DBT therapists' attitudes and perceptions regarding potential benefits of meditation and mindfulness, changes over time in meditation and mindfulness, and best avenues to acquire as well as maintain meditation skills and the ability to be mindful.

In the context of this study, mindfulness is defined as a purposeful and nonjudgmental observation of the ongoing stream of physical, mental, or environmental phenomena as they arise (Baer, 2003; Kabat-Zinn, 1994). Meditation refers to the act of intentionally training one's mind in order to become familiar with as well as learn how to affect mental processes (Brefczynski-Lewis, Lutz, Schaefer, Levinson & Davidson, 2007). The concept of mindfulness is understood as a universal human potential that can be cultivated through training. Mindfulness is both a process and an outcome—a fundamental way of being that penetrates one's moment-by-moment experience.

Empirical research on the general utility of mindfulness-based interventions provides data confirming that formal mindfulness training seems to decrease stress and increase psychological, emotional, and physical well-being (Baer, 2003; Grossman, Niemann, Schmidt & Walach, 2004). More specifically, it appears that meditation practice is effective for learning mindfulness skills, increasing one's capacity for empathy, and may lead to excellent treatment outcomes and enhanced therapist skills and attitudes (Barnhofer et al., 2009; Dalrymple & Herbert, 2007; Grepmair et al., 2007; Shapiro, Astin, Bishop & Cordova, 2005).

In the majority of mindfulness studies conducted over the past decade, researchers have examined client improvements, and far fewer researchers have investigated the benefits of meditation and mindfulness in relation to therapist skills, attitudes and well-being (Davis & Hayes, 2011; Gökhan, Meehan & Peters, 2010). Bruce, Manber, Shapiro and Constantino

(2010) highlighted the importance of conducting more qualitative research projects that focus on how therapists use mindfulness practices and how these help them in their personal lives as well as in their work with clients (p. 93). Consequently, one goal of this study is to gather data that show how psychotherapists experience a personal formal meditation and mindfulness practice.

In this study, I will draw from theories of classical Buddhism as well as contemporary mindfulness theories from western psychology. Additionally, I will reference research from the field of neuroscience. Neuroscientists have increasingly been able to show how and why different mental training practices, such as meditating and being mindful, seem to have a healing effect.

Occupational stress, burnout, and compassion fatigue remain a high risk in the mental health profession and particularly so for clinical social workers who often work in high-stress situations and with the most vulnerable populations (Newell & McNeil, 2010). With the demands placed on mental health practitioners, my study is highly relevant for clinical social workers who help those most in need. Qualitative therapist narratives that may, for instance, suggest less occupational and personal stress mediated by meditation and mindfulness practices may encourage clinical social work, psychology and counseling programs around the nation to invest resources in systematically training psychotherapists in mindfulness meditation practices.

The research questions for this study are as follows:

- How do DBT trainers apply formal meditation and mindfulness practices in their personal lives?
- What are the experienced benefits of having a long-term formal personal meditation and mindfulness practice?

- What do DBT trainers consider the best avenues of learning meditation and mindfulness skills and maintaining a formal personal practice?

Following this introduction, the thesis will be divided into four more parts. First, Chapter II is a Literature Review; followed by Chapter III, Methodology; Chapter IV, Findings; and Chapter V, Discussion.

CHAPTER II

Literature Review

Introduction

The purpose of this thesis is to examine how DBT therapists, who professionally teach mindfulness skills to their clients, experience a personal meditation and mindfulness practice that goes beyond the clinical setting. In order to set the research topic in context and provide the reader with the necessary background information, this chapter begins with a definition of terms drawing from classical Buddhism as well as western psychology. In the second section, I will present how the principles of mindfulness have been incorporated into the application of DBT. In that section, I will also talk about a possible contemporary western theory of mindfulness. In the third segment, I will give a critical account of current empirical research on mindfulness-based interventions.

To date, mindfulness-based stress reduction (MBSR)—a systematic, standardized, therapeutic program developed by Jon Kabat-Zinn in 1979—is one of the most widely known and well-researched mindfulness-based interventions (Carmody, Baer, Lykins & Olendzki, 2009; Shapiro et. al, 2005). Even though MBSR and DBT differ in purpose and implementation, MBSR and DBT both draw from traditional Buddhist mindfulness teachings. Most importantly, MBSR as well as MBCT researchers have conducted studies in which they were able to single out the mindfulness component and show how mindfulness relates to enhanced treatment

outcomes. Therefore, it seems relevant and appropriate to base this literature review on MBSR and MBCT studies, particularly since to date researchers have not conducted any DBT studies that single out the DBT mindfulness component in order to show the relationship between mindfulness and enhanced DBT treatment outcomes.

Mindfulness in Buddhism and Western Psychology

Buddhism. In traditional as well as contemporary Buddhism, mindfulness practices have had the purpose of transcending general human suffering rather than explicitly treating mental illness. From a general Buddhist point of view, human suffering is manifested through the daily struggle of wanting things to be different than they are—driven by one's desires, aversions, and ignorance. Khema (1999) concluded as follows: "Our own mind makes us happy or unhappy—nothing else in the world can" (p. 22).

After his spiritual awakening, the historic Buddha Siddhartha Gautama, put forth the well-known and most fundamental discourse of Buddhism, the teachings on *The Four Noble Truths* and the *Noble Eightfold Path*. In the Four Noble Truths, the Buddha described the truth about fundamental human anguish, the truth about the origin of this anguish, the truth about the possibility for the cessation of this anguish, and the path leading to the cessation of this anguish: "Anguish, he [Buddha] says, is to be understood, its origins to be let go of, its cessation to be realized, and the path to be cultivated" (Batchelor, 1997, p. 4). The Noble Eightfold Path has been broken down in the three practice areas of ethics, meditation/mindfulness practice, and knowledge generation/wisdom.

From a classical Buddhist perspective, existence and life are characterized by constant flux and change—nothing is permanent and all phenomena are transient. All human beings will encounter losses, age, get sick, and die. Thus, in essence, life remains dissatisfactory and filled

with anguish unless we fully accept that everything is transitory, including the things we like and the things we dislike—tragedy as well as happiness will pass (Batchelor, 1997).

The goal of Buddhist practice is to attain freedom from mental anguish by following the Noble Eightfold Path and developing wisdom, unconditional love, and generosity. Mindfulness is considered the basic foundation for becoming wiser, more loving, and more generous. Mindfulness combined with clear comprehension is said to lead to freedom from desire, aversion, and confusion facilitating a deep sense of connection, interdependence, joy, empathy, unconditional love, and equanimity (Khema, 1999). Buddhist theory promises that people will attain inner freedom and lasting satisfaction via training the mind and cultivating wisdom as well as ethical behaviors.

Nonetheless, the different Buddhist schools have different names for the applied formal practice of mindfulness. While an extended explanation regarding diverging mindfulness practice terms goes beyond the scope of this project, the reader should understand that, for the different Buddhist traditions, the purpose for practicing mindfulness is identical, yet the tools used to cultivate mindfulness and attain insight are specific to each school (Flickstein, personal communication, 2006). Similarly to the saying, "All roads lead to Rome," western mindfulness-based interventions may differ in their application from traditional Buddhist practices yet provide comparable outcomes.

In the classical and oldest form of Buddhism, which is Theravada Buddhism, mindfulness meditation or insight meditation is called *Vipassana*. Liberating insight is seen as a means to an end as well as the end itself. This is why scholars and mindfulness researchers have considered mindfulness a process, a trait, and an outcome (Grossman, 2008). MBSR is closely related to Theravada Buddhism and the practice of Vipassana. In Zen Buddhism, the formal mindfulness

meditation practice is referred to as *Shikantaza*. DBT draws from principles of Zen Buddhism. In Tibetan Buddhism, practitioners call the formal meditative practice of mindfulness *Dzogchen*.

Flickstein (2010) posed that mindfulness practice or synonymous terms such as Vipassana, Shikantaza, Dzogchen, open/choiceless awareness, *just* sitting, or *bare* attention have three things in common. In being mindful, the meditator's *bare* attention is *bare* of judgment, *bare* of decision-making, and *bare* of commentary. Flickstein (2001) explained that mindfulness training rests on the transmission of one of the most important Buddhist discourses. This discourse is valued by all Buddhist schools and is called the *Mahasatipatthana Sutta*, which means "Great Discourse on the Foundations of Mindfulness." According to the Mahasatipatthana Sutta, the foundation of mindfulness is fourfold. When practicing mindfulness, one trains the mind to be aware of (a) one's body, such as breathing; (b) one's feelings, such as physical sensations as well as psychological emotions; (c) one's consciousness/mind, including thoughts, perceptions, and one's mood; and (d) mental objects as they relate to everything that exists in one's mind and one's environment (Bodhi, 2000; Flickstein, 2001; Goldstein, 2003). In accordance with the Mahasatipatthana Sutta, mindfulness can be practiced sitting, standing, walking, or lying down.

Meditation generally refers to the act of intentionally training one's mind in order to become familiar with mental processes as well as become able to affect mental processes (Brefczynski-Lewis at al., 2007; Flickstein, 2001; Khema, 1999). Buddhist traditions distinguish two main forms of meditation—concentration meditation and mindfulness/insight meditation.

In mindfulness/insight meditation, the meditator uses *every* external or internal sense stimulus that arises, moment-by-moment, as the object of meditative awareness. In concentration meditation, the meditator focuses his or her attention on one chosen stimulus

only—to the exclusion of every other sense stimulus that may arise—over and over returning his or her attention to the object of concentration. The object of concentration may be the breath or any other focal point. Nonetheless, Flickstein (2001) has pointed out that all meditators need to be able to assert a minimum amount of concentration in order to calm the mind to a certain degree (p. 34). Concentration meditation and mindfulness/insight meditation are both considered important for training one's mind.

The end of the meditation and mindfulness path is the "direct realization of psychological and spiritual freedom" (Flickstein, 2001, p. 34). Meditation practice is, thus, not an end in itself—meditation practice is the means to an end. Moreover, meditation teachers have stressed that mindfulness practices must be applied in everyday life so that mindfulness becomes a fundamental way of being that penetrates and informs one’s moment-by-moment experience (Kabat-Zinn, 1994; Khema, 1999).

Western psychology. In the context of western psychotherapy, mindfulness has been defined as the purposeful and nonjudgmental observation of the ongoing stream of physical, mental, and environmental phenomena as they arise (Baer, 2003; Davis & Hayes, 2011; Kabat-Zinn, 1994). Mindfulness is the ability to develop deep insight and wisdom into the nature of one’s mental processes as well as the development of psychological well-being (Walsh, 2008). Siegel (2010) added that mindfulness is "a form of mental activity that trains the mind to become aware of awareness itself and pay attention to one's own intention" (p. 86). The rising and falling of mental states is to be experienced without attachment or evaluation (Davis & Hayes, 2011). Mindfulness definitions in western psychology appear closely related to traditional Buddhist conceptualizations.

Bishop et al. (2004) proposed a two-component model to operationalize mindfulness. The first component is identified as self-regulation of attention focused on one's immediate experience allowing recognition of mental states in the present moment. The second component addresses personal attitudes and intentions (i.e., curiosity, openness and acceptance) directed towards what is happening in the present moment (p. 232). Operationalizing the concept of mindfulness has led to the development of several mindfulness scales. Nevertheless, some researchers question the validity and reliability of mindfulness scales for reasons explained later in this chapter (Grossman, 2008).

Mindfulness in Theory and Practice in Dialectical Behavior Therapy

History. Linehan (1993a, 1993b) created DBT to help women with a diagnosis of Borderline Personality Disorder (BPD) and strong self-harm tendencies and suicidality. DBT is based on the key dialectic (i.e., inquiring into/holding opposing truths) of balancing acceptance of the client for who she is with encouraging change of self-destructive client tendencies. The therapeutic relationship is essential in DBT, and the dialectical process unfolds within the container of this relationship. In creating DBT, Linehan (1993a) drew from personal studies in meditation and eastern spirituality, so much so that mindfulness became the core skill taught throughout the yearlong program.

DBT has been recognized as an evidence-based practice with high rates of success (Feigenbaum, 2007; Kliem, Kröger & Kosfelder, 2010; Lynch, Trost, Salsman, & Linehan, 2007; Scheele, 2000). DBT has been shown to reduce the frequency and severity of (a) self-injurious behavior, (b) the days of psychiatric hospitalization, and (c) symptoms of depression, binge eating, and substance abuse. Further, DBT has been shown to increase social functioning and global adjustment (Robins, Smidt III & Linehan, 2004, p. 42). Nevertheless, to date

researchers have not attempted to single out the DBT mindfulness component to show that mindfulness is indeed an essential key ingredient responsible for the success of DBT (Linehan, personal communication, October 2011; Shapiro & Carlson, 2009, p. 71). While a comprehensive account of theory and practice of DBT goes beyond the scope of this project, I will briefly explain DBT's main structure and characteristics in order to illustrate the application of mindfulness skills for therapists and clients.

Treatment structure. Standard DBT (Linehan, 1993a, 1993b) has four modes of treatment: individual psychotherapy, group skills training, telephone consultation for clients, and case consultation for therapists. Weekly individual therapy is at the center of the different modes of treatment. DBT skills groups are conducted in a psychoeducational format. Mindfulness is the core skill taught throughout the year. The other three skills modules are emotion regulation, distress tolerance, and interpersonal effectiveness. In standard DBT, all skills groups and consultation meetings start with a mindfulness exercise (3-5 minutes long).

Core mindfulness skills are at the center of treatment because these core mindfulness skills support clients in mastering emotion regulation, distress tolerance, and interpersonal effectiveness. Furthermore, core mindfulness skills are also the skills that support therapists in holding the central dialectic of acceptance and change (Robins, Schmidt III & Linehan, 2004, p. 37). Two additional dialectical therapist stances are unwavering centeredness versus compassionate flexibility and benevolent demanding versus nurturing (Linehan, 1993a, p. 109).

Core mindfulness skills. DBT core mindfulness skills are divided into two categories—three core mindfulness *what skills* and three core mindfulness *how skills*. The three *what skills* (i.e., what to do in order to become more mindful) are observing, describing, and participating.

The three *how skills* (i.e., attitude in practicing mindfulness/how to be mindful) are nonjudgmentally, one-mindfully, and effectively (Linehan, 1993a, 1993b).

The three *what skills* have the purpose of helping clients to lead a lifestyle characterized by awareness rather than impulsive and mood-dependent behaviors (Linehan, 1993a, p. 144). When practicing observing, the client is asked to watch the coming and going of thoughts, sensations, or environmental occurrences without reacting. The skill of describing refers to verbally labeling one's experiences—i.e., naming thoughts, sensations or environmental occurrences without judgment. Participating is the ability to fully and spontaneously engage in one's present-moment experience without self-consciousness (Linehan, 1993b, pp. 63-64).

The purpose of the three *how skills* is to clarify the manner in which one needs to practice the *what skills*. One of the most important attitudes throughout DBT is embracing a nonjudgmental stance, which is the first *how skill*. Linehan (1993a) explains: "a nonjudgmental stance means just that—judging something as neither good nor bad" (p. 146). DBT therapists encourage clients to focus on consequences of behaviors and events as opposed to regarding behaviors or events as worthy or worthless. This is in alignment with the basic tenets of Buddhist mindfulness practice and other mindfulness-based interventions. In Buddhism, teachers encourage discriminating wisdom, asking students whether certain behaviors or events are wholesome or unwholesome. If they are deemed wholesome, teachers encourage continuation; if they are deemed unwholesome, teachers encourage change (Khema, personal communication, 1996). Furthermore, DBT principles ask therapists as well as clients to *radically* accept everything for what it is. Mindfulness, radical acceptance, and change appear to go hand-in-hand.

The second core *how skill* is one-mindfully or doing-one-thing-at-a-time. DBT therapists ask clients to learn and practice *beginner's mind*—a concept adapted from Zen Buddhism. Beginner's mind means to be awake, alert, fresh, curious and without preconceived notions or judgment—"free of habits of the expert, ready to accept, ready to doubt, and open to all the possibilities" (Suzuki, 1987, p. 14).

The third *how skill* is to do things effectively. Linehan (1993a, 1993b) recommended using an attitude derived from eastern meditative techniques called *Upaya*, which translates into the application of *skillful means* in order to achieve one's intrapersonal and interpersonal goals. One phrase used in DBT skills trainings is: "Do you want to be right, or do you want to be effective?" (Tiedeman, personal communication, September 2011).

In addition to mindfulness, the intrapersonal and interpersonal client goals are distress tolerance, emotion regulation, and interpersonal effectiveness. In DBT as well as in Buddhism, mental and physical pain is considered to be an unavoidable part of life; trying to avoid pain creates unnecessary suffering. Linehan suggested that practicing mindfulness enables clients to more effective tolerate distress, regulate emotions, and engage in interpersonal relationships (personal communication, April 2012).

Wise mind. Wise mind is another central concept in DBT. DBT operates on the premise that individuals experience three states of mind—reasonable mind, emotion mind, and wise mind (Linehan, 1993a, 1993b). Reasonable mind is the state of mind in which people are able to access logic and rational thinking. Emotion mind is the state of mind that is driven by feelings, desires, and aversions. Wise mind is the synthesis of reasonable mind and emotion mind—a synthesis between intuitive knowing/emotional experiencing and logical analysis (Linehan, 1993b, p. 63). Linehan poses that therapists and clients need mindfulness in order to access and

realize wise mind. In her DBT skills training manual, Linehan (1993b) elaborated that the focus of core mindfulness skills is to learn how to be in control of one's mind instead of letting one's mind run the show. In order to master and control one's mind, clients need to practice mindfulness with dedication and perseverance (p. 65). I would like to suggest that controlling one's mind, impulses, thoughts, and emotions might be equally important for psychotherapists.

A Preliminary Overarching Western Mindfulness Theory

Shapiro, Carlson, Astin and Freedman (2006) and Shapiro and Carlson (2009) have proposed a theoretical model of mindfulness attempting to explain how mindfulness practices may possibly affect psychological change, well-being, and transformation. The researchers clarified that their proposed theory is a working model with the purpose of finding common ground for all mindfulness-based approaches in order to develop a more comprehensive understanding of the primary mechanisms that may underlie the mindfulness construct (Shapiro et al., 2006, p. 376).

The main proposition of Shapiro et al.'s (2006) theory is that mindfulness entails three fundamental components, which are intention, attention, and attitude (IAA). Intention involves a voluntary and purposeful turning of the mind towards goals. Attention refers to one's moment-by-moment awareness. Attitude describes the quality of mindfulness, which is identified as nonjudgmental and with curiosity and kindness. The researchers have proposed that intention leads to attention—leads to connection—leads to regulation—leads to order—leads to health (p. 380).

It appears that DBT may incorporate aspects of the IAA conceptualization. In DBT, intention seems related to the goal-oriented approach of the *how skill* effectively. Attention can

be found in the DBT *what skills* observe and describe, and the *how skill* one-mindfully. Attitude may be related to the DBT *how skills* non-judgmentally as well as one-mindfully.

In their theory, Shapiro and Carlson (2009) have suggested that through mindfulness practice a process occurs that they have termed *reperceiving*. Reperceiving is defined as a shift in perspective. This shift in perspective is assumed to be at the heart of the change mechanisms of mindfulness (p. 103). MBCT is based on the concept of *decentering*. Fresco et al. (2007) wrote: "Decentering is defined as the ability to observe one's thoughts and feelings as temporary, objective events in the mind, as opposed to reflections of the self that are necessarily true" (p. 234). Shapiro and Carlson have considered reperceiving to be similar to the mechanism of decentering.

Mindfulness practice may lead to decentering and a shift in perspective because when people start to non-judgmentally observe and describe their inner experiences, people shift from being the subjects to becoming the objects of their experiences. In Buddhism, the process of shifting one's perspective is seen as a *lessening* of identification. An example would be such as a practitioner's realization of: "I am not my pain. There are just unpleasant physical sensations in this body or unpleasant thoughts and emotions in this mind. I am not my feelings and thoughts." According to Shapiro and Carlson (2009), the hallmark of mindfulness is an increasing capacity for objectivity. Furthermore, the awareness leading to reperceiving allows deep equanimity and clarity to arise (p. 95).

In their theory, Shapiro and Carlson (2009) have identified reperceiving as a metamechanism. This metamechanism spans four other mechanisms that have been proposed to account for the changes brought forth by mindfulness practices. These four underlying

mechanisms are (a) self-regulation; (b) values clarification; (c) cognitive, emotional, and behavioral flexibility; and (d) exposure.

Self-regulation is the first mechanism named by Shapiro & Carlson (2009) to underlie the metamechanism of reperceiving, and researchers have confirmed that people who scored higher in mindfulness reported significantly higher scores in self-regulation (Brown & Ryan, 2003; Farb et al., 2007; Perlman, Salomons, Davidson & Lutz, 2010). The acquisition of more effective self-regulation skills in DBT and DBT's proven efficacy in reducing self-harm behaviors may be related to Shapiro and Carlson's (2009) mindfulness theory and the mindfulness theory's change mechanisms.

Similarly to Shapiro and Carlson (2009) who have suggested self-regulation as a change mechanism of mindfulness, Siegel (2007) has proposed that the ability to observe the self with a witnessing and nonjudgmental attitude may disengage otherwise automatically coupled neural pathways (p. 260). More specifically, Siegel postulated that the capacity to actively engage some mental capacities and disengage others might be an underlying mechanism of mindfulness practice (p. 262). Siegel built his hypothesis on a study conducted by Farb et al. (2007).

Farb et al. (2007) conducted an empirical study in which participants were subject to functional magnetic resonance imaging (fMRI) scans after the completion of an 8-week MBSR training. The researchers studied the differences between self-referential thinking (i.e., thinking about the self in a narrative way that includes meaning, past, and future) and present-moment thinking (i.e., observing thoughts, feelings and sensations in the present moment without attempting to make meaning of one's present-moment experience). The fMRI scans showed that experienced meditators (MBSR training) in comparison to the control group (no MBSR training) had reduced activities in the brain regions associated with self-referential thinking and showed

increased activity in brain regions associated with present-centered self-awareness as well as sensory experiences. In an earlier study (Lazar et al., 2005), researchers measured greater cortical thickness in experienced meditators versus nonmeditators. The increase in cortical thickness was found in the same brain regions investigated by Farb et al. (2007). It appears that neuroscientists have been able to measure mindfulness-induced changes of brain function as well as brain structures associated with psychological and behavioral changes.

In reference to Farb et al.'s (2007) study, Siegel (2007) suggested that people trained in mindfulness meditation may be able to purposefully disengage otherwise automatically coupled neural pathways and that this process of decoupling may lead to a disengagement from habitual prior learning. According to Siegel, this disengagement process does not just involve momentary awareness and attention, as often measured in neuroscientific studies, but also executive functioning and meta-cognition as confirmed by Farb et al.

Values clarification is the second aspect of the metamechanism of reperceiving. Shapiro and Carlson (2009) pointed out that values are driven by society, culture, or family expectations, leading people to live their lives determined by the needs and wants of others (p. 99). Linehan (1993a) posed that one contributing factor to the development of a diagnosis of BPD is growing up in a chronically invalidating environment. However, one should note that Shapiro and Carlson as well as Linehan seemed to address values clarification from a western perspective, based in a culture that upholds individualistic values. From a cross-cultural point of view, one could argue that adjusting one's own personal values to the values of the larger community may be appropriate and not lead to psychological impairments. Nonetheless, the concept of values clarification entails that reperceiving may help people to choose values more congruent with their own needs.

Cognitive, emotional and behavioral flexibility is the third aspect believed to underlie the metamechanism of reperceiving. Shapiro and Carlson (2009) posed that "reperceiving...enables a person to see the present situation as it is...and respond accordingly" instead of reacting habitually and as determined by one's conditioning or habits (p. 100). Seeing the ever-changing and transient nature of mental, emotional, and physical experiences allows cognitive and behavioral flexibility. Since everything is in constant flux—from a Buddhist point of view impermanent and fleeting—rigid thinking and behavior naturally relaxes. Letting go happens.

Exposure is the fourth aspect of the proposed metamechanism of reperceiving. Reperceiving promotes *experiencing what is*. In this regard, even negative states of mind and very strong emotions can be observed nonjudgmentally, with acceptance, openness, and curiosity. In traditional CBT, exposure leads to desensitization and less avoidance. A broad range of thoughts, emotions and sensations can be explored and tolerated. In DBT, mindfulness is considered a form of exposure therapy. Linehan's (1993a, 1993b) concept of radical acceptance is a form of exposure to painful situations acknowledging that pain is part of life and cannot be avoided. From a Buddhist point of view, the more willing a practitioner is to accept the painful experiences in his or her life, the less unnecessary suffering this person will experience. Unnecessary suffering arises when people resist the experience as it presents itself (Kolk, personal communication, 2002).

Carmody et al. (2009) attempted to empirically test whether mindfulness induces a process of reperceiving (Shapiro & Carlson, 2009; Shapiro et al., 2006). In this research study, Carmody et al. (2009) worked with a sample of white-collar professionals with a variety of psychopathology (N = 309, mean age 50, 68% female). In an initial analysis of responses from participants in this MBSR study, the researchers did not find support for the mediating effect of

reperceiving on self-regulation; values clarification; cognitive, emotional and behavioral flexibility; and exposure. However, when reperceiving scores and mindfulness scores were combined, the researchers did find partial support for Shapiro et al.'s (2006) mindfulness theory. Carmody at al. highlighted that mindfulness and reperceiving may be overlapping constructs. They emphasized the importance of collecting more data from research that assesses whether mindfulness and reperceiving are distinctly different phenomena, and whether reperceiving and mindfulness develop simultaneously or sequentially. Participant narratives may support an exploration of those questions. Nonetheless, empirical evidence from a variety of research projects seems to validate the efficacy of mindfulness even though researchers have not yet been able to fully understand and explain why and how mindfulness mediates change.

Empirical Support for the Efficacy of Mindfulness-Based Interventions

Over the past two decades, mindfulness researchers have conducted a variety of studies examining the efficacy of mindfulness-based interventions. MBSR remains one the best-researched and most well known mindfulness-based therapeutic programs. This next section will summarize and analyze the progress that has been made in the field of mindfulness research in general and across disciplines and even continents. I will also highlight findings from researchers who have looked at the relationship between formal meditation practices and enhanced mindfulness skills as well as therapist-enhanced treatment outcomes for clients. Last, this segment will present research on how meditation and mindfulness may help psychotherapists to prevent and alleviate occupational stress, burnout and compassion fatigue.

General benefits across populations, disciplines, and diagnoses. Baer (2003) conducted a meta-analysis reviewing 21 mindfulness-based empirical studies completed between 1982 and 2001. The mean age of participants, if reported, was 45 years. Most participants were

females, and almost no data existed regarding clients' educational background, race and ethnicity. In this meta-analysis, Baer quantified the findings comparing studies across populations (e.g., clinical, non-clinical), disciplines (e.g., mental health, physical health), diagnoses (e.g., depression, anxiety, stress) and treatment applications (e.g., MBSR, MBCT). Baer quantified the results by calculating Cohen's *d* for the studies that did not provide an effect size. Cohen (1977) evaluated effect sizes as follows: 0.2 = small, 0.5 = medium, 0.8 = large, respectively.

The studies included in Baer's (2003) review were based on mindfulness-based interventions, and the majority of studies were based on examining MBSR programs. As mentioned earlier, MBSR singles out mindfulness as the primary treatment component. Therefore, Baer excluded both DBT as well as ACT, since neither DBT nor ACT single out mindfulness as *the* main treatment component.

Two studies in Baer's (2003) meta-analysis were MBCT studies assessing major depressive disorder relapse. These two MBCT study designs used control groups and randomized assignments, which most of the MBSR studies did not do. MBCT patients showed a decrease of depressive relapse when comparing patients who had had three or more major depressive episodes before the MBCT intervention with patients who received treatment as usual (TAU). Relapse was assessed over a time period of one year. Patients with only one or two previous major depressive episodes did not benefit more from MBCT than TAU. Similarly to the results of these two MBCT studies, MBSR patients with generalized anxiety and panic disorder reported significant improvements as well (Cohen's $d = 0.88$).

Four studies of the 21 studies of Baer's (2003) meta-analysis compared non-clinical populations (i.e., premed and med students, community volunteers). Similarly to clinical

populations, non-clinical populations receiving MBSR interventions reported improvements in medical and psychological symptoms, reduced stress levels, and significant effects on empathy ratings and spiritual experiences. However, none of the studies conducted before the year 2001 assessed the efficacy or mechanisms of mindfulness-based interventions with mental health practitioners and psychotherapists. Even to date, only a few studies have been published recruiting psychotherapists as participants (Grepmair et al., 2007; Shapiro et al., 2005; Shapiro, Brown & Biegel, 2007).

The empirical literature reviewed by Baer (2003) suggested that mindfulness-based interventions may help to reduce a variety of physical as well as mental health problems. The strength of Baer's meta-analysis was that Baer calculated and compared effect sizes across disciplines and treatment applications. Furthermore, in three studies reviewed by Baer, researchers provided follow-up data with large effect sizes (d = 0.67, d = 1.10, d = 1.35). Additionally, in one of the studies reviewed by Baer, researchers working with a sample of women with binge eating disorder reported a significant correlation (d = 1.65) between mindfulness home practice (i.e., approximately 2.5 hours of mindfulness exercises/per week, over the course of six weeks) and improvements on the Binge Eating Scale and the Beck Depression Inventory (BDI). More studies should investigate the correlation between mindfulness practiced out-of-session and improvements in mental and psychological functioning.

Nonetheless, it appears that most studies analyzed in Baer's (2003) review had some methodological flaws. Although Baer calculated effect sizes for all 21 studies, for a number of studies researchers did not provide means, standard deviations, or t-values. Therefore, Baer calculated effect sizes from p-values, which may not have provided the most accurate results since some p-values were based on a range (e.g., p = .01-.05) without specifying the precise p-

value (p. 135). Additionally, six studies (including MBSR for anxiety, MBSR-variant for binge eating disorder, MBSR study with healthy college students) had sample sizes smaller than N = 33, the minimum sample size required to reliably detect medium-to-large treatment effects (Cohen, 1977). Further, only six of the 21 studies used control groups and randomized assignments in order to account for confounding factors such as placebo effects or passage of time. None of the researchers used standardized and specific psychological TAU's as comparison or investigated outcomes such as subjective well-being and quality of life. Additionally, none of the studies used therapists as subjects or evaluated therapist-enhanced treatment outcomes for clients. The studies assessing non-clinical populations collected data from either college students or community volunteers. Only roughly 50% of the psychological studies reported follow-up data. Nevertheless, in MBSR interventions assessing patients with chronic pain, those patients reported improvements in ratings of pain and medical as well as psychological symptoms (d = 0.15 to 0.7). For these chronic pain studies gains had been maintained at post-treatment follow-up, 3 months to 3 years later.

In more recent MBSR studies (Goldin & Gross, 2010; Hargus, Crane, Barnhofer & Williams, 2010; Jha, Stanley, Kiyonaga, Wong & Gelfand 2010; Smith et al., 2011; Woo & Hee, 2010) researchers have been able to account for some of the methodological flaws and shortcomings of earlier studies by using control groups, randomized assignments, long-term meditation practitioners, more non-clinical samples (including therapists and therapists in training), and more racially/ethnically diverse samples.

For example, a recent randomized trial compared clients who received MBCT with a waitlist control group (Hargus et al., 2010). Clients who received MBCT showed increases in meta-awareness and were less likely to miss cues for an impending suicidal crisis. This MBCT

study confirmed that meta-awareness may help clients with major depressive disorder to, more accurately, recall past memories. At the same time, clients learned to *decenter* (MBCT technique of learning to step back, observe objectively, become a witness of) from negative thought content utilizing more adaptive coping mechanisms that can prevent future relapse.

Similarly, in a recent MBSR study, Goldin and Gross (2010) used fMRI (a technique not employed by any researchers of Baer's [2003] meta-analysis) to measure how clients with social anxiety disorder process negative self-beliefs and negative experiences. In this study, 16 clients underwent standard 8-week MBSR training as well as fMRI before and after the training. The researchers exposed clients to negative self-beliefs and then asked each client to either use an MBSR breath-focusing technique or to distract him or herself by counting backwards from the number 168. After the MBSR intervention, clients reported a reduction in negative emotional experiences. FMRI scans revealed that when clients used the breath-focusing technique, brain regions associated with attention rather than self-referential thinking were activated. Furthermore, clients showed clinically significant symptom reductions of social anxiety, depression, rumination, state anxiety, and an increase in self-esteem. Although this study had a rather small sample ($N = 16$) and was a within-group/pre-post design, lacking a control group and randomization, this is one of the few studies that worked with a racially more diverse population (i.e., eight whites, five Asian Americans, two Latinos, one Native American). Large-scale mindfulness studies with racially diverse samples remain rare.

In regard to working with a more diverse and cross-cultural population, a team of international researchers has utilized and tested a mindfulness-based treatment program with middle-aged women in Korea assessing the efficacy of MBCT, adding a self-compassion component, to decrease perceived stress and enhance well-being (Woo & Hee, 2010). Woo and

Hee worked with 75 Korean women (ages 37-55) who were randomly assigned to either the treatment group or the control group. Women participated in an 8-week standard MBCT program and also practiced self-compassion. After the intervention, clients reported improvements on all measures (i.e., psychological well-being, depression, anxiety, hostility, somatization, and positive affect).

Two other studies assessed in two different designs the protective function of mindfulness in relation to preventing PTSD symptoms in men. In one study Smith et al. (2011) used Brown and Ryan's (2003) Mindful Attention Awareness Scale (MAAS) to assess the relationship between trait mindfulness and mental health in 124 racially diverse urban firefighters (93% males, 50% Hispanic, 37% Whites, 4% African American, 3% Asian American, 2% Native American, 4% Mixed race). Higher scores in mindfulness were associated with fewer symptoms of depression, less perceived stress, fewer physical symptoms, fewer alcohol problems, and fewer PTSD symptoms. However, the researchers did not address whether firefighters utilized mindfulness meditation techniques. It may prove advantageous to not just assess the degree of trait mindfulness but also the quality of mindfulness by using Baer, Smith, Hopkins, Krietemeyer and Toney's (2006) Five Factor Mindfulness Questionnaire (FFMQ), a mindfulness scale that explicitly assesses the quality of mindfulness. Future research should also include asking whether participants use particular skills to maintain various aspects of self-care.

In another study Jha et al. (2010) investigated if and how predeployment stress may affect working memory capacity (WMC) in U.S. marines. People use WMC for emotion regulation and the management of cognitive demands. Brewin and Smart (2005) have identified that people with lower WMC suffer from emotionally intrusive thoughts. Intrusive thoughts are

also a symptom of PTSD and rumination on negative thoughts can lead to depression. High-stress environments and persistent and intensive demand may deplete WMC (p. 54).

Jha et al. (2010) used a between-group design and recruited three groups. The treatment group (n_{MBSR}) and the first control group (n_{control}) were both military personnel from a base of U.S. Marine Corps reservists. N_{MBSR} received a variant of standard MBSR training called *mindfulness based fitness training* (M-FIT) taught by military personnel trained in MBSR. The MBSR program included home practice assignments. N_{control} was a waitlist control group. The third group/second control group was a group of civilians (n_{civilian}). The civilians were teachers who participated in a separate, not specified, mindfulness training for teachers.

In Jha et al.'s (2010) study, all marines were in the process of predeployment for Iraq. Predeployment is considered an extremely stressful phase of life because soldiers (a) receive intensive training to prepare for deployment, and (b) experience emotional strain due to having to leave loved ones behind and facing uncertainties about the possible dangers ahead (p. 55). Jha et al. hypothesized that mindfulness training may be able to mitigate effects of cognitive failure and emotional disturbances associated with a stress-related degradation of WMC. WMC was assessed in all three groups (n_{MBSR} = 29 males, mean age 30; n_{control} = 17 males, mean age 25; n_{civilian} = 12 teachers/genders not specified, mean age 34) before and after the intervention. In civilians, WMC remained stable; in the MBSR intervention group WMC degraded in participants with fewer reported home practice hours but increased in participants with a higher number of reported home practice hours. It appears that sufficient time of formal and informal mindfulness practice hours may protect against functional impairments associated with high-stress demands and a degradation of WMC.

A strength of this study was that Jha et al. (2010) measured WMC instead of relying on self-reports and used a control group design. Furthermore, the research sample comprised only men, which enhances the mindfulness knowledge base since many prior studies have assessed a higher percentage of females. Additionally, it seems insightful to teach and title the MBSR training in ways acceptable to military personnel. Unfortunately, researchers did not report on the genders of the members of the civilian control group. However, the researchers did report that all the civilians were teachers. The United Nations Statistics Division (2011) reported that in the United States more women than men are teachers (percentage of female teachers in 2009: primary education = 87%; secondary education = 61%; tertiary education = 46%). With these data in mind, whether the civilian control group was gender-matched remains unclear. Furthermore, what kind of mindfulness training the teachers received remains unclear.

In conclusion, Baer's (2003) meta-analysis established MBSR and MBCT as mindfulness-based interventions that are "probably efficacious" (p. 140). Randomized, controlled studies conducted between 2001 and 2011 have replicated many of the initial mindfulness-based research projects reporting significant effect sizes and confirming various benefits associated with mindfulness-based interventions.

Future researchers should conduct more randomized, controlled, double-blind studies examining the efficacy of the mindfulness treatment component for a broader range of mental health problems as well as compare mindfulness-based therapies with other established treatment models. Researchers should continue to focus on recruiting diverse samples in regard to gender, class, age, race, and ethnicity. Furthermore, we need more research that investigates the efficacy of mindfulness for psychotherapists assessing the relationship between mindfulness-based interventions and overall well-being as well as quality of life. Moreover, researchers should

attempt to investigate the efficacy of the DBT mindfulness component within the DBT treatment package.

Meditation practice as a means to cultivate mindfulness. Meditation is a group of mental training practices designed to familiarize practitioners with specific types of mental processes (Brefczynski-Lewis et al., 2007, p. 11483). Nonetheless, to date researchers do not fully agree on an overarching definition on meditation. For example, none of the contemporary mindfulness meditation researchers or Buddhist experts have considered relaxation techniques a form of meditation (Ospina et al., 2007). In mindfulness as well as concentration meditation, feeling relaxed may be an outcome, or better a byproduct, but relaxation is not the purpose. The primary purpose of mindfulness meditation is learning to become aware of and radically accept all phenomena as they are—with the spiritual goal of transcending suffering, ignorance, desire, and aversion. Nonetheless, regardless of purpose and goal, neuroscientists have been investigating whether and how the human brain changes when people practice meditation and, more specifically, when people practice meditation over an extended period of time.

In the past, researchers have been able to show changes in the brain's functional structures via electroencephalograms (EEGs). Building on these EEG findings in which researchers have been able to display functional changes of the brain, Lazar et al. (2005) conducted a study hypothesizing that meditation practice might also be associated with changes in the brain's physical structures. Lazar et al. recruited 20 long-term meditators who had had a mindfulness meditation practice for about 10 years and had been practicing formal meditation almost every day, for at least 40 minutes per day. These long-term meditators were US American lay practitioners—not Buddhist monks—holding careers and having families. The researchers used magnetic resonance imaging (MRI) to measure cortical thickness. Compared to

a control group (matched in age, sex, gender, education, race, right-handedness) long-term meditators showed a significant increase in cortical thickness in brain regions associated with attention and sensory processing. The increased thickness of certain brain regions correlated with meditation experience measured by total years of practice, total hours of practice, and as confirmed by measuring respiration rate of meditators during formal practice (more experienced meditators had a lower respiration rate during formal practice than less experienced meditators or nonmeditators). Lazar et al. concluded that cortical plasticity could occur in adults in areas important for cognitive processing (p. 5). Furthermore, it appears that long-term mindfulness meditation may be able to offset age-related thinning of the prefrontal cortex. Studies like the Lazar et al. study seem important when investigating theories and conceptualizations of the mindfulness paradigm because neuroscientists may be able to clarify the subjective experiences of meditators. However, this study used 100% white middle-class participants. Future researchers should attempt to recruit samples heterogeneous in race, education, and professional background yet homogeneous in meditation experience.

In a different study, Brefczynski-Lewis et al. (2007) recruited eight experienced meditators from Tibetan Buddhism with a practice background in concentration meditation and compared them to a group of novice meditators. Brefczynski-Lewis et al. measured brain activity in relation to the effort exerted during a concentration meditation exercise. The group of experienced meditators was divided into (a) experienced meditators with more meditation hours (44,000 hours), and (b) experienced meditators with less meditation hours (19,000 hours). All of the experienced meditators outperformed the control group, as measured by fMRI scans. FMRI scans also revealed that all experienced meditators ($N = 8$) performed equally well on the concentration task. However, the experienced meditators—who had had about twice as many

meditation hours as compared to the experienced meditators with less practice hours—exerted significantly less effort in order to sustain the ability to concentrate and remain focused. Brefczynski-Lewis et al. concluded that expertise in concentration meditation may lead to increased mental processing efficiency. This study showed that concentration meditation and mindfulness meditation may be complementary practices with different outcomes yet mutually supportive effects. Buddhist teachers have posed that expertise in concentration practice may lead to mind states of equanimity and tranquility (Flickstein, 2001; Khema, personal communication, 1997; Kolk, personal communication, 2000). Equanimity and tranquility—in turn—may support a nonjudgmental attitude and more clarity of mind.

In addition to neuroscientific studies, Shapiro, Oman, Thoresen, Plante & Flinders (2008) conducted one of the very first controlled studies investigating whether and how the systematic cultivation of mindfulness mediates well-being. The two main questions of this study were: Can the cultivation of mindfulness arise from distinct meditation-based interventions (mindfulness meditation versus concentration meditation)? And if so, can such gains in mindfulness lead to improved well-being? Shapiro at al. (2008) hypothesized that formal meditation practice would lead to an increase in mindfulness and that an increase in mindfulness would lead to an increase in personal well-being. In order to assess the accuracy of their hypotheses, Shapiro et al. ran a between-group randomized controlled study ($N = 44$) in which undergraduate college students from a Jesuit college (mean age 18 years; 80% female; 75% white; 50% Catholic) were randomly assigned to either an 8-week meditation course based on formal and informal mindfulness practices ($n = 15$), or an 8-week meditation course based on concentration meditation as well as informal mindfulness practices ($n = 14$). The control group was a waitlist control group ($n = 15$).

Shapiro et al. (2008) assessed mindfulness at three points in time—at pre-treatment, at post-treatment, and at a 2-month follow up. The researchers used the Mindfulness Attention and Awareness Scale (MAAS) to measure mindfulness. Positive outcomes in well-being were defined as reduction in perceived stress, reduction in rumination, and increase in forgiveness for others. In addition to the pre-, post-, and follow-up self-report tests, students filled in diaries that the researchers analyzed for adherence to the training schedule (i.e., how often students practiced formal meditation and informal mindfulness skills on every given day of the 8-week program).

Shapiro et al. (2008) found that mindfulness can be cultivated and an increase in mindfulness may lead to an increase in well-being. Moreover, through this study the researchers confirmed that mindfulness can be cultivated by distinctly different practices (i.e., mindfulness meditation as well as concentration meditation). But most importantly, more consistent and frequent adherence to a practice schedule seemed to mediate more gains in trait mindfulness.

A weakness of Shapiro et al.'s (2008) study was that the findings cannot be generalized due to the relatively small and very specific sample (white, 18 years old, all females, Jesuit college students). Furthermore, using self-report measures to assess mindfulness and well-being may be confounded by demand characteristics and not accurately measure how mindful participants think they are versus how mindful they really are.

The strengths of this study were that this was a controlled between-group design that included a 2-month follow-up and compared two different treatments (mindfulness meditation versus concentration meditation). Furthermore, Shapiro at al. (2008) used adherence to practice as a variable to measure increases in mindfulness, which showed the mediating function of daily formal and informal practices. Additionally, through this study the researchers identified that the MAAS—used to assess mindfulness in this study—may not measure all mediating mechanisms

of mindfulness such as acceptance and a nonjudgmental attitude. This may explain why other researchers found controversial results as well, such as binge-drinkers being as mindful as experienced mediators when using mindfulness scales designed to assess trait mindfulness (Grossman, 2008). Future researchers should rely more on measures of actual meditation practices and include Baer et al.'s (2006) FFMQ to assess mindfulness as a multifaceted construct. Researchers need to pay close attention to discriminating between trait mindfulness and quality of mindfulness in close adherence to the Buddhist understanding of mindfulness as a non-judgmental, warm and kind attitude towards one's personal experience.

Schoormans and Nyklíček (2011) conducted a study similar to Shapiro et al.'s (2008) study. Schoormans and Nyklíček investigated how mindfulness and psychological well-being may relate to a particular kind of meditation practice. This study was conducted in the Netherlands comparing mindfulness meditation (MM) outcomes to transcendental meditation (TM) outcomes. TM does not explicitly teach nor focus on mindfulness. Trait mindfulness was measured with the MAAS and the Freiburg Mindfulness Inventory (FMI). No differences were found between both groups of meditators in trait mindfulness. While it may be appropriate to only assess trait mindfulness when comparing experienced meditators of different meditation styles with each other, it seems that it may also be beneficial to assess state mindfulness. Similar to the findings in the studies by Shapiro et al. (2008) and Carmody and Baer (2008), Schoormans and Nyklíček found that more home practice positively correlated with a decrease in stress and an increase in well-being.

Carmody and Baer (2008) conducted the first large-scale empirical study of its kind (N = 174, 63% females, mean age 47, middle-class professionals with a wide variety of psychopathological symptoms) in which the researchers were able to establish a relationship

between mindfulness, formal mindfulness home practice, and well-being. In order to assess mindfulness, the researchers used Baer at al.'s (2006) FFMQ, a scale that measures trait mindfulness *and* the quality of mindfulness (i.e., ability to observe, describe, act with awareness, perceive phenomena nonjudgmentally, and be non-reactive to one's experiences).

Carmody and Baer (2008) found that the relationship between practice time and psychological well-being is completely mediated by increases in mindfulness skills. If participants adhered to an 80% completion rate (i.e., home practice for 33 days out of 42 assigned days, with about 30 minutes of formal practice/per day), participants attained higher scores on the FFMQ. Carmody and Baer concluded that the practice of mindfulness meditation may lead to increases in mindfulness, and increases in mindfulness may lead to symptom reduction and improved well-being. Formal home practice appeared essential for learning and maintaining mindfulness skills. Nonetheless, in this study the researchers found no relationship between informal practices and increases in mindfulness. Carmody and Baer speculated that it might be challenging for participants to accurately report on informal mindfulness practices. This study was a well-designed research project using multiple measures for assessment. Furthermore, this study used a large enough sample population to detect significant effect sizes. Future researchers should expand on the studies of Shapiro et al. (2008) and Carmody and Baer (2008), recruiting more diverse participants and especially comparing mindfulness meditation to other forms of meditation such as concentration meditation or, for example, loving kindness meditation. Researchers should also attempt to collect follow-up data.

Another, first-of-its-kind, study was conducted by Shapiro, Brown, Thoresen and Plante (2010). These researchers were interested in learning more about for whom mindfulness-based interventions may be most effective. The results of this randomized controlled trial (N = 30)

showed that MBSR participants with higher pre-treatment levels of trait mindfulness (measured with the MAAS) showed a larger increase in mindfulness, subjective well-being, empathy, and hope and larger declines in perceived stress, up to one year after the treatment. The researchers assessed mindfulness at pre-intervention and then two months and one year after the intervention.

In summary, it appears that meditation is an effective means to cultivate mindfulness. Moreover, it seems that different kinds of meditation practices may have the potential to increase mindfulness and psychological well-being. Of value for future mindfulness research may be more original research projects such as the study conducted by Jha et al. (2010) assessing U.S. military personnel; Woo and Hee's (2010) study with middle-aged Korean women, a study that included a self-compassion component; Schoormans and Nyklíček's (2011) study comparing different forms of meditation in a sample of Dutch meditators; or the studies conducted by neuroscientists assessing changes in brain function and brain structures associated with meditation practices and psychological and behavioral changes.

Therapist mindfulness and enhanced treatment outcomes. To date only a small body of research exists examining whether therapist mindfulness affects better treatment outcomes (Davis & Hayes, 2011). Additionally, some researchers have noted that the existing self-report scales for mindfulness may not accurately measure the mindfulness construct (Davis & Hayes, 2011; Grossman, 2008). For example, Davis and Hayes pointed out that practitioners with a high degree of self-awareness and mindfulness may report lower scores since they are so keenly aware of when they are not mindful. At the same time, there is the potential for less mindful people to score higher since they are less aware of blind spots (p. 203). Grossman (2008) noted the potential shortcomings of currently used mindfulness scales, such as the FMI and the

Kentucky Inventory of Mindfulness Skills (KIMS), highlighting that mindfulness concepts have been borrowed from Buddhist practices yet Buddhist and western approaches to mind and body differ (p. 408). For example, the FMI has been developed with meditators but is used for the assessment of meditators and nonmeditators alike. A critical issue appears to be that the creators of mindfulness scales disagree about the definition of mindfulness and its components. Furthermore, researchers who have designed mindfulness scales have limited, if any, personal experience in mindfulness meditation. Moreover, scales such as the KIMS have been developed and tested with student populations. Grossman pointed out that self-report measures might neglect responder biases and profound differences in how respondents semantically understand the scale items. Practitioners' self-evaluation of mindfulness skills may not accurately reflect how mindful—meaning nonjudgmental, open, curious—those practitioners really are. Nonetheless, it seems important to note that Baer at al. (2006) have tried to address potential limitations of other mindfulness scales by devising the FFMQ, which appears to more reliably and validly measure mindfulness as a multifaceted construct by assessing state mindfulness/quality of mindfulness as well as trait mindfulness. In the development of the FFMQ, the researchers used a large sample of 613 undergraduate students (mean age 20 years, primarily white female nonmeditators). Even though this was a large sample, the sample represents a very specific population, and Baer at al. (2006) emphasized the importance to test the FFMQ with more diverse populations. In a follow-up study, researchers were able to confirm the validity and reliability of the FFMQ using a large sample (N = 1,017) of meditators, nonmeditators, highly educated participants, community volunteers, as well as mental health professionals (Baer et al., 2008).

Similarly to the researchers Shapiro and Carlson, Baer has worked in the field of mindfulness research for numerous years and appears to be familiar with the conceptualization and experience of mindfulness in its close relationship to traditional Buddhism from which western mindfulness trainings have been derived. As a response to the potential inaccuracy of mindfulness scales, a team of German researchers conducted a rigorous empirical study based on the experiential application of mindfulness meditation.

Grepmair et al. (2007) conducted a randomized, controlled, double-blind study in the South of Germany examining how promoting mindfulness in psychotherapists may influence treatment results in their patients. To date, this is the first and only study of this kind. Mindfulness researchers acknowledge that it is challenging to implement randomized, controlled, double-blind meditation studies. In Grepmair et al.'s study, 18 German psychologists in residency (primarily female) treated 124 inpatients who were randomly assigned to either the therapist intervention group or the therapist control group. The intervention took 9 weeks. The therapist intervention group was instructed in daily Zen meditation and practiced *before* the workday began, for one hour, five days a week. The therapist control group received the same Zen training but meditated at another time during the day. A well-known Japanese Zen master residing in Germany provided the instructions and daily practice. The Zen master was not aware of the research project. The researchers found that the patients assigned to the psychologists who meditated for an hour before they began their workday scored significantly higher in their subjective assessment of the therapy sessions. Furthermore, patients assigned to the therapist intervention group reported that they better understood their own psychodynamics, the structure and characteristics of their difficulties, and the goals for their future development. Moreover, the

perceived results of the entire treatment were significantly better for the therapist intervention group.

Grepmair et al.'s (2007) study showed that mindfulness meditation taught to therapists may have the potential to positively influence treatment outcomes in clients. Since this study was conducted in Germany with female psychotherapists in their residency year, it seems important to replicate these findings with more diverse samples (e.g., outpatients, experienced psychotherapists, clinical social workers, or therapists who already have an established long-term meditation practice). Nevertheless, Grepmair et al.'s study appears to be one of the more rigorous studies in mindfulness research since it was a randomized, controlled, double-blind trial using the therapist as *the* intervention medium. This study addressed how therapists may use the *self* in ways that may enhance treatment outcomes. This appears to be a promising direction for future research. An additional measure to Grepmair et al.'s study could be to specifically assess whether clients perceive psychotherapists who practice meditation and mindfulness as kinder and more empathic.

Mindfulness, therapist burnout, and self-care. Empathic attunement (i.e., warmth, understanding, compassion) and being able to be present and attentive have been identified as essential therapist skills for attending to clients' needs and for conducting successful treatment (Greenberg, Watson, Elliot & Bohart, 2001; Lambert & Barley, 2002). Beginning clinicians highly value the importance of empathy. Nevertheless, the longer clinicians practice in their profession the less important empathy becomes (Walsh, 2008). Moreover, the longer a therapist practices the more likely burnout becomes, which Barnett, Baker, Elman and Schooner (2007) classified as the "deleterious impact of distress, left untreated over time" (p. 604). More

specifically, Figley (2002) conceptualized psychotherapist burnout as *caregiver burnout* and named this phenomenon *compassion fatigue*.

Shapiro and Carlson (2009) have highlighted that specific means to develop and implement self-care strategies for therapists in training and seasoned clinicians alike are not systematically being offered. Further, Shapiro and Carlson have suggested that mindfulness training may be a way to teach therapists systematic self-care in support of preventing compassion fatigue and burnout (p. 110). The authors conceptualized that mindfulness practice may be relevant for therapists, because mindfulness research points towards the potential for mindfulness training to decrease stress, increase self-compassion, and enhance overall well-being. Moreover, in order to be kind and compassionate towards others, one needs to first be kind and compassionate to oneself (p. 111). In her talks, Khema used to repeatedly declare: "Self-love is not selfish. Self-love and self-compassion must come first if you wish to ameliorate the suffering of other people" (personal communication, 1996). Similarly, before the takeoff of an airplane, flight attendants instruct adult passengers who accompany children to put on their own oxygen mask *before* putting a second oxygen mask onto a child, in case the cabin should loose air pressure. Grepmair et al. (2007) confirmed that therapists who have a daily sitting meditation practice may be able to work with their clients more effectively.

Researchers have summarized the consequences of stress as follows: Stress may lead to depression, anxiety, psychological isolation, loneliness, reduced self-esteem, decreased job satisfaction, disrupted personal relationships, psychological strain, suicidality, decreased professional effectiveness, reduced concentration, and a reduced ability to establish strong relationships with clients (Shapiro et al., 2005; Shapiro et al., 2007). Furthermore, as identified by Jha et al. (2010), juggling the demands of high-stress situations may lead to a decrease in

WMC, which may lead to cognitive impairments. In the context of psychotherapy, Shapiro et al. (2007) defined the term *high-stress* as follows: Clinical high-stress situations may be such as working in hospitals or demanding agencies, or working with clients who have a history of abuse, trauma or an Axis II/personality disorder diagnosis (p. 105). In this way, high-stress—accumulated over time—may lead to compassion fatigue and burnout.

Shapiro et al. (2005) conducted one of the first randomized, controlled, pilot studies with health care professionals (*N* = 28, mean age 40). The purpose of this study was to examine the effectiveness of MBSR as a stress management program for health care professionals actively engaged in clinical practice. The health care professionals were nurses, physician, social workers, and psychologists. All employees worked at an agency for Veteran's Affairs (VA). Clinicians participated in an 8-week MBSR program. Shapiro et al. used multiple measures to assess mood, perceived stress, burnout, satisfaction with life, and self-compassion. After the intervention, MBSR participants reported a significant reduction in perceived stress and increases in self-compassion, quality of life, and overall well-being. Moreover, an increase in self-compassion predicted positive changes in perceived stress. Similarly to other mindfulness studies, a weakness of this trial was the small sample. Additionally, the control group did not complete post-intervention measures. Furthermore, it would be interesting to know how many of the clinicians were psychotherapists—and more specifically—how many were clinical social workers, since it appears that psychotherapists and social workers experience very specific forms of burnout such as the phenomenon of compassion fatigue.

In a more recent study, Shapiro et al. (2007) replicated the above described research project with a graduate student population at a small private college. In this study, instructors taught MBSR to a group of psychotherapists in training (*N* = 54, mean age 29, 77% white,

primarily female). The researchers wanted to test whether MBSR training would enhance mental health in therapists in training. Further, they wanted to examine (a) the processes of MBSR's efficacy and how MBSR may lead to increased mindfulness, and (b) whether increased mindfulness mediates positive outcomes. Additionally, Shapiro et al. wanted to look at the association between the type and amount of mindfulness practice performed and the relationship between MBSR outcomes and well-being. In this study, the researchers employed multiple pre- and post measures assessing state and trait mindfulness, positive and negative affect, anxiety, rumination, and self-compassion. In the previous study (Shapiro et al., 2005) conducted with clinicians at the VA, the researchers did not measure anxiety and rumination.

Similar to the results from Shapiro et al.'s (2005) study, participants from the Shapiro et al. (2007) study reported a significant decrease in perceived stress, negative affect, state and trait mindfulness, and rumination. Furthermore, the participants reported a significant increase in positive affect and self-compassion. More specifically, increases in mindfulness predicted a drop in rumination, trait anxiety, and perceived stress, and an increase in self-compassion. While Shapiro et al. (2005) did not find a significant relationship between home practice time and enhanced outcomes, Shapiro et al. (2007) did find a significant relationship between home practice time and enhanced outcomes. These opposing results are most likely explained by the small sample size of the 2005 study. Further, one may question whether therapists in training encounter the same stress levels as seasoned clinicians in a VA.

Lykins and Baer (2009) ran a comparison study to determine whether practicing mindfulness meditation over a longer period of time is associated with increased mindfulness in daily life leading to less rumination, less fear of emotions, and increased behavioral regulation. Lykins and Baer sent out questionnaires and collected data from 182 long-term (mean meditation

practice = 10 years) meditators and compared the sample to a demographically similar group of 78 nonmeditators. This meditator sample included many health care professionals. The researchers found that having had a regular long-term (mean = 7.6 years, *SD* = 3.76) mindfulness meditation practice was associated with increased levels of mindfulness when comparing this sample of long-term meditators to nonmeditators. The researchers used Baer at al.'s (2006) FFMQ to assess mindfulness. Long-term meditators reported less rumination, less fear of emotions, and increased behavioral regulation. Moreover, decreased rumination and less fear of emotion were partially responsible for the relationship between mindfulness in daily life and well-being (p. 238).

In conclusion, mindfulness researchers have found evidence that mindfulness practices may not just lower stress but also enhance a therapist's ability to regulate emotions evidenced in the decline of rumination (Shapiro et al., 2005; Shapiro et al., 2007). One of the most salient outcomes of mindfulness practice may be the potential for psychotherapists to become more self-compassionate. An increase in self-compassion may prevent compassion fatigue and therapist burnout. Mindfulness-based interventions appear to have the potential to address the need for systematic, professional self-care for psychotherapists. Mindfulness-based training programs could be systematically implemented in social work school curricula and throughout mental health agencies.

Summary

Inspired by Buddhist mindfulness concepts and supported by empirical research conducted between 1982 and 2011, mindfulness researchers have established mindfulness-based interventions as "probably efficacious" (Baer, 2003, p. 139) suggesting that practicing mindfulness skills appears to be beneficial for a wide range of problems such as chronic pain,

depression, anxiety, stress, compassion fatigue, and burnout. Researchers have advocated that mindfulness can be cultivated—and an increase in mindfulness may lead to an increase in overall well-being. Meditation seems an effective means to acquire mindfulness skills. Consistent and frequent formal and informal mindfulness practices appear to mediate more gains in trait and state mindfulness. Moreover, different kinds of meditation practices may have the potential to increase mindfulness and psychological well-being. Neuroscience and the theory of neuroplasticity—the brain's ability to develop new structures and functions in response to physical, mental, or psychological experiences—support the claim that the mind can change in accordance with mental training. Further, contemporary studies have suggested that mindfulness practices may be effective across race, gender, and nationality. After all, Buddhist mindfulness teachings come from a culture and time much different than modern US American society.

Nonetheless, even though attempts have been made to operationalize and measure mindfulness, to date researchers do not fully agree on an overarching theory, terms, and definitions. Agreement on how to define and measure mindfulness may continue to be challenging because mindfulness is a multifaceted construct and, as Rosch (2007) has pointed out, potentially as much wisdom-based as mindfulness-based. If we consider Rosch's claim of including the aspect of wisdom into mindfulness research, one may ask: How do we reliably and validly define and measure wisdom?

Drawing from classical Buddhism, Davis (2010) has proposed that people can only provide authentic guidance in teaching mindfulness after having explored and experienced the *mindfulness path* themselves. In DBT, mindfulness is a core skill that supports clients and therapists in holding the central dialectic of acceptance and change. Linehan has encouraged

formal and informal mindfulness practices for psychotherapists and has maintained a formal meditation practice of her own (personal communication, October 2011).

To date, the number of generalizable, large-scale, or longitudinal studies remains limited. In many cases, the study population has been rather specific, such as patients with BPD, college students, or Buddhists. Only a handful of studies provide data derived from mental health practitioners. Presently, insufficient research exists regarding whether therapists who do have a meditation practice attain better treatment outcomes. Additionally, the proposed helpfulness of mindfulness training is not systematically applied and taught in educational and training settings for beginning as well as seasoned clinicians.

Based on the review of current research, I have identified that in-depth reports from meditators, and particularly narratives from psychotherapists, seem to be missing from the literature. Considering the complexity of the mindfulness construct, more first-hand narratives might be able to illuminate the subjective meditation and mindfulness experiences of western psychotherapists.

CHAPTER III

Methodology

Research Purpose and Design

The purpose of this exploratory, qualitative study was to examine how DBT therapists, who professionally teach mindfulness skills to their clients, experience a personal meditation and mindfulness practice that goes beyond the clinical setting.

The research questions for this study were as follows:

- How do DBT trainers apply formal meditation and mindfulness practices in their personal lives?
- What are the experienced benefits of having a long-term formal personal meditation and mindfulness practice?
- What do DBT trainers consider the best avenues of learning meditation and mindfulness skills and maintaining a formal personal practice?

In-depth, one-on-one interviews were the key element for finding answers to the research questions. In addition, a short questionnaire was distributed in order to collect data about participants' demographics and professional background as well as to assess type, frequency, and length of meditation and mindfulness practices.

Qualitative research is characterized by flexible and relatively unstructured observations such as, for example, interviews. In the process of qualitative data analysis, the researcher

attempts to detect patterns and themes that may contribute to a deeper understanding of the phenomenon under investigation (Rubin & Babbie, 2010, p. 75).

In accordance with Rubin and Babbie (2010), the rational for a qualitative study and the use of in-depth interviews was based on wanting to develop a deeper understanding about therapists' experiences with a personal meditation and mindfulness practice. Moreover, it seemed useful to interview a population (i.e., DBT therapists) who—by the very nature of their work—appear to already be familiar with the mindfulness construct and mindfulness applications.

The Human Subjects Review (HSR) Committee of Smith College School for Social Work approved this research study (see Appendix A, HSR-Approval Letter(s), 12/27/2011 and 01/10/2012).

Data Collection Instruments

For the data collection process, I used two instruments: (a) in-depth interviews, and (b) a short paper-and-pencil questionnaire. The interviews lasted between 45 and 60 minutes. In order to provide a semi-structure for the interviews, I asked five open-ended questions (see Appendix B, Interview Guide). In the questionnaire, I posed 16 questions asking the interviewees about their demographics and professional background and the nature of their personal meditation and mindfulness practices (see Appendix C, Interviewee Questionnaire). The estimated time for answering the questionnaire was between 5 and 10 minutes.

Characteristics of Participants

The participants of this study were a nonprobability expert sample chosen for their ability to provide insight into the phenomenon of interest (i.e., DBT therapists' personal meditation and mindfulness practices). All participants were DBT therapists trained by and affiliated with

Behavioral Technology, LLC (BTech), the nationwide organization for DBT practitioners. At this point, no official DBT certification exists. Dr. Marsha Linehan, who developed and formalized DBT, has asked that psychotherapists who practice DBT and use the title *DBT Therapist* adhere to the training standards set by BTech (personal communication, 10/18/2011).

Thirteen self-identified DBT therapists were selected for the interviews in accordance with the inclusion and exclusion criteria provided below.

For the interviews, the inclusion criteria were as follows:

- Minimum of two years working as a licensed therapist
- Minimum of two years working as a DBT therapist (i.e., professionally practices DBT, practices in adherence with the standards and manuals created by Dr. Marsha Linehan and taught through BTech)
- Meditation and mindfulness practice for a minimum of two years

These inclusion criteria reflect that it takes time to learn and incorporate a new skill. In order to understand how the integration of meditation and mindfulness impacts practitioners' lives, I wanted to look at long-term practices. For the purpose of this study, long-term referred to having had a meditation and mindfulness practice for a minimum of two years. Further, I used the following criteria to define *a personal meditation and mindfulness practice*:

Meditation practice:

- The interviewee practices formal meditation (i.e., the interviewee practices training his or her mind in order to become familiar with mental processes and learn how to affect mental processes) with the intention to practice daily for 20 minutes or more, but at least three days/per week, 10 minutes per meditation session

- The interviewee's personal meditation practice may be a mindfulness meditation practice *or* a concentration meditation practice
- Formal meditation may be sitting *and/or* walking meditation

Mindfulness practice:

- The interviewee practices mindfulness formally (i.e., during regular sitting and/or walking meditation as defined above), *and/or*
- The interviewee practices mindfulness informally during daily life activities
- Informal mindfulness refers to an intentional mindfulness practice done outside of formal practice on the meditation cushion (i.e., intentionally being mindful during a variety of daily life activities)
- Informal mindfulness practice periods may be brief (e.g., 1-5 minutes)

DBT practitioners who did not practice in the United States or were not fluent in English, the language in which the interviews were conducted, were not eligible for this study.

I made an effort to draft a sample as diverse as possible in regard to gender, age, race/ethnicity, and clinical education, as well as geographic location. Nine interviewees were female and four were male. Participants ranged in age from 33–62 years (mean = 51.4 years, *SD* 8.9). All interviewees identified as white. Five participants held degrees in clinical social work; four participants had a doctoral degree in psychology; and four interviewees were licensed mental health counselors. Seven participants practiced in the West/Southwest, three practiced in the Midwest, and three worked in the Northeastern region of the United States. Most participants practiced in urban settings of small, midsize or larger cities (9 in private practice; 4 in agencies). Eight clinicians said that they did not have a religious affiliation, two identified as Christians, two stated they were Jewish, and one was a Buddhist.

Data Collection Methods

Outreach and screening. A local DBT trainer who is a consultant and faculty member of BTech supported the recruitment process. This contact person provided personal introductions to local DBT colleagues with a long-term meditation and mindfulness practice. Additionally, with the support of this contact person, I posted an inquiry on the nationwide DBT LISTSERV in order to recruit a geographically more diverse sample.

I implemented screening for the participation in this study in accordance with the inclusion and exclusion criteria mentioned in the previous section. The inclusion and exclusion criteria were listed in my written outreach statement (see Appendix D, Recruitment). Further, I screened all potential participants at the time when they responded to my written outreach and before the actual interview session (see Appendix E, Screening Tool). All screenings were conducted via email exchange.

Informed consent. After participants had been screened and approved for participation in my study, I obtained informed consent before I conducted the interview meetings (see Appendix F, Informed Consent Form). First, I sent an electronic copy (pdf) of the informed consent form to all participants giving them a chance to familiarize themselves with the study and ask questions. All participants replied on email writing that they understood the study; that they did not have any further questions; and that they felt comfortable to participate in my research.

For the local participants, who were all interviewed face-to-face, I gave each interviewee a hard copy of the informed consent form before beginning the interview. Once more, I briefly explained the study, rights, and expectations and gave each interviewee a second opportunity to read the form in full length and ask clarifying questions. Thereupon, participants signed two

copies of the informed consent form. I retained one copy of the form, and each interviewee retained the other copy for their records. At the time when the local interviews were conducted, local participants also answered the questionnaire.

For the out-of-state participants, who were all interviewed via telephone or video chat, I sent two hardcopies of the informed consent form 14 days before the interview was scheduled. In this mailing, I also included the paper-and-pencil questionnaire. The documents were sent via regular postal mail and including a stamped return envelope. For these out-of-state participants, I offered to schedule a phone call to talk about the study and the informed consent addressing any concerns. None of the participants had any questions. All out-of-state participants signed the informed consent form and filled-in the questionnaire returning both documents in a timely manner before the actual telephone/video chat interviews took place.

Interviews. During the interview sessions, which lasted between 45-60 minutes, I asked the interviewees open-ended questions following a semi-structured format. The local interviews took place in person at a location convenient for the participant. The out-of-state interviews were conducted via telephone or video chat. I collected participant responses via digital tape recording. I met with participants only once; all research-related activities were completely voluntary; and participants did not receive any monetary pay.

Data Analysis

For analyzing the questionnaire data, I used descriptive statistics. For the qualitative data analysis, I used content analysis listening through the recorded interviews transcribing about 75% of all interview data. I used open coding independently reviewing each transcribed interview, inductively collecting themes as concepts and ideas emerged. Individual codes and ideas were refined until a final coding structure had been achieved. In order to derive a major

theme, the theme had to be presented by at least three interviewees. Themes and ideas were the unit of analysis. For the presentation of the major findings, direct quotes have been included in the following findings chapter.

CHAPTER IV

Findings

Introduction & Major Findings

The purpose of this exploratory, qualitative study was to examine how DBT therapists, who professionally teach mindfulness skills to their clients, experience a personal meditation and mindfulness practice that goes beyond the clinical setting.

The first major finding was that all participants reported numerous benefits derived from a personal meditation and mindfulness practice. Benefits included (a) increase of personal well-being, which also related to the generation of self-knowledge; (b) decrease of judgment and attachment; (c) increased self-control: being less reactive and more responsive; (d) increased sense of joy derived from being present; (e) increased ability for compassion/self-compassion; (f) burnout prevention/prevention of compassion fatigue; (g) increased personal and professional effectiveness. Further major findings were (a) formal meditation was perceived as the foundation for an effective informal mindfulness practice; (b) meditation/mindfulness has a spiritual/wisdom component; (c) participants agreed that they experienced changes from when they began a meditation/mindfulness practice to now, yet participants were unable to specify stages of change; (d) the main challenges for maintaining a meditation/mindfulness practice were a lack of time and personal frustration regarding the inability to focus/concentrate one's mind. One other finding was that all therapists placed a high value on the therapist's personal characteristics as they related to one's presence, compassion, integrity, and authenticity. Before

discussing these major findings in detail, I will report on the demographics in regard to participant's professional background and the personal application of meditation and mindfulness practices.

Demographics and Meditation/Mindfulness Background

Following, I have summarized data derived from the questionnaire regarding therapists' length of professional practice as well as their personal meditation and mindfulness practices. Most interviewees had been psychotherapists for more than 10 years (mean = 16.5 years, *SD* 7.3, ranging from 3-30 years). Similarly, most therapists had been practicing formal meditation for more than 10 years (mean = 16.1 years, *SD* 12.7, ranging from 2-20 years). Therapists reported that they were committed to practicing formal meditation for an average length of 25-35 minutes per day (range 15 minutes-2 hours). Nine therapists stated they meditated every day. Of the other four therapists, one said to be meditating five days per week, one stated to be meditating four days per week, and two said to be meditating three days per week. All interviewees practiced concentration meditation as well as mindfulness meditation. In regard to concentration meditation, most frequently mentioned were focusing on the breath, a mantra, visualization, and loving-kindness practice. In regard to mindfulness meditation, all interviewees practiced a form of open presence/Vipassana/Shikantaza. Seven participants reported that they attend 1-2 meditation retreats per year (mean length of retreats = 4 days). Two interviewees said they attend annual retreats that average 10-14 days per retreat. With the exception of one interviewee, all meditators who reported to attend regular meditation retreats said that they participate in Buddhist meditation retreats. The four meditators who did not attend retreats gave as main reasons scheduling conflicts and a lack of time.

Interviewees were asked to define how they understood and differentiated meditation versus informal mindfulness practices. Practitioners agreed that the main characteristics of a formal meditation practice were a specific form and structure (i.e., specific time commitment, quiet place, particular meditation practice). Ideally, one's formal meditation practice included working with a teacher as well as participating in regular meditation retreats. Informal mindfulness was seen as less structured, less specific, and as an extension of the practice on the meditation cushion (e.g., practiced in various settings/situations and throughout the day with a focus on mundane daily-life activities, feelings, body sensations, cognitions).

Major Findings

Key benefits. All interviewees found a personal meditation and mindfulness practice beneficial in many different areas of life. Benefits were broking down into the following seven categories.

Personal well-being and the generation of self-knowledge. Having a meditation and mindfulness practice was seen as essential to one's personal overall well-being and seemed to also relate to a deeper understanding of the self.

In regard to the personal value given to one's meditation and mindfulness practices, one clinician said: "To...have a certain amount of effectiveness in life and personal fulfillment and inner peace, for me it [meditation/mindfulness] is essential."

Another interviewee related the generation of self-knowledge to choices and values: "I see more of my limits, which means I can make more informed choices of what I'm doing and how I'm doing it. It's like, I can make decisions in a way that's closer to my own integrity and values..."

A third participant related self-knowledge to gaining more insight about one's own personal inner struggles: "The formal [meditation] practice—the longer time where you are really just in it and trying—it made me more knowledgeable, the struggle that goes on. So, I think I know my mind a little bit better."

A fourth clinician conveyed how meditation/mindfulness helped in gaining more clarity of mind:

> I think it [meditation and mindfulness] opened my eyes to that I was judgmental but claiming to not be judgmental, like: "What, I don't judge people. I'm not possessive. I just want people to be who they are." I was a judgmental person and living that kind of life. And for some reason I thought I wasn't and that's okay. ... It [my mindfulness practice] created a huge awareness.

Lastly, one practitioner emphasized that a daily meditation practice was essential for maintaining a successful career as a therapist:

> I work with a sometimes volatile population, and I've been doing the meditation for [x] years, sitting every morning for [x] years. And I don't think I could come to work if I didn't do that [meditate every morning]. I feel like it grounds me.

Decrease of judgment and attachment. The increased sense of personal well-being seemed related to a decrease of judgment about oneself and others. One interviewee provided a quote that summed up how the majority of the study sample felt about taking a non-judgmental stance: "I'm less judgmental overall. ... Not automatically moving to judgment, not automatically categorizing someone as good or bad...deliberately being open to what each person or each situation has to offer." Another one said:

I believe that I'm significantly less judgmental. And there is also absolutely a part of me that is judgmental. Maybe the thing that is...different is that I can be judgmental in my head, and that doesn't mean that it has to come out of my mouth. My level of effectiveness has gone up exponentially. I like the idea that we are going to be judgmental, and the success is in noticing it and then deciding what to do next.

In regard to non-attachment and inner flexibility, one therapist noted:

Mindfulness has helped me to be able to question my goals, not in a bad sense but in a healthy: "Now wait a second, I may be having this thought but what's it based on?" Mindfulness has helped me to step away from assumptions and be more careful...and continue to be flexible about being wrong—let new information in, let new information inform you.

Increased self-control was specified as being less reactive and more responsive. One interviewee talked about how mindfulness is a way of being more responsive and less reactive and how mindfulness seems to have become a way of life:

Mindfulness throughout the day...I can recognize when a situation comes up that might pull me away from being centered, and I can recognize the breath change, the emotional change, the physical sensations change. And then I can re-ground myself in mindfulness and open myself up to the awareness of what is happening without being reactive. Those things can come as needed, but they are not something that I'm actually consciously thinking of doing throughout the day.

Another person talked about how mindfulness was used in responding more effectively to a crisis situation: "I just remember where we were in a whole crisis situation and the ability to go

inward and recognize my breath helps me stay calm and centered and attentive to what was going on in ways that were very helpful."

One therapist clarified that one essential outcome of mindfulness is a greater clarity of mind combined with feeling more equanimous:

> I think lots of people have this idea it's [meditation/mindfulness practice] about being nice, being kind. And that could be one outcome. But really as you start practicing, you realize it's not about being kind so much as about being able to see and being able to have clarity. And so, if you are not clouded by automatic responsive judgment or extreme emotion that goes along with a lot of judgment, you can have greater equanimity.

Increased sense of joy derived from being present. Several interviewees emphasized that simply being present and aware was a particularly precious benefit, which allowed these interviewees to experience more joy. Three interviewees described the experience of finding joy in everyday activities as follows:

> Cracking open the moment, finding joy. And I think the only way that that will happen for you is if you practice enough. It's the practice itself that prepares you for those moments that come along. And you don't miss them because your brain is somewhere else.
>
> The difference between people who are satisfied with life and people who are really not is the ability to take joy and just the tiniest...moment of: "Oh, there is that beautiful bird I'm watching. Listen to that music." And just the enjoyment of everyday life.
>
> Bringing mindfulness to the activity has enhanced the activity... There are certain activities that I'm more attentive to... To bring mindfulness to in an effort to enhance my joy... I feel like I'm stealing moments.

Increased ability for compassion/self-compassion. For most participants, compassion and self-compassion were linked. Self-compassion was being seen as a requirement for true compassion towards others. However, most therapists noted that they seemed to naturally have been endowed with an adequate amount of compassion, while they had to work much harder on developing self-compassion. The development of self-compassion was often linked to a decrease of self-judgment and a decrease of feelings of guilt and shame. Following four quotes exemplify the over-all experiences of participants:

> I think that compassion has always been there. It really is part of who I am. Self-compassion has gotten a lot better. It's the whole practice of something like loving-kindness and the understanding...that it has to start with yourself.
>
> I think a healthy distance...the notion that a thought is just a thought, a feeling is just a feeling... Those ideas have started to ring true... When I find myself making judgmental statements about myself, I might be more likely to catch myself and say: "Well, wait a minute. Is there a different way to look at that?"... There may be some truth in it,...even a judgmental statement has probably an element of truth... So, let me acknowledge that I made a mistake, but let's not jump to: "What an idiot I am!" ... Let's learn something from this mistake. I think those are all aspects of mindfulness.

"I'm less likely to feel guilty: 'Just leave it be!' So, I'm less likely to beat myself up about it. That could be a function of getting older or it could be having more compassion for myself."

"Maybe I used to be more caught up in feelings of shame, you know, that somewhere beneath the surface I'm an incompetent and inferior person..."

Burnout prevention/prevention of compassion fatigue. Therapists emphasized that a personal meditation and mindfulness practice was the foundation of detecting early signs of burnout and effectively preventing compassion fatigue. One therapist noted the following:

> Somebody that is in my profession, that isn't using mindfulness, will take personally people that don't get better, will take personally remarks that the client says: "Oh, you are a terrible therapist." You wont be able to not attach to those kinds of situations... You'll lose sleep... So, yeah, mindfulness has a direct impact on one's ability to do this kind of work without burning out.

Another therapist pointed out how essential a mindfulness practice was for living in the world. This therapist emphasized the relationship between non-attachment, well-being, and self-care in one's professional life:

> It [the practice] washes away all of that clinging and false attachment...bringing you into a place of freshness. I think the real risk for those of us in the field is getting too busy, seeing too many people, and not taking time for practice. I could not do this work without that. I could not do it. I don't know how people do. I really don't.

One therapist was rather specific about the mechanism that allows staying fresh, present and energized:

> One of the ways that being mindful has helped me to not feel burnt out is the opportunity to just be focused on the client in front of me. If I thought about this client in front of me and then also thought about the next client that I'm going to see and the client after that... then I think that raises my risk of burnout ... I'm not doing other things in my head. I'm not attending to other clients in my head... The burnout comes from the fact that, in DBT, we work with difficult clients.

Lastly, one therapist pointed out that mindfulness serves as a kind of burnout-prevention-thermometer:

> I'm never surprised. Burnout never comes out of nowhere. I pay attention to it. I'm aware of it. ... My burnout does not last very long, because of it [mindfulness practice]. It takes huge amounts [of work/stress] at this point in my life to get me burnt out, because I practice. ... Generally, when I do get burnt out, it's because I let my practice go; I worked too many hours; I have not done a seated practice, ... or I somehow believe I don't have five minutes before I go to bed, I get caught in that. ... And usually the minute I put things [formal meditation practice] back in, it shifts.

Increased personal and professional effectiveness. Therapists reported to think that they were more effective in three major areas: (a) as therapists, (b) as DBT skills trainers, and (c) in their personal lives.

In regard to being more effective as therapists/DBT skills trainers, interviewees provided the following four quotes: "I think I'm much more effective with [clients]. It's much easier to find compassion for very difficult behaviors."

> The quality that I would have to say might be different... You know it's one thing to believe something and it's another to know... I think I teach it [mindfulness skills] with a lot more passion. There is a lot more passion, a lot more excitement...it is contagious. Joy is contagious.

> I don't think it would make much sense to advocate an activity if I was not willing to undertake myself... and, of course, undertaking it myself, gives me a better chance to explain it and if somebody comes in and says: "Gee, I tried that thing that you were talking about ... and you know what, I really cannot do it, my mind was all over the

place..." I can say: "That's fine...keep going with it...don't be so hard on yourself...I experience exactly the same thing."

I think it's a different quality to really embody the skills of DBT when you have a practice ... It commands an awareness of mindfulness ... If somebody has their own practice, they can teach the [mindfulness] skills in a more effective way, because I think they are actually the hardest skills to teach.

In an idiosyncratic finding, one skills trainer suggested that it might be more important to be an effective teacher than having a personal mindfulness practice in order to teach clients mindfulness skills. This DBT skills trainers said: "If they're not wired to teach, if you are not wired to teach, all the mindfulness practice in the world is not going to wire you to teach."

Therapists who have children emphasized that their mindfulness and meditation practice enabled them to be better parents:

I try very hard to be connected to them [my children] in such a way, modeling as well as I can...I mean I lose it sometimes and am ineffective and I'm usually able and come forward and say: "That was really ineffective and unfair." And I think they [my children] are generally able to do the same. And if we can meet on that level, that's really helpful.

Other major findings. In addition to experiencing numerous benefits, participants spoke about specific aspects of having a meditation and mindfulness practice. Following four categories summarize additional major findings.

Formal meditation as foundation for an effective informal mindfulness practice. There was consensus that meditation practice seemed to be an essential foundation for becoming skilled in applying informal mindfulness in day-to-day activities. Some interviewees agreed that mindfulness appears to be a "byproduct" of meditation practice. Nonetheless, none of the

participants thought that a formal meditation practice conducted once a day was sufficient for change. Meditation needs to be accompanied by daily informal mindfulness. All practitioners thought that practicing formal meditation as well as informal mindfulness provided a sense of continuity.

One interviewee noted that a certain amount of concentration seems essential for successful informal mindfulness practices:

> I don't think that they [meditation and informal mindfulness] are equal. I think that you have to have cultivated the ability to have a focused centered awareness, where when your mind drifts off, you bring it back; your mind drifts off, you bring it back; your mind drifts off, you bring back. I think you have to have a focused present-centered awareness before you can really be mindful, where you are able to let go of focusing and controlling and aiming the mind, and you are able to have an open awareness without being carried away in your thoughts, sensation, emotions or whatever is happening in your body. One before the other. I don't think that you can have mindfulness without first cultivating concentrated meditation.

Another interviewee talked about how formal meditation and informal mindfulness intersect comparing the intersection to how athletes train their bodies:

> My view is that the two go hand-in-hand. I would see the meditation, perhaps as, like an exercise session. If a person wanted to be a tremendous runner they would do practice sessions...and then they would go to the race and make use of the training that they have done. There might be a parallel there—the meditation would be...the training and the mindfulness bringing it to bear in the actual activities.

A third practitioner spoke about how meditation affects informal mindfulness:

When I'm too busy, [and] I cannot get to it [formal meditation], the informal practice...becomes much more challenging. I might notice more judgment, getting much more frustrated... No matter what, I always have to come back to it [meditation]. Otherwise, the informal practice does not...hold.

Meditation/mindfulness has a spiritual/wisdom component. All but two interviewees agreed that their meditation/mindfulness practices did have a spiritual component. The most often named components of spirituality were interconnectedness/ethical behavior, unconditional love, compassion, wisdom, and Buddhist philosophy. Interconnectedness and love were seen as one of the main characteristics of spirituality: "The more I try to discover myself...mindfulness has been my way to discover connection." "Therapy allows me to exercise. It's like exercising a part of my heart."

It's about love. There is something really activating about love or being tuned into love that comes through practice, for me. I think it feeds my loving kindness. Spirituality for me is about being the best person I can be...being centered...being intuitive...doing the right thing at the right moment.

In regard to different aspects of spirituality, mutuality was important as well: "If you give compassion away, compassion comes back to you..."

Further, ethical behavior was especially important for one therapist who put it this way:

The Buddha was not entirely about sitting and meditating and reaching enlightenment within oneself. It is also about carrying this enlightenment to the world, ... using it in day-to-day activities, especially one's interactions with other living beings. The idea of applied attention and right speech and right action are very much part of it. It's not just,

"Let's meditate once a day; let's gather with the sangha [community of practitioners] once a week." And the rest of the time you are whatever jerk you want to be.

More often than not, interviewees referenced fundamental Buddhist teachings. Everybody resonated with Buddhist concepts of impermanence and how suffering and anguish are part of life. One participant said:

> What resonated initially was something about the Four Noble Truths...the idea that live inherently involves suffering, and that there is a way out of suffering, and the clarification that it's not bad to have fun. The Buddhists are not necessarily ascetics... There is a way out [of suffering] that's mindfulness, non-attachment... It's okay to have fun; it's okay to enjoy your food and play miniature golf and stuff like that. What really trips us off is the desire for something to be in one way or another.

Other participants emphasized the value placed on one's personal experience and the freedom to question:

> I really responded to the idea that the Buddhist track really asks one to take nothing unseen. "Don't believe anything that I tell," that's what the Buddha said... "Try it. Try it for yourself... See if anger isn't wrecking your life. See what anger is doing to your life.... Try meditating and see what that does..." I really responded to that.

> This is one of the things that I love about Buddhism, that Buddhism... says to be free of concepts, free of beliefs, free of expectation and interpretations and all these things that the world is supposed to look... So I try to hold my concepts lightly.

In an idiosyncratic finding, two participants who did not regard their meditation/ mindfulness practice as spiritual gave as reasons that they defined meditation/mindfulness more as a science of the mind: "Buddhism is a psychology...not a religion. I think it [Buddhism] is all

about working with the mind." They also said that they were not spiritually/religiously inclined: "It's totally more, for me, around the psychology of mind and just something that I like. For me it doesn't resonate as spirituality at all." As an expression of spirituality, one interviewee practiced Christianity rather than feeling an affinity with Buddhism or regarding meditation/mindfulness as a spiritual practice.

Stages of Change. Participants agreed that they had experienced much positive change, yet were unable to specify exact stages of change. Most participants talked about experiencing a change in their practice related to the quality of/motivation for their practice, which shifted from being driven and doing to acceptance and being:

> I think I was really searching when I came [to the practice]. I was a little desperate... I had an intense doubt. I had a lot of doubt.... a lot of judgment... I was driven. And I don't know how that all changed... I think the practice itself softened my edges, made me more relaxed, made me realize that *this* and *not-this* are no different, you know: "Don't worry about it. Don't freak out. Don't waste your breath on these thoughts and these worry thoughts."

Another participant commented, "I used to be driven to practice in order to avoid...my mind. But now I feel that I'm driven to be present because there is so much love in the present moment and I don't want to miss that."

Others emphasized changes in regard to decreased effort, increased flexibility, more self-compassion, and increased concentration and acceptance: "At this point, it feels like bringing mindful attention to whatever task I'm doing requires less effort. It's something that comes a little more easily." "Now I can, according to the needs as they arise, I can shift gears." "Early on in my practice I had more aversion." "I approached mindfulness first out of a place that was not

very compassionate...that was very much rigid and perfectionist. 'You gotta be doing this! If not, you're failing.' And so I think I had to develop more kindness." "I still have times where I have some of that monkey mind, but I don't think it happens that often and when it does, I notice it more quickly." "I don't feel like I get attached to things like I used to..."

Main challenges for maintaining a meditation/mindfulness practice. All participants mentioned as the main challenges juggling busy schedules, a perceived lack of time, as well as personal frustrations with a mind that is unwilling to focus and concentrate. Nonetheless, for everybody the benefits outweighed the effort needed for maintaining one's practice. Some interviewees noted that they struggled with the lack of having a community of meditation practitioners. Meditation retreats were seen as very helpful for maintaining one's practice and fulfilling the need for community and a teacher.

Practitioners gave several poignant examples for their frustrations regarding their inabilities to focus/concentrate their minds: "Some days it's excruciating, it's awful. It feels like you are in misery: 'Oh, my gosh—I cannot follow my breath past one without wandering.'" "I'm still prone to the, 'yeah, but' and monkey mind, getting distracted and doing to-do-lists when I'm supposed to be counting my breath...That's challenging and frustrating, at times." "Time, what else? ... Mostly, the biggest struggle I have is with paying attention. My mind wanders a lot."

Other findings. One additional finding was that therapists seemed to place a high value on therapist characteristics. The majority of DBT therapists agreed that the therapist's capacity for empathy and compassion is of uttermost importance. While the DBT therapists of this study were passionate proponents of evidence-based change technologies, everybody agreed that the therapist as interventionist and the therapeutic relationship are as important as practice-specific

applications and may even outweigh practice-specific applications. In regard to that, therapists said:

> Your effectiveness as a therapist is based more on who you are as a person than on whatever theory or technique you try to employ. And the best method to cultivating who you are as a person is to personally practice meditation and mindfulness. It helps you be more centered, less likely to put your own beliefs, interpretations and judgments onto your client and adapt to their needs rather than holding your own.

Others pointed towards the relationship between self-awareness and knowing/understanding the client: "I think you have to have a capacity to understand your mind to be the most useful to somebody else." "Just know yourself ... just as much effectiveness can come out of that ... Who you are in the presence of that person can make a huge difference."

Another said,

> This is a noble profession... We...have a chance to help people change their lives, and that's a big deal. I would ask the next generation of clinicians: "Get into the nuts and bolts of what is the technology of change... That technology is very important. But most important is...one's presence with another human being."

The findings presented in this chapter show that psychotherapists experience numerous benefits derived from having a personal long-term meditation and mindfulness practice. In the following discussion chapter, I will examine the analyzed therapist narratives in regard to implications for social work, strengths, limitations, and future research questions.

CHAPTER V

Discussion

Major Findings and Implications for Social Work

In this last section of my thesis, I will provide a discussion of the major findings in relation to their implications for clinical practice and social work. Further, I will examine the strengths and limitations of this study and provide questions for future research.

One major finding of my research study was that therapists experienced numerous benefits related to having a personal meditation and mindfulness practice that goes beyond the clinical setting. Benefits included increased overall well-being, self-knowledge, self-control, compassion/self-compassion, professional and personal effectiveness, as well as the prevention of compassion fatigue and burnout. These findings are consistent with the existing literature (Baer, 2003; Brown & Ryan, 2003; Carmody & Baer, 2008; Davis & Hayes, 2011; Gökhan et al., 2010; Grepmair et al., 2007; Grossman et al., 2004; Lykins & Baer, 2009; Shapiro et al., 2005; Shapiro et al., 2007; Shapiro et al., 2008; Siegel, 2007; Walsh, 2008).

In their mindfulness theory, Shapiro and Carlson (2009) have proposed *reperceiving* as a metamechanism that may underlie the changes brought forth by a meditation/mindfulness practice. Similar to Shapiro and Carlson's theory, interviewees agreed that life continued to present challenges but that their attitudes had shifted and were now more characterized by qualities such as openness, acceptance and letting go—feeling less attached and feeling less judgmental. In particular, interviewees specified Shapiro and Carlson's four change

mechanisms, which are an increase in (a) self-regulation, (b) values clarification, (c) cognitive/emotional/behavioral flexibility, and (d) exposure to and radical acceptance of all daily-life experiences.

Further, the participants of my study agreed that formal meditation and informal mindfulness intersect with overlapping benefits. The intersection of meditation and mindfulness and the overlap of benefits seem to confirm the potential complexity of the mindfulness construct (Grossman, 2008; Rosch, 2007). In addition to confirming conclusions of other researchers, several findings were able to augment current knowledge.

While all participants regarded informal daily mindfulness as essential, interviewees experienced meditation as *the* foundation for an effective informal mindfulness practice. This observation points to following implication.

It appears that daily, extended periods of sitting meditation may be imperative for implementing and maintaining a meditation/mindfulness practice, even after having practiced for more than a decade. This points towards the importance of homework and the necessity for continuity between one's daily meditation and one's daily informal mindfulness practices.

Researchers have highlighted the importance and effectiveness of mindfulness-based home practice (Carmody & Baer, 2008; Jha et. al, 2010; Schoormans & Nyklíček, 2011; Shapiro et. al, 2008). Nonetheless, researchers have not always specified homework and/or home practice as a daily concentration or mindfulness meditation practice. This may mean to instruct social work students and therapists explicitly in formal meditation emphasizing the necessity of a consistent daily sitting practice. For psychotherapists who are interested in using mindfulness skills as a tool for burnout prevention and enhanced therapist effectiveness, it may be advisable to focus on teaching a variety of meditation skills (e.g., mindfulness meditation, concentration

meditation, loving kindness meditation), which the practitioner must also regularly practice a home.

In regard to interviewees' reports on compassion and self-compassion, therapists disclosed that being truly self-compassionate was experienced as more challenging than being compassionate towards clients. Therapists mentioned a proactive self-compassion practice such as formal *metta* meditation (metta = loving-kindness, Sanskrit word from the Theravada Buddhist canon) in order to cultivate more self-compassion. More specifically, some therapists mentioned that a formal loving-kindness practice is not part of standard DBT training. These therapists said that they had to look outside of the DBT mindfulness framework for a structured metta/self-compassion component. Further, therapists regarded self-compassion as essential for true compassion with their clients. In alignment with instructions from Theravada Buddhism and formalized MBSR training, it may be useful to include a systematic self-compassion training component when instructing psychotherapists in meditation and mindfulness. This may prove especially effective for therapists who wish to use meditation/mindfulness a tool for burnout prevention and compassion fatigue.

Another major finding was the connection between a personal mindfulness practice and spirituality. Shapiro (1992) conducted a study with 27 long-term meditators (mean length of meditation experience = 4.27 years) investigating how practitioners' goals, religious orientations, and cognitions changed on a continuum from self-regulation over self-exploration to self-liberation. Shapiro identified that regardless of practitioners' initial reasoning for beginning a formal meditation/mindfulness practice—over time—the majority of long-term meditators began seeking and developing a self-liberation component related to personal values, beliefs, spirituality and religion. Similarly, the majority of the participants of my study mentioned how

meditation and mindfulness have become a "way of being/living" rather than a simple technique for attaining/maintaining personal well-being. In regard to the connection between mindfulness and spirituality, most often mentioned was the importance of interconnectedness, compassion, and love. Interviewees referred to meditation/mindfulness as a spiritual "practice of the heart."

In my study, I did not focus on whether and how therapists bring spirituality into the clinical encounter. It appears that future researchers should continue investigating the intersection between regular long-term meditation, mindfulness, and spirituality in regard to personal therapist experiences as well as the implications those experiences have for therapist-client interactions.

Through my research study, I was also hoping to explore how therapists maintain a personal mindfulness practice and what main challenges they encounter in doing so. While I did expect therapists to talk about the difficulty of integrating a daily meditation and mindfulness practice with busy work and family life, I was surprised to hear many therapists note that they struggled most with the inability to focus and concentrate during meditation. I believe this is an important detail with implications for the secular teaching of meditation and mindfulness.

From a Buddhist point of view, there are no good or bad meditation sessions, and Buddhist practitioners are instructed—over and over again—to let go of any goal orientation. Therefore, a mind that is unable to focus is just that: *A mind that is unable to focus*. Similarly to the challenge experienced by the sample of my research study, Buddhist meditators often struggle with embracing and accepting a mind that is scattered. Two implications for therapists who are interested in taking up a personal meditation and mindfulness practice might be to stay close to Buddhist meditation instructions and (a) emphasize that the inability to focus one's mind

is rather natural for the mind, and (b) highlight the importance of practicing non-attachment to certain states of mind and outcomes.

In addition to a lack of time and inability to concentrate during meditation, a third challenge experienced by the study participants was the lack of having a community of meditation practitioners and/or a readily available teacher. Some therapists noted that, for them, meditation retreats served an important function for feeling connected and supported. This finding points towards the importance of creating community. This practice is not a solo ride. For example, therapists who live in rural communities without a Buddhist center or other meditation groups may want to create their own group. Creating one's own meditation group was highly encouraged by my Buddhist teachers Ven. Ayya Khema and Dr. Sylvia Kolk (personal communications, 1997). Since almost every therapist of this research study mentioned interconnectedness as a value, it seems valid to encourage the proactive creation of a student/therapist community of meditators.

Many therapists of this study made statements about the importance of the therapist's presence and integrity. One aspect of therapist integrity was to have a personal mindfulness practice in order to teach mindfulness skills from a place of embodied understanding and authenticity. An implication of this finding is to encourage or even require DBT therapists, and especially DBT skills trainers, to have their own regular meditation/mindfulness practice. Although Linehan does encourage the implementation of a personal meditation/mindfulness practice, to date, DBT therapists are not required to have a practice that goes beyond the clinical setting.

Lastly, participants agreed that, while the DBT change technology is imperative, the therapist's presence might outweigh change technologies. The major implication of this finding is the importance mindfulness may hold in relation to personal transformation.

Strengths and Limitations

A strength of this study was the data analysis derived from a rather homogenous sample in regard to practice experience as a psychotherapist, time of having had a meditation practice, and adherence to a daily meditation/mindfulness routine. The majority of participants had been therapists for more than 10 years; most of the participants have had a meditation/mindfulness practice for more than 10 years; and the majority of participants practiced daily. Moreover, my study sample represented clinical social workers, psychologists, and counselors (9 women; 4 men). A third of the interviewees were employed in agencies and all others worked in private practice, which shows that interviewees had similar experiences regardless of professional background and practice setting. However, it may be relevant to investigate whether clinicians who work at an agency versus in private practice bring different stressors into their meditation/mindfulness practices and how a variation in stressors may affect one's meditation and mindfulness practice.

Due to the method of convenience sampling and the small number of study subjects (13 interviewees), findings are not generalizable. Further, the sample lacked diversity in regard to race/ethnicity. Future researchers should try to sample a more ethnically/racially diverse as well as a more gender-balanced study population. However in regard to race/ethnicity as well as gender, this study sample was representative of the larger DBT community. Nevertheless, it remains questionable whether this study sample is representative of the larger DBT community

in regard to having a meditation/mindfulness practice. Future researchers should attempt to assess how many DBT therapists maintain a personal meditation and mindfulness practice.

When I asked interviewees questions concerning whether they went through stages of change related to their meditation/mindfulness practice, all participants agreed that things had shifted. Often these shifts were related to one's motivation and quality of meditation/mindfulness practice. However, none of the participants were able to identify particular stages of change. Future researchers should conduct longitudinal studies to enhance our knowledgebase regarding changes over time.

While my personal background of 15 years of an integrated Buddhist meditation and mindfulness practice may have proven advantageous in regard to asking questions from an emic perspective, consideration needs to be given to the potential of confounding factors such as interviewer and interviewee biases. One bias that I hold as a Buddhist practitioner is that meditation and mindfulness are beneficial. Therefore, I may have introduced some leading questions and interviewees may have engaged in responder expectancy.

Future Research Questions

This research study led to several questions that future researchers may want to explore:

1. How do others, for example, clients rate therapists who have a meditation practice in regard to effectiveness of therapy, empathy, compassion, and unconditional love?
2. How many DBT therapists/skills trainers have a personal meditation and mindfulness practice?
3. In addition to benefits gained from one's personal meditation/mindfulness practice, how may the prevention of compassion fatigue and burnout for DBT therapists be related to the weekly DBT consultation team meetings?

4. How do benefits derived from one's formal meditation and mindfulness practice overlap with the natural developmental process of maturation?
5. How many clients who graduate from a DBT program begin a personal meditation practice?
6. What stages of change do practitioners who hold a long-term meditation practice go through?
7. Do clinicians who work at an agency versus in private practice bring different stressors into their meditation/mindfulness practices? If so, how does a variation in stressors affect one's meditation and mindfulness practice?

Conclusion

It appears that the mindfulness construct is complex and potentially as much based on wisdom as it is based on mundane experiences and measurable outcomes. Concerning the complexity of the mindfulness phenomenon, Rosch (2007) wrote: "To try to isolate and manipulate single factors that actually operate only systemically is like killing a rabbit and dissecting it to look for its aliveness" (p. 263). For Rosch, it seems essential to leave room for not-knowing, the mystery, beginner's mind. More specifically, Rosch quoted a Tibetan Buddhist teacher who yelled at one of his students, who kept asking question over question, "Leave your gap alone!" (p. 263). While researchers favor finding answers to their questions, maybe the field of clinical practice needs to also allow room for the mystery and the unknown.

One interviewee, a clinical social worker, said: "This [Buddhism/meditation/mindfulness] basically could be the religion of social workers or the practice of social workers. It's so natural [natural fit]." It is my hope that through this study other clinicians will learn more about how therapists experience life and therapeutic practice in relation to the use of meditation and

mindfulness skills that go beyond the clinical setting. May the narratives of the DBT therapists who participated in this study inspire clinical social work students and beginning as well as seasoned clinicians to adopt a meditation and mindfulness practice in order to live a balanced, healthy, and successful personal as well as professional life.

"May all beings be happy."

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APPENDIX A

HUMAN SUBJECT REVIEW APPROVAL LETTER(S)

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

December 27, 2011

Felicia Marohn

Dear Felicia,

I think your responses to me and the committees were quite professional, thoughtful and clear! Nice work! Your project has been officially accepted. Thank you for your efforts.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Sincerely,

David L. Burton, M.S.W., Ph.D.
Chair, Human Subjects Review Committee

CC: Mary Beth Averill, Research Advisor

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

January 10, 2012

Felicia Marohn

Dear Felicia,

Those changes make great sense. I hope the ideas we last sent were helpful. Thank you for the revision and your amended project is accepted with that addition/change. I look forward to seeing your results and am doing two DBT studies right now - in both of which we seek the answers to some of your questions!

Sincerely,

David L. Burton, M.S.W., Ph.D.
Chair, Human Subjects Review Committee

CC: Mary Beth Averill, Research Advisor

APPENDIX B

INTERVIEW GUIDE

Instructions for myself: Establish Trust – Listen Intently – Be Curious and appropriately Inquisitive – Pursue Unanticipated Directions

As you know, I am interested to learn more about your experiences with a personal meditation and mindfulness practice. For the next hour, I would like to hear stories that illustrate your perceptions and experiences as a DBT therapist who meditates and practices mindfulness.

1. Let's start by having you tell me a little about yourself.
Instructions for myself: Provide a comfortable way into the interview; begin to establish a relationship; gain a sense of personal experiences.
Possible Probes:
- What attracted you to becoming a therapist?
- What attracted you to DBT?
- What inspired you to start meditating?

2. Tell me about your personal meditation practice and what inspired you to integrate mindfulness skills into your personal life.
Possible Probes:
- How do you understand and define meditation and mindfulness?
- How did you learn to become more mindful?
- How did you learn to meditate?
- Are sitting meditation and informal mindfulness practices equally important to you?
- How do you integrate the two?
- Why do you practice?
- What do you gain from formal sitting meditation?
- What do you gain from informal mindfulness practices applied in daily life?

3. Tell me a bit more about the stages you went through or are still going through in your meditation and mindfulness practice.
Possible Probes:
- How has your practice changed over time?
- How has your state of mind changed over time?
- Let's talk about nonjudgmental awareness:
    - How was that for you when you began practicing?
    - What has changed?
    - How is it now?
- What do you find challenging?
- What motivates you to continue practicing?

4. I am also interested in learning whether and how you resonate with Buddhist philosophy, thoughts and values.

Possible Probes:

- What do you resonate with?
- What do you not resonate with?
- In your personal experience, how do mindfulness and spirituality relate?

5. How do you see your meditation and mindfulness practice making a contribution to the larger world and towards elevating suffering?

I very much appreciate your sharing so much of your experiences with me. Is there anything else you would have liked me to ask or would like to add?

Instructions for myself:
When an interviewee begins to describe a situation that was meaningful or difficult, the curious question is "Why was this important/challenging?" At each step along the interview, the interviewer should **follow the story and ask questions to help us understand the story.** To better understand each interviewee's experiences and perceptions, some general probes are below.

General probes:

Can you tell me more about that?
What did you mean when you said "______"? Or
You just referred to "_______. What did you mean by that?"

APPENDIX C

INTERVIEWEE QUESTIONNAIRE

PART I – DEMOGRAPHICS & PROFESSIONAL BACKGROUND

1. What is your gender?

2. What is your age?

3. What is your religious affiliation?

4. What is your race and/or ethnicity?

5. For how long have you been a psychotherapist?

6. For how long have you been a DBT therapist?

7. What setting do you work in?
Private practice:
Agency:
Other___________________

8. What is your clinical education? (e.g., MSW, PsyD, PhD in Counseling Psychology)
Masters Degree:
Please specify:_____________

Doctoral Degree
Please specify:_____________

9. What kind of diagnoses do you primarily work with? (e.g., BPD, anxiety, trauma)

10. What kind of clients do you primarily work with? (e.g., female adults, teenagers, low-income)

PART II – MEDITATION & MINDFULNESS PRACTICES

11. For how long have you been practicing meditation?

12. What kind of meditation practice do you do?
Please check all that apply.

Concentration Meditation

Breath
Mantra
Visualization
Other — **Please Specify**_____________

Mindfulness Meditation

Open Presence/Choiceless Awareness
Vipassana
Zen-Shikantaza
Tibetan-Dzogchen
Other — **Please Specify**_____________

Other Type of Meditation (e.g., walking meditation, Yoga, Tai Chi Chuan)
Please Specify_____________

13. How often do you practice formal meditation?

Daily
Every other day
Other— **Please Specify**_____________

14. When you formally meditate, for how long do you meditate?

15. Do you participate in regular meditation retreats?

Yes
No

If yes:
How often in a given year?

What is the average length of those retreats?

What is the tradition, affiliation or lineage of those retreats/retreat leaders? (e.g., Zen Buddhism, Vipassana/Theravada, Catholic Zen Priest, Advaita Vedanta)

If not, why not? Please explain below.

16. Do you have an informal mindfulness practice?

Yes
No

If yes, please provide examples for your informal mindfulness practices? (e.g., mindfully eating a meal, making coffee, doing the dishes, being aware of thoughts, feelings, intentions/motivations)

If not, why not? Please explain below.

APPENDIX D

RECRUITMENT: EMAIL OUTREACH/TALKING POINTS

Dear __________ [Insert Name if applicable]:

My name is Felice Marohn, and I am a graduate student in the clinical social work program of Smith College, Northampton, MA. This winter, I will be working on a research project used for my master's thesis.

The purpose of my research study is to examine how DBT therapists who professionally teach mindfulness skills to their clients experience a personal meditation and mindfulness practice that goes beyond the clinical setting. My goal is to explore attitudes and perceptions regarding potential benefits of meditation and mindfulness, changes over time of meditation and mindfulness, and best avenues to acquire and maintain meditation skills and the ability of being mindful.

I am planning to invite up to 15 DBT therapists to individually participate in a one-hour interview session during which I will ask questions pertaining to one's individual meditation and mindfulness practices and experiences.

The inclusion criteria for the one-hour interviews are:

- Minimum of two years working as a licensed therapist
- Minimum of two years working as a DBT therapist (i.e., professionally practices DBT in adherence with the standards published and taught by Behavioral Tech, LLC)
- Meditation and mindfulness practice for a minimum of two years
- Fluency in English
- Practices in the United States

For the purpose of this study, I will use the following criteria to define a personal "meditation and mindfulness practice":

Meditation practice:

- The interviewee practices formal meditation (i.e., the interviewee practices training his or her mind in order to become familiar with mental processes and learn how to affect mental processes) with the intention to practice daily for 20 minutes or more, but at least three days/per week, 10 minutes per meditation session
- The interviewee's personal meditation practice may be a mindfulness meditation practice **or** a concentration meditation practice
- Formal meditation may be sitting and/or walking meditation

AND

Mindfulness practice:

- The interviewee practices mindfulness formally (i.e., during regular sitting and/or walking meditation as defined above), **and/or**
- The interviewee practices mindfulness informally during daily life activities
- Informal mindfulness refers to an intentional mindfulness practice done outside of formal practice on the meditation cushion (i.e., intentionally being mindful during a variety of daily life activities)
- Informal mindfulness practice periods may be brief (e.g., 1-5 minutes)

If you are interested in participating in this study, please contact me via email: **(personal information deleted by Laura H. Wyman, 11/30/12)**

Thank you very much for your time and consideration of my request.

Respectfully,

Felice Marohn
MSW Candidate, Smith College School for Social Work
(personal information deleted by Laura H. Wyman, 11/30/12)

APPENDIX E

SCREENING TOOL

Thank you so much for getting back to me regarding my planned study about DBT therapists' meditation and mindfulness practices. Before we talk more about your possible participation in this study, I would like to confirm that you fulfill the requirements for participation.

Would you be willing to answer following questions?

1. Have you been working as a licensed therapist for at least two years?
2. Have you been working as a DBT therapist for at least two years?
3. Did you receive your DBT training from BTech?
4. Do you practice DBT in accordance with manualized BTech standards?
5. Have you had a formal meditation and mindfulness practice for at least two years?
6. Do you practice sitting or walking meditation for at least three days per week and for at least 10 minutes per session?
7. Do you practice either mindfulness meditation or concentration meditation?
8. Do you have a formal and/or informal mindfulness practice? (Specific Probe: "Your formal mindfulness practice may be your regular mindfulness meditation practice. Your informal mindfulness practice may be being mindful during daily life activities.")
9. Do you practice in the United States?

(All questions must be answered with "yes.")

Thank you very much. I think you will be a great candidate for this study.

Do you have any questions regarding the study or your participation?

I will mail you a form for Informed Consent that you will be required to sign after you have read it and we have discussed the study.

Again, thank you so, so much for your time. I really appreciate your contribution.

APPENDIX F

INFORMED CONSENT FORM

Dear Participant,

My name is Felice Marohn, and I am a graduate student in the clinical social work program of Smith College, Northampton, MA. I am inviting your to participate in a research study that examines how DBT therapists, who professionally teach mindfulness skills to their clients, experience a personal meditation and mindfulness practice that goes beyond the clinical setting. This research will be used for my MSW thesis and may be used for other presentation and publication. Your participation in this study is entirely voluntary. Please read the following information, which provides specific details about this study. If after reviewing the information you decide to participate, please sign the form and we will begin the interview.

You are one of twelve to fifteen DBT trainers from the nationwide DBT network whom I have invited to participate in this qualitative study. All participants will partake in in-depth interviews led by me, Felice Marohn. The inclusion criteria for this study are as follows:

- A minimum of two years working as a licensed therapist
- A minimum of two years working as a DBT therapist (i.e., professionally practices DBT, practices in adherence to the standards and manuals created by Dr. Marsha Linehan and taught by Behavioral Tech, LLC)
- Fluency in English
- A meditation and mindfulness practice for a minimum of two years

DBT practitioners who do not practice in the USA do not qualify for this study.

The interviews will take approximately between 60-75 min. and will be conducted face-to-face at a location convenient for you. In the case that a face-to-face meeting is not feasible, I will conduct the interview via video chat or telephone. Your comments will be recorded by a digital audio device and transcribed by a professional transcriber who will sign a confidentiality pledge. At the end of the interview, I will ask you to fill in a short questionnaire to collect demographic data and gather information about your meditation and mindfulness practice. This is a one-time meeting; there are no follow up sessions after this interview.

Some questions may include sensitive subject matter related to your personal experiences; therefore, there is a minimal risk that you may feel uncomfortable at some point during the interview. You have the right not to answer a question, stop the digital audio recording, or end the interview at any time.

I hope that by conducting these interviews, researchers, clinical educators and practicing psychotherapists, such as you, will develop a better understanding about the relevance of a meditation and mindfulness practice that goes beyond the clinical setting. Your participation may contribute to increasing the knowledge base of the mental health profession and may directly and

indirectly benefit you, other mental health professionals as well as the future of clinical education. There will be no monetary compensation for participating in this study.

I will make every effort to ensure your confidentiality. To protect your identity, I will not use your name during the interview session. I will retain copies of your comments for three years in a safe location and then I will destroy them. Should I need the materials beyond the three-year period, I will keep the data in a secure location and destroy the data when no longer needed. The professional transcriber will sign a confidentiality agreement. Your interview and questionnaire data will be marked only with a code number, and the informed consent form will be filed separately in a secure location. All data stored electronically will be password protected. My research advisor will have access to analyzed data from which identifying information has been removed. In publications and presentations, data will be presented as a whole. Brief illustrative quotes will be carefully disguised; I will remove all names.

In case you mention your clinical experiences, please be careful not to identify any of your clients.

Participation in this study is voluntary. You may choose not to participate in this study or not to answer a question at any time during the interview. You may ask that the digital tape recording be turned off at any time.

You have the right to withdraw from having your interview included in the study at any time before March 1st, 2012, when I will write the report. Should you request to withdraw from the study, I will immediately destroy all materials pertaining to you. In order to withdraw, please contact the researcher via email or phone requesting a confirmation of the withdrawal request. Withdrawals after March 1st, 2012 cannot be accepted.

If you have any concerns regarding your rights or about any aspect of the study, please contact me via email: **(personal information deleted by Laura H. Wyman, 11/30/12)**. Or please feel free to contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

______________________________________ ____________________

Signature of Participant Date

______________________________________ ____________________

Signature of Researcher

Date

(personal information deleted by Laura H. Wyman, 11/30/12)

Thank you for your participation. ***Please keep a copy of this form for your records.***