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The air that I breathe : how Buddhist practice supports psychotherapists in the midst of vicarious trauma and burnout

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The Air That I Breathe: How
Buddhist Practice Supports
Psychotherapists in the Midst
of Vicarious Trauma and
Burnout

ABSTRACT

This qualitative study sought to explore whether Buddhist practice is supportive to psychotherapists at risk for developing burnout and vicarious trauma. Eleven psychotherapists, practicing within the Shambhala Buddhist tradition, were interviewed. They were asked to reflect upon the risks and benefits of their clinical work and their work environments. Participants were Masters level clinicians from a range of professional backgrounds, with caseloads including at least three individuals with a trauma history. Participants identified inspiring aspects of their work, as well as aspects of their work they find discouraging or stressful. Participants were asked how they cope with work related stressors. In addition, they were asked to discuss whether their spiritual practice helps them to cope with symptoms of vicarious trauma and burnout.

All the therapists interviewed identified coping strategies related to their Buddhist practice as particularly helpful to them. Every participant indicated that both the *view* and *practice* of Buddhism were supportive to them in coping with job stress. Practices identified as helpful to clinicians were: mindfulness-awareness meditation and the practice of *tonglen.* Participants cited Buddhist views of impermanence, basic goodness, egolessness, and suffering as helpful cognitive frameworks to manage work related stress.

The findings of this study are relevant to non-Buddhist individuals and agencies concerned with preventing burnout and vicarious traumatization. This study demonstrates the utility of mindfulness practice for all clinicians coping with work stress. In addition, it points to cognitive coping strategies, which may prove helpful to many therapists.

THE AIR THAT I BREATHE: HOW BUDDHIST PRACTICE SUPPORTS
PSYCHOTHERAPISTS IN THE MIDST OF VICARIOUS
TRAUMA AND BURNOUT

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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TABLE OF CONTENTS

CHAPTER I

INTRODUCTION

Work is love made visible.

   -Kahlil Gibran

While the field of psychotherapy can be rich and rewarding, the job risks of being a psychotherapist have been well-documented (Figley, C.R., 1995; Maslach, C, Schaufeli, W.B. & Leiter, M.P. 2001; McCann, L. & Pearlman, L.A., 1990; Pearlmann, L.A. & Saakvitne, K.W., 1995). Clinical work can be challenging and heartbreaking, as therapists work with individuals facing loss, trauma and injustice on a daily basis. In addition, work environments can be stressful and unsupportive to professional helpers. Burnout and vicarious traumatization have both been recognized as job risks for psychotherapists (Farber, B.A. & Heifetz, L.J., 1982; Figley, C.R., 1995). The stresses of demanding agency settings, the isolation of private practice, the challenges of managed care, as well as the clinical stress of working with difficult populations can all impact clinicians.

Originally a colloquialism, "burnout," was first conceptualized and measured by researchers in the 1970s, to describe the cumulative negative effects of workplace stressors upon employees (Maslach, Schaufeli, & Leiter, 2001). Later research highlighted the negative consequences of burnout in the field of human services. Burnout

1

can lead to decreased clinical effectiveness, feelings of cynicism and detachment, negative attitudes toward clients, and exhaustion (Maslach, Schaufeli, & Leiter, 2001).

In addition to navigating the difficulties of the workplace, helping clients who have survived a traumatic event can prove to be one of the most stressful aspects of being a psychotherapist (Figley, 1995). Therapists who work with many individuals with a trauma history are at greater risk for developing *vicarious traumatization.* The term vicarious traumatization was coined to describe the cognitive, emotional and physiological effects of working with traumatized populations (McCann, L. & Pearlman, L.A., 1990). Constructs such as compassion fatigue (CF) and secondary traumatic stress (STS), have also been used to describe vicarious traumatization (VT). The distinctions between such terms will be explored in greater depth in the literature review. However, all of these terms point to the ways in which therapists' own mental health can be jeopardized by working with trauma.

Recent research has begun to focus upon the importance of clinician self-care, in the midst of clinical challenges and increasingly stressful work environments (Barnett, Baker, Elman, & Schoener, 2007). Meditation is one such avenue of self-care, which has been empirically validated as a helpful way to manage stress (Grossman, Niemann, Schmidt & Walach, 2004). Interventions such as mindfulness-based stress reduction have been used to treat a variety of problems, such as chronic pain, anxiety disorders, psoriasis, and stress (Grossman, Niemann, Schmidt & Walach, 2004). In addition, the mental health field has embraced empirically validated mindfulness-based therapies such as Acceptance and Commitment Therapy, Dialectical-Behavioral Therapy, and

Mindfulness-Based Cognitive Therapy, all of which rest upon a foundation of mindfulness-awareness practice (Hayes, Follette & Linehan 2004).

Spiritual practice has also been cited as an aspect of self-care, which may be protective for psychotherapists (Cunningham, 2004). Research has been done on the utility of religion and spirituality in coping with trauma (Weaver, A.J., Flannelly, L.T., Garbarino, J., Figley, C., & Flannelly, K.J. 2003). Religion and spirituality can allow individuals to make meaning of great suffering and can provide individuals with tools with which to engage with difficult material.

Buddhist practice encompasses both the empirically validated technique of mindfulness awareness meditation, as well as specific practices and views unique to the Buddhist tradition. Buddhist teachings on the nature of suffering, egolessness, basic goodness and impermanence all inform the way Buddhist practitioners live and work in the world (Mipham, S., 2002). In addition, the *mahayana* Buddhist tradition, presented in the following chapter, emphasizes selfless service and boundless compassion (Mipham, S., 2002). In this sense, Buddhist practice may provide a helpful practical and conceptual framework for therapists to manage secondary trauma and burnout.

This qualitative study will explore how Buddhist psychotherapists use spiritual practice to cope with job risks such as burnout and vicarious trauma. Buddhist clinicians from the Shambhala Buddhist tradition were interviewed about the challenging and inspiring aspects of their work, and asked how they cope with work-related stress. This study sought to learn more about how spiritual practice supported clinicians, which may inform self-care approaches for a broad range of psychotherapists.

The inspiration to study the confluence of Buddhist practice, burnout, and vicarious trauma arose from the motivation to better help psychotherapists cope with work stress. While research points to the benefits of meditation, there has been less exploration of how Buddhist practice might help therapists maintain resilience and motivation. By exploring how the Buddhist tradition may support clinicians, such research has the power to help practitioners to serve their clients better and maintain resilience in the face of difficulty.

Further scholarship on the usefulness of spiritual practice, meditation and Buddhism in particular, may have implications for the way organizations train and support professionals. Research in this direction has the power to influence institutional developments in the way mental health agencies help employees manage burnout and compassion fatigue. In addition, such research might offer individual psychotherapists personal strategies to mitigate the effects of burnout and compassion fatigue.

CHAPTER II

LITERATURE REVIEW

Introduction

The purpose of this study is to explore what inspires, motivates, and sustains

Buddhist therapists in the midst of challenging clinical work. Thus, literature in the

following categories will be reviewed to create a context for this study: (1) The effect of

burnout and vicarious traumatization on today's mental health professionals; (2)

compassion satisfaction and other measures of engagement and effectiveness within

clinical work and their relationship to strength and resilience; (3) spiritual practice as a

prevention of vicarious traumatization and burnout, and a source of compassion

satisfaction; (4) Shambhala Buddhist practice, encompassing both mindfulness training

and view philosophical view, and its benefits for therapists who seek to strengthen

compassion satisfaction. (5) Contemplative psychotherapy as an expression of Buddhist

principles in psychotherapy practice, and the contemplative understanding of burnout and

vicarious trauma.

Burnout and Vicarious Traumatization

In the last four decades, extensive research has conceptualized and measured the

detrimental effects of burnout in the workplace (Maslach, Schaufeli, & Leiter, 2001) and

in the mental health field specifically (Pines, A., & Maslach, C., 1978). More recently,

vicarious traumatization has been recognized as a job hazard within the mental health

professions. Preliminary research has begun to conceptualize the phenomenon of

vicarious trauma. Researchers have sought to establish measures of vicarious

traumatization (Bride, Radey & Figley, 2007) and to investigate the effects of vicarious

traumatization (Brady, Guy, Polestra & Brokaw, 1999). Burnout and vicarious

traumatization both take their toll in the field of mental health, affecting the personal and

professional performance of clinicians, impacting the quality of service to clients, and

hampering institutional effectiveness.

<div align="center">Burnout</div>

Maslach, Schaufeli, & Leiter (2001) defined *three key dimensions* of burnout: "an

overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense

of ineffectiveness and lack of accomplishment" (p. 399). Such attitudes are omnipresent

within the human service field, resulting in a diminished quality of service as well as

lower job satisfaction for individuals in the field. Farber and Heifetz (1982) described

some of the ways burnout can manifest in the field of psychotherapy:

> Burned-out professionals may become cynical toward their clients, blaming them
> for creating their own difficulties or labeling them in derogatory terms. To
> maintain a safe emotional distance from an unsettling client, professionals may
> increasingly resort to technical jargon and refer to clients in diagnostic terms.
> Furthermore, the emotional frustrations attendant to this phenomenon may lead to
> psychosomatic symptoms (e.g., exhaustion, insomnia, ulcers, headaches) as well
> as increased family conflicts. (p. 293)

In their qualitative study of 60 psychotherapists, Farber and Heifetz (1982) came

to the conclusion that burnout is connected to a sense of therapeutic ineffectiveness.

73.7% of therapists interviewed in their study cited "lack of therapeutic success" as the

most stressful aspect of their work. The authors of the study conclude from this finding

that "the primary factor underlying burnout" for psychotherapists, is "the non-

reciprocated attentiveness and giving that are inherent within the therapeutic

<div align="center">6</div>

relationship." (p. 298). The implication of this is that burnout is connected to therapists'

unfulfilled expectations for their clients and themselves. As will later be discussed,

contemplative psychotherapy also understands burnout as partly resulting from

caregivers' unmet expectations.

Maslach, Schaufeli, & Leiter (2001) noted that "research has found that

situational and organizational factors play a bigger role in burnout than individual ones,"

(p.418) which leads to the conclusion that organizational interventions may be more

effective than personal interventions in addressing burnout. Organizational interventions

might include individual and peer supervision and creating organizational policy that is

supportive to clinicians.

Though the cause of burnout may be largely environmental, Wicks (2008)

contends that clinicians' vulnerability to burnout can be decreased by "strengthening

one's own self care protocol" (p. 42) as well as by "solitude, silence and mindfulness" (p.

80). While institutional factors contributing to burnout may be hard to control, individual

clinicians can increase their resilience and develop coping skills to manage burnout. As

will be discussed later, the Buddhist tradition, based upon the practice of meditation, is

one such avenue of self-care.

Secondary Traumatic Stress, Compassion Fatigue, and Vicarious Traumatization

The concept of vicarious traumatization (Pearlman & Saakvitne, 1995) developed

out of an effort to recognize and delineate the negative effects of trauma work upon

helping professionals. Other terms, such as compassion fatigue (CF) and secondary

traumatic stress (STS), have also been used to describe vicarious traumatization (VT).

Each term focuses on different areas, with STS and CF highlighting symptomology and

VT focusing more on the "existential impact" (Allen, 2001, p. 377) of secondary

traumatic stress:

> …the vicarious-traumatization approach focuses on the individual as a whole, placing observable symptoms in the larger context of human adaptation and quest for meaning." (Pearlman & Saakvitne, 1995, p. 153)

Research about vicarious trauma is still largely exploratory and descriptive, with

little empirical research. Yet, in this preliminary phase, vicarious trauma has been

established as a risk of working with traumatized populations. The negative impact of

such work upon therapists includes

> depression, despair, and cynicism; alienation from friends, colleagues, and family; professional impairment, often resulting in premature job changes; and a host of psychological and physical symptoms similar to those experienced by untreated trauma survivors. (Pearlman & Saakvitne, 1995a, p. 157)

Though each term addresses the phenomenon differently, all of the constructs

point to similar constellations of symptoms, etiology and characteristics. In this study, I

will favor the term vicarious traumatization, as it accounts for the existential and spiritual

aspects of secondary traumatic responses.

Secondary traumatic stress disorder. Figley (1995) used the term *secondary*

traumatic stress disorder to conceptualize vicarious traumatization in terms of

symptomology He described STSD as nearly identical, symptomatically, to PTSD, with

characteristics meeting the DSM IV TR criteria such as: "re-experiencing of the traumatic

event (Criterion B), persistent avoidance of stimuli associated with the trauma and

numbing of general responsiveness (Criterion C), and persistent symptoms of increased

arousal (Criterion D)." (DSM-IV-TR). However, in Secondary Trauma, the precipitating

stressor (Criterion A) affects the individual *indirectly*, while in PTSD the stressor affects

the individual directly. The DSM IV-TR acknowledges the potential for secondary trauma in its description of the diagnostic features of Post Traumatic Stress Disorder, including: "*learning about* unexpected or violent death, serous harm, or threat of death or injury *experienced by a family member or other close associate*" (p. 463, italics added).

Figley (1995) highlighted that the empathy, sympathy, involvement and caring which makes a therapist effective is also a risk factor for developing vicarious trauma. This is evident in Figley's definition of secondary traumatic stress disorder as "the *natural consequent* behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person" (p.7, italics added). Rather than viewing compassion fatigue as an abnormal reaction, this definition normalizes compassion fatigue as a common response to a stressful situation. Unlike burnout, which is largely related to situational factors and can affect people in many different professions, compassion fatigue is a job hazard specific to clinicians working with traumatized people (Bride, Radey & Figley, 2007).

Vicarious traumatization. Vicarious Traumatization is characterized by "profound changes in the core aspects of the therapist's self, or psychological foundation." (Pearlman & Saakvitne, 1995, p.152). Wicks (2008) defined vicarious traumatization or "acute secondary stress" as: "the destabilization of one's own personality as a result of constant treatment of the severe psychological, physical, and sexual trauma experienced by others" (p. 29). Both definitions emphasize how vicarious trauma has the potential to change the very structure of the therapist's personality and self-concept.

9

Focusing on mental health workers in the aftermath of terrorism, Cunningham

(2004) wrote about the myriad ways in which secondary trauma can affect therapists:

> Therapists may have difficulty getting images of their clients' trauma out of their minds, and these images may persist or come upon them unexpectedly between sessions. They may have nightmares, feel anxious, and have less regard for humanity, because they are witness to the shocking horror other beings can cause. Therapists may feel vulnerable, have difficulty trusting, or be flooded by strong emotions such as grief or anguish. They may defend themselves against the pain by feeling numb or even callous. (p.330)

Secondary trauma can impact a mental health worker's sense of meaning, trust in the

goodness of the world, and emotional regulation.

McCann and Pearlman (1990) explained these changes using *constructivist self-*

development theory to describe vicarious traumatization as a disruption of cognitive

schemas. The authors proposed that, like trauma, secondary trauma can upset one's

cognitive schemas, or "beliefs, expectations, and assumptions about the world"(1990, p.

137). This change in the therapist's cognitive structure can in turn affect the therapist's

relationships, emotional life, and behavior.

Such changes can be devastating, in that they disrupt one's cognitive "frame of

reference," changing the therapist's identity, worldview, and spirituality:

> We have come to believe over time that the most malignant aspect of vicarious traumatization is the loss of a sense of meaning for one's life, a loss of hope and idealism, a loss of connection with others, and a devaluing of awareness of one's experience. This constellation of experience seems best described as spirituality…Disruptions in this realm may be the most troubling, and perhaps the least explored, aspect of the experience of both trauma survivor and trauma therapist. (Pearlman & Saakvitne 1995, p.160).

Thus, vicarious traumatization can affect individuals in very deep and profound ways,

conceptualized by Pearlman and Saakvitne as one's spirituality.

Yet, as will be explored later, one's spiritual beliefs may also be a protective factor for therapists coping with traumatic material. Spirituality, and Buddhist practice in particular, may prevent vicarious traumatization, by providing a cognitive framework with which to understand great suffering (McIntosh, 1995).

Some scholars have also contended that the challenges to one's beliefs presented by trauma can also *strengthen* individuals' sense of spiritual connection and engagement. Decker (1993), paraphrased by Brady, Polestra, Guy, & Brokaw (1999) asserted that

> no matter what the psychological condition of the survivor, trauma will influence his or her spiritual development. He asserted that the survivor will become more focused in his or her search for meaning and purpose because trauma necessarily calls into question old perspectives, requiring a reexamination of values and core beliefs (p. 387)

If this is the case, it follows that therapists working with traumatized populations may also strengthen their spiritual engagement through trauma work.

Pearlmann and Saakvitne (1995) identified strategies, both personal and professional, by which therapists can address vicarious traumatization. The authors presented a range of strategies, one of which is spiritual practice. Personal strategies included: identifying disrupted schemas, maintaining a fulfilling personal life, using personal psychotherapy, identifying healing activities, and *tending to one's spiritual needs*. Professional strategies included: Arranging supervision, developing professional connection, developing a balanced work life, and remaining aware of one's goals.

Compassion Satisfaction and Passionate Commitment

The research on compassion fatigue has brought attention to an important and still overlooked vulnerability for mental health clinicians. Yet, despite the risks of the field of psychotherapy, there are also many positive reasons why individuals pursue the field of

11

psychotherapy and choose to work with difficult populations. Within the context of challenging clinical situations, the benefits of doing such demanding work are also evident, such as:

> …a heightened sensitivity and enhanced empathy for the suffering of victims, resulting in a deeper sense of connection with others; increased feelings of self-esteem from helping trauma victims regain a sense of wholeness and meaning in their lives; a deep sense of hopefulness about the capacity of human beings to endure, overcome, and even transform their traumatic experiences; and a more realistic view of the world, through the integration of the dark sides of humanity with healing images. (McCann & Pearlman 1990, p. 147)

Scholarship on compassion fatigue and burnout underscore the need for more understanding of the risks of clinical work. Yet, research on the benefits of working with traumatized people, and scholarship addressing the positive coping skills clinicians bring to their work can support and inform clinicians.

Based upon the findings from vicarious trauma and burnout research, recent scholarship has moved toward clinician resilience and characteristics of positive coping. *Compassion satisfaction* and *passionate commitment* are terms developed by researchers to describe such positive coping skills and enthusiastic engagement within clinical work. Compassion satisfaction and passionate commitment are seen in high functioning clinicians at the other end of the burnout spectrum. Such research can help clinicians develop tools and understanding about how to support themselves while engaging in challenging clinical work.

Compassion Satisfaction

Drawing upon the notion of compassion fatigue, Radley and Figley (2007) coined the term "compassion satisfaction," to create a framework to examine positive clinician coping and resilience. Defining compassion satisfaction as "feelings of fulfillment with

clients, rooted in positive psychology and expanded to incorporate the social work perspective"(p. 207), they sought to conceptualize what contributes to "compassion satisfaction" within the field of social work.

The authors conceived of three key components of compassion satisfaction: 1) affect; 2) physical, intellectual, and social resources; and 3) self-care, as working together to create resilience and thriving in the context of social work. Depending upon whether affect, resources, and self-care are tended to, the author's contend that the result is either compassion satisfaction or compassion fatigue.

Positive affect helps clinicians to find inspiration and hope in their work, helps widen the range of clinical responses, and allows clinicians to work in flexible, creative ways. Positive affect in turn influences (and is influenced by) the resources available to clinicians. Such resources include inner resources (wisdom, life experience) and social resources. Self-care encompasses both personal care (exercise, eating right, taking time off, socializing, making time to reflect) and organizational care (supports within the work environment, such as supervision.) (Radley & Figley 2007).

Buddhist practice has the potential to affect all three realms of compassion satisfaction, as identified by Radley and Figley. Buddhism can help foster positive affect (through meditation and compassion contemplation), inner resources (Buddhist teachings and practice leading to the development of insight), social resources (through community) and self-care (through the practice of meditation, which leads to the cultivation of *maitri*, or "friendliness" toward oneself (Wegela, 1996).

Passionate Commitment

In a similar vein, Dlugos and Friedlander (2001) identified the traits associated with positive therapist coping. They conducted a qualitative study of twelve *passionately committed* mental health professionals, nominated by their peers. Passionate commitment was defined as "a) a sense of being energized and invigorated by work rather than drained and exhausted by it; b) the ability to continue to thrive and love one's work in spite of the personal and environmental obstacles one might face in it; c) a demonstrable sense of balance and harmony with other aspects of one's life; and d) a sense of energizing and invigorating those with whom one works" (p. 298).

Using open ended semi-structured interviews, and coding with the method of "Consensual Qualitative Research", Dlugos and Friedlander identified four traits common to passionately committed therapists: 1) Balance; 2) Adaptiveness/openness; 3) Transcendence/humility; and 4) Intentional learning. Their findings indicated that passionately committed therapists have a balance of professional and non-professional activities in their life and seek out diverse work experiences or caseloads. While they recognized obstacles to their work, they all approached obstacles as challenges to be met. They also sought out personal and professional learning to support their clinical work.

Of particular relevance to this study, these therapists all acknowledged a spiritual dimension to therapy and had a spiritual or humanitarian view of their work, characterized by the researchers as transcendence/humility. Unfortunately, the study did not indicate what type of spiritual practice the individual therapists engaged in, nor did it go into detail about this aspect of passionate commitment (Dlugos & Friedlander, 2001).

14

There is a need for more research in this area, to flesh out what types of spiritual engagement are supportive and effective for clinicians. By interviewing Buddhist clinicians, this exploratory study seeks to determine whether such individuals see their spiritual practice as supportive to their work and investigate whether they are able to stay balanced and inspired in the face of professional obstacles.

While not all therapists acknowledge the importance of spirituality in coping, (Coster, & Schwebel, 1997), Dlugos and Friedlander's study shows that spiritual practice can and does support some clinicians who are identified by their peers as particularly effective.

Spiritual Practice

Religion and Cognitive Schemas

Scholarship on religious and cognitive schemas suggests that religion or spiritual practice may serve as a protective factor for individuals at risk for developing compassion fatigue. Spirituality may allow for therapists to make sense of trauma, thereby increasing the potential for compassion satisfaction. McIntosh (1995) presented a framework for understanding religion as cognitive schemata, defining a schema as "a cognitive structure or mental representation containing organized, prior knowledge about a particular domain, including a specification of the relations among its attributes" (p. 2). This understanding of religion-as–schema can shed light on religion's place in coping with traumatic material.

McIntosh discussed the way religious schemas can provide a structure to integrate new information, favoring information that fits into, rather than challenges, the schema. Schemas enable individuals to cognitively process schema-relevant information more

15

efficiently and smoothly. These schemas can thus allow individuals to more quickly

organize and make sense of traumatic material.

> Two particular functions of schemas seem applicable when considering the
> influence of religion in coping: (a) increased speed of processing domain-relevant
> information and (b) assimilation of stimuli to a form congruent with an extant
> schema. The first function may expedite cognitive processing of the event, and
> the second may facilitate the finding of meaning in the event. (McIntosh, 1995, p.
> 9)

> Having a religious framework may allow an individual to make sense of traumatic

events, provided one's belief system incorporates some understanding of such events:

> Hastie (1981) noted that any specific event can be evaluated as congruent,
> incongruent, or irrelevant with regard to a particular schema. How a particular
> event relates to one's religious schema is likely to have an impact on coping and
> adjustment. (McIntosh, p. 8)

One's religious schemata can thus be useful in coping with secondary trauma insofar as

they address the questions and concerns most salient to trauma work.

Buddhism provides a cognitive structure, which addresses many of the issues

pertinent to trauma work such as suffering, impermanence, and death (Mipham, S.,

2002). At the same time, Buddhist teachings also maintain a view of humanity as

basically good, interconnected, and worth helping. The specific teachings of Buddhism

will be discussed in detail later on.

McIntosh (1995) acknowledged that more research needs to be done to flesh out

the characteristics of religious schemas, and to elucidate how religious schemas vary

between different individuals. Yet the construct of religion-as-schema can also account

for how religion and spirituality may be a protective factor for therapists dealing with

traumatic material.

While this research accounts for the cognitive benefit of spiritual beliefs, it does not address the other ways religion and spirituality can function as a protective factor for therapists. Factors such as social support, positive spiritual coping behaviors (such as meditation) and emotional and physical well being resulting from spiritual practice may also play a role in supporting Buddhist psychotherapists. (Gall, et al., 2005)

Shambhala Buddhist Practice

Mindfulness Meditation: Shamatha

The Tibetan Buddhist tradition describes two stages of meditation: mindfulness meditation (*shamatha*) and awareness, or insight meditation (*vipashyana*). Presented by Western scholars as mindfulness awareness meditation, this type of meditation is common to most Buddhist traditions.

Mindfulness meditation focuses on training the mind to align with the present moment, by letting go of thoughts and returning to the object of meditation, often the breath (Mipham, 2003). Another word for this type of meditation is *Shamatha,* which is Sanskrit and translates as "peaceful abiding":

> In peaceful abiding, we ground our mind in the present moment. We place our mind on the breath and practice keeping it there. We notice when thoughts and emotions distract us, and train in continually returning our mind to the breath. (Mipham, 2003, p. 24.)

There have been many studies pointing to the effectiveness of mindfulness meditation (in the context of Mindfulness Based Stress Reduction) in the decrease of symptoms related to: anxiety disorders (Kabat-Zinn, Massion, Kristeller, Peterson, et al. 1992), psoriasis (Kabat-Zinn, J. et al., 2003), chronic pain (Kabat-Zinn, Lipworth, & Burney, 1985) as well as increased immune and brain function (Davidson, et al., 2003).

A meta-analysis (Grossman, Niemann, Schmidt & Walach, 2004) of twenty studies

examining mindfulness-based stress reduction concluded that:

> the consistent and relatively strong level of effect sizes across very different types of sample indicates that mindfulness training might enhance general features of coping with distress and disability in everyday life, as well as under more extraordinary conditions of serious disorder or stress. (p. 39)

In light of this research, meditation can be seen as an effective tool for clinicians' self

care, contributing to physical and emotional health.

Mindfulness Meditation and Helping Professionals

In addition to establishing that meditation can be helpful for a range of

psychological and physical conditions, studies have also addressed the effects of

mindfulness on the performance of helping professionals. Grepmair and colleagues

(2007) conducted a fixed method study of how mindfulness might increase therapeutic

effectiveness of psychotherapists in training. The study was undertaken in order to see

what effect daily Zen meditation practice had upon the effectiveness of psychotherapists

in training, who were in their second year of a three-year internship at the hospital. Zen

meditation is virtually identical in practice to mindfulness-awareness meditation.

The study compared two patient groups: those treated during a nine week period

where psychotherapists in training practice one hour of meditation before work each day,

and those treated during a nine week period where psychotherapists in training did not.

Student's psychotherapeutic effectiveness was measured by: Structured clinical

interviews, The Session Questionnaire for General and Differential Individual

Psychotherapy (STEP), The Questionnaire of Changes in Experience and Behavior

(VEV), and the Symptom Checklist (SCL-90-R).

The authors found that effectiveness of therapists who meditated significantly higher than the effectiveness of the therapists when they were not meditating. Although the data could have been affected by other variables, this study suggests that meditation, even when practiced for a short time, can improve therapist effectiveness. As a sense of ineffectiveness can be a sign of burnout in therapists, Grepmair and colleagues' findings suggest that meditation may protect therapists from burnout by helping them to be effective clinicians.

The authors (Grepmair and colleagues, 2007) determined that mindfulness can have an impact upon performance quickly, and the study includes data related only to the short-term effects of meditation practice. The question of how long term mindfulness meditation might impact therapeutic effectiveness remains unanswered by this study, and unexplored in the literature.

Shapiro and colleagues (1998) sought to explore how mindfulness might affect empathy and spiritual development in helping professionals. In this study, the authors focused on a population of notoriously stressed out helpers: premed and medical students. Using this sample, they attempted to determine whether an eight week course in mindfulness-based stress reduction could reduce self reported state and trait anxiety levels, reduce reports of depression, increase scores on empathy levels, and increase scores on a measure of spirituality levels.

Mindfulness-based stress reduction consists of a variety of interventions, all of which have a common focus on mindfulness. Course participants were taught "sitting meditation", which they practiced individually and logged in a journal, "hatha yoga", "body scan" exercises, as well as "loving-kindness" and "forgiveness" contemplations.

The experimenters found significant reductions in state anxiety (anxiety in response to situational demands or dangers) and trait anxiety (individual tendencies toward anxiety) and depression, and increased scores on tests measuring empathy and spirituality.

Flexible method research has also investigated the ways in which a personal mindfulness meditation practice supports social work practice (Brenner, & Homonoff, 2004). While few studies have addressed the effects of Buddhist practice upon clinical work, one exception is Brenner and Homonoff's flexible method study of 10 clinical social workers who were also practicing Zen Buddhists. The researchers focused on how clinicians' Buddhist practice informs their professional work in three areas: "practice framework, clinical practice, and interactions within larger systems." (p. 261).

The authors identified *awareness, acceptance*, and *responsibility* as three ways in which Zen practice (which has a strong emphasis on mindfulness-awareness meditation) influenced the social workers in the study. Awareness, in the context of this study, was characterized as "a focus on the present moment, allowing for the suspension of their reactions and hypotheses." (p. 264). This ability to rest in the present moment, without fixating on conceptual understandings, was seen as a helpful and effective mode of therapeutic engagement by the practitioners in the study: " I want to be right with the client in the moment, and there is something about being present, moment by moment, which has a healing quality." (p. 264).

Brenner and Homonoff (2004) also identified acceptance as another quality present in the participants' approach to therapy. Acceptance took many forms, ranging from a non-judgmental stance, to an ability to respect multiple points of view, to a "nonhierarchical view of the treatment relationship," (p. 264) to an acceptance of the

presence of suffering. As one participant noted: "You want to be able to hear what somebody else is saying without holding tight to what you think should be done." (p. 265)

The final area, described as responsibility, is the "enactment of the themes of awareness and acceptance," or, as one participant put it, the ability to "see clearly and take appropriate action." (p. 264). Respondents reported both a willingness to take action when appropriate as well as a more nuanced understanding of what kinds of change are truly powerful:

> I think that what Zen has done is expanded the meaning of what being a change agent is. To be able to sit with somebody, and have them be clear about what their own process is, what their own issues are, and what steps they want to take. This is as powerful, and sometimes more powerful, a form of being a change agent than being very action oriented in the traditional ways. (p. 266)

This research supports the hypothesis that Buddhist practice, including mindfulness meditation, has the power to profoundly affect the ways Buddhist social workers engage with clients and with larger systems. This article also discussed how Buddhist practice impacts the individual social worker's interaction with larger systems, with less of an emphasis upon the patient-client exchange.

Much of the research that addresses the potential benefits of mindfulness or Buddhist meditation in the mental health field focuses on clinical utility or job performance. There is currently little research looking at how Buddhist practice influences the *therapist's* ability to cope with job stresses and difficult clinical work. Review of the literature in this area suggests that further study of how Buddhist practice informs and influences psychotherapists professionally and personally would be illuminating.

Although preliminary, these studies suggest that mindfulness meditation can support helping professionals by reducing stress, improving empathy, providing a method and conceptual framework for working with clients, and increasing clinical engagement. Such factors may serve as protective, preventing burnout and vicarious traumatization in vulnerable therapists.

Awareness Meditation: Vipashyana

Vipashyana, awareness or insight, arises naturally, after the mind has stabilized within the context of *Shamatha*. *Vipashyana* has been translated as "clear seeing," and can be characterized as momentary glimpses of "the true nature of reality. " "Vipashyana is an experience of the world that stands outside of our expectations and wishful thinking. It is felt as an experience of things 'as they are'" (Ray, R. 2000, p. 306). In this sense, *vipashyana* insights begin to shape the practitioner's understanding of the world. Such insights have given rise to the body of teachings of the Buddhist cannon.

Cooper (1999) used a case study to illustrate the way in which his personal Buddhist practices of mindfulness (*shamatha*) and awareness (*vipashyana*) affected his ability to work with transference and countertransference as a therapist. The author presented a case, which illustrated the intersection of Buddhist practice and psychoanalysis, particularly as it relates to countertransference. Cooper focused on *vipashyana* practice in the context of Tibetan Buddhism in particular, noting that *vipashyana* practice "develops the practitioner's capacity to analyze and resolve negative emotional states, which Buddhists contend derive through unconsciously concretized or reified images of self and other." (Cooper, 1999). In this case, Cooper employed

vipashyana awareness, to expand his understanding of his client, beyond concept and emotional response.

Cooper contrasted the psychoanalytic concept of a self with the Buddhist notion of egolessness: that, on an absolute level, there is no inherent, solid existing self. He proposed that this understanding, which is a central insight of *vipashyana*, can inform a psychoanalysis based on a notion of the self that is fluid and illusory. In the case study presented by Cooper within his article, the author showed how understanding his client as fluid and illusory helped Cooper better serve him

The Shambhala Tradition

This study focuses on Buddhism within the context of the Shambhala tradition. An overview of the Shambhala world-view, which runs parallel to many Buddhist teachings, is presented below.

In 1976, Chogyam Trungpa, a Tibetan Buddhist teacher who had begun to teach in the West in the late 1960's, introduced the Shambhala teachings on warriorship. Presented as particularly relevant to modern Western life, these teachings emphasize engaging in the world, with a balance of gentleness and fearlessness. While not explicitly Buddhist, the Shambhala teachings arose out of a tradition of warriorship found in the wisdom traditions of many Asian Buddhist countries. These teachings are presented alongside more traditional Buddhist teachings, within Shambhala Buddhist tradition.

Trungpa's description of a warrior contrasts with conventional notions of bravery and warriorship involving violence and aggression. In the Shambhala worldview, rather than perpetuating violence or ruling through fear, warriors cultivate fearlessness and gentleness by relating directly to their own minds and hearts. An intimate understanding

23

of one's own mind allows the warrior to develop the compassion, skill and motivation to help others.

The ground of warriorship is the individual's realization of his or her own inherent wisdom, sanity and the workability of their own mind, expressed in Trungpa's teaching as *basic goodness.* Basic goodness is seen as the fundamental nature of human beings and the world, which transcends duality:

> When we speak of basic goodness, we are not talking about having allegiance to good and rejecting bad. Basic goodness is good because it is unconditional, or fundamental. It is there already, in the same way that heaven and earth are there already. (Trungpa, 1984, p. 29)

Trungpa taught that the best method to access and recognize basic goodness is the practice of *shamatha vipashyana* meditation. The meditation technique Chogyam Trungpa introduced as part of the Shambhala teachings was identical to Buddhist mindfulness awareness meditation, yet he viewed it as transcending any particular tradition:

> By meditation here we mean something very basic and simple that is not tied to any one culture. We are talking about a very basic act: sitting on the ground, assuming a good posture, and developing a sense of our spot, our place, on this earth. This is the means of rediscovering ourselves and our basic goodness, the means to tune ourselves to genuine reality, without any expectations or preconceptions. (Trungpa, 1984 p. 20)

Trungpa maintained that the discovery of basic goodness, through the practice of meditation, allows one to begin to help others effectively:

> Experiencing the basic goodness of our lives makes us feel that we are intelligent and decent people and that the world is not a threat. When we feel that our lives are genuine and good, we do not have to deceive ourselves or other people. We can see our shortcomings without feeling guilty or inadequate, and at the same time, we can see our potential for extending goodness to others. (Trungpa, 1984, p. 16)

Meditation thus allows the practitioner to relate directly to their own world, renouncing

anything that interferes with direct engagement with others.

The Shambhala teachings, presented specifically to the Western audience,

emphasize that the fundamental ground of the mind is workable, good, and wholesome.

In this sense, these teachings can be powerful allies for therapists encountering traumatic

material and stressful work situations. My study will explore how practitioners, informed

by these teachings, cope with and contextualize difficult clinical material.

The Tibetan Buddhist Tradition

In addition to presenting the Shambhala teachings, Chogyam Trungpa was also

one of the first teachers to bring Tibetan Buddhism to the west. As a lineage holder of

the *Karma Kagyu* and *Nyingma* traditions of Tibetan Buddhism, Chogyam Trungpa was

recognized at the age of thirteen months as a *Tulku*, or incarnate teacher:

> According to Tibetan tradition, an enlightened teacher is capable, based on his or
> her vow of compassion, of reincarnating in human form over a succession of
> generations…Thus, particular lines of teaching are formed, in some cases
> extending over several centuries. Chogyam Trungpa was the eleventh in the
> teaching lineage known as the Trungpa Tulkus. (Trungpa, 1994, p. 164.)

Raised in a monastery in Tibet, Trungpa received rigorous training in the theory

and practice of Buddhist teachings, studying and practicing for 18 years until he was

forced to flee Tibet in 1959. After leaving Tibet, he studied in England and eventually

settled in The United States and began to teach young westerners about Buddhism, which

he presented in the context of *the three yanas*.

Within the tradition of Tibetan Buddhism, which is used as a context for this

study, the Buddha's teachings are categorized into three *yanas,* or vehicles. Each *yana* is

a path of study and practice, which has a specific view, culminating in an understanding

of the nature of reality. The insight of each *yana* builds cumulatively on the

understanding gained in the preceding vehicle:

> What are these three disciplines, these three *yanas* or paths? They are the Buddha
> expressing reality from three different perspectives, each one getting more
> profound, each one getting closer to the truth. We can look at the hinayana,
> mahayana, and vajrayana in terms of which one is more valid, and say that these
> yanas are three stages…of understanding the truth. (Mipham, 1999, p. 2)

The hinayana. Translated as the narrow vehicle, the *hinayana* is the basis for the

Tibetan Buddhist path. The teachings of the hinayana focus upon renouncing cyclical

patterns of desire and dissatisfaction. One of the foundational teachings within the

Hinayana, which forms a basis for the teachings of all Buddhist traditions, are *The Four*

Noble Truths, which describe: 1) the truth of suffering 2) the truth of the origin of

suffering 3) the truth of the cessation of suffering and 4) the truth of the path. These four

truths acknowledge that suffering does exist, and pervades our existence, point to a cause

of suffering, hold out the possibility that there can be an end to suffering, and illuminate

the way to end suffering: the Buddhist path (Ray, 2000).

The teachings on the four noble truths can give Buddhist practitioners working

with difficult populations and situations a framework to relate to suffering, helping them

to manage overwhelming clinical material. By acknowledging the pervasive quality of

suffering, the Buddhist worldview provides a framework for therapists to begin to accept

the pain around them, and to thus be able to work with it more directly. While

acknowledging that life is filled with dissatisfaction and suffering, the four noble truths

also point toward a way of living that can eliminate unnecessary suffering.

In addition, the hinayana teachings strengthen the practitioner's commitment to

the Buddhist path by highlighting the reasons one should practice, known as "the four

reminders." These four reminders point to the characteristics of relative existence, according to the Buddhist world view: (1) The preciousness of human birth, affording us an opportunity to practice meditation (2) The reality of impermanence and death (2) Samsara (or cyclic existence) and its faults (3) The truth of karma (or the law of cause and effect) (Ray, 2000).

The fruition of the hinayana is the realization of egolessness, or selflessness. The practitioner who fully realizes the insights of the hinayana sees that the conventional notion of the self as independent, solid and unchanging is a misunderstanding. The hinayana master knows the self to be nonexistent, in that it is a fluid and intangible collection of physical form and mental processes, which we misunderstand to be a self.

The mahayana. Translated as "the greater vehicle" (Mipham, S., 2002), the *mahayana* path in Buddhism emphasizes the development of boundless compassion and openness. The practice of *tonglen*, as well as the overall orientation of contemplative psychotherapy, (both discussed below) are informed by traditional mahayana Buddhist teachings. With an understanding of the pervasiveness of suffering, and an insight into selflessness, the mahayana practitioner begins to aspire to help others who are suffering:

> Because we have discovered egolessness, because we have discovered that *me* does not exist, we find that there is lots of room, lots of space, in which to help others. That is the basis of compassion. (Trungpa, 1981, p. 5)

The cultivation and enactment of *bodhicitta* is the foundation and the path of the mahayana (Mipham, S. 2002). Translated from the Sanskrit, *bodhi,* meaning awake, and *citta,* translated as mind or heart (Mipham, S. 2002)., is a quality of awakened heart or mind, which is characterized by compassion and openness:

Sometimes the completely open heart and mind of bodhicitta is called the soft spot, a place as vulnerable and tender as an open wound. It is equated, in part, with our ability to love. (Chodron, 2001, p. 4.)

Accessing this sense of tenderness and vulnerability allows individuals to engage effectively and compassionately in the world. Bodhicitta is the heart of what Trungpa calls warriorship, and is the basis of the bodhisattva path. Chodron (2001) described how bodhicitta manifests as warriorship in the world:

Those who train wholeheartedly in awakening unconditional and relative bodhicitta are called bodhisattvas or warriors—not warriors who kill or harm but warriors of nonaggression who hear the cries of the world. These are men and women who are willing to train in the middle of the fire. Training in the middle of the fire can mean that warrior-bodhisattvas enter challenging situations in order to eliminate suffering. It also refers to their willingness to cut through personal reactivity and self-deception, to their dedication to uncovering the basic, undistorted energy of bodhicitta. We have many examples of master warriors— people like Mother Teresa and Martin Luther King—who recognized that the greatest harm comes from our own aggressive minds. They devoted their lives to helping others understand this truth. (p. 5-6)

In the Buddhist tradition, setting out on the path of the mahayana is marked by taking the bodhisattva vow (Mipham, S. 2002). Taking this vow involves making the commitment to working with one's own mind and heart in order to realize one's own true nature for the benefit of all beings. Trungpa (1981) described the intention of the mahayana:

The *mahayana* goes beyond the hinayana ideal of individual liberation alone. Its aim is the liberation of all sentient beings, which means that everyone, everything is included in the vast vision of mahayana. All the chaos and confusion and suffering of others and ourselves is part of the path.

The primary discipline of the hinayana is helping others, putting others before ourselves. The training of the mahayana practitioner is to exchange himself for others…Thus the mahayana is expansive and embracing. (p. 2-3)

The fruition of the mahayana is the realization of *twofold egolessness*. Trungpa (1976) described the two stages of realizing egolessness, the first accomplished in the hinayana, the second accomplished in the mahayana:

> In the first stage we perceive that ego does not exist as a solid entity, that it is impermanent, constantly changing, that it was our concepts that made it seem solid. So we conclude that ego does not exist. But we still have formulated a subtle concept of egolessness. There is still a watcher of the egolessness, a watcher to identify with it and maintain its existence. The second stage is seeing through this subtle concept and dropping the watcher. So true egolessness is the absence of the concept of egolessness. In the first stage there is a sense of someone perceiving egolessness in that there is no fixed entity because everything is relative to something else. In the second stage there is the understanding that the notion of relativity needs a watcher to perceive it, to confirm it, which introduces another relative notion, the watcher and the watched. (p. 12)

The vajrayana. The next path, the *vajrayana,* translated as the diamond or indestructible vehicle (Trungpa, 1981) builds upon the practitioner's intention to liberate all beings from suffering. While the intention is the same, the approach to eliminating suffering is very different from that of the mahayana. In this stage, students are initiated into relationship with a vajrayana lineage holder, who can help them more quickly realize their own "true nature" (Trungpa, 1981). In addition, the vajrayana practitioner works directly with the energy of the world, using everything they encounter in their life as part of their spiritual path. Trungpa (1981) talked about the importance of a spiritual teacher within the vajrayana, or tantric path:

> In the vajrayana, it is absolutely necessary to have a teacher and to trust in the teacher. The teacher or vajra master is the only embodiment of the transmission of energy. Without such a teacher, we cannot experience the world properly and thoroughly. We cannot just read a few books on tantra and try to figure it out for ourselves. Somehow that does not work. Tantra has to be transmitted to the student as a living experience. The tantric system of working with the world and the energy of tantra have to be transmitted or handed down directly from teacher to student. (p. 61-62)

Contemplative Psychotherapy

Contemplative Psychotherapy arose from the intersection of Western Psychotherapy and the teachings of Buddhism and Shambhala, centering on Naropa university, a contemplative university founded by Chogyam Trungpa and his students in 1974. One of the underlying assumptions of Contemplative Psychotherapy is that healing takes place when someone is fully present with another's experience (Wegela, K. 1996). However, the ability to be fully present with another person is possible only if the helper has first become intimate with his or her own mind:

> A contemplative approach to helping teaches that in order to be capable of benefiting others, we need to first of all deal with our own confusion---our own lack of confidence, our lack of clarity, and our fear and pain. To be helpful to others, we need to begin by working with ourselves. (Wegela, 1996, p. 5)

The basis of being present with another's pain is the practice of sitting meditation, which allows one to become familiar with one's own emotions and thought processes. Just as in the Shambhala and Buddhist traditions, meditation practice allows one to cultivate the intention, understanding, and skill to help others. (Wegela, K. 1996).

Brilliant Sanity

In addition to developing familiarity with one's own mind, sitting practice also helps individuals recognize their own *Brilliant Sanity.* In contemplative psychotherapy, brilliant sanity refers to the ground of intrinsic health and wholesomeness, accessible to everyone, regardless of their current mental state (Wegela, K. 1996).. Brilliant sanity can be seen as equivalent to the Shambhala notion of basic goodness. In this approach, the fundamental nature of mind is seen as healthy and workable. Psychopathology arises when one loses connection with this intrinsic health and goodness. However, brilliant

sanity being the basis of the mind, it is always accessible even in the midst of neurosis and even psychosis (Podvoll, 1990).

Maitri

In addition to helping one connect with the brilliant sanity within oneself and others, meditation also allows one to begin to cultivate an open and friendly attitude toward one's own internal experience. The contemplative psychotherapy tradition uses the term *maitri* to describe this natural welcoming and non-aggressive attitude, which develops out of sitting meditation:

> Maitri is being gentle with who we are in any one moment—whoever we are right now. We can let ourselves be who we are right now, we don't have to pretend to be somebody else. Who we are is just fine. We can trust in our brilliant sanity." (Wegela, 1996, p. 64)

Sitting practice allows one to first cultivate maitri for oneself. This gentleness and acceptance then naturally begins to extend outward to include others (Trungpa, 1976).

Wegela (1996) noted that maitri is not based on an ego-centered tendency to "have a fixed or solid reference about who we are." (p. 64). Thus, maitri is not a "rationalization," or a way to let oneself off the hook for acting cruelly or aggressively. Rather, maitri is the ability to see experience as it is, without judgment:

> Maitri is not even particularly about liking ourselves, which is really just a judgment, another condition. Maitri is more about seeing clearly and letting be. We could use the word acceptance, not in the sense of judging something as acceptable, but rather, in the sense that we simply see what's happening. It is, perhaps, akin to forgiveness. (p. 64).

In the therapeutic encounter, an atmosphere of maitri is one that is welcoming and encourages honesty and directness. In clinical work, maitri provides an atmosphere of

31

openness, gentleness, and truthfulness without which transformation would be very difficult (Wegela 1996).

Exchange

The notion of exchange is a central concept in contemplative psychotherapy. Exchange describes how the emotional energy of a person or situation can be felt subjectively by another person in the environment, in the clinical encounter and beyond, (Podvoll, 1990). Described by Wegela (1996) as "our direct experience of someone else," (p. 127) exchange is seen as a natural phenomenon, which can be used in psychotherapy to help the clinician understand and have compassion for the client's experience.

The phenomenon of exchange highlights the subtle ways in which we influence one another and shows us how we are inextricably connected to others:

> If we sit with a friend who is very sad we might find ourselves feeling sad. Our sadness is not merely our response to hearing about what is happening for our friend. It is as though we catch their sadness. Because we're permeable, we actually pick up on how other people feel. We can pick up on speediness, sadness, anger, any feeling. (Wegela, 1996, p. 128).

In this sense, we can use our subjective experience to give us information about others. Wegela also points out that "exchange goes in both directions at the same time." (p. 128). Thus, if we cultivate maitri and our connection to brilliant sanity, our optimism and openness can be contagious for those in the midst of pain and confusion.

The concept of exchange can also provide a context for accepting the challenging aspects of clinical practice. Understanding exchange means realizing that practicing psychotherapy means meeting experiences and emotions we might like to push away:

> Being willing to help means having all these unpleasant feelings. Because of our longing to be helpful and our natural compassion, we are inspired to be present, even though it is often no fun at all. (Wegela, 1996, p. 130.)

The ability to accommodate such unpleasant feelings allows for the development of maitri, in both the psychotherapist and client.

Tonglen

Tonglen is a meditation technique employed in the contemplative tradition, taken from Tibetan Buddhist Mahayana practice. Translated from the Tibetan, *tonglen* means "sending and taking" (Chodron, 2001) "It refers to being willing to take in the pain and suffering of ourselves and others and send out happiness to us all" (Chodron, 2001, p. 55). The practice of tonglen can help psychotherapists to accommodate the difficulty and confusion met, through the process of exchange, in clinical practice. (Wegela, 1996).

Practiced in the context of a session of sitting meditation, tonglen reverses the natural, ego oriented tendency take in what is positive and nurturing and reject that which is painful and difficult. In doing so, it lays the groundwork for exchange with others, and cultivates compassion.

> Because we possess brilliant sanity—openness, awareness and compassion—we have the aspiration to help others. We do tonglen practice so that we can take this longing to be of benefit and start to transform it into compassionate activity so all of us can recognize our brilliant sanity. (Wegela, 1996, p.137)

Thus *tonglen* is a practice that can help therapists move from compassionate intention to compassionate action.

The practice of *tonglen* involves four steps: 1) Making contact with a sense of brilliant sanity 2) Breathing in a texture of negativity, heat and claustrophobia and breathing out a sense of openness, clarity and relief 3) Connecting with a specific painful

situation, in our life or in someone else's life, and breathing in the difficulty and pain of

that situation, then breathing out relief and well-being for that person or situation 4)

Expanding the practice out, to include others suffering in a similar way, broadening the

scope of our compassion (Chodron, 2001). Chodron (2001) described the process of

tonglen:

> We breathe in what is painful and unwanted with the sincere wish that we and
> others could be free of suffering. As we do so, we drop the story line that goes
> along with the pain and feel the underlying energy. We completely open our
> hearts and minds to whatever arises. Exhaling, we send out relief from the pain
> with the intention that we and others be happy. (p. 55)

The practice of *tonglen* can help the practitioner cultivate a mind which can

accommodate great suffering and also hold the possibility of great relief. In this sense, it

may give therapists a tool to transform feelings of ineffectiveness and feeling

overwhelmed into compassion. Thus, *tonglen* may be useful in combating burnout and

vicarious traumatization.

Contemplative Approaches to Burnout

In the context of contemplative psychotherapy, burnout is seen as a phenomenon

arising from the ambitions and expectations of ego and a lack of mindfulness. Dass and

Gorman (2001) identified "motives, needs, expectations, the models we have for

ourselves" (p. 188) as the factors which put caregivers at risk for burnout. Wegela (1996)

pointed out that while expectations and hopes can arise from genuine compassion,

expectations can also set helpers up for disappointment, and can lead us away from the

present moment:

> Instead of being present with the situation as it is, we start to imagine what could
> be happening if only we did the right thing…If we have built plans for someone

else based on our own desires—even if they are compassionate ones—we can become fed up and tired. (p. 217)

Wegela (1996) contended that burnout is also a result of losing a sense of mindfulness in our life and in the work we do. Burnout, in this sense, is a result of losing our connection to the present moment, and not attending to our basic self care needs:

> Becoming exhausted is sometimes the result of starting to ignore our bodies…We become somewhat mindless about whether we are hungry or tired…If this happens to us, sometimes it is a sign that our helping itself has become a mindlessness practice. (p. 216)

The contemplative understanding of burnout focuses upon the intentions and expectations of the helper, rather than emphasizing the role of environmental stressors:

> Without minimizing the external demands of helping others, then, it seems fair to say that some of the factors that wear us down we seem to have brought in with us at the outset. (Dass & Gorman, 2001, p. 191).

While the contemplative tradition emphasizes mindlessness as a contributing factor to the development of burnout, it offers mindfulness and awareness, particularly in the form of the practice of meditation, as the antidote to burnout. In order to work with burnout, Dass and Gorman (1985) recommend cultivating "the Witness: that stance behind experience in which we merely acknowledge *what* is, without judgment of ourselves or of others" (p. 187). The practice of meditation is designed to help one cultivate this non-judgmental awareness of internal experience and external events. This consciousness can *witness* the conflicting emotions and motivations, which contribute to burnout:

> By simply witnessing the character and conflict of our reasons for helping out, then, we are making room for an essential change of perspective. Our actions are less hostage to our needs. We can call upon a deeper, more universal source of action, one that is steady, reliable, less likely to burn out. (Dass & Gorman, 1985, p. 193)

Dass and Gorman also contended that burnout results from an over identification with the role of "helper":

> We can see how often we define ourselves as "helpers," even to the point of buying into an illusion of indispensability. We become so invested in our work that we actually begin to equate who we are with what we do. It becomes a social mannerism, a way we introduce ourselves to one another. (Dass & Gorman, 2001, p. 194)

Dass and Gorman contended that, as we cultivate the witness consciousness, our identity as a "do-er" becomes less reified, and we are able to work more effectively.

At the same time, Dass and Gorman acknowledged that, in addition to arising from internal causes, burnout can also come about due to "external pressures" in environments and organizations. Their advice is to work to change unhelpful environments when necessary, but to also maintain a witness-awareness of structural situations: "Institutions are formalized mind-sets. These too can be witnessed" (p. 199). In this sense, mindfulness and awareness can be applied even to organizational challenges.

Dass and Gorman also pointed out that the act of helping is often characterized by ambiguity, doubt and uncertainty. Rather than trying to resolve ambiguous questions, constantly evaluating whether our efforts are working, whether we are helping, they advised helpers to rest in the moment and give up their agenda:

> We do everything we can to relieve someone's suffering—our dearest's, our beloved's, anyone's—but we are willing to surrender attachment to how we want things to be, attachment even to the relief of their suffering. (p. 208)

Conclusion

As the literature shows, Buddhist practice can help individuals cultivate habits of self care, based on friendliness toward oneself and compassion for others, while also

providing a conceptual framework to make sense of great suffering and cruelty. Tibetan Buddhism incorporates an emphasis on the practice of meditation, complemented by a thorough examination of the nature of reality, both of which may help clinicians work with job stress.

The view of Shambhala Buddhism, including the three yanas of Buddhism and the Shambhala teachings on warriorship, provide cognitive schemata which may be protective for therapists. At the same time, Buddhist teachings about the nature of suffering, impermanence, and selflessness also provide a framework which can help clinicians relate to daily work stresses and bear witness to great pain and devastation.

As the review of the literature shows, the practice of meditation allows individuals to cultivate a friendly and accepting attitude toward oneself and others, tolerate difficult emotions, and cultivate courage, compassion and empathy. In addition, research has shown that meditation can be an effective tool for coping with physical challenges and stress. Meditative practice can also help one to cultivate a connection to the present moment, allowing practitioners work with clients without expectations for specific results. Contemplative psychotherapy literature and research on burnout both contend that burnout is, in part, the result of clinicians' disappointed expectations. Buddhist practice may therefore help practitioners develop resilience in the face of burnout.

In this sense, Buddhist practice may help psychotherapists to manage difficult job environments and the stressors of clinical work. Given the dangers of vicarious trauma and burnout, documented in the literature above, the insights of Buddhist practitioners may offer helpful strategies for all clinicians coping with job stress. This project will

explore how Buddhist psychotherapists use spiritual practice to support themselves in the midst of burnout and vicarious trauma.

CHAPTER III

METHODOLOGY

The purpose of this study is to understand what sustains, motivates, and inspires Buddhist therapists in the midst of challenging clinical work. This investigation explored the positive and inspiring aspects of clinical work, as well as the challenges and frustrations Buddhist clinicians meet in their professional practice. While there has been research in the areas of vicarious traumatization and burnout, there has been little exploration of how spiritual practice might support clinicians facing these challenges. The study employed a qualitative, flexible research method.

The goal of the study was to learn more about how a specific group of people, Buddhist psychotherapists, maintain commitment and passion for their work. In the hopes of learning more about this particular group, an exploratory design with open-ended interviews was employed to gather narrative data. This design allowed for exploration of each therapist's personal experience of the research question.

> In flexible method research, unstructured data are used in order to capture the phenomena of interest in the words or actions of those who embody or live them and to capture them in context in terms that are as "experience near" as possible." (Anastas, 1999, p. 57)

Thus, the research design of this study sought to gather a rich, descriptive understanding of the phenomena in question by speaking with individuals with insight into the research question.

Sample

This study focused on a population of eleven mental health professionals

including clinical social workers, counselors, and psychologists. Inclusion criteria for the

sample was as follows:

a) To hold at minimum a masters degree in social work, counseling or psychology
    and to be currently practicing as a psychotherapist.

b) To have at minimum of three years post-degree of clinical experience.

c) To have a caseload of clients, three of whom are individuals with a trauma
    history, comprising at least 10 direct service hours per week.

d) To have a minimum of five years of committed meditation practice.

e) To practice Buddhism within the Shambhala Buddhist tradition, a Tibetan
    Vajrayana lineage of Buddhism.

f) To have taken the *Bodhisattva vow*, which is a formal commitment to the
    Buddhist path in order to achieve enlightenment for the benefit of all sentient
    beings.

This study employed purposive, snowball sampling. The researcher first posted a

recruitment letter on *Sangha-Announce*, an international list-serve for people affiliated

with the Shambhala community. This email recruited participants for the study, stating

the intention of the study, and clearly indicating the inclusion criteria. The researcher

asked that potential participants email with any questions about the study, or if they

would like to participate.

At the same time, the researcher also contacted specific individuals, via email,

who fit the inclusion criteria for the study. These individuals were Buddhist

psychotherapists living in the Boulder, Colorado area, who were referred by

acquaintances or other study participants. The email to these individuals indicated that

their name was given to the researcher as a potential participant, outlined the study and stated the inclusion criteria.

Recruitment largely took place over the Internet and in Boulder, Colorado. Boulder has a large population of Buddhists practicing in the Shambhala tradition. At the same time, the list-serve reaches people all over the world. In the final sample, 6 therapists were from the Boulder area, and 5 were from elsewhere in the United States or Canada, and these interviews were conducted over the phone.

Some effort was made to recruit people of color for this study. In the recruitment letter sent to the list-serve, the researcher noted that clinicians of color are encouraged to participate, in order to achieve a more diverse sample that represents the voices of non-white Buddhist therapists. However, there is not a lot of racial diversity within the Shambhala Buddhist community, which made it difficult to have a diverse sample in relation to race. The small sample size also made it difficult to ensure diversity in other respects, as well, though some effort was made to have some gender and age diversity. Potential participants were screened by phone to ensure they met the study's criteria and to schedule interviews. Information about the demographics of the sample is included in the following chapter.

Ethics and Safeguards

Potential risks and benefits of participation in this research were outlined in an informed consent letter signed by all participants. The potential risks of participating in this study were the possibility that participants might feel strong or uncomfortable emotions while participating in an interview addressing the challenges and difficulties of their clinical work. Interviews addressed the emotional, physical and psychic impact of

clinical work upon clinicians, in addition to exploring whether clinicians experienced the symptoms of burnout or vicarious trauma. Because the sample was made up of psychotherapists, participants were not given a list of referral sources for mental health care. Confidentiality was maintained, as names and identifying information have been changed in the reporting of the data. In the findings, participant names are not associated with the information provided in the interview.

Participants received no financial benefit for their participation in the study. However, individuals may have benefited from knowing they contributed to a better understanding of both Buddhist practice and resilience in psychotherapy. Some participants also noted that they appreciated the opportunity to share their experience and gain a new perspective.

Informed consent was obtained by giving potential participants an informed consent letter to sign (see Appendix C). The letter was either emailed to the participant or sent via mail. The letters were then read and signed by the participants, who mailed it back to the researcher or returned it in person. All participants were over 18 and were fluent in English.

The researcher transcribed the interviews. The research advisor for this project had access to the data, after identifying information was removed. In the findings chapter, care was taken not to include identifying information, or to disguise it. Alternatively, findings were presented as related to the whole group, rather than in relation to individuals. Coding the information and storing the data in a locked file for a minimum of three years will protect confidentiality. After three years, data will be destroyed unless the researcher continues to need it, in which case it will be kept secured

Data Collection

The data collected was in narrative form, gathered via semi-structured in-person or telephone interviews with participants. Interviews began with the participants answering a series of demographic questions. The interview proceeded with 16 open-ended questions, some of which included contingency questions (see Appendix B). The interviews were scheduled to take place at mutually convenient, quiet, and professional locations, or over the phone. Interviews ranged from 45 minutes to an hour and a half and were audio recorded for transcription purposes.

The Human Subjects Review Board of the Smith College School approved the design of this study for Social Work (see Appendix A). This process ensured that the study met ethical standards for research. In addition, the HSR review looked over the interview guide and approved the interview questions.

Data Analysis

Narrative data for this study was analyzed by both inductive and deductive means. Themes relevant to the research question, such as: inspiring and discouraging aspects of clinical work, the effects of trauma upon therapists, coping strategies developed in the face of difficult work, and the impact of Buddhist practice upon clinician resilience were identified. In addition, review of the data also suggested important themes, which had not been explicitly delineated by the interview guide.

Due to the small sample size and highly specific characteristics of the sample, findings from this study cannot be generalized to a larger population. Rather than seeking to provide broadly applicable information, the intention of this study was to

explore the intersection between work-related challenges and spiritual practice specific to Buddhism.

Expected Findings

The initial inspiration for this study was the hypothesis that spiritual practice may be a protective factor for Buddhist clinicians. Therefore, the researcher expected to find that interviewees consider Buddhist practice helpful, if not essential, to their resilience. Another expected finding was that, while there may be difficulties associated with clinical work, this population would not generally exhibit the symptoms of vicarious trauma and burnout.

Limitations

As this was a qualitative study, the researcher did not endeavor to quantitatively assess whether or not participants suffered from burnout or vicarious trauma, though measures have been developed for both (Maslach, Jackson, & Leiter, 1996; Bride, Radey, & Figley, 2007). Some questions about symptoms of burnout and vicarious trauma were included in the interview guide to allow for a preliminary sense of whether participants were very negatively impacted by job stress. However, these questions are not valid or reliable measures of either burnout or vicarious trauma.

In addition, due to technological difficulties, half of one interview was not audible, and therefore some of the data from this interview could not be coded. Another limitation of the study is that the sample did not all work with a large caseload of traumatized individuals and thus had less exposure to work circumstances which might put clinicians at risk of vicarious trauma. It would have been preferable to have interviewed a sample of trauma therapists. However, this was not possible because it

would have been difficult to recruit a large enough sample, which still satisfied the other

inclusion criteria.

CHAPTER IV

FINDINGS

This study sought to learn more about how spiritual practice supports Buddhist psychotherapists in the midst of challenging clinical situations and work stress. Interviews addressed issues such as what motivated participants to become a Buddhist and to become a therapist, as well as what inspired therapists to continue clinical work. Interviewees also discussed what they find discouraging in their work. Participants were asked to talk about the challenges they faced in their clinical work and share their perception of how these challenges impacted them. In addition, they were asked to talk about how they coped with work stresses, and whether their spiritual practice was supportive in the face of clinical difficulty.

The findings of this study are divided into six areas: 1) Participant demographics 2) Inspiration 3) Work related challenges, 4) Effects of work related challenges, 5) Methods of coping with work related stress, and 6) Spiritual practice and coping with work related stress.

Participant demographics

This section describes the characteristics of participants, including age, gender, race, relationship status, and geographic location (Table 1). Interviewees were also asked to share information about their clinical work, such as what type of practice they have (private or agency), how many clients they have on their caseload, average number of direct client hours per week, and the average number of clients on their caseload with

trauma in their background (Table 2). In addition, participants were asked questions regarding their spiritual practice, such as number of years they have been meditating. The demographic characteristics of the sample are summarized in Table I below.

There was some variation among the participants in terms of gender, with five men and six women interviewed; and geographic location, with six participants from the Boulder/Denver area, three from the Northeastern United States, one from the Southeastern United States, and one individual from Canada. All participants identified as Caucasian, or European American.

Nine clinicians were Master's level psychotherapists and two participants had Doctoral Degrees. Six of the participants worked in private practice settings and five worked in agency settings. Only two participants had been in the field of mental health for less than ten years. The majority of participants had between eleven and thirty years of experience as psychotherapists. In addition, participants had extensive experience meditating, with the vast majority of participants (n=8) having meditated for over twenty years.

Participants described their caseloads, including the number of clients on their caseload, number of clients with a trauma history, and number of direct client hours per week (see Table 2). The sample varied in terms of numbers of clients on caseload, ranging from 10 to over 40 (see Table 2 for more details on caseload distribution.) Most participants (n=7) worked directly with clients for 10-20 hours per week. The remaining participants worked with clients between 20 to 40 hours per week. The majority of the sample worked with an average of 5-12 clients with a trauma history (n=6).

Participants were also asked to describe how they work with people, including what particular theoretical influences inform their work. Seven interviewees said their work was informed by contemplative psychotherapy, citing theories of Buddhist psychotherapy, basic sanity, the Windhorse model, or body centered psychotherapy. Seven practitioners said their work was informed by psychodynamic theory, including relationally focused theories, trauma theory, and attachment theory. Seven of those interviewed also mentioned evidence-based practice as being supportive to their work, citing solution focused therapy, cognitive-behavioral therapy, or EMDR. Other practitioners cited humanism, person-in-environment, logosynthesis, and infant mental health theories as influential.

Table 1

Demographic Characteristics of the Sample

		30-39	40-49	50-59	60-70
	Age Range	N= 2	N=1	N=4	N=4
N=11					
Race					
	Caucasian	2	1	4	4
Gender					
	Male	1	-	3	1
	Female	1	1	1	3
Partnership Status					
	Single	-	-	-	1
	Married	2	1	3	2
	Partnered	-	-	1	1
Years meditating					
	10-20	2	-	1	-
	21-30	-	1	2	2
	31-40	-	-	1	2
Location					
	Boulder/Denver	1	1	3	1
	Northeast	1	-	-	2
	South	-	-	1	-
	Canada	-	-	-	1
Type of Degree					
	MFT	1	-	-	-
	MSW	-	-	-	3
	MA	1	-	3	1
	PhD	-	1	-	-
	PsyD	-	-	1	-
Type of practice					
	Private	-	1	1	4
	Agency	2	-	3	-
Years in Field since graduation					
	1-10	2	-	-	-
	11-20	-	1	3	-
	21-30	-	-	1	3
	31-40	-	-	-	1

Table 2

Description of participant caseload characteristics

	Age Range	30-39	40-49	50-59	60-70
		N= 2	N=1	N=4	N=4
Average number of clients on caseload					
	10-20	-	-	1	1
	21-30	1	-	1	2
	31-40	1	1	-	1
	>40	-	-	2	-
Average direct client hours per week					
	10-20	2	-	2	3
	21-30	-	1	1	1
	31-40	-	-	1	-
Average # of clients with trauma					
	5-12	-	-	2	4
	13-20	-	1	1	-
	21-27	1	-	-	-
	28-35	1	-	1	-

Inspiration

Questions related to "Inspiration" addressed what initially motivated participants

to become Buddhist what inspired them to become psychotherapists and what they

currently find most inspiring about their work.

Inspiration to Become a Buddhist

Connection to Buddhist teacher or teachings. The majority of those interviewed

cited an encounter with the teachings of Buddhism (n=7) as an initial inspiration to

become Buddhist. Participants discovered the teachings of Buddhism in books by

Buddhist teachers, by attending practice centers, classes, classes, programs or lectures.

The teachings of Buddhism are often referred to as the dharma, which has been translated

as "the truth," and many participants spoke of an intuitive connection with the teachings

as truth. Two participants speak of their sense of resonance with the teachings:

> My sophomore year, [at college], first semester, 1967, introduction to Buddhism.
> My professor at [college] edited the textbook. Read the first chapter, and just
> reading the four noble truths and immediately for me, a light bulb went off. I was
> looking for something and this was the first and only thing, actually, since that, to
> me, speaks the truth and doesn't bullshit around with metaphysical--the whole
> non-theistic approach, and working with your own mind. How to deal with being
> alive, suffering, impermanence and death, and how, if we work with our minds
> well, one can actually be happy in the suffering.

> …

> It felt to me like the first time I felt that there was this wholeness and clarity in a
> worldview, that I had not felt in my studies in the past.

Many of the people interviewed cited a connection to a Buddhist lineage holder

(n=4) as something that initially drew them to Buddhism. Participants spoke of their

connection to a teacher in a similar way to their connection to the teachings, many

emphasizing an intuitive, immediate connection. Here, a respondent speaks of meeting

Zen meditation master, Thich Nhat Hahn:

> …when I met Thich Nhat Hahn, I sort of became very clearly Buddhist. I never
> wanted a teacher but when I met Thich Nhat Hahn, it was so obvious that he was
> my teacher that it just sort of changed at that point.

Another participant spoke of how the teachers she met within the

Shambhala community embodied the *dharma* through their presence:

> I think by example a lot of the teachings were--became appealing--to me, because
> of how I saw their presence. And the more teachers I saw, the more I saw the
> same quality of curiosity and simplicity that was very inspiring to me.

> *Connection to Buddhist practitioners.* In addition to meeting Buddhist teachers,

some interviewees (n=3) connected to the teachings of Buddhism through other

individuals, such as an acquaintance, or by becoming familiar with the Shambhala

community, or *sangha*. One participant described his first encounter with a Buddhist

practitioner:

> I met somebody in an Outward Bound course in Texas, who came from a
> traditional background and yet nothing in his affect and his worldview could I
> place as being—he seemed detached or he had gone beyond his upbringing, as an
> East Coast son of a dentist from White Plains, New York. He seemed detached,
> had gone beyond that kind of limited view. And, just in the way he related to
> people, in the desert of Texas, I could tell there was something going on. I was
> very curious.

Another interviewee, living in a small, out of the way city found herself

connected with Buddhism when Buddhist practitioners began settling in her town.

Connection to meditation practice. Other participants (n=3) noted that their

primary connection to Buddhism came by way of meditation practice. One participant,

describing his initial involvement with Buddhism reflected: "… the main thing that made

a difference to me is meditation. I could really tell if I didn't meditate in a day, it made a

difference." Another person talked about encountering meditative practice in a Christian

setting, before learning about Buddhism:

> My interest in meditation really started around the same time because my class
> did some kind of workshop thing or process weekend at a Catholic contemplative
> place that was focused on improving relationships within the class and they had a
> contemplative meditation room downstairs, just like a little crypt. And I really
> strongly connected with silence, and just meditating without knowing what
> meditation was.

Many individuals (n=6) described their first encounter with Buddhism, whether it

was through meditation practice, by encountering the teachings or by meeting a teacher,

as something which felt intuitively right or familiar: "a light bulb went off," or:

> "I felt like I had come home, I felt like it was what I was looking for. It was like
> my people and it was the first thing I had ever heard that made sense, that really

made sense from the top to the bottom, inside outside. It just resonated. So, that was it."

Other responses. While experiences of personal suffering had led some individuals to become psychotherapists, one interviewee also cited that experiences of suffering had led him to Buddhism. Another therapist, who had found Buddhism after years in the mental health field, talked about how Buddhism's psychological focus appealed to her.

Inspiration to Become a Psychotherapist

In addition to sharing what inspired them to become a Buddhist, participants were also asked to reflect upon what inspired them to become a psychotherapist. Responses fell into the categories of: 1) Suffering, 2) Sense of calling 3) Helping others 4) Therapy/therapist connection and 5) Interest in the mind.

Suffering. In reflecting upon their inspiration to become a psychotherapist, many people talked about experiences of personal suffering (n=4) or the suffering of a family member (n=2) as a catalyst for wanting to help others. Below, two participants talk about how personal difficulties and challenges led them toward becoming a psychotherapist:

> I'm kind of a damaged person frankly, I suffer a lot. It feels karmic to me. It's about the only thing I can do. I've tried to do other things. I just feel this is my destiny, so to speak. This is what I do. And it comes out of the same thing that leads me to the *Buddhadharma*, which is suffering. Being a therapist, psychotherapist, is pretty natural to me.
>
> …
>
> At some point, back before I ever ran into Buddhism and Rinpoche, I had a period of pretty intense tumult in my life. I don't know if you are familiar with the concept of Saturn return? Well, my life really went on its ear. And that was exactly what needed to happen, but it just reorganized my situation. But at one particular point I remember thinking about some things, contemplating things, and it struck me, I'm not doing anything to help anybody.

In addition, some interviewees talked about how death or illness within their family pointed them toward becoming a therapist. One therapist described how death in her family caused her to re-evaluate her life:

> Also my dad had died. He had got sick around the time that I left accounting. It was his illness that made me realize my own kind of major like shock of impermanence and that I was not going to be happy if I just wasted my time and then looked back on my life and said this is not what I want to do.

Another participant spoke of how caring for his family and friends led him to caring for others later in life:

> And I had friends, family members who had difficult times in life, and I kind of attended them, at different times in my life, including my parents. That started at a very young age. The whole notion of attending to others started early on. And then, professionally, it became clear that I wanted to be connecting with people, talking with people, attending people. Maybe being beneficial to people, just the whole kind of mutual beneficial-ness was attractive to me.

Sense of calling. In addition to being motivated by suffering, many of the individuals interviewed described a longstanding interest in the profession of psychotherapy, expressing sentiments such as "I have always wanted to be a psychotherapist." Multiple participants (n=4) expressed a sense that they are naturally suited to this work. One participant described another therapist telling her she "had a natural gift." This participant recalled that "people sought me out" for therapy, even after she had decided not to be a therapist. Another, reflecting on some counseling she had done with a couple in crisis, before she had received formal training, said: "I was doing a lot of counseling with them and I thought, I should do this for a living." Another clinician stated: "Being a therapist, psychotherapy, is pretty natural to me."

Helping others. This sense of competence and intuitive connection was often connected to a wish to help others:

So it felt very organic. There was no "oh, I'm picking a career, I think I'll be a social worker."…. When I let everything fall away, that's what I wanted to do. And I think it's because I care about people and I'm interested in them and I feel more or less able.

Many participants (n=4) cited an interest in helping others, as a motivating factor in their decision to become therapists. Along with this, two therapists talked about how practicing therapy aligned with their values. One participant described it this way:

Having meaningful conversations with people about the things that are most important to them, whether their fears or problems in their life that they have difficulty talking about with others and it's just always where I sort of felt a calling to. So going to back to school felt very aligned with my personal values.

Another therapist traced her decision to become a social worker to the values she had learned from her family:

I think I was raised in a family that valued this kind of work. It was sort of embedded in my values system. As a kid, I was volunteered at organizations like Hull House in Chicago…It was the original social work, Jane Addams started Hull House in Chicago. And my mom, it was a value, so I always volunteered, and did that stuff, even in college. I was always interested in psychology...I was always interested in the mind. Always.

Therapy/therapist connection. Other therapists talked about becoming interested in therapy on the basis of experiences in therapy, with therapists, or interest in particular psychotherapy theorists. Two individuals connected their desire to become a therapist to their own experiences in therapy. One participant talked about how she came to therapy during a time of great suffering in adolescence:

I had a pretty rough adolescence with a lot of loss and some trauma and when I was 17, there was a period where I was really extremely depressed. It all accumulated and it became way too much. And I didn't know that I was depressed, I just felt suicidal and horrible. And, was sort of just thinking to check off some things before I was going to kill myself really. 17-year-old drama intensity. But it was pretty serious and my Aunt had been having problems with anxiety and was seeing a therapist and at some point my mother suggested that I see that person and I really didn't think much of it but I thought, ok, whatever.

But that experience was really life changing for me and it included a lot of mindfulness and a lot of body.

In addition to experiences in therapy, some individuals (n=4) cited the encouragement of mentors, individual practitioners in the psychotherapy field, or theorists who inspired them. One individual also cited the influence of his spiritual teacher on his decision to become a therapist.

Interest in the mind. Two interviewees also cited an interest in the mind as one of the reasons they decided to become a psychotherapist. An interviewee reflected on his decision to become a therapist as motivated by the fact that "My job would make me work with my mind":

And then kind of right around that time I had the opportunity to hear Otto Will talk…one of the old lines of the analytic tradition, and he said, "here, I'm 80 years old and I'm still learning about my mind through my work. And I still feel really alive and engaged that way." Which just rang like a bell for me.

Another participant explicitly connected his Buddhist training to his wish to become a therapist:

I figured I'd learned all this stuff in Buddhism, learning about compassion, and I figured that it would be something that would apply. I wanted to see if it would apply. It seemed the most practical thing, after studying Buddhism since I was about 20, 21.

What is inspiring about your work?

Altruistic motivation/interest in people. Participants were asked to share what they find inspiring about their work. The majority of interview participants talked about their relationship with others as an inspiring aspect of their work. Respondents characterized this in different ways. Clinicians were inspired by interest in or positive feelings toward clients (n=5), meaningful relationships (n=4), helping people (n=8), and being an advocate for people (n=1).

The majority of the participants (n= 9) said that being able to help people

improve, or have more meaningful lives, inspires them:

> Well, I think I'm in it because I really think I am helping some people…I really do feel you can be there at a point when somebody's really willing to make some changes in their life.

Many interviewees also talked about the value of being in relationship with others

in a therapeutic context as meaningful. Three different participants commented:

> The connection with another human being on a deep soulful level. The connection of one human being to another. It's pretty powerful stuff. Being completely there for another human being, who is in suffering, and we know about suffering.
>
> …
>
> I'm inspired by watching people grow and wake up.   I love being in relationship with people like this.
>
> …
>
> And so, what is most inspiring is to be able to communicate with people on such a deep level so quickly. I really, that's kind of where I live all the time and so its really not hard for me to get to that place, but for some other people it is.

One participant, discussing his clientele, many of whom struggle with extreme

psychiatric states, commented:

> I would say the people I work with are just so brilliant and so real. More real. In many ways more presently connected to their own life experience, because it's been so compelling.

Sense of competence. In addition to being inspired by helping people, and

working with interesting people, some therapists also expressed a sense of their own

competence (n=3) in the work as being inspiring:

> My work is so easy for me. It comes really easy. I don't mean to be conceited because I obviously have my own issues like we all do, and working on my stuff, and going through my mood swings and everything, but I feel like a pretty gifted therapist. Like, people come in, I don't have problems keeping them, they stay

for years, my practice has been full for years. So that's inspiring, that I actually feel like I'm really helping people

Another respondent spoke about the importance of positive feedback from clients, in a context where his efforts are not always recognized.

Occasionally, yeah, people get better even and they thank you and say, "that was helpful." Some fruition is good. Because there's many cases that that's not so obvious, that you're helping, or that people are getting better, that they appreciate it even.

Challenging work. Two interviewees, both of whom worked in the public sector and interacted with numerous systems, cited the challenges in their work as inspiring to them. One participant, who works in the corrections system, described his work:

Finding creative ways to help people in a very difficult system. That—that inspires people--being able to help people but having to be creative about it. Because I have to tread the interesting---I'm a team player for the jail, and I'm working on behalf of the clients. So it's a very interesting line to tread. So that everyone thinks they're on your side. And you have to be skillful. So that's inspiring to me, it's fun.

Another clinician, working with abused children, described the challenge within the field:

… it's just an incredibly challenging and an incredibly diverse field. Just, the types of trauma that can occur. You know, neglect is very different from sexual abuse is very different from physical impact is very different from losing a parent due to suicide, is very different from having multiple attachment disruptions.

Inspiring co-workers. Other respondents cited inspiring co-workers (n=2) as a positive aspect of their work.

Work Related Challenges

The questions in this area elicited participants' perceptions of what is discouraging about their work. Participants were asked to talk about both challenges within and outside of the clinical arena.

What is Discouraging About Your Work?

When asked what they find discouraging about their clinical work, three respondents indicated that they do not find their work discouraging. One interviewee said that, even though he sees much suffering in his field, he still considered his situation to be "workable.":

> It's a hopeless, completely hopeless sea of suffering. It's a mess and it's infuriating at times…But, there's nothing else to do. There's nothing discouraging for me at this point.

Another clinician, in private practice, talked about how her understanding of her patients' progress prevents her from feeling discouraged:

> I don't get discouraged in the actual clinical work that I do. I have a strong faith in people's paths. And although there are times that I'm very concerned about individual patients, I have learned over the years to see more or to have more patience with people's paths than to get discouraged when they seem to be stuck or not progressing in the therapy the way I may like.

Suffering. All of these individuals, upon further reflection, were able to identify challenging aspects of their work. Some of those interviewed (n=4) said that they found the suffering they encounter in their work to be discouraging. One participant described the seemingly infinite stream of clients in crisis at his two jobs:

> The endless quality of the booking room, or the emergency room. Booking is where people come in, where they get processed and where they get classified. And there's no end in sight—a new day, a new crop. Its just--there's no-- its endless. The emergency room, same thing, where people I see for psychological crises. It's just a different flavor, just endless repetition. So that's discouraging. It's sort of like, you're never done. It's full employment but it never ends. Its always like, "we gotta quit meeting like this."

Another clinician described the difficulty of seeing clients in pain, who are not willing to engage in therapy.

Some people just don't want to be helped and there's some real suffering and I just can't believe people have to live with that. What they do, what they suffer through. So, I find that fairly discouraging.

Systemic challenges. Six participants identified systemic challenges as a discouraging aspect of their work. Individuals identified stressors outside of the clinical realm, such as billing, insurance, dealing with managed care, and challenges within public mental health systems. One participant talked about the worrisome dynamics of the child welfare system as discouraging:

The systemic re-enactment of perpetration and abuse and the inadequacy of the system, and in part even the legal structures that we have to address adequately these children's needs. That's really the main--and I think the blindness of the system to it's own trauma, it's own repetition compulsion, it's own transferences, and the feeling of helplessness, in the face of a lot of ignorance.

Another clinician described his frustration with what he calls the "medicalization" of "suffering":

I'm not anti-medication or anti-diagnosis, but I feel, in working with particularly poor folks, they often have an over-simplified explanation that doesn't particularly account with the full range of experience. So, for example, that they have a chemical imbalance in their brain and that they ought to be on medication, without looking at the incredibly diversity of their life situation. The rigidity in the field of looking at depression, anxiety and categorizing them and they develop treatments to get rid of them, and so much of the individual life gets thrown out.

Internal challenges. Two interviewees identified challenges related to their own attitude, behavior or emotions as discouraging aspects of their work. These individuals identified lack of self-care, preconceived ideas, or struggles with personal depression as discouraging. One individual talked about how his assumptions and his tendency to become overly "busy" challenge him:

So, I think the biggest frustration could probably be labeled as what Tibetans call "the busy sickness." You're not available, you're not as relaxed as you could be. You can get busy, busy isn't a bad thing, but chronic business all the time is really hard when you're already working with a level of overwhelm of other people's

lives. Busyness is a form of laziness. And I am lazy, that's maybe my biggest frustration. So, I can either bag it and veg out or I'm just overbooked basically. And if I'm overbooked, I'm not doing a contemplative practice, I'm not exercising, I'm not taking a walk. It could be as simple as that.

Clinical performance. The final challenge identified by clinicians as discouraging related to disappointment in their clinical performance. Clinicians talked about a lack of connection with clients or having difficult clients (n=5), and feelings of not doing a good job (n=2) as discouraging. One clinician talked about his disappointment when he "screws up":

> That's the hardest part, it's not doing a good job, its when I screw up. Where, yeah, I've been a lousy therapist, where I just wasn't there in the right way for somebody and they fire me. That happens, being rejected, not having everybody love you. I'm not completely enlightened, so I do like to have positive feedback.

Another clinician talked about her frustration with "irritating clients":

> But, I just--you just get those unlikable ones. So that's discouraging, because I feel like it's my job to really like everybody, especially if I'm trying to help them. And if I can't see through their stuff to see their basic goodness, and I'm still, like, in that trap of, kind of, judgment, then that is disappointing to me, because I feel like I'm not really doing my job.

Effects of Work Related Stress

Participants were asked to share their perception of how working with trauma affects them. In addition, they were asked about whether they have experienced specific symptoms of vicarious trauma, in relation to clinical material. Participants were also asked to discuss how work stress outside of the clinical setting has impacted them, with questions specifically addressing whether they have experienced the symptoms of burnout.

The Personal Effects of Working with Trauma

The psychotherapists were asked to reflect upon how difficult clinical material, such as trauma has affected them. Of those who were able to describe how trauma impacted them, respondents described trauma as affecting them in four different ways: 1) physiological effects, 2) emotional effects, 3) inspiration for learning, practice or growth, and 4) motivation for clinical effectiveness. Participants were also questioned about whether trauma has impacted their beliefs about the world, in a series of follow up questions.

Physiological effects. Two interviewees described the physical effects of trauma upon them. One participant, working with abused children, described how such work impacts her, triggering her to act:

> There's a profound level of exhaustion, often. I think, from a body centered psychotherapy perspective, what happens when the attachment system gets mobilized is that a lot of impulses kick in, of wanting to fight for a baby or fight for a parent. Wanting to run away with a kid, grab them and go.

Another participant talked about a tendency to experience his clients' psychic distress physiologically:

> I tend to feel things physically pretty hard, and I exchange really fast with people. Sometimes I'm in such a despondent, crushed, anxious, pained place, that I can't be with people for the evening when I go home. And I go for walks, I do things like that. Those are some responses I have to some of this kind of stuff. Its really painful, and I get it on a body level a lot. Body and emotion level. I've had other body things, I know it hits me in my body. Its intense, and its also great information, just let it come in, let it go.

Emotional effects. Many of the clinicians interviewed described being deeply touched and by witnessing the trauma in their clients' lives. One of the most commonly

reported reactions to traumatic clinical material reported by clinicians was a feeling of

sadness. (n=3) One therapist commented:

> Well I think it touches my genuine heart of sadness. I think I really feel a sense of compassion, you know. And like, why does it have to be this way? It's like so sad when people—again, everyone's had some trauma, but the higher trauma situations, the more intense trauma situations, they just feel really unfair to me, you know. And, you know, why does someone have to suffer that much? And so it just makes me feel sad, it affects me.

In discussing the effects of working with traumatized individuals, two

respondents discussed the experience of "exchange," where one person's state of mind

can color another person's emotional experience. One participant described the

phenomenon of exchange and its effects, in discussing challenging clinical experiences:

> It can invoke really difficult emotional and cognitive experiences, really difficult. And part of that has to do with exchange, where you feel somebody else's pain and you feel your own pain. Because your pain is not their pain, there's a difference. Their pain is their pain. You don't have their pain. They have theirs, you have yours. But it resonates with something in you and that can just be really difficult to deal with. So you have to find ways to ventilate and to work with it.

In addition to experiencing sadness and picking up on the emotional states of

others, as in exchange, another therapist also described a feeling of being "desensitized"

by encountering traumatic stories:

> One, you can't help but get somewhat desensitized, you read enough traumatic stories, I mean you read the 100th story about a stepfather molesting the teenage girl in the home while the mother's working. You know, you don't want to get too desensitized so you don't feel it, but you have to get somewhat desensitized or you can't do the work. I mean you can't get blown out of the water. But it's hard.

Inspiration for learning, practice, or growth. While many participants

acknowledged some of the challenges of working with trauma, the majority of

respondents also saw trauma as an opportunity for personal growth, inspiration, spiritual

practice, or further learning. Three participants talked about how traumatic clinical material has made them feel fortunate for their own life circumstances. Of those, one participant reflected on her good fortune to not have experienced personal trauma:

I think one of the things I am very aware of is how incredibly fortunate I've been to not have been subject to anything I consider in the DSM definition of trauma.

Another participant, reflecting on a client's multiple traumas, expressed gratitude for her spiritual practice:

And I'm thinking, "how could somebody cope?" So, that makes you feel very fortunate that you have a path and that you can work with things.

Motivation for clinical excellence. Some respondents (n=3) discussed how they worked with trauma, or used trauma to inform their clinical work. Some also discussed their use of traumatic material to cultivate compassion for their clients.

Cognitive effects of trauma. Clinicians were then asked about whether their work with trauma has affected their view of the world, sense of trust in the world or their faith in people. These questions focused on the ways vicarious trauma can negatively affect clinicians' cognitive schemas, influencing their perception of safety trust and faith in their world.

Of the participants who answered directly, five felt that working with traumatic clinical material had not affected their view of the world, while three felt that it had. Five participants felt that their sense of trust in the world had not been affected by working with trauma, while two felt that it had.

In addressing the question of trust in the world, many participants (n=4) talked about not being surprised by trauma, as they expect trauma, "darkness" or "suffering" to happen. One participant reflected: "I guess that's how I can say, is that having heard

stories and seen, nothing surprises me. I don't think I can be surprised." Another

therapist shared her view of suffering:

> I think I was drawn to the whole Buddhism and therapy, because I believe in the
> truth of suffering. I think that's what's really the truth. I think it's there. I think
> life is hard. I don't have this feeling that you should wake up and feel perfect all
> the time. That doesn't, that's not my goal, nor do I think that many people have
> that experience. So, I think that as I get older myself, certainly--it's the--I'm not
> that surprised by suffering. It's not that shocking.

Others (n=4) talked about how their work has sensitized them to the pervasiveness of

trauma in the world. One therapist shared how her view of the world has changed in this

respect as a result of their work with trauma:

> I feel like there's so much more trauma happening and it's more profound. That
> might be a change in view. The older I get, the more I see and it feels like things
> are getting much more difficult and more complicated and a lot of people have
> multiple traumatic stuff going on in their lives. Not just one thing; there's always
> lots of things happening.

Another talked about how her work with trauma has sensitized her to the danger in the
world:

> So this is a constant reminder to me how possible it is for things to happen
> without warning. And so it's not about blame or otherness, it's really about just
> being able to really recognize how much potential there is for it all the time.

A third respondent talked about how her work with trauma has triggered early

developmental challenges for her:

> Yeah, I think that's a piece of vicarious trauma that comes up very regularly. You
> identify with –its easy to identify with kids' mistrust in the world when they have
> been so profoundly hurt and when the world is not helping. It's easy to have my
> own early doubts and mistrust take over and get sort of joined in that.

Another participant questioned whether he ever really trusted the world. He

described his work with trauma as giving him a context to understand this lack of trust in

the world:

I think actually that I didn't have a lot of trust and I understood it better in the context of understanding trauma and understanding that, I had a context for my own cynicism, lets say. I don't think I was a very trusting person, and so I, I was gonna say I've become a more trusting person, by actually understanding how, maybe I always thought things are horrible, now I know they are (laughs). I don't trust people, I have good reason not to trust people. So, knowing I can't trust people, I can begin to trust people. Or, I can learn to trust people, trust my feelings about them, lets say, rather than my mental chatter, trust my feelings more.

Interviewees were asked if working with difficult clinical material has affected their faith in people. Of those who answered the question directly, eight participants felt that their faith in people had not been affected by their work with trauma, while one participant felt that his faith in people had been affected by such work.

Respondents overwhelmingly talked about how working with people with trauma has inspired or amazed them (n=4) or has strengthened their faith in, what some interviewees described as people's *basic goodness* (n=3). Two therapists shared how trauma work has strengthened their faith in people:

I think working with traumatic people has made me more open to seeing the good things that people do, because I'm so inundated with the bad things that people do, so when I see good things I appreciate them. So, yeah. Yeah, its only affected my faith in the good things that people do.

…

The thing about working with extreme states, trauma, is that within the midst of trauma and extreme states you can quite often see people's basic goodness, basic un-deterable ability to meet the challenge and experience their life in a direct way. And actually move what is an absolutely horrendous situation, put it on some kind of a path and create it to be more workable, permeable and sustainable. I think that's where the kind of faith and the basic goodness come together.

Another participant said her sense of faith in people has been unaffected by work with trauma, reflecting on her clients: "I don't have an expectation that they're supposed to be a certain way."

A respondent, involved in the public mental health system, felt that her work with trauma has given her insight into the systems she works with and made her more cautious about making assumptions:

> I think its affected my faith in people in the sense that I have more respect for system dynamics and how incredibly strong they are and karmic dynamics and how incredibly strong they are. I think we often--I'm not so sure altogether about knowing what I know and doing what I--I think I'm more slower in making assumptions. I'm just not so sure. I think I'm not so sure about easy solutions anymore.

Symptoms of Vicarious Trauma

Clinicians were then asked whether they had ever experienced specific symptomatic reactions to traumatic material, in a series of four questions. These questions related to the DSM IV-TR criteria for post-traumatic stress disorder symptom clusters of re-experiencing, avoidance, and hyperarousal. Psychotherapists were asked to consider whether they had experienced any of these symptoms in relation to traumatic material they were exposed to in the context of clinical work.

Re-experiencing. The first question addressed whether therapists had had the experience of "Re-experiencing traumatic material, as in intrusive thoughts or dreams." Nine of the participants said that they had re-experienced traumatic material.

Of the nine who re-experienced traumatic material, two clinicians talked about how their personal experience of trauma or difficult family dynamics have sometimes led to re-experiencing their own personal trauma, when they are triggered by clinical work.

One respondent said she had not re-experienced traumatic material, and did not elaborate on this question. Another participant, who felt that her experience could not be classified clinically, described the way clients "come up" in her mind:

Situations I hear about come up in my mind. They're not intrusive thoughts in the clinical way of intrusive thoughts. They come up. Less than I would think, actually. And for not too long afterwards. But they do come up in my mind. And often when I see the person again, it sort of all flashes. You know, their story kind of flashes in visual.

Avoidance. The next question addressed whether participants had found themselves: "avoiding internal or external stimuli that reminds you of traumatic clinical material. For example, avoiding certain thoughts, feelings, people, places or activities." Eight of those interviewed indicated that they have engaged in some type of avoidance related to clinical material. Three clinicians talked about avoiding violent media: watching horror movies, the news, reading books or watching movies with traumatic content. One participant discussed her reluctance to watch violence in the media:

I don't watch horror movies. I don't watch Lifetime TV. I don't--not that I watched this before either--but I'm much clearer about the fact that I do not want to spend my time--Even some really worthwhile films, like *Schindler's List,* like *Amistad*…I haven't seen them because I don't have much tolerance for violence in the media… I'm just much more clear that I don't have to subject to myself to it. I get enough of that at work and it feels more gratuitous to expose myself to it unnecessarily.

Other therapists (n=2) said their work has led them to avoid certain places. One participant talked about how she tries not to go into the large metropolitan area where she works, on her free time (she lives in another town.) Another talked about avoiding a certain part of her town after hearing that someone had been attacked there. Another interviewee, who has worked with plane crash survivors, talked about how she flies less frequently now, though she was not sure if this is attributable to her trauma work.

In relation to the question of avoidance, two interviewees described how they work with difficult internal experiences. Both therapists indicated that, rather than avoiding, they *allow* difficult internal reactions to happen:

Once again, I tend to feel fine about letting things in, and letting them go. I'm pretty good at that, learned how to do that a lot. I'm not saying that that doesn't stick sometimes. And I've learned how to, for the most part, not let that kind of thing keep me awake at night. So I've learned how to do a certain amount of compartmentalizing in coping with the stress

…

That's part of the Buddhist training as well. It's like dealing with whatever is. If something gets triggered in me, I just deal with it. Experience it, feel it. Either I cry or get angry or whatever else, because it's triggered something in me.

Another participant, while denying that he experiences avoidance in general,

talked about how he is more cautious in engaging with some people in his personal life

(in the context of AA) due to his work experiences:

No, I don't feel like I'm particularly avoiding anything but sometimes I--I want to say--I'm a little more careful with my choices of, particularly like in AA, how people talk to people on the phone. That kind of thing, I've had a couple of experiences where there are a couple of people who are pretty unstable and so I try to be more careful about how much I'd engage with them, avoiding that, there's a greater level of self-protection where I wouldn't offer myself in the same way I used to.

As in the above quote, some therapists answering this question indicated that

some avoidance can be adaptive and helpful. One participant described this avoidance as

"compartmentalizing":

Yeah, sometimes I think avoiding thinking about cases, which, I actually think is a defensive strategy. I have to tell myself that, when I take a shower I am not to think about cases. First thing in the morning, it's just not healthy. Compartmentalizing has become just a tool, really.

Numbing/detachment. In the next question, participants where asked whether, in

response to clinical material, they had felt "a sense of numbing or detachment. For

example, feeling estranged or detached from others, noticing a restricted range of affect,

or less interest or participation in activities." Seven participants said that they sometimes

experience this, while four interviewees said that they do not. In answering this question,

three individuals noted that they sometimes feel less social as a consequence of their

work:

> Yeah, I think I do have that actually. Like I said, I come home and I don't go
> anywhere. So it does impact my activity. It's not just me, I talk to a lot of other
> therapists who would say the same thing. You've been talking all day and you
> just don't want to keep going at night.

Another therapist commented, "I'm much less social and people oriented now

because I really get my dose working with the people at my office."

One of the therapists, who earlier in the interview had said that she finds her work

very satisfying and easy, questioned why clinical material does not affect her as one

might expect:

> I have questioned before why I think my work is so easy, and why now I am able
> to not take it home with me. And I think there is an element of, like, survival
> aspect that I have acquired after 20 years of practice that I—it just feels more
> comfortable for me now not to take it home. So I think I might block it out a little
> bit. Maybe that is a little bit of repression. I feel like it's adaptive, I don't feel
> like it gets in the way of me being a good therapist.

Like other respondents, this therapist saw the negative potential in coping through

avoidance, but also recognized its adaptive potential.

Hyperarousal. The next question addressed whether clinicians have experienced

"Increased levels of arousal, agitation or anxiety. For example, difficulty falling or

staying asleep, irritability, difficulty concentrating, or an exaggerated startle response."

Seven participants indicated that they have experienced symptoms in this cluster. One

participant, who works with a lot of trauma, commented on feeling anxiety in relation to

work stress:

> I have hyperarousal at times definitely. I have to really focus on practicing or
> winding down. Often when I come home at night, I have a lot of leftover
> countertransference and hyperarousal and I really have to track and say "ok its

time to let all of that go." Constantly regulate. I think in this job there's a lot of conscious self-regulation that you have to do because it just doesn't happen automatically.

Another clinician talked about how she uses symptoms of hyperarousal to help her be more clinically effective:

Sure, sure. Because I'm thinking about them or I'm thinking about that incident, or whatever. But I use that for learning. If I wake up because I'm thinking about a patient whose going through some stuff and I don't know what to do, then I just sit with it, be with it. See what happens. If it triggers something in me, that's clinical information. Is it counter-transference? What's going on here? What do I have to take a look at? What do I need to do? And it also helps me with compassion.

Two individuals said that they had not experienced anxiety or symptoms of hyperarousal in relation to clinical material. One participant said she did not feel that she had these symptoms, but did say that she had been affected by personal trauma, which caused her to have some of the symptoms of PTSD. She then commented on the importance of tracking one's own life situation when working with trauma:

I mean just like everybody else, my personal trauma is worse than anything. So, when you're working with trauma people, you always have to ask what else is going on in your life, because if there's something else happening, that's enough to make whatever traumatic experience is happening that much worse.

Non-Clinical Work-Related Stress

Clinicians were also asked if there are other aspects of their job, outside of the clinical encounter, which they find stressful. This question sought to elicit information related to stresses in the work environment, which, under some circumstances can lead to burnout. Participants were also asked whether they had experienced any of the three key dimensions of burnout (Maslach, Schaufeli, & Leiter, 2001): 1) a sense of overwhelm, 2) cynicism or detachment, or 3) ineffectiveness, as a result of such stresses in the work environment.

All participants identified some aspects of their job they considered stressful. However, two individuals questioned the notion of stress as a negative consequence, rather than an expected and potentially beneficial experience. As one such participant said, "I'm not expecting to have a stress free life." Another commented that, while there are aspects of his job he finds stressful, such as administrating an agency, "this is in the context of stress as not a bad thing, particularly."

The responses of those who elaborated upon non-clinical sources of stress can be categorized in three different areas 1) Issues related to supervisors, colleagues, or work related relationships 2) Administrative responsibilities and 3) Issues related to systems.

Issues related to work relationships. Four respondents talked about having difficulty with supervisors (n=1) or co-workers (n=3). Two individuals, both of whom work in community mental health settings, talked about the challenge of working with cynical colleagues or individuals with little training. One interviewee talked about the benefits and drawbacks of working with people with less experience:

> You have to work with people with varying degrees of training and understanding. One of my positions…feels like the people I work with, they're as much clients as the clients, it feels like. So, sometimes that's very stressful and sometimes it's rewarding, to train them, you know, or feel like you're making some kind of benefit for the clients by helping staff see the client differently. But some days you just wish they'd shut up. Their cynicism sometimes is unbearable.

Another clinician, who is in a leadership position at his agency, said that he finds negotiating relationships at his agency stressful. However, he also talked about the benefits of the "politics" and "relationship tensions" at his agency, noting that working with such situations is "part of learning."

Administrative responsibilities. Other individuals (n=4) talked about administrative duties beyond the clinical work as stressful. These participants said that they find tasks such as scheduling and billing difficult. Another individual, in private practice, cited marketing, lack of benefits and lack of sick time as drawbacks to his self employed status.

Issues related to systems. Some clinicians (n=4) discussed stresses related to larger systems, such as public mental health systems and insurance companies, as taxing. Two individuals said that working with insurance companies, or working within managed care causes them stress. Two respondents talked about the challenge of paperwork requirements, particularly in the context of large agencies. One participant elaborated upon why he sees paperwork as detrimental to his clinical work:

> I think what's emphasized the most, at least in the two places I've worked at, is how to cover your own butt as a therapist and limit your liability… what it does is that it sort of sets up, instead of one human being working with another human being on suffering, it turns into some sort of "us against them" kind of thing and perpetuates the therapist as expert and the client as the subject, the resistant subject, who, where you know if they could just get their shit together and listen to the therapist, then everything would be better…I feel like it just gets in the way of establishing a genuine relationship.

Symptoms of burnout. Participants were then asked to identify whether they had felt: overwhelmed, cynical or detached, or ineffective in their job as a result of non-clinical stressors. Feelings of overwhelm, detachment, and ineffectiveness are identified as the three key dimensions of burnout (Maslach, Schaufeli & Leiter, 2001). Of those who directly answered yes or no to these questions: eight of the eleven participants said that they had experienced feeling overwhelmed, with no respondents saying they had not felt overwhelmed; four participants said that they had felt cynical or

73

detached in relation to non-clinical stressors, while three participants said they had not felt this way; seven clinicians said that they sometimes feel ineffective as a result of non clinical stressors while one participant said he has not felt ineffective.

<center>*Methods of Coping with Work-Related Stress*</center>

Participants were then asked how they cope with feeling discouraged. Interviewees described ways of coping, within three domains: 1) Self –Regulation 2) Work related strategies, and 3) Attitude or view.

Self-Regulation

Many respondents talked about different activities they engage in related to self-care and leisure. Participants mentioned exercise (n=3), leisure activities (n=4), taking a mental health day (n=1), solitary time (n=3), domestic activity or a satisfying home life (n=2), personal therapy (n=3), bodywork (n=1), an awareness of self care needs (n=2), and teaching (n=1). Participants also talked of the importance of intimate relationships and friendships (n=4). One participant discussed how exercise helps him:

> I'm addicted to physical exercise, combined with meditation. Those things keep me going. If I didn't have the physical outlet of, like, this morning, I went snowshoeing for an hour and a half before work, and it was perfect. I came to work without anxiety, I really had a positive frame of mind and I was looking forward to seeing my client.

> Another respondent talked of the importance of solitary time:

> I think that one of the ways I cope is that I don't see a lot of people a lot. I stay home. Because, you come home at the end of the day from seeing all these people and you just can't talk to anybody. I just need to rest. So, that's one way I cope.

Work-life Strategies

Some participants (n=3) also talked about ways their work environment helps

them cope with disappointment. Three participants cited supervision as an important

support, while two clinicians said that they found support through positive relationships

with co-workers. One participant reflected on his co-workers: "this is a really cool bunch

of folks. And that's inspiring, it's good to come to work. It's good to see people here."

One clinician said she copes with her frustration by becoming a better

advocate for her clients:

> I think within my work, by becoming an even better advocate, by fighting for
> these kids, by fighting with attorneys, by getting really good at court testimony,
> getting really good at staying on top of the research and being able to vocalize
> that.

Another therapist, when asked how she copes, described a specific clinical

intervention she made with a client. A different clinician mentioned the value of having a

caseload with individuals with diverse diagnoses and situations, to prevent

discouragement.

Attitude

When asked how they cope with discouraging aspects of their work, many

clinicians identified different ways in which they relate to their view of difficult

situations, or their attitude toward stress. One clinician talked about shifting her point of

view in relation to disappointing aspects of her work: "I try to look at what I'm not

seeing. I try and think-- I start to think that some of the things I'm talking about are also

the flipside of some real opportunities."

A number of individuals (n=3) talked about letting go of preconceived ideas as a way of coping with (or preventing) disappointment:

> I don't have this expectation of what's supposed to happen. So, I'm not surprised by what happens most of the time. So, if I'm surprised--I've been doing this for a long time--so if I'm surprised, really surprised, when something happens, then I go, "oh, you've missed something." Other than that, I feel like I mostly try to just meet people on their journey and go with them, wherever they go.

Another clinician talked about the way she copes with difficult emotions related to her work:

> I acknowledge the feeling and I don't become it. There's a real differentiation between having the feeling and becoming it, which is also very Buddhist.

One individual talked about how she often copes with the difficult aspects of her work "not very well" "by being angry. I get angry a lot, I get angry." Another said that he copes by trying to leave his work at the office when he comes home.

Spiritual Practice and Coping with Work Related Stress

Every therapist interviewed for this study said that their Buddhist practice was a support to them in their professional life. Many interviewees expressed deep gratitude for their practice. As one participant said: "I am deeply grateful for my practice. I'm a better clinician that I ever would be if I weren't a Buddhist." Many respondents said that Buddhist practice was essential to their work: "If I didn't have a practice, this would not be a sustainable field for me." One person shared that "Buddhism has helped me to love my work," while another said that her Buddhist practice is "the air that I breathe."

Interviewees identified ways in which their practice supported them, helping them to cope with disappointment and the symptoms of vicarious trauma and burnout. Their

responses fit within two themes: 1) View: cognitive understandings of the world and 2)

Practice: ways of working with one's mind

View: Cognitive Understandings of the World

Participants identified aspects of their view or attitude, related to Buddhism,

which help them cope with vicarious trauma and burnout. As one interviewee explained,

within Buddhism, "the view," or one's understanding or attitude, is the foundation for an

individual's complete engagement in the world:

> Well, the main part of the Shambhala Buddhist thing is the view. If you have the
> view, you have a way to bring everything to the path. There is no outside. So,
> then you can do your personal practice to rejuvenate yourself, and bring that, then
> you're offering your full attention. Nothing's excluded so you're never out there
> really.

"The view" within a Buddhist context encompasses teachings such as

impermanence, emptiness, suffering, karma, basic goodness and the four reminders. All

of these teachings were mentioned by practitioners as supportive in coping with difficult

clinical situations, and will be discussed below.

Expanded view. Many interviewees (n=5) said that their practice helps them have

an "expanded view" or a "bigger view" of situations, which helps them to deal with

difficult clinical material or work stress. One participant talked about this in relation to

getting caught up in "people's worlds":

> It helps keep me from getting so engaged that I'm the subject of the frustrations,
> difficulties, depressions, anxieties, fears, hope, vision of the people that I work
> with. It helps keep me from getting too narrow in my viewpoint.

Another participant talked about how keeping a bigger view helps him cope:

> In terms of view, it's expanded my view, so that I feel that I can accommodate
> more...And so, it's just somehow, helps me make the world bigger. So when it's

bigger, somehow it lightens the pain, it puts things in a bigger perspective, things don't feel as catastrophic.

Another therapist spoke of how she "expands" her awareness to accommodate

difficult situations:

 One of the things I do a lot that I've learned in my Buddhist practice is to widen, broaden my field of awareness, letting my mind expand beyond the confining or difficult issue. Literally allowing my mind to become bigger, to become aware of space, surrounding places. Sometimes when I have to go into places where I hate going into or I don't want to be for a long time, like a courtroom, where people are just fighting, I really literally imagine the space beyond the room, and imagine that the room is a really big place and this is just one small part, and that really helps.

Basic goodness. A number of individuals (n=3) cited the view that people have

basic goodness as supportive to them. One participant talked about basic goodness in this

way: "I do believe in basic goodness and Buddha nature and there's more right with you

than not, as long as you're breathing." Another participant explained how her view of

basic goodness has supported her in the midst of difficult clinical work:

Yeah, the main practice, I think is my belief in basic goodness. I couldn't do this work, with all these distorted and crazy people, if I didn't fundamentally, really believe that they would have basic goodness, and that it's there. I'm able to contact it, and work with it.

Many participants (n=4) talked about how this understanding, that individuals and

situations are fundamentally good, allows them to see people and situations as

"workable." One participant explains:

It's all workable. Every state of mind, every experience… There is a sense of workability, which I think is part and parcel of the basic goodness …Whether it's living or dying, things can be worked with. I think that's what I've really learned from the Shambhala teachings.

Suffering. Interviewees also cited their understanding of impermanence, suffering

and emptiness as supportive to them in coping with difficult clinical material and work

stress. Six of those interviewed talked about how the Buddhist understanding of

suffering has helped them work with clients and engage with challenges in their work.

One person talked about how his professional work has led him to understand the first

noble truth: the truth of the existence and pervasiveness of suffering:

> The trauma makes me realize that horrible things are happening to people, horrible things have happened to people, will happen to people and maybe spiritual practice is a way to stay sane and be more helpful.

Another practitioner talked about how this understanding helps him better

understand his clients: "I think because I'm a Buddhist, I understand how people are

trapped. I see how people are caught in their own confusion." A different clinician talked

about how an understanding of the Buddhist teachings on samsara (cyclical patterns of

suffering) helps him understand his work in a larger context:

> I think my Buddhist practice helps me realize that samsara is endless, and so that gives me some perspective, some insight that it's not going to end. And that I can't help everybody, I can only do what I can.

Another clinician attempts to work with "unending suffering" by reflecting on the

bigger picture, including an understanding of the causes and conditions which create

suffering (another way of talking about karma):

> I think a lot about what confidence really is, and how to have confidence in the face of unending suffering and that weird paradox is really something that I find myself thinking of quite often. How to have confidence in the face of unending suffering. And how to not get lost in the suffering, how to not solidify it to such an extent that you lose your view, and you lose the understanding that what you see is just a fraction of all the causes and conditions that are operating.

Impermanence. Two interviewees said that an understanding of impermanence

helps them to see difficult experiences as temporary "states that come and go," which are

therefore manageable. One psychotherapist talked about how his understanding of

impermanence supports him:

I think the key thing is that within any thought, pleasant or unpleasant, within any emotion, pleasant or unpleasant, difficult, horrendous or joyful, within any experience, it's transitory and basically fundamentally absent of any intrinsic shape, form, color. In other words, it's not solid. It's a dynamic. A thought is a dynamic, an experience is a dynamic. It's more like a river than a piece of concrete. And even a piece of concrete isn't altogether solid…It's always changing and there are gaps between thoughts, gaps within emotions, gaps between physical pain and extreme emotional pain. And it's beginning to understand on a more subtle level what the actual experience is. Because by doing that, what can happen over time, you can actually let go of the experience.

Another therapist uses her understanding of impermanence to help her and her clients work with challenges:

First of all, you learn about impermanence, so you don't get really attached to things. You know they're going to change. So, even if you see somebody who's just, like, totally depressed and miserable, you know that that's going to change. And I actually work with people a lot around that, how to change

Mahayana view. Other therapists contextualized their work within the mahayana view of compassion and selfless service to others. One participant described the mahayana path as helpful:

The whole mahayana path of working with the suffering of others, being open to the suffering of others. Giving up one's own comfortableness. Giving up one's own cocoon, as Shambhala language would say. Opening yourself up, out of your own position of comfort and security, to others.

Two individuals spoke of their work in the context of the Bodhisattva vow (n=2), a mahayana vow taken by Buddhists to help free all sentient beings from suffering.

I mean, I still feel discouraged, but I think having a bodhisattva vow is sort of a good framework of switching from the stuff that I want to the unconditional aspiration of " I will help these kids, no matter what the result is."

Practice: Ways of Working with Self and Others

Participants also spoke of different ways of working with their mind, drawn from Buddhism, which help them work with themselves and with others. One of the assumptions, within Shambhala Buddhism is that one cannot be of benefit to others

80

without first relating to one's own mind. A participant, quoting his teacher, Sakyong

Mipham Rinpoche, put it this way: "In a stressful situation we must first begin with our

own mind." In the Shambhala Buddhist tradition, mindfulness-awareness meditation is

the foundational practice, which teaches practitioners to work with their own mind.

Participants talked about different practices they use to work with their mind,

describing ways of being present, staying open, and relating to emotions. One approach

to working with emotions and thoughts mentioned by some participants (n=2) was "touch

and go." One interviewee described how he uses "touch and go":

> The Buddhist practice has to do with "touch and go," so you actually can touch
> something like a thought and let it go. So you touch whatever the experience is
> and then letting go. So you're not evading it, you're not getting away from it, but
> you're also continually inviting in some freshness into the experience.

Participants also mentioned specific practices within the hinayana,

mahayana and vajrayana teachings of the Shambhala Buddhist tradition, which they find

helpful. These practices included shamatha-vipashyana meditation, tantric (vajrayana)

practices, mahayana mind training, or *lojong* practices, contemplations related to the four

reminders and cultivating maitri and meditation-in-action practices.

Many interviewees mentioned using *tonglen*, a practice within the Mahayana

tradition, to cultivate compassion and work with difficult emotions:

> And so, I find sometimes that to deal with the emotions, I do tonglen in practice.
> When I don't know what to do with someone, I breathe in their suffering. They
> don't know it, I'm not telling them, I'm just sitting there. Not all the time, but if I
> don't know what else to do, and I don't know what to say and I know something's
> going on.

Other participants reflected that cultivating compassion (n=1), or "loving-

kindness" (maitri) (n=2) for their clients, keeps them from becoming discouraged.

Conclusion

This chapter summarized the findings of eleven interviews with Buddhist psychotherapists. Participants were asked a series of sixteen questions, eliciting clinicians' views of what inspires and sustains them in the midst of difficult clinical situations. Clinicians described the stresses related to their work, and answered questions related to symptoms of burnout and vicarious trauma. In particular, participants reflected upon how their Buddhist practice has helped them cope with work related stress. The following chapter will discuss these findings, and will consider the implications of the data.

CHAPTER V

DISCUSSION

This qualitative study sought to learn more about what kinds of challenges Buddhist psychotherapists encounter in their work, what inspires them in the midst of such challenges, and how their Buddhist practice supports them in their work. Interview questions explored what effect secondary trauma and job stress have on clinicians in the sample. In addition, therapists were asked whether they had experienced the symptoms of vicarious trauma and burnout. This chapter will present the following in relation to the findings: 1) key findings 2) implications, 3), limitations and 4) conclusion.

Key Findings

One of the central questions of this study was whether Buddhist practice is supportive to clinicians in the field, in the face of job risks such as vicarious trauma and burnout. All of the participants in this study considered Buddhist practice to be helpful, if not critical, to maintaining resilience in the midst of challenging clinical situations and stressful work environments.

Throughout the study, participants were honest and self-reflective about the challenges of their work, and the way such challenges affect them. Participant's reflections on the effects of job stressors indicated high levels of self-awareness and sophisticated understandings of their own self care needs.

Inspiration

Many of the participants became interested in Buddhism as a result of connecting with Buddhist teachers or practitioners. A significant percentage of interviewees also connected to Buddhism through the practice of meditation or the teachings of Buddhism. Of particular note, many participants talked about their discovery of Buddhism as something which felt intuitively right. Many spoke of an immediate, intuitive connection to the teachings or to Buddhist teachers. This strong intuitive connection points to the level of support many practitioners found within the Shambhala Buddhism. For many, Buddhism gave them a community: "my people"; a way of understanding the world: "immediately a light bulb went off"; a teacher to work with "it was so obvious that he was my teacher" and a sense of belonging: "I felt like I had come home."

Participants became interested in psychotherapy through experiences of suffering, wanting to help others, having a sense of calling about becoming a therapist, and resonance personal values. Some individuals also cited an interest in the mind, or experiences within therapy as meaningful.

Speaking about what inspires them about their work, the overwhelming majority of individuals cited an altruistic motivation: wanting to help people, wanting to build meaningful relationships, or help clients live a better life. Such motivations are congruent with the compassionate intention of the mahayana. The focus of the mahayana is working to relieve the suffering of others. Indeed, one might see the choice to become a therapist as a way to put mahayana ideals of selfless service into practice. One interviewee said as much when he commented on his decision to become a therapist: "I

figured I'd learned all this stuff in Buddhism, learning about compassion, and I figured that it would be something that would apply."

Challenges

Over a quarter of those interviewed maintained that, overall, they did not find their work discouraging. This points to resilience and enthusiasm among the sample. This may also indicate that this portion of the sample most likely did not suffer from the cynicism, detachment, and cognitive effects characteristic of burnout and vicarious trauma.

Those therapists who found discouraging elements in their work cited witnessing suffering, systemic challenges, and dissatisfaction with their clinical performance as the most challenging aspects of their work. Systemic challenges (Maslach, Schaufeli, & Leiter, 2001) and dissatisfaction with clinical performance (Farber and Heifetz, 1982) have both been identified as factors that can lead to burnout. Farber and Heifetz (1982) found a sense of therapeutic ineffectiveness to be the most frequently identified source of clinical stress for therapists in their sample. The authors recognized the "non-reciprocated attentiveness" inherent in clinical work as "the primary factor underlying burnout" (p. 298).

Effects of Work Related Stress

The majority of participants endorsed having experienced symptoms of vicarious trauma, and to a lesser extent, burnout. However, participants in general did not seem to have been adversely affected by their work. While they acknowledged having experienced symptoms of vicarious trauma and burnout, the majority of participants' cognitive assumptions about their world had not been damaged. In addition,

85

most respondents spoke enthusiastically about their work. Participants also employed

coping strategies, many related to their spiritual practice, which help them to manage

work stress.

Vicarious trauma. When asked about how working with trauma affects them,

participants mentioned physiological effects such as hyperarousal, emotional effects such

as sadness, and cognitive effects as most prominent. When assessed for whether they had

experienced the symptoms of vicarious trauma, the vast majority of participants said that

they had experienced avoidance, re-experiencing, numbing/detachment, and

hyperarousal. Most participants endorsed having these symptoms at least once.

However, the question did not assess whether participants suffered from symptoms that

interfered with their daily functioning. Such findings don't necessarily indicate that

therapists have been traumatized by their work, and may point to expected and temporary

reactions to clinical stressors, rather than chronic disorders.

Burnout. When asked about work stressors beyond the clinical situation,

participants cited issues related to supervisors or colleagues, administrative

responsibilities, and issues related to larger systems, as stressful. Stressors related to the

work environment have been identified as the primary risks for developing burnout

(Maslach, Schaufeli, & Leiter, 2001). In addition, two participants maintained that they

do not view stress as negative, nor as unexpected. These therapists viewed stress as an

expected, and potentially positive, aspect of their work life.

There was more variation between clinicians in relation to participants'

experience of the symptoms of burnout,. The majority said that, in their professional life,

they had felt ineffective or overwhelmed, while fewer individuals said they had felt

cynical or detached in relation to their work. Like the questions related to Vicarious

Trauma, these questions did not asses whether emotions related to burnout interfered with

participants' work or negatively impacted their work or their life.

    Cognitive effects. Participants were asked to expand upon the cognitive effects of

trauma work. The majority of interviewees indicated that trauma work has not affected

expectations about their view of the world, their sense of trust in the world, or their faith

in people, or cognitive schemas. Questions assessed whether therapists' "beliefs,

expectations, and assumptions about the world"(McCann & Pearlman, 1990, p. 137) have

changed due to vicarious trauma. Using *constructivist self development theory*, McCann

and Pearlman understand vicarious trauma to be a disruption of cognitive schemas about

the world and oneself. While this study did not use a quantitative measure, the

exploratory data suggests that work with trauma did not change the majority of

interviewees' cognitive schemas about the world and other people.

    Based on self-reports, this group of participants seemed to demonstrate resilience

in the face of difficult clinical material and workplace challenges. Though the majority

of participants indicated that they have experienced some of the symptoms of vicarious

trauma and burnout, overall their cognitive beliefs about the world and themselves seem

to not have been adversely affected by their work. While participants acknowledged

suffering and darkness in the world, the vast majority seemed able to integrate their

awareness of suffering into a view of the world as fundamentally good. This ability to

hold great suffering in a context of compassion and optimism is directly related to the

view and practice of Buddhism.

Methods of Coping

Many of the strategies Pearlmann and Saakvitne (1995) identified as helpful for therapists coping with vicarious traumatization were employed by the interview participants. In the findings chapter, strategies for coping with vicarious trauma and burnout were grouped into four categories:1) self-care/leisure, 2) work life, 3) attitude, and 4) spiritual practice. These strategies overlap with those conceptualized by Pearlmann and Saakvitne as *personal strategies* and *professional strategies*. Self regulation strategies identified by participants related to Pearlmann and Saakvitne's categories of *maintaining a fulfilling personal life, using personal psychotherapy, and identifying healing activities*. All of the participants also identified Buddhist practice, or *tending to one's spiritual needs* as a critical coping strategy. In addition, participants mentioned many of the professional strategies identified by Pearlmann and Saakvitne, including: *arranging supervision, developing professional connection, developing a balanced work life, remaining aware of one's goals* and *identifying disrupted schemas*.

Spiritual Practice and Coping

Clinicians discussed how their spiritual practice helps them cope with job stressors. Findings in relation to this topic were divided into two areas: view, or cognitive understandings, and practice.

View/cognitive understandings. All of the participants viewed difficult clinical material and work stress within the context of Buddhist teachings. McIntosh's (1995) insight, that religion provides individuals with cognitive schemata with which to understand the world, may account for Buddhist participants' resilience in the face of secondary trauma. In discussing their ability to deal with the stresses of their clinical

practice, many participants cited Buddhist teachings, which help them make sense of their world. Participants seemed able to work with trauma and suffering without becoming chronically overwhelmed, as they had all had a cognitive frame of reference which allowed for the existence of suffering in the world. The implications of specific teachings, such as suffering, impermanence, basic goodness, compassion and emptiness will be explored below.

Expanded view. As Pearlmann and Saakvitne, (1995) contended, "There is great restorative value in stepping back from one's work and putting it in perspective" (p. 167). Many participants said that their Buddhist practice helps them to contextualize their work within a bigger understanding of the world and of reality. Buddhist views of suffering, basic goodness, and impermanence helped practitioners to frame their work and their personal reactions within a larger perspective.

Suffering. Many clinicians said they were less surprised by trauma and more sensitized to the presence of trauma in the world, due to their work as psychotherapists. Many participants spoke of their awareness of trauma and suffering in Buddhist terms, connecting their expectation of trauma to their understanding of suffering: "I believe in the truth of suffering…I don't have this feeling that you should wake up and feel perfect all the time." This is consistent with hinayana Buddhist teachings on *the four noble truths*, which acknowledge the reality of suffering in the world, and point to the Buddhist path as a way to end unnecessary suffering. Such a worldview, which includes suffering as an expected part of life, may reduce clinician stress, as therapists do not have an expectation that they can eliminate personal suffering or their clients' suffering.

89

In addition, many of the clinicians used their emotional reactions and discouragement in relation to suffering to cultivate compassion for their clients. As one participant described the anxiety she sometimes feels in relation to clinical material: "I use that for learning…And it also helps me with compassion." Sakyong Mipham discussed the natural compassion that arises when we allow another's suffering to penetrate us:

> When we open our eyes to the truth—that people are in pain at a very basic level—we feel a natural response. This response is called compassion. It's called love. We want to help. Compassion and love have no limit, especially if we encourage their growth with the practice of stepping beyond ourselves. This is bodhisattva activity, which is endless, for as we practice this way, our courage and willingness to help others grow. Our mind and motivation only get bigger. (http://shambhala.org/teachings/view.php?id=51)

Basic goodness. The vast majority of participants said that trauma had not affected their faith in people. Over half of the therapists interviewed said that work with trauma has actually inspired them or strengthened their faith in people's basic goodness. Such responses indicate that the Buddhist view of *basic goodness* may help Buddhist psychotherapists to contextualize suffering and wrongdoing within a view of people and the world as fundamentally sane and workable.

Participants cited this view of basic goodness as helpful in maintaining enthusiasm and commitment: "I couldn't do this work...if I didn't fundamentally, really believe that they would have basic goodness." Such a view seems to be directly connected to clinicians' ability to maintain enthusiasm and a positive frame of mind within their work. In addition, as some participants noted, an awareness of basic goodness also promotes an understanding that all people and situations can be worked with.

Impermanence. Many participants indicated that having a view that all phenomena are impermanent has helped them work with clients and cope with job stress. One participant described his view of impermanence, noting that situations or people are: "more like a river than a piece of concrete." This understanding helped participants to more effectively work with their clients: "even if you see somebody who's just, like, totally depressed and miserable, you know that that's going to change." In addition, an understanding of impermanence also helped therapists to work with their own personal reactions to clinical material and job stress. The experiential understanding that difficult states of mind come and go seemed to help therapists allow difficult reactions to arise and pass: "I tend to feel fine about letting things in and letting them go."

Mahayana view. Participants also spoke of their work with clients within the context of their mahayana commitment to free all beings from suffering. A mahayana practitioner acknowledges pervasive, endless suffering while paradoxically vowing to bring an end to suffering. This paradox can, in some ways, free individuals to give freely without attachment to the result of their action. One participant spoke of her bodhisattva vow in the context of her clinical role, as: "the unconditional aspiration of 'I will help these kids no matter what.'"

An approach that embodies service without expectation of result may serve as an antidote to burnout. As Dass and Gorman (2001) maintained, letting go of attachment to a specific clinical outcome may protect psychotherapists from burnout. These authors identified "motives, needs, expectations, the models we have for ourselves" (p 188) as the factors which put caregivers at risk for burnout. Wegela (1996) also asserted that expectations pull caregivers away from the present moment, leading therapists to

"become fed up and tired" (p. 217). Some participants indicated that they do not have

preconceived ideas or expectations about where their clients should be, with comments

such as: "I don't have an expectation that they're supposed to be a certain way; " or: "I

have a strong faith in people's paths." Without the burden of expectation,

psychotherapists may be better able to enjoy their work life, and may also serve their

clients with more energy and enthusiasm. Buddhist teacher Sakyong Mipham (1999)

described how a selfless focus on others, without attachment to results, can lead to greater

inspiration and joy:

> We might think that helping others will drain us. But when we use prajna
> [wisdom] and compassion to extend our lives to others in this way, our own
> suffering actually becomes relieved. Just placing our mind on others is a kind of
> meditation. Mind is like a muscle that relaxes that way. When we begin to think
> about ourselves it tightens up, until we can't even help ourselves properly. But
> working for the happiness of others brings lightness of mind. When we know this
> truth, extending love and compassion is all there is to do. Then everything we
> encounter becomes part of our journey as practitioners of meditation. (Mipham,
> S., 2002 Paragraph 11)

Practice

While a Buddhist view underscored all participants' approach to their clinical

practice and self-care, this view was grounded in the practice of meditation. As one

participant noted, cognitive understanding can be helpful, but Buddhist practice

fundamentally helps individuals to relate to the present moment, beyond conceptual

knowledge.

Most participants discussed the importance of shamatha vipashyana meditation as

critical to their self-care. Such findings are consistent with the large body of research

related to the benefits of mindfulness awareness practice (Grossman, Niemann, Schmidt

& Wallach, 2004). This research indicates that meditation can "enhance general features

of coping with distress and disability in everyday life, as well as under more extreme conditions of serious disorder or stress. " (p. 39). The present study supports the notion that meditation is beneficial in coping with stress.

Participants also mentioned other meditative and contemplative practices from the Shambhala Buddhist tradition, drawn from the vajrayana and mahayana, which they found supportive in their work. In particular, participants cited *tonglen*, a mahayana practice of "exchanging self for other" as helpful in their work with clients. Participants used *tonglen* to cultivate compassion for clients and to "deal with the emotions" which arise in the context of therapy.

Passionate Commitment

This sample of psychotherapists embodied many of the qualities defined by researchers as *passionate commitment* (Dlugos and Friedlander, 2001). Dlugos and Friedlander identified four traits common to effective and engaged therapists: 1) Balance 2) Adaptiveness/Openness 3) Transcendence/Humility and 4) Intentional learning. All participants identified ways they find *balance* in their lives, such as employing self-regulation strategies, using work resources such as supervision, and engaging in spiritual practice. Participants' responses also indicated *adaptiveness and openness* in response to challenges: "I don't get discouraged," and an understanding of all difficult situations as "workable." In discussing their spiritual practice, participants all touched on aspects of *transcendence or humility* they bring to their work; participants mentioned having a sense of gratitude in the face of suffering and a "bigger view" of difficult situations. Some participants also demonstrated openness to *intentional learning,* discussing the benefits of continuing training and study, and viewing obstacles as learning opportunities.

Questions were asked in a consistent way throughout the interviews, by the same interviewer, in order to maintain reliability. However, the limitations of personal interviews apply, in that there were inevitably variations in the tone of the questions, the pace of the interviews and the rapport between participant and interviewer. In addition, some questions were interpreted differently by different participants, resulting in answers with a different focus, in some cases. At the same time, as this was a qualitative study, individual interviews allowed for the collection of rich, personal and meaningful data.

As was mentioned in the methodology chapter, one limitation of the study related to the questions addressing clinicians' experiences of symptoms of vicarious trauma and burnout. As the interviews were qualitative and exploratory, the sample was not assessed using an existing reliable measure of vicarious trauma or burnout. Thus, this study is not able to provide an authoritative answer to whether the population of therapists interviewed suffered from burnout or vicarious trauma. Positively answering such questions merely pointed to the fact that, at some point in their clinical career, therapists had experienced such symptoms. In the course of years in the field, it would not be surprising to have experiences such as overwhelm, avoidance, re-experiencing, or hyperarousal. The inclusion of existing measures may have provided a richer understanding of where the sample of clinicians fell, within the continuum of burnout and vicarious trauma.

In addition, the study was limited by the fact that the sample was somewhat heterogeneous. This was particularly true in the case of race. All the clinicians identified as European American or Caucasian, meaning that the study did not include the point of

view of any clinicians of color, which would have enriched the data. In terms of gender, the sample was almost evenly split, with five men and four women.

The sample was also limited in that participants were not trauma therapists, but were psychotherapists who self identified as having at least three individuals on their caseload with a trauma history. Thus, many individuals in the sample did not work with high numbers of trauma survivors. This limits the research, as the study in part sought to determine how participants were affected by trauma work and whether their Buddhist practice was a protective factor against developing vicarious traumatization.

Pearlmann and Saakvitne (1995) made a distinction between "trauma work verses general psychotherapy," noting that trauma work in particular exposes the therapist to stories about trauma, which reveal the extent of humans' vulnerability to harm. The authors also noted that trauma work exposes the clinician to client re-enactments within therapy, projective identification from clients, and reminders of therapists' personal traumas.

Ideally, the sample would have been made up of trauma therapists, in order to get a more accurate sense of whether spiritual practice was protective for therapists who were particularly vulnerable to developing vicarious trauma. However, as the recruitment pool was already limited due to other inclusion criteria, it may not have been possible to find enough participants to interview had this criteria been in place.

In addition, as mentioned in the methodology section, half of one interview was not audible, and so could not be transcribed or coded. While recoverable data from this interview was included in the coding process, some of the answers were unfortunately lost, and cannot inform the study.

Implications

While this study focused on Buddhist psychotherapists and sought to learn how these individuals coped with job related stress, the findings may be applicable to a broad range of psychotherapists. In addition to mindfulness, therapists in this study endorsed a wide range of self-regulation strategies, which all therapists may benefit from. Participants cited personal activities such as exercise, meaningful relationships, creative expression, personal therapy, time off, and a satisfying domestic life as helpful in coping with work stressors. In addition, those interviewed cited work related strategies such as supervision and positive relationships with co-workers as supportive to them.

Mindfulness meditation has moved beyond its Buddhist roots and is now embraced by many outside of the Buddhist community as a viable self-care strategy. Adding to the current body of literature on mindfulness, this study suggests that mindfulness meditation can contribute to resilience in the face of stress.

At the same time, while understandings of suffering, impermanence, selfless service, and basic goodness are rooted in the Buddhist tradition, they are not so much religious beliefs as observations based upon meditative experience:

> When he began to teach, the Buddha was just reporting his observations: 'This is what I see about how things are.' He wasn't presenting any particular viewpoint. He wasn't preaching dogma; he was pointing out reality. Saying that impermanence is a Buddhist belief is like saying that Buddhists believe water is wet. The Buddha didn't create impermanence or selflessness, suffering or peace; the Buddha just saw reality, noticed how it works, and acknowledged it for the rest of us. (Mipham, 2003, p. 16-17.)

While insights into impermanence, suffering and peace are taught within the Buddhist tradition, they are not exclusive to the Buddhist world. Such concepts can be found in many other religious as well as secular belief systems. Thus, therapists of many

96

traditions can recognize the transitory nature of experience, the common experiences of anxiety and hardship faced by ourselves and our clients, and the fundamental strength and resilience within human beings.

In addition, this study suggests that spiritual practice may be a protective factor for therapists at risk of developing vicarious trauma or burnout. Some research indicates that therapists identified by their peers as exceptional approach their work from a spiritual framework (Dlugos and Friedlander, 2001). However, there has not been any research directly addressing whether spiritual practice promotes clinician resilience. Though this study focuses on Buddhist practice, it points toward an unexplored area of research, related to spirituality as a support for therapists, which should be further investigated.

Conclusion

Participants in this study all acknowledged the importance of Buddhist practice in their ability to maintain enthusiasm for their work, engage with people skillfully, and care for themselves in the midst of clinical challenges and workplace stressors. Many believed that Buddhist views and practices have allowed them to survive and flourish within their chosen profession. The practice of Buddhism provides practitioners with cognitive schemata with which to make sense of great suffering and loss, without losing faith in human nature. At the same time, the Buddhist tradition offers practitioners a practical and empirically validated way of working with their mind: mindfulness awareness meditation. The practice of meditation allows individuals to cultivate self-care, maintain self-awareness, and cope with stress. As one participant shared: "If I didn't have a practice, this would not be a sustainable field for me."

97

The practices and cognitive frameworks offered by Buddhism point to the possibility for greater resilience among clinicians of diverse spiritual backgrounds. In the face of systemic stresses, clinical challenges, and personal struggles, the practice of meditation, as well as an awareness of suffering, basic goodness, impermanence and compassion may be of benefit to all clinicians.

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Appendix A

Human Subjects Review Approval Letter

February 20, 2009

Simone Lichty

Dear Simone,

Your revised materials have been reviewed. You did an excellent job in their revision and your study seems more focused and clear. It should produce some very interesting and useful information. We are glad to give it our final approval.

Please note the following requirements:

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

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

In addition, these requirements may also be applicable:

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

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

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

Good luck with your project.

Sincerely,

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

CC: Heather Pizzanello, Research Advisor

Appendix B

Interview Guide

1) Can you please briefly describe your clinical training?

2) Can you please briefly describe your Buddhist training?

3) Can you speak a bit about what inspired you to become a psychotherapist?

4) Can you speak a bit about what inspired you to become a Buddhist?

5) Can you briefly describe the way you work with people?
   a) *What theories or conceptual frameworks inform your therapeutic work?*

6) What do you find most inspiring about your work?

7) What do you find discouraging about your work?
   a) *How do you cope with feeling discouraged?*
   b) *Does your spiritual practice help you cope with feeling discouraged?*

8) How does working with difficult clinical material, such as trauma, affect you?
   a) *Has working with traumatic material affected the way you view the world?*
   b) *Has working with traumatic material affected your faith in people?*
   c) *Has working with traumatic material affected your own sense of trust in the world?*

9) Have you experienced any of the following in relation to traumatic clinical material? :
   a) Re-experiencing traumatic material, as in intrusive thoughts or dreams.
   b) Avoiding internal or external stimuli that reminds you of traumatic clinical material. For example, avoiding certain thoughts, feelings, people, places or activities.
   c) A sense of numbing or detachment. For example, feeling estranged or detached from others, noticing a restricted range of affect, or less interest or participation in activities.
   d) Increased levels of arousal, agitation, or anxiety. For example, difficulty falling or staying asleep, irritability, difficulty concentrating or an exaggerated startle response.
      a) *If there are negative effects, in what ways do you cope with these effects?*

10) Do you believe that your Buddhist practice supports you in dealing with any of the negative effects of working with traumatized populations?

11) Are there ways in which your professional work, particularly working with trauma, has impacted your spiritual life?

12) Are there other aspects of your job, outside of the clinical encounter, which you find stressful?
   a) *How do you cope with these stressors?*
   b) *Do theses stressors ever cause you to feel:*
      i. *Overwhelmed?*
      ii. *Cynical or detached?*
      iii. *Ineffective in your job?*
   c) *Does your spiritual practice help you cope with any of these effects?*

13) Can you speak a bit about how Shambhala Buddhist teachings or practices help you cope with work related stress and difficult clinical material?

14) Does your Buddhist practice help you to make meaning out of what you witness in clinical practice?

15) What experiences or individuals have been most supportive to you in your professional life?

16) Is there anything else you would like to share with me about how your Buddhist practice relates to your experience of job stress and traumatic clinical material?

italics indicate contingency questions

Appendix C

Informed Consent Letter

February 25, 2009

Dear Potential Research Participant:

My name is Simone Lichty. I am a Sangha member and a graduate student at the Smith College School for Social work. I am conducting an exploratory study, interviewing Buddhist psychotherapists about what sustains, motivates, and inspires them in their clinical work. This research study for my thesis is being conducted as part of the requirements for the Master of Social Work degree at Smith College School for Social Work and future presentations and publications

Your participation is requested because you are both a practicing Buddhist as well as a psychotherapist. I will interview you about how your Buddhist practice supports your clinical work, and what brought you to both Buddhism and psychotherapy. Questions will address issues related to workplace and clinical stress as well as your spiritual practice. I will also ask you to provide demographic information about yourself. The interview will be conducted on the phone or face-to-face and will last for approximately 45 minutes to one hour and a half. Interviews will be audio recorded with your consent, and recordings will be coded numerically to ensure your confidentiality. After three years have passed, recordings will be destroyed after the interviews have been transcribed. If I use a transcriber, he or she will sign a confidentiality pledge.

The potential risks of participating in this study are the possibility that you might feel strong or uncomfortable emotions while participating in an interview addressing the challenges and difficulties of your clinical work.

You will receive no financial benefit for your participation in this study. However, you may benefit from knowing that you have contributed to a better understanding of both Buddhist practice and psychotherapy. Such research may lead to a richer understanding of how a Buddhist practice may support psychotherapists. You may also benefit from receiving the opportunity to share and reflect upon your experience.

Confidentiality will be maintained, as consistent with federal regulations and the mandates of the social work profession. Your identity will be protected, as names and identifying information will be changed in the reporting of the data. Your name will never be associated with the information you provide in the questionnaire or the interview. The data I collect may be used in other educational activities, such as

publications or presentations, as well as in the preparation for my Master's thesis. Your confidentiality will be protected by coding the information and storing the data in a locked file for a minimum of three years and after three years it will be destroyed unless I continue to need it in which case it will be kept secured.

Your participation in this study is completely voluntary. If you participate, you are free to refuse to answer specific questions and to withdraw from the study at any time before April 31, 2009 without penalty. If you decide to withdraw, all materials pertaining to you will be immediately destroyed. If you have additional questions about the study, please feel free to contact me via email or by phone. If you have any concerns about any aspect of the study, I encourage you to call myself or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

Simone Lichty
(contact information deleted)

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

_____   _____
SIGNATURE OF PARTICIPANT   SIGNATURE OF RESEARCHER

_____   _____
DATE   DATE

Please return this consent form to me prior to the interview to indicate your intention of participating in the study (I suggest that you keep a copy of this consent form for your records).

Thank you for your time, and I greatly look forward to having you as a participant in my study.

Best wishes,

Simone Lichty

By this merit, may all attain omniscience
May it defeat the enemy, wrongdoing,
From the stormy waves of birth, old age, sickness and death
From the ocean of samsara, may I free all beings.

By the confidence of the golden sun of the great east
May the lotus garden of the Rigdens' wisdom bloom
May the dark ignorance of sentient beings be dispelled
May all beings enjoy profound, brilliant glory.