

**Engaging Emotion in Cognitive Behavioral Therapy:
Experiential Techniques for Promoting Lasting Change**

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Part I: Acceptance as Engagement: Noticing, Allowing and Being with Emotion

Chapter 2: Mindfulness: It's Not What You Think

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When we make pain the enemy, we solidify it.

This resistance is where our suffering begins.

-Ezra Bayda-

Lauren suffered from panic attacks for most of her adult life. She explained in the intake interview that she had tried just about everything to get rid of her anxiety, including relaxation, cognitive restructuring, exposure therapy, insight-oriented psychotherapy, and medication. With the help of therapy she managed to go from being housebound to keeping a job, but she dreaded getting up in the morning to white-knuckle her drive to work. “Why am I still so anxious despite doing all the right things?” Lauren wondered aloud. She had recently read about the benefits of mindfulness and hoped that mindfulness might provide an answer.

From a mindfulness point of view, Lauren would remain a fugitive from her anxiety as long as she tried to get rid of it. The dictum is, “What you resist, persists.” We create problems in our lives to the extent that we fight against difficult sensations and emotions. For example, struggling with sleeplessness may lead to chronic insomnia and trying not to grieve can result in depression. Conversely, “What you can feel, you can heal.” Our difficulties subside when we

allow them into our lives, gradually and safely. What would it take for Lauren to allow the sensations of anxiety to come and go in her body, and to let her fears of having a heart attack simply be “thoughts” without catastrophizing them?

Two key questions in the case conceptualization of a mindfulness-based therapist are: (1) What pain is the client resisting?, and (2) How can I help the client develop a more accepting *relationship* to his or her pain? In Lauren’s case, she was resisting the experience of anxiety and the therapist’s task was to help her gradually open to it. That is a tall order, especially with panic disorder where clients feel they’re fighting for their lives. Therefore, mindfulness-based therapy moves in stages toward acceptance. We start with *exploring* (turning toward discomfort with curiosity), and then move to *tolerating* (safely enduring discomfort), then to *allowing* (letting discomfort come and go), and finally to *welcoming* (embracing difficult experience as part of life). The stages of acceptance correspond to a gradual loosening of resistance.

Lauren was invited by her therapist to *explore* the non-threatening tensions that resided in her body but didn’t presage a panic attack. Then she learned to *tolerate* anxiety by focusing on her breathing rather than her catastrophic thinking. Thereafter, Lauren discovered that she could disentangle from her panic when she learned to name her emotions and *allow* them to be there (“That’s loneliness.” “That’s fear.”). Finally, she began to *welcome* the opportunity to surf the waves of anxiety rather than being tumbled over by them, savoring her newfound freedom. This entire process corresponded to a radically new relationship to anxiety.

Background and Theory

There are many definitions of mindfulness, all of which are inadequate to the task because mindfulness is a preconceptual, preverbal experience of direct awareness. Mindfulness can’t be put into words. There is a subtle difference, for example, between knowing that a car backfired outside

your office and consciously *feeling* the sound in your body. Similarly, you may see a flash of green at your door before you notice it is the green dress of the woman you are expecting for your next appointment. Mindfulness is the first moment of sensory experience, the earliest stage of information processing, before we have a chance to think further about it or to formulate our ideas into words. In this regard, mindfulness is profoundly experiential.

A basic definition of mindfulness is “moment-by-moment awareness.” Other definitions include: “Keeping one’s consciousness alive to the present reality” (Hanh, 1976, p. 11); “The clear and single-minded awareness of what actually happens to us and in us at the successive moments of perception” (Nyanaponika, 1972, p.5); and “the awareness that emerges through paying attention, on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment by moment” (Kabat-Zinn, 2003, p. 145).

Although the word “mindfulness” is an English translation of the Buddhist Pali word *sati*, even different traditions within Buddhist psychology do not agree on the meaning of mindfulness (Williams & Kabat-Zinn, 2011). In modern scientific psychology, we have arrived at our definitions by looking for commonalities found in various training programs (Carmody, 2009) or by investigating what seems to be useful to patients in mindfulness-oriented treatment. In a consensus opinion among experts, Bishop et al. (2004) proposed a two-component model of mindfulness: “The first component involves the self-regulation of attention so that it is maintained on immediate experience, thereby allowing for increased recognition of mental events in the present moment. The second component involves adopting a particular orientation towards one’s experience that is characterized by curiosity, openness, and acceptance” (p. 232). A shorthand definition of mindfulness in the therapeutic context is “awareness of present experience with acceptance” (Germer, 2013).

Mindfulness can be understood as a *process* (defined above) and a *practice*, such as meditation. Three types of meditation practices are typically taught under the umbrella of “mindfulness meditation” in the West (Salzberg, 2011): (1) focused attention, (2) open monitoring, and (3) loving-kindness and compassion. Focused attention calms the mind by returning again and again to a single object, such as the breath; open monitoring cultivates equanimity in the face of challenges, using methods such as labeling emotions or scanning the body for sensations; and loving-kindness and compassion meditation adds an element of care, comfort and soothing to our awareness. Meditation can occur formally (e.g., sitting meditation) or informally throughout the day.

The first two types of meditation are attention regulation strategies which are currently the primary focus of clinical research (Carmody et al., 2009). Over the past few years, however, there’s growing interest in loving-kindness and compassion (Hofmann, Grossman, & Hinton, 2011). Neurological evidence suggests that the mental skills cultivated by all three meditation types represent overlapping, yet distinct, brain processes (Brewer et al., 2011; Desbordes et al., 2012; Lee et al., 2012; Lutz, Slagter, Dunne, & Davidson, 2008). Preexisting brain function may even predict which kind of meditation an individual prefers (Mascaro, Rilling, Negi, & Raison, 2013).

Mindfulness in Cognitive Behavior Therapy

We are currently in the third generation of cognitive behavioral therapy (CBT) (Hayes, 2011). The first generation was behavior therapy, focusing on classical, Pavlovian conditioning and contingencies of reinforcement. The second was cognitive therapy aimed at altering dysfunctional thought patterns. The third generation is mindfulness, acceptance, and compassion-based psychotherapy, in which our *relationship* to experience, often intense and disturbing emotions, shifts during the course of therapy.

In this new approach, we are interested in more than cognitions. In a critical review of the evidence, Longmore and Worrell (2007) challenged a key tenet of cognitive therapy that “all therapies alter dysfunctional cognitions,” and they found that (1) cognitive *interventions* like behavioral activation, cognitive therapy, exposure, and response prevention did not add significant value to one therapy over another, and (2) cognitive *change* was not causal in improvements in symptoms, i.e., changes in the content of thinking occurred as readily in non-cognitive therapies. From a mindfulness perspective, the possibility exists that we were unknowingly helping our clients cultivate mindfulness whenever we asked them to monitor their thoughts and behavior and explore the antecedents and consequences of their beliefs.

Mindfulness-based therapy is designed to establish a new relationship to *all* experience, including emotions, cognitions, sensations, behaviors, and intentions. Learning to hold any difficult experience in mindful awareness, without resistance, dismantles the scaffolding that maintains psychological problems. Progress in mindfulness-based treatment is a process of gradually opening to and feeling unpleasant experience.

Mindfulness training also *refines* our awareness. The power of mindful awareness to dismantle symptoms becomes most evident when we have the capacity to witness how our symptoms subtly arise upstream as we process information. In Lauren’s case, for example, she was invited to drop her attention into her body and see how her heart naturally sped up and slowed down before it mushroomed into a panic attack, which dissipated her reactivity. Similarly, if we can witness the arising of difficult emotions as a change in physical sensations or compulsive urges as a shift in intention—if we can get *underneath* our symptoms—then we have more choice in how we behave in the world.

Mindfulness, Acceptance, and Compassion

When mindfulness is in full bloom—when we feel calm and vibrant amidst the full range of our thoughts, feelings, and sensations—our experience is permeated with acceptance and compassion. Particularly in the clinical arena, however, mindfulness is usually tinged by distressing emotions, such as in “worried attention” or “sad attention.” That is when we need to intentionally activate acceptance and compassion to become more mindful. Acceptance is “active nonjudgmental embracing of experience in the here and now” (Hayes, 2004, p. 21) and compassion is “basic kindness, with deep awareness of the suffering of oneself and other living beings, coupled with the wish and effort to alleviate it” (Gilbert, 2009, p. xiii). Acceptance and compassion contribute a tone of warmth and affection to our awareness.

Since the advent of mindfulness-based treatments in the 1990’s, acceptance has typically focused on *moment-to-moment experience* (non-resistance and non-avoidance of sensations, emotions, and thoughts) (Kabat-Zinn, 1990; Hayes, Strosahl, & Wilson, 1999; Linehan, 1993; Segal et al, 2002). However, earlier giants in the field of psychotherapy such as William James, Sigmund Freud, B.F. Skinner, and Carl Rogers all considered *self-acceptance* to be psychologically beneficial (Williams & Lynn, 2010). Modern compassion-based treatments are staunchly reclaiming the *experiencer* as an important object of acceptance (Germer & Neff, 2013; Gilbert, 2010a), in addition to moment-to-moment *experience*.

Self-compassion is central to mindfulness and compassion-based treatment. Self-compassion may be considered the heart of mindfulness when we meet suffering. Mindfulness says, “*Open* to your suffering with spacious awareness and it will change.” Self-compassion adds, “*Be kind to yourself* in the midst of suffering and it will change.” Mindfulness asks, “What do I *know*?” and self-compassion asks, “What do I *need*?” Together, mindfulness and self-compassion comprise a state of warmhearted, connected presence during difficult moments in

our lives.

Although the definitions of mindfulness, acceptance and compassion differ, the capacity to “be with” our experience in a mindful manner engages not only higher cortical processes of awareness, but also our emotions. If we turn away from our experience with disgust, or hide from ourselves in shame, we cannot be mindful. Alternatively, learning to hold our emotions and ourselves in affectionate awareness opens the mind to new possibilities and positive change (Fredrickson et al., 2008.)

Evidence

The research literature on mindfulness has been growing exponentially exponentially over the past 10 years. Whereas only 365 peer-reviewed articles on mindfulness were indexed in PsychINFO in 2005, there are now over 2200 articles, as well as over 60 mindfulness treatment and research centers in the United States alone. The effectiveness of mindfulness-based treatments is well-established. We have structured interventions for treating a broad range of mental and physical disorders, randomized controlled trials supporting these interventions, and numerous reviews and meta-analyses of those studies (Chen et al., 2012; Chiesa, Calati, & Serretti, 2010; Davis & Hayes, 2011; Fjorback et al., 2011; Greeson, 2009; Grossman, Niemann, Schmidt, & Walach, 2004; Hoffmann, Grossman, & Hinton, 2011; Hoffman, Sawyer, Witt, & Oh, 2010; Keng, Smoski, & Robins, 2011; Khoury et al., 2013; Piet & Hougaard, 2011; Rubia, 2009; Vollestad, Nielsen, & Nielsen, 2012). Please see www.mindfulexperience.org for a comprehensive, mindfulness research database with monthly updates.

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The four, most frequently cited, empirically-supported, mindfulness-based treatment programs are mindfulness-based stress reduction (MBSR; Kabat-Zinn, 1990), mindfulness-based cognitive therapy (MBCT; Segal, Williams, & Teasdale, 2012), dialectical behavior therapy

(DBT; Linehan, 1993), and acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999). The latter two programs do not emphasize mindfulness meditation per se, but are based on the principles of mindfulness and acceptance. There are many other mindfulness programs that have grown out of these templates, or were developed for specific populations, conditions, or skills training, such as: mindfulness-based relapse prevention (Witkiewitz & Bowen, 2010); mindfulness-based eating awareness training (Kristeller & Wolever, 2011); mindfulness-based cognitive therapy for children (Semple, Lee, Rosa, & Miller, 2010); mindfulness-based stress reduction for teens (Biegel et al., 2009); mindfulness and acceptance-based behavioral treatment of anxiety (Roemer, Orsillo, & Salters-Pedneault, 2008), mindfulness-based relationship enhancement (Carson, Carson, Gill, & Baucom, 2004); mindful self-compassion training (Neff & Germer, 2012), and compassion focused therapy (Gilbert, 2010a, 2010b, 2010c).

Mechanisms of Action

There is good evidence that mindfulness interventions can be helpful for a variety of problems, such as anxiety, depression, emotion dysregulation, low self-esteem, attentional difficulties, and chronic pain. A key question in the mindfulness literature is, “How does mindfulness actually work?” What are the internal mechanisms that enable clients to live their lives more fully and meaningfully? Mindfulness may be considered a mechanism of action in its own right, but a variety of subprocesses correlated with identifiable brain regions seem to be active when we’re being mindful. Hölzel and colleagues (2011) identified six mechanisms for which we find corresponding brain activity during mindfulness meditation:

- *Attention Regulation* – stability of awareness in spite of competing input
- *Body awareness* – noticing subtle sensations, being conscious of one’s emotions

- *Emotion regulation* – decreased reactivity, not letting emotional reactions interfere with performance
- *Reappraisal* – seeing difficulties as meaningful or benign, rather than as all bad
- *Exposure* – global desensitization to “whatever is present in the field of awareness”
- *Flexible sense of self* – disidentification with emotions, increasing adaptivity

Additional mechanisms with empirical support are: *self-compassion* (Hölzel, et al., 2011; Neff & Germer, 2013), *values clarification* (sense of purpose) and *flexibility* (cognitive, emotional, and behavioral adaptiveness) (Hayes, Strosahl & Wilson, 1999; Shapiro, Carlson, Astin, & Freedman, 2006); *emotion differentiation* (awareness of emotional experiences) (Hill & Updegraff, 2012); and *metacognitive awareness* (Cocoran, Farb, Anderson, & Segal, 2009). These mechanisms of action seem to map nicely to a variety of psychological disorders. For example, mindful attention regulation for attention deficit disorder (van der Oord, Bögels, & Peijnenburg, 2012), body awareness for eating disorders (Kristeller, 2011), and self-compassion for shame-based disorders (Gilbert, 2006).

Currently, the field of cognitive behavior therapy has largely adopted the core processes of mindfulness even in treatments where the word “mindfulness” is not used. One example is the unified protocol for the transdiagnostic treatment of emotional disorders by David Barlow and colleagues (Farchione et al., 2012). It consists of four modules familiar to mindfulness-oriented therapists: (1) increasing emotional awareness, (2) facilitating flexibility in appraisals, (3) identifying and preventing behavioral avoidance, and (4) situational and interoceptive exposure to emotion cues.

Overall, mindfulness appears to be an underlying, *transdiagnostic*, psychological process that alleviates a broad spectrum of disorders. We will now explore ways that mindfulness practices and processes can be applied to the clinical context.

Application

As described above, a variety of structured treatment protocols have been designed for mindfulness-based treatment of psychological disorders. We will now describe a heuristic for applying mindfulness into individual treatment—“the three P’s.”—matching *person*, *process* and *practice*. Mindfulness-based clinicians are encouraged to understand each of these elements and keep them in mind during treatment.

Mindfulness-based treatment is decidedly idiographic—it depends on moment-to-moment fluctuations within the *person* in his or her context. A common instruction of mindfulness meditation is “pay attention to what is most salient and alive in your field of awareness.” This instruction pertains to mindfulness-based treatment as well, and translates into the therapeutic question: “What emotional pain is the client resisting?” Furthermore, a client’s painful emotions are nestled in values. For example, unemployment might be welcomed by a person who values free time but it could be devastating for someone who wants to provide for his or her family. By understanding what emotional pain a client is resisting and what he or she values, we can begin to understand the client and tailor treatment appropriately.

And as mentioned earlier, mindfulness seems to work through a variety of change *processes*, or mechanisms of change. Understanding these change processes is a lens through which the clinician can begin to design an intervention. For example, cultivating body awareness may help a client disentangle from obsessive thinking, regulating attention away from a panic attack can reduce anxiety to a manageable level, exposure (non-avoidance) to traumatic memories through the cultivation of spacious awareness may facilitate desensitization, and self-compassion training could ameliorate the destructive impact of shame.

Finally, there are *practices*—practical exercises and instructions—that clinicians can teach their clients to help them cultivate a more mindful, accepting relationship to their emotional pain (see also Germer, Siegel, & Fulton, 2013; Pollak, Pedulla, & Siegel, 2013; Siegel, 2010). The three general types of mindfulness practices mentioned earlier are focused attention, open monitoring, and compassion. Clinicians might ask: Could focusing on the movement of the breath in the body help to defuse a volatile domestic situation? Might monitoring self-judgments reduce a depressed person’s self-critical thinking? Would a client stricken with grief over the suicide of a friend find relief by repeating the compassionate phrase, “May I learn to forgive myself?”

By matching the three P’s—person, process, and practice—the mindfulness-based clinician can customize mindfulness for individual therapy. A clinical example follows:

Clinical Example

Ed was a 29-year-old, single, gay male who referred himself to treatment for depression. His chief complaints included two years of low moods, hypersomnia, lack of energy despite sufficient sleep, impaired concentration, and low self-esteem. He described general discontent that stemmed, in part, from his inability to find his “true calling.” Ed lamented being single and worried that he would never find true love (“the one”). At the time of intake, Ed was self-employed as a freelance commercial music composer. His father was a Thai-American and his mother was white. Due to his father’s work, Ed moved from one continent to another throughout his childhood. He described himself as a “third culture kid,” an identity he saw as core to his personality.

My (one of the authors, C.C.) original CBT treatment plan focused on identifying Ed’s automatic thoughts, using the Dysfunctional Thought Record, and then systematically adjusting

his lifestyle with an emphasis on sleep regulation and reintroducing pleasurable activities, especially those that would provide additional social support. At intake, Ed requested that the course of treatment be brief because he was intending to leave fairly soon for a year or two in Thailand, although he had not set a specific date for his departure.

Ed's depressed mood apparently worsened after his father's death a few years prior. Ed had difficulty with his traditionally-minded father ever since Ed came out as a gay man at age 16. Around the same time, Ed rebelled against his parents, experimented with drugs, and lived lavishly with his parents' money. He managed to complete college with a degree in music but soon thereafter he tried to earn a living by making music and it became a chore for him. After the death of his father, Ed found sporadic jobs and had difficulty maintaining them. More recently, he worked for an NGO and did what he considered meaningful work, but resigned within a year saying that his employer, whom he initially admired, disappointed him. Thereafter, Ed survived with freelance work and money inherited from his father, which he felt guilty spending. His relationship with his mother, who lived in a different geographic area, was reasonably good. Although Ed and his mother did not see each other on a regular basis, they tried to stay in touch with one another.

My initial efforts at treating Ed's depression were fraught with difficulty. Ed claimed to enjoy the structured, interactive, and collaborative approach of CBT, which he contrasted with his previous "talk" therapy, but he was reluctant to adhere to the homework assignments. He did not put much effort into the behavioral activation exercises, either. He dismissed the weekly homework as rigid and described them as routines that could not teach him anything he did not already know.

Person

In the three-P model, we first try to identify what sensations, thoughts, or emotions a person is struggling with (i.e., resisting/not accepting) and what he or she values in life (see also Hayes, Strosahl, & Wilson, 1999; Orsillo & Roemer, 2011). For Ed, it was difficult to accept that he had not found the “right” career path and the “right” person for a long-term romantic relationship. Upon further probing, it also became clear that he resented his father for not accepting him for who he was (“What kind of father would reject his own son because he is gay?!”), and behind his anger was a lingering sense of sadness for their estranged relationship and shame for living off his father’s money.

When asked what he valued, Ed said he liked “being useful,” and “engaging in work that is meaningful and exciting.” What he could not accept was to live a routinized life. When asked about pleasurable activities, Ed reported that he enjoyed cooking and travelling. We discovered that his love for cooking stemmed from the social interaction that the activity provides, especially when he prepared food for his friends. Scheduled dinner parties lifted his mood. As for travelling, he despised tourists and described himself as a traveller who, unlike a typical tourist, immersed himself to the host culture. He was looking forward to leaving everything behind and go on his next voyage.

Process

What change process might help Ed to begin to lead a more meaningful, productive life? As mentioned above, treatment began in a traditional CBT manner by inviting Ed to monitor the thoughts that made him depressed and what triggered them. For example, Ed said he felt most depressed when he stayed in bed too long in the morning. This led to an “unproductive day,” in which he “wasted time doing nothing.” He would then stay up all night to make up for lost time, but low energy and motivation would prevent him using the extra time productively. This cycle

frequently resulted in the recurring thought “I’m wasting my life.” I suggested to Ed that we collaborate on a daily schedule that would include work, leisure, and rest. Ed rejected the idea of living by a schedule because he believed schedules were for “businessman and boring people” and not free-wheeling individuals like himself.

It gradually became clear that Ed’s rigid way of viewing himself as an unstructured, counter-cultural person was interfering with achieving his goals in life. Therefore, developing a more *flexible sense of self* began to emerge as a possible therapeutic change process.

Ed refused to get an office job, even though he needed the money, because office jobs were “mundane” and “boring,” a contradiction to his identity. Another example of a rigid sense of self was his identity as “third-culture kid” (“we are constantly restless”) and the need to get away from wherever he was. I suggested that perhaps his trips were in a way a form of avoidance or escape from certain responsibilities and aspects of life that are not “exciting”. This was met with hostile defensiveness and caused a breach, albeit brief, in our alliance.

Furthermore, Ed’s rigid sense of self seemed to be a reaction to the anger, sadness and shame he felt in relationship to his father. Since his father had passed away, there was no chance for healing that relationship, but perhaps Ed could find a new relationship to the emotions themselves? Could he become more aware of his emotions, and gradually desensitize to the distress they elicit, through awareness of how they manifest in his body, rather than engaging in endless arguments in his mind with his father? Therefore, *body awareness of emotion* appeared to be another change process that might help Ed release the exhausting and destructive power of anger, and perhaps *self-compassion* for sadness and shame (Gilbert & Proctor, 2006).

Practice

After using the Dysfunctional Thought Record, Ed reported that he was glad to discover how his thoughts made him more depressed, but he found it difficult to separate his thoughts from his feelings (“This is just how I feel, no matter what!”) or to change his thoughts. Similarly, initial efforts to engage him in pleasurable activities were not entirely successful (“They don’t excite me the way I expected”). Given the difficulties we met in the effort to help altering Ed’s thoughts, feelings, and behaviors, mindfulness meditation appeared to be a potentially beneficial alternative route to bring about changes. Perhaps, through the more intimate self-monitoring practice of mindfulness meditation, Ed could begin to distinguish between his thoughts and emotions, and see his emotions as simply emotions, not facts bearing directly on his self-identity or self-worth.

Ed had some prior exposure to meditation practice. He was therefore receptive to mindfulness meditation in the therapeutic context. We began with 3 minutes of mindful breathing during the therapy session, which gradually was increased to 10 minutes and, eventually, 20 minutes per sitting. Ed was encouraged to practice in the same manner at home by setting aside a fixed time of the day for his practice. It was a time when he was not easily disturbed or tired. Like all behavioral exercises, this one was not without its challenges, so weekly monitoring was implemented and obstacles discussed and tackled in session.

Over time, Ed learned to “sit with” difficult emotions, especially anger, sadness, and shame, both in and between sessions. When those emotions became too intense in meditation, Ed shifted his attention to his breathing (focused attention) to calm down. Then he explored where in his body the emotions of anger, sadness, and shame expressed themselves most readily (anger was tension in his belly; sadness was heartache, and shame was hollowness in the head region), and he learned to “allow and soften” those emotions—allowing the them to come and go as

sensations in the body, and softening or relaxing the muscles where the emotions were felt.

Through this practice of finding and transforming emotion in the body, Ed's anger, sadness, and shame were slowly brought down to manageable levels.

Mindfulness appears also to help increase flexibility in sense of self. Ed's self-concept (free-spirited, third-culture, gay man) gradually began to soften through mindfulness practice. By keeping his attention more often with moment-to-moment experience (experiential processing) rather than obsessively promoting and protecting his rigid sense of self (narrative processing; Farb et al., 2007), Ed found he had more creative energy at his disposal to think in adaptive ways about his life. After two months, Ed agreed to search for a day job and found one. This led to further improvement because he was able to recognize some of his inaccurate assumptions about "cubical jobs." Ed remarked, "Just having a place to go to each morning does wonders!"

Ed returned again and again to the topic of his father in therapy. His anger, sadness, and shame seemed to be driven by the conviction that his father did not love him, especially as a gay man. Self-compassion is considered an antidote to sadness and shame, so we folded loving-kindness meditation with self-compassion phrases into his meditation practice. Ed used the phrases "May I be free from sadness," "May I be free from shame," "May I be kind to myself," "May I be kind to others." These phrases helped Ed to shift his attention from his father and how angry he was with him to his own emotional pain and his natural longing to be loved by his father. The phrases validated, over and over, how painful it was to feel rejected, and how important it was to Ed to be seen, heard, and appreciated for who he was. Since his father had passed away, Ed was finally giving to himself what he desperately wanted to receive from his father.

Over time, through intentional softening of the pain and anger associated with his father, Ed's frame of reference began to expand and he was able to entertain the possibility that perhaps his father, with his traditional upbringing, did not know how to handle that fact that his son was gay. Ed reported an incident that he had not previously shared with anyone. Ed had apparently visited his father in the hospital a few days before his father died. Knowing his father's condition, Ed overcame his anger and told his father that he loved him. His father wept and replied, "Hearing this is the best medicine I can ever take!" Although his father never explicitly reciprocated Ed's verbal expression of love, Ed felt it was implied in his father's words. Ed's growth in therapy since starting meditation exercises, particularly this important shift in how he viewed his father, enabled him to look beyond his anger toward his father and to contact healing feelings such as forgiveness and even love. From that point onward, we focused on cultivating those feelings by expanding Ed's loving-kindness meditation to include his father, imagining him in the afterlife: "May you and I both be happy and free from suffering."

Our treatment ended when Ed finally left for Thailand. Prior to his departure, his attitude toward the trip had also shifted as a result of a more flexible understanding of his identity. In session, we explored explicitly the goals he hoped to accomplish through this trip. The cultivation of acceptance allowed Ed to entertain the possibility that he had been using travelling as avoidance. The practice of nonjudgmental observation of his thoughts and feelings, Ed was able to be honest with himself and, in turn, explore his deep desires and yearning. Travelling was no longer simply an expression of his restless nature, but an opportunity to enjoy the freedom of a foreign culture to practice new forms of self-care, self-identity, and self-expression.

Strategies for Helping Clients Build and Maintain a Meditation Practice

Mindfulness meditation may be practiced *informally* during the day, such as by taking a mindful breath, or *formally* in sitting meditation (Germer, 2013). Ultimately, however, mindfulness-based therapists are trying to help their clients be more aware and accepting of moment-to-moment experience, not to transform them into good meditators. The mindfulness-based CBT therapist needs to be flexible and collaborative to determine which practices fit each individual client, including how to use the therapy relationship to enhance a client's mindfulness. For a more detailed consideration of how to integrate formal and informal meditation into therapy, please see Pollak, Pedulla, & Siegel (2014).

Habits, especially good ones, are hard to develop. It is especially difficult to develop a formal mindfulness practice. Formal meditation is like going to the mental gym, and progress in mindfulness appears to be “dose-dependent” (Lazar et al., 2005; Pace et al., 2009; Rubia, 2008). Therefore, if a client has a taste for it, meditation should be encouraged. In Ed's case, his earlier meditation habit had fallen by the wayside. It was easy to engage him in meditation with the support of therapy, but as the weeks progressed, his practice waned again. We needed to carefully monitor, in a non-judgmental, non-shaming way, the conditions under which he practiced and didn't practice. Most importantly, we needed to manage Ed's expectations. The assumptions that clients have about meditation largely determines if they will practice formal meditation. Below are some tips that many clients (and clinicians!) to maintain a regular meditation practice.

Start Small

Our ideas about the length of time we should be meditating can make the practice unnecessarily burdensome. It helps to apply the “3-minute rule”—to simply *begin*. This is how

Ed reengaged in meditation, and over time he developed a taste for it and extended his periods of practice.

Make it Pleasant

When we practice correctly, meditation feels like a vacation rather than yet-another task to squeeze into a busy day. It helps to ask oneself, “What can I let go of to make meditation less like work and more like play?” “Can I shed the need to be relaxed or to concentrate better, and just *be*?” “Am I trying to achieve a particular state, or can I simply open more fully to the state I’m in?” The point is to make meditation more pleasant and self-reinforcing.

Connect to Core Values

Does meditation have a place in what you consider a meaningful and valuable life? For example, do you want to be awake and aware of the beauty of each passing moment so you don’t feel you’ve wasted your life preoccupied with problems? Do you want to be happy? Is it important to you to be as compassionate as possible? Reminding ourselves of our core values may be an incentive to meditate rather than answering emails or reading the newspaper every morning.

Good Will, Not Good Feelings

When we meditate, we are likely to feel good, bad, and often we feel nothing at all. Meditation cultivates a new relationship to all these feelings. One way that meditation works is by desensitizing difficult emotions that inevitably arise during states of calmness. When we meet difficult emotions with loving awareness rather than fear or anger, we usually feel better as an inevitable byproduct. The point of meditation is long-term emotional wellbeing, but we need to let go of the need to feel good during meditation itself in order to achieve that salubrious state.

Social Support

Meditation can feel quite lonely for some people, so they lose interest. Some suggestions to make meditation less solitary are to meditate with your cat or dog, listen to guided meditations, connect to other meditators in real time with a mobile phone application like the *Insight Timer*, join an online meditation support group, read a passage from a book, listen to a talk by an inspiring teacher before practicing, meet weekly with a practice group, or go on retreat,

Physical Support

Make a cozy, attractive space in your home dedicated to meditation. Include objects that have very special meaning to you. It helps to practice roughly the same time each day so that you get entrained to move toward your meditation space rather than beginning other activities. It is also important that you are comfortable while meditating. You will not meditate very long if it is physically painful. Try to find a chair that you like, or if you want to sit on a cushion or bench, make sure your posture is properly adjusted to support your body without effort.

Limitations and Future Directions

Considering the broad range of mindfulness practices available to clinicians, there do not seem to be any specific contraindications for mindfulness-based treatment, only limitations due to insufficient understanding of a client, the change processes, or the practices. For example, it is unwise to recommend open monitoring sitting meditation to a recently traumatized client who wants to relax because it will probably activate traumatic memories. Instead, establishing safety through grounding techniques such as feeling the soles of the feet would be a more useful first step.

Some clients feel that mindfulness is not for them because they can't meditate. However, taking a breath and asking a few simple questions is often all that's required: "What am I

sensing?” “What am I feeling?” “What am I thinking?” “What am I doing?” Clients should also be encouraged to become their own best teacher, perhaps by asking, “What do I need now?” As Mary Oliver (1986) eloquently expressed it, “You only have to let the soft animal of your body love what it loves” (p. 14).

Meditation, and mindfulness in particular, is now one of the most thoroughly researched psychotherapeutic methods available to clinicians (Black, 2013; Smith, 2004; Walsh & Shapiro, 2006). Research on the influence of mindfulness meditation on brain structure and function, combined with findings from cognitive, affective, and social research, are uncovering key mechanisms of action for mindfulness, which, in turn, are being targeted for particular psychological disorders (Jha, 2013). Their effectiveness might vary across contexts and disorders, but the sheer volume of randomized, controlled clinical trials and meta-analyses of those trials demonstrates that mindfulness-based treatment is now a well-established treatment modality (Germer, 2013). Limitations to the research remain, however. For example, the effect sizes of the randomized controlled trials are generally not large, many of the [1] sample sizes are relatively small, and there is some likelihood of publication bias (Bohlmeijer, Prenger, Taal, & Cuijpers, 2010; Eberth & Sedlmerier, 2012; see also funnel plots in Hofmann et al., 2010). [2]

Although research demonstrates positive effects of engaging in mindfulness practice, there will always be ambiguity and room for clinical wisdom in mindfulness-based treatment. Mindfulness-based treatment is a uniquely complex undertaking insofar as it is about transforming a particular client’s relationship to his or her moment-to-moment experience, all of which is constantly changing. Furthermore, clinical practice occurs in a social context and “the therapy relationship accounts for why clients improve (or fail to improve) as much as the particular treatment method” (Norcross & Lambert, 2010, p. 2). There is even preliminary

evidence that clinician's personal meditation practice has a positive impact on treatment outcome (Grepmaier et al., 2007).

How can we best prepare ourselves to become mindfulness-based psychotherapists? Most fundamentally, we should continue to hone our clinical skills—to understand psychopathology, explore the latest theory and research, develop interpersonal skills, cultivate cultural sensitivity—and *practice mindfulness meditation*. During the early evolution of MBCT, the program developers did not practice meditation themselves and the results were disappointing (Segal et al., 2012). Soon thereafter, they visited a MBSR class (upon which the MBCT program is based) and were surprised to notice that the MBSR teachers were not trying to “fix” their clients, they behaved like fellow travellers on the path to emotional wellbeing, they seemed unintimidated by strong emotions in their clients, and mostly they inquired into the precise nature of each student's experience without suggesting it should be otherwise. In their tone and style of conversation, MBSR teachers modeled for their students how to practice mindfulness. This approach to teaching—embodying the practice and modeling for others—is now an intrinsic part of both MBCT and MBSR, two of the most widely practiced mindfulness training programs available today.

Whither mindfulness-based treatment? Mindfulness is an ancient Buddhist practice to know the mind, shape the mind, and free the mind (Nyanaponika, 1965) and the convergence of that ancient psychology and western psychology has just begun. In light of the burgeoning research, we can expect to further refine the change processes and practices relevant to clinical practice. We will surely develop creative new techniques to address the needs of specific populations and diagnostic groups, perhaps targeting interventions to alter specific dysfunctional brain patterns. More generally, since mindfulness appears to be an underlying change process in

psychological treatment as well as a set of practices designed to promote emotional wellbeing, it has the potential to draw clinical practitioners and scientists closer together, as well as integrate the professional and private lives of clinicians.

Further Resources

Books for Clinicians

- See Germer, C. K., Siegel, R., & Fulton, P. (Eds.) (2013) for the bestselling professional text on mindfulness and psychotherapy.
- For a companion handbook to the clinical text mentioned above, see Pollak, S., Pedulla, T., & Siegel, R. (2014).
- See Hayes, S., Follette, V., & Linehan, M. (Eds.) (2011) for an overview of mindfulness and acceptance in the cognitive-behavioral tradition.

Books for Clients

- For a jargon-free, empirically-based, primer on the psychology and practice of mindfulness, see Baer, R. (2013).
- For a step-by-step guide to applying mindfulness and self-compassion to manage difficult emotions, see Germer, C. K. (2009).
- See Williams, J., Teasdale, J., Segal, Z., & Kabat-Zinn, J. (2007) for the essential reader on mindfulness-based cognitive therapy for depression.

Mindfulness Meditations

- To address everyday problems with mindfulness, go to www.Mindfulness-Solution.com
- To cultivate mindful presence, go to www.TaraBrach.com
- To develop mindful self-compassion, go to www.MindfulSelfCompassion.org

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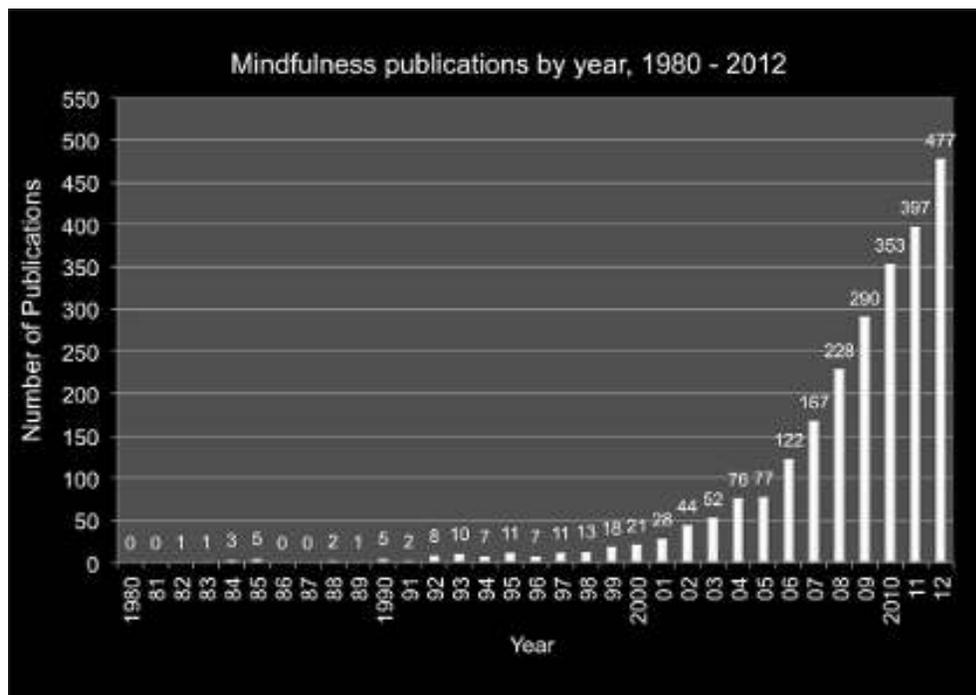
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Figure 1. Research publications on mindfulness, 1980 - 2012



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