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Sonia Hsieh
Sharing our Edges: The Mindfulness
Influence on Therapist's Formulation
of Insight

ABSTRACT

This inductive qualitative research study explored therapist's experiences of using Mindfulness in session with patients. Through 12 semi-structured interviews with therapists who self-identified as Mindfulness practitioners with a psychodynamic orientation, narrative data was gathered on participant's explicit and implicit uses of Mindfulness within the therapeutic encounter. Major findings revealed that Mindfulness first and foremost attunes the therapist's attention to the body. Therapist's awareness of personal bodily sensations then initiated the therapist's process of understanding disavowed content from the patient.

Upon pinpointing the therapist's own bodily sensation, participants then discussed how tenets of Mindfulness informed their therapeutic presence. Qualities of this presence included a spirit of inquiry and staying with the immediate experience with openness, nonjudgment, and compassion. In addition, findings showed how Mindfulness and Buddhist philosophy informed the therapeutic frame overall through the therapist's use of language and sense of *being with* instead of *taking away* patient suffering. Lastly, this study presents a framework for how therapists can use a Mindfulness practice to aid in the formulation of insight and reminds clinicians that the use of Mindfulness is a deeply personal choice to be used discerningly with clients.

**SHARING OUR EDGES: THE MINDFULNESS INFLUENCE ON THERAPIST'S
FORMULATION OF INSIGHT**

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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2015

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	ii
TABLE OF CONTENTS.....	iii
LIST OF TABLES.....	iv
LIST OF FIGURES.....	v
CHAPTER	
I INTRODUCTION.....	1
II LITERATURE REVIEW.....	5
III METHODOLOGY.....	24
IV FINDINGS.....	32
V DISCUSSION.....	48
REFERENCES.....	60
APPENDICES	
Appendix A: Interview Questions.....	65
Appendix B: Consent to Participate in Research Study.....	66
Appendix C: HSR Approval Letter.....	68

LIST OF TABLES

Table

1. Participant Demographics	32
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LIST OF FIGURES

Figures

1. Therapist's Formulation of Insight.....	33
2. Buddhist Tenets	45

CHAPTER I

Introduction

This qualitative study seeks to observe and capture therapist's experiences of using Mindfulness in sessions with clients. The research on Mindfulness is vast, and its popularity has shown that Mindfulness is here to stay. With the help of ever-sharpening functional MRI technology and the evolving field of neuroscience, Mindfulness benefits are continuing to be supported through concrete scientific evidence. And, as the scientific field of mindfulness grows, so does its implications for clinical work. As Mindfulness merges with scientific and medical modalities, in order to prevent a conflation of Mindfulness philosophy and practice, this research seeks to unpack the influence of Mindfulness as embodied by the therapist. While much research is accomplished through brain scans or numbered surveys, the laboratory for therapists lies in the therapy room where theories are truly tested and their benefits and shortcomings revealed. This study looks to observe the therapeutic action of Mindfulness.

Existing literature has shown that mindfulness reduces anxiety and depression, enhances sense of wellbeing and compassion, and encourages a host of neuro-biological activity including increased grey matter and a lessening of the emotional reactivity centers of the brain (Kabat-Zinn, 2003). Past social work research has looked into how to operationalize mindfulness in social work programs and student learning (Gockel, 2010), while some studies seek to enhance measurements of mindfulness to move it beyond simply "deep-breathing" or "relaxation" techniques (Garland, 2013). Additionally, other research has looked into how Mindfulness helps clinicians manage internal anxiety and countertransference (Gockel, 2013). While there are a number of quantitative studies

published in the field of social work, psychology, and neuroscience, more literature needs to focus on the experiences and narratives of clinicians using Mindfulness.

This inductive study seeks to observe how clinicians are currently practicing Mindfulness in sessions with clients. In other words, how do clinician's self-defined understanding of Mindfulness play out in the clinical encounter? This research seeks to understand the mechanisms of Mindfulness that clinicians choose to engage in and find most useful in their clinical work. With narrative evidence, this research holds the potential to encourage current and future clinicians to use Mindfulness in ways that extend beyond relaxation techniques.

The purpose of the study is to look at therapist's experiences of using Mindfulness in their clinical work with clients. This study hopes to fill the gap left by current quantitative research, which has pursued Mindfulness as a skills-building approach to therapy. While the quantification and enumeration of Mindfulness benefits is useful, there is more to be found in its ephemeral qualities. Mindfulness transposes easily across therapeutic models and is seen as a trans-theoretical process (Dunn, Callahan, & Swift, 2013). Because of its easy adaptability, it has been adopted by many manualized treatments modalities such as Dialectical Behavioral Therapy, Mindfulness-Based Cognitive Therapy, and Acceptance-Commitment Therapy. In order to understand more fully which aspects of Mindfulness philosophy and practice correlate to dynamism in the therapeutic process, this study asks clinicians to recount their use of Mindfulness. The hope is to fill the research gap left by quantitative research and to add to the research on the dynamic and inter-personal use of Mindfulness and Mindfulness in action between therapist and client. This study is needed to ensure that Mindfulness' integrity and therapeutic valences become as well understood as possible before becoming so blended and co-

opted into the popular culture at large that we no longer recognize Mindfulness in its original form, which is Buddhism.

12 clinicians participated in semi-structured interviews that explored their use of Mindfulness. Through anecdotal evidence of their work with patients, clinicians with a self-defined Mindfulness practice and who practiced from a self-defined psychodynamic orientation, recounted case vignettes in which they felt that Mindfulness informed their clinical interventions. This inductive study's framework was informed by relational psychodynamic theory and Buddhist psychology.

There are several limitations to this study. Racial and ethnic makeup was fairly homogenous; however, racial identity was not explicitly asked during interviews. Participants were 50% men and 50% women and 11 out of 12 participants were in private practice. While this study is not generalizable due to its small sample size and purposive sampling technique, this study does provide an in-depth and highly descriptive look at Mindfulness in action.

Looking at Mindfulness *in situ* holds the potential for understanding the mechanisms of Mindfulness at work in the therapeutic encounter. It is the hope for this study to contribute to the literature on Mindfulness, its contemporary uses with clinicians, and the scope under which Mindfulness is used personally and inter-personally. By gaining a deeper understanding of the aspects at work in during clinician's formulation of insight, this may hold promise for Mindfulness to be studied and embodied within the clinician instead of its more common iteration as a behavioral intervention.

The following chapters describe the past and current environment of Mindfulness research, the methodology used for this study, the narrative and phenomenological findings of

the study, and lastly a discussion where findings are reviewed and contemplated for future implications.

CHAPTER II

Literature Review

Introduction

This section will review past and current research on Mindfulness, its historical and religious origins, and directions for future practice by researchers and clinicians alike.

The review begins by setting up and operationalizing the word Mindfulness and rooting its origins with Buddhism. After reading through quantitative and qualitative, as well as the neuroscientific literature on Mindfulness, this chapter was divided into four sections that mirror the research domains of this study. They are, Mindfulness in the client, clinician's use of Mindfulness, Mindfulness and Buddhism, and lastly, the practice of relational Mindfulness.

Mindfulness is a practice of attention that was created within the Buddhist tradition to enhance concentration and knowledge of the mind. While Mindfulness has its roots within the spiritual tradition of Buddhism, since the 1970's its influence has spread into the academic and clinical realms. In order to study mindfulness in a qualitative study, it is first important to study key aspects of mindfulness that comprise this practice. While there remain a wide variety of definitions, definitions of Mindfulness are often personally defined. For the purposes of this study, participants will self-define Mindfulness. For the purposes of this literature review, the operational definition of Mindfulness will be, "paying attention on purpose, in the present moment, nonjudgmentally." The Institute of Mindfulness and Psychotherapy in MA uses this definition as so do many research articles and textbooks (Didonna, 2009, p. xxviii). This

definition can be broken down into four distinct practices. First is the act of paying attention. What follows is paying attention on purpose in the here-and-now, nonjudgmentally, and with acceptance. Most research papers tackle these concepts either separately or as a whole depending on their research goals. For the purpose of this research, the entire and integrated definition of Mindfulness will be accounted for.

For other researches, Mindfulness can be separated into three categories: as a state of being (ie. Being compassionate, accepting, open-hearted), a practice or set of practices (the act of meditating, reciting mantras, walking meditation, etc..), and a trait (ie. presence) (Garland, 2013). Combined, these qualities have been documented to enhance wellbeing and self-compassion (Neff & Germer, 2012). On a neurological level, mindfulness has been shown to increase grey matter and lessen the emotional reactivity centers of the brain (Leung, Chan, Yin, So, & Lee, 2013).

Mindfulness has captured the minds of psychologically minded professionals because of its ability to train the mind (Childs, 2006). In 1975, in Barre, Massachusetts, three western students, after many years of personal practice in India and Southeast Asia, founded the Insight Meditation Society. Since that time, Sharon Salzberg, Jack Kornfield, and Joseph Goldstein, have written many books and run numerous workshops across the country to increase access to this form for many thousands of people. In turn, mindfulness has rightfully claimed its place as a useful and beneficial practice in the West. Mindfulness literature dominates self-help sections of many bookstore shelves and its popularity continues to rise today. This is seen in the surge (“1 in 1984 to over 2,200 by 2013”) of popularity mindfulness research has seen within the past 20 years (Fulton, 2014, p.208) and its adaptations in treatment modalities such as Acceptance and Commitment Therapy, Mindfulness-Based Cognitive Behavioral Therapy, Dialectical Behavioral

Therapy, and Mindfulness-Based Self-Compassion (Gockel, 2010). While the connection between mind and body has been thoroughly proven, its influence has been slow to enter the academic classroom (Olsen, 2002).

There exists a plethora of evidence to support the efficacy of Mindfulness. Countless surveys monitoring participant symptoms before and after learning Mindfulness practices, particularly Jon Kabat-Zinn's 8-week Mindfulness-Based Stress-Reduction course, randomized-control studies, and brain fMRI studies have shown that Mindfulness changes the brain and changes people's ability to withstand difficult emotions. These studies have had a profound impact in the field of social sciences and pop culture at large. While this literature review plans to summarize these studies, it also will point to gaps left by these studies. Gaps such as, how does the therapist's personal practice of Mindfulness influence treatment? How is treatment impacted when both therapist and client are engaged in Mindful awareness? And lastly, what are the interpersonal mechanisms of Mindfulness at work in sessions?

Through phenomenological investigation of these gaps, this study hopes to refine the way Mindfulness is taught in clinical settings—a move that would take clinical uses of Mindfulness beyond the skills-building approach towards an embodied understanding of the here and now.

Mindfulness is unique for a number of reasons including its emphasis on compassion (Salzberg, 2001). Compassion within the Buddhist tradition differs from empathy in that compassion not only seeks to place oneself in the experience of others, like with empathy, but with the added intention of relieving the suffering of others and the self. Also, for the purposes of this study, I plan to use the terms client and patient interchangeably as patient in latin means “one who suffers.”

On a fundamental level what may be difficult in analyzing this data is trying to understand an Eastern philosophy from a Western lens. While contemplative therapeutic practices such as Mindfulness emphasize self-reflection as the essence and perhaps even the pillar upon which contemplative psychologies are founded, qualitative research and analysis will always remain under the purview of a western, analytic, and linear approach. While it may be difficult to try and capture the essence of a dynamic (right-brain) process such as Mindfulness, within the analytic (left-brain) realm of Western, research methods, the emerging field of contemplative neuroscience is paving the way for new cognitive frameworks to be used and explored.

Mindfulness for Patients

“No feeling is final” -Rumi

A main topic of concern on the study of Mindfulness is how to maintain its potency and research validity within social work research. In order to provide for internal legitimacy in the field, Garland (Garland, 2013) divides mindfulness into three discrete categories. He defines mindfulness as a state of being, a trait, and practice. Because of mindfulness’s increasing popularity within social work literature, he advocates for randomized control designs, behavioral measures of mindfulness *through time*, mixed method approaches, and remembering to keep mindfulness within the context Buddhism. He is also a proponent of asking by what *processes* is a type of treatment successful; he calls this investigating “therapeutic mediators” (Garland, 2013, p. 442). The author does not explore therapist’s process of using mindfulness and stresses the importance of remembering culturally where Mindfulness belongs and to try and maintain its integrity through respect of its religious origins. These points of specificity will be essential in the creation of this study’s methodology.

Clients often come to therapy because of feelings of unhappiness, malaise, discomfort, trauma or crisis. In any work with clients, there are moments of tension that therapists must learn to contain, interpret, and intervene. Mindfulness works to regulate the emotional reactivity centers of our brains and bodies. Sometimes, however, therapists cannot always be there with their patients at which time scaffolding self-soothing skills may be necessary. In a pilot study by Neff and Germer (Neff & Germer, 2012), they explored the impacts of an 8-week workshop on “Mindful Self-Compassion” on participant wellbeing. Using a 26-item Self-Compassion scale, they found that participants did indeed benefit from this practice and reported less self-judgment, self-criticism, and less depression/anxiety, and an increase in self-compassion, feelings of connectedness, and life satisfaction after 6 months of the program. What this study demonstrates are the ways in which mindfulness can be used within the client as a form of self-soothing and containment and as a learned skill to be practiced away from the therapy room.

Similarly, another popular intervention is Jon Kabat-Zinn’s Mindfulness-Based Stress-Reduction (MBSR) 8-week course. This course has been taken by thousands of participants and is offered at many integrated health centers. This program offers an introduction to Mindfulness techniques and encourages daily meditation for at least 45 minutes a day and a daylong retreat at the end of the program (Kabat-Zinn, 1982). Testimonials of its benefits range from helping people with anger, chronic pain, depression, anxiety, and on a greater level, providing clarity to one’s inner experience and finding personal meaning of life (Kabat-Zinn, 2003). In addition, in one thorough neuroscientific article, researches carefully documented aspects of the brain associated with “narrative focus” versus “experiential focus” (Farb et al., 2007). Researchers linked a narrative focus with places in the brain associated with more ruminative thoughts and mind-wandering. These types of thought characteristics make up the “default-mode” network as

located within the “cortical-midline” of activity (Farb et al., 2007, p.314). This paper demonstrated how after Mindfulness training, participants were better able to access “experiential focus” when given distracting tasks and through fMRI imaging found activity in parts of the brain associated with task suppression and lateralization away from the default-mode network towards the somatosensory cortex. This ability to “de-couple” thoughts from action is part what makes Mindfulness such an effective tool in cognitive-based treatments and indeed might be considered the main thrust of Mindfulness’ mode of therapeutic action in these modalities.

Fortifying the evidence on Mindfulness efficacy is research done by neuroscientists across North America and Europe. In a recent neuroimaging study done in 2014, neuroscientists found a positive correlation between increased levels of psychological wellbeing (PWB) and increased levels of gray matter concentration in the brain stem (Singleton et al., 2014). By building off of previous studies that have located certain areas of the brain with the synthesis and creation of certain mood regulating neurotransmitters such as serotonin, dopamine, and norepinephrine, these scientists were then able to reasonably conclude that gray matter changes in these regions might contribute to improvements in wellbeing. The study took data from a previously published set of 14 participant’s pre-and post-PWB scores and anatomical MRI imaging for an experiment studying the effects of an 8-week Mindfulness-Based Stress Reduction course. Using a regression analysis between the two scores, the researchers found a correlation between PWB scores and gray matter concentration. While impressive, the researchers acknowledge that this study is speculative at best and wish for the results to be used as fertile grounding for more future research. Also, due to the small sample size, the researchers call attention to the data’s unreliability. Despite this speculative claim, since the 2000’s,

advances in fMRI technology are allowing the neuroscience of Mindfulness to take a firm and steadier stride towards integrating contemplative practices within the Western medical model.

Still, in a lecture given by Sara Lazar (one of the lead researchers in the field of Mindfulness neuroimaging), she stated that the benefits of Mindfulness have become known as a kind of panacea, and at best, that changes in the brain from Mindfulness are to be taken as “modest” (Lazar, 2014). While it is true that Mindfulness’s benefits have been co-opted by celebrities and other media personalities, it is because there is something within the practice that resonates deeply with people. Lazar (Lazar, 2014) and Shapiro (Shapiro, 2009) have gone on to suggest that future research should potentially focus on the impact equanimity within the therapist has on therapeutic outcomes. In other words, studying how emotion regulation within the therapist impacts the therapy, shifting the spotlight away from patient’s skills-attainment of affect regulation. This indeed appears to be yet another fruitful avenue for explorations into the mechanisms of Mindfulness and an avenue this research hopes to explore further.

Acceptance and Commitment Therapy, Dialectical Behavioral Therapy, and Mindfulness-based Cognitive Therapy all work along the lines of acceptance, impermanence, and a heightened awareness of the present moment. Their effectiveness has been well documented in the literature as well (Hayes, 1990; Linehan, 1993; Teasdale, 2002). In other words, the question of *Does* Mindfulness work is no longer relevant—it does. The following research that now must be done is answering the *how* of Mindfulness. Philip Bromberg, in his essay “Standing in the Spaces” refers to psychotherapy like the bumblebee—structurally it should not fly, but it does (Bromberg, 1998). This same metaphor can be applied to Mindfulness. How does a 2, 600 year old practice of sitting and noticing one’s thoughts promote healing? Researchers Shawna Shapiro and Linda Carlson in their book, “The Art and Science of

Mindfulness” identify an important gap within the literature and pose the question, is there a link between the therapist’s ability to maintain emotion regulation with the therapeutic relationship? They propose Mindfulness as a “common factor” of therapeutic success and cite preliminary evidence linking practitioner practice with more successful therapy outcomes. In a study done by Grepmaier and collaborators in Germany (Grepmaier et al., 2007), they compared outcomes of 196 patients treated by therapist trainees who either did or did not have a personal Zen Meditation practice. In this study they found that patient’s of Zen-practitioners scored better on self-understanding of their psychological difficulties and problems and were better able to identify their treatment goals. This study brings us to the next part of this literature review, which is Mindfulness within the Clinician.

Clinician’s Use of Mindfulness

Clinician’s use of mindfulness can be divided into three categories: self-disclosure, management of countertransference, and as a form of self-care (Garland, 2013). Research demonstrates how mindfulness can help clinicians become more aware of client’s avoidance of difficult affects and hence promote attention to these difficult affects within the therapy hour (Dunn, Callahan, & Swift, 2013). Dunn et al. used de-identified clinical vignettes of authors’ patients to demonstrate moments of awareness both within the patient and the therapist themselves. These therapists come from various theoretical stances (transtheoretical) and demonstrate formal and informal uses of mindfulness within the therapeutic encounter, thus re-emphasizing the separate and individual process of being aware of the present moment. Through the use of clinical case vignettes, this article shows how self-awareness then led to a moment of self-disclosure, which led to a successful insightful interpretation.

The surge of popularity in the research of mindfulness has exploded in the past 20 years. Its influence has been documented across disciplines (Gockel, 2010). Gockel (2010) suggests that mindfulness can foster clinical skills implicitly and explicitly (with and without the client knowing). Gockel also suggests that mindfulness helps with the management of countertransference and aides in self-care—two key aspects of effective social workers. Gockel encourages a move away from a *how to* model towards the development of a quality within the therapist. This article is not prescriptive in what steps to take to achieve this and does not explore the underlying influences at work between both patient and therapist. This article would suggest then that the mechanisms of mindfulness lie solely within the therapist, not the client, and requires a separate, regular, and consistent mindfulness practice in order to succeed. In other words, one cannot be practicing the clinical aspects of mindfulness without have a regular and consistent mindfulness practice in order for it to succeed. Logically this makes sense; you can only teach as much as you yourself have studied.

Additionally, studies within the social work literature using qualitative methodologies have shown mindfulness can be employed within social work schools as a way to ease student clinician anxiety and manage countertransference (Gockel, Cain, Malove, & James, 2013). Gockel employed mindfulness training for student clinicians in which to learn mindfulness techniques such as observing one's thoughts, feelings and emotions in the present moment. Gockel posited that development of these traits would increase capacity for clinician empathy and compassion and countertransference management. A random sample of 20 students participated in in-depth interviews to explore their experience of this training group. These interviews took place one time after the training during student's field internships and through phone interviews, as a way to show long-term effects and benefits. A doctoral-student researcher

conducted the interviews so as to minimize personal relationship bias. Questions were open-ended to reduce bias towards mindfulness. Transcripts were analyzed by Atlas-IT and a coding method by Charmaz (2006) was employed. Results showed that students had improved attention skills, less reported anxiety, more openness, and found mindfulness a useful vocabulary to use with clients. This study did not reveal itself to be a study about mindfulness at the outset, allowing for the spontaneity of student mindfulness learning to arise.

A danger in viewing meditation as a *kind of* psychotherapy is the way in which meditation is analyzed and subjugated *through* the lens of psychotherapy. Epstein illuminates an important drive within mindfulness as a “yearning to merge with an internalized image of a lost state of perfection” or an “idealized oceanic feeling” (Epstein, 1990, p. 161). Here, Epstein is alluding to the mindfulness practitioner’s propensity to idealize mindfulness as a kind of Eden. He also provides an in-depth exploration of how the formation of the split ego strengthens the ego’s synthetic functioning and ability to observe itself—that is, the ability of the self to know that it knows and to experience disparate narratives and sensations all at the same time. Another danger of mindfulness that Epstein points out is its concentration on a sole object (one’s self) and its inherent narcissistic pre-occupation that is potentially solipsistic. Epstein argues that mindfulness can be complimentary to therapy in how it “[informs] the ongoing experience of the self” (Epstein, 1990, p. 163). This idea of the self as a continuum is a potential avenue for understanding the unfolding process of therapist insight.

Continuing with the intersection between psychoanalysis and mindfulness is research by Clinical Psychology Instructor at Harvard Medical School, Christopher Germer. In Germer (Germer & Neff, 2013), he describes the processes in which self-compassion is developed within clients and therapists, which emphasizes, “how we *relate* to stress” instead of the narrative

around it. Germer argues that this process is a kind of “portable therapy” to have in between sessions and that the development of self-compassion is a kind of introjection of the therapist within the client during times of high stress and anxiety. This particular form of research views mindfulness as a process that develops *outside* the therapy hour within the patient. For example, the article recounts the treatment of one individual— Brian, a white, heterosexual male, and his journey through therapy and through taking the mindful self-compassion (MSC) course. The MSC program is an 8-week group training that encourages participants to integrate mindfulness into their daily lives. This process encourages participant ownership and creativity of the learned material. This model is useful in how to show mindfulness’s explicit use by clients in between sessions.

As with CBT practices, psychoanalysis has been deeply interested in the overlap of therapeutic concepts and Mindfulness. Where the two diverge significantly is, as opposed to using Mindfulness as a singular entity and concept to be “learned,” psychoanalysis sees Mindfulness within its holistic sphere—as a philosophical and religious stance that exerts meaning and reveals psychoanalysis’s more universal themes. For example, Mark Epstein (Epstein, 1990) explores how the intersection of meditation and psychoanalysis began with Freud and his correspondence with Romain Rolland, a French philosopher. This article illuminates the ways in which meditation aligns with the way Freud viewed psychoanalysis, as “preverbal,” “symbiotic,” and as a state of “regression” (Epstein, 1990, p.159). Similarly, Mindfulness can be described as having these same traits. Others, such as Alexander, called it a “psychotechnique” to be used therapeutically. The language of Mindfulness complements western psychology in many ways and that interest has been there since the time of Freud.

Mindfulness and Buddhism

Mindfulness is a practice embedded within the practice of Buddhism whose main tenet is the belief that attachment and desire are the roots of suffering (Goldstein, 1993). The Four Noble Truths are the main pillars upon which Buddhism stands, while Mindfulness is considered the path to freedom from *dukkha* and the cessation of thoughts (Epstein, 1995)

The story of the Buddha is important of us to understand in order to ground Mindfulness within its historical context. Joseph Goldstein, one of the founding members of the Insight Meditation Center and major figure in bringing Mindfulness to the United States, in his essay “The Buddha’s Sacred Journey” recounts Siddhartha Gotama’s path to enlightenment. It is said that around 2,500 years ago around the 5th and 6th centuries, in what is today known as the border between Nepal and India, Siddhartha Gotama, Prince of the Shakya at age 29, felt the “call” to awakening. (Prince Gotama is referred to as Bodhisattva or one who is destined for enlightenment before become the Buddha.) His journey is recounted into four parts: 1. The Call to Awakening 2. The Great Renunciation 3. The Great Struggle and lastly, 4. The Great Awakening. In part one of the Bodhisattva’s journey, he meets the “4 heavenly messengers” in the form of an old person, a person stricken with disease, a corpse, and a wandering monk. This provided the Bodhisattva a chance to reflect on the inevitability of death, how we should live, and how at the time of death it is only the Dharma practice of compassion, love, equanimity and wisdom that remain our only true refuge.

In part two of the journey, the Bodhisattva puts himself through a set of austerity practices to separate himself from the desires of his body/mind and to “subdue the ego” (Goldstein, 2001, p. 13). It is said he renounced all possessions, even food, only eating a grain of rice a day in order to understand and fight the powers of human “desire”. After 6 years of this

practice of mortification of the body, Siddhartha decided to give up this extreme process to nourish himself for the third part of his journey.

In the Great Struggle, the Bodhisattva decided to sit at the foot of the Bodhi Tree until he attained “supreme” Enlightenment. During this period of sitting, he battled the forces of Mara, which are personified versions of anger, doubt, desire, and “illusion and ignorance” (Goldstein, 2001, p. 14). It is under the Bodhi Tree where Siddhartha was able to overcome the forces of Mara to become the Buddha. It was during the practice of meditation that he understood how attachment is the root of suffering and how through cultivation of a “courageous heart” can lead us towards that which assails the mind.

The Buddha’s story is not only historical but serves as a heroic archetype that becomes easily transposed onto today’s struggles and tribulations. What are the forces of desire guiding our actions? How are the forces of fear, doubt, and restlessness blocking us from attaining what it is we truly seek? The journey of the Buddha teaches us a model of being to be admired and reflected upon, not copied or replicated. It is a journey that praises our inner witness and our inner voices of insight that we each hold and can cultivate for the sake of relieving suffering and finding authentic satisfaction in life.

Other fundamental tenets of Buddhism to be aware of in order to understand Mindfulness more clearly are the teachings of the Four Noble Truths. These are:

1. Life is Suffering of *Dukkha*. We are born into a life of suffering—it exists a priori to everything.
2. Suffering is caused by desire and desire for certain outcomes, which can take many forms.
3. Suffering can be overcome and

4. Suffering can be overcome by following the 8-fold path.

The Eight-fold path teaches the following:

1. Right View
2. Right Intention
3. Right Speech
4. Right Action
5. Right Livelihood
6. Right Effort
7. Right Mindfulness
8. Right Concentration

Paths 1 and 2 fall under the division of *Wisdom*. Paths 3,4, and 5 comprise the division of *Compassion*, and paths 6, 7, and 8 comprise the division of *Concentration*. This is not a linear path to be followed, but rather are distinctions of the middle-way to help guide one's way of being in the world.

As you can see, Mindfulness is contained deep within the matrix of fundamental Buddhist tenets and teachings and is inextricably linked to the idea that life is suffering; however, this is not to say that Mindfulness is a religious practice. Mindfulness, in the West, is seen as a tool for focusing the mind and staying within the present moment, and does not follow any doctrinal laws or texts. This is a fuzzy distinction, but a common metaphor that is used is to say that while Newton discovered gravity, we don't call gravity "Newtonism." While Buddhism might have 'discovered' this tool for the mind, does not make it permanently associated with the religious practice of Buddhism. It is, however, important to understand the context through which it was born and tested.

Relational Mindfulness

There is Mindfulness within the therapist, Mindfulness within the client taught as relaxation and deep breathing, and a third, newer avenue— Mindfulness as in inter-personal and relation aspects. Surrey (2005) defines relational mindfulness as “as a process whereby both the therapist and patient are working with the intention to deepen awareness of the present relational experience, with acceptance” (Surrey, 2005, p. 92). Within this model, both therapist and client are attendant to the “shifting qualities of connection and disconnection” (Surrey, 2005, p. 94). It is within this model that this thesis seeks to gain deeper insight.

Relational Mindfulness is a relatively new endeavor in the field, but the concept of relational therapy is not. While many psychoanalysts argue that the term “relational therapist” does not exist as a title, they see it rather as a catch all term for those who prescribe and share the same outlook of a two-person psychology. In other words, relational therapists are those who acknowledge their own and their patient’s subjectivity and the “reciprocal and mutual influence” patient’s have on their therapists and vice versa (Aron, 2001, p.18). This terminology is important because it provides the scaffolding upon which to explore relational Mindfulness.

Martha Stark in her book “Modes of Therapeutic Action” provides a distinction between 3 different modes of therapeutic action within the psychoanalytic and psycho-dynamic framework (Stark, 1999). In model one, she calls this a one-person psychology. The therapist is seen as being a neutral and un-intrusive entity in the room to allow for the patient’s unconscious thoughts to rise to the surface through the process of free association. These associations are then interpreted through the lens of oedipal themes and drives of sex and aggression. Healing in this

model is through the discharge and understanding of previously disavowed and unconscious material of the mind. Model two is Self-psychology, whose main tenet rests on the idea of a “corrective experience” as given by the therapist to the patient. Stark calls this a one and a half-person psychology because the emphasis still remains more on providing the patient with a previously unmet needs and focuses more on the patient’s perceptions of the therapist and internalized selfobjects instead of the realness of others and their contributions to the present interactional dynamic. Stark highlights the most essential aspect of model three as the therapist’s *authenticity*. The relational model of psychoanalysis accepts the notion that each person within the therapeutic dyad has a mutual impact on the other. This is not to say the relationship is symmetrical or equal because there is an inherent power different; however, it acknowledges the shifting subjectivities between patient and therapist. Healing in this model arises from understanding what the patient elicits or “enacts” within the therapist in the here-and-now which provides the patient with an understanding of how the patient “delivers” herself in relationships.

How do these concepts of relationality and mutuality connect to our understanding of clinical Mindfulness? They connect because this study seeks to understand the unfolding nature of Mindfulness at work within the clinical dyad, and relational psychoanalysis has, since the 1980’s, developed a sophisticated vocabulary around relational dynamics, and it makes sense to use this literature as a framework for interpreting forthcoming data.

From a relational standpoint, the therapist’s personality impacts “not only the therapeutic alliance or the so-called real relationship, but also the nature of the transference itself” and that it is natural for the therapist’s theory to guide the therapist in “shaping and organizing the patient’s free associative material” (Aron, 2011, p. 37). Theory guides practice as much as practice shapes theory. How does the theory of Mindful attention to the present moment with acceptance

influence a therapist's style and understanding of their patients? Does heightened attunement to one's countertransference reactions provide the therapist a deeper understanding to *how* the patient "brings" herself to the therapy? Does Mindfulness provide a sense of internal containment or self-"holding" for the therapist? Does Mindfulness enhance the ability of the therapist to embody both "observer" (paying attention) and "participant" (with intention and compassion)? Or, is it something that Lazar (2014) and Shapiro (2009) suggest, that it is the therapist's *equanimity* that gives the therapy an extra liminal edge for healing?

The language of Mindfulness lends itself easily to that of Psychoanalysis and vice versa because each arena's interest lies in the quality of attention the therapist brings to the *process* of therapy. Whereas manualized treatments emphasize decreasing symptoms (or the content) of a patient's psychopathology, Mindfulness and Psychoanalysis both take an open stance towards all "arising" material with acceptance, empathy, and compassion. Relational psychotherapy and Mindfulness also seek to help people create different relationships to their suffering as opposed to manipulating their experience. Mindfulness, in other words, invites a hand *off* approach because of its distinction that desire and attachment to different outcomes creates more suffering.

In Mark Epstein's (1995), "thoughts without a think", he examines the complementary nature between meditation and psychoanalysis. For example, he explains the shift in one's psyche when using Buddhist tenets as opposed to western psychology by describing a move "from an appetite-based, spatially conceived self preoccupied with a sense of what is *lacking*, to a breath-based temporally conceived self capable of spontaneity and aliveness [emphasis added]" (Epstein, 1995, p. 147). To understand the difference between eastern and western ideology one need to look no further than to the difference between Greek architecture, such as the Pantheon, and the Buddhist knot imprinted over and over in temple facades. Western ideology praises and

finds comfort in that which is fixed, stable, and symmetrical, whereas Eastern ideology finds peace within infinity and the ongoing nature of living, being, and dying. It makes sense then that a shift to Mindfulness, with its special attention to inner equanimity and a self that is already *full*, would be a welcome breath of fresh air to the psychological profession.

Conclusion

This literature review shows that there is much to be examined and explicated within the mechanisms of mindfulness in a triadic sense: how the therapist's personal practice effects the therapy, how the client's use of mindfulness impacts their treatment, and the interpersonal space that is created as a result of mindfulness at work implicitly and explicitly. I've identified gaps within the literature, mainly relational Mindfulness, because of the glut of research focused on Mindfulness as a skill-based approach to therapy.

Many themes on the benefits of mindfulness remain clear. It aids self-reflexive thinking and feeling, it increases tolerance of difficult affective states, it provides a methodology on how to stay with thoughts and emotions, and how to create a different relationship to our thoughts. It increases our sense of connectedness to ourselves and others and increases the ability to listen and attend non-judgmentally and without attachment to the world around us.

This literature review has explored uses of Mindfulness within the client, which is shown most appropriately through manualized treatment protocols and Mindfulness within the clinician, as a personal practice to aid with self-care, emotional attunement, and difficult countertransference material. This literature review also explores the history of Mindfulness within its context of Buddhism and the origins of suffering, attachment, and compassion. It also explained how the story of the Buddha can be seen as an archetypal journey of the soul whose language and metaphor can be used to help people living in contemporary society.

This literature review concludes with how contemporary psychoanalytic trends of relationality and mutuality aid in our understanding of relational Mindfulness and how these theories can serve as a useful framework for understanding the unfolding and dynamic use of Mindfulness within clinical practice today.

CHAPTER III

Methodology

While vast quantitative research has been conducted on Mindfulness, this inductive, phenomenological qualitative study explores therapist's shared experiences of using Mindfulness in their clinical practice. Considering the dearth of research on the experiences of clinicians using this newly popularized form of therapy, there is much to be explored on how Mindfulness looks in practice versus how it is taught or explained in therapy manuals. This study sought to fill the research gap on Mindfulness as an experiential and dynamic process and its use towards the formulation of insight.

Through 12 semi-structured interviews, this study explored the here-and-now experience of Mindfulness in clinical practice. This process was done in hopes of understanding Mindfulness beyond the realm of affect regulation. While the ability to monitor one's thoughts is an advanced skill in and of itself, this study asked how Mindfulness shapes the relational dynamic between client and therapist. The desired outcome for this research question was to further explore and explicate the usefulness of Mindfulness in clinical practice.

Question domains for this study were Mindfulness in the client, Mindfulness in the therapist, Mindfulness as a relational process, and Mindfulness and Spirituality. Mindfulness in the client includes client's use of mindfulness for relaxation or concentration, while mindfulness in the therapist refers to therapist's moments of self-awareness and their personal self-practice and study. Mindfulness as a relational process is a triadic process in which the therapist is

involved in being aware of their arising sensations, what's happening between themselves and the client, and observing the client's experience with the purpose of gaining clinical insight. Mindfulness and spirituality refers to mindfulness as a sense of inter-connectedness to others. Participants provided their own definitions on Mindfulness and what it means to them.

Sample

The sample size for this study was 12 participants as recommended by the Smith College School for Social Work Thesis Guidelines (Smith Thesis Guidelines, 2014). I conducted 12 open-ended interviews with self-identified Mindfulness practitioners and therapists. Through semi-structured interviews that kept the interview flexible, this allowed for new topics to be explored as they arose and spontaneity of responses. Therapists were also asked to describe their Mindfulness experience and if or how they used Mindfulness with their clients.

Participants were gathered through purposive sampling and were chosen based on their expertise and personal interest in Mindfulness. Based on a list of people that I met once at a Mindfulness and Psychotherapy conference, I asked each to participate. Afterwards, I asked each person to recommend one other person to participate in this study. Other participants were chosen based on my connection to them through my second-year field placement. Participant inclusion criteria were based on their self-definition as therapists and Mindfulness practitioners. Participant exclusion criteria consisted of retired or provisionally licensed mental health care workers and those who did not consider themselves therapists or Mindfulness practitioners.

This research method's feasibility was increased due to the large number of Mindfulness practitioners in the Boston area and Mindfulness's growing presence in clinical practice in general. Also, due to a dearth of research on Mindfulness's more dynamic and iterative qualities, participants were interested in sharing their personal experiences in support of forwarding the

evolution of clinical Mindfulness practice. This study's practicality was enhanced because of its simple interview structure that did not require talking about distressing or traumatizing experiences.

Ethics and Safeguards

Participant responses were recorded on a digital recording device. First, I began by asking participants if I could start recording, and with their knowledge and consent, began recording on a digital voice recorder.

After the interview, I took the interview off of the recording device and stored it onto my password-protected computer. I then deleted the recording as soon as the information was moved onto my computer.

All research materials including recordings, transcriptions, analyses and consent documents will be stored on my password-protected computer for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.

In order to protect participant confidentiality, I created a numbered list of participant names without their identifying information. From there, I assigned each participant a randomly selected corresponding number to use while analyzing data. While writing and describing this data, I took out all identifying information. This code sheet was stored on my password-protected computer and kept in a different folder and document away from my data analysis documents. Consent letters were kept separate from notes and transcripts, and each participant was assigned a code number, which was placed on all materials. All participants were referred to by their randomly assigned number.

The benefits of participation were having the opportunity to speak about their experience with the possibility of gaining insight into their clinical use of Mindfulness.

The benefits to social work/society are: to provide information for future research and to identify strengths and potential areas of growth for clinicians and student clinicians. Participants were also given the option to obtain a list of referrals if emotional issues related to their participation in this study arose.

Data Collection

See “Interview Questions” in Appendix A for interview questions. Participants were asked questions that addressed these topics: Mindfulness in the clinician, Mindfulness in the therapist, Mindfulness as a relational process, Mindfulness as a spiritual practice, and demographics.

Once participants were recruited, they were asked to sign a consent form detailing the risks and benefits of participation, the nature of this study, and confidentiality. Once consent forms were signed, the interview process began. To ensure the trustworthiness of this study and after HSR approval, I asked experienced Mindfulness practitioners and mental health professionals to answer these questions as a pre-test. I also pre-tested their face and content validity with other social work students.

This study took place in carefully selected mutually agreed upon locations during the 2014-15 academic year. Interview locations included my internship location, Jamaica Plain, MA and over the phone. Interviews averaged around 45 minutes in length. Interviews were recorded on a recording device. I transcribed interviews and began to look at recurring patterns of experiences before arriving at codes that represented superordinate themes. This coding process was meant to take an inductive stance on making meaning out of these shared experiences of

using mindfulness in clinical practice and looked for insight into the particular perspective of each participant. Analysis of superordinate themes and coding statements were then interpreted to look for all possible meanings into what participants might have meant when discussing certain topics. Consultation with peers also occurred for consensus on these coded themes.

Data Analysis

After all interviews were transcribed, I began to look for any and all potential themes and emergent data. After a list of potential themes was created and through the process of memoing, I then went back to the data and pared down my list of codes to be included in my codebook. Once my codebook was completed with several examples listed under each code and sub-code, I began the process of interpreting and synthesizing the data through a process of content analysis, narrative analysis, and grounded theory.

Meanings constructed by participant narratives were also taken in context of the participant's worlds and the social context of the self as therapist. This idiographic mode of inquiry looked at the individual's unique experience to try and draw out potential shared experiences, which can then be studied further.

In order to enhance code trustworthiness and to guard against my blind-spots, I asked two fellow Smith College School for Social Work graduate A'15 students to review themes through a process called peer debriefing. Data given to peers was de-identified to protect participant privacy. I also looked at data that disconfirms Mindfulness's usefulness through negative case analysis to add another layer of dimensionality to my research.

In other words, I examined data participants may not have intended to explain in the way they had explained it, and self-reflexively, I looked at unintended and unexpected responses to the question domains I had created. Also, through Narrative analysis, which "seeks to put

together the big picture about experiences or events as the participants understand them,” narratives were summarized and conceptualized into categories of dynamic process (Engel & Schutt, 2013, p. 312). Narrative analysis was used to arrive at a theoretical process of insight formulation while Grounded theory was used to “suggest plausible relationships among these concepts” (Engel & Schutt, 2013, p. 312). I then used grounded theory to relate these concepts back to Buddhist tenets.

Coding Process and Results

“The coding strategy revolves around reading the stories and classifying them into general patterns” (Engel & Schutt, 2013, p. 314). My coding process began by looking for emergent themes. Many potential findings were collected but it was through the process of memoing and writing through potential schematic approaches to organizing the data that a pattern of insight formulation arose. In examining the question, “How does Mindfulness show up in your clinical process?” alongside the question of rooting it in a case example, a similar pattern across therapists emerged.

Expected results of this study are that therapists use both Mindfulness explicitly in the form of breathing or relaxation techniques and Mindfulness implicitly in helping to contain and attune one’s self to the transference-countertransference dynamics in the session. In addition to trying to find a possible a new consensus around Mindfulness’s dynamic and relational use in clinical practice, this study found unexpected results. Such unexpected results include the use of Mindfulness as an external object upon which to observe transference reactions and the breakdown of Mindfulness to be used for specific psychopathology ie) Mindful Self-Compassion for Depression and Relaxation and Breath work for Anxiety.

Limitations of this study are that data cannot be generalizable nor be considered causative. In other words, if trends in data were found, they cannot be linked to one aspect of Mindfulness to uncover cause and effect. In addition, with the purposive sample, this study only represented a very small and specific type of clinician. This kind of sample limited the kinds of narratives that were documented and has most likely shed Mindfulness in a more positive light than otherwise. This study also leaves out client's experiences of using Mindfulness in therapy, which narrows the scope further.

Implications for this study are manifold. Mindfulness's popularity is expanding exponentially. With that in mind, the way it is taught and understood must be refined with the same kind of attention other treatment modalities such as psychodynamic psychotherapy and CBT are taught. While data may not be generalizable, it can be transferable and taught with a clinical lens. We know how Mindfulness can reduce anxiety, depression, manage pain, and enhance sense of wellbeing. We also know that Mindfulness can change the brain through a process called neuroplasticity. Now, how is it understood as a relational process? How do clinicians use it to become better therapists, join with clients, understand the nature of client suffering better, and overall, help the therapy's dynamic flow? With this study, I hope to answer some of these questions to bring further rigor to clinical Mindfulness and to help future clinicians, such as myself, embark upon becoming better skilled and prepared therapists.

Qualitative research has set itself up with the great task of capturing and measuring ephemera like fleeting states of being. Mindfulness lends itself harmoniously with this process as Mindfulness focuses on enhancing self-awareness and on noticing and stilling the fluctuations of the mind. Both practices place self-reflexivity and the unfolding experience as the agenda, as opposed to a means to an end. The importance of researching experiences and people's stories is

a practice as old as the beginning of language. Stories captivate our imaginations, help us to understand our lives more clearly, and enhance our connection to others. While there have been thousands of published articles on Mindfulness, which begs the question, why another? We research because we are curious, we seek to understand the other, whether that be other people, our minds, or the world around us; we search because in that effort we find meaning and perhaps with spontaneous delight, find ourselves.

Chapter IV

Findings

Demographics

There were 12 participants in this study (n=12). This included four Psychiatrists, three Psychologists, three LICSW's, and two LMHC's. Participants were recruited for one 45-60 minute interview in regards to their use of mindfulness with patients. There were 6 women and 6 men, all were in private practice (with the exception of one participant), had a self-defined Mindfulness meditation practice, and practiced from a self-defined psychodynamic orientation.

Table 1. Participant Demographics.

Average years of clinical experience: (For MD's, years counted when they graduated from medical school)	16.3 years
Average years of Mindfulness Meditation practice:	17.75 years
Average daily Meditation practice: (4 did not report specific times)	33.75 minutes/day
Number of Participants with a retreat practice:	7 participants
Registered Yoga Teachers:	4 participants
Clinician's who use Jon Kabat-Zinn's definition of Mindfulness: <i>"Paying attention, on purpose, in the present moment without judgment"</i>	11 participants

Primary Findings

This study reveals that the practice of Mindfulness first and foremost attunes the therapist's attention to the body. Awareness of bodily sensations arising within the therapist then begins to inform the therapist's understanding of relational dynamics unfolding in the room. This awareness of the body then goes on to guide the therapist's line of inquiry in a curious and

nonreactive manner that I argue allows for the conditions of insight and self-awareness to arise within the patient.

All participants reported that they *do not* teach explicit Mindfulness skills to all of their patients, but rather use their personal mindfulness meditation practice to inform the therapeutic frame. The data suggests that major Buddhist tenets influence therapist's philosophy on suffering and informs their use of language and sense of compassion.

The following is a flowchart organizing the coded data to demonstrate the process by in which Mindfulness informs the clinician's formulation of insight.

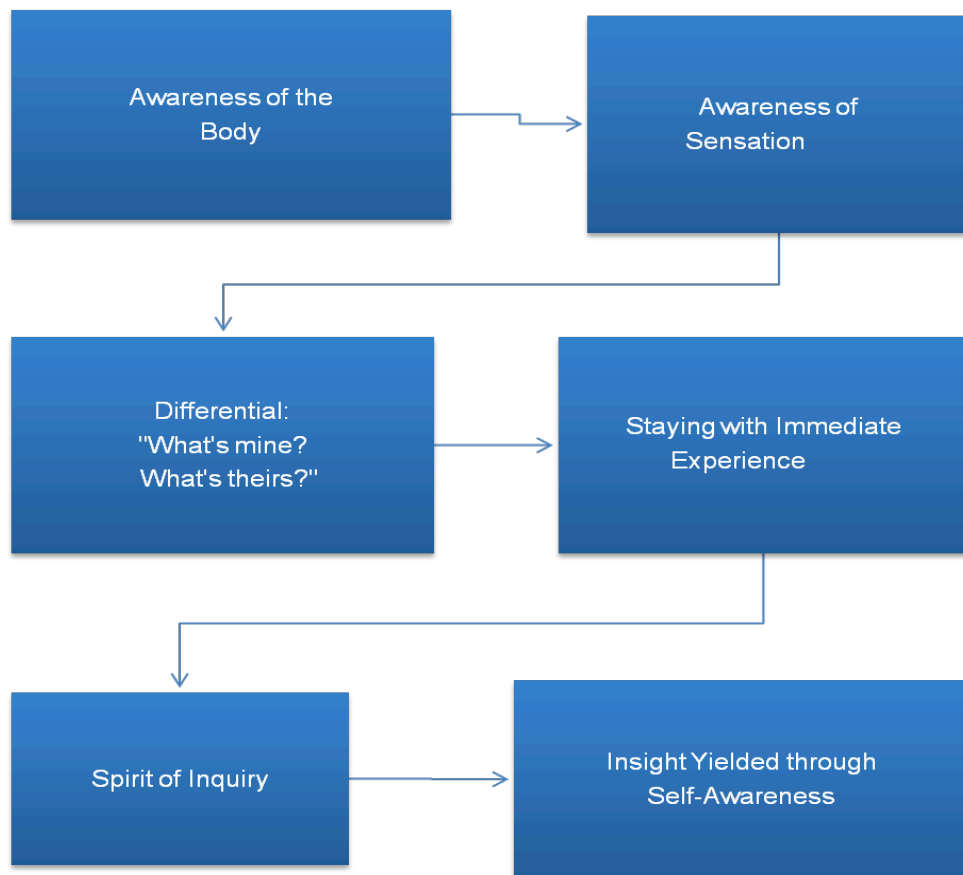


Figure 1. Therapist's Formulation of Insight.

Awareness of the Body: Checking In

Freud in his seminal paper “The Ego and The Id” wisely pronounces, “The ego is first and foremost a bodily ego” (Freud, 1923). A primary theme in the interviews was the therapist’s attention and awareness to their own physical body. This is the first step of the mindful therapist—becoming aware of his or her own body in the present moment.

To the majority of participants, belief in the body-mind connection exists a priori to all other theories. This can be seen in the daily mindfulness meditation practice of these therapists, which averaged 34 minutes/day and included some kind of “checking in” with the breath, the body, and the mind to “turn on all the systems ” as participant 10 noted. Meditation practices varied to include “sitting meditation, moving meditation, and breath work...in addition to just paying attention to smaller day to day things (8)” or, “If I’m feeling really scattered, I’ll listen to a dharma talk (5).” The link between Mindfulness and the body can also be seen in the one-third percentage of therapists who are also registered yoga teachers.

Many therapists connected and saw their personal meditation practice as a training ground for staying present. For example, as participant 1 noted, “I think the practice of focusing on the moment to moment experience of the body and the breath...allows you to be more grounded in a moment to moment way when you’re sitting with patients.” Here, participant 1 is speaking to the parallel process of noticing the body and the breath as a means towards becoming more present with patients. Many Mindfulness practices first begin by taking notice of the body. So, it would then make sense that this would be transposed into becoming aware of the body in the therapy setting.

Awareness of Sensations

In this first step towards insight, evidence shows the therapist checking in with their bodies as their opening stance. After becoming aware of the body, participants were shown to bring this awareness down to a deeper level—to an awareness of sensations in the body. These sensations include the quality of the breath, sights, sounds, touch, taste, smell, and in particular, an awareness of sensations corresponding to the central nervous system. This step entails being able to name the somatosensory experience arising within them in the present moment. This is in contrast to most therapies that leave the body out entirely. Simply acknowledging that one inhabits a body is the crux of step one while step two is taking one's somatosensory awareness down to the visceral body.

Participant 4 illuminates this process, “My breathing is getting very fast and I feel tense in my diaphragm. That’s my barometer.” This participant is acknowledging a change in their physical experience—her breath is getting faster, and they root that experience as a sensation—tense. Their use of the word “barometer” is interesting, too, as it demonstrates the therapist’s awareness that something has changed. The therapist is tracking and scanning through the body noticing shifts from where they were to where they are now. Before, their breathing was steadier, now, it is getting faster and they are feeling tense in their diaphragm. This serves as evidence of the therapist noting physical sensations.

Similarly, Participant 6 notes how instead of focusing solely on the experience of the patient, they are “much more tuned into my own experience.” This participant is alluding to a process where instead of being outwardly and “other”-focused, the therapist is more inwardly attuned to fluctuations in their bodily experience of sitting with a patient.

In regards to an awareness of their central nervous system, many participants commented on the process of knowing when they were activated in the sympathetic nervous system of fight-flight-freeze versus being in their parasympathetic nervous system of rest and digest. For example, Participant 7 reflected, “What thoughts are turning on my fight-flight response?” Using language and sensation of the nervous system were also cues to alert the clinician to shifts in sensation. Symptoms of sympathetic nervous system activation include increased heart rate, sweating, anxiety, quickening thoughts, and a tensing of the smooth muscles of the body. Symptoms of the parasympathetic nervous system include the ability for the person to digest and so one might feel it is easier to digest and eliminate foods and feel an enhanced ability to relax and listen. Participant 1 notes how listening to “stomach gurgles” were indications of the other person being “more in his parasympathetic, cholinergic-adrenergic system, instead of a more adrenaline-based system.”

Differential: “What’s mine? What’s yours?”

This next step towards the formulation of insight involves the therapist being able to differentiate between “What is mine? And what is yours? What is the therapist’s reaction or sensitivity to the material versus what is the patient’s?” As participant 9 aptly summarizes, Mindfulness “helps therapists get realer and less judgmental and less afraid of their own issues so that when they get stirred by an issue they can really own what’s theirs.” What they are speaking to is an open and nonjudgmental attitude the therapist must take towards their own reactions so as not to let their “issues” or countertransference experiences cloud the treatment.

Diagnostically speaking, passing through this crossroads is key in moving forward in a therapeutic manner. As participant 3 remarks, “[Mindfulness] helps with boundary setting—that sense of knowing what’s your work and what’s the person’s work.” This participant also goes on

to advise, “You need to know what the patterns that cause you suffering are very honestly and clearly in order to free yourself.” This boundary setting is developed through a mindfulness practice, and therapeutically speaking, allows the therapist a chance to contemplate how to use their reactions. This process could go several ways. One, the therapist realizes this a personal sensitivity and so drops their reaction and continues to listen to the patient. Two, the therapist realizes this is a foreign experience outside their normal range of reactions and begins to bring more attention to this sensation and to what the patient is saying that is stirring this reaction. This ability for the therapist to “own” what is their stuff versus what is the patient’s is a process these participants note as a result of their personal mindfulness practice.

Staying with Immediate Experience: Restraining the Urge to Fix

This next stage involves the therapist’s ability to stay with the immediate experience of the patient with non-reactivity and restraining the urge fix or change. Participant 9 described how their extensive retreat practice had “primed” their ability to be able to hold “whole physiological states” such as agitation, anger, sadness, terror, and dread. Participant 10 goes on to describe this step, “Can you sit with this bad feeling...not necessarily formulate it, but be with it, and find a way to tolerate and accept whatever it is you’re feeling and get closer to the experience?” This participant is speaking to a sense of restraint. They are speaking to not rushing in to “formulate” or intellectualize what is happening, but rather *being* with it. This step involves the therapist reining in their urge to fix or change what it is their client is experiencing. Mindfulness not only helps the therapist accomplish this through acceptance, but expands their tolerance of “bad feelings.”

Another reason for arresting the therapist’s urge to fix is elucidated by participant 1, “that sense of fixing someone takes something away from them.” From a psychodynamic perspective,

“fixing” something for the patient takes away the ability for the patient to do something themselves. From a Mindfulness perspective, retraining the urge to fix brings the patient closer towards acknowledging their present moment experience with acceptance.

As participant 6 says, “My goal isn’t to try and change it. My goal is to maybe try and talk about how they might take a different view or experience of that instead of making it go away.” Or more simply, as participant 5 stated, “I can get caught in wanting them to shift their thoughts and make it go away...and that’s unhelpful.”

These two participants are suggesting the importance of staying with the immediate experience of the client. This is because, as a Mindfulness perspective would posit, it is our disavowal of what is happening and our wish for things to be different from how they truly are that creates suffering. Staying with the immediate experience is also important because it sets the stage for inquiry and curiosity, which brings us to the next step towards the formulation of insight

Spirit of Inquiry: Remaining Curious

A hallmark of the next step that participant’s commented upon was the stance and process of curiosity. After staying with the uncomfortable sensation that was disrupting the therapist’s sense of equanimity, Mindfulness helped the therapist remain open and curious to this discomfort. Participant 9 outlines this exact process:

What is it about sitting with this patient that is difficult? And my hunch would always be something the patient is enacting or not feeling themselves. If they are behaving in a way to elicit the feeling in you, that there is something about developing our equanimity in being with that feeling, and rather than being urgent to act on it, and in fact precisely not being urgent at, what kind of state is operating in you? Mindfulness is the therapist using

their understanding of being mindful to rather than change how they feel about the experience to instead, get curious about what the feeling experience is.

There is much to be de-coded in this statement. What they are speaking to, however, is the overall insight formulation process. They are first noticing that something is amiss or “difficult” (noticing the body). Next, they comment on how what is unspoken is being elicited by a “feeling in you, “ which is the next step in Figure 1, awareness of sensation. The differential step is demonstrated through acknowledging how a patient’s enactment is stirring within the therapist a foreign experience. They go on to explain the next steps of staying with the immediate experience and staying curious quite clearly. To them, staying with the experience is “not being urgent to act” or “change how they feel” and to “instead, get curious about...the feeling experience.”

This spirit of inquiry is part of the Mindfulness practice of “choiceless awareness” and of being nonjudgmental to whatever is arising in the present moment. By not judging and suspending our need to put a value judgment or fix the experience, the therapist remains open to a large realm of potential meanings, feelings, and experiences.

Another participant commented similarly, they stated, “I rarely feel like, ugh, I don’t want to talk with you. So, what happens if I’m curious to that?” This participant made a differential diagnosis to notice that they “rarely” don’t feel like speaking with a certain client, then stayed with it, and remained curious. This is yet another example of Mindfulness guiding the therapeutic process by illuminating the therapist’s own process first to then connect the physical experiences of the unnamed and unspoken back to the patient. This occurs only through a noninterventionist stance and an open and curious line of questioning. This line of questioning,

as demonstrated through case examples, in most cases, helped guide the patient towards a new understanding of themselves through a process of self-awareness and self-reflectivity.

Insight Yielded through Self-Awareness

Lastly, once the previous steps have occurred, narratives from participants suggested a yielding of insight within their patients through self-awareness. The majority of participant's narratives of case examples support this process. The following is a case example linking all of these steps together:

What comes to mind is a situation where the client is really angry or upset and kind of ranting about something that may or may not have to do with me...A client last week was ranting about Harper Lee and her novel that's being published and he's convinced she's being exploited...and just all these things he feels are unjust an unfair in the world, and as I listened *I find myself getting stirred up myself* and kind of angry. I just feel what he's feeling and what Mindfulness can help me do in that situation is first of all be present, *to feel it in my body*, to feel my feet on the floor, my breath, *to pause and not just blurt out something*. Also, *to find a way to name it* and *to bring it back to him*, and *ask questions*. 'You sound really angry about this and I'm wondering what this has to do with you and your life?

Participant 2 is describing firstly, awareness of the body, "feel it in my body." They then proceed to name the sensation in the body, "I find myself getting stirred." In other words, stirred by the anger. The differential is, it "may or may not have to do with me," but he proceeds by pausing—to "not just blurt out something," thus staying with the immediate experience. Through the spirit inquiry, the participant is able to try and "bring it back" to the client and "ask

questions.” Participant 2 then describes, through his curiosity, how they were able to provide space for the client to arrive at some insight into the situation:

This [gave] him an opportunity to talk about that he feels like he’s been exploited a lot and he’s a frustrated artist who hasn’t been able to get his work out there...his book never got published...and he’s still grieving over this.

Through an awareness of some discomfort within the therapist and by means of the therapist tolerating, staying with, and remaining curious to this sensation of being “stirred,” this process invited the client an opportunity for self-reflection. In this case, this gave the client an opportunity to discover for himself the nature of his displacement and to connect his angry feelings back into his own process of grief over missed opportunities and felt sense of being exploited.

Participant 9 also describes a case where this process unfolds:

I think for instance a young man, gay, who depends in a very emotional way on anonymous sex. So for me, there’s been a dilemma...to me feels like a betrayal of the relationship to do that, but he doesn’t feel that way. He feels that there are certain emotional needs that are fulfilled by his anonymous sex that are not fulfilled in his committed relationship. In sitting with him, I thought and I started to pay attention to what his conflicts about this are.

The participant is picking up on her own conflicts on her patient’s infidelity and is able to identify her feelings of “betrayal.” While this example is not as explicit in terms of identifying the body and bodily sensations as other case examples, through the differential process the therapist is able to identify and own what is her “dilemma.” The therapist, staying with “what the

patient says their distress is and what they're bothered by (9)" is demonstrating sticking with the immediate experience of the patient's need "to excite the other person." The case continues:

We've worked on something in which he feels the need is to excite the other person, to have the other person respond at the site of body with excitement—that is what he's needing. He has to go through with it, as an obligation, is what we've been working on. Does he have to submit to something he doesn't want...I'm suspending my own sense of my rules are and what his rules are, and suspending my need to treat the bi-polar experience with meds.

Here the therapist is pointing out many steps in the formulation of insight. After the differential and owning what is hers, she stays with the immediate experience of the patient's need to excite the other person, which leads to questioning that excitement as an "obligation." Having stayed with this, she begins to disrupt the narrative of "does the patient have to follow through with this?" The therapist is referencing a suspension of her own personal need to treat the bi-polar with medications and to intervene with her own sense of "rules" in order to invite the patient to contemplate the urgency and obligation behind the anonymous sex. Through the therapist's acknowledgement and restraint of her needs, this allows the patient an opportunity towards self-reflection and insight in the form of maintaining independence from medications and gaining an observing distance towards his sexual behaviors.

In another example, Participant 1's case description goes as follows:

The woman who had the traumatic childhood...I once early on hospitalized her as suicidal, and it was useful to her...but she always experienced me as trying to prevent her suicide and there was an element of her suicide that was dear to her self-expression, kind of her self-assertion. Part of the experience, over time, of her getting less dangerously

dissociated and dangerously suicidal, and we could both feel that. I think my practice [of Mindfulness] allowed me to listen to her in a more physically balanced way.

This part of the narrative demonstrates a shift of when the clinician was more interventionist, “hospitalizing her as suicidal,” to the clinician being able to stay with the immediate experience of the patient and being in their body in a “balanced way.” Later, participant 1 goes on to explain how non-reactivity paved the way for the patient’s process of healing. The case continues:

So she described a moment where she waded into this very cold... drowning type waters setting on the coast of ---. She’d always had fantasies of drowning herself and she described this moment as one of her children was having a terrible time, and she felt guilty and suicidal. *She no longer experienced me as pulling her away* from that suicidality. So, what happened was she could tell me that there was a moment where she was *really balanced* and was going to go further in the water...she’s started to feel her body numb and turn around and come back. She just *decided that she wanted to come back* so it was, it felt to me like a physical initiative moment for her that was *her decision to live* and wasn’t done for me for anyone but herself. It’s been kind of a turning point in that treatment. So, I think that maybe *my own sense of physical presence* is felt somehow. *I’m less alarmed. I don’t get as interventionist* with the trouble. I stayed with the person’s exploration of that more.

Step 1, the therapist was able to notice in their body the fear of their patient committing suicide as evidenced by their decision to hospitalize the patient. Next, the therapist uses a mindfulness approach to differentiate their need to keep the patient alive with the patient’s need for suicide as a means of “self-expression.” So, in an act of being non-interventionist, the therapist stayed with the immediate experience of the patient wading out in “drowning type

waters.” Next the therapist remained open and curious to this dangerous situation, which she was able to experience as the therapist no longer “pulling her away” from her suicidal ideations. The next step was the patient’s inexorable insight of being able to decide for herself the decision to live, “she decided that she wanted to come back” and it was “her decision to live.” If the therapist had been unable to contain their fear of their patient’s suicidality or threats of self-harming, this would have prematurely disrupted the patient’s process of needing to be able to decide for herself the desire to stay alive.

As one can see through these three case examples, therapist’s use of mindfulness permeates and influences the therapy in an implicit manner and *not* through an intervention of skills. These examples show the therapist noticing their bodies, acknowledging arising sensations, then pausing to ask if these sensations are theirs or the patients, staying with this with openness, and lastly with curiosity, asking questions in a spirit of inquiry that invites the patient to explore their own personal understanding of what is happening for them.

Buddhist Influence on the Therapeutic Frame

Now, with a “beginner’s mind,” we might begin to ask how Mindfulness shows a successful working through of transference-countertransference material and projective identification by participant’s case material (Ogden, 1979). I argue that successful outcomes of therapist’s use of Mindfulness in yielding insight is a result of Buddhist philosophical influence on the therapeutic frame overall. Guiding each of these participants’ work is an understanding of the meaning of suffering, or as most commonly voiced, “life is suffering” (Participant 4).

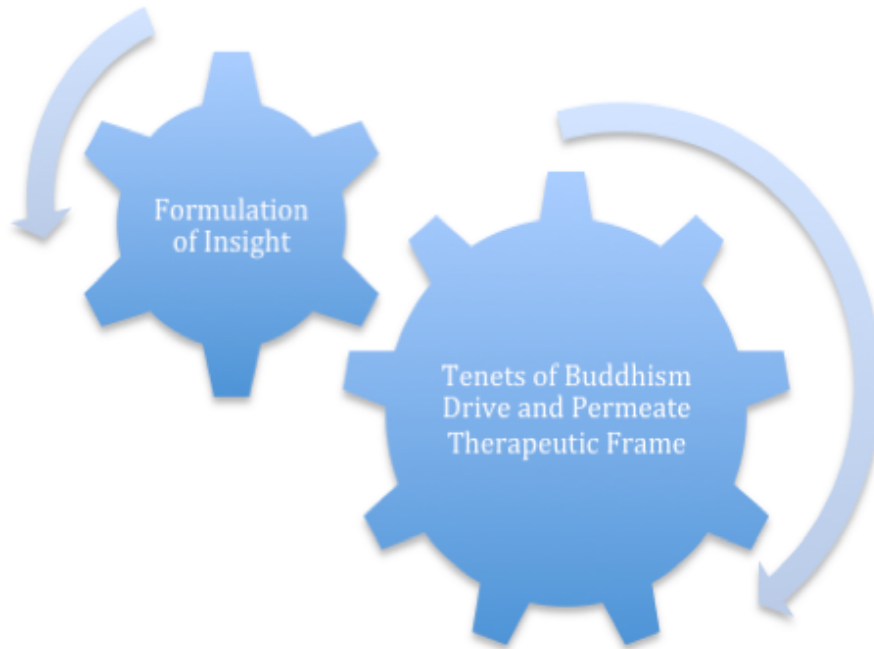


Figure 2. This figure demonstrates how Buddhist tenets drive, inform, and permeate the therapist’s work on a macro-level.

Many participants commented on the tenets of Buddhism directly and indirectly. Participant 3 stated that Buddhism informs “my understanding of suffering, the nature of suffering, and the way out of suffering.” What many of these participants are speaking to and referencing are the “4 Noble Truths,” which are the main philosophical beliefs that make up Buddhism. To reiterate, they are:

1. Life is Suffering or *Dukkha*. We are born into a life of suffering.
2. Suffering is caused by desire and desire for certain outcomes, which can take many forms.
3. Suffering can be overcome.
4. Suffering can be overcome by following the 8-fold path.

The Eight-fold path directs the practitioner out of the cycle of suffering by way of cultivation of a wise and open heart. While therapists were discerning in their decisions with

whom to teach or talk to about Mindfulness, it is clear how Buddhist psychology influences their style of therapy.

Other ways in which Buddhism permeated the frame is that it normalizes suffering. It “gives people permission to be with their suffering, to have compassion for their suffering,” as participant 5 noted. Adding to this sense of normalizing is what participant 6 stated, “It evens the playing field. Everyone feels this way.”

Indeed some participants articulated how it “permeates the whole framework” while participant 9 commented how through extensive practice over many years, there comes a “steeping of Buddhism” that infiltrates everything that they do.

Other participants commented upon how Buddhist philosophy increased their sense of interconnectedness, thus informing their clinical work to “the idea that none of us exist in a vacuum,” as noted by participant 12.

Buddhist principals influence the therapeutic frame by normalizing pain and suffering and remembering our sense of interconnectedness during periods of pain and duress. Therapists then bring these principals into the therapeutic encounter simply through their daily practice of Mindfulness, which shapes their use of language and understanding of pathology. Pathology becomes neutralized and can be investigated with curiosity and a sense of nonjudgment and compassion.

Summary

Therapists are taught to use “evenly hovering attention” and to take a “participant-observer” stance, but how can these skills be developed and taught? This data suggests how Mindfulness can be used as a kind of technology towards developing these essential therapeutic skills.

This study shows how Mindfulness does not have to be taught explicitly as a skills-approach to life in order to be effective, and as a matter of fact, appears to be more effective when used by the therapist to shape the therapeutic frame. The therapist's choice to study Mindfulness is a deeply personal one and so is their decision to "teach" it to their clients or not. All participants noted that they are not insistent on their patients using or practicing Mindfulness skills and will often wait until the patient has expressed interest first before proceeding with any Mindfulness exercises. Many practitioners stay away from teaching all together so as to avoid confusion between "therapist" and "teacher," while others try and balance both but only at the request of the patient.

Most importantly, this data points to a nuanced process in which information gathered from sensations in the body is then used to infer and make inquiries into something about the patient's experience. This priming of the patient's experience by way of the therapist's tolerance of the physical sensations induced in them by the patient allows for the conditions of insight to arise through restraint and curiosity.

CHAPTER V

Discussion

“The body says what words cannot” -Martha Graham

Summary of Key Findings

Primary findings of this qualitative inductive research study show that therapist’s experiences of using Mindfulness helps to attune clinician’s to their bodies. This differs dramatically from manualized treatment models of MBCT (Segal, 2002), ACT (Hayes, 1990), and DBT (Linehan, 1993) that work to regulate affect within the client. Previous research in the field often focuses on Mindfulness’ ability to help patients relax, breathe, and notice their thoughts dispassionately (Kabat-Zinn, 2003). This study, with its focus on narratives of therapist’s experiences in session with patients reveals an enhanced attunement to the clinician’s own bodily and sensory experience in the here-and-now. The findings then show how the therapist uses this somatosensory information gathered within the body to pause and explore which aspects are personal triggers versus those the patient is eliciting. Through a noninterventionist stance and the spirit of inquiry (Goldstein, 2013) as espoused through a Mindfulness practice, both patient and therapist are then able to engage in a curious and open manner towards the therapeutic material being presented in the room. I argue that it is through the environment generated by the therapist’s embodiment of Mindfulness principals that creates optimal conditions under which patient insight can be derived.

Evaluation and Interpretations of Findings

This project began with a review of Mindfulness literature, which was broken down into three categories: Mindfulness in client, clinician's use of Mindfulness, and relational mindfulness.

Clinical Mindfulness is most frequently used explicitly with clients in order to help with affect regulation (Linehan, 1993). It is used to help clients learn relaxation techniques, notice their breathing, and their thoughts (Kabat-Zinn, 2003). The main theory driving this practice of present moment awareness is that it is through the process of *accepting* whatever is arising with compassion and nonjudgment in the present moment helps the client learn that suffering is impermanent and that through distant observation this allows the client a *choice* on how to respond (Hayes, 1990). This kind of skills-building approach to therapy occurs most frequently through treatment modalities such as MBSR (Kabat-Zinn, 1990), MBCT (Segal, 2002), ACT (Hayes, 1990), and DBT (Linehan, 1993). These treatment modalities often assign homework of a daily meditation practice of 20-45 minutes a day and/or other exercises that encourage self-reflectivity and stillness. Neuroscience research on these manualized-treatment protocols have shown successful reduction of anxiety, depression, chronic pain, and reduced reactivity in centers of the brain associated with stress and trauma (Kabat-Zinn, 1992; Lazar et al., 2005; Hozel et al., 2007).

Implicit Mindfulness refers to the therapist's use of Mindfulness. Categories of implicit Mindfulness are Mindfulness as a form of self-care, Mindfulness as an aid for management of difficult counter-transferential material, and as a tool for self-disclosure (Garland, 2013). Tenets of Buddhism inform this process. Buddhist tenets of equanimity, impermanence, curiosity, and compassion prime the therapist and the practitioner of Mindfulness to cultivate what has been

deemed “therapeutic presence” (Pollack et al., 2014). The Noble Truths of Buddhism also inform the therapist’s beliefs on suffering—life is suffering, suffering is caused by desire, suffering can be overcome, and it can be overcome through the eight-fold path (Goldstein, 2013). This steeping of Mindfulness is accomplished through the therapist’s personal daily practice (sitting formally for a certain period of time each day and/or taking time each day to be mindful while eating, walking, etc...) and a personal retreat practice (Brach, 2003). These qualities of awareness, stillness, compassion, and nonjudgment are cultivated in the therapist’s personal time that then becomes transposed in the therapy but only in an implicit manner through the therapist’s personal experience of Mindfulness.

Explicit and implicit forms of Mindfulness come together in a new form of Mindfulness called relational Mindfulness (Surrey, 2005). Relational Mindfulness is a blend of relational psychodynamic theory and principals of Mindfulness Meditation. Guiding the principals of relational theory is the concept that both patient and therapist have an impact on each other (Aron, 1996). Relational Mindfulness takes this one step further to posit that both patient and therapist are attendant to the arising experience with acceptance (Surrey, 2005).

Using this research on explicit, implicit, and relational Mindfulness, this study came to the following findings. Mindfulness first and foremost attunes the therapist’s attention to the body. It is through this awareness of the body that then initiates the process of attunement to disavowed content from the patient. Findings revealed that insight is yielded through the following process:

1. Awareness of the Body
2. Awareness of Sensation
3. Differential: “What’s mine? What’s theirs?”

4. Staying with Immediate Experience
5. Spirit of Inquiry
6. Insight yielded through patient self-awareness

Narratives from participants, specifically participants 9, 2, and 1 (See Chapter IV Findings), show how awareness of the body, followed by awareness of sensation, led them on a path of inquiry towards the patient's unspoken experience. Upon pinpointing a sensation within their body, participants used careful discernment to differentiate between if their reactions to patient material were their own or something the patient was eliciting within them. From this step, the therapist then pauses. They do not react, they do not problem-solve, they do not rush in to help—they stay with the “immediate experience,” which is step 4. After staying with the uncomfortable affect, with curiosity and openness, the therapist then proceeds to ask questions in a “spirit of inquiry.” Through this process of nonjudgmental inquiry, conditions within the therapeutic encounter make it possible for patient insight to arise.

The following is a case example linking all of these steps together:

What comes to mind is a situation where the client is really angry or upset and kind of ranting about something that may or may not have to do with me...A client last week was ranting about Harper Lee and her novel that's being published and he's convinced she's being exploited...and just all these things he feels are unjust an unfair in the world, and as I listened *I find myself getting stirred up myself* and kind of angry. I just feel what he's feeling and what Mindfulness can help me do in that situation is first of all be present, *to feel it in my body*, to feel my feet on the floor, my breath, *to pause and not just blurt out something*. Also, to find *a way to name it* and to *bring it back to him*, and *ask questions*.

‘You sound really angry about this and I’m wondering what this has to do with you and your life?’ (Participant 2)

Participant 2 is describing firstly, awareness of the body, “feel it in my body.” They then proceed to name the sensation in the body, “I find myself getting stirred.” In other words, stirred by the anger. The differential is, it “may or may not have to do with me,” but he proceeds by pausing—to “not just blurt out something,” thus staying with the immediate experience. Through the spirit inquiry, the participant is able to try and “bring it back” to the client and “ask questions.”

Participant 2 then describes, through his curiosity, how they were able to provide space for the client to arrive at some insight into the situation:

This [gave] him an opportunity to talk about that he feels like he’s been exploited a lot and he’s a frustrated artist who hasn’t been able to get his work out there...his book never got published...and he’s still grieving over this.

Through an awareness of some discomfort within the therapist and by means of the therapist tolerating, staying with, and remaining curious to this sensation of being “stirred,” this process invited the client an opportunity for self-reflection. In this case, this gave the client an opportunity to discover for himself the nature of his displacement and to connect his angry feelings back into his own process of grief over missed opportunities and felt sense of being exploited.

Part 2 of the major findings show how tenets of Buddhism drive and permeate the therapeutic frame, including the therapist’s use of language and physical presence. Buddhist principals influence the therapeutic frame by normalizing pain and suffering as stated by the first noble truth that “life is suffering” (Goldstein, 2013). Buddhist philosophy also emphasizes our

sense of interconnectedness to all beings through the practice of metta or lovingkindness (Salzberg, 2001). In addition, dharma (meaning “law”) practices or practices that “refines our insight into the natural laws of our being” inform the therapist’s ability to distinguish clearly between mind and body processes (Kornfield, 2012, p. 113). Therapists then bring these principals into the therapeutic encounter simply through their daily practice of Mindfulness, which shapes their use of language and understanding of pathology. Pathology becomes neutralized and can be investigated with curiosity and a sense of nonjudgment and compassion. Further strengthening these findings are the experience of the participants. Participant’s average meditation practice per day was 33 minutes, while their average of years practicing Mindfulness averaged 18 years.

The purpose of this study was to look into the *how* of Mindfulness in contrast to the *what* of Mindfulness that has already been studied and implemented in many forms through manualized treatments. Given the dearth of qualitative research on the relational and unfolding nature of Mindfulness, this research study sought to uncover the more subtle aspects of Mindfulness at work in the therapeutic encounter.

Findings in light of the current state of Mindfulness research and this paper’s literature review show that advances in neuroscience have shown clear evidence of Mindfulness’ benefits on the brain (Singleton et al., 2014). Alongside this evidence is the quantitative research demonstrating clear before and after benefits of symptom improvement of ailments such as chronic pain, depression, anxiety, and addiction (Kabat-Zinn, 1992; Lazar et al., 2005, Hozel et al., 2007). The literature review found research gaps such as, how does Mindfulness enhance the ability of the therapist to embody being both “observer” (paying attention) and “participant” (with intention and compassion)? Also, more research needs to be done on the emerging field of

relational Mindfulness. In other words, looking at how a Mindfulness practice in both patient and therapist impacts treatment.

These findings show great utility for the field and advancement of social work practice. How can students learn to be more attuned and sensitive to arising sensations in their bodies and learn to tolerate them? How can students and clinicians use these sensations as data towards understanding their clients with more acuity and compassion? Findings can be interpreted in several ways. I argue that Buddhist philosophy in fact permeates the entire framework from which a clinician works, thus informing the clinician's presence, thought process, and sense of inquiry. While Mindfulness is a secular practice, the "steeping" in Buddhist thought seems to have a powerful impact on the therapist's sense of containment and metabolization of difficult affective states.

In addition, it's important to also note that the therapist's decision to even teach Mindfulness skills to a patient is a deeply personal choice and should be acknowledged as such. Both teaching Mindfulness to patients or having the therapist practice Mindfulness should not be decisions forced upon either party. It's essential that both patient and therapist feel a personal connection to Mindfulness before engaging in the practice. This is a crucial distinction that manualized treatments do not acknowledge. What is clear is that each participant felt some kind of connection to the practice of Mindfulness and made a personal choice to study it further. The majority of participants commented that they did not teach Mindfulness to every client but rather waited until the client expressed interest. While implicit use of Mindfulness was ever present in the participant's sessions, explicit use was used only when requested by the client.

Themes

In noticing the relative explosion of the popularity of Mindfulness in therapy models and society at large, this study sought to identify more closely the mechanisms of Mindfulness at work during the therapeutic encounter. Seeking to bring Mindfulness beyond its most common connotation, which most popularly is used as a technique for relaxation and calming, this study opted instead to look at how it influences therapist's style of working and how it's used in shaping clinical insight.

Major themes included attention to the body and the influence of major pillars of Buddhism such as the spirit of inquiry, choiceless awareness, and acceptance that life is suffering has on the therapeutic frame. Most tellingly, Mindfulness also helps to bring the clinician out of being an "other" focused clinician to more self-, inward-, and contemplative clinician.

These findings advance the literature on the benefits of contemplative practices and mind-body practices for clinician's. I propose that more self-awareness and Mindfulness practices be emphasized in therapist trainings that is most needed and therapeutic.

Considerations for Practice

This research study has social work, psychoanalytic and psychological implications on micro and macro levels. For clinicians in general, this study reveals the importance of therapist's being trained on a somatic level. Therapist's need to become more aware of their bodies and bodily sensation as there is much therapeutic material to be mined here. Additionally, this study pushes the concept of therapy as a noninterventionist approach of *being with* instead *taking away* patient suffering as the main modus operandi of healing.

CBT approaches often focus on symptom reduction and leave out therapist reactions or contributions to the therapeutic encounter. This study shows how Mindfulness efficacy is lost when the therapist themselves does not embody the principals of Mindfulness. This study

implicates that there might be something lost in translation if the therapist only teaches but does not have personal Mindfulness experience to draw from. For therapists in training this means including more training on embodiment practices such as breath and movement work to enhance body awareness. While CBT practices are often “other” focused, psychoanalytic work oftentimes is too intellectual or esoteric. This study shows how Mindfulness can aid psychoanalysts to bring their theories into the here-and-now. While the concept of projective identification elucidates the transference-countertransference dynamics of therapist and patient, this study shows how Mindfulness can be used to breakdown and metabolize this process for the therapist (Ogden, 1979). Additional implications include the idea of a noninterventionist or alarmist approach—*being with* patient suffering instead of trying to make the symptoms go away. This has implications on a macro scale in the age of managed care and quick fixes. Similar to the slow food movement happening in agricultural and local farms, this study reveals the need for slow medicine and a slow approach to therapist training and patient healing. While integrative health practices are increasing in popularity, still, these treatments go unfunded by health insurance companies. By improving the quality of research on contemplative practices, this could galvanize an approach to slow medicine, as seen in the slow food movement happening in the world of agriculture today.

Most importantly, cultivation of wise and discerning minds are needed today in our fast-paced culture. As participant 1 noted, it’s not that therapists need to abandon being therapeutic, but in general, more training is needed to help therapists sit and stay with difficult sensations arising in their bodies. This stems for the radical notion that we can only be as helpful to others as much as we know and can contain ourselves (Brach, 2003). Finding ways for mental health

professionals to use their minds *and* their bodies in an *integrated* and holistic fashion has the potential to increase patient health outcomes and reduce clinician burnout.

Study Strengths and Limitations

Strengths of this study are the experience and expertise of the participant pool. The average daily meditation practice was above 30 minutes a day, the average years of Mindfulness practice was 17 years while average years of clinical practice was 16 years. Most participants were recruited due to their visibility in the Mindfulness community and their reputation for being long-term practitioners. I enhanced code trustworthiness by consulting with fellow students through a process called peer debriefing.

Limitations of this study are its small sample size. Due to this small sample size this means that findings cannot be generalizable. Also, patients of clinician's were not studied meaning that patient perceptions of successful outcomes of treatment were not tested. Success was only held within the mind of the therapist as a useful intervention. Also, this study did not include a before and after aspect to this study so no contrasting data could be used. These are limitations because they leave out the impact of patient perspectives and the longitudinal impacts of Mindfulness.

Generalizability is difficult because of the study's focus on narratives instead of a large sample size, but given the flow chart of insight (see Graphic A of Chapter 4), these concepts could potentially be translated into the classroom and therapeutic setting. Limitations of Graphic A is that is linear and does not show the back and forth that happens between steps or even sometimes the omission of certain steps that may still lead to patient insight.

Given the strong evidence of the usefulness of therapist's body awareness, areas for future research include awareness of therapist's body awareness on therapeutic outcomes or

patient's responses to therapy where the bodily sensations are stressed. Another potential avenue is interviewing patient's experiences of therapy before and after their therapist began a Mindfulness practice or training. This could give us contrasting material to study and find newer avenues of efficacy and shortcomings.

Researcher Bias

A researcher bias is my personal practice of Mindfulness for the past three years of 20 minutes a day. While I do not have a retreat practice, I am also a dedicated yoga practitioner and have been practicing for over seven years. My undergraduate studies also focused on movement and dance, so my perspective biases towards body approaches. This means that despite my best efforts to remain neutral on the benefits of somatosensory awareness, it is inherent within my perspective and analysis of the data that the body matters.

Conclusion

Study results show the benefits of bringing Mindfulness beyond a set of relaxation exercises, beyond using therapist as teacher or coach of Mindfulness, and beyond using Mindfulness as a skills building approach to psychopathology. This study shows the benefits of staying with the immediate experience of one's suffering with openness and curiosity towards helping patients gain a sense of self-awareness and insight. Most importantly, this study demonstrates how awareness of one's somatosensory experience as rooted within the body and bodily sensation is the crucial first step towards the process of patient insight and successful outcomes in clinical interventions.

These findings are important as they confirm trends of bringing therapy from a left-brain (analytic and content focused) to a right-brain (experiential and process focused) process of therapy (Siegel, 2007). Mindfulness is used by clients to help with affect regulation and deep

breathing (Linehan, 1993) and by therapists as a form of self-care and containment of difficult transference-countertransference dynamics (Gockel, 2013), but this study takes these roles one-step further. This study examined the unfolding and nuanced dynamics of Mindfulness at work in the here and now experience of therapy as recounted by participants. What participant's narratives overwhelmingly pointed to is acknowledgement of the body and of the information arising in their sensations that then goes on to inform the therapist's line of questioning.

While Theravaden Buddhism or Insight Meditation as it's most commonly known in the U.S. is not mentioned explicitly in treatment or by therapist's themselves, its influence continues to inform and influence therapist's conceptions of suffering, the roots of suffering, and the way out of suffering through their embodiment of these principals.

Social work, psychotherapy, and neuroscience through advances in research and technology are pushing the edges therapeutic approaches today. As we go forth, we must continue to share our edges and explore that which causes us discomfort, to pause, reflect, and with compassion, venture deeply into our psyches to find new depths in the world of "talk" therapy. As therapists we act as sherpas or midwives. We help guide the patient to sights unknown and emotions yet to be acknowledged. What better tool to help us become healing facilitators in our patient's lives than to have undergone that journey of personal transformation and reflection ourselves. This is the radical promise of Mindfulness.

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Appendix A

Interview Questions

Demographics

- a. How long have you been a practicing clinician?
- b. How long have you been practicing mindfulness?
- c. Do you study at an Institute or have a Mindfulness Sangha?
- d. How do you define Mindfulness?

1. Mindfulness in the clinician.

- a. Thank you for meeting me. As you know, I'm interested in how clinicians experience mindfulness in their clinical practice and so I'll be asking you questions on how Mindfulness plays a part in your clinical work. What does your practice of Mindfulness usually consist of?
- b. (If personal or professional realms not addressed, ask here)
- c. How did you get involved with practicing Mindfulness?
- a. How does Mindfulness inform your process of formulating clinical interventions?

2. Mindfulness in the client.

- a. How do you think Mindfulness can be useful in clinical practice?
- b. How, if at all, has Mindfulness impacted your interventions with clients?
- c. Do you integrate mindfulness skills into your practice?
- d. How do you decide what kind of Mindfulness skills to teach a client, if ever?
- e. How have you found clients to respond to your Mindfulness interventions?
- f. What do you think was useful?
- g. Not useful?

3. Mindfulness as a relational process.

- a. How does Mindfulness inform your clinical process?
- b. How does Mindfulness show up in your clinical process?
- c. Can you tell me about a clinical experience in which you used your Mindfulness experience with a client?
- d. Can you tell me about a clinical experience in which you used your Mindfulness practice to be more present in a session?
- e. How do you think it was useful?
- f. Not useful?
- g. What helps you decide when to use Mindfulness as opposed to other forms of clinical interventions/theories?
- h. Ideally, how do you think the practice of Mindfulness should be used with clients?
- i. What do you think is most useful about integrating Mindfulness into clinical practice?

4. Mindfulness as a spiritual practice.

- d. How do you see Mindfulness as creating a different relationship to suffering?
- e. How do you see Mindfulness creating community?
- f. How do you see Mindfulness increasing your sense of connectedness or inter-connectedness?

Appendix B

Consent to Participate in a Research Study Smith College School for Social Work • Northampton, MA

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Title of Study: Investigating the Present: Clinician’s Experiences of Using Mindfulness in sessions with Clients

Investigator(s): Sonia Hsieh

.....

Introduction

- You are being asked to be in a research study of the experience of therapists using Mindfulness in the clinical encounter.
- You were selected as a possible participant because you are a therapist who self-identifies as a therapist and practitioner of Mindfulness.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is learn about the experience of therapist’s use of Mindfulness in sessions with clients.
- This study is being conducted as a research requirement for my master’s in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: you chose to be interviewed individually by the researcher for one hour to one hour and fifteen minutes. The interview will be audio recorded.

Risks/Discomforts of Being in this Study

- The study has little foreseeable risk but should discomfort arise, discretion and disclosure is left to the participant’s choice.

Benefits of Being in the Study

- The benefits of participation are having an opportunity to talk about your experience and possibly gaining insights into your clinical use of Mindfulness.
- The benefits to social work/society are: to provide information for future research and to identify strengths and potential areas of growth for clinicians and student clinicians.

Confidentiality

- Your information will be kept confidential. The researcher will be the only person who will know about your participation. The interview will take place either at a carefully selected quiet location or

another private location of your choice that provides privacy. *In addition*, the records of this study will be kept strictly confidential. I will be the only one who will have access to the video or audio recording, with the exception of a potential transcriber, who will sign a confidentiality agreement. Recordings will be destroyed after the mandated three years. They will be permanently deleted from the recording device.

- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. I will not include any information in any report I may publish that would make it possible to identify you.

Payments/gift

- You will not receive any financial payment for your participation.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* up to April 1, 2015 without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by April 1, 2015. After that date, your information will be part of the thesis and final report.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me,
Sonia Hsieh
Email: sshsieh@smith.edu
Address:
- If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep. You will also be given a list of referrals and access information if you experience emotional issues related to your participation in this study

.....

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

Appendix C



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

December 8, 2014

Sonia Hsieh

Dear Sonia,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

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.

Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Jennifer Willett, Research Advisor