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Lindsay Stonecash  
Clinician perspectives on using  
mindfulness based therapeutic  
interventions when working with  
veterans

## **ABSTRACT**

The purpose of this research study was to explore clinicians' perspectives on using mindfulness practices with veterans suffering from Posttraumatic Stress Disorder (PTSD) and other stress-related problems. While applying mindfulness techniques in clinical settings is not new to mental health fields, researchers have yet to agree on an explicit definition of mindfulness, and amid growing support for its efficacy, it remains to be categorized as evidence based practice for PTSD. Due to the high need for more widely available treatment interventions for veterans with PTSD, researchers are exploring the potential for mindfulness to be broadly applicable among populations seeking PTSD treatment.

This exploratory study employed qualitative research methods to interview fourteen clinicians within the New Mexico Veterans Affairs Health Care System. The sample included licensed clinical social workers and clinical psychologists. Qualitative analysis indicated that mindfulness is seen and experienced as a helpful stand-alone intervention and also an adjunct to exposure therapies and clinical work in general. Naturally emerging themes in the interviews included discussion of the overarching impact mindfulness practices have had on participants' personal and professional lives, barriers that exist within the VA in some part due to large scale differences between VA and military culture and the culture of mindfulness. The study also generated discussion of opportunities for further use of mindfulness for veterans and clinicians with attention to the extent that mindfulness was already used. Limitations to the study were considered and questions for further inquiry stated.

**CLINICIAN PERSPECTIVES ON USING MINDFULNESS BASED  
THERAPEUTIC INTERVENTIONS WHEN WORKING WITH VETERANS**

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

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2013

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## **CHAPTER I**

### **Introduction**

Since the military conflicts in Iraq and Afghanistan commenced following terrorist incidents on September 11, 2001 in New York City, over two and a half million military service members have been deployed (Institute of Medicine, 2012). Up to 20% of these soldiers are estimated to be coping with a Posttraumatic Stress Disorder (PTSD) diagnosis and trauma-related issues due to this deployment (IOM, 2012). The Department of Defense and Veterans Affairs anticipate more need for PTSD treatments as troops are pulled out of these conflicts in the next few years. Researchers and historians agree that the combat circumstances in the Middle East are unique to these conflicts and are causing soldiers to develop PTSD at a higher rate (Stanley, Schaldach, Kiyonaga, & Jha, 2011; IOM, 2012).

A 2012 study collaboratively conducted by the Department of Defense with VA support and the Institute of Medicine (IOM) found that a significant gap in accessible mental health services continues to exist for military service members with trauma-related issues or PTSD (IOM, 2012). “Of the U.S. service members who deployed to Iraq and Afghanistan, only slightly more than half of those diagnosed with PTSD actually received treatment for it” (IOM, 2012, para. 10). The IOM study posits reasons why this treatment gap exists. Contributing reasons may include military service members’ concerns about PTSD stigma having a negative impact on their career and concerns about attending appointments with mental health providers in combat

zones (IOM, 2012). They cite additional barriers to care as including providers who lack the necessary training to treat PTSD and issues related to restrictions on medications that active-duty service members can take (IOM, 2012). Among other recommendations that the IOM makes, they say, “the DoD and the VA also should support research that investigates emerging techniques and technology” (IOM, 2012, para. 11). The problem of accessible and efficacious treatments for veterans with stress-related disorders continues to plague the veteran population and it continues to be a bane in the VA’s mission to help and heal wounded warriors in the United States. The DoD and the VA have worked together to remedy this issue. The DoD has invested millions of dollars in pre and post-deployment resiliency-building programming designed to help veterans cope with the high risk combat conditions in Iraq and Afghanistan (IOM, 2012). Since 2005 the VA has more than doubled funding towards PTSD research and employed over 7,500 mental health workers in their facilities, training over 6,600 in evidence-based treatments for PTSD (IOM, 2012).

Still, the effort falls short. Only 10% of veterans seeking treatment at VA hospitals are military service members from the Iraq and Afghanistan conflicts (Rosenberg, 2012). Veteran suicide rates continue to be higher than rates gathered from general U.S. population samples, with eighteen veterans committing suicide daily in the United States (Dao, 2012). Despite the grim statistics for Iraq and Afghanistan veterans, the vast majority of patients at VA’s are not veterans from these recent conflicts. Further, one million troops are expected to leave the military by 2017, so the need for wide reaching treatments will become more critical (Mulrine, 2012).

The 2012 IOM study indicated a need for “innovative” therapies, explicitly identifying acupuncture, animal-assisted therapies, and yoga. The research committee reported their

investigation into these therapies was hampered due to lack of evidence about these alternative modalities (IOM, 2012). The VA is beginning to look beyond the most well-documented, evidence-based therapies so as to aim to meet the high need for treatment for veterans from the recent Iraq and Afghanistan conflicts. There are not as many studies on yoga, acupuncture, and mindfulness-based therapies. Though, as one of the few studies on these treatments says, these treatments can be delivered in group format, reaching more veterans than an individual treatment, and it's being documented that they reduce PTSD symptoms similarly or at better rates than evidence-based individual therapies (Rosenberg, 2012). The Center for Mind-Body Medicine's program is seen as being the most comprehensive model that uses alternative therapies for PTSD treatment in VA hospitals (Rosenberg, 2012). This program uses mindfulness, breathing, loving kindness meditation, guided visual imagery, among other practices and they note it has significantly lower drop-out rates than individual treatments that compare in terms of efficacy (Rosenberg, 2012). The chief of addiction treatment services at Walter Reed National Military Medical Center uses it and says it's a "very effective" model because it treats in a "broad-spectrum" way as she has seen it work for depression, pain, sleep disorders, and substance abuse (Rosenberg, 2012).

My own practice of mindfulness meditation has had a substantial influence on my choice to become a mental health professional, and my personal training with mindfulness meditation regularly impacts the meaning I make of my experience in a clinical setting as a graduate student intern. In preparing for my second year clinical field placement in a VA hospital in New Mexico, I began to notice some of the above mentioned stories on the radio and in newspapers. I heard how mindfulness was being successfully used as a therapeutic treatment or within other therapeutic interventions for veterans with PTSD and trauma. I wondered how military service



members were responding to these kinds of alternative practices and therapies. A doctor in one of the articles reported some debate over whether or not to find an alternate name for loving kindness meditation. One of the veterans interviewed also described the mild apprehension about alternative approaches to healing saying that some veterans in the group were rolling their eyes and he reported some sentiment that “this is kind of soft” when doing the practices in the treatment group (Rosenberg, 2012, para. 14).

As I continued to explore, I read that some mindfulness based therapies are well-researched and some aspects of mindfulness research is evidence-based to indicate efficacy in treating psychological conditions and improving psychological health (Davis & Hayes, 2011). Mindfulness has moved from an “obscure Buddhist concept to a mainstream psychotherapy construct” (Davis & Hayes, 2011, p. 198). I was interested in how this convergence of mindfulness and science came to be.

Due to interest in Zen Buddhism in the 1950s and 1960s in the United States, mindfulness meditation began to be studied in Western medicine in the 1960s (Keng, Smoski, & Robins, 2011). Using mindfulness in the therapeutic setting for the purposes of psychotherapeutic treatment largely began in the 1970s in the United States. “Application of mindfulness meditation as a form of behavioral intervention for clinical problems began with the work of Jon Kabat-Zinn, which explored the use of mindfulness meditation in treating patients with chronic pain, now popularly known as Mindfulness Based Stress Reduction” (Keng, Smoski, & Robins, 2011, p. 1043). Since this time, other therapies that use mindfulness or teach mindfulness skills have emerged as evidence based treatments (Keng, Smoski, & Robins, 2011). These include Mindfulness-Based Cognitive Therapy, Dialectical Behavior Therapy, and Acceptance and Commitment Therapy. Mindfulness researchers have created “operational

definitions” of mindfulness as they attempt to streamline the inclusion of mindfulness as a therapeutic modality in the mainstream scientific research community (Bishop, et al., 2004). Progressively, therapies or interventions that included mindfulness began being used to treat depression, anxiety, personality disorders, and Post Traumatic Stress Disorder.

As a result of the large number of soldiers returning to the United States from recent conflicts Operation New Dawn (OND), Operation Iraqi Freedom (OIF), and Operation Enduring Freedom (OEF), with PTSD, there is a well-known need for VA’s to have effective treatments in place for returning military service members (Brooks, et al., 2012). Alongside the enduring stigmas around mental health care in military culture, I wondered if these more gentle approaches to therapy that used concepts like acceptance, compassion, equanimity with application of progressive muscle relaxation and breathing exercises might still be a hard sell to veterans or VA clinicians.

Last year I attended a seminar during a social work conference that outlined some of the alternative therapies that are available to veterans coping with PTSD. The veterans on the panel spoke about how helpful things like acupuncture, yoga, mindfulness meditation, and tai chi had been in their recovery from traumatic combat experiences. At one point a young male veteran said, “I’m a man’s man, I’m tough, and I’m here to tell you that this stuff ain’t just for tree-huggin’ hippies!” The whole room erupted in laughter. He had touched on something significant, and I laughed especially hard because I was pleasantly surprised to hear that combat veterans were indeed meditating! However, it seemed like the veteran who made the announcement wanted to dispel a myth that there was something wrong with being a veteran and using alternative therapies. I wanted to know more about any tension that existed between being a combat veteran with PTSD and practicing mindfulness. Being a student and new to the field of

social work, I was curious to see how these practices were being taught to veterans in treatment at VA's in the United States. What kind of measures did therapists need to go to in order for veterans to practice mindfulness? If some veterans still perceived alternative therapies, specifically mindfulness, to be for "tree-huggin' hippies" and not dignified warriors, then what was the clinician's experience like when engaging the veterans in treatment? In other words, I wondered what kind of preparation clinicians could expect when working with a veteran population.

In a review of empirical studies conducted that assessed the impact of mindfulness on psychological health, it was overwhelmingly determined that there are many positive outcomes to applying mindfulness in the clinical setting (Keng, Smoski, & Robins, 2011). Keng, Smoski, and Robins (2011) invited future researchers to look into the application of mindfulness and "examine practical issues concerning the delivery, implementation, and dissemination of mindfulness-oriented interventions" (p. 1052). This study will fill this gap in the research by exploring clinicians' experiences of the implementation and dissemination of mindfulness therapies in therapeutic settings with veterans.

The purpose of this study is to explore the experiences and perspectives of clinicians who utilize mindfulness based therapies in their clinical practice with military service members at the VA in Albuquerque, New Mexico. The questions that guide this study include: 1) What are clinicians' perspectives on using mindfulness with veterans, 2) How do clinicians introduce mindfulness based therapies and interventions to veteran populations, 3) What kind of additional opportunities for the application or integration of mindfulness exist in VA therapeutic environments, and 4) What, if any, barriers exist for veterans to gain access to mindfulness therapies when seeking treatment for PTSD?

This study is relevant to the field of Social Work because social workers play a significant role in the delivery of mental health treatment to military service members and veterans. In the New Mexico VA Health Care System alone there are over eighty social workers employed. Nationally, over 10,000 social workers are employed throughout VA health care systems (Association of VA Social Workers, 2012). As has been mentioned, the place of mindfulness in clinical treatment settings is still being established. With mindfulness not being classified as an explicit protocol, the incorporation of mindfulness into clinical work with veterans is still in process. While there is literature on where mindfulness theoretically fits in clinical settings, a gap exists in the discussion of how clinicians bring mindfulness concepts and practices into the clinical setting (Davis & Hayes, 2011). Social workers play an integral role in treatment delivery—they are on the front lines gaining first hand knowledge of veterans' experiences and needs. Therefore, hearing the social work perspective is valuable in shaping the future of how mindfulness is brought into clinical settings. Thus, the study makes a contribution to the field of social work in providing an opportunity for social workers to offer their insight about the use of mindfulness with veterans and military service members.

I conducted a qualitative, exploratory study using flexible methods through interviews with fourteen clinicians who integrated mindfulness based therapies into their work with a veteran client population. Semi-structured, open-ended questions gathered narrative data from the clinicians on their experiences of using mindfulness as a therapeutic intervention with veterans. Narrative research methods were appropriate because I wanted to understand the nuances of the clinicians' perspectives on how they introduced and taught mindfulness to the veterans, why they chose to use mindfulness, and their opinions of how mindfulness was responded to by coworkers, the larger VA hospital, and clients. I aimed to understand on a

deeper level how they approached mindfulness meditation with veteran populations. My research questions necessitated a qualitative design because I sought the clinicians' in depth reflections and evaluations on mindfulness in the VA clinical milieu.

The following chapter will identify and define terms like mindfulness and PTSD and review the literature on PTSD, military-supported treatments for PTSD, and mindfulness based therapies that are approved for use with veterans in VA facilities. The subsequent chapter will address the methods of this study and discuss recruitment, data collection, ethics of the study, data analysis, and limitations to the study. The next chapter will describe the findings from the narrative data. Finally, there will be an expanded discussion of the study where implications of the study are analyzed and further questions that surfaced during research are addressed.

## **CHAPTER II**

### **Literature Review**

This chapter will review literature to support this study. The literature review will assess Posttraumatic Stress Disorder incidence in veteran populations and explain why the combat environments of the current conflicts in Iraq and Afghanistan play a specific role in the development of PTSD among returning military service members. I will then describe common treatment modalities applied to veterans with PTSD to offer a picture of what the U.S. military is doing to address the large numbers of veterans suffering from PTSD as well as best practices in the treatment of PTSD.

Mindfulness will be explained specifically and situated in the literature that addresses treatment of trauma, stress, and chronic disease. I will give a historical frame of reference for when and where the phenomenon and concept of mindfulness was introduced into clinical settings for the use of mental health treatment. I will highlight the trend in research studies on mindfulness based treatments and go into detail about the most commonly researched mindfulness based interventions.

Next I will report on the integration of mindfulness based interventions with U.S. military efforts to find and utilize effective treatment for PTSD. I will discuss the relationship between the nature of trauma and how research shows that mindfulness is an effective choice for treatment. The role of the clinician or therapist in delivering treatment will be addressed, and

potential barriers to access mindfulness based treatments will be discussed. I will give an overview of the study and why it is relevant to learn more about clinicians' perspectives on mindfulness based therapeutic interventions.

### **Incidence of Posttraumatic Stress Disorder Among Veteran Populations**

U.S. Department of Veterans Affairs (VA) has designated Posttraumatic Stress Disorder (PTSD) as one of the “signature injuries” of recent conflicts Operation New Dawn (OND), Operation Iraqi Freedom (OIF), and Operation Enduring Freedom (OEF) (Brooks, et al., 2012). The large numbers of returning military service members with PTSD symptoms contributes to the urgency to find and deliver effective treatments for PTSD and trauma related medical conditions. Since 9/11, over two million military service members have deployed to Iraq and Afghanistan (Peterson, Luethcke, Borah, E., Borah, A., & Young-McCaughan, 2011). It is reported that 13 to 20% of these returning soldiers experience significant PTSD symptoms (IOM, 2012). The U.S. Army Office reports that close to 89,000 cases of PTSD have been diagnosed in veterans who served between 2000 and 2010 during OND/OEF/OIF (Fischer, 2010).

PTSD began to be considered the formal diagnosis that it is today in 1980 (Brown, N., 2008). However, as a condition caused by enduring traumatic events, posttraumatic stress is not new to the human experience. The PTSD diagnosis evolved out of attempts to describe soldiers' experiences in combat. In the Civil War soldiers were said to suffer from “soldier's heart” (Brown, N., 2008). In World War I, doctors called it “combat fatigue,” and in World War II, “gross stress reaction” (Brown, N., 2008). During the Vietnam Era it was called “post-Vietnam syndrome” (Brown, N., 2008). “Battle fatigue” and “shell shock” are other ways PTSD has historically been described (Brown, N., 2008). It was following the Vietnam War that the

military began to consider this syndrome as a brain injury rather than an indication that a soldier was inclined toward cowardice (Rosenberg, 2012).

PTSD is a complex syndrome caused by exposure to traumatic events—experiencing or witnessing something horrible and frightening. Hallmark diagnostic symptoms include intrusive recollections, avoidant/numbing symptoms, and hyperarousal (American Psychiatric Association [APA], 2000). PTSD diagnosis is associated with impairment in social functioning, sleep, anxiety, and anger, and is increasingly linked with suicidal ideation (Brooks et al., 2012). Acute PTSD is categorized as having symptoms for one to three months; prolonged symptoms lasting more than three months is categorized as Chronic PTSD (APA, 2000). The diagnostic manual used by mental health providers, the DSM-IV, also includes acute stress disorder as a potential category within 4 weeks after a traumatic event. The important characteristic of PTSD is not that an individual experienced something traumatic, “the fundamental problem is the mental persistence of the trauma in the present” (Allen, 2001, p. 104). Secondly, the core of PTSD involves the individual moving between intrusive re-experiencing thoughts and avoidance (Allen, 2001).

Posttraumatic Stress Disorder is a unique medical condition and anxiety disorder; experts theorize that the origin of the condition can be specifically traced to exposure to traumatic stressors or events (Peterson et al., 2011). The basic model for PTSD can be understood as “the development of conditioned responses after a potentially traumatic event” (Peterson et al., 2011, p. 166). It is “an emotional illness that can develop as a result of severe emotional stress or perceived life-threatening events” (Brown, N., 2008, p. 344). Using the example of military service members, unconditioned responses to stimulus are generated while in combat theater—physical responses of fight or flight, emotional responses like fear or disgust, cognitive responses



like helplessness or guilt. After prolonged exposure to the stimulus, the traumatic events that the veteran experienced may have caused these unconditioned responses to become conditioned.

Edna B. Foa, the highly influential anxiety disorder expert, conceptualizes anxiety disorders by arguing that fear is acquired from classical conditioning and the subsequent avoidance of the fear-inducing stimulus then maintains the anxiety (Foa, 2011). Therefore, the avoidance behavior inhibits the individual from the “extinction learning” that allows the individual to see that the stimulus no longer causes harm (Foa, 2011, p. 1043). Early theorists observed that during a traumatic event people experience “‘vehement emotions’ that interfere with the integration of the overwhelming physical experience” of the trauma (van der Kolk, 2003, p.174). This serves as an adaptive defense when faced with traumatic circumstances but serves no adaptive function as time goes on. In the example of combat veterans, when the veteran has returned home, it can be difficult to unlearn the conditioned responses to stimuli that saved their life in theater but are no longer necessary back home (Peterson et al., 2011). As early theorists noticed in psychiatric hospitals, “when patients fail to integrate the traumatic experience into the totality of their personal awareness, they seem to develop similar problems assimilating new experiences, as well” (van der Kolk, 2003, p.174). Therefore, the individual’s efforts to keep the dissociated traumatic memories at bay ends up consuming a lot of energy and hinders the individual from moving beyond the trauma (van der Kolk, 2003).

Exact prevalence of PTSD among veteran populations is difficult to determine. PTSD incidence data is gathered in part from a Post-deployment Health Assessment that the Department of Defense mandates which includes a PTSD screen. Researchers have studied the survey results and found that symptoms of PTSD often surface weeks or months after service members return home, indicating that PTSD rates may be underestimated (Shiner, Drake,

Bradley, Desai, & Schnurr, 2012). Further, studies indicate that soldiers may underreport current symptoms out of fear that reunion with their family will be delayed (Shiner et al., 2012).

The population of military service members vulnerable to PTSD has increased due to the circumstances of the conflicts in Iraq and Afghanistan. Experts have agreed that the conflicts in Iraq and Afghanistan “may create even more suffering for those who fought them” compared to other military conflicts (Rosenberg, 2012, para. 5). The nature of the combat environment in Iraq and Afghanistan has been described as vastly different from other wars like WWII and the Vietnam War. There is not a “front line” in Iraq as there was in WWII or Vietnam (Stanley et al., 2011). Combat soldiers on the ground in Afghanistan and Iraq encounter a setting in which they are potentially always on guard for roadside bombs and insurgent fire. The use of improvised explosive devices, I.E.D.’s, in the combat theater in these conflicts has contributed to the changing environment for combat service members (Rosenberg, 2012). Soldiers are likely to be in a constant state of hypervigilance. These factors may contribute to the rise of PTSD incidence in the OND/OEF/OIF veteran population (Stanley et al., 2011; Institute of Medicine, 2012). Researchers agree that there is a positive correlation between PTSD prevalence and combat exposure (Peterson et al., 2011; Back, Killeen, Foa, Santa Ana, Gross, & Brady, 2012). The 2012 Institute of Medicine study previously mentioned supports this stance as well. Additionally, military service members are being required to deploy and serve multiple combat tours in the long-term conflicts in Iraq and Afghanistan. The demands of multiple deployments have resulted in a broad range of psychological and physical health challenges for military service members related to prolonged exposure to stressful environments. This changes the face of what it means to be a veteran suffering from trauma. Returning home often doesn’t offer the rest it used to because the threat of redeployment looms.

The VA offers veterans disability benefits related to medical conditions developed during military service. Not surprisingly, due to the prevalence of the PTSD diagnosis, the literature indicates that the rates of veterans seeking disability compensation for PTSD from VA hospitals has increased at an alarming rate (Sayer et al., 2011). As a result of the growing number of cases of PTSD, VA health care systems have become aware of the need to reach a growing number of potential clients in need of treatment for PTSD (Brooks et al., 2012). As a result of the impending high need, researchers have begun to look into what influences a patient with PTSD to seek treatment. Brooks et al. (2012), discussed that while younger people in general are typically more likely to seek care for mental health problems than older populations, this is not true for young veteran populations from the OND/OEF/OIF conflicts suffering from PTSD. While researchers cannot specifically determine why treatment seeking behavior differs, they propose that the younger OND/OEF/OIF veterans may be more likely to believe they don't need care, more likely to seek non-VA healthcare, and may be more busy and engaged in the work and family obligations that go along with being younger (Brooks et al., 2012). The enduring stigmas that exist in the military against seeking mental health treatment inevitably contribute to veterans' treatment seeking behavior. The large numbers of returning combat service members who have been exposed to traumatic circumstances combined with the hesitance of OND/OEF/OIF veterans to seek treatment for PTSD, or underreport, leaves the VA seeking new ways to get patients connected to services. VA systems are fighting the old enduring stigmas by integrating mental health screenings for PTSD, depression, and substance abuse into primary care (Rosenberg, 2012).

## **Effective Treatment for PTSD**

Due to the high incidence of PTSD in returning veterans from OEF/OIF/OND conflicts and additionally among older veterans from combat in the Vietnam War, and due to the volume of returning veterans in general, the Department of Defense and Veterans Health Administration commissioned an outside group, the National Academy of Sciences' Institute of Medicine (IOM) to complete a rigorous assessment in 2007 of the available scientific data on effective psychotherapeutic treatment modalities for PTSD (Peterson et al., 2011). This group in conjunction with the VA recommended empirically backed pharmacologic and psychotherapeutic treatments for PTSD (Kearney, McDermott, Malte, Martinez, & Simpson, 2012). Selective serotonin-reuptake inhibitors (SSRIs) and prazosin were included as pharmacologic options for PTSD treatment by the 2007 IOM study (Peterson et al., 2011; Kearney et al., 2012). They found that there was sufficient evidence to cite the exposure-based therapies, Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), and eye movement desensitization reprocessing (EMDR), as scientifically viable and effective modalities in terms of psychotherapeutic approaches for PTSD treatment (Peterson et al., 2011; Kearney et al., 2012). The study concluded that other interventions lacked enough evidence to endorse.

Theory that undergirds exposure therapy is based on the idea that erroneous perceptions of safe situations or stimuli can be reworked internally so a more realistic interpretation of stimuli occurs (Foa, 2011).

Influenced by modern learning theories that conceptualize extinction as creating new associations rather than modifying old associations...exposure therapy does not alter the existing pathological structure, but rather forms competing structures that do not include

pathological associations among stimulus, response, and meaning representations (Foa, 2011, p. 1044).

Patients learn new narratives about their trauma by deliberate confrontation of the troubling content.

Prolonged Exposure (PE) therapy consists of 8-15 sessions between a client and a therapist lasting from 60-90 minutes (Foa, 2011). The sessions are guided by four main components: psychoeducation, breathing retraining, imaginal exposure, and in vivo exposure (Peterson, Luethcke, Borah, E., Borah, A., & Young-McCaughan, 2011; Foa, 2011). PTSD patients chronically avoid processing their trauma and use avoidance when frightening memories repeatedly arise. PE is informed by the psychopathology of PTSD wherein it assists patients in directly facing and methodically processing their index trauma (Foa, 2011; Peterson et al., 2011). Therefore, PE therapy provides an exit from the destructive cycle of PTSD.

Cognitive Processing Therapy (CPT) is another empirically backed treatment intervention for PTSD (Peterson et al., 2011). There are 12 sessions between the patient and the therapist trained in CPT that involve psychoeducation about PTSD, cognitive restructuring, and exposure in retelling their trauma narrative (Peterson et al., 2011).

While these exposure based therapies have been deemed effective for trauma-related issues and identified as evidence based in their efficacy, there are some researchers who argue their limitations as well (Kearney et al., 2012). This group of researchers cite that behavioral interventions “often fail to address the entire realm of psychopathology” of PTSD (Kearney et al., 2012, p. 102). As proponents of mindfulness point out, PE and CPT require highly trained clinicians to perform individual therapy with clients in order for treatment to be effective. These modalities are noted to have a “high dropout rate” of 38% (Kearney et al., 2012, p. 102).

Therefore, their benefit is limited due to the current circumstances that call for treatments to reach the influx of patients with PTSD.

It is notable that no other treatment modalities for PTSD were identified as being backed by scientific evidence. Studies indicate that the practice of mindfulness meditation is associated with enhanced cognitive flexibility and increased ability to temper reactivity to emotional stimuli (Keng, Smoski, & Robins, 2011). It is also increasingly noted in research that mindfulness practices can act as a “powerful agent of neuroplasticity” in the brain (Badenoch, 2008, p. 175). So it is surprising, in light of the growing discourse around the influence of mindfulness, it is not recognized as a treatment suitable for the recent efforts by the VA to widely disseminate, or rollout, evidence-based treatments for PTSD (Kearney et al., 2012).

### **What is Mindfulness?**

There are multiple ways to interpret the term mindfulness. “The word *mindfulness* may be used to describe a psychological trait, a practice of cultivating mindfulness, a mode or state of awareness, or a psychological process” (Germer, Siegel, & Fulton, 2005 as cited in Keng, Smoski, & Robins, 2011, p. 1042). Many researchers have offered definitions or interpretations. The most commonly cited definition comes from Jon Kabat-Zinn’s influential book *Wherever You Go There You Are: Mindfulness Meditation in Everyday Life* and says that mindfulness is “paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally” (1994, p. 4). Other researchers that are often cited as defining mindfulness for mental health purposes are Baer (2003) and Bishop et al. (2004). Baer concentrates on the attentional aspects of mindfulness, and defines mindfulness as “the nonjudgmental observation of the ongoing stream of internal and external stimuli as they arise” (2003, p. 125). Notably, “the literature is lacking consensus on an overarching theoretical framework for mindfulness, and by extension, a

well-accepted definition” (Bishop et al., 2004). In 2004, a group of mindfulness researchers gathered with the intention to address these disparities. They hoped to generate an operational definition of mindfulness that would withstand scientific scrutiny and therefore allow mindfulness to be incorporated into diverse clinical settings and work environments more easily. The operational definition is twofold: the first component refers to self-regulating one’s focus, and the second component refers to one’s attitude of curiosity and openness towards one’s experience (Bishop et al., 2004). Others simply state that mindfulness is to see with discernment (Shapiro & Carlson, 2009). Even more simplified, mindfulness can be understood as “bare attention” (Cigolla & Brown, 2011, p. 709). There are inconsistencies in how mindfulness is discussed or contextualized in the literature. Writers variously indicate mindfulness as a “technique, a psychological process or an outcome” (Cigolla & Brown, 2011, p. 709). Despite the fact that the literature consistently calls for more empirical studies of mindfulness so as to meet the needs of the increasingly evidenced-based field of mental health, the difficulty in conceptualizing mindfulness is a barrier to generating such studies.

Many researchers note how the concept of mindfulness has roots in the ancient spiritual tradition of Buddhism (Keng, Smosky, & Robins, 2011; Davis & Hayes, 2011; Baer, 2003; Zolli, & Healy, 2012; Melbourne Academic Mindfulness Interest Group, 2006). Although this is how the origin of the concept of mindfulness is most often discussed, the phenomenological nature of mindfulness exists in most religious and spiritual traditions in addition to Western philosophical and psychological schools of thought (Shapiro & Carlson, 2009). The religious or spiritual connotation associated with mindfulness is relevant because it influences public perception of mindfulness and might impact clinicians’ interest in utilizing the intervention. The literature notes that new teachers and students of mindfulness often ask whether or not they will need to

adopt a new spiritual philosophy in order to practice mindfulness due to its Buddhist roots (Melbourne Academic Mindfulness Interest Group, 2006). Kabat-Zinn (in Baer, 2003) says that mindfulness may remain a somewhat unfamiliar concept in some of Western culture due to its origins in Buddhism. Treatment does not occur in a vacuum and clinicians and clients are influenced by public perception. Therefore, until there is more evidence demonstrating efficacy, clinicians may hesitate to utilize these modalities in clinical encounters due to lack of familiarity with an intervention rooted in Eastern spiritual traditions. The literature suggests that for the integration of mindfulness into Western culture, it is crucial to clarify that mindful and contemplative practice has roots in many religious traditions. Further, that mindfulness needs to be introduced and taught in a pragmatic, non-religious way in order for it to become accessible to more audiences and client populations in mental health fields (Melbourne Academic Mindfulness Interest Group, 2006).

### **Mindfulness in Social Work, Psychology, and Mental Health Fields**

Since the 1970s, the concept or phenomenon mindfulness has grown to become a pervasive aspect of research and practice in health care fields (McCracken, 2011; Keng, Smoski, & Robins, 2011). Theoretical and empirical evidence has been gathered and recorded in efforts to apply mindfulness to psychological health, well-being, and healing. Literature on mindfulness in mental health research journals has quickly developed and mindfulness has come to occupy a significant place in the literature on effective clinical and therapeutic interventions.

Research funding trends show that studies on mindfulness based therapies are increasingly getting support. The National Institutes of Health (NIH) funded zero studies including the subject “mindfulness based” in 1998 and only 3 in 1999. Funded grants increased from 5 to 32 from 2003 till 2005. In 2008 there were over 40 grants awarded to studies



addressing mindfulness based interventions (Shapiro & Carlson, 2009). In 2004 a comprehensive review of the literature on mindfulness was conducted that called for more evidence in order for mindfulness based treatments to be endorsed as effective (Bishop et al.). Researchers find mindfulness based treatments to improve psychological functioning and be useful as interventions for a broad range of chronic conditions and disorders (Baer, 2003; Grossman, Neimann, Schmidt, & Walach, 2004 in McCracken, 2011).

This study focuses on the integration of mindfulness into therapeutic settings, so I will review the ways mindfulness is brought into mental health treatment settings. As already noted, the concept of mindfulness can be interpreted differently, and the term can be used in various ways. Therefore, instruction on learning mindfulness varies depending upon context and theoretical background of the teaching style and who is teaching. In both clinical and nonclinical settings, mindfulness is often initially introduced with basic meditation instructions.

As the previously noted definitions of mindfulness indicate, mindfulness is about paying attention to mental and emotional states of the mind and physical states of the body with an accepting attitude. Beginning mindfulness instruction teaches the client to take a seat and cultivate focused attention to something, frequently the breath. When attention wanders away from the focus, the client is asked to notice where their attention has wandered to and gently returns focus to the breath. In mindful meditation one refrains from making judgments when attention wanders. Outside of formal practice, during the course of the day, if the client notices that their focus has rested on ruminations, thoughts, or worries, they are taught to bring their awareness “back to the here-and-now...using the breath as an anchor” (Bishop et al., 2004, p. 232). Thoughts and feelings that arise in awareness are seen as “events in the mind, without over-identifying with them and without reacting to them in an automatic, habitual pattern of

reactivity” (Bishop et al., 2004, p. 232). Thus, the practice of mindfulness creates the space to respond to stimulus rather than react to it. The space carved in the pause between perception and reflection is where the possibility of therapeutic growth occurs. This is supported: “there is burgeoning evidence from neurobiological and laboratory behavioral research that indicates the potential roles of trait mindfulness and mindfulness meditation practices in reducing reactivity to emotional stimuli and enhancing psychological well-being” (Keng, Smoski, Robins, 2011, p. 1044). It is also noted in the literature that while meditation techniques are used during the basic instruction phase of mindfulness practice sometimes, researchers and practitioners report that mindful states of awareness can be accessed via alternate modes as well (Bishop et al., 2004).

The elements of mindfulness, awareness and nonjudgmental acceptance of one’s moment-to-moment experience, serve as “antidotes against common forms of psychological distress—rumination, anxiety, worry, fear, anger” (Keng, Smoski, & Robins, 2011, p. 1042). Researchers and clinicians have noted that mindfulness may act as a tool that assists in offering insight into internal mental processes (Bishop et al., 2004). Practitioners of mindfulness “replace avoidance of anxiety with an open curiosity about it, thereby lessening its ability to interfere with one’s ability to function” (Brown, Davis, LaRocco, & Strasburger, 2010, p. 226). This is how mindfulness has been adopted in clinical psychology settings. For example, through the lens of mindfulness, the suffering caused by anxiety is tied to an aversion and unwillingness to experience it. “During stressful situations, mindfulness reduces self-absorption and distortions and enhances clarity and accuracy in the assessment of both the stressor and available resources, resulting in acceptance and effective responding” (Ying, 2008, p. 407). Mindfulness approaches are not aimed at relaxation or mood enhancement (although these may result over time)—they

are considered mental training “to reduce cognitive vulnerability to reactive modes of mind that might otherwise heighten stress and emotional distress” (Bishop et al., 2004, p. 231).

Most studies of mindfulness address the part of Buddhist meditation that attends to mental content, thoughts, current arising feelings or sensations, and the breath (Hofmann, Grossman, & Hinton, 2011). Beyond just paying attention to thoughts and present moment body sensations, a less researched aspect of mindfulness involves cultivating attention to personal experiences with interest and unconditional friendliness (Gockel, 2010). This aspect of mindfulness is also rooted in the Buddhist tradition of compassion meditation and “loving-kindness” practice (Hofmann, Grossman, & Hinton, 2011, p. 1127). In compassion and loving-kindness meditation one does not, “in reality cultivate compassion, but you can cultivate, through investigation, the qualities that incline your heart toward compassion... With mindfulness and investigation, you find in your heart the generosity and understanding that allow you to open rather than close” (Feldman, 2005 in Hofmann, Grossman, & Hinton, 2011, p. 1127). In compassion meditation one proceeds through stages wherein contemplative focus is placed on different people representing different kinds of challenges. Practice often starts with focus on kindness towards oneself and moves to a friend, a neutral person, a difficult person, and finally outward towards the entire universe (Hofmann, Grossman, & Hinton, 2011). These exercises are believed to broaden attention, increase positive and lessen negative emotions, and enhance capacity for empathy towards self and others (The Dalai Lama & Cutler, 1998 in Hofmann, Grossman, & Hinton, 2011).

There is literature on the bridging between Eastern spirituality and Western psychology (Epstein, 1995). Some have said there is now a marriage between mindfulness and psychotherapy (Cigolla & Brown, 2011). Both mindfulness practice and psychotherapy ask us to

engage with our experience similarly and therefore fit well together (Brenner, 2009). Theorists in both worlds have noted that differences exist. “Meditation is much more generic than psychotherapy: it is less about the individual details of a person’s history and more about the fundamental predicaments of being” (Epstein, 1995, p. 131). The term *mindfulness* might be relatively new in the field of social work but the concept of mindfulness is not new to the field. Freud described the therapist’s open and aware stance as an “evenly hovering attention,” and we can see similarities to Freud’s perspective when mindful presence is described as cultivating receptivity, openness, and acceptance (Brenner, 2009, p. 464). The field of social work has typically called this “reflective practice” (Shier & Graham, 2011, p. 30). Reflective practice is a tool that has always been valued by the field of social work. Maintaining self awareness and being attuned with clients has been recognized as good clinical practice. As the clinician or the client, in clinical practice we “attend to experience without judgment, bringing kindness and acceptance to the process of witnessing the mind and its contents” (Gockel, 2010). One study noted that particularly around issues of countertransference it is imperative that clinicians be able to use discernment and self awareness to maintain effective treatment relationships, both examples of healthy reflective practice (Ying, 2008). In these examples we see the link between clinical work and mindfulness practice.

Jon Kabat-Zinn’s work at the University of Massachusetts Medical School beginning in the 1980s introduced basic meditation techniques as tools for stress reduction to individuals who suffered from long-term chronic pain. His program came to be widely known as Mindfulness Based Stress Reduction (MBSR) and has become the prototype from which most current treatments that include mindfulness were developed (McCracken, 2011). The most well known mindfulness based interventions are MBSR, mindfulness-based cognitive therapy (MBCT),

dialectal behavior therapy (DBT), and acceptance and commitment therapy (ACT) (Shapiro & Carlson, 2009). Mindfulness therapies can be separated into two camps: mindfulness-based and mindfulness-informed therapies (Cigolla & Brown, 2011). Mindfulness-based therapies directly use mindfulness as a part of the therapeutic intervention. In the mindfulness-informed camp mindfulness offers a theoretical basis for the intervention. MBSR, MBCT, DBT, and ACT are all considered mindfulness-based therapies (Cigolla & Brown, 2011). Some of these modalities have been studied more than others. The four most researched mindfulness based therapeutic interventions will be outlined in the following paragraphs.

Mindfulness Based Stress Reduction (MBSR): Jon Kabat-Zinn developed this program in the early 1980s at The University of Massachusetts to treat patients who were suffering from chronic pain. It is a group modality, and occurs over the span of eight to ten weeks. Group meetings occur on a weekly basis for a couple hours. Participants are given introductory meditation instruction on how to meditate, engage in simple yoga poses, and practice an activity called the body scan (Keng, Smoski, Robins, 2011). Additionally, participants are asked to complete homework nightly over the course of the ten weeks, consisting of mindfulness meditation exercises and yoga practice, and attend an all-day meditation retreat. MBSR has been researched to the extent that it is now categorized by the American Psychological Association as a “probably efficacious treatment” (Gockel, 2010). Studies looking at MBSR have consistently found that this version of a mindfulness based intervention showed marked results in reduction of trauma symptoms (Horowitz, 2012).

Mindfulness Based Cognitive Therapy (MBCT): MBCT was developed off the MBSR model, and is also an eight to ten-week group seminar. This program aimed at treating patients suffering from depression, and it combines cognitive therapy with mindfulness. For example,

cognitive therapy focuses on examining thoughts and checking them out for validity, while MBCT focuses on noticing the relationship that one has to reoccurring thought patterns. The theory behind it says that people who have previously suffered from major depression are more vulnerable to future relapses and mild dysphoric states can reactivate depressive thinking (Baer, 2003). MBCT teaches patients to notice mild depressive thoughts with nonjudgment and to observe these thoughts as outside of the self rather than as aspects of themselves (Baer, 2003). MBCT intends to loosen the association between negative thoughts and depression, in effect breaking the patient's depression pattern or cycle (Keng, Smoski, Robins, 2011).

Dialectical Behavior Therapy (DBT): This treatment modality was developed by Linehan for populations who are self-injurious, suicidal, and potentially linked with a borderline personality disorder diagnosis. DBT integrates cognitive behavior therapy with Zen philosophy and practice to help patients modulate strong affect and intense emotions (Keng, Smoski, Robins, 2011). The basis for the treatment is the notion that we are in a dialectic world of opposing forces and that “synthesis of the forces leads to a new reality” (Baer, 2003, p. 127). In DBT the primary two opposing forces, or dialectic, are acceptance and change—clients are encouraged to accept themselves and their behaviors while working diligently to change their behaviors to build a better life (Baer, 2003). Patients are taught ways to “increase self-acceptance as an exposure strategy aiming to reduce avoidance of difficult emotion and fear responses” (Linehan, 1993, in Keng, Smoski, Robins, 2011, p. 1047). Linehan organizes the mindfulness practices into “‘what’ skills (observe, describe, participate) and... ‘how’ skills (nonjudgmentally, one-mindfully, effectively)” (Baer, 2003, p. 127). DBT can occur in individual therapy, group skills training, telephone consults, and group telephone consults with a clinician.

Acceptance and Commitment Therapy (ACT): ACT is theoretically based in behavior analysis (Baer, 2003). ACT is based on the premise that psychological suffering can be connected with attempts to control or turn away from negative or unpleasant thoughts or emotions (Keng, Smoski, Robins, 2011). ACT intends to grow patients' psychological flexibility. Psychological flexibility is learned when the patient comes into "more fuller contact with their experiences" (Keng, Smoski, Robins, 2011, p. 1048). ACT does not use meditation techniques specifically to do this. Instead of using terms like mindfulness or meditation, ACT uses the concept of the "observing self" who is separate from the client/practitioner (Baer, 2003, p. 128). An example of this is saying "I'm having the thought that I'm a bad person," rather than "I'm a bad person" (Baer, 2003, p. 128).

These modalities have been developed to assist patients and clients who are suffering. Ancient techniques rooted in Buddhism are brought into the treatment interventions. Researchers call for more empirical evidence to back the interventions, however there is evidence indicating that these therapies are helpful in mental health fields, specifically with, increased awareness of cognitive and emotional changes as they are happening, relaxation, and self-acceptance.

### **Mindfulness Based Treatment for PTSD**

Due to stigma in the military around seeking mental health help, and the increased need for effective treatments due to the higher numbers of veterans with PTSD, depression, and traumatic brain injury, and the surge in research around these modalities, mindfulness based approaches are now being regarded as worthy treatment options, especially as adjuncts to exposure protocols (Gockel, 2010; Keng, Smoski, & Robins, 2011; Melbourne Academic Mindfulness Interest Group, 2006; Baer, 2003; Davis, & Hayes, 2011; Kearney et al., 2012). While mindfulness based treatments have begun to receive more attention, there remains a gap in

empirical evidence about efficacy of mindfulness in treating trauma in veterans. But researchers and mental health professionals agree it is an intervention suitable to treat PTSD, albeit not technically deemed evidence-based (Vujanovic, Niles, Pietrefesa, Schmertz, & Potter, 2011).

Mindfulness, defined by some as “bare attention,” helps us retrain ourselves to notice our experience in a more pared down way (Cigolla & Brown, 2011, p. 709). This is where a link exists between the training in exposure therapy and mindfulness. Both modalities share the idea that by loosening up how we interact with our thoughts, beliefs, and feelings we might experience more freedom and flexibility in our lives.

A 2012 study by a group of researchers from the Seattle VA gathered a sample of veterans with PTSD for participation in a MBSR trial (Kearney et al.). The study aimed to measure quality of life and mental health before and after participation in the group treatment. A course of MBSR was provided “as an adjunct” to routine VA health care and delivered in groups of 20-30 veterans (Kearney et al., 2012, p. 102). The purpose of the study in large part was to determine the “acceptability and safety” of MBSR for veterans (Kearney et al., 2012, p. 103). Other goals of the study included assessing improvement in PTSD symptoms, depression, behavioral activation, quality of life, experiential avoidance, and mindfulness (Kearney et al., 2012). The study spanned over a 17-month period and 92 veterans were studied, 70 male and 22 female. Participants either self-referred to the study or were referred by a health care provider. Veterans were eligible for the study after watching a 45-minute video (Bill Moyers ‘Healing and the Mind’) and if they did not meet clinical exclusion criteria. “Clinical exclusion criteria for participation in MBSR are as follows: a history of a psychotic disorder; mania, or poorly controlled bipolar disorder; borderline or antisocial personality disorder; current suicidal or homicidal ideation with intent; and active substance use disorder” (Kearney et al., 2012, p. 104).



The MBSR course was eight weeks long and follow-up assessments were done immediately following the course, and then two additional follow-ups were obtained, two months and six months following the end of the course. The study utilized the MBSR model and curriculum in the way that Jon Kabat-Zinn established it for use in clinical settings. Participants met weekly for two and a half hours at the hospital and practiced mindfulness meditation and yoga getting instruction from certified instructors. Between the sixth and seventh week, participants convened for a seven-hour intensive daylong meditation retreat. Teachings centered on intention, attention, and attitude with a quality of openness, kindness, curiosity, and nonjudging of present-moment experience. Participants also practiced the “body scan,” a 45-minute exercise that fosters body awareness (Kearney et al., 2012). Veterans were asked to notice the feeling of their breath, and to redirect their attention when it wandered back to the task of the body scan. Sitting meditation practice encouraged participants to solely focus on their breath, to note thoughts as they arose, and to include sound.

The researchers found that veterans in this study “experienced significant improvements in measures of mental health, including measures of PTSD, depression, experiential avoidance, and behavioral activation as well as mental and physical health-related quality of life” (Kearney et al., 2012, p. 111). The researchers concluded that this study supports the literature that considers MBSR a “form of exposure therapy” (Kearney et al., 2012, p. 112). As mindfulness asks participants to conjure an open and curious stance to experience, difficult or otherwise, the findings suggest that this type of practice “decreases emotional numbing and hypervigilance” (Kearney et al., 2012, p. 112). Furthermore, “there is evidence that avoidance of intrusive thoughts through thought suppression has the paradoxical effect of increasing re-experiencing for persons with PTSD” (Kearney et al., 2012, p. 112). MBSR directs participants to greet difficult

memories or thoughts that arise as “passing mental events, not to be avoided or suppressed” (Kearney et al., 2012, p. 212). So, the study researchers make “speculative” claims that MBSR could instigate PTSD symptom reduction (Kearney et al., 2012, p. 212). The researchers from this study encourage clinicians to utilize MBSR in the available format for veterans. They also stated that more investigation is warranted to determine if MBSR can or should be tweaked specifically for clinical work with veterans.

Baer (2003) conducted another influential study in which a comprehensive review of mindfulness training as a clinical intervention was done. Similarly defined in the above study on MBSR, “mindfulness meditation involves observation of constantly changing internal and external stimuli as they arise” (Baer, 2003, p. 126). This review summarizes mindfulness approaches and utility of empirical studies of mindfulness based interventions. The summary includes analysis of the literature on MBSR, Mindfulness-Based Cognitive Therapy, Dialectical Behavior Therapy, Acceptance and Commitment Therapy, and Relapse Prevention. This review confirms that MBSR has been researched more than other modalities in its category. Baer cites a few studies that show that after an MBSR protocol patients showed improved symptoms for chronic pain, generalized anxiety and panic disorders, and binge eating among a sample of women (2003, p. 134). Another MBSR study showed that due to participation in the mindfulness training symptoms of fibromyalgia improved. When patients with psoriasis listened to meditation audiotapes during light therapy sessions their skin cleared faster (Baer, 2003). MBSR has helped cancer populations with “mood disturbances and stress levels” (Baer, 2003, p. 135). MBSR treatment regimen also showed improvement for groups of patients in long-term psychodynamic therapy with anxiety, obsessive neuroses, and narcissistic and borderline personality disorder diagnoses (Baer, 2003). A study showed that patients with a history of more than three major

depressive episodes had a lower relapse rate after a course of MBCT than patients who did not participate in MBCT (Baer, 2003).

Baer (2003) also looked at thirteen studies that assessed rates of program completion. Baer reports that the lowest completion rates were documented (60%) in a study that took place in an urban health clinic and the highest completion rate of a mindfulness based programs was 97% and the study sample was composed of medical students (Baer, 2003, p. 137).

Studies assessing patient responses and reactions to treatment were also looked at. 86% of participants from a 1987 study said they “‘got something of lasting value’ from the program. Most commonly reported changes included a ‘new outlook on life’ and improved ability to control, understand, and cope with pain and stress” (Kabat-Zinn, Lipworth, Burney, & Sellers in Baer, 2003, p. 138). Further, when research participants were followed up with, they attributed 50-100% of any improvement in symptoms to MBSR (Baer, 2003, p. 137). It is stated that interpretations should be made cautiously because those interviewed were patients who completed the protocol and those who dropped out might have had less positive comments (Baer, 2003).

Baer (2003) illustrates methodological flaws amidst the literature review mostly related to lack of control groups in the studies. Small sample sizes in studies are indicated as a limitation to mindfulness research (Baer, 2003). Also, due to the lack of consensus on what defines mindfulness based therapies, some treatment interventions weren’t included in Baer’s review. Because MBSR and MBCT intend to offer “stress reduction” in a broad way, their outcomes are difficult to study because populations who engage in the treatments are often experiencing a variety of symptoms (Baer, 2003, p. 140). The review calls for the need for randomized clinical trials of mindfulness therapies.

Conclusions to Baer's review say that MBSR can be classified as "probably efficacious" and that MBCT is approaching becoming "probably efficacious" (2003, p. 140). The empirical literature that exists strongly supports the efficacy of mindfulness in easing suffering from physical and psychological symptoms related to PTSD and may be a way to reach greater numbers of veterans (Baer, 2003).

This study lays groundwork to support linking mindfulness based treatments with exposure based therapies. Once clinicians and health care delivery systems begin to see mindfulness based interventions as a form of exposure therapy, and once it is studied more, more veterans can get treated via large systems like VAs.

The VA and DoD have made concerted efforts to recognize and inquire into the effects of stressors of military deployment as the incidence of PTSD grows as a public health concern. (IOM, 2012). Comparatively less is known about effective methods for buffering against stress related dysfunction and disease, but the different combat experiences and the high incidence of PTSD have caused the U.S. military to invest in training programs that bolster psychological resilience (Stanley et al., 2011). Cultivating and researching new treatments like mindfulness based interventions for the new veteran climate is a priority (IOM, 2012). The military has demonstrated their motivation to this end with their Mindfulness-based Mind Fitness Training (MMFT) program that is used pre and post deployment. This program is modeled on MBSR, but with a more "top down" approach that fits with the hierarchical structure of military culture. This program hopes to address internal issues including how veterans are suffering from the stress of recent deployments and redeployments, compromised effectiveness of the fighting force due to post deployment trauma and multiple deployments, and the high cost of caring for vets with stress related ailments (Stanley et al., 2011). MMFT is a new modality and it is still being

assessed for efficacy in reducing soldiers' stress-related psychological and physical pain under "the morally ambiguous and emotionally challenging counterinsurgency environment" (Stanley et al., 2011, p. 575).

### **Clinicians' Role in Mindfulness Based Therapies**

Many leaders in the application of mindfulness to health care like Jon Kabat-Zinn, Marsha Linehan, and Alan Marlatt began by having a formal mindfulness practice themselves. Therapeutic mindfulness-based interventions like MBSR, MBCT, DBT, and ACT often incorporate formal meditation instruction and practice as the tool to integrate mindfulness into therapeutic interventions. This personal interest and experience pushed them to try to adapt mindfulness practice so that it benefited their clinical work with patients (Wilson & DuFrene, 2008). The literature indicates mixed views on whether or not it is necessary for clinicians imparting instruction in these modalities to be practitioners of mindfulness in their personal lives like Linehan, Marlatt, and Kabat-Zinn (Melbourne Academic Mindfulness Interest Group, 2006).

Research indicates that when therapists practice mindfulness, their ability to attend widely to stimulus is improved, rather than remaining narrowly focused in session with clients (Shapiro & Carlson, 2009). Should clinicians engage in these practices, research says the longer they have practiced, the more they may benefit from the effects; in particular, therapists will manage distractions better and be more present with their clients (Davis & Hayes, 2011).

Another study showed that mental health workers' participation in an 8-week MBSR course in the wake of a disaster decreased PTSD and anxiety symptoms (Davis & Hayes, 2011). This suggests that these types of practices may serve as a buffer for mental health workers and make it relevant to gain a more in depth understanding of what clinicians' perspectives are on the ground when trying to implement these practices.

Research indicates that people who practice mindfulness report less emotional stress in relationship, respond more constructively to conflict, report more empathy and less anger and anxiety in relationship (Davis & Hayes, 2011). Researchers have said, “given that the therapeutic relationship is emotionally intimate, potentially conflictual, and inherently interpersonal,” the client would benefit from the therapist’s engagement in a mindfulness practice (Davis & Hayes, 2011, p. 201).

A 2011 qualitative study documented clinicians’ understanding of mindfulness, their personal experiences with mindfulness and how it was integrated into their therapeutic practice (Cigolla & Brown, 2011). The major theme that surfaced during the interviews was that the clinicians saw mindfulness as a “way of being” (Cigolla & Brown, 2011, p. 712). They cited that mindfulness, and Buddhist philosophy, was incorporated into their personal belief system. The study participants clearly emphasized the overlap of the personal with the professional. Participants highlighted the importance of the experiential nature of mindfulness, and “the necessity to practice it to understand it” (Cigolla & Brown, 2011, p. 713). They concluded that their identity as a mindfulness practitioner was integrated with their skill set as a therapist—that since the therapist is an integral “tool” in any therapy due to the importance of the relationship and therapeutic alliance between client and therapist, the participants could not separate their identities as mindfulness practitioners with being therapists (Cigolla & Brown, 2011). Mindfulness was embedded in their sense of self and personal worldview (Cigolla & Brown, 2011).

A review of the literature reveals that this area is in need of more discussion. While it seems there is support of clinicians engaging in mindfulness practice due to potential benefits for their work with clients, the literature is inconclusive as to whether or not clinicians need to be

familiar with mindfulness in order for mindfulness treatment to be effective (Melbourne Academic Mindfulness Interest Group, 2006). Nor does it address what the barriers to adopting mindfulness interventions may be for clinicians.

### **Current Study**

Therapists hold beliefs and attitudes towards therapeutic modalities that may or may not function as barriers to treatment (Peterson et al., 2011). These beliefs may influence their perceptions and cause them to doubt applicability of treatments (Peterson et al., 2011). Learning more about what guides therapists' decision-making processes when working with veterans suffering with PTSD will contribute to a more complex understanding of how mindfulness is or is not used in VA clinical settings. There is a gap in the literature addressing the specifics of what it looks like for clinicians who are incorporating mindfulness into therapy offices. "Despite abundant theoretical work on ways to conceptually merge Buddhist and Western psychology to psychotherapy, there is a lack of literature on what it looks like in session when a therapist employs Buddhist-oriented approaches to specific clinical issues and diagnoses" (Davis & Hayes, 2011, p. 205). This study hopes to contribute towards this demand.

This study contributes to the field of social work because it elicits clinicians' experiences in a detailed way and places them in a field of growing research about the clinical use of mindfulness with veterans. Social workers are on the front lines in clinics and medical centers serving populations with PTSD and trauma issues and therefore have a unique perspective that is integral to treatment delivery. As the literature cites the clinical benefit of clinicians' mindfulness practice (Davis & Hayes, 2011), there is cause to inquire into social workers' personal experiences with incorporating mindfulness practice into their work at the VA. Clinicians, more

than administrators or researchers, are working directly with veterans and know intimately what works, what doesn't, and why.

In addition to the clinical benefits of mindfulness for patients, researchers have made a call to bolster social workers' sustainability and resilience due to the changing landscape of the social welfare system and the field of social work (Ying, 2008; Shier & Graham, 2011). Studies note that mindfulness can have a positive impact on overstressed caregivers. A study that looked at the extent that mindfulness impacts clinicians' careers indicated that mindfulness has an overall positive impact on clinicians' satisfaction with their work. In light of the expectation that the need for clinicians to work with veterans with PTSD, this makes this area of study of mindfulness a very relevant subject of research for social work professionals who are high risk for burnout (Shier & Graham, 2011). Mindfulness may be a tool to help social workers cope with future systemic challenges in the profession (Shier & Graham, 2011).

This study will solicit clinicians' beliefs, attitudes, and perspectives on applying mindfulness based therapeutic interventions and approaches to practice when working with veterans. This will be a qualitative study using open ended questions to gather narrative data. As current research continues to indicate that mindfulness based treatments are effective, we must understand what barriers may exist for veterans gaining access to mindfulness based treatments. Whether a clinician's prior experience with mindfulness has any influence on their perspective on bringing mindfulness based interventions into clinical settings will also be investigated.

The next section reviews the methods of this study. Findings are then offered from the fourteen interviews conducted with clinicians who work with military service members and apply mindfulness based therapies in the clinical setting. Narrative data collected from interviews highlights any barriers or opportunities for further use of mindfulness based



interventions with this client population. Finally, there is a discussion section that addresses study limitations and further questions.

## **CHAPTER III**

### **Methodology**

The purpose of this study is to understand and assess clinician perspectives on using mindfulness based therapeutic interventions in treating military service members seeking mental health treatment for trauma-related issues or PTSD diagnoses. The following research questions were explored: 1) What are clinicians' perspectives on using mindfulness with veterans, 2) How do clinicians introduce mindfulness based therapies and interventions to veteran populations, 3) What kind of additional opportunities for the application or integration of mindfulness exist in VA therapeutic environments, and 4) What, if any, barriers exist for veterans to gain access to mindfulness therapies when seeking treatment for PTSD? This study gathered data from clinicians who practice therapy or clinical case management with U.S. veteran client populations who suffer from PTSD or trauma. I contacted clinicians who work at the VA hospital where I did my field placement in Albuquerque, NM and asked them to volunteer to be participants in my study (see Appendix B).

The purpose of this study is to gain a deeper understanding of how mindfulness gets used and clinicians' feelings and thought processes about how veterans respond to mindfulness. Research on mindfulness based therapies is an area that is continuing to grow and researchers continue to seek to understand where mindfulness therapies fit in the field of mental and behavioral health. As stated in the literature review, the clinician's role in delivering mindfulness

based treatments is significant, and it will serve the field to learn more about how clinicians navigate using mindfulness in therapy with veterans.

The study methodology was qualitative, and the data was gathered during an interview arranged between myself and participant clinicians. I used an interview guide (Appendix E) to ask open-ended questions to collect the narrative data from clinicians. A qualitative approach is called for when trying to comprehend and analyze phenomena like feelings, thought processes, and emotions (Corbin & Strauss, 2008). This approach offers the opportunity for a deeper and more complete assessment of clinician perspectives on how mindfulness is getting integrated with veteran populations. How clinicians conceptualize their work with mindfulness and veterans professionally, personally, and interpersonally is relevant to see how practice is informed. The qualitative method allows for the nuances and complexities of what it means for clinicians to implement a therapeutic approach that is somewhat under-researched. A quantitative approach that utilized a survey would generate a data set that was more fixed and specific than what this topic calls for. A qualitative exploration of clinicians' experiences using these types of interventions with veterans might also help generate avenues for mindfulness in current and future research.

### **Recruitment and Sample**

This study called for the use of a non-probability, purposive sampling technique due to the time constraints of the study, access to clinicians who worked with military service members, and the VA facility's requirements for contacting clinicians. Special permission would have been required in order to contact clinicians outside of the New Mexico VA Health Care System, and the administrators who had agreed to circulate my recruitment email did not have ability to circulate my email outside of the New Mexico VA Health Care System where I was working.

I applied a snowball sampling approach to locate and recruit participants for this study. Inclusion criteria for the study were clinicians (practicing clinical social workers, counselors, psychologists, or psychiatrists with a master's or doctoral degree) working in the New Mexico VA Health Care System who primarily saw military veterans in mental health treatment and were somewhat familiar with mindfulness based approaches to therapy. Additional eligibility criteria established that participants' client base consisted primarily of veterans with PTSD or trauma-related issues and that participants could schedule an hour-long interview with me. My contact on the VA social work intern research committee, Art Camacho, LISW, asked the social work administrator for the Behavioral Health Care Line (BHCL) at the New Mexico VA Health Care System, Richard Meth, LISW, to help recruit participants. Mr. Camacho forwarded Mr. Meth my recruitment email (Appendix B) and asked for his help in locating participants for the study. The BHCL administrator agreed to circulate my recruitment email to all VA employees in BHCL and did so in early March 2013. The email reached BHCL employees throughout the main VA campus in Albuquerque and extended to clinicians at the thirteen satellite community-based outpatient clinics throughout the state of New Mexico that fall under the purview of the New Mexico VA Health Care System.

Subsequent to receiving approval from the Human Subjects Review (Appendix A) at Smith College, recruitment of participants commenced with the head social work administrator forwarding the recruitment email and screening questions to BHCL via email. To additionally speed recruitment, my contact on the VA social work intern research committee provided me with four names of clinicians who had expressed interest in being interviewed and I contacted them directly with my recruitment email and screening questions to arrange a time for an interview. After receiving the BHCL-wide email (Appendix B), six clinicians responded

independently stating they answered “yes” to all eligibility criteria and interviews were scheduled. All clinicians who responded were eligible for the study. In order to achieve my target sample size of fourteen, I began asking clinicians during interviews if they could refer me to other potential participants. Upon receiving names from participants, I sent my recruitment email and screening questions (Appendix D) addressed directly to the suggested potential participants. Four additional clinicians agreed to be interviewed and interview times were scheduled. I was aware of clinicians’ work obligations and respectful of the challenges that coordinating scheduling presents and prioritized clinicians’ needs. Participants were asked to reserve up to an hour for the length of the interview at a location most convenient to them. As stated above, BHCL employees received my recruitment email the first week of March 2013 and the recruitment process lasted for three weeks till the end of March 2013, and interviews continued to be held till the end of the first week of April 2013.

The sample attained included eight social workers and six psychologists. The sample was made up of eleven women and three men. All clinicians included in the sample were employed at the Albuquerque VA. I aimed for my sample to consist of clinicians from diverse backgrounds. I made every effort to interview a varied group of clinicians in regard to individual identities of professional training, race, ethnicity, and gender. Should I have had more than fourteen respondents during recruitment, my plan was to ask respondents about their clinical training background and ethnic, racial, and cultural background so as to interview those who might bring a different perspective to the sample. Due to time constraints and the small number of clinicians available to be interviewed, I ended up needing to use the willing and available participants for the study. Therefore, attaining a diverse sample was not feasible.

I arranged the locations of the interviews at the convenience of the participant. Most participants reported that they would prefer to meet me at their office. If they shared an office with others and we wouldn't have privacy, I offered to hold the interview in my office or another vacant and available office. Upon scheduling a time for an interview I emailed participants the informed consent form (Appendix C) and asked them to print two copies and sign both, keeping one for their records and bringing one to the interview that I could keep for my records. At the time of the interview I greeted the participant in person and ensured they had no outstanding questions related to the study. Next, I informed them I was ready to begin the interview and reminded them I would be using an audio recording device and to refrain from using names or identifiers during the interview. I turned on the audio recording device and began the interview. I typically began the interview by asking the clinician about their clinical training background and how they became familiar with mindfulness based therapies. The interview between myself and the participating clinician went on to consist of demographic questions, inquiries into their experiences with mindfulness based approaches, perceptions of the usefulness of mindfulness based approaches with service members, and perceptions of barriers and/or opportunities related to using mindfulness based approaches with service members. I sought demographic data of participants to include professional background, age, gender, race/ethnic identification, religious/spiritual practices, and geographic location/VA service area. Please refer to Appendix E.

### **Ethics and Safeguards**

Precautions were taken to ensure that ethics and safeguards were protected per federal guidelines and per social work Code of Ethics standards.

The interviews were conducted in person in private offices at the Albuquerque VA medical center so as to protect confidentiality of participants. Most interviews were held in the participants' offices, however if a participant happened to share their office with a number of other people, I offered to host the interview in my office or another vacant office. Interviews were conducted in private offices. I planned on conducting phone interviews if I needed to use participants from VA community-based outpatient clinics and didn't have enough participants from the main hospital. However, this was not necessary as I was able to recruit fourteen participants from the main hospital to interview in person. Interviews were audio recorded with the consent of the participant.

This was a low-risk study due to the non-intrusive nature of the subject matter. This study asked clinicians about their opinions, perspectives, and clinical experiences working with veterans. However, any interview can bring up unpleasant feelings, discomfort, etc. Given the nature of the professionals' backgrounds I trusted that they could locate resources for support if needed. Still, careful attention was paid to reduce the risks of harm done to the participants. Informed consent forms (Appendix C), which addressed risks and benefits of participation in the study, were discussed prior to each interview. Benefits to participation discussed included the potential opportunity to reflect on one's career, develop an interest in mindfulness based treatments, and contribute to a more in depth understanding of any barriers that exist for veterans suffering from PTSD or other post-deployment conditions. I informed participants that there was no financial compensation for their contributions. I supplied them with a list of resources and a bibliography on mindfulness based approaches (see Appendix F) in the event they have questions or want to learn more. Since the veterans being discussed during some aspects of the interview had not given their consent for their providers to discuss their treatment, it was crucial

that clinicians maintained their clients' anonymity during interviews. I informed participants that participation was voluntary and they were free to withdraw from the study at any time. One clinician who a participant had referred me to ended up declining participation in the study. After the process of recruitment was complete and clinicians had agreed to be interviewed, no one withdrew from the study.

Audio recordings of interviews were transcribed into a written data file and immediately assigned a number so as to ensure privacy. The key to the participant's assigned data numbers was locked with the informed consent forms and will be destroyed upon completion of the thesis. Interviews are being kept in a locked drawer in a locked office. I transferred the files to my computer where they were password protected during data analysis. Only advisors to my study had access to coded data. Upon completion of the thesis project all data files will be removed from my computer. The coded data, the transcripts, and the recorded interviews will be held for a period of at least three years, per federal regulations. After this time, when I no longer need the data, I will destroy it.

The Smith College School for Social Work Human Subjects Review Committee approved this study (see Appendix A).

### **Data Collection**

I obtained the data for the study via semi-structured interviews using an interview guide (Appendix E). In the interview I asked participants about what kind of veteran population they work with and about their basic understanding of mindfulness based interventions. I asked clinicians to reflect on their experiences using mindfulness based modalities in treatment with veterans suffering from PTSD or trauma related issues. I asked about their perspectives on the efficacy and usefulness of mindfulness in treatment, any opportunities for further use of



mindfulness with veterans or in in the VA in general, and any barriers they noticed during their working life at the VA for utilizing mindfulness based practices with veterans.

I used my office at the VA to conduct interviews. Additionally, and for convenience to the participant, I offered to meet for interviews in clinicians' offices. Although I was able to recruit enough participants from the Albuquerque VA, I was prepared to conduct telephone interviews for clinicians who did not live within 50 miles of the Albuquerque VA. A total of fourteen interviews were conducted. Interviews ranged from 25 minutes to 55 minutes in length of time. The vast majority of interviews were conducted in the participants' offices, and one interview was conducted in my office and one in my supervisor's unoccupied office.

I conducted all interviews with participants. Interviews were recorded using a digital recording device. While interviews were being recorded, I took notes additionally. The notes I took during the interview concentrated on any countertransference I observed, any key words that the participant emphasized, and any other remarkable moments of nonverbal communication. I noted what the interaction was like getting in touch with the participant and any hiccups in the process, and process oriented information in general. Following the interview, I transcribed the narrative data from the recording within two weeks of when the interview occurred. I removed or disguised all identifying information from the recording to ensure confidentiality.

The open-ended question guide served the purpose of gathering a wide-ranging mix of information from clinicians. I observed in conducting the interviews that participants found some topics to be more thought-provoking. Therefore, I paid attention to participants' tendency towards some themes and tweaked the interview guide so as to solicit clinicians' perspectives on the themes that other participants found to be most salient. For example, the study aimed to

gather data around what kinds of training participants had received for professional use of mindfulness. Participants were asked about the trainings they had attended. After responding they often elaborated on the backstory about why they were chosen to attend a training, or why their department at the VA had not supported their interest in seeking training if that was the case. This discussion was stimulating and frequently relayed a lot of information about the way mindfulness was utilized and perceived in the VA workplace. Sometimes during this aspect of the interview participants would remark on their understanding of barriers and opportunities. In other words, I might learn valuable information when I wasn't expecting it. Therefore, attempts were made during the following interviews to incorporate questions aimed to elicit information that was related to themes from prior interviews. So, the narrative material from interviews and the original question guide steered the collection of data and subsequently shaped data analysis.

### **Data Analysis**

Interviews were transcribed completely to maintain accuracy. The narrative data was manually coded and analyzed for themes. The interview guide asked open-ended questions which allowed clinician responses to guide analysis of data. The data was organized by question. Concepts from grounded theory were applied when identifying patterns and themes as they emerged in the transcriptions of the data (Corbin & Strauss, 2008). These themes shaped the findings section. The findings were separated into sections relating to the most salient data gathered from the narratives. Themes included a discussion of the participants' experiences with mindfulness, whether or not clinicians had begun incorporating mindfulness into their work with veterans due to prior personal interest in mindfulness or due to prior professional trainings. Then participant responses on the kind of impact mindfulness has had in their clinical practice was highlighted. Then the findings focused on participants' ideas around navigating the

implementation of mindfulness with veteran client populations. As one of the goals of the study was to identify barriers for using mindfulness and further opportunities, these themes were outlined. Institutional barriers and smaller idiosyncratic barriers specific to the nature of the clinical practice and mindfulness practice were noted. Finally, attention was paid to summary statements participants made as to their observations of benefits of mindfulness for veterans. I used open coding to identify similarities and differences of responses (Rubin & Babbie, 2010). I also used memoing to note theoretical ideas that surfaced in interviews (Rubin & Babbie, 2010).

I read transcripts multiple times so as to see repeating themes and relevant content. Narrative data was pasted from the original transcripts into files organized around themes and ideas that arose in participant responses. Any salient quotes from participants in the transcripts were set aside to be included in the section on findings. I generated quantifiable lists to analyze some of the data like clinicians' responses to yes or no questions. For example, in columns I listed participants' responses to the interview questions that asked about whether participants tended to adhere to a manualized protocol that incorporated mindfulness when working clinically with veterans or tended to use mindfulness techniques more spontaneously. I also noted any responses that were outside of the norm and included those in the collection of findings to account for outliers in the study.

### **Limitations**

This study drew data from a small sample and had a number of limitations. The study gathered the impressions and perspectives of a small group of clinicians from one VA health care system. The sample was gathered from a pool of clinicians from within the New Mexico VA Health Care System. During recruitment the email notifying clinicians of the study was sent to all clinicians in the Behavioral Health Care Line within the New Mexico VA and did not exclude

any clinicians based on race, ethnicity, gender, sexuality, ability, religion, or age. In this way I attempted to protect the study from gathering a sample that was discriminatory. However, in the end due to time constraints of the study, I was forced to include those in the study who responded to the email inquiry for participants. The participants who responded during the recruitment phase did not result in a diverse sample in terms of race and ethnicity, and this is a major limitation of the study. Another significant limitations of the study is its lack of representativeness of all VA clinicians because how the constraints of time, funding, and accessibility impacted recruitment.

Due to my personal connection and experience with mindfulness based practices and meditation, I was cognizant of needing to prepare and adjust so researcher bias interfered in the most minimal way possible. The most significant effort I made towards this end was to audio record the participant interviews. By doing so, I was able to maintain the integrity of the participants' responses and prevent as much selective listening as possible. During the flow of the interview I may have felt a strong affiliation with the way a participant spoke about their clinical practice or use of mindfulness due to my personal interests in the subject. This impacted my sense of the interview throughout it and afterward. However, during data analysis I was able to look at the narrative transcripts and make objective coding decisions. This protected the study as much as possible from researcher influence.

In future expansions of this study, perspectives of clinicians who work in different VA health care systems in various parts of the United States could be assessed. The impact of geographic location could be incorporated. Also, with a larger sample this study could learn more about the differences or similarities between how social workers versus psychologists utilize mindfulness based therapies.

The following chapter will review the findings gathered from the narrative data. Themes and subthemes will be highlighted and the most noteworthy quotes from participants will be used to emphasize the themes.

## **CHAPTER IV**

### **Findings**

The following chapter will present findings of qualitative analysis of interviews that explored clinicians' perspectives on the use of mindfulness in clinical settings with military service members. A demographic profile of the fourteen study participants is provided as well as an overview of their experience and current client population. Following this outline of participants, I will describe findings in six areas that the study explored: clinicians' experience with mindfulness, impact of mindfulness based therapies on practice, implementing mindfulness in clinical setting with veterans, barriers to using mindfulness with veterans, further opportunities for mindfulness, and benefits of mindfulness to veterans. Themes within each of these areas will be detailed.

#### **Demographics**

Fourteen participants generated the narrative data for this study in interviews that lasted from 25-55 minutes. Inclusion criteria for the study required that participant clinicians had obtained either a master's or doctoral level degree. The sample was comprised of eight social workers and six psychologists. There were three men in the sample, two LISW's and one PsyD. The remaining eleven participants were women, six LISW's and five PhD's or PsyD's. Of the fourteen participants, eleven worked with veterans in an outpatient setting and three worked with veterans in an inpatient setting. Due to time constraints and the need to utilize those clinicians

who were willing and available to participate, making concerted efforts to attain a diverse sample was not feasible. Therefore, I did not ask participants to supply very much demographic information about themselves. It should be noted that I asked participants what their racial or ethnic background was and all participants identified as White or Caucasian.

The demographic information also relevant for the study was a professional profile that collected information regarding clinicians' client population, length of time in practice with veterans, and religious or spiritual background.

It was also relevant to collect demographic information from participants related to their experience and background with mindfulness. I asked participants to report their current personal mindfulness practice, how a clinician first encountered the phenomenon or idea of mindfulness, and attendance at any mindfulness based therapy trainings in which a clinician might have participated.

**Client population.** All clinicians in the study sample were under the Behavioral Health Care Line umbrella in the New Mexico VA Health Care System. Most clinicians (n=11) participating in the study worked with an outpatient client population. Three clinicians, two psychologists and one social worker, served a residential population. The residential units represented in the sample were the dual diagnosis PTSD and substance use disorder clinic, the inpatient unit for homeless veterans with substance use disorders, and the step-down clinic for veterans with PTSD and substance abuse issues. The outpatient veteran populations represented include those served by the outpatient mental health clinic, the men's PTSD clinic, the substance use disorders clinic, psychosocial rehabilitation, intensive case management unit for veterans living in the community with severe mental illness, and the program for homeless veterans. All clinicians in the sample reported the vast majority of veterans they worked with were men. They

reported that veterans they saw ranged in age from “young to old,” specifically from their early 20s into their 80s, but that most of their clients were older men. Two clinicians spoke specifically to what it’s like to work with the younger veterans from OEF/OIF/OND. They said,

The younger veterans are much more difficult. They have all the issues that younger people have, not being quite settled... and traumas on top of this. Many of them have done several tours of duty. With the older vets it was usually one or two, a lot of the younger have done four or five, which makes it more complex—they’re not ready to settle down, there’s more dangerous risk-taking among younger vets, they’re challenging in that way. The way they drink and use drugs is different from older veterans. It’s more intense.

Eligibility for this study required that clinicians worked with veterans experiencing PTSD symptoms or trauma related issues, therefore all clinicians reported a significant part of their client population carried a PTSD diagnosis. Five participants in the study practiced on units in which all veterans carried a PTSD diagnosis. The VA is unique in that PTSD does not necessarily have to be derived from combat-related circumstances in order to be treated at the VA. The etiology of a PTSD diagnosis that qualifies a veteran to get treatment in a dual diagnosis unit might be childhood trauma rather than combat trauma. One participant noted that all veterans on the inpatient dual diagnosis PTSD and substance abuse unit do not technically meet the criteria for PTSD diagnosis. They attributed this to the fact that,

Trauma can express itself in a number of ways psychiatrically, PTSD is one of those ways. Other ways are personality issues, depression, interpersonal problems. We feel like we’re well situated to work with people who have sequelae of trauma. Most of the time they do have frank PTSD, but we wouldn’t say you don’t have enough intrusive



symptoms, it's just a matter of do we think we can work with them. I think it's a good thing to have people coming in with a variety of trauma histories.

Clinicians also spoke about their feelings that there is clinical significance to treat veterans in diverse groups. They said, "by having a mixed group it prevents people from rehearsing bullshit like, 'I can't trust a woman.' We have four women in group right now and so they don't say that...because there are women present." The clinician reiterated that therapy should remain flexible and not aim to separate combat and non-combat veterans. Doing this challenges the clients' tendencies only to align with other veterans whose experience exactly mirrors theirs. The clinician said, "they need to embrace the humanity of suffering rather than my particular brand of suffering."

**Professional experience.** Participants' years of clinical experience varied; but the majority of participants had ten years or more of clinical experience. Four participants had one to two years of work experience. One participant had been a practicing clinician for six years. Five participants had been in practice for ten to fifteen years. Finally, four participants were seasoned clinicians with twenty-five or more years of professional experience. Compared to the participants' overall professional experience that added up to 174 years of experience, their experience working directly with veteran populations was 103 years.

**Spiritual and religious background.** Due to the spiritual roots of mindfulness therapies identified in the literature review the study asked about the spiritual or religious backgrounds of the participants. This investigation is not intended to look very far into what kind of spiritual background they might have, but rather if they identify one or not. Thirteen participants identified as having a spiritual or religious identity. Of those thirteen, nine participants reported that they attended some sort of spiritual or religious center periodically or

regularly. Six participants reported they were “raised Catholic” and one participant reported being “raised Christian.” One participant reported attending a Unitarian Universalist church with her children. Another participant reported attending Anglican Episcopal services mainly due to the “remarkable pastor.” Three participants identified as Buddhists. Additionally, many participants (n=8) reported that while they don’t identify as Buddhists, they attend Buddhist meditation centers periodically and reported they felt their lives were guided by Buddhist philosophy. One participant reported, “I would never define myself as a Buddhist, but I follow a lot of Buddhist teaching, Buddhist philosophy.” This was a theme throughout the interviews when the topic of spirituality and religiosity came up. One participant noted she was “kind of anti-theology” however regularly attended a Zen sitting meditation group. One participant reported being “curious” in different religions in general but did not report any religious or spiritual affiliation. Participants broadly interpreted the question about spirituality and religious background. One participant reported, “honestly, my spiritual practice is getting out and camping during the summer, going into nature. The more time I spend in nature the more grounded I am...getting into the woods and spending a significant amount of time, that’s my spiritual practice.” Another participant similarly echoed this and said, “I’m a beekeeper and that’s probably the most spiritual thing I do.”

As will be discussed in the following chapter, one of the limitations to this study was the sample’s diversity. Due to the nature of the study and the time constraints, I was unable to control for achieving diversity, however the recruitment process protected against discrimination or prejudice as it was sent to all VA clinicians in the New Mexico VA Health Care System. I used the participants for the study who came forward and were interested, and so the sample is not a cross section of the Albuquerque VA population. Those clinicians who volunteered to

participate all had prior experience with mindfulness practice, either personally or professionally. Therefore, the sample is reflective of a portion of the clinicians at the Albuquerque VA who employ mindfulness practices within their own lives and within clinical settings.

### **Mindfulness Background**

The study sought to explore how clinicians came to know about mindfulness practices and through what avenues they gained their knowledge. Most clinicians noted that mindfulness was something they encountered both in their clinical work and outside of their professional lives. I asked participants to describe what types of trainings they had and how they initially encountered the concept of mindfulness. The salient themes that emerged in this category included mindfulness training, personal mindfulness practice, and experience with mindfulness.

**Experience with mindfulness.** As is stated in the literature, the effectiveness of a type of therapy increases when the client believes that the clinician stands behind the treatment modality they're providing. How a clinician comes to learn about mindfulness therapies might be influential in how they disseminate the therapy. For example, it is relevant to know if the clinicians who are disseminating mindfulness based therapies at the VA are doing so due to personal experiences with mindfulness being effective, and so they're incorporating it into sessions without formal training. If all clinicians are being trained in Mindfulness Based Stress Reduction (MBSR) and it is getting promoted in the workplace then it may be more utilized by clinicians. Therefore, as a way to understand how clinicians are coming to learn about and use mindfulness therapies I asked clinicians how they first encountered the idea of mindfulness as a phenomenon or as a therapeutic intervention. The study sought to locate and identify any barriers in the dissemination of mindfulness based therapies. By understanding the ways that clinicians were trained in mindfulness based approaches to therapy the study could highlight potential

barriers. Were the clinicians who were applying mindfulness based approaches in the clinical setting all trained by VA means? How many clinicians in the study were applying mindfulness based interventions that they had learned from personal trainings? Further, did clinicians who had different training backgrounds incorporate mindfulness into clinical encounters differently?

The majority of participants (n=11) reported first encountering mindfulness in their personal lives. Two psychologists and one social worker in the study sample reported they first learned about mindfulness through professional avenues. One participant who reported learning about mindfulness outside of the professional setting reported feeling like they should conceal their use of mindfulness in the VA. The participant stated that mindfulness was

not really endorsed or condoned by the VA in any sort of formal way, so you kind of bring it in, but you don't talk about it...because the VA is a military culture, and there's this unconscious/conscious fear of reprisal this is not the VA way—these are soldiers. I don't know if that [idea] exists at the VA or we bring that to it. It's probably some kind of cooperative subterfuge.

The participant spoke about their training prior to working at the VA in a non language based alternative form of therapy as a hindrance to being easily accepted by colleagues when they began their VA career. They stated, “the VA hasn't really embraced alternatives, because if they really said, ‘wow, this is what really works for veterans,’ and they embraced it, then it would change the whole culture.”

**Mindfulness training.** Something this study aimed to gain information on was how clinicians were learning about mindfulness based interventions and therapies. I asked clinicians specifically how they have been trained to use mindfulness in clinical settings and what trainings they have attended, not necessarily specific to veterans. I also asked clinicians if the VA

financially supported their mindfulness training. Most participants reported that they sought out and paid for trainings independently. It was notable that no social work participants had been financially supported to attend trainings to become more educated about mindfulness based treatments while in their VA job positions but psychologists had been. One participant reported having attended a class teaching yoga instructors how to instruct veterans with PTSD with certain poses, however this was before she began working at the VA. Three of the psychologists, or half of the participants from this profession in this study, reported being officially trained in either Dialectical Behavior Therapy (DBT) or Acceptance and Commitment Therapy (ACT) protocols by means of VA financial support. One participant reported that she wasn't financially supported to attend mindfulness based therapy trainings due to her VA job description as a mental health intensive case manager who worked mostly with patients with bipolar disorder and schizophrenia. This participant stated, "VA supported is difficult because they don't see it as part of my job so they're not very supportive."

Most social work participants admitted they had not attended any work-sponsored training sessions that were on mindfulness therapies even though the participants reported using mindfulness based therapies and techniques. It was common for participants to be surprised when they reflected on their lack of attendance at formal trainings geared towards their job at the VA. One participant said her perception is that most clinicians have applied their own knowledge of mindfulness rather than learned formal evidence-based ways to apply mindfulness with veterans. This participant reported the wish that there was an "official route" for "best practices" because "I just kind of use it automatically, I've kind of found my own way with the veterans."

**Personal mindfulness practice.** As addressed in the literature review, clinicians' sense of the validity and worth of the modality is integral to the effectiveness of the modality.

One participant talked about this aspect of the mindfulness literature when she said, “there’s a belief component, so people have to believe it. Throughout psychotherapy literature the practitioner who believes in the therapy they’re providing gets better results.” Another clinician reiterated this, “it was a convergence, well this is appealing to me professionally and personally. I don’t think you can really do it right in your office and not be at home practicing in some form or another.” So, I asked participants if they had ever meditated or practiced mindfulness. Typically, clinicians would volunteer information about what their current practice consisted of when I asked them if they had ever meditated.

Four participants reported a daily personal mindfulness meditation practice. Some participants used traditional methods to incorporate mindfulness practice like sitting meditation. Four participants reported more nontraditional ways of practicing mindfulness in their lives. For example, two clinicians reported they practice mindfulness when they exercise. One clinician reported that the dishwasher broke in her home and she decided to involve her kids in what she called, “mindfulness based dishwashing.” She joyfully laughed as she explained to me,

But what I’ve really enjoyed with the dishwashing that I didn’t think I would enjoy, is that I’ve gotten my kids involved in drying the dishes, and they love it. I didn’t realize how many of our great technological advances have ruined what is a natural connection for families... Now no one is watching TV, we’re talking in the kitchen, we’re chattering about their day, they’re figuring out how to get all the wetness off the dishes, and I’m washing, and it’s really cool, and I’m mindful of how cool that is. So, I don’t have a formal practice, but I incorporate it a great deal into my life. I’m appreciative of it. There’s nothing I teach that I don’t try to practice.

Another participant reported that while she also has children, indicating not a lot of alone time, and doesn't have a formal sitting regimen, she practices yoga three times per week and she identifies this as her mindfulness practice.

Participants identified there was a range of precipitating factors to influence them on the path towards using mindfulness in their own lives or at work with their clients. A few participants noted a daily sitting meditation practice of their own, and many others noted that their mindfulness practice had become integrated into their lives in creative and nontraditional ways. I noticed a disparity between psychologist participants and social work participants in their backgrounds of formal work-related mindfulness trainings. Yet, both types of participants reported that they had used their various knowledge bases of mindfulness for use in the VA setting in flexible and adapted ways and did not necessarily stick strictly to protocols and manuals.

### **Impact of Mindfulness on Clinical Practice**

During the interview participants were asked, how has mindfulness impacted your clinical practice? This question was key to understanding the significance that the practice of mindfulness has played in the clinicians' careers. Basically, was mindfulness practice something important and relevant to be studying according to the participants? The second part of this question was whether or not clinicians saw that these practices and therapies were helpful. What also emerged was how clinicians conceptualized mindfulness and where mindfulness fell in the scheme of their clinical practice. These ideas generated by participants are woven throughout this section on the influence of mindfulness.

Overwhelmingly, participants reported that mindfulness has had a significant impact on their clinical work and on their personal lives. Two clinicians used the word, "tremendous" when

discussing the impact mindfulness has had, three participants reported a “big” impact, and one person used “huge” to describe the influence of mindfulness on their personal and professional life. When it came to elaborating on the quality of the impact that mindfulness has had on their lives, I usually did not need to prompt participants to reflect on the role of mindfulness in their personal and professional lives. Participants spoke about the way mindfulness influences both aspects of their life. Analysis of the data resulted in two themes that characterize how participants feel mindfulness impacts their clinical work.

**Promotes calm and patience.** A participant reported that having a personal mindfulness practice or awareness of mindfulness skills has made them “more calm, more tolerant, and more patient” throughout all realms of their day-to-day life. Similarly, a participant said mindfulness has helped them cultivate “internal stability.” Another reflected on the “space” they have that helps them be “less reactive” interpersonally and in the workplace. Three participants spoke about their increased ability to listen and be more attuned with clients due to their mindfulness practice. A number of clinicians specifically reported that mindfulness practices have supported their abilities to attend to difficult or strong affect in clinical situations. The following quote exemplifies this response.

This morning we almost had a fight break out in group, and it’s really easy to get uncomfortable... and just stay in the moment, what’s going on in this moment in time, for me. So, I can then take that, and use that in therapeutic relationship, as opposed to just chatting because I’m uncomfortable sitting with quiet, or chatting to fix things, being able to sit in the moment and say, ok, you’re feeling anxious right now, the quiet feels a little uncomfortable, but this isn’t about you... I think that has brought a lot of benefit to my practice, just that silence, allowing people the space and the time to sort this thing thru.



Another clinician echoed this by saying mindfulness helps support her in remembering that how she responds to clients is her responsibility.

**Overarching impact.** Most participants spoke about the interaction between the effect mindfulness has had on their personal life and the way that transfers to their clinical work with veterans. One theme that emerged in the narrative data was that mindfulness had become a part of clinicians' personal and professional identities. Nine participants spoke directly to the interplay of their personal use of mindfulness practice and their professional clinical skills. Participants reported that mindfulness is an important aspect of how they practice self-care as therapists. One participant talked about how through practicing mindfulness and meditation she has become more at ease with things in her day to day life and in her relationships with self and others. She reports, "and I think that naturally comes into my work." A participant reported how mindfulness has impacted "every aspect of my life," and another participant noted the "foundational" role mindfulness has in her clinical work with veterans. Another participant spoke to this overarching impact mindfulness has brought to clinicians' personal and professional lives by saying, "it sort of becomes your lens."

Participants also expanded on this question and spoke to how they conceptualize mindfulness within their clinical skillset and related to their spiritual background. As one participant said,

It's a part of my worldview. In my mind I don't really call it mindfulness, I call it Buddhism. It's influenced me a lot so I feel like I'm taking advantage of the fashion, the trend, to get the mileage out of those wonderful concepts. I'm pretty influenced by psychodynamic stuff too and I see a lot of overlap there—having that relationship with yourself and having self regulation, having that inner life, strong inner life, it's almost the

same thing to me with different terminologies. I try to emphasize the commonalities, a lot of the things we talk about have a common theme underneath.

This quote reflects how this participant theoretically incorporated mindfulness into their scope of practice and where mindfulness as a model becomes situated in their treatment repertoire.

Another participant said, “it wasn’t long after hearing about ACT when it was like, ‘oh, this is Buddhism.’” One participant discusses the meaning that the integration of mindfulness into mental health fields has had for them over the course of their 25-year career. They said,

I’ve had a really strong spirituality my whole life... At the beginning of my VA career those two things were very separate. So another interesting thing is the merging of those with mindfulness becoming an evidence-based intervention. So to me it’s really wonderful.

The same participants and others also acknowledged the constant need to pay attention to the fluidity between the personal and the professional. Another participant noted the need for diligence around boundaries between personal and professional use of mindfulness. This participant said,

You have to be careful when you have your own practice, putting your own countertransference into it, careful about putting your own ideas into it. I had to be very careful in setting up my spiritual space to include as many religions as I can so I’m not pushing my own agenda. It has to be, it’s an art to figure out how to walk that line because you don’t want to be pushing your agenda on a patient.

The major finding from this question was that the practice of mindfulness impacted most aspects of clinicians’ personal and professional lives in big ways.

## **Introducing Mindfulness to Veterans**

The study aimed to gain a deeper understanding about ways clinicians might introduce or teach mindfulness to veterans or military service members that would be specific to this client population. While participants denied the existence of any bias against mindfulness as a valued treatment among VA clinicians or within the hospital, participants consistently reported that they were careful when first inviting or recommending veteran clients to practice mindfulness. One participant reported, “ I think it all depends on how you deliver it, how you introduce it.” As the narrative data demonstrates, clinicians were strategic in how they presented mindfulness as a concept to veterans and familiarized veterans with mindfulness. The three themes that were used to categorize data in this area were selling mindfulness, demystifying mindfulness, and being careful.

**Selling mindfulness.** Throughout the interviews with participants, clinicians reported on the fact that veterans had some preconceived notions of mindfulness that might get in the way of trying mindfulness techniques in therapy. Due to this, participants said they tried to cleverly introduce mindfulness so that veterans would attempt the practices. As one clinician stated, “I want them to buy what I’m selling.” A participant described how they use metaphors and analogies to try to help the veterans connect with the idea of paying closer attention to our internal experience. The participant reported that they “sold” it to the veterans by saying, “in order to get through an exposure protocol, we need you to attend to your experience of what you felt and thought. This training can help you learn how to attend.” Another participant reiterated that mindfulness doesn’t get presented the traditional way that John Kabat-Zinn and Marsha Linehan present it. This participant says,

‘This is a tool, these are things going on, you’ve got hypervigilance, here’s a way for you to actually be vigilante about everything going on because you’re actually probably missing some of this.’ So we really try to put it in a context of what will work for a vet with PTSD to go, ‘yea, this is a skillset I want to learn.’

A participant noted, “sometimes I can get to them by saying, ‘people that are meditating are not in a trance, that’s a misconception. People that are meditating are very alert, they’re tuned in to everything that’s going on around them.’ Sometimes they can get that.”

Participants reported that if veterans had never practiced mindfulness techniques before then they typically not want to start out “too hard-core.” Two participants indicated that they tried to keep instructions simple with deep breathing exercises, breathing retraining, and a guided body scan. Another participant echoed this thinking,

I do slowed breathing for relaxation, slowing your exhalation to engage your parasympathetic nervous system...that’s an entryway...because once they get the good feeling part of it, I’ll bring the hard stuff. If I start with the hard stuff you’re going to lose them. Just being in their body at all is often the last place they want to be with PTSD.

Four clinicians supported this theory of starting slow and in a way so the veteran can see immediate results. They reported that due to trauma-related issues and diagnoses, slowing down and noticing what’s going on in one’s body might feel overwhelming for patients. A participant reported another way they try to connect mindfulness practices to something that might carry more meaning for veterans. They said,

They get the breathing stuff, the attentional stuff... They learned that stuff in the military, when you learn to fire a gun, you always do it on the out-breathe, and you always try to be steady, on the exhalation, because that’s when you’re your most calmest and steadiest.

So I go, the government knows about this stuff, they trained you this way, they didn't tell you how, why, but on the out-breathe you're engaging that parasympathetic nervous system, you're able to relax, focus. They like that.

This participant gave another example of how she compares mindfulness with military training.

The participant reported saying to veterans,

'How'd you learn to shoot a gun at another human being? You had to be trained over and over. They had dummies to look like people, because it's not natural for an animal to kill it's own species. So they trained you, they habituated you to kill.' They know, they get it... 'You have to do it over and over again so that no matter how anxious you are you still do it. They've been using this science to train you to do what you need to do out in the theater.'

One participant reported that she uses the word freedom to help her teach mindfulness to veterans. This participant said, "I promote 'freedom,' it's a big motivator for me, and for a lot of our veterans it really is too. The idea—'do you want to be free or be a slave to your mind? It's up to you. If you don't practice, work at it, you'll be a slave to your mind.' They like the idea of freedom."

**Demystifying mindfulness.** Part of the interview with participants addressed clinicians' perspectives on what veterans and coworkers thought about mindfulness. I asked participants what it was like to meet veterans' preconceptions of mindfulness during the clinical encounter. Participants discussed where they imagined these ideas about mindfulness might come from and how best to work with the veterans' sense of what mindfulness was.

Many participants noted their experiences with veterans thinking that when clinicians ask them to experiment with some mindfulness techniques they're asking them to "convert to

Buddhism” or “become a Buddhist.” Participants noted negative connotations associated with mindfulness. One participant reported that veterans have positive and negative associations to mindfulness. One participant said that some of the veterans she works with have the idea that mindfulness is “Hindu crap.” Another participant reported they have had veterans with a strong Christian faith tell them that they are afraid meditation will interfere with their faith. One participant said they make a concerted effort to not use the word meditation when they’re introducing the practice due to noticing that there’s a “spiritual connotation with meditation, people go, ‘woah, arrg... I’m Christian, and meditation is not’—I guess they see meditation as more Buddhist.” One participant said, “we try to start at a very basic level and sort of demystify any attachment to Zen Buddhism, or to more of a ‘liberal, get in touch with yourself, emotional, soft, fluffy’ kind of thing.” Another participant reiterated this by saying, “I’m a big fan of demystifying the language. No matter what language you’re going to use I think in varying degrees they see the value of being present and being more compassionate towards themselves and more able to recognize what they’re feeling.” A participant reported that when they introduce mindfulness in their unit,

We both downplay it and play it up. Downplay—it’s not very hard...I use the weightlifting analogy a lot of times, it doesn’t take a brain surgeon to lift weights, it’s hard it takes effort, this is simple. Right now at the beginning of a mindfulness class I might say, ‘okay close your eyes, feel your butt on the chair, feel the pressure of your body on your bottom, feel the contact, warm, cold, any pain any discomfort just feel that, you just did mindfulness, that’s it, 100% it.’ The hard part is going back and back and back, but there are no secrets, no mystery. That’s it, moving your consciousness and awareness around, demystifying it, that’s all we do.

The participant went on to say that they “play it up” by emphasizing the importance of the repeated and consistent practice component of mindfulness to veterans.

Another clinician reported, “trying to keep it somewhat eclectic... what I’ve been emphasizing is that this kind of practice is found in all the old spiritual traditions, the commonality is that every tradition has found the power of this practice.” One participant indicated that he had a “spiritual space” in his office that he set up so as to make veterans feel comfortable and included symbols and icons from a variety of religions and spiritualities. One participant spoke at length about this tension between spirituality and mindfulness when working with veterans.

So usually we’ll start off talking about mindfulness or relaxed breathing. And eventually I’ll get around to saying, ‘hey, this is really the same as meditation.’ I also talk about the potential for a spiritual component... One of the things that some vets really hold onto is their religious faith, and I think that’s a source of strength for them. And I think this can all be brought together. We talk about how in the Buddhist tradition meditation is fundamentally a spiritual act, we’re using it a little differently, but there’s a long Christian tradition of using meditation, they call it contemplative prayer. St. John of the Cross, “Dark Night of the Soul,” Teresa of Avila. This is an important tradition, so you certainly can bring your own spirituality into your meditation if that’s useful to you. For some people that gives it a special meaning, then there are other things supporting the practice. I think usually I bring it [religion/spirituality] up, because probably many of them don’t realize that in the Buddhist tradition it has a lot of spiritual importance. If they do know it, that’s not where we’re coming from and they need to understand that. So I think that’s usually something I need to bring into the situation. As the VA we can’t

promote spirituality, but I also think that we can't ignore the research that says that those that have active spiritual lives do much better, are much stronger, and people that have spiritual communities do better. Even if their PTSD is way up here, they're still going to do better. So I bring it up.

Three other participants said they also used this explanation with veterans in order to educate their clients about the loose ties mindfulness has with most spiritual traditions.

Two participants noted that fear might be some of the basis for veterans' resistance to mindfulness. One participant reported some responses to the idea of mindfulness have been "oh no, I can't do that, sit still, noooo..." It's more fear... When you think about PTSD and people's need to be hypervigilant, if I turn that off for a second, then the world becomes a dangerous place and can I manage that? Part of it is part of their illness." Another participant echoed this, "Some people say, 'I feel like I need to be kind of on edge to feel safe.' That's kind of also part of the PTSD probably, but it's also part of what keeps the problem going."

Many clinicians talked about veterans' misconceptions about what mindfulness is. One participant reported that one of their veteran clients said, "Hey, I thought I was coming here to make these bad feelings go away and you're telling me to feel them?! Or, I thought my trauma was supposed to go away, and you're saying let it in?!" This participant also reported that the veterans often expect mindfulness therapies to be focused on relaxation so they're confused when they begin the practice and feel pain in their bodies. One participant reported asking their client where their resistance to mindfulness came from. "And I asked him, 'what was it for you that made you so resistant to it?' He said, 'it was just a bunch of mumbo jumbo.' People see it as kind of new-agey with crystals... It edges more on the fence of these modalities. Some of these hard-core marines are like, 'nah, I'm not going there.'" Another participant explained how she



clarified things for veterans, “They think that if you’re thinking positively you’re doing it. So you have to cut that out and understand it’s not a thinking thing, we’re trying to get some distance from thought. Most people are so fused with thinking that they don’t understand what else there is.”

**Carefully introducing mindfulness.** Most participants highlighted how it was crucial to initially introduce the concept of mindfulness in a way that veterans could connect to it. Participants referred to veterans’ preconceived notions of mindfulness practices as a contributing factor as to why they were careful in their introduction. The importance of language choice when working with veterans was a reoccurring theme. This study asked participants to discuss the language used when introducing mindfulness based interventions to veterans in the clinical setting. The language used was relevant because this helped the veterans conceptualize the idea of mindfulness if they’d never encountered it before. Many participants reported that they don’t use the word “mindfulness” when they are first teaching veterans about these kinds of techniques and practices. One participant said,

I don’t call it mindfulness in the beginning because I think it’s a put off, you know, it’s like one of those woo-woo... ‘It’s kinda way out there, I’m a soldier, I’m a guy, I don’t do that kinda stuff.’ I think they associate it with being effeminate, there’s kind of this gender thing attached to it, or weakness. ‘How can you be strong and practice these things?’ So, I generally don’t call it that in the beginning.

Another participant similarly said,

There are a lot of sects, religious groups that do not think meditation is good, or combine it with new age, so I wouldn’t use that [meditation]. People will often say, ‘is this

meditation?’ And I’m like, ‘eh, words.’ I know we’re not teaching religious things, but I’m concerned people would just be turned off.

One participant said they used the terminology “attention training” rather than mindfulness in order to try to appeal to veterans. Another participant reported using “mindfulness or grounding techniques as the terminology” used. One clinician reported that if mindfulness was a new concept to a veteran they tried using metaphors as a way to reach the veterans in a place that might make sense to them so that they could understand:

A lot of the vets own dogs, so I’ll say, ‘our mind can be like a dog, they’re untrained, running into the garbage, sniffing the girl next door, running into traffic, running here, there. And we need it to heel, and when we need it to heel, we need it to be able to heel. Not all the time, not twenty-four hours a day, but when we want it to, mindfulness is a way to get our brain to heel, stay with us when we need it to stay with us.’ Like if they’re married, in arguments with their wife: ‘we need them to stay on track, not have the dog run off into danger...’ ‘When you train a dog you have to do it daily, you can’t just do it once in a while, as you get better, you train it with distractions, because you don’t want it to go jump on the toddler that comes up, or the little old lady, you don’t want him to bite at a kids party.’

One participant spoke about making an effort to sync mindfulness to the veteran’s specific treatment need. They reported how veterans with PTSD sometimes struggle with the mundane irritations of life. They said,

“A lot of people with PTSD, that’s a constant problem for them. When something like that comes along, I can say, ‘well here’s the best tool I have, do you want to do it?’ I always preface it with saying, ‘we’re going to do it right here, but you gotta do this on

your own for this to really help you. We may learn something by doing it right here but this is something you have to do every day.’ A part of that becomes teaching them how to practice, you connect it to something you do every day—when you brush your teeth, before you eat supper...if you connect it to something you have a better chance.

This participant reported that their intentional strategy had been effective in laying a solid base from which veterans could learn about mindfulness techniques.

Participants reported on the delicate and deliberate ways they introduced mindfulness concepts to veterans at the VA. They stated that although the practices might be undoubtedly helpful, engaging the veterans towards mindfulness practices was the first significant hurdle. They referred to the attention they paid to educating veterans on what mindfulness was, demystifying the enduring confusions and misconceptions about mindfulness, and doing so with intentionality around language and timing during the clinical setting.

### **Application of Mindfulness**

An aim of the study was to identify how mindfulness is applied clinically. As previously stated, participants were asked about the impact mindfulness has had on their clinical practice, and how they introduce the concept of mindfulness. However, participants often began exploring the circumstances that lead up to them making the choice to introduce mindfulness to clients when they were asked the questions about impact and introduction of mindfulness. Therefore, as interviews went on and this topic continued to surface, I began asking participants, “When do you decide to use mindfulness with a veteran?”

**When to choose mindfulness.** Clinicians have a choice in when they may choose to use mindfulness with an individual or with a group of veterans they may be working with. One participant reflected on his decision-making process:

Then there's just a lot of people that the reason they're coming is supposedly depression, but as soon as you start working on it you see a level of emotion dysregulation... So it just seemed to me like a big percentage of people I was dealing with would benefit from this [mindfulness] somewhat, so I started working on it. I don't just do it with everybody, but sometimes it seems like I end up doing it with almost everybody. I wait till there's some reason, until something comes up and it's pretty clear, okay this could help you with that. So it's not like we start the first session and do it.

This question also elicited participant responses related to the manner in which mindfulness might guide their treatment planning. One participant spoke about state-dependent learning and expressed a belief that mindfulness can be the "platform" that can offer veterans the space to return to in order to make healthier decisions. They said, "I think a main issue with residential programs is that historically they've tried to cram a bunch of information into people and this is when people are receptive and fairly sober, and it just doesn't stick." They claimed that when veterans then leave the program they're functioning in a different state, many of them are using substances again, and they don't have access to the skills they learned while sober. They said, "We're seeing mindfulness as the platform...any sort of flag about 'upset'...and if you can withdraw into mindfulness you might actually be able to remember reflective listening, a skill we teach." They said, you can't get to a place where you can practice your reflective listening skills from an angry state very easily.

Another participant contrasted mindfulness with cognitive therapy, saying they believed forms of cognitive therapy that focus solely on thoughts to be a bit of a "set-up" sometimes. This is due to the therapist being in the position of teaching clients how to "think correctly" while the therapist has most likely had different life circumstances than the client and therefore has

different thought processes. The participant argues for why they might choose mindfulness over Cognitive Behavioral Therapy:

Whereas mindfulness is so much easier, it's like, 'you and I are both human beings, lets relax and feel your butt in the chair and talk about that.' It's hard to argue with. Then you're accepting that people who have had different experiences are going to have different thoughts travel through and that's natural... People that have been abused as children will often have thoughts of abusing. That's because of what they've been exposed to, it's just traveling thru, it's not who you are. Veterans often feel very alienated because they'll go into a room and the first thing they're doing is they're looking at who's dangerous, who's safe, what would they do if they were attacked, there's a weapon, there's a weapon. They know that's not normal civilian behavior, but on the other hand that's normal for them... I can choose what I do with that thought. I can choose to say, 'you know I'm having that feeling of unsafety but [breathe] I think I'm okay, I think everybody's alright.' You've gotta accept that thought first, you can't say, 'there's something wrong if I have that thought.' It's like, 'don't think of a pink elephant!'

Other clinicians also contrasted mindfulness with more evidence-based models of therapy like Cognitive Processing Therapy (CPT) and Cognitive Behavioral Therapy (CBT). One said,

CBT is a great form of treatment but it works a lot with your thoughts. Well, we're human beings and we have thoughts and we have feelings, you have to have to integrate both of those, you can't just stay stuck on the negative thoughts. Those have come from somewhere, if people can get an understanding of what the feelings are, where they may have gotten generated, how they may get played out in their life, how those impact their

thoughts, that's going to be a more solid level of healing. With CPT, you're asking people to come up with their index trauma and to talk about that stuff then to review it and continue to work on it—that's very anxiety provoking. Again, people have to have some kind of tool with how do I manage that, and mindfulness is a simple way, easy way, quick way, efficient way for people to learn how to do that.

In summary, mindfulness was determined to be a good choice for working with veterans whose thoughts were not connected to feelings. Participants noted the importance of acknowledging that the thoughts that run through veterans' minds are a product of life experience. Due to the diversity among veterans' backgrounds, and potentially between veterans and clinicians, mindfulness was considered a modality that met the veteran where they were. In this way, mindfulness allowed the space for veterans' thoughts that might be labeled or deemed unproductive or negative. Participants reported that they chose to invite veterans to try mindfulness when it seemed most clinically appropriate or helpful amidst a diversity of diagnostic presentations. It also seemed like participants talked about the ways they saw mindfulness as more than an adjunct to exposure-based therapies or evidence-based treatments.

**Influence of evidence-based treatment.** The topic of evidence-based therapies came up throughout the interviews often around the questions of how do you introduce mindfulness to veterans. Participants were split in how they embarked on including mindfulness into their clinical practice. A few participants (n=3) reported they strictly adhered to the protocol for any given modality. The three participants who indicated this were psychologists. For example, one participant said,

That's generally my approach to anything—if it's a new population or new protocol, or new way of applying something—do it exactly the way the research has said to do it, and

then don't make modifications till my local population has given me feedback saying we need it to be a little different.

Most participants (n=11) reported that they do not strictly adhere to a manual or protocol when they incorporate mindfulness concepts or practices into clinical work. This participant's quote illuminates this stance:

I listen to the vet and see what might work best, gear some mindful or grounding work towards them, creatively shape something, not pulling it out of a textbook but shaping it to what's going on with them. Because I have quite a background in this area it's not hard for me to do, it comes naturally.

One participant commented on the current role of evidence-based treatments and said that right now it is an "interesting time at the VA in terms of the evidence-based stuff." The participant cautioned clinicians to maintain some awareness around their reliance on manualized treatments:

Protocols are being concretized. They're not perfect yet, they only help a certain percentage of symptoms, and they're being concretized like, 'don't do anything other than this, and on session seven you better be doing session seven.' I don't think it's going to get stuck there, but there's a danger of that, that somehow that particular iteration is somehow superior to everything else, so you shouldn't try anything else. I can't imagine that it's really going to get stuck there.

This participant spoke about how they see clinicians clinging to protocols and manuals for evidence-based therapies in a rigid way. The participant said they thought it was "silly that they [clinicians] don't have any discretion." However, the participant also balanced their stance by arguing in support of VA efforts aimed at "shaking people up." This participant reflected on

early in their career when “people were saying, ‘oh you can’t ask the trauma survivor to talk about the trauma, that would put them in the psych unit!’ And that’s complete bullshit, that’s changed.” The participant cited the VA “rollouts” as an indication of VA administration’s awareness that clinicians will “defend” what they’re comfortable doing without trying new or different approaches to treatment. The rollouts the participant refers to are a series of efforts the VA has made to widely disseminate evidence-based treatments for PTSD (Kearney et al., 2012). Due to the recent rollouts, many clinicians have become trained in prolonged exposure therapy (PE) and cognitive processing therapy (CPT) with the intended effect that more veterans have access to PTSD treatment. Thus far, these efforts at increasing accessibility “have been met with initial success” (Kearney et al., 2012, p. 102).

Participants diverged on whether or not they utilized mindfulness based practices via strict protocols or by drawing upon their own experience and integrating mindfulness in a more eclectic way. Some participants who used approaches in protocols were able to critique the way manualized therapeutic interventions are shaping the field currently.

### **Barriers for the Use of Mindfulness**

The study sought to explore what might interfere with veterans accessing mindfulness therapies for PTSD treatment. Themes explored include: VA workplace as barrier, veteran bias as barrier, and the nature of the practice of mindfulness as a barrier.

**VA as a barrier.** Participants talked about large structural barriers that exist within the large and complex VA health care system. A few participants reported the time and staffing issue of trying to incorporate more mindfulness into the clinical setting. One said, staffing is a barrier, “what do you take away to put this in?” Another participant said,



There are...structural barriers in terms of workload expectation, in terms of the amount of paperwork that the VA expects...There's a point where the plate isn't big enough... and nobody seems to think that they need to remove anything from your plate. What tends to get cut...is the actual treatment... because the paperwork is always presented as the most important thing.

Another clinician referenced the systemic barriers: "This is a medical institution, the majority of vets who come here are coming for medication, the people at the top of the food chain here are medical doctors. The funding system works on the medical model." A couple participants talked about how mindfulness is geared toward long-term results and therefore a conflict exists because many VA patients present to the hospital in acute crisis situations and needing emergency services. They spoke about how mindfulness functions best as a therapeutic intervention after a strong base of consistent practice has been established by a patient, and so mindfulness might not be as useful for acute patients with no knowledge of the practice. Finally, a participant reported the VA's culture of acceptance around alternative approaches in general by saying, "the VA hasn't really embraced alternatives, because if they really said, 'wow this is what really works for veterans,' and they embraced it, then it would change the whole culture."

Most participants shared that thus far, their experience had been that mindfulness was very well-received and respected by their colleagues as a treatment modality. Most clinicians reported that when mindfulness-based therapies were discussed in clinical meetings, everyone was familiar with the different therapies. Every participant I interviewed was familiar with the four most-researched mindfulness based therapies: MBSR, ACT, MBCT, and DBT. However, many participants reported that they were unaware if other clinicians used mindfulness while working with veterans as much as they did. One said, "I actually don't know whether or not

other people use it as much as I do.” These reports indicated that lack of communication between clinicians about treatment modalities might act as a barrier to clinicians sharing knowledge. As addressed in the above section addressing participants’ mindfulness training background, social workers and psychologists often reported different experiences acquiring knowledge about mindfulness; also contributing perhaps to this lack of communication.

When I asked participants about barriers, they additionally cited a “territorial” issue between social work and psychology departments at the VA. Three participants brought up the issue of a minor turf war on mindfulness knowledge. For example, one participant said,

I don’t know how much Social Work uses mindfulness. I hear more that Psychology uses mindfulness in the VA here... It always seems like a psychology thing to me. They seem to be able to pull more off academically, own it: Motivational Interviewing, definitely social work-y, but the psychology people own it...and programs are kind of isolated.

One participant spoke about their perspective that an appreciation of mindfulness practices is integral to being a trauma therapist and that other professions could express skepticism about the treatment:

Most people who go into that kind of trauma work have an awareness of needing to be mindful, that’s one of the hallmarks of PTSD, not living in the moment, either spending a lot of time focusing on the past or focusing on the future, so I think it’s pretty hard to be a trauma therapist without having some awareness of mindfulness and seeing that as valuable. When I was down on the outpatient mental health team several years ago and brought DBT to the outpatient arena there was a little of, ‘this seems a little new agey, scary, and weird,’ but then seeing, okay, clients that are chronic who we’re sending to this [mindfulness group] are saying that it’s helpful, so I guess it must be helpful.

Therefore, initial skepticism among colleagues might dissipate when results are seen. Another participant reported a similar experience with meeting some minor resistance from psychiatrists in a unit they were working on that inevitably went away after veterans showed growth. One participant said, “the only barriers are my own anxiety that somebody’s going to get upset because I talk about Buddhism. It seems like the road’s wide open and it’s just growing like crazy, that everyone’s literate in it.”

A couple of participants’ perspectives on the acceptance of mindfulness at the VA fell outside the norm for the responses and focused on the culture of the VA and military as being a barrier rather than specific aspects of the institution. One participant said they didn’t feel like mindfulness was talked about at the VA, saying, “it’s not really endorsed or condoned by the VA in any sort of formal way, so you kind of bring it in, but you don’t talk about it.” The participant offered an explanation, saying, “maybe because the VA is a military culture, and there’s this unconscious/conscious fear of reprisal—‘this is not the VA way, these are soldiers.’ And I don’t know if that exists at the VA or we bring that to it.” One participant said,

The only anxiety I have is that the culture is still afraid, there’s fear in the culture about being too frou frou in psychology, this may be particular to my perception of psychology, which is that there’s such an anxiety about being evidence-based and scientific, and sometimes I think that stuff to me can lead to very shallow level of discussion. I can’t tell if it’s in the culture or me or both, but the fear of, ‘don’t go too deep, don’t be too radical, don’t be too intense and don’t talk about spirituality.’

As these quotes illustrate, social workers and psychologists at the VA display restraint when embarking on mindfulness practice in the professional environment.

**Veteran bias.** Most clinicians reported that despite some preconceived notions, veterans were responsive to being introduced to mindfulness therapies. One participant reported some initial bias against mindfulness from the veterans, “but 95% of the vets who do it for a couple sessions, they’re like, ‘yea I think that was helpful.’”

As previously stated, participants relayed some confusion, resistance, and fear due to religious beliefs on veterans’ parts. One participant highlighted an issue that has come up when they teach the concept of non-judgment:

We say your attitude is to be gentle, we’re striving for gentleness and non-judgment. And people with an evangelical background will say, ‘what do you mean non-judgment, I have to judge!’ But that’s pretty easily handled—you say, ‘it’s different than discernment, you definitely have discernment over who you want to be with and what you want to do with your life, but in the moment can you practice not doing that prematurely, closing off doors.’ I think it’s really more confusion, because people are taught, judge and judge harshly... I think it’s some ego fear around annihilation, ‘who am I if I’m not mad at this group?’

This participant’s comment indicates their attempt at conceptualizing some of the push-back from veterans when they have introduced mindfulness based ideas to veterans.

Another clinician drew a connection between veteran bias and military culture. They said, The word itself [mindfulness] generally is a barrier, so I don’t use that word. And the word, mindfulness, I usually couch it as a practice for self-soothing, calming down, being more present, not being as impulsive, just allowing myself some space sometimes to think through something. Some people think they have to hit things so straight on, which I think is part of the military culture actually, ‘we have to deal with this right now, attack

this.’ Wait a minute, ‘what about allow yourself some space from it, let it go, don’t persevere about it.’

The above participant’s comments highlight the circumstances that might cause clinicians in the VA to exercise caution when introducing mindfulness to veterans. These comments point to the bias and confusion around the relationship of mindfulness with religion. These participants’ responses also underscore why clinicians report the need to choose their language wisely when explaining or teaching mindfulness to veterans.

**Nature of mindfulness practice.** Participants said repeatedly that a mindfulness practice that can withstand stressors, PTSD symptoms, and extreme emotional dysregulation, all issues that veterans regularly present with, requires a strong commitment from the veteran to practice daily. Maintaining a consistent schedule of practice is a challenge for patients with chaotic and often unstable lives. A participant who worked with homeless veterans cited their homeless status as a barrier to practicing mindful meditation on any given day. Other participants cited client willingness as a barrier to veterans committing to mindfulness practice.

Another clinician referred to the inherent challenges of compassion practice: “The barrier I see is that people don’t have great ability, capacity, to care about themselves—it’s really hard! To suggest that you should care about yourself and you can learn, you can go inward, find these resources inside of you, it’s hard.”

Another clinician reflected on mindfulness as a non-language based therapy and the threat that this might pose to clinicians in a VA setting:

I think in this culture we’re so reliant on language and words, it can be a defense mechanism in and of itself where we don’t go beyond the language... I’d like them to

move away from the language, and that would frighten, that would terrify a lot of people—all the people who that's all they do.

Therefore, the very nature of mindfulness as a practice can act as a barrier in service delivery. As these participants identify, some of the methods of practice inherent to mindfulness and meditation might be deterrents among veteran populations or among VA clinicians. Participants indicate that the non-language base of mindfulness and some aspects of mindfulness, like compassion practices and the need for a consistent and regular practice regimen, might fundamentally challenge clinicians to move outside of their ordinary realm of clinical practice. And these aspects might challenge veterans to attend to their mental health care regimen in a different way.

This section reviews the barriers that participants identified for mindfulness based interventions reaching veteran populations in need of treatment. Some of the barriers identified speak to the nature of the practice itself and the ways that mindfulness might be a shift from established approaches to mental health. Some participants reported that the institutional structure of the VA could function as a barrier due to scheduling and time constraints for clinicians. Participants also noted that some bias against mindfulness continues to exist from clinicians and veterans. Misconceptions around mindfulness practices endure among veterans and within VA and military culture.

### **Opportunities for Mindfulness at VA**

An intention of this study was to identify places or times at the VA that clinicians might have noticed where mindfulness could be utilized. I asked an open-ended question, what opportunities for mindfulness based treatments do you see? I was interested in clinicians' perspectives for the immediate VA facility they were working in and was also curious to see if

clinicians spoke more broadly about how mindfulness becomes situated in the field of mental health.

**Mindfulness for veterans.** Only two participants, both new to the New Mexico VA within the year, said they hadn't seen any opportunities for mindfulness to be used further due to the fact that they had noticed mindfulness was being used throughout the VA already. One clinician stated, "I don't know any place it's *not* being used." Five participants reported feeling that mindfulness could and should be used throughout the entire VA. Another participant said, "I think it can be steeped in everything we do, but I'm also aware that I have the bias of having a really strong DBT training so I see that everywhere." Another participant spoke to this effect as well, saying, "I think the thing is that if you find things that work, if you like your CBT skills or DBT skills you want to incorporate those skills into everything." One participant reported influence from other theoretical backgrounds: "The psychodynamic and Jungian, client centered, humanistic stuff is important to me, so there are lots of ways to skin a cat, I don't think it has to be mindfulness all the time."

Participants had specific ideas about places mindfulness could be used further. "There's a lot of complaining about VA doctors, and complaining to your doctor doesn't necessarily help the situation—how do you start mindfully communicating with your doctor?" This participant went on to suggest incorporating mindfulness skills into a nutrition class and medication management class. A participant made more recommendations:

Shoot, they could even use it on the medical side to deal with high blood pressure, a patient who just had heart attack and had a bypass. Learning mindfulness would be helpful in that situation too. It's like eating healthy I think, it's just a practice that can be helpful for all kinds of patients, on the medical side and the Behavioral Health Care Line

side. Instead of 12:30 p.m. AA meetings we could have 12:30 p.m. mindfulness in the rec hall where people could just go.

One participant spoke about a veteran who was experienced with teaching tai chi and he led a group independently and without VA employee supervision. This participant saw that the day-long silent meditation practice session that is a part of the MBSR protocol could be organized so that it happened more independently as well. He reported that he thought there was value in the veterans taking ownership of the direction of some of the mindfulness groups. He proposed clinicians “loosening our reigns,” “setting it up and letting it grow.”

One participant seemed surprised by the question. They said,

I tend to keep a low profile and pay attention to myself, so I don't tend to pay attention to other situations where these things could be used and they're not. I don't even know how I'd think about that. I guess because I find it so useful, if someone was working with this population and never used it, I'd just kinda wonder if they were overlooking something that was pretty obvious. It's also kind of like, what do I know, maybe they've got something that works better. That's just not a place that I go very much.

This participant did not explain why they chose to work at the hospital in a way that was under the radar. However, it refers to how the participant may have learned to function as a clinician within the complex and vast VA system. This quote echoes previous themes that were identified about the lack of communication between and among departments and clinicians at the VA.

**Mindfulness for VA employees.** Most clinicians reported their desire for a mindfulness group to exist at the hospital that would offer an opportunity for self-care and support to employees. Some clinicians reported that a mindfulness practice would offer support to clinicians in the VA setting. One participant said that mindfulness can be helpful “even for



clinicians... It's really good to listen, pick up on people's strengths, truly be in the moment with them, especially when you have many appointments, one after another, like in some of the clinics." One clinician made a compelling argument for this. She said,

They just had the big conference for Google and all the big Internet companies, Wisdom 2.0. And so all these big corporations see the value of using mindfulness in the environment with their employees. I always find it fascinating that places that provide healing don't help their employees, support their employees, with modalities that could keep them, you know, because we're always giving. It's something that could help the individual practice.

A participant stated, "I think it could be used with employees more, a daily group or something, or starting a meeting with a little bit of mindfulness. It could be used more as a front line in behavioral medicine. I think it is quite a bit, but personally I'd step it up a little more." Similarly, another participant expressed, "I would love to see clinicians practicing with each other...have our own community, because I can go meditate at the sangha but the people at the sangha are not people who work with vets." A participant reported wanting time in their schedules carved out for mindfulness practice: "It'd be nice to have it built in." But they also said the only way they imagined that self-care time while at work would ever be protected is if it was evidence-based, "it's gotta be research supported."

One participant referred to her plan to fulfill the need for a clinician's mindfulness group. "A post doc and I are talking about a voluntary group soon for clinicians, like in the morning, 8 a.m. or something. We'll see. It would have to be voluntary. Once something is institutionalized, it's like going to mass."

This subsection covered the participants' suggestions for further use of mindfulness, and identified locations or areas in which mindfulness could be applied in the VA. Their vision spanned between clinicians and clients. Opportunities for the integration of mindfulness practices were identified across lines between the medical and behavioral health sides of the hospital. Participants reported seeing that mindfulness could be applied for use in veteran-led groups. And many participants saw the opportunity for mindfulness groups for VA employees and clinicians to foster self-care. Therefore, the opportunities that participants reported seeing for the use of mindfulness were aligned with the previously stated view that mindfulness was something that impacted the clinicians in an all-encompassing way, in their personal and professional lives. As participants noted in previous sections how mindfulness has had an overarching impact on their clinical practice and on their personal lives, they also saw opportunities for mindfulness within the professional VA clinical environment for veterans and within the community of clinicians to offer them support for their clinical work with high risk populations.

### **Benefits of Mindfulness for Veterans**

Finally, each participant had positive things to say about the way mindfulness has facilitated healing and increased stability in their veteran clients. The notion that mindfulness offers veterans some space to make better choices was discussed during interviews. Clinicians reported that they observed the benefit of pausing, which then positively influenced veterans' ability to regulate their emotions. These two themes are highlighted from the findings.

**Teaches pausing.** A few clinicians talked about how they have witnessed veterans learn how to interrupt their negative thought processes or behavior patterns with the help of mindfulness. One participant talked about how mindfulness allows their clients to learn about their internal experience then make a choice under stress. They said that they witness veteran

clients travel through the thinking process of, “okay, I could decide to do some deep breathing and manage this situation, I could walk away, or I could deck this guy. I’ve got these different options, what do I want to do.” These participants stated that often conditioning from substance use or PTSD symptoms are telling the veterans to do familiar behavior, acting on impulses like physical aggression as a way to resolve conflict. Another participant said,

For a lot of people it is that ability to stop and pause and go back to being able to have some choice in their behavior. As opposed to feeling like their behavior is just happening and they’re disconnected from what they’re thinking and feeling was that led up to that behavior.

**Emotion regulation.** Participants cited that a lot of what they teach veterans with mindfulness is how to learn to slow down the process of responding to stimuli. Veterans with PTSD and trauma-related issues often struggle with irritability and anxiety, making appropriate responses to stimuli difficult. Most participants reported that mindfulness can be used to address emotion regulation among veterans. Participants reported that veterans may present for treatment for depression, PTSD, or substance abuse. However, the participants saw that the level of emotion dysregulation occurring in the veterans’ lives on top of other problems was significant enough that the clinician saw the need to tackle the emotion dysregulation first by teaching mindfulness skills. Participants reported that veterans have said they feel like they’re “not up for it,” when it comes to embarking on an exposure protocols, but that mindfulness can help prepare a veteran for further treatment. A participant reported that mindfulness benefits a veteran by, “calming them down, slowing them down, it can help them stop ruminating on problems, can help them settle.” Another participant indicated in their commentary that mindfulness helps with emotion dysregulation by helping veterans “get comfortable in their own skin.” Participants also

noted that mindfulness assists veterans' ability to "self-soothe" and "self-monitor." Participants generally indicated that due to the additional information mindfulness can provide veterans on their internal experience, veterans are more able to act wisely and with discretion from a more balanced state.

A participant referred to the training veterans receive in the military as shaping and rewarding impulsive behavior. In this way, the behaviors that might have been helpful have become problematic for veterans. The participant says mindfulness is,

helping them to be less reactive, approach things more mindfully, decrease the sense of urgency...and of course they've learned in their military training that everything is an emergency, everything is a crisis, there's always this anxiety, so the mindfulness can help with anxiety reduction, which impacts sleep, a lot of things.

Participants reported that mindfulness was a simple way to teach veterans how to cope with chaotic life circumstances and emotional instability in an accessible way.

### **Summary of Findings**

The narrative data generated many themes and ideas for reflection and further study around mindfulness in clinical settings and at the VA. Themes that emerged from participant narratives featured the benefits of mindfulness practices to veterans and clinicians with opportunities for clinician self-care mindfulness groups and solely veteran-led mindfulness groups.

Barriers were explored among participants in the narratives. The findings suggested that there are institutional barriers including limits of available staffing and time constraints that inhibit the further application of mindfulness in clinical settings. However, the major barriers that emerged in the narratives involved larger discrepancies between military style approaches

versus mindfulness based approaches to psychological internal processing and decision making. For example, participants reported that due to combat theater circumstances, veterans have been trained to act quickly before their thinking processes kick in. Mindfulness practice asks veterans to pause and identify thoughts and feelings before making decisions in their lives. This finding calls for the need to create a bridge between the culture of mindfulness and military culture. The participants also discussed persistent stigmas and biases against alternative approaches to healing. Another major finding that emerged directly from participant narratives suggested the need to also create a bridge between the connotations that mindfulness carries as linked to “new-agey” spiritual practices and the current VA clinical milieu. Participants indicated their attempts to bridge this gap between the assumptions about mindfulness and VA clinical settings by being very intentional about the language they use when introducing mindfulness practice to veterans. Differences were also noted for clinicians in social work and psychology departments in having access to clinical trainings.

The next chapter will discuss how the findings reflect upon and interact with the literature. I will discuss implications of the study on clinical practice in VA’s and on PTSD treatment. I will discuss what meaning the study carries for the field of clinical social work. Limitations of the study will be assessed, and researcher bias will be explored.

## **CHAPTER V**

### **Discussion**

This study sought to explore clinicians' perspectives using mindfulness based therapies with veterans. The study also aimed to acquire an in depth understanding of how mindfulness is being used by clinicians. Information was collected from the study participants, which consisted of fourteen clinicians at the VA Medical Center in Albuquerque, New Mexico. The sample was made up of fourteen mental health professionals; both LISW's, PhD, and PsyD. During the interview minimal demographic information was collected. The researcher asked clinicians to share their experiences with and perspectives on mindfulness based therapeutic approaches when working with veterans with PTSD and those coping with trauma-related issues in general. The participants discussed their mindfulness backgrounds, the impact mindfulness has on their clinical practice, how and when they apply mindfulness techniques in the clinical setting, how they introduce the concept of mindfulness to veterans, barriers and opportunities for mindfulness in the VA, and finally they reported on benefits to veterans that they'd witnessed over the course of their experience working with veteran client populations. This chapter reviews the findings in the following order: 1) key findings and how they interact with the literature, 2) limitations to the study, and 3) areas for further research.

## **Relationship of Key Findings to Literature**

Narrative data was gathered via an interview that utilized a semi-structured questionnaire with follow-up questions. The central investigation of this study was the exploration of clinicians' perspectives on the use of mindfulness with veterans struggling with PTSD or trauma-related issues. Clinicians were asked to describe their experiences using mindfulness in clinical settings with veterans. The study asked clinicians to reflect upon their background with mindfulness and how they first encountered the concept. The study also asked clinicians what types of training they have attended. They were asked about the meaning that mindfulness has had in their clinical work and the kind of impact it's had on their clinical practice. Participants were asked what they have noticed about the kind of impact mindfulness has had on the lives of veterans and in their mental health care. Clinicians were asked to describe barriers for veterans accessing treatments and opportunities for use of mindfulness based treatments in VA settings.

A principal intention of the study was to gain a better understanding of the clinician's role in treatment delivery. While mindfulness has become increasingly considered a viable treatment intervention, a deficit in the literature remains around what it looks like for clinicians to use mindfulness and meditation practices in session with clients (Davis & Hayes, 2011). The literature continues to call for more research on mindfulness in mental health, specifically social work, in order for mindfulness to be considered an evidence based practice (Turner, 2011). This study sought to understand more about how mindfulness fits into the clinical setting even while it is not yet distinguished technically as an evidenced based treatment for PTSD. As stated in the literature review, this study contributes to the field of social work because through it we learn about the experience of those who are most directly connected to the veteran population in need of treatment, the clinicians working with veterans in treatment settings.

The major findings collected from the fourteen interviews were aligned with the literature and echoed research indicating that mindfulness is effective and helpful for treating trauma-related issues and PTSD. When asked what kind of impact mindfulness had on practice, participants consistently reported an overall benefit. Participants noted experiencing a benefit from incorporating mindfulness into their professional life, their personal spiritual practice, or self-care routine. Participants noted that benefits to their personal lives included a more calm approach to day to day tasks and a less disjointed life between work and home. Participants said that they experienced less dissonance between their internal and external experience due to mindfulness practice, in other words, they felt less fragmented. The data around mindfulness practice as identity shaping was consistent with the literature that says mindfulness practice can support a clinicians' sense of well-being (Shier & Graham, 2011). As such, participant responses were aligned with the literature indicating mindfulness is a useful tool for clinicians beyond their professional roles (Shier & Graham, 2011). This bodes well for the future use of mindfulness in mental health fields—a clinician will ultimately help their clients more when they are able to handle professional stressors more adeptly (Ying, 2008).

The literature on mindfulness in mental health fields remains to be focused on establishing a more agreed-upon definition of mindfulness (Bishop et al., 2004; Baer, 2003; Vujanovic et al., 2011). The literature says that until mindfulness is collectively defined and agreed upon, it may be difficult to expand upon its application and usefulness in practice settings. One of the main findings in conducting the interviews with VA clinicians was learning that this lack of cohesion among researchers in defining terms around mindfulness shows up the field of practice as well. The participants consistently reported that there is concerted effort made on the part of clinicians to clarify what mindfulness is for clients. Participants spoke at length



during the interviews about how veterans have preconceived notions, both negative and positive, about what mindfulness is. Participants reported that before they ask veterans to practice mindfulness, and before veterans embark on a practice regimen, they often must “demystify” mindfulness. The literature also speaks to this end, often clarifying that mindfulness is not an act of thought suppression, and that mindfulness approaches seek to change cognitive processes rather than content (Bishop et al., 2004; Melbourne Academic Mindfulness Interest Group, 2006). Participant responses around explaining mindfulness to veterans and coworkers were congruent with the literature on definitions and conceptualizations of mindfulness. For example, in significant reviews of mindfulness literature, it is stated that for the purposes of use in clinical settings, mindfulness is “not considered relaxation or mood management...but rather a form of *mental training* to reduce cognitive vulnerability to reactive modes of mind” (Bishop et al., 2004). The participants echoed the way mindfulness is conceptualized in the literature. The literature advocated for a strict adherence to mindfulness as a technique and tool. Participants reported their adherence to these terms as well. Participants described how they placed importance upon the language they chose to use with veterans so as to clarify what mindfulness practice was. As some participants said, it was “all about the delivery,” indicating how imperative it was that mindfulness be sold to the veterans in a way that made them interested in buying it.

The spiritual and Buddhist roots of mindfulness was described as a point of confusion in practice settings. Participants told stories that veterans had preconceptions that mindfulness might conflict with their religious faith, or that they might need to “convert to Buddhism.” As outlined in the findings, this had a big influence on the extent to which participants were careful with their introductions of mindfulness to veterans. The participants noted that they informed

veterans that most spiritual traditions maintain some form of contemplative, reflective practice. However, the literature says that a presumption equating mindfulness with Buddhism may act as a barrier for the applicability of mindfulness in clinical settings among religiously and spiritually diverse populations (Kabat-Zinn, 1994). Most participants reported that once veterans were educated about mindfulness and on the history of the connection of mindfulness with most forms of spirituality, they did not feel conflicted about incorporating the practice.

The findings showed that the link between Buddhism and mindfulness contributed to some bumps in practice. In their discussion of the connection and some misconceptions and confusions that ensued, participants reported veterans' stigma against mindfulness practices. It was during this aspect of the interview that military culture was often referred to and I learned about VA culture and the climate of discourse among VA clinicians. Participants cited the bias against "new-agey" spiritual practices as a barrier in practice and referred to Buddhism as being perceived, or misperceived, as such. Further, some participants expressed an attitude of openness when talking about the connections between mindfulness and Buddhism. They referred to their own spiritual bond with Buddhist concepts and mentioned this as one reason they were interested in teaching mindfulness to their veteran clients. There were many clinicians who did not indicate a connection to Buddhism and they tended to speak about mindfulness in more a pragmatic, scientific way. This finding about participants' and veterans' relationship to the spiritual roots of mindfulness suggests that more education about mindfulness would facilitate the dissemination of mindfulness in VA settings. Furthermore, these findings might reflect why participants were so careful in how they chose to introduce mindfulness to veterans.

Participants in this study often brought up the timing and appropriateness of when to suggest, or choose to use mindfulness in clinical practice settings. Clinicians cited many reasons

why they might choose to use a mindfulness approach with a veteran, but most clinicians reported that the common thread was that the veteran was experiencing some form of emotion dysregulation. These findings match the literature indicating that mindfulness is positively related to emotion regulation (Vujanovic et al., 2011). Research says that since mindfulness works directly to enhance emotion regulation and reduce anxiety and depression, it is also a beneficial adjunct to exposure protocols for trauma focused therapy (Vujanovic et al., 2011). Participants concurred with this perspective. The participants reported that oftentimes veterans are not able to engage in the CPT or PE protocols for trauma treatment for a multitude of reasons. This is consistent with literature stating that veterans may not be “ready” for a trauma protocol (Vujanovic et al., 2011). Participants spoke about how mindfulness was a skill that might give veterans a more grounded and solid base from which to withstand the demands of exposure treatment for PTSD like CPT or PE. Participants believed that mindfulness could teach skills that might combat PTSD symptoms like avoidance, and therefore assist the veteran in their ability to complete an exposure protocol. This recommendation, that mindfulness can support clients in completion of exposure therapy, is also supported by research reviews of empirical studies of mindfulness based treatments (Baer, 2003).

**Implications for practice.** The findings identify many themes that have implications for clinical practice. The findings highlight the usefulness of mindfulness as an adjunct to evidence based treatments. Due to the dominant role that evidence based treatments have in VA hospitals and in mental health fields right now, it is imperative that mindfulness be tailored to the nature of the current clinical environment. The findings also suggest that mindfulness has been a very useful intervention in clinical settings and among clinician populations as a mode of self-care. This implies that further application of mindfulness in these settings would continue to

benefit veteran and clinicians. The clinical task is therefore to weave mindfulness practices into these settings despite there not being a clear avenue on which to do this. Clinicians need to remain creative and imaginative when they are introducing mindfulness concepts to veterans. And clinicians need to work with VA administration to carve out the needed time during the workday to rejuvenate and protect against burnout with mindfulness.

Many implications for knowledge and further research surfaced in the findings. More calls for research on mindfulness based therapies are stated throughout the findings. Specifically, there is a call for more research on mindfulness in clinical social work (Hick, 2009). The findings support this as well, saying that more knowledge would increase generalizability for mindfulness efficacy. Participants echoed the literature (Bishop, et al., 2004; Kearney et al., 2012) that called for more studies assessing the ways mindfulness can be measured and applied in various populations. The findings suggest that due to the reoccurring misconceptions and confusions around the ties mindfulness has with Eastern spirituality, more education is needed. More education could make it so mindfulness could reach a wider audience. It might facilitate a larger conversation among clinicians about their uses of mindfulness, a need identified in the findings. More research could also establish a universal definition of mindfulness. Standards would help clinicians navigate implementation in certain clinical settings that are less familiar with mindfulness based interventions, increasing accessibility.

**Implications for policy.** The study also sought to understand the role of formal mindfulness training in clinicians' use of mindfulness with veterans. A question the study tried to answer was if clinicians who had been formally trained in mindfulness based therapies applied it in therapeutic settings with veterans, or if those without formal training incorporated mindfulness into their therapeutic encounters as well. Further, how was mindfulness incorporated based on a

clinician's training background? This data has policy implications because it demonstrates the ways clinicians seek knowledge and disseminate their knowledge of treatments.

When asked about further opportunities for the use of mindfulness, many participants spoke about their wish for development of mindfulness practice groups for VA employees and clinicians. It has been proven that mindfulness can act as a protective factor against distress for MSW students, with the assumption that this would be true for licensed social workers as well (Ying, 2011). Participants reported the improvement they'd seen in their own lives due to mindfulness practice. Due to the increased sense of feeling more grounded and stable from personal practice, clinicians understood some of the ways mindfulness can help with emotion regulation. Overall, participant responses from this study were aligned with research—participants sought mindfulness groups for VA employees that would offer support in the workplace for clinicians as well as provide opportunities to share knowledge.

Most participants in the study had not first encountered mindfulness via professional training. Most participants learned about mindfulness practice by way of a meditation group or retreat setting, a yoga class, some mindfulness instruction given to them following a medical procedure, participating in an online learning module, reading a book, or a personal therapist who taught them mindfulness. Participants of this study were all actively using mindfulness techniques in some form with clients at the VA, but might not have been officially trained in the mindfulness based treatments that are backed by research, like ACT, DBT, MBSR, or MBCT. The data revealed that while most participants might not have received formal training, they continued to successfully apply mindfulness with veterans and have positive outcomes. This finding is aligned with the literature in a number of ways. There is not a clear consensus on the proficiency requirements for becoming an instructor of mindfulness. For example, ACT and

DBT do not make practice requirements for clinicians before they can engage patients in those therapeutic interventions, but MBSR and MBCT do (Melbourne Academic Mindfulness Interest Group, 2006). The data from this study showed that regardless of training history, clinicians were applying the extent of their mindfulness knowledge with veterans. Interestingly, lack of formal professional training in mindfulness treatments like ACT, DBT, MBSR, and MBCT did not seem to hold clinicians back from using mindfulness with veterans, per their report. However, a lack of cohesiveness among VA clinicians became a theme as participants reported that they sometimes didn't discuss with each other the ways they used mindfulness. Many participants reported that they wished for more collaboration around the use of mindfulness, especially across department lines and between clinicians who had formal training and who did not have formal training. These findings suggest a lack of leadership when it came to how mindfulness was being incorporated into clinical settings at the VA. One participant reported that they wished for more promotional material to offer veterans so they could better understand mindfulness concepts and how to practice them outside of therapy sessions. A few of the clinicians interviewed reported that mindfulness was not something they discussed with colleagues often. The findings indicate that clinicians would like help getting on the same page with each other, and could benefit from more internal support and more resources. Therefore, the policy recommendations include more clinically informed guidance and oversight from administration related to the dissemination of mindfulness while it remains a non-manualized treatment.

A theme that surfaced in the findings highlighted the differences between how social workers implement mindfulness with veterans and how psychologists implement mindfulness based interventions. Social workers were more likely to improvise and freestyle when they used

mindfulness in the clinical setting. The three participants who reported they stuck strictly to manualized application of treatment were psychologists. Participants who were psychologists were more likely to have been trained in treatment protocols like DBT, ACT, and MBSR. With specific training in these modalities, these participants were presumably more likely to apply them in clinical contexts. Comparably, social workers were less trained in protocols and therefore applied their knowledge in an eclectic way. Some have said, “mindfulness and social work are called a ‘perfect fit’ due to the mutual emphasis on a strength-based approach to change” (Turner, 2011, p. 134). And yet the gap in research on mindfulness in the field of social work is reflected in the findings. “Currently, most theory and research into mindfulness is being undertaken in the fields of neurobiology and psychology rather than social work” (Turner, 2011, p. 133). Therefore, the policy implications from the findings suggest that departments of social work need to pull together and harvest their knowledge until more research can be conducted.

### **Limitations to the Study**

Social work researchers call for further research specifically geared towards social workers’ clinical practice (Turner, 2011). They indicate that available research includes pilot studies, and anecdotal or qualitative studies. Therefore, a limitation of my study is that it does not move social work research on mindfulness beyond where it already is.

As stated in the introduction, I undertook execution of this study with a fair amount of personal bias that mindfulness was a beneficial practice that facilitated clarity of mind, peace with oneself and others, sense of strength and dignity, and a sense of personal efficacy. I have taken Jon Kabat-Zinn’s MBSR training and attended numerous silent meditation retreats in the Vipassana tradition of Buddhist meditation. Therefore, I felt personally connected to some of the material, and knew that I was going to need to take precautions in order to maintain the integrity

of the study so as to minimize the influence of my bias on the study. I audio recorded interviews in order to protect the data in its most authentic form. Further, as interviews went on, I noticed that when some participants spoke about mindfulness in a way that resonated with my experience or knowledge base, I felt a synergy with the participant. Additionally, when the participant and I did not share as much of a similar experience, or if the way the participant spoke about mindfulness was different than my knowledge base, I did not feel this connection with them. This reflects my inherent bias in the data collection, and the importance of the audio recording in preserving what might otherwise have been lost on me. As I returned to the transcripts of the interviews with the participants who I did not feel an affinity with I noticed to my surprise that the transcripts contained relevant and helpful narrative data for this study. Therefore, the data was able to be utilized with less personal bias.

Another limitation to this study relates to the fact that mindfulness has not been fully defined for the purposes of use in mental health fields yet. Without a clear definition or consensus in the literature, data on mindfulness can be tricky to analyze. Going into the study I aimed to protect against this limitation by asking each participant to define what mindfulness was to them. As interviews began and I started asking participants to define their terms by asking, “describe your understanding of what mindfulness is.” Typically participants did not give me a concise answer presented in a straightforward way. Often clinicians began talking about how mindfulness impacts their perspective on healing, spirituality, and happiness. I wasn’t able to get clear data on how participants understand the definition of mindfulness. But, as the literature, indicates, this may be due to the lack of a unified stance on the matter among researchers. One study says, “likely the most salient issue facing mindfulness research and



practice is the aforementioned lack of consensus about its definition” (Vujanovic et al., 2011, p. 29).

Another limitation to the study was related to the diversity of the sample of participants. All participants identified as white in terms of race and ethnicity. This does not represent a spectrum across racial and ethnic identities and this is not reflective of the demographics among all employees at VA’s. VA statistics say that in 2012, 61% of VA workforce is composed of white employees (Department of VA, 2013). It is likely that the total VA employee population has more diversity in terms of race and ethnicity than the population of clinicians and professionals in the VA workplace, based on my personal observation. The lack of racial and ethnic diversity of the sample, however, is a limitation to this study.

Another limitation to this study sample is that the clinicians that came forward and volunteered to be participants were all clinicians who had previously used mindfulness and potentially found it to be effective and so might have carried a bias. Each participant was an advocate of the practice, and most participants had an active personal mindfulness practice in some way, and were therefore believers in the treatment as well. It is normal for clinicians to believe in the treatment they are delivering and one participant even referred to this fact and reiterated that there are benefits to client outcomes when clinicians believe in the treatment they’re delivering. Despite this normality, the make-up of the sample contributed to generating a data set that enthusiastically supported incorporating mindfulness into mental healthcare, with some outliers noting the shortcomings of mindfulness. Some literature discusses adverse consequences to mindfulness practices that have been documented throughout the history of meditation practice (Melbourne Academic Mindfulness Interest Group, 2006). These adverse effects are comprised of the discomfort that one sometimes becomes privy to upon beginning

mindfulness. When one begins to slow down and pay closer attention to their internal world, they usually notice how busy their mind is and how they may have pain in their body. This is a common experience for anyone who begins a meditation or mindfulness practice. However, for a patient with severe PTSD or anxiety symptoms this can be an alarming experience and can cause a dangerous reaction if unanticipated. These adverse effects are easily processed with a meditation teacher, or in this case, an experienced clinician. In conclusion, it might have benefited the study to have been able to include participants who were not advocates of mindfulness.

A final limitation of this study is that the data did not include an assessment of the participants' efficacy of the mindfulness treatment interventions that they were using in sessions. While the study gathered data on the clinicians' perspective of how effective they saw mindfulness to be, no data was gathered from the veterans on their perception of helpfulness. The study could have asked participants their sense of their own efficacy with clients in general, and in terms of with mindfulness specifically. Therefore, we do not know objective perspectives or data on clinicians' efficacy.

### **Questions for Further Research**

The small study sample created a narrative data set that only represents the perspective of clinicians at the Albuquerque VA. It would be relevant to the field of social work to duplicate this study with a more diverse sample. Diversity in areas of professional background, gender, race and ethnicity, physical ability, geographic location would be more explicitly sought in further studies. The lack of diversity troubled me on another level because there is literature that references a trend indicating that in meditation communities in the United States there are issues of racism, lack of racial integration, and issues around cultural appropriation by white people

(Hickey, 2010). In this study the vast majority of the clinicians who volunteered to participate identified as white and also identified that they commonly had acquired their knowledge of mindfulness from meditation communities. Therefore, I saw that I might be getting a sample that supported the literature indicating there are many communities of meditators who are from the dominant racial and ethnic group in the United States. It would be important to offer more time for recruitment in future studies so as to gather a mixed sample of clinicians from diverse backgrounds.

A significant characteristic of this study is the specificity of the data to the experience of the clinicians at the New Mexico VA Medical Center. This study is connected to a time and place. If I were going to repeat this study I might aim to expand the study to other VA medical centers so as to gain more diversity of experience. A few participants brought up the question of the comparison of how mindfulness might be perceived by veterans and clinicians from VA's in other parts of the country. Some participants who received their clinical training in parts of the country where major mindfulness research has happened, like in Seattle with Linehan (1993) and Marlatt (1994), for example, reported that mindfulness based approaches to therapy are more commonly discussed in the workplace than at the Albuquerque VA.

The study calls for further inquiry into the enduring role of stigma against mental health in the military. This study came out of the idea that there are myths to dispel about alternative approaches to working with trauma. This theme was brought up by a few participants when they reflected during their interviews that VA clinicians tend to rely on language based approaches to therapy, and so they wondered how VA clinicians generally responded to non-language based approaches to therapy like mindfulness. Further, related to stigma in general, some participants spoke about the resistance from social work students and psychology residents to personally

engaging in mindfulness based practices. Due to the small amount of literature on mindfulness based approaches, researchers often cite that students have been the subjects of many studies and there are beneficial outcomes for students according to studies (Ying, 2008). The anecdotal evidence from participants indicated that mindfulness was not well-received by students. This was interesting because it was incongruent with the literature. Future studies could include research on how students respond to mindfulness in VA settings.

Finally, as the study went on I began to feel like getting the perspectives of the veterans would be the most logical next step. This kind of future exploration would be similar to the conference on alternative approaches to healing trauma that I attended over a year ago in which combat veterans spoke. It would be invaluable to gather narratives of first hand experiences from veterans. Interviewing veterans directly might offer more solutions to better ways to reach populations that are not seeking treatment or that drop out of treatment.

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<http://www.npr.org/2012/07/27/157489677/-resilience-looks-at-how-things-bounce-back>

# Appendix A

## HSR Approval Letter

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

February 19, 2013

Lindsay Stonecash

Dear Lindsay,

Thank you for making all the requested changes to your Human Subjects Review application. Your project is now approved by the Human Subjects Review Committee. Data collection may begin once you receive approval from the VA Albuquerque's institutional review board.

*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.

Good luck with your project.

Sincerely,

A handwritten signature in cursive script that reads "Marsha Kline Pruett".

Marsha Kline Pruett, M.S., Ph.D., M.S.L.  
Acting Chair, Human Subjects Review Committee

CC: Kate Didden, Research Advisor

## **Appendix B**

### **Preliminary Recruitment Email**

Dear friends and colleagues:

I am a Social Work intern at the Albuquerque VA. I'm working on my Master's thesis for my Master's of Social Work at Smith College School for Social Work. I am seeking participants to interview for my thesis and am requesting your assistance in identifying participants.

My research topic is related to the use of mindfulness based therapeutic interventions with veterans and military service members. I am interested in learning about clinicians' perspectives on and experience with using mindfulness based approaches in treatment with veterans and military service members. You would be an eligible participant if you are a clinician who works with veterans and has some familiarity with mindfulness, meditation, or mindfulness based approaches to therapy either in your personal or professional life. I will be asking participants to meet with me for up to an hour so that I can ask them more about their experience.

Please pass this email on to anyone who might be eligible or interested.

Thank you,

Lindsay Stonecash

xxxxxxxxx@smith.edu

(XXX) XXX-XXXX

## Appendix C

### Informed Consent

Dear Participant,

My name is Lindsay Stonecash and I am a social work intern at the Albuquerque Veterans Health Administration hospital. I am a graduate student from Smith College School for Social Work and I'm in the process of conducting research for my master's degree, a requirement of which is to complete a research project. I am exploring clinicians' perspectives on using mindfulness based interventions in therapy with military service members who are suffering from PTSD or trauma-related issues. For my study, I will interview clinicians who work with military veterans in order to learn how mindfulness based interventions are being used, how clinicians perceive their efficacy in clinical settings, and what barriers for access to mindfulness based treatments they see or experience.

Eligible participants are mental health professionals with a master's or doctoral degree who primarily work with veterans and have some knowledge of mindfulness based practices. Participation will involve scheduling a time with me to be interviewed. Interviews should last about one hour. Interviews will be audio recorded and I will transcribe the interviews from this audio recording.

During the interview I will ask you to reflect on your practice and your perceptions of the usefulness and barriers to using mindfulness based approaches with veterans. Sometimes reflection on one's career can cause mild discomfort, and so we can pause or stop the interview at any point. Given the nature of the professionals' backgrounds I trust that participants will be able to locate resources for support if needed. I will supply them with a list of resources and a bibliography on mindfulness based approaches (see Appendix F) in the event they want to learn more. Financial compensation will not be provided.

Your confidentiality will be maintained throughout the study. You will not be able to participate anonymously because I will be interviewing you. But I will take steps to ensure confidentiality. I will store the consent form and the data separately. Each participant will be assigned a number to ensure confidentiality during analysis, and in any writing or presentation of the data, quotes will be disguised. I will save data and interview transcriptions for three years after the study per federal guidelines and then destroy the materials. I will urge you to not use names of clients when discussing your practice.

Should you choose to participate, remember that your participation in this study is voluntary. You may refuse to answer any of the questions during the interview. Should you need to withdraw from the study, I will ask that you notify me of this by April 1, 2013. If you have any questions about your rights or any other aspects of the study, please get in touch with me. My email is [xxxxxxxx@smith.edu](mailto:xxxxxxxx@smith.edu) and my phone number is (XXX) XXX-XXXX. You should also feel free to call the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974, and my contact on the social work research committee at the Albuquerque VA, Art Camacho at (XXX) XXX-XXXX ext. XXXX.

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

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

Researcher Signature \_\_\_\_\_ Date \_\_\_\_\_

Please obtain a copy of this informed consent form for your records. Thank you for your consideration and participation. Please feel free to contact me.

Thank you,

Lindsay Stonecash  
[xxxxxxxx@smith.edu](mailto:xxxxxxxx@smith.edu)  
(XXX) XXX-XXXX

## Appendix D

### Email Screening Questions

- Are you a practicing mental health professional with a master's or doctoral degree?
- Does your primary client base consist of veterans?
- Does your client base include veterans with PTSD or trauma-related issues?
- Are you familiar with mindfulness based approaches to therapy, either having read about them, studied them, or having personal or professional experience with them?
- Are you able to schedule about an hour of time with me when I could audio record an interview with you?

Do you meet these criteria?

\_\_\_\_ Yes

\_\_\_\_ No

If yes, you are eligible to participate. Do you agree to do so?

If no, you are not eligible, and thank you for your interest.



## **Appendix E**

### **Interview Question Guide**

#### About You:

- Please describe your professional background.
  - How long have you been in practice, how long working with veterans?
- Demographic information:
  - Religious or spiritual background? Race/ethnicity?
- What is the geographic location of your clinical practice and setting—where do you work (VA hospital/outpatient VA satellite/private practice)?
- Tell me about the characteristics of the veterans who you typically work with:
  - What proportion of your veteran client population is coping with trauma or PTSD? Primary or dual diagnoses?
  - Do you work with younger or older veterans?
  - Gender of clients?

#### Your experience with mindfulness based approaches:

- Describe your knowledge or experience with mindfulness based approaches.
- Have you ever meditated or practiced mindfulness?
- If yes, what kind of influence has mindfulness or meditation had in your life? In your practice as a clinician?
- Have you studied or received training in mindfulness based approaches?

#### Your professional opinions about mindfulness based approaches with veterans:

- What's your overall opinion or perspective on mindfulness based interventions in clinical settings?

- Tell me about how you would define mindfulness based therapeutic interventions.
- Please describe your familiarity with:
  - MBSR, MBCT, ACT, DBT
- Have you ever incorporated mindfulness or mindfulness based therapeutic interventions into a therapy session with a client?
  - If yes, have you found them to be effective or helpful?
- Tell me about how you introduce mindfulness or mindfulness based interventions.
  - Do you do anything that is specific to working with veterans and military service members? If yes, why?
- Where or when have you seen mindfulness based approaches being incorporated into treatments at the VA?
- What opportunities for mindfulness based treatments do you see?
- How would you describe how mindfulness or mindfulness based approaches to therapy/treatment are seen by clinicians and veterans who you work with?
- What barriers to using mindfulness based interventions do you see or experience?
  - Are you aware of any bias against mindfulness based interventions from other professionals or colleagues?
  - Are you aware of any barriers to mindfulness based interventions among clients or veterans seeking mental health treatment?

## Appendix F

### Mindfulness Resources for Participants

#### Books:

Kabat-Zinn, J. (1994). *Wherever you go there you are: Mindfulness meditation in everyday life*. New York, NY: Hyperion.

Wilson, K., & DuFrene, T. (2008). *Mindfulness for two: An acceptance and commitment therapy approach to mindfulness in psychotherapy*. Oakland, CA: New Harbinger Publications.

#### Websites:

Mindfulness Based Stress Reduction homepage:

<http://www.umassmed.edu/cfm/stress/index.aspx>

Mindfulness Resources for Clinical Training and Practice:

<http://kspope.com/memory/mindful.php#books>

#### Current news:

Standen, A. (2012, November 21). Through meditation, veterans relearn compassion.

*National Public Radio*. Retrieved from

<http://www.npr.org/2012/11/21/165667696/through-meditation-veterans-relearn-compassion>

Zolli, A., & Healy, A. (2012, July 27). “Resilience” looks at how things bounce back.

[Review of the book *Resilience: Why things bounce back*]. *National Public Radio*.

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