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Clinicians' use of mindfulness as an adjunct to trauma treatment : a project based upon an independent investigation

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Lisa Beth Rogers
Clinicians' Use of Mindfulness as an
Adjunct to Trauma Treatment

ABSTRACT

This project was undertaken to explore how clinicians use mindfulness as an adjunct to trauma treatment. Data collection for this exploratory study consisted of hour long, face-to-face interviews or telephone interviews with a qualitative, flexible method of data inquiry.

Eleven experienced clinicians from a variety of mental health disciplines whose practice of psychotherapy was informed by mindfulness training participated in the study which was designed to collect their perspectives about mindfulness practice. This study examined therapist perceptions of the effectiveness and contraindications of mindfulness, and their application of mindfulness in sessions through the use of case samples.

Major findings of this study revealed noteworthy benefits of mindfulness as an adjunct to trauma treatment. Participants reported significant positive changes across all aspects of investigation for the study including reduction of trauma related symptoms and improvement in therapeutic relationship, as well as use of mindfulness to reduce overstimulation, dissociation, and confusion over locus of control. In addition, findings identified several reasons clinicians seek training in mindfulness.

CLINICIANS' USE OF MINDFULNESS AS AN ADJUNCT TO TRAUMA
TREATMENT

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

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My thesis was a learning experience in many ways. I have come to revere Mindfulness as a quilt of ways of practicing presence in my life. I discovered patterns in my own life while writing this thesis which were no longer helpful to me. I am working on mindfully letting them go. So in conclusion I appreciate this gift of ways to live life in the present moment. It has become a comforting blanket in a sometimes uncomfortable world.

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CHAPTER I

INTRODUCTION

The history of science is rich in the example of the fruitfulness of bringing two sets of techniques, two sets of ideas, developed in separate contexts for the pursuit of new truth, into touch with one another (Oppenheimer, 1954).

The focus of this study was to explore the reasons behind clinicians' use of mindfulness as a part of individual psychotherapy to treat adults with trauma-related symptoms. This study also concentrated on the ways in which clinicians found this approach to be effective in their experiences with clients. Integrative medicine or mind body modalities of treatment are now being used to treat a multitude of physical and psychological disorders with very promising results. The purpose of this study was to 1) investigate clinicians' decision-making process related to their use of mindfulness with adults diagnosed with trauma-related symptoms and 2) explore the ways clinicians are finding this approach effective in the treatment of adults with trauma symptoms.

Many physical and psychological disorders that have been resistant to standard Western medical model treatments such as trauma are now benefiting from mind body applications as an adjunct to psychotherapy. Mindfulness is one of several modalities that are growing in interest and investigation. *Mindfulness* is a meditation based practice designed to enhance the ability for a person to remain immersed non-judgmentally in the present moment, harnessing the faculties of the mind to decrease anguish in an empowering manner (Kabat-Zinn, 2000).

Adults with trauma-related symptoms may be a population that could greatly benefit from individual therapy that incorporates mindfulness. There is an alarmingly large population of adults suffering from trauma symptoms. Landmark studies have revealed that one out of four women have experienced physical or sexual abuse during their lifetimes (Herman, 1992). Veterans of wars, survivors of disasters, physical and sexual abuse survivors, and returning soldiers are among the vast population of adults requiring effective treatment and services. Complementary treatment approaches such as mindfulness that demonstrates effectiveness would inform developing trauma theory, research, and practice initiatives in the field of Social Work.

According to Krasner (2004), until recently mindfulness has been a relatively unfamiliar concept in various areas of our culture, including the field of health care. Krasner (2004) noted that recent studies on clinical applications investigated the use of mindfully based approaches with steadily increasing frequency and their popularity appears to be growing at record numbers. According to Saki Santorelli (2001), a head teacher and researcher at the Center for Mindfulness in Medicine, Healthcare, and Society at the University of Massachusetts Medical School, there are now more than 240 hospitals, clinics, and other health related settings worldwide that offer clinical interventions based on mindfulness training.

The rationale for the use of mindfulness as an adjunct to psychotherapy is twofold. First, meditation contains similar components of Western psychotherapy. Second, there is increasing evidence that demonstrates the effectiveness of mindfulness as an adjunct to psychotherapy in the treatment of depression, anxiety, chronic pain, and many other psychological and or physical illnesses (Kabat-Zinn, 1993). Numerous

researchers have explored innate qualities of mindfulness which parallel contemporary goals of psychotherapy (Germer, 2005).

An overarching goal of psychotherapy is to reduce distress. Psychotherapy aims to decrease psychological and physiological symptoms and modify destructive coping mechanisms, teaching clients to function more adaptively (Germer, 2005).

Mindfulness is a paradigm that is easily incorporated into various psychotherapeutic approaches. Mindfulness techniques open many avenues to developing insight (Hayes, Strosahl, & Wilson 1999). Many modalities of psychotherapy rely on a client's insight, a process of understanding how previous events in one's life have affected a person's thoughts, emotions, behavior patterns, and motivations. Learning and knowledge about these connections previously unknown to the client can help the client to change current beliefs that are negatively affecting optimal functioning in the present. Psychotherapy is often a way for a client to live more fully in the present. One of the core goals of mindfulness is to enhance this philosophy of living (Epstein, 1995). According to Epstein (1995), the inherent qualities in mindfulness are so aligned with the goals of psychotherapy as a discipline, that it is an excellent tool to achieve the goals of improving quality of life as a whole. Mindfulness may solidify or enhance in some clients the participation and commitment to the psychotherapeutic process (Epstein, 1995).

Previous studies on this new phenomenon have not sufficiently examined how the techniques of mindfulness are being applied to clients in individual therapy who present with trauma-related symptoms. Thus, the aim of this study is to explore the positive effects of mindfulness as an adjunct technique with survivors of trauma.

As the mental health industry continues to be hammered and squeezed by the strictures of managed care and the reduction of state and government funding, it is incumbent on the mission of social workers to find treatment initiatives that are more cost effective and provide long lasting results. Mindfulness as an adjunct to psychotherapy may be one way to meet this challenge. We as a profession must make it our duty to create and advocate for quality services that are widely accessible for all clients.

CHAPTER II

LITERATURE REVIEW

This literature review contextualizes the research question for this study which is: Why are clinicians using mindfulness to treat adults with trauma-related symptoms, and how are these clinicians perceiving its efficacy? The first section reviews the current theory and treatment regarding trauma symptoms in adults. The next section describes the constructs and use of cognitive behavioral therapy (CBT). The third section explores the treatment modality of mindfulness and reviews the current research on using this approach in conjunction with psychotherapy. Literature on mindfulness and trauma is nascent and scant; therefore, this review examines related areas of inquiry that include: mindfulness and anxiety, mindfulness and depression, and the use of mindfulness in relation to chronic pain. The final section explores the implications of the current research on the use of mindfulness in the treatment of trauma and why further study is warranted.

Trauma

This section of the literature review defines trauma, explains precursors to trauma, and describes trauma related disorders. Next, a brief overview on the history of trauma in psychiatry is presented followed by a discussion of current trauma theory and treatment approaches. A critical review of literature pertaining to trauma and mindfulness will be explored later in the chapter.

Definition

Trauma has been defined by Herman (1992) as an event or events that are so extreme, severe, powerful, harmful or threatening that they demand extraordinary coping efforts. These events may take the form of an unusual event or a series of continuous events that subject people to extreme, intensive, overwhelming bombardment of perceived or real threat to themselves or others' sense of safety and security (Herman, 1992). Trauma in its many guises can cause very long-term changes in affect, behavior, psychological functioning and overall well being in individuals.

Trauma affects individuals both psychologically and biologically; but the effects on persons vary depending on a host of variables. Not all individuals who are exposed to traumatic events develop long lasting symptoms (van der Kolk, 2002). Some parameters regarding the possible effects of trauma include how close the person was to the event, the intensity of the event, and how long the stressful event lasted (van der Kolk, 2002).

According to van der Kolk (2002), there are three types of trauma reactions: acute, chronic and delayed. *Acute* trauma is characterized by symptoms that last between one and three months following the trauma. *Chronic* trauma symptoms refer to symptoms that last for at least three months following the trauma. *Delayed* trauma is noted when symptoms do not show up for at least six months after the trauma. Delayed trauma symptoms are often found with adult survivors of childhood trauma.

Trauma Related Disorders

Since trauma affects individuals uniquely, a wide spectrum of trauma related disorders exists. Disorders resulting from trauma specified in the in the *Diagnostic and Statistical Manual* (DSM-IV-TR) are classified under the category of anxiety disorders

(American Psychological Association, 2000). These disorders include Post Traumatic Stress Disorder (PTSD), Dissociative Identity Disorder (DID), and Acute Stress Disorder. Other mental disorders that have been shown to highly correlate with trauma include anxiety disorders, depressive disorders, chronic physical illness, eating disorders, substance abuse disorders, conduct disorders and borderline personality disorder (Allen, 2001). Oftentimes clients presenting with mental health problems do not realize that trauma is involved in their current difficulties. For example, many clients who originally seek treatment for depression or anxiety later reveal a trauma history during individual psychotherapy (Friedman, 2006).

Previous research has shown that many survivors of trauma have experienced traumatic situations repeatedly over a prolonged period of time (Herman, 1992). In a need to further address long term trauma survivors, the development of a new classification in the *DSM-IV* has been proposed and is currently being reviewed (van der Kolk, 2002). Possible descriptions for this new classification are *Disorders of Extreme Stress* and *Complex Trauma* (van der Kolk, 2002).

Trauma Symptoms

Symptoms of trauma are characterized as reactions that cause a person to continue to be affected negatively by the traumatic event or events in a way that disrupts social and occupational functioning and causes life distress (Herman, 1992). Typical symptoms resulting from trauma include anxiety, hypervigilance, insomnia, nightmares, concentration problems, irritability or outbursts of anger, exaggerated startle response and reduced capacity to enjoy oneself (van der Kolk, 2002a).

Precursors to Trauma Symptoms

Empirical studies published over the last thirty years have noted well recognized precursors to trauma (Allen, 2001). There are several conditions and variables regarding the etiology of trauma in adults. Examples of situations and events associated with trauma related symptoms and disorders include, but are not limited to, repeated sexual abuse, rape, incest, physical abuse, domestic violence, ongoing harassment, and chronic exposure to social oppression (Allen, 2001; Herman, 1992; Levine 1997; van der Kolk, 1987).

Historical Context of Trauma

Trauma symptoms, theory, and treatments were first explored by Freud (1893), Janet (1889), and Charcot (1887). Janet, Charcot and Freud were all observing and trying to understand the effects of trauma (van der Kolk, 1996, 2002a.). These pioneers also configured ideas on how to treat the ensuing symptoms resulting from trauma.

Janet was a neurologist in Paris working at a mental institution called the Salpetriere. Much of Janet's early work can be seen in trauma theory today. However in the social context of his era, psychoanalysis eventually crowded out other schools of thought in regards to trauma. Charcot was a neurologist also working at the Salpetriere. Like Janet, Charcot observed that a history of trauma such as sexual abuse correlated with the symptoms they witnessed, but their work and observations were discarded as other researchers at the time challenged them with false memory arguments. Researchers who took over the Salpetriere at the time were more interested in studying a new phase of treatment called hypnotic suggestibility. The social context of the time was a barrier to

any public discussion of sexual abuse and incest (van der Kolk, Weisaeth, & van der Hart, 1996).

Freud visited Charcot and also sought to understand trauma related disorders that were called *hysteria*, a disorder attributed to the uterus (Herman, 1992). As Freud studied hysteria, he eventually found that when the women talked about their difficulties, these women frequently revealed memories of sexual abuse, incest, and physical abuse. Although Freud originally initially believed that these events were precursors to trauma symptoms, he later did not include trauma in his theories. Van der Kolk (1996) summed up this lack of connection when he stated, “Although psychoanalysts, including Freud, tended to acknowledge sexual trauma as tragic and harmful, the subject seems to have been too awful to seriously consider in civilized company” (van der Kolk, Weisaeth & van der hart, 1996, p .56).

Another vein of efforts to understand trauma occurred within the military. Trauma related symptoms evident in soldiers resulting from armed combat and the conditions of warfare became increasingly apparent during World War I and II (van der Kolk, et al., 1996). World War I and World War II presented military psychiatrists with the challenge of understanding and rehabilitating soldiers who had trauma-related symptoms as a result of combat. In many cases during World War I, it was documented that in treating combat related trauma, doctors were pressured by the military to attribute trauma symptoms to character weakness and soldiers were to be retrained by extreme physical conditioning and returned to the front lines (van der Kolk, 1996, 2002a). *Shell shock* was the first term used to describe the phenomenon of combat trauma and was coined in 1915 by Myers, a British military psychiatrist. Trauma could now be named as an illness.

Although interest and psychiatric aims to prevent or treat war related trauma in World War I were explored, none of these attempts added significantly to the literature on trauma in the psychiatric community. However, Kardiner (1941) a psychiatrist treating war veterans as World War II was breaking out, compiled his entire research into a book he published titled *The Traumatic Neuroses of War*. This landmark publication was full of detailed descriptions and case histories describing the nature of trauma. According to van der Kolk (1996), “more than anyone else Kardiner defined PTSD for the remainder of the 20th century” (p. 57).

Trauma theory with soldiers serving in the Vietnam War moved trauma treatment in a new direction, forward. The emergence of Vietnam veterans who advocated for themselves as a group in the 1970s finally established the credibility of trauma as a diagnosis, gained further attention from the Veterans Administration, and legitimized the condition and needs of this population. Programs were set up by the government to treat returning soldiers suffering from post traumatic stress disorder (PTSD) at long last (Herman, 1992).

These efforts inspired and enabled the women’s liberation movement to then carry the cause of trauma and treatment into the domestic realm that included traumas such as rape, domestic violence, and child sexual abuse. The classification of PTSD finally made its way into the *DSM* in 1980 (Herman, 1992).

The collective history and research conceptualized from early investigations by Freud and other practitioners contributed ideas that would inform current trauma theory and treatment in the way of etiology, progression and the application of psychodynamically grounded practice. Due to the characterization of the history of

trauma theory as one of “episodic amnesia” (van der Kolk, 2003, p.177), experts such as Herman (1992) and van der Kolk (2003) warned that we as a society should not lose the ground that had been hard won in regards to our knowledge and treatment of trauma and that we as practitioners must continue to make sure trauma theory and treatment remain current and visible for traumatized clients.

Current Trauma Theory and Treatment

The most effective treatment for trauma symptoms cited in the current literature is a combination of psychotherapy and psychopharmacology. Many psychotherapeutic approaches are used to address trauma symptoms. These approaches include cognitive behavioral therapy (CBT), psychodynamic psychotherapy, eye movement desensitization reprocessing (EMDR), and dialectical behavior therapy (DBT) (van der Kolk, 1987, 2002a).

Many theorists have written about the reasons for trauma reactions and the treatment for ongoing symptoms. Herman, who wrote extensively on trauma as a disconnection in individuals’ lives, published a landmark book titled *Trauma and Recovery* (1992) that analyzed trauma and treatment from a historical lens. Herman has developed a multi stage model of treatment for trauma symptoms. Psychodynamically oriented trauma treatment endorsed by Herman focused on the establishment of safety for the individual, building an alliance with a trusting relationship, the processing of traumatic events and memories into consciousness, and developing a sense of meaning and connectedness in life after trauma.

Van der Kolk, another prominent trauma theorist, wrote about trauma in 1987 basing his theoretical framework of trauma as a biopsychosocial model of the

development of trauma symptoms. Van der Kolk (2002b) brought together many facets to his theory on trauma combining cognitive, behavioral, and psychoanalytic paradigms.

Van der Kolk has developed a collective view combining these elements into a theoretical framework that explained trauma as a complex reaction to multiple variables.

Van der Kolk has also been a strong proponent of body oriented therapies. He proposed that trauma treatments should include methods to promote self regulation. Van der Kolk stated that psychotherapy is much more effective when using a model in which psyche and soma are both attended to (Wylie, 2006). Van der Kolk (2006) stressed these therapeutic aims when he wrote, “If past experience is embodied in current physiological states and action tendencies and the trauma is reenacted in breath, gestures, sensory perceptions, movement, emotion and thought, therapy may be most effective if it facilitates self-awareness and self-regulation” (p.289).

A prolonged traumatic event in its various manifestations not only affects the cognition of the growing organism but the physiology of the organism as well (van der Kolk et al, 2002a). Treatment for adults with trauma-related symptoms is a complicated process due to the possibility of retraumatization and the debilitating symptoms involved with these disorders (van der Kolk et al., 2002a).

Levine, a well known trauma expert and author of *Waking the Tiger - Healing Trauma* (1997), based his trauma theory around biological, adaptive and primitive responses to threat. Levine compared the coping styles of human beings to trauma in relation to that of animals in the wild who were subjected to similar stressors. Levine explored the primitive flight and fight stress model and described how formerly adaptive mechanisms can become hardwired and maladaptive.

Allen (2001), an authority on trauma and a researcher at the Menninger Clinic has based trauma theory in attachment and has viewed trauma in the context of one's relationships with others. Allen proposed treatment strategies for symptoms that include containing the trauma, developing a trusting relationship with another person, narrating and transforming trauma, and psycho educational implementations.

Siegel (1999) presented trauma theory and treatment initiatives as a model of brain development that is affected by trauma. Siegel cited evidence that trauma changes brain chemistry and these changes lead to personality characteristics and ways of functioning that operate out of these profound early changes. Siegel devised methods for repairing the brain through environmental interactions.

The number of traumatized persons currently continues to be considerable, pervasive, and alarming, yet trauma clients are still often negated and blamed for their symptoms (Herman, 1992). Thus more research on trauma theory and practice is needed, as well as continued advocacy for increasingly effective strategies for prevention and treatment. Trauma continues to be a large scale societal ill that demands awareness, knowledge, and action (Levine, 1997).

Treatment Approaches

Individual and or group psychotherapy modalities are used to treat clients suffering from trauma-related symptoms. Several modalities are frequently combined to address a client's symptom picture. Symptom control and improved functioning are achieved through an array of psychotherapeutic approaches and psychopharmacological initiatives.

The goals of trauma treatment seek to manage symptoms and restore overall functioning. According to Herman (1992),

Because the traumatic syndromes have basic features in common, the recovery process also follows a common pathway. The fundamental stages of recovery are establishing safety, reconstructing the trauma story, and restoring the connection between survivors and their community (p 3).

Establishing a sense of meaning and restoring an internal of control are also part of the treatment process (Allen, 2001).

Psychopharmacology is frequently used as an adjunct to psychotherapy for trauma-related symptoms. *Psychopharmacology* is the use of medications to treat trauma related symptoms such as anxiety, depression, and insomnia. Psychopharmacology is often prescribed for symptom management to enable the client to more actively participate in psychotherapy (Friedman, 2006).

Cognitive Behavioral Therapy (CBT) is a treatment modality for trauma that Albert Ellis started in the 1950's and Alfred Adler further developed in the 1970's (Follette & Ruzek, 2006). When used to treat trauma symptoms, CBT involves the therapist working with the client's cognitions in an attempt to change emotions, thoughts, and behavior. CBT also utilizes specific techniques that include exposure therapy and desensitization. CBT for trauma related symptoms also includes learning affect management skills for coping with anxiety, changing negative thought patterns and managing stress reactions (Follette & Ruzek, 2006).

Eye Movement Desensitization Reprocessing (EMDR) is a treatment for trauma developed by Francine Shapiro in 1987 (Shapiro & Schwartz, 1999). EMDR is a set of techniques using bilateral eye movements to reduce trauma related symptoms. In the first

phase of EMDR an assessment of the client's past or recent trauma is taken. The client then tells the therapist the symptoms and thoughts that the client wants to decrease. Next the client is evaluated as to whether they are stable enough to talk about the traumatic material. Education regarding relaxation techniques may be taught to decrease difficulties in going through the traumatic events again mentally (Shapiro & Schwartz, 1999).

In the next phase of EMDR clients focus on the images, beliefs, emotions and body sensations related to the trauma while following the therapist's finger that is moving back and forth (Shapiro & Schwartz, 1999). The client does this until the client is no longer distressed thinking about these memories and the client is then instructed to think of a positive belief that the client and psychotherapist have agreed on earlier. Between sessions clients monitor their thoughts in relation to the trauma. The theory behind EMDR proposed by Shapiro is called the Adaptive Information Processing Model. Please see www.emdr.com for further information.

Dialectical Behavior Therapy (DBT) is a form of CBT designed by Marsha Linehan in 1993 and is often used in a group format. DBT has two components, a behavioral problem solving focus mixed with acceptance based strategies. DBT also emphasizes a dialectic approach to modify thoughts and behaviors. Linehan (1993) originally developed this approach to target the symptoms of Borderline Personality Disorder (BPD). BPD has been cited in the literature as having a strong correlation with trauma histories and trauma-related symptoms in clients (Linehan, 1993). One of the four core skill sets of DBT is based upon the principles of mindfulness meditation.

Psychodynamic psychotherapy originated in the early 1900's. Freud, Jung, Adler, and Erickson are credited with the development of this approach. Current proponents of

this model are Gabbard, Kernberg and Ogden. In psychodynamic psychotherapy the therapeutic relationship is of critical importance. This psychotherapeutic technique is often referred to as the earliest form of “talk therapy.” In relation to trauma, psychodynamic psychotherapy focuses on the emotional conflicts caused by traumatic event(s) specifically related to early life experiences.

In psychodynamic psychotherapy the client retells the traumatic memories or events to a therapist who responds with calmness, empathy, compassion, and a non judgmental stance. Through this retelling the client is able to develop a greater level of self esteem, and develops more effective ways of thinking, coping, and learning to deal more successfully with intense emotions (Herman, 1992).

Cognitive Behavioral Therapy and Related Therapies

This next section of the literature review covers Cognitive Behavioral Therapy, including description and history of CBT, use of CBT for trauma, CBT and mindfulness. Dialectical Behavior Therapy and Acceptance and Commitment Therapy are reviewed here.

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) is a psychotherapeutic approach that aims to influence dysfunctional emotions, behaviors and thoughts through a goal-oriented, planned out procedure. CBT can be seen as an overarching term for a number of psychological techniques that share a theoretical basis in behaviorist theory and cognitive psychology (Follette & Ruzek, 2006).

CBT treatments have received empirical support for efficient treatment of a variety of clinical and non-clinical problems, including mood disorders, anxiety

disorders, personality disorders, eating disorders, substance abuse disorders, and psychotic disorders (Brantley, 2003). Often brief and time-limited, CBT has been used in individual therapy as well as in group settings, and the techniques here have also commonly been adapted for people to use at home.

Description

Some CBT therapies are more oriented towards predominately changing thoughts while others are more focused on changing behaviors. In recent years cognitive behavioral approaches have become more and more popular and are used in multiple settings such as schools, hospitals, and prisons (Brantley, 2003). These programs are designed to teach clients cognitive and behavioral skills in order to reduce distressing actions, thoughts, or moods. In cognitive oriented therapies, the objective is typically to identify and monitor thoughts, assumptions, beliefs and behaviors that are related and accompanied to debilitating negative emotions and to identify those which are dysfunctional, inaccurate, or simply unhelpful (Follette & Ruzek 2006). This is done in an effort to replace or transcend thoughts and beliefs with more realistic and useful thoughts and beliefs.

History of CBT

CBT came into the field of psychology in the 1950s when an emphasis on behavioral approaches gained prominence. It was developed by Albert Ellis (1950) and was later expanded upon by Alfred Adler (1970). Cognitive behavioral therapy (CBT) is considered a general classification of psychotherapy that includes several approaches to CBT. These approaches include rational emotive behavior therapy, cognitive therapy,

rational behavior therapy, rational living therapy, schema focused therapy, and dialectical behavior therapy (DBT). Each approach has its own developmental history.

According to the National Association of Cognitive Behavioral Therapists (2008), the first therapeutic approach to CBT to be developed was Rational Emotive Therapy (RET), originated by Albert Ellis in the mid-1950s. Ellis developed his approach in reaction to his dislike of the indirect nature of psychoanalysis. The philosophic origins of RET go back to the Stoic philosophers, including Epictetus and Marcus Aurelius. Epictetus wrote in *The Enchiridion*, "Men are disturbed not by things, but by the view which they take of them." (Follette & Ruzek, 2006) The modern psychotherapist most influential to the development of RET was Alfred Adler who later developed individual psychology. Adler, a neo-Freudian, stated, "I am convinced that a person's behavior springs from his ideas." Ellis was also influenced by behaviorists such as John Dollard, Neal Miller, and Joseph Wolpe.

Ellis developed and popularized the ABC model of emotions, and later modified the model to the A-B-C-D-E approach. In the 1990s Ellis renamed his approach Rational Emotive Behavior Therapy. In the 1960s, Aaron Beck, M.D. developed his approach called Cognitive Therapy. Beck's approach became known for its effective treatment of depression (Follette & Ruzek, 2006).

According to the National Association of Cognitive Behavioral Therapists (2008), other influential theorists and or practitioners include Michael Mahoney, Ph.D., Donald Meichenbaum, (Stress Inoculation Therapy) and David Burns. Burns popularized CBT with his 1980's best-selling book, *Feeling Good*. More recently, cognitive-behavioral therapy has been influenced by the work of Aldo Pucci, (Rational Living Therapy),

Marsha Linehan, (Dialectical Behavior Therapy) and Arthur Freeman. (National Association of Cognitive-Behavioral Therapists, 2008).

Many people think that CBT is very impersonal, having a “cookie cutter” approach; but in reality it is relationally based. CBT can be individually tailored to a person’s unique struggles. The therapist uses the therapeutic relationship to set the stage so that a client will feel safe in trying out new ways of thinking and behaving. Cognitive behavioral therapists believe it is important to have a good, trusting relationship; but that, in and of itself, is not enough. CBT therapists believe that clients change because they learn how to think differently and they act on that learning. Therefore, CBT therapists focus on teaching rational self-counseling skills (Brantley, 2003).

CBT is a collaborative effort between the therapist and the client. Cognitive behavioral therapists seek to learn what their clients want out of life, meaning what their goals are, and then help their clients achieve those goals. The therapist's role is to listen, teach, and encourage, while the client's role is to express concerns, learn, and implement that learning (Bien, 2006). CBT challenged the leading methods of the time which were psychoanalytic in nature and CBT as a treatment modality was measurable, more cost effective to apply and was and still is appealing to managed care.

CBT for Trauma

CBT has been widely used in treating trauma (Follette & Ruzek, 2006). Friedman (2006) stated that:

Cognitive behavioral therapy (CBT) for trauma represents a broad class of therapies unified by a strong emphasis on observable outcomes, symptom amelioration, time limited and goal oriented intervention, and an expectation that patients will assume an active role in getting better. An additional strength of

CBT applied to trauma is its adherence to evidence based conceptualization of patient's posttraumatic psychopathology (p.1).

There are clients with trauma histories who may not respond well to more insight oriented, psychoanalytic approaches or may not be ready for that intensity of work for a number of reasons. This could be the case especially with trauma survivors who need to form a foundation of feeling safe and keeping themselves safe. Many trauma survivors struggle with self harming behaviors. In Herman's (1992) theory, the therapeutic goal for stage one is to create an environment of safety for the client. This sense of safety may come in the form of psycho education and teaching clients to self soothe and better regulate their moods. For more information on Judith Herman's stage theory, see *Trauma and Recovery* (1992). CBT is compatible with Herman's three stage theory because it employs measurable goals and homework practice where a client may monitor their thoughts feelings and behaviors in the context of the goal of creating safety in their psychological and physical world.

Various psychotherapists have developed CBT approaches for the treatment of trauma related symptoms. These all share a focus on the interruption of the stress reaction cycle and all contain mindfulness techniques. These CBT approaches also address the triangular model of the thinking-feeling-behaving continuum and use mindfulness meditation as a way to bring awareness to unhealthy thought patterns (Brantley, 2003). The most current literature emphasizes CBT as the premier treatment for trauma related symptoms.

The Stress Response

All CBT trauma treatments work to interrupt the “stress response” (Follette & Ruzek, 2006, p.304), which is counterproductive and maladaptive to the client in regards to healing and becoming stronger physically and psychologically. The *stress response*, which is also called the fight, flight, or freeze reaction or the fear response, really puts many people in a state of disregulation in their thoughts and body physiology. Brantley (2003) wrote,

Chronic stress means chronic hyperarousal of the body through its fear system. The price for this is high, both physically and emotionally. Fortunately, there is good news. You have a balancing response to fight or flight wired into you. There are different ways to activate it, and meditation is one of them. (p. 36).

Using mindfulness to mitigate the stress response can be extremely helpful. If the pattern of the stress response can be altered, healing for trauma survivors can be promoted, so CBT as a mind body therapy to treat trauma makes sense. These approaches can also be called life skill sets that help a person function more adaptively and live a more satisfying life (Brantley, 2003). Follette and Rusek (2006) categorized the approaches of CBT into four sets: a) coping skills training, b) prolonged exposure, c) cognitive therapy processing, and d) acceptance methods.

CBT, Trauma, and Mindfulness

CBT is an evolving method that is becoming more and more associated with mindfulness meditation techniques. CBT is able to partner with this approach as the inherent qualities are similar. In CBT clients are asked to observe their thoughts, actions, and behaviors. Mindfulness also asks people to observe and witness their thought

patterns, mood states, and ways of being in the world in order to learn about themselves and create more peace in their lives (Brantley, 2003).

The emphasis of CBT is on paying attention to thoughts, beliefs, affects, feelings and behavior. Maladaptive beliefs and thoughts are common in trauma survivors and result in distress. The stress cycle switch gets stuck in the on position, which affects mind and body. Mindfulness brings the body into awareness where other western therapies may fail to do so.

Specific Applications of CBT

Many studies have linked trauma to Borderline Personality Disorder. DBT was created to repair or build up emotional regulation skills and to decrease self destructive behavior. There are many other CBT approaches that incorporate mindfulness meditation to address trauma that have been or are currently being developed, it is beyond the scope of this paper to address them all. Two methods that are highlighted here are DBT and ACT.

Dialectical Behavioral Therapy

Dialectical behavior therapy (DBT) is a type of cognitive behavioral therapy. Its main goal is to teach the patient skills to cope with stress, regulate emotions, and improve relationships with others. DBT is derived from a philosophical process called dialectics. *Dialectics* is based upon the concept that everything is composed of opposites and that change occurs when one opposing force is stronger than the other, or in more academic terms: thesis, antithesis and synthesis (Linehan 1993).

DBT was developed in the late 1970s by Linehan and colleagues when they discovered that cognitive behavioral therapy alone did not work as well as expected in

patients with borderline personality disorder. Linehan and her team added additional techniques and developed a treatment which would meet the unique needs of these patients (Linehan 1993).

There are three fundamental aspects of DBT: cognitive behavioral therapy (CBT), validation, and dialectics. In the CBT aspects of DBT, the therapist and client focus on learning new behaviors. Four main strategies are used in DBT to change behavior: skills training, exposure therapy, cognitive therapy, and contingency management (Linehan 1993). *Skills training* involves attending skills groups, doing homework assignments and role playing new ways of interacting with people. *Exposure therapy* is used to expose oneself to feelings, thoughts or situations which were previously feared and avoided. *Cognitive therapy* is about recognizing and reassessing patterns of negative thoughts and replacing them with positive thoughts that more closely reflect reality. *Contingency management* is about identifying how maladaptive behavior is rewarded and how adaptive behavior is punished and using this knowledge to modify behavior in positive ways (Linehan, 1993).

A second aspect of DBT is *validation*. For patients with borderline personality disorder, the process of cognitive behavioral therapy can cause a great deal of distress. The push for change for clients can feel to them as if it invalidates the emotional pain they are feeling. Linehan and her team found that by offering validation along with the push for change, patients were more likely to cooperate and less likely to suffer distress at the idea of change. The therapist validates that the person's actions make sense within the context of his personal experiences without necessarily agreeing that they are the best approach to solving the problem (Linehan, 1993).

Finally, DBT involves dialectics. *Dialectics* contains three basic assumptions: (a) all things are interconnected, (b) change is constant and inevitable, and (c) opposites can be integrated to form a closer approximation of the truth. In DBT, the patient and therapist are working to resolve the apparent contradiction between self-acceptance and change in order to bring about positive changes in the patient (Linehan, 1993).

DBT is designed for use by people who have the urge to harm themselves, such as those who self-injure or who have suicidal thoughts and feelings. It was originally intended for people with borderline personality disorder, but has since been adapted for other conditions where the patient exhibits self-destructive behavior, such as eating disorders and substance abuse (Linehan, 1993).

Acceptance & Commitment Therapy

Acceptance and Commitment Therapy (ACT) is a relatively new treatment model developed by Steven Hayes which most directly uses mindfulness to address trauma. It is the third generation of behavioral and cognitive therapy where clients are not only monitoring their thoughts but they are also developing a relationship to their thoughts. In the past, trauma treatment has focused on the client gaining a sense of control. However, in ACT control is viewed as an illusion (Hayes, 2005). Walser and Westrup (2007) stated:

ACT asks whether it is possible to let go of conscious, deliberate, purposeful control that no longer works. Instead it walks through the process needed to come into the present and still to care, even when we have abandoned the security blanket of feel-goodism and the illusion of omnipotence (p. ix).

Developed within a coherent theoretical philosophical framework, Acceptance and Commitment Therapy is a unique, empirically based psychological intervention that

uses acceptance and mindfulness strategies together with commitment and behavior change strategies to increase psychological flexibility. *Psychological flexibility* means contacting the present moment fully as a conscious human being and, based on what the situation affords, changing or persisting in behavior in the service of chosen values (Hayes, 2005). Walser and Westrup (2007) suggested the following:

Instead of lives that are orderly, maybe it is better to seek lives that are open, flexible, and connected. Instead of feelings that are positive and controlled, maybe it is better to seek feelings that are deep, known, and accepted. Instead of thoughts that are proper, balanced, and rational, perhaps it is better to seek a relationship with our thoughts that is mindful, defused and undefended (p. viii).

Based on relational frame theory, ACT illuminates the ways that language entangles clients into futile attempts to wage war against their own inner lives. Through metaphor, paradox, and experiential exercises, clients learn how to make healthy contact with thoughts, feelings, memories, and physical sensations that have been feared and avoided. Clients gain the skills to re-contextualize and accept these private events, develop greater clarity about personal values, and commit to needed behavior change (Hayes, 2005).

Steven Hayes (2005) stated that ACT asks clinicians and clients alike to put down their needless defenses, show up, and begin to live in a more open, compassionate, and values based way, knowing full well that painful events can penetrate human lives at any moment. The core components of Acceptance and Commitment Therapy are a) creative hopelessness b) control as the problem, c) willingness, d)self as context and e) valued living. The next section of the literature review covers mindfulness including mindfulness meditation, Mindful Based Stress Reduction, and Mindfulness Based Cognitive Therapy.

Mindfulness Meditation

The word *mindful* has come into our everyday conversation and language. This new buzz word may just be the new age pause button we need in our ever increasingly technological world. Previous generations had more defined stereotyped roles and no access to the unending informational stimuli we take in via our computers, blackberries, and ipods (Brantley 2003). No wonder we are looking for a way to recenter and ground ourselves in general. In contrast, to be mindful is to do one thing at a time in an intentional manner (Brantley 2003). The following sub-sections will describe how researchers and practitioners have incorporated mindfulness into a range of psychotherapeutic initiatives. Mindfulness Meditation will be explored. Specific applications that incorporate mindfulness such as Mindfulness Based Stress Reduction (MBSR), Mindfulness Based Cognitive Therapy (MBCT), Dialectical Behavioral Therapy (DBT), and Acceptance and Commitment Therapy (ACT) will be discussed.

The benefits of practicing mindfulness have been well reported (Brantley, 2003). Even in the field of neuroscience, mindfulness is receiving sustained attention. Davidson, Kabat-Zinn, Schumacher, Rosenkranz, Muller, Santorelli, Urbanowski, Harrinton, Bonus, & Sheridan (2003) noted that mindfulness is part of the new paradigm of neuroplasticity. Many studies addressing a wide range of health concerns have shown that mindfulness - paying attention on purpose, without judgment, has both immediate and longer lasting effects. Davidson, et al. (2003) reported that people completing an eight-week course in mindfulness can experience decreased anxiety, a boost in their immune system, and an increase in brain activity related to resilience and positive mood. There is growing

evidence that such contemplative practice creates new pathways in the brain that can influence our lives for the better (Davidson, et al. 2003).

The Recent Mindfulness Frenzy

Mindfulness has been cited as the most popular psychotherapy technique of the last decade (Bien, 2006). Mindfulness techniques can be found in the latest treatment modalities ranging from depression and anxiety to programs addressing eating disorders and substance abuse (Bien, 2006). Mindfulness techniques, however, have been gaining interest in psychiatric circles since the 1970's (Brantley, 2003). With increasing interest and application, researchers have been trying to demonstrate the empirical validity of mindfulness techniques on wellness (Baer, 2006).

Mindfulness Meditation: Overview

According to Kabat-Zinn (1990), *Mindfulness Meditation* is a form of the ancient monastic tradition of Buddhism referred to as the Theravada School. Mindfulness Meditation is also known as insight meditation, called the *vipassana* tradition. The vipassana tradition is based upon Buddhist teachings that relate to living in the moment and operating from a keen level of internal and external awareness (Kabat-Zinn, 1990). Mindfulness Meditation is a way in which persons repeatedly practice or engage in the act of being present, observing their thoughts without reacting to them and attempting to focus on living in the moment in a non judgmental, self accepting manner (Hahn, 1976). Historically, mindfulness has been called the heart of Buddhist Meditation.

Mindfulness Meditation (Bien, 2006) is unlike *concentrative meditation* where the task is to focus on a single object of attention such as a phrase or sound. Mindfulness Meditation is considered to *not* be purposeful. Instead, the meditator is asked to observe

whatever is in the present moment whether it is thoughts, sensations in the body, or a sunset. In mindfulness meditation the position of an objective or detached observer is cultivated (Brown & Ryan, 2003). Kabat-Zinn, (1990) stated, “An operational definition of mindfulness is the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience, moment by moment” (p.145).

Interventions Based on Mindfulness Training

Mindfulness Based Stress Reduction

Mindfulness Based Stress Reduction (MBSR) is a stress reduction program credited with being the oldest and largest academic medical center-based stress reduction program in the United States (Santorelli, 2001). According to the Center For Mindfulness, “more than 15,000 people have completed our 8 week Mindfulness-Based Stress Reduction Program and learned how to use their innate resources and abilities to respond more effectively to stress, pain and illness” (Boyce, 2007).

Mindfulness-Based Stress Reduction (MBSR) was developed in by Jon Kabat-Zinn, Ph.D. in 1979 at the University of Massachusetts Medical School. Jon Kabat-Zinn, then a molecular biologist working at University of Massachusetts Medical Center, became increasingly interested in meditation and had the idea of bringing mindfulness to “where the pain was” within the hospital setting. In the early years the program was modest. In 1990, however, Kabat-Zinn published his first book, *Full Catastrophe Living* which described the MBSR program in detail. The book also explained the mindfulness philosophy behind the program and the transformative effects Kabat- Zinn observed in his clients. The book elicited a lot of interest and then the program was featured in Bill

Moyers' 1993 documentary *Healing and the Mind*' which presented average persons practicing MBSR at the clinic. Interest in the program skyrocketed (Germer, 2005).

Today MBSR is used internationally and the program has been applied to many clinical and medical modalities to restore health and diminish suffering.

The Center for Mindfulness

The Center for Mindfulness in Medicine, Health Care, and Society created in 1995, functions as a home base and an umbrella organization in the division of preventative and behavioral medicine at The University of Massachusetts Medical School. The Center is the hub of the MBSR program. The center fosters research, creates additional advanced programs, provides professional education and offers certification in MBSR teaching (Santorelli, 2001).

MBSR Research

Initially the first MBSR research participants were clients suffering from chronic pain. Baer (2003) conducted an empirical review of the literature on MBSR and chronic pain in which she evaluated four studies (Kabat-Zinn, 1982; Kabat-Zinn, Lipworth & Burney, 1985; Kabat-Zinn, Lipworth, Burney & Sellers, 1987; Randolph, Caldera, Tacone, & Greek, 1999). Baer (2003) found that:

In general, findings for chronic pain patients show statistically significant improvements in ratings of pain, other medical symptoms, and general psychological symptoms. Many of these changes were maintained at follow up evaluations. Most of these comparisons used pre post designs with no control group (p134).

Research initiatives in regards to MBSR were later conducted in areas such as anxiety and binge eating disorders with promising results (Kabat-Zinn et al., 1992; Kristeller & Hallett, 1999).

MBSR Program Description

The MBSR program is comprised of eight weekly, two hour classes and one day long class. The program includes guided instruction in mindfulness meditation and mindful yoga practices. These practices teach the participant to enhance awareness in everyday life. This stress reduction program is designed to develop more awareness of mind and body states with a concentrated effort to assist in the holistic treatment of physical illnesses in a way that empowers the client to be fully involved in the healing process. The program also includes daily mindfulness homework assignments lasting 45 minutes to an hour and methods for improving communication (Kabat-Zinn, 2005).

In the MBSR program, attending to the body is strongly emphasized. The body is worked through mindfulness meditation practice, yoga exercises and body scanning which promotes “full-body conditioning.” These methods strengthen the body and provide a way to release muscular tension. When practicing at home, participants use two guided mindfulness tapes and a workbook designed for the program (Kabat-Zinn, 2005).

The MBSR program challenges participants to develop insight in relation to their difficulties and empowers participants to take an active role in learning to take care of themselves. Kabat-Zinn (2005) believes that people know the basics of promoting good health such as exercise, a proper diet, and sleep, but states that,

If people don't have something that brings them to self-awareness of the importance of taking care of themselves, no matter how many presentations, lectures, or brilliant talks you give to the population, they go back to their same environment and continue with old patterns of coping and behaving and they don't take care of themselves.

Kabat-Zinn stresses that, “if we empower them by teaching them mindfulness, people start to remember that being human is something wonderful (Boyce, 2007, p. 5).

Training for Professionals

The Center also offers a professional education practicum. Physicians, nurses, psychotherapists and educators are among those who seek training so they may then integrate MBSR in their working relationships with patients and students. The department of psychiatry at the University of Massachusetts Medical School is a co-sponsor of this program. The University Program is approved by the American Psychological Association to sponsor continuing education (Santorelli, 2001).

Mindfulness Based Cognitive Therapy

In 1995, Mindfulness Based Cognitive Therapy (MBCT) came onto the scene. Researchers felt that mindfulness could help clients stop ruminating before their distorted thoughts spiraled out of control into a full blown depressive episode. Mindful Based Cognitive Therapy (MBCT) is an innovative, proven program designed to prevent relapse into clinical depression. Based on the research of Drs. Zindel Segal, Mark Williams, and John Teasdale and documented in their book *Mindfulness-Based Cognitive Therapy for Depression* (2007), MBCT combines the tools of cognitive therapy with the practice and clinical application of mindfulness meditation. As clients who suffer from depression and anxiety improve and no longer need ongoing therapy, there is still a need for specific psycho-educational tools for understanding the cause of relapse and for the maintenance of good mental health.

The focus of the MCBT program is the utilization of mindful (relaxed and focused) attention as an alternative to a ruminative and worrying thought process.

Research clearly indicates that worrying, looping and over-thinking amplify and aggravate the hallmarks for depression: feelings of worthlessness, guilt, global negativism, perfectionism, self-condemnation, and intense fear of the future.

Summary

This literature review has examined the literature on trauma from historical and treatment approach perspectives. Specifically Cognitive Behavioral Therapy was chosen as the theoretical perspective. Therefore, literature on CBT, CBT for trauma, the stress response, Dialectical Behavioral Therapy, and Acceptance and Commitment Therapy were reviewed. Mindfulness meditation was the treatment approach this researcher reviewed in depth. Mindfulness meditation was presented starting with an overview and proceeding with interventions including Mindfulness Based Stress Reduction and a discussion of training for professionals. While not every trauma intervention has been described, this literature review provides a basic understanding of trauma, CBT, and mindfulness. Based on the literature review the next chapter sets out the methodology for exploring the reasons behind clinicians' use of mindfulness as part of individual psychotherapy for adults with trauma related symptoms.

CHAPTER III

METHODOLOGY

The research question for this qualitative, exploratory study was: Why and how are clinicians deciding to use mindfulness with adults with trauma symptoms? The sub questions include: How are clinicians finding mindfulness effective or not effective? How are clinicians integrating mindfulness into individual sessions? Why are clinicians deciding to get trained in the approach of mindfulness?

I conducted a study using open-ended questions to gather narrative data to explore treatment strategies in the context of mindfulness. I chose the interview process to collect data for this study due to my desire to obtain subjective experiences from participants, which could better be captured in words than through a close-ended survey. This semi-structured interview allowed for probes to initial responses, thereby affording the flexibility to elicit richer and more detailed narrative responses. The participant's point of view gives the reader a glimpse into the participant's feelings, motivations, memories, and experiences. As noted in Anastas (1999), "people are often more willing and able to reflect at length on complex feelings, understanding, and past experiences through the spoken word than the written one" (p. 351).

Gathering narrative data helped to understand this phenomenon in greater depth. Flexible methods enabled me to ask relevant questions in regards to cases with positive and negative outcomes.

There was very scant literature on using mindfulness as a treatment modality with trauma symptoms in adults. This strategy with clients has not been sufficiently investigated. The findings of this study add to the literature concerning theory and practice.

Sample

This expert sample consisted of eleven psychotherapists recruited via my professional network and by using the snowball method. In order to qualify, participants had to possess at the minimum a master's degree in mental health or human services that included licensed professional counselors, licensed clinical social workers, licensed marriage and family therapists, licensed psychologists and psychiatrists who are board certified. Clinicians also needed to be proficient in English. All clinicians were previously trained in mindfulness techniques through an accredited mindfulness based program such as Dialectical Behavior Therapy (Linehan, 1993), Mindful Based Stress Reduction (Kabat-Zinn, 2000) or others. Participants also had to have prior experience working with adult clients presenting with trauma related symptoms in outpatient settings.

I chose to interview clinicians due to their training and availability. My sample consisted of a non-probability, convenience sample of experts. I felt that this sample was warranted since previous research (Germer, 2005) noted that a limited number of clinicians are utilizing this approach. It was my assumption that there are a limited number of clinicians trained in mindfulness working with adults with trauma symptoms. I wanted to recruit a range of diverse individuals within the sample but my composition of the participants was homogeneous due to the need for an expert sample.

Clinicians who did not work with adult clients with trauma symptoms were excluded. Clinicians who had been practicing mindfulness for less than a year were also excluded. Participants were not compensated for taking part in the study.

Data Collection

Narrative data from open-ended questions conducted through face to face or telephone interviews were obtained from a sample of eleven clinicians who met the selection criteria. Procedures to protect the rights and privacy of participants were presented to the Human Subject Review Board at Smith College School for Social Work before data collection began. Approval of the project (see Appendix A) assured participants that the study was in accordance with the NASW *Code of Ethics* and the Federal regulations for the Protection of Human Research Subjects. An informed consent form (see Appendix B) detailing the risks and benefits of the study was sent to the participant prior to the telephone interview. The participant and researcher retained a signed copy of the informed consent document for their records. The initial contact, as well as the beginning of the interview, offered the participants an opportunity to inquire about the researcher, the study, their expectations as to how the data might be used and ask additional questions. Finally, clinicians were told that the data collected for this study will be used for possible presentation and publication as well as completing the thesis project that is a partial requirement for a Masters in Social Work.

The Instrument

The first section of the interview guide asked the participants to provide descriptive data. Demographic characteristics focused on when participants were trained in mindfulness and how long participants had been using mindfulness in their practice.

Participants were asked about their age, gender, education and specific post graduate school training.

A combination of semi-structured and open-ended questions to elicit clinicians' information about their choice to use mindfulness and experiences of efficacy with clients was researcher developed. Semi-structured, open-ended questions included a query about what led participants to use mindfulness in their practices. Participants were also asked to provide a sample case that illustrated the use of mindfulness with trauma treatment. Finally, clinicians were asked to give an explanation of how the participants felt mindfulness works to reduce trauma symptoms.

Enhancing Reliability and Validity

Face validity of the interview instrument was enhanced by having my research advisor and another social work clinician with trauma and mindfulness experience review the interview guide and give feedback. The interview guide was also pilot tested with two fellow colleagues who were not part of the sample. The purpose of pilot testing was to get feedback on clarity of the questions, logical flow, timing, etc. This feedback was also incorporated into the final version of the interview guide.

Risks and Benefits

There was minimal risk or discomfort associated with participation in this study because the sample consisted of professionals in the field of mental health. The benefits for participating in this study are that it may have helped clinicians explore the issue of mindfulness as an approach to treating trauma related symptoms at a greater depth. Participants were not compensated for taking part this study.

Protection of Confidentiality

Confidentiality was maintained throughout this study. No clinicians' names, nor their clients' names appeared on any papers or recordings, as numerical codes were assigned to their information. This researcher and her thesis advisor reviewed and analyzed the data together after all identifying information was removed. Any writings or publications on this topic will be presented in the aggregate. Any quotes used for illustrative purposes did not include identifying information. The information gathered (audio recordings, transcriptions, notes, and signed informed consent forms) will be locked for a period of three years, as required by federal guidelines. After that three-year period, all data will be destroyed when no longer needed or kept safely stored.

Participation in this study was voluntary. Participants could have withdrawn from the study at any time during or after the study until April 15, 2009 and they could have refused to answer any question. They could have withdrawn from the study, or chosen not to answer certain questions without penalty. Participants were asked to contact this researcher at the number or email stated in the informed consent if they chose to withdraw from the study, or if they had any questions regarding this process. No participants withdrew from the study or contacted the researcher after the interview.

Data Analysis

Unstructured narrative data gathered by way of face to face or telephone interviews were tape recorded and transcribed verbatim. Transcriptions were coded by reducing narrative data into conceptual themes and categories. Consistency was maintained since there was one researcher conducting interviews and analyzing data. Content/theme analysis worked to systemize the complex and content related data that

were collected in the process of flexible method research. Coding reduces “narrative data to conceptual categories, into which parts of the text can be grouped and in terms of which the text can be described or displayed.” (Anastas, 1999, pp. 419-420).

Narratives were compared throughout the process of the study and data were coded in overlapping stages. In this sense, there was open coding and provisional codes were assigned to all indicators. The qualitative responses were grouped by similarities and differences using this inductive method. Themes and similar responses were noted throughout the process as the data were being gathered. This was done by cutting and pasting all responses to questions together, reading through the responses, and highlighting themes, keywords, and unusual responses in different colors.

Discussion

All participants stated that mindfulness decreased trauma related symptoms giving case examples. All interviewees said that mindfulness enhanced their therapeutic effectiveness. These were expected findings. Therapists gave diverse reasons for getting trained in mindfulness and this was an unexpected finding.

There were limitations for this study. First it was a very small sample: eleven interviews. Second there was very little diversity. Ten clinicians identified as Caucasian and one clinician identified as Hispanic. Ten out of eleven participants resided in the northeast, providing for a very narrow geographic area.

There are two sources of bias: the researcher and the method. My bias as a clinician doing this research is I believe that mind body approaches are needed and that mindfulness is an important tool as an adjunct to talk therapy. Because of my personal bias, I only interviewed people who used mindfulness and did not look for people who

thought that mindfulness was not a good adjunct to psychotherapy. I also chose to do interviews as my method of data collection and that resulted in depth of information from a small number of people, which is not generalizable to the larger psychotherapeutic community.

CHAPTER IV

FINDINGS

Demographics

Eleven clinicians participated in this study: 9 females and two males. Ten of the participants were Caucasian and one was Hispanic. Ten out of eleven participants were employed in New England. The other participant was employed elsewhere in the United States. Two participants worked in a mental health agency, six worked solely in private practice and three worked in both an agency and private practice.

All participants had at least a Master's level degree in social work or mental health counseling. All eleven of the participants were clinicians. One participant had a PhD. in clinical psychology. Another participant had a Masters degree in psychology. Two interviewees had a Masters degree in counseling. Seven participants had LICSW licensure. Participants' length of time using mindfulness as an adjunct approach at the time of the study ranged from 6 years to 28 years with a mean of 12 years. Certifications that participants held in addition to mindfulness included EMDR, substance abuse, education, clinical hypnosis, and human sexology.

There were six major findings for this study. First, all participants affirmed the usefulness of mindfulness in reducing trauma related symptoms giving specific case examples. Second, participants described using mindfulness to reduce overstimulation, dissociation, leaving the body and confusion over locus of control. Third, all participants stated that mindfulness positively impacted their therapeutic effectiveness. Fourth,

participants discussed the ways in which they used mindfulness in therapy sessions. Fifth, participants described contraindications to using mindfulness. Sixth, participants gave diverse reasons for getting trained in mindfulness. The following sections describe these six findings in greater detail. Illustrative quotes are included that highlight the perceptions of the participants.

Usefulness of Mindfulness in Specific Case Examples

All participants affirmed the usefulness of mindfulness in reducing trauma related symptoms in specific case examples. Participants noted the usefulness of mindfulness in reducing anxiety, developing compassion, working with dissociation, and tolerating the present moment.

Anxiety

One participant talked about using mindfulness to reduce anxiety in the following way:

One lady actually was an amazing example of mindfulness. She came in and she was so anxious that she couldn't even sit down through the intake interview and she had to stand in the doorway and we could only do 20 minutes of the intake. She had just a lot of phobias and a lot of panic and a high degree of anxiety. So we just started working with mindfulness to help her look at ok what are the triggers to your anxiety? What is happening? What is the story you tell? What is a way to find a safe place to calm yourself? We worked over three or four months together and the anxiety totally disappeared for her. She went on to basically drop all her phobias she had and connected to a central calm we also did meditation with that and for some reason through all the work we did she had some kind of insight which shifted everything for her and she hasn't had any panic attacks since. So she learned some great skills and it was fantastic to watch and basically it was all mindfulness stuff.

This participant also described how this client went on to write a book about her own healing and now works with other people to help them with their anxiety.

Another therapist described how a client's anxiety was getting in the way of the psychotherapeutic process. The therapist related using mindfulness to reduce the client's anxiety so that the client was able to make use of the therapy. The therapist stated "so I did 10 minutes of mindfulness meditation and at the end of it, he was at a different place he was able to talk about the difficulty in his life. There was a certain kind of vulnerability and accessibility that he was not able to get to before." A third participant reported using mindfulness with a client who was struggling with anxiety around leaving an abusive marriage. The clinician said that by using mindfulness over a period of months the client was able to reduce her anxiety and move on to get a divorce. The clinician said that mindfulness "really helped the client to manage her anxiety and face the denial around the abuse... she was able to make profound changes in her life."

Developing Compassion

One clinician talked about a client with a trauma history who was able to use mindfulness to develop compassion for herself and stop listening to internal critical voices. This participant explained how the client was having difficulty playing a musical instrument and slowly, through compassion, was able to make progress.

Another therapist related an example of using mindfulness to develop or cultivate compassion. She described a client who had to take care of her elderly father. The therapist said the client was under a lot of stress and resented having to take care of an older parent that really never took care of the client's needs. The therapist described how the client used mindfulness to cultivate compassion for herself and her ailing father. The therapist related that developing this compassion helped the client to seek out more

personal resources which led to her feeling less stressed in caring for her father. The therapist stated:

Using mindfulness she is more compassionate with her father. She can see him as lonely and scared and is able to see things differently. She is working with it and she kind of goes back and forth between her child self reacting and her adult self responding compassionately... I see increasingly her capacity to handle it and feel less burdened over it.

A third interviewee said that cultivating compassion in trauma survivors is like opening a special place where the client can have a rest from negative interjects or critical voices from the past. She said, "it opens up space for healing, cultivating compassion for the self is very nurturing."

Dissociation

One therapist described working with a client diagnosed with dissociative identity disorder who would dissociate and have periods of self injury. At one point the clinician said she talked to the whole "gang of parts" and said to them, "You are not going to find any peace until you all learn how to use mindfulness." This therapist then described how she was able to teach the mindfulness skills and distress tolerance skills to all of the alters and then the self injury stopped. She stated, "I guess they are motivated...to stay safe...ready to be mindful of the moment and use the distress tolerance skills." This clinician stated "it seems like mindfulness just really hit the spot."

Another clinician said she worked with a client who struggled with frequent dissociation and was able to ground herself and use mindfulness to decrease the dissociation dramatically. The client achieved this by intently focusing on an object in the room or by being mindful of her breath.

Tolerating the Present Moment

One interviewee described a client who was suffering from depression and anxiety who learned to better tolerate the present moment through mindfulness. This therapist talked about a client who dreaded the mornings due to high anxiety. The clinician described how the client began to better tolerate her mornings by mindfully doing tasks one at a time such as listening to a radio program, pouring and preparing her coffee and doing stretching exercises. The participant stated,

She has a lot of severe anxiety in the morning and so she would get up and kind of just talk herself through activities like just being really mindful of each step she was doing... and be mindful of each thing ... really helped to reduce some of the aversion to the morning.

This same clinician also described using mindfulness with another client who was very disregulated and was able to slow down and tolerate the present moment better by being mindful of his breathing and just noticing his thoughts as they came up. She stated, “He did some major work [and] that was his first time he was ever in therapy.”

Another therapist described a client who learned to tolerate the present moment and get in touch with her trauma related grief. The therapist said that initially the client could only do this in session but eventually through mindfulness learned to tolerate what was happening for her in the present moment and then work with those emotions in her daily life. The therapist stated:

She started allowing the pain to be there, to tolerate it and she started to cry. She started to grieve very deeply and initially she could do it only with me and every time it would come up in other situations she would be completely panicked about it but she learned to do it even on her own, to deal with a lot of ghosts. She learned to tolerate the intense pain and feel her vulnerability that she still carries.

Participants Views on the Reduction of Symptoms Using Mindfulness

Participants shared their views on the reduction of symptoms using mindfulness.

Participants talked about locus of control, overstimulation, grounding properties and creating safety.

Locus of control

One participant discussed the subject of locus of control in regards to mindfulness. She said that teaching people how to be mindful of their thoughts “gives them a much better sense of control internal control.” This therapist noted that people can develop a way to relate to their thoughts where they are not on “automatic pilot.”

Another interviewee talked about giving clients locus of control back by teaching clients that they can mindfully have a relationship with their thoughts and they are not their thoughts. In this way, clients are mindfully observing their thoughts and are not getting caught up in them.

A third participant described increasing locus of control using mindfulness in this way:

...helping people to be with things, when they develop awareness of their thoughts and how their thoughts affect them and are less scared of their thoughts or emotions you can eventually see a shift in the way they feel more central in their relationship with themselves and to the present moment.

Overstimulation

One clinician described mindfulness as helping people who have trouble with overstimulation. She related that,

When people... are over stimulated ... I think mindfulness can be helpful for them to both soothe themselves and to the process of soothing in the moment and also be able to differentiate the past from the present equally because the present is usually safer than the memories [you] let them feel in the present moment. So

helping them in the context of the present moment and the safety of where they are I think is really important.

The next therapist discussed mindfulness and overstimulation by saying that she often has a client rate their emotional intensity from zero to a hundred and this helps them see where they are at and think about which skills they need to use to decrease their emotional intensity. This clinician added that she encourages clients to then be mindful of what they are noticing in their body and stated, “ So, as the clinician you are helping them tolerate and be with their intense feelings while they are out in the world.”

A third participant said that mindful breathing exercises really help clients deal with intense feelings. He said when a person becomes aware that they are over stimulated they can come back to their breath. They can bring their awareness to the breath coming in and going out and get themselves to a better place emotionally.

Grounding Properties

One interviewee talked about the grounding properties of mindfulness. She said,

I have clients who have dissociative disorders and avoid by dissociating. I found that one way to work on the impulse to dissociate is to help people use mindfulness to ground them...with physical sensations in the present moment or literally talking aloud about what they can feel or hear or feel in the present moment. That seems to be really helpful... for people who are beginning to make contact with their emotions I think mindfulness is really important for helping them objectively observe their emotions and describe the sensations and the thoughts that go along with them. They can gradually become more comfortable having emotions and not be so scared of them.

Another participant talked about grounding in relation to mindfulness. She said,

I think a lot of the time folks are disconnected from their body and there is a way in which the goal is to synchronize the body and the mind within the context of the environment... so the mindfulness sort of gives people tools to come into their body to notice what is happening and to not feel overwhelmed by their states of mind given in which they work with some of the fear and the anxiety.

The next participant explained grounding in this way. She stated,

Mindfulness or awareness, especially when it is grounded in the body, is a huge resource. The resource has to create faith and support to help people tolerate ... to have more room emotionally and physiologically to digest uncomfortable sensations... when [a client] is seeing things in a very narrow perspective it can be overwhelming... mindfulness helps to expand the container so you know the container can grapple with change... and [looking at a problem as if] it's on your little finger nail, it might be big, but if it is floating in a huge field, it's small. You are not actually changing the pain, you are changing the container and we experience the change in perspective.

Developing Resources to Create Safety

Some participants talked about using mindfulness as a way of developing resources to create safety. These therapists spoke about using mindfulness to help clients access resources in the present or past that made them feel safe. One said,

I think another thing that mindfulness allows people to do is to move toward traumatic materials in a safe way...especially of learning how to build bridges and developing other resources we are talking about when we are doing the therapy and you are asking them to bring in a human being or a protector who find can help ... asking them to hold all of the things... faces, animals, nature, whatever helps to contribute to their sense of emotional, spiritual, physical, intellectual being.

Another clinician talked about always making sure that a client had a “safe refuge” to come back to and the use of mindfulness to create this refuge. She stated,

One can use mindfulness to help focus on anything that gives you a sense of well being or safety. Some people may just focus on feeling neutral, even neutral can be a refuge. Neutral is different than numb. Or a client could mindfully focus on sounds or music that makes them feel a sense of safety and comfort. By mindfully creating this refuge it is a place that the client can come back to again and again when they need it.

A third interviewee pointed out the safety of the present moment as a resource that clients can work with to increase feeling safe. Helping clients focus on the present moment can get them out of their pasts. They can learn to see the present moment as a touchstone and know they are safe in the present moment. This clinician noted “the

ability to access the safety of the present moment is probably a pretty fundamental skill I teach people.”

Impacting Therapeutic Abilities

All participants claimed that mindfulness positively impacted their therapeutic effectiveness. Some therapists reported that mindfulness positively impacted their therapeutic alliances and their ability to tolerate their own affect. Other clinicians said mindfulness gave them insight into transference and counter transference issues and enhanced their ability to work with difficult populations.

One participant described mindfulness this way, “It makes me a lot more aware of what is happening with the client and what is happening with myself ... transference and counter transference issues.” Another therapist described how her own practice of mindfulness affected her “ability to sit with what was in the room” and her “ability to stay present in the room” as well as increasing her own awareness of when her mind wanders off.

A third clinician talked about the way mindfulness helped her manage her own anxiety as a therapist. She reported that it helped her to “really see what someone is showing me in a session.” A fourth participant described the positive impact on her therapeutic abilities in this way:

I think it is a real orienting principle for me. When I am deregulated or puzzled about what is in front of me, I can remind myself that the most important thing is what is happening right now in this moment and use the present moment in whatever way might be helpful...

Another clinician described her experience of mindfulness as follows:

It [mindfulness] has allowed me to tolerate situations that I don't know I would have been able to tolerate so well otherwise. I don't think I would have chosen to

work with a population that is as extreme as this one. The practice has really allowed me to stay ready within myself enough to be able to be in relationships with people.

Finally, a sixth therapist stated that:

I am in a good place right now where I am practicing mindfulness regularly for myself and [it] definitely has a huge impact in therapy sessions. Just how you can feel about your day how you can shift gears quicker with mindfulness there is an alert you can kind of like put other stuff away....

Examples of Using Mindfulness in Sessions

Some participants gave examples of using mindfulness in sessions. They talked about soothing clients, helping clients to make space to experience feelings, and providing psycho education around mindfulness in sessions.

Calming and Soothing

Several participants described using mindfulness in sessions to soothe or calm a client. One clinician gave an example saying,

Sometimes I do it within the session when people are getting like stuck or they are getting themselves worked up a little bit so they are starting to get like hyper aroused within the session. I sometimes say just let's take a moment to breathe you know. I might give them like some sort of prompt you know breathe in a color breathe out a color or breathe in blue light around you like so they can ground and calm themselves.

A second participant described using mindfulness within the DBT model of distress tolerance skills. This clinician said she would have a client describe soothing images involving all five senses. She then would suggest that a client imagine cooking and smelling the food and describing the color of the food. The client would often take those in-session exercises and use them at home as a way to self-soothe.

A third clinician said she would often brainstorm mindful ways a client might calm themselves in stressful situations in sessions. She stated "we might make a list of

mindful activities that are soothing such as mindful walking in the woods, mindfully listening to sounds in a park, or mindfully drinking a cup of tea in a café.” She said that clients often came back the next session and noted positive results of these exercises.

Making Space to Experience Feelings

A few therapists talked about using mindfulness in sessions as a way to slow clients down and help them connect to their feelings. One participant put it this way,

So, what I do with people is encourage them to slow down and so sometimes like in sessions, I will just say let’s just pause right here you know let’s take time with that and that is where I feel like mindfulness is fuel to add some time to get the pain with that feeling or deal with that sensation using the idea that it is just to give it time to flow because people will kind of jump right over and on to the next story so really inserting time to deal with the emotions briefly, which is often what is missing in a traumatic event like a car accident... you give people the time to feel it.

Another clinician described making space to experience feelings as a profound way for the client to connect with their pain and have the clinician share this space and experience with them. She said:

When clients are doing work in therapy, there usually comes a point where you say “So that really hurts, that really sucked. It is what happened in your life, it is really sad and it hurt.” As a therapist, you can’t make that better, so you teach them mindfulness, not necessarily calling it mindfulness but practicing it. It is teaching the client how to sit with those feelings and how we can sit together in that experience. It is part of just learning some way to just be with someone in their pain in the session. It is also sort of like a life skills kind of thing, allowing a shared experience and developing the capacity to be with things.

Psycho Education about Mindfulness

One interviewee noted the benefit of providing psycho-education about mindfulness in sessions. This professional reported that many clients seemed intimidated or turned off to mindfulness due to its association with Buddhist teachings or intense

meditation practices. She often had to frame mindfulness in ways where clients could see it as a useful tool that was accessible to them. She stated,

I think just recognizing that for some people it can be really unfamiliar. I think there is still for some people, they don't really understand it ... like it is...they sometimes think there is like some unknown yoga or whatever and they think you are doing something. Something a little bit funky and they don't get it. So I think education and explaining it a little better and making sure that you really keep it in laymen's terms is the way you can sell it to different people really. It is all the same but it is the way you kind of sell it that someone sees it as useful.

Another clinician reported that psycho education can be an important part of adding mindfulness to treatment. This clinician stated that “inviting clients to become engaged in compassionate dialogue” about mindfulness helps take any possible worry or fear out of trying mindfulness, and instead invites clients to try something new or look at their thought process in a very different way. He also said conversations like this seemed to help further the relationship with the client as more trusting. Talking with the client about what you would like to try tends to put them at ease and make them more receptive.

Contraindications for Using Mindfulness

Several therapists mentioned active psychosis, acute crisis, safety concerns and lack of readiness as reasons they may not use mindfulness with a client. Three participants commented on a lack of acuity in clients as being a contraindication for using mindfulness. These three clinicians, overall, stressed the need for there to be a current state of present safety for clients to be able to access and apply the skill of mindfulness.

One participant discussed using mindfulness with actively psychotic patients as contraindicated. She said that:

There are definitely ways in which it is contraindicated for people with active psychosis. When people are in psychosis they are so much in their minds that using mindfulness practices can sort of increase the focus on minds to the point

where it is not enough and not productive so for that reason it is not always indicated.

A second therapist stated that if a client was in direct crisis, mindfulness might not be a tool that could be accessed until other resources were developed. Another participant talked about skill building with mindfulness and noted that if the client was not feeling safe, mindfulness might not be helpful. She stated “I mean certainly it would be bad for a client to learn mindfulness of fear or anger if they weren’t also able to use mindfulness to stay safe.” This therapist also noted, “It would be flooding for some clients perhaps to focus mindfully on something that was too horrific for them to handle currently.” The third interviewee said that if a client was enduring a current trauma, being mindful of the trauma may be too much for the client to handle. All three participants stressed creating safety as the first goal for clients.

A fourth participant spoke to the readiness of the client to handle certain distressing material. This clinician stated that it may be a drawback to use mindfulness with someone who just wants to dig into traumatic material before doing some work to build resources for the client first. This participant stated:

So I think that if you are working with trauma to remember the want. They desperately want their lives to be different and they want it now because it's like they need to change. So to lower the risk factor you take the slowest path. You slowly keep building a foundation.

Other clinicians mentioned cognitive readiness, stating that some clients were not able to learn mindfulness skills due to cognitive challenges.

Reasons for Getting Trained in Mindfulness

Participants gave diverse reasons for seeking training in mindfulness. Some interviewees were interested in mindfulness because of personal life experiences. Others

talked about an interest in spirituality or their practice of yoga. One clinician felt that mindfulness was a strategy that helped her combat her own lifelong symptoms of depression, and she now teaches mindfulness to persons with depression all over the country. This therapist believed that mindfulness is something to be used when one's thoughts get in the way of healing. She said,

I actually wouldn't be alive today if it wasn't for mindfulness ... I struggled with suicidal thoughts from the time I was five... For 20 years I struggled with depression and suicidal thoughts and I was on medication for a while... but there was a point when the mindfulness kind of won out because it took me to another place. For the last four years there has been no depression. It is gone. The whole symptomology went away. It's been phenomenal. I see that we use thoughts as a tool ...it is totally fine but we don't need to bring that tool bag with us you know everywhere we go. We put down the tools of the mind.

Another participant said that she found mindfulness helpful during her college years and later decided to use it in her practice. Three participants stated that their historical interest in spirituality was a reason for seeking training in mindfulness. One interviewee explained it this way:

As long as I can remember even as a small child I was interested in what the Buddhist picture is. You could call it a spiritual interest in life. So I was drawn to a course in college called Introduction to Consciousness Evolution. It had one part meditation and one part was a group called Arica. It was classic meditation.

Another therapist described his interest as follows:

I was looking for some kind of prayer practice that would be more meaningful to me than most of what was being offered. And in a very odd set of circumstances, I met a Roman Catholic monk and he talked with me and he taught me how to do it. I was not looking for a technique; basically I was looking for someone to teach me contemplative prayer and not just ordinary prayer.

One participant described his interest in this way, "Well I was interested in mindfulness before I started it with clients although that is not specifically what drew me

to it at first. I was interested in spiritual questions I guess... a lot of learning about different spiritual paths.”

Two participants described coming to mindfulness through yoga. One clinician said that yoga led her to a meditation class and then to other meditation centers. As she explained it,

I had done yoga for many years and one day after my yoga class there was a meditation class going on and I was like I am going to check that out. And so I took a class for about a year in traditional meditation and then I started working with [clients at a residential treatment facility] where there is a requirement to have a [personal meditation practice]...then I got introduced to the Shambala Center where I started sitting and from there [was] introduced to place which is a sort of a British Shambala retreat center up in Vermont.

The other therapist who came to mindfulness through yoga described it this way:

Yoga really helped me when I was in my early and mid twenties. I went to the yoga ... and ... she would do a lot of mindfulness...and then I went to [an ashram]...We did a lot of meditation and so then I had kind of gotten into doing it ... and then probably through my own kind of you know issues in working in my own therapy kind of using that as a tool.

Summary

This chapter presented the findings from semi-structured interviews with eleven participants. The major finding was that all clinicians felt that mindfulness decreased trauma related symptoms. Participants reported many and varied ways that mindfulness can be used as an adjunct to trauma treatment. All therapists also felt that mindfulness positively impacted their therapeutic effectiveness.

Clinicians reported specific symptom reduction, how they have used mindfulness in sessions, and contraindications to using mindfulness with trauma survivors. In addition, participants discussed a range of useful approaches and considerations for the integration of mindfulness in psychotherapy.

The following chapter will compare this study's finding with current literature and discuss the significant implications to clinical social work practice and education that arise from the findings. Chapter V will also outline the limitations of the study, offer suggestions for future research on the topic, and conclude the document.

CHAPTER V

DISCUSSION

The objective of this qualitative study was to explore the decision making process and perceptions of effectiveness of clinicians using mindfulness as an adjunct treatment for trauma related symptoms. The complexities of using mindfulness as an adjunct technique were explored through the narratives of seasoned professionals in the field. This chapter discusses the findings in the following order: 1) key findings, 2) implications, 3) limitations, and 4) conclusion.

Key Findings

The majority of the findings were consistent with the previous literature. Citing case examples, all clinicians felt that mindfulness reduced trauma related symptoms. Participants noted the usefulness of mindfulness in reducing anxiety, developing compassion, working with dissociation, and tolerating the present moment. These observations are consistent with Bien's (2006) report of using mindfulness to reduce anxiety and cultivate compassion. Hayes and Smith (2005) and Linehan (1993) also reported using mindfulness for symptom reduction. Brantley (2003) recommended using mindfulness to reduce anxiety and depression. Hayes and Smith (2005) discussed using mindfulness to reduce dissociation. Segal et al. (2007) conducted research that showed mindfulness was useful in addressing depression and later wrote a book giving recommendations on how to use mindfulness with clients who are depressed.

Participants shared their views on the reduction of specific symptoms using mindfulness. Namely, overstimulation, dissociation, lack of grounding, feeling unsafe, and loss of locus of control. In the literature, Brantley (2003) wrote about how clients are often taught mindfulness skills to modify these symptoms of overstimulation and dissociation. Linehan's work (1993) also included many DBT skills that focus on reducing dissociation and decreasing distressful emotions such as overstimulation. Grounding exercises are prominent in the literature on trauma. Hayes and Smith (2005) and Brantley (2003) cited examples of breathing exercises, walking meditation, and body scan exercises designed to address clients' struggles with grounding. Creating safety is the first thing that the literature on both mindfulness and trauma addressed (Herman, 1992; Linehan, 1993). Clients need to establish safety before they can take on the work of addressing their trauma. Linehan (1993), in her DBT skills manual, mentions having clients open their eyes during short mindfulness practice to increase feelings of safety. Hayes and Smith (2005) and Linehan (1993) also suggested using mindfulness as a method for putting clients back in the driver's seat in relation to their emotions. Giving clients the tool of mindfulness often results in clients' increased awareness that their own "minds" are creating symptoms. Thus, clients have an opportunity to look at how their thoughts and mental chatter lead them to experience certain mood states.

All participants claimed that mindfulness positively impacted their therapeutic effectiveness. Some therapists discussed mindfulness positively impacting their therapeutic alliances and their ability to tolerate their own affect during difficult sessions. Other clinicians said mindfulness gave them insight into transference and counter transference issues and enhanced their ability to work with challenging populations.

Mindfulness positively affecting therapeutic effectiveness is also well documented in the previous literature. Several books have been written on how mindfulness can benefit clinical effectiveness. Germer (2005) edited one book on therapeutic effectiveness and mindfulness techniques called *Mindfulness and Psychotherapy*, which has various chapters on the connections between mindfulness training and clinical training. These chapters address many clinical subjects including therapeutic alliances, tolerating affect, understanding transference and counter transference issues, and working with challenging clients.

Some participants gave examples of using mindfulness in sessions. They talked about soothing clients, helping clients to make space to experience feelings, and providing psychoeducation around mindfulness in sessions. Their descriptions of mindfulness being used in sessions were similar to current understanding in the literature. Germer (2005), provided examples of therapists soothing clients using mindfulness. Linehan (1993) talked about mindfully using the five senses to help clients self soothe. Bien (2006) wrote about the use of mindfulness to help clients make more space to feel, experience, and tolerate emotions. Germer (2005), Kabat-Zinn (2005), and Hahn (1976) also discussed making space for awareness of feelings. Linehan (1993) and Hayes and Smith (2005) encourage clinicians to provide information on mindfulness and trauma in a manner that can be readily understood.

This thesis demonstrates that some people may not be good candidates for mindfulness. Several therapists mentioned active psychosis, acute crisis, safety concerns and lack of readiness as reasons they would not use mindfulness with a client. These contraindications were substantiated in the literature. Gaudiano, Miller, and Herbert

(2007) and McPhee, Papadakis, and Tierney (2008) both identified untreated psychosis as a contraindication for using mindfulness as an adjunct approach. Linehan (1993) and Hayes and Smith (2005) encourage clinicians to stabilize the client during inpatient treatment before teaching mindfulness skills. Safety as an utmost goal is the hallmark of programs for trauma and has been well documented in the works of Herman (1992), Linehan (1993), and Hayes and Smith (2005). Segal, et al. (2007) stress the need for clients to be ready to be able to utilize mindfulness skills.

The varied reasons for getting trained in mindfulness was a somewhat unexpected finding. In general, the literature noted that the reasons for getting trained to be mostly for personal experiences or workplace requirements (Baer, 2003). This researcher, based on the search of the literature, expected personal experiences to dominate. However, three participants came to mindfulness through spirituality and two participants explored mindfulness through yoga. Interest in spirituality was an interesting finding although reasonable to expect considering the context of mindfulness and Buddhism.

Implications

Mindfulness can enrich clinical work as an adjunct to trauma treatment. Its versatility and focus on being aware of the present moment can enrich the lives of both clinicians and clients alike. Used wisely, mindfulness will likely continue as a popular approach in helping clients address their trauma.

With many trauma interventions focusing on a combination of talk therapy and medication, mindfulness may prove to be a gift or a tool that clients can access in the present moment in the privacy of their own home if they wish. Even instructing a client to practice breathing in and out for five minutes it may be valuable exercise for a

clinician to do in a session with a client. Introducing mindfulness practices in the office can be followed up by a therapist assigning homework, which may be as simple as a client showering or washing the dishes mindfully to connect with the present moment.

Modalities for treating trauma are increasingly incorporating body-based approaches. Mindfulness, with its emphasis on staying connected and in tune with the body, falls under this category. Van der Kolk, a leader in the field of trauma treatment, highly endorses the inclusion of these body-based approaches (1987; 1996; 2002a; 2003).

If clients are in acute crisis or presently going through a major trauma, they may not have the capacity to focus so intently on their emotions. It is imperative that clinicians adhere to the safety guidelines outlined by Herman (1992), Linehan (1993) and Hayes and Smith (2005), and to make sure clients are ready for an approach such as mindfulness. Clients may need more stabilization of their symptoms by other means before they can be ready to use mindfulness. Using mindfulness with clients who are actively psychotic is not recommended.

One advantage of adding mindfulness to the therapeutic tool box is its versatility. The therapist can tailor the use of mindfulness to a client's individual needs. Mindfulness can be used briefly in a session, take up the whole session, or can be given for homework. Clients can employ the practice of mindfulness while sitting, walking, doing the dishes, and cooking, among other things. Clients can use mindful breathing exercises to become more grounded in their bodies. As we find new approaches to trauma, therapists need to recognize that the client may need to try out different things and see what works given a particular history and present circumstances. When so many programs and approaches

are more standard and less customized, mindfulness as an adjunct can be molded in to many ways of working with a client's trauma related symptoms.

Therapists are using mindfulness in their own lives and then are able to bring this same framework to the clinical hour or group. The very things therapists teach their clients to do, they can do for themselves. Clinicians can learn to take a moment in between clients. New clinicians may find mindfulness particularly helpful as a way to re-center themselves after difficult sessions or in the context of building a new case load.

Being too much in the mind and not enough in the present experience can lead to excess worry and anxiety that is not productive. Using mindfulness to make this shift is a journey of paying attention to what you experiencing in the moment. The cover of Hayes' (2005) workbook on Acceptance and Commitment Therapy challenges one to "Get out of your mind and into your life." The book and program takes mindfulness of one's thoughts and patterns of intellectualizing to new levels of changing one's outlook and behavior. I was very excited to learn about ACT for PTSD and Acceptance and Commitment Therapy arrival on the scene of new trauma treatment, not negating that trauma can and does happen, but living the best you can with that knowledge. This notion seems to be in line with the thoughts of Jon Kabat-Zinn (1990) in *Full Catastrophe Living*. Kabat-Zinn (1990) stated, "Mindfulness practice provides an opportunity to walk along the path of your own life with your eyes wide open, awake instead of half unconscious, responding consciously in the world instead of reacting automatically, mindlessly" (p.442). Encouraging those touched by trauma to seek needed treatment when necessary, trauma no longer holds the legacy of being denied and ignored. It is faced head on. Mindfulness is a good adjunct in helping people with trauma related symptoms.

The finding that all participants stated that mindfulness helped them with their therapeutic effectiveness is noteworthy. With so much burnout, budget cuts, and recent economic struggles at the moment, therapists who have the resource of using and benefiting from mindfulness may be more resilient and more in tune with themselves and their work with clients.

Limitations

The sample for this study was small and homogeneous. Interviews were conducted with eleven clinicians who mostly resided in the same part of the country. These data are not then generalizable to a larger population.

Bias was also a limitation in this study. A researcher's beliefs, prior experiences, and current training can influence what types of literature are reviewed and what questions are asked in interviews. I brought a personal perspective of being interested in mind body approaches to trauma in adults and a holistic health philosophy to this study. I believe a researcher who conducts in-person interviews brings a pulse to the data collection. Therefore, I monitored my subjectivity as I collected and evaluated the data. I made an effort to pull the themes solely from the data.

This questionnaire was self-developed and therefore subject to scrutiny. An effort to obtain information from participants without influencing them was the framing of questions as open-ended. Using a flexible method also afforded the opportunity to "follow the data where they lead and minimize the intrusion of the researcher's own preconceptions into the study results" (Anastas, 1999, p. 58).

Recommendations for Future Research

In summation a quantitative study with a larger, more diverse sample would be desirable. I would like to know more about the differences in how DBT trained therapists and MBSR trained therapists view the role of mindfulness in treatment. More studies on mindfulness and trauma should be conducted so that more understanding about how to use this adjunct approach can be gained and expanded upon in the literature.

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Appendix A

HSR Approval Letter

October 14, 2008

Lisa Schoendorf

Dear Lisa,

Your revised documents have been reviewed and are approved. Good luck with your very interesting study.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Jean LaTerz, Research Advisor

Appendix B

Informed Consent For Clinicians

Dear Participant:

My name is Lisa Schoendorf and I am a graduate student in the Smith College School for Social Work located in Massachusetts. I am conducting a research study about the experiences of clinicians who use mindfulness as an adjunct to individual psychotherapy in order to reduce trauma-related symptoms in adults. I will be talking with clinicians choosing this modality of treatment in order to gather data on the integration of mindfulness in individual therapy with the aim of reducing trauma-related symptoms. The purpose of this study is to further determine why clinicians choose to be trained in and use this psychotherapeutic technique in relation to treating trauma-related symptoms in adults. I will be asking clinicians who work with adults with trauma-related symptoms what they perceive to be effective or contraindicated in this population. The information will be used in professional articles, professional publications, and academic presentations on this issue and to complete a thesis that is in partial fulfillment of the requirements for a Masters in Social Work.

Nature of Participation

You are being asked to participate because you are a clinician who has been trained in and has used the clinical application of mindfulness. You have been selected as a participant because you work individually with adults with current trauma-related symptoms. Participants will need to be practicing for a minimum of one year.

You will be asked to share your experiences about the therapeutic process in regards to the application of mindfulness to trauma-related symptoms in your individual case work with adults. You will be asked to relate experiences having to do with how you came to be trained in mindfulness and how you decided to use this approach in regards to trauma-related symptoms. You will also be asked to provide brief case vignettes without revealing names or identifying information that demonstrate treatment outcomes in using this approach to reduce trauma-related symptoms including the negative and positive aspects of using this modality within psychotherapy. You will be asked about the strengths of this modality in terms of this population and also the challenges or contraindication of using this approach. Some demographic information will be collected at the beginning of the interview such as your age, your gender, your race, the length of time you have practiced, the locations you have practiced in, and you're previous academic training.

The interviews will take place during fall and winter 2008-2009. Each interview will take approximately 45-60 minutes of your time. The interview will take place at a mutually agreed upon location that ensures confidentiality or by telephone. The interview will be audio taped; however, your name will not be mentioned on the tape.

Risks

There is a risk that asking you to reflect upon your past experiences, and talk about previous or current cases may cause you to feel distressed and upset. Please tell me if you feel that way so that I can stop the interview and ask if you wish to take a break, skip the question or stop the interview. Please do not give names or identifying information for any clients you mention.

Benefits

The benefit of participating in this interview is that you will have an opportunity to share your clinical experience with others in the field. Your experiences will be included with those of other clinicians being interviewed and may inform theory and the practice of using this new modality with adults with trauma-related symptoms. This study will be one of the first to examine this application with the population of adults who present with trauma-related symptoms. You will not receive monetary compensation for your participation in this study.

Confidentiality

Maintaining your confidentiality is of utmost importance. I will make every attempt to arrange a meeting place that maintains your confidentiality. Your name will not be placed on the tape or on any notes that are taken during the interview. An identification code will be assigned to the tape and notes. The list containing names and identification codes will be kept in a separate location. All data will be stored in a locked location. All notes, tapes and transcripts must be stored for at least three years according to U.S. federal requirements. After this time the data will be destroyed by shredding the documents. Your name or identifiable characteristics will not be used in any publication or presentation that includes this data. Illustrative quotes that may be used will not contain identifiable information. The person who will transcribe the data from the audiotape will be required to sign a confidentiality statement.

Informed Consent Procedures

Participation in this study is voluntary and you may withdraw from this study at any time during the interview or immediately after the interview before I leave at the end of the day. You can decide to withdraw from the study without any penalty you can also tell me if you do not want to answer any specific questions and we can skip them. The final date to withdraw from this study is June 15, 2009.

You can contact me with any questions or concerns you may have regarding the interview or the study. My contact information is:

Lisa Schoendorf

Email: lschoend@email.smith.edu

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 THIS STUDY.

Participant's Signature: _____ Date: _____
Researcher's Signature: _____ Date: _____

Please keep a copy of this Informed Consent form for your records.
Thank you very much for participating in this study.

Appendix C

Recruitment Letter

To: Clinicians who have completed training in **mindfulness**

My name is Lisa Schoendorf, and I am currently a master's student at Smith College School for Social Work in Northampton, Massachusetts. I am writing to ask for your assistance with a research project that will serve as my thesis. I am very interested in the integration of **mindfulness** techniques in the individual psychotherapeutic treatment of adults presenting with trauma related symptoms. I initially learned **of mindfulness** during my first internship (working with DBT). I then attended a lecture one summer at Smith College School for Social Work, by Saki Santorelli, director of the Stress Reduction Center at University of Massachusetts Memorial Medical Center, where I became more interested in how clinicians are using **mindfulness** techniques in individual psychotherapy. Presently there is very little empirical research on the clinical effectiveness or use of **mindfulness** techniques in individual Psychotherapy focused on trauma- related symptoms. There is a significant need to expand our knowledge in this emerging area of practice.

The intent of this letter is to ask you to volunteer to participate in an interview session with me. The interview will consist of asking you some questions about your decisions, perceptions, and experiences of the effectiveness of using **mindfulness** techniques with your clients. This study is designed to gather qualitative data regarding **whether mindfulness**, as an adjunct to psychotherapy is viewed by clinicians as an effective method of treating adult clients with trauma- related symptoms. This study will not involve any contact with clients or patients of participating clinicians.

The participation criteria are as follows: 1) licensed psychotherapist (social worker, psychologist, psychiatrist, counselor, or what would qualify in any given state); 2) have completed **accredited** training in **mindfulness** and 3) have been practicing for at least one year.

Data will be collected through a face to face or telephone interview that will take approximately 45-60 minutes to complete. Open-ended interview questions will be focused upon how integrating the techniques of **mindfulness** into your practice have been effective or not effective in reducing trauma related symptoms in your clients. These interviews will be audio taped. In order to ensure confidentiality, all tape recordings, transcriptions of these tape recordings, and notes taken will be coded with a number for each participant. Names and identifying locations will be removed from all presented material.

Participation in this study poses very little risk to you as you are a mental health professional. If at anytime during the interview you do not wish to answer a question, you

have the right to refuse to answer the question. You will also have the right to withdraw from this study at any time before, during, or after the interview, until April 15, 2009.

The benefits of participating in this study would be the opportunity to share your expertise using these techniques with your clients. This study will bring new knowledge to the field on this emerging topic. Participation would also allow you to reflect on your own personal investment in using **mindfulness** and how it may impact your practice.

If you are willing to participate in this study, please contact me by telephone at 860-967-8941, or e-mail (lschoend@email.smith.edu). Thank you so much for your assistance with this research project. I realize the great value of clinicians' time and would be very appreciative of your participation. I look forward to hearing from you.

Sincerely,

Lisa Schoendorf

Appendix D

Interview Guide

Basic Demographics

1. gender
2. race/ethnicity
3. age

Area and Level of Expertise

4. professional degree(s)
5. certification(s)
6. Any **mindfulness** training received and given
7. Number of years in practice using mindfulness as an adjunct technique
8. place of employment
9. average caseload
10. Approximate number of clients with whom **mindfulness** was used
11. Approximate number of clients treated with trauma-related symptoms you have worked with using **mindfulness**

Note: I will now remind participants that when they discuss case material to not mention any names or identifying information.

Open-Ended Interview Questions

1. What in your practice or your life led you to be trained in **mindfulness**?
2. How did you decide to use **mindfulness** with clients presenting with trauma related symptoms?

3. Please describe the trauma symptoms presented by your clients?
4. How does **mindfulness** reduce these symptoms?
5. In what ways do you use this approach in therapy?
6. What specifically do you do?
7. Is the application used during the session or is there at home practice and self monitoring?
9. How to you keep the client safe as they work through their symptoms?
10. Can you talk about a client that was able to apply these skills and gain benefit?
11. Please talk about a client who did not respond well to using these techniques?
12. What drawbacks have you seen to using **mindfulness** with adults with trauma-related symptoms?
13. Do you feel **mindfulness** has had an impact on your therapeutic abilities?
14. Please take a moment and think about anything else that you feel is pertinent to the discussion of **mindfulness** and trauma-related symptoms that you would like to add to this interview?

Talking Points for Telephone Screening for Potential Participants

Thank you for getting in touch with me about participating in my study.

I got your name from (contact). I am studying clinician decision making in regards to using Mindfulness Meditation with adults with trauma-related symptoms and clinicians perspectives on the efficacy of using Mindfulness Meditation as an adjunct to psychotherapy with adult clients presenting with trauma-related symptoms.

Thank you for responding to the recruitment letter that you received

Are you interested in participating in my study?

Do you meet the following criteria?

1. Have you been trained in Mindfully Based Stress Reduction from the Center for Mindfulness in Worcester, Massachusetts?
2. Do you presently work as a clinician with adults presenting with trauma-related symptoms in the context of individual therapy?
3. Do you hold a license to practice psychotherapy in the state in which you work? (These degrees include but are not limited to professional counselor, social worker, psychologist, psychiatrist and marriage and family therapist.)
4. In your present work with clients do you employ the modality of MBSR as an adjunct to psychotherapy with adults presenting with trauma related symptoms?
5. Have you been practicing for a year or more?

Thank you for your willingness to participate.

I would like to schedule a face to face interview. Is this convenient? If it is convenient, is there a comfortable quiet place where we can meet that is convenient for you? (Possibilities may be the clinician's office or a local coffee shop) At the time of our meeting I will need you to sign two copies of an informed consent document. One I will keep in my files and the other copy is for you to keep.

If a face to face meeting is not convenient, I could interview you over the telephone. If we conduct the interview over the phone I will need to mail you two copies of an informed consent document. One I will keep in my files and the other copy is for you to keep .I will need you to send back one of the copies in the self addressed stamped envelope that will be enclosed. I will need to receive it before our scheduled telephone meeting time. Thank you for your time and interest.