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Mindfulness

What Is It? What Does It Matter?

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> To live is so startling, it leaves but little room for other occupations. . . .
>
> —Emily Dickinson (1872)

Psychotherapists are in the business of alleviating emotional suffering. Suffering arrives in innumerable guises: as stress, anxiety, depression, behavior problems, interpersonal conflict, confusion, despair. It is the common denominator of all clinical diagnoses and is endemic to the human condition. Some of our suffering is existential, in the form of sickness, old age, and dying. Some suffering has a more personal flavor. The cause of our individual difficulties may include past conditioning, present circumstances, genetic predisposition, or any number of interacting factors. *Mindfulness*, a deceptively simple way of relating to experience, has long been used to lessen the sting of life's difficulties, especially those that are self-imposed. In this volume we illustrate the potential of mindfulness for enhancing psychotherapy.

People are clear about one thing when they enter therapy—*they want to feel better.* They often have a number of ideas about how to accomplish this goal, although therapy doesn't necessarily proceed as expected.

For example, a young woman with panic disorder—let's call her Lynn—might phone a therapist, hoping to escape the emotional turmoil of her condition. Lynn may be seeking freedom *from* her anxiety, but as therapy progresses, Lynn actually discovers freedom *in* her anxiety. How does this occur? A strong therapeutic alliance may provide Lynn with courage and safety to begin to explore her panic more closely. Through self-monitoring, Lynn becomes aware of the sensations of anxiety in her body and the thoughts associated with them. She learns how to cope with panic by talking herself through it. When Lynn feels ready, she directly experiences the sensations of anxiety that trigger a panic attack and tests herself in a mall or on an airplane. This whole process requires that Lynn first turn *toward* the anxiety. A compassionate "bait and switch" has occurred.

Therapists who work in a more relational or psychodynamic model may observe a similar process. As connection deepens between the patient and the therapist, the conversation becomes more spontaneous and authentic, and the patient acquires the freedom to explore what is really troubling him or her in a more open, curious way. With the support of the relationship, the patient is gently exposed to what is going on inside. The patient discovers that he or she need not avoid experience to feel better.

We know that many seemingly dissimilar forms of psychotherapy work (Seligman, 1995; Wampold, 2012). Is there a common curative factor across various modalities that can be identified and refined, perhaps even *trained*? Mindfulness is proving itself to be such an ingredient.

A SPECIAL RELATIONSHIP TO SUFFERING

Successful therapy changes the patient's *relationship* to his or her suffering. Obviously, if we are less upset by events in our lives, our suffering will decrease. But how can we be less disturbed by *unpleasant* experiences? Life includes pain. Don't the body and mind instinctively resist or avoid painful experiences? Mindfulness is a skill that allows us to be less reactive to what is happening in the moment. It is a way of relating to *all* experience—positive, negative, and neutral—such that our overall suffering diminishes and our sense of well-being increases.

To be mindful is to wake up, to recognize what is happening in the present moment with a friendly attitude. Unfortunately, we're rarely mindful. We are usually caught up in distracting thoughts or in opinions about what is happening in the moment. This is mind*less*ness. Examples

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of mindlessness include the following (adapted from the *Mindful Attention Awareness Scale* [Brown & Ryan, 2003]):

- Rushing through activities without being attentive to them.
- Breaking or spilling things because of carelessness, inattention, or thinking of something else.
- Failing to notice subtle feelings of physical tension or discomfort.
- Forgetting a person's name almost as soon as we've heard it.
- Finding ourselves preoccupied with the future or the past.
- Snacking without being aware of eating.

Mind*ful*ness, in contrast, focuses our attention on the task at hand. When we're mindful, our attention is not entangled in the past or future, and we are not rejecting or clinging to what is occurring at the moment. We are present in an openhearted way. This kind of attention generates energy, clearheadedness, and joy. Fortunately, it is a skill that can be cultivated by anyone.

When Gertrude Stein (1922/1993, p. 187) wrote "A rose is a rose is a rose is a rose," she was bringing the reader back again and again to the simple rose. She was suggesting, perhaps, what a rose is *not*. It is not a romantic relationship that ended tragically 4 years ago; it is not an imperative to trim the hedges over the weekend—it is just a rose. Perceiving with this kind of "bare attention" is commonly associated with mindfulness.

Most people in psychotherapy are preoccupied with past or future events. For example, people who are depressed often feel regret, sadness, or guilt about the past, and people who are anxious fear the future. Suffering seems to increase as we stray from the present moment. As our attention gets absorbed in mental activity and we begin to ruminate, unaware that we're ruminating, our daily lives can become sorrowful indeed. Some of our patients feel as if they are stuck in a movie theatre, watching the same upsetting movie over and over, unable to leave. Mindfulness can help us to step out of our conditioning and see things anew—to see a rose as it is.

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DEFINITIONS OF MINDFULNESS

The term *mindfulness* is an English translation of the Pali word *sati*. Pali was the language of Buddhist psychology 2,500 years ago, and mindfulness is the core teaching of this tradition. *Sati* connotes *awareness, attention*, and *remembering*.

What is awareness? Brown and Ryan (2003) define awareness and attention under the umbrella of consciousness:

> *Consciousness* encompasses both awareness and attention. *Awareness* is the background "radar" of consciousness, continually monitoring the inner and outer environment. One may be aware of stimuli without them being at the center of attention. *Attention* is a process of focusing conscious awareness, providing heightened sensitivity to a limited range of experience (Westen, 1999). In actuality, awareness and attention are intertwined, such that attention continually pulls "figures" out of the "ground" of awareness, holding them focally for varying lengths of time. (p. 822)

You are using both awareness and attention as you read these words. A tea kettle whistling in the background might command your attention if it gets loud enough, particularly if you would like a cup of tea. Similarly, we may drive a familiar route on "autopilot," vaguely aware of the road, but respond immediately if a child runs in front of us. Mindfulness is the opposite of functioning on autopilot, the opposite of daydreaming; it is paying attention to what is salient in the present moment.

Mindfulness also involves *remembering*, but not dwelling in memories. It involves remembering to reorient our attention and awareness to current experience in a wholehearted, receptive manner. This reorientation requires the *intention* to disentangle our attention from our reverie and fully experience the present moment.

The word *mindfulness* can be used to describe a theoretical *construct* (the idea of mindfulness), *practices* for cultivating mindfulness (such as meditation), or psychological *processes* (mechanisms of action in the mind and brain). 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). Ultimately, mindfulness cannot be fully captured with words because it's a subtle, nonverbal experience (Gunaratana, 2002). It's the difference between *feeling* a sound in your body and *describing* what you might be hearing.

Therapeutic Mindfulness

A precise definition of mindfulness may further elude us because modern definitions diverge from their multidimensional Buddhist roots

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(Grossman, 2011; Olendzki, 2011), and different traditions within Buddhist psychology don't necesssarily agree on the meaning of mindfulness (Williams & Kabat-Zinn, 2011). Practical approaches to defining mindfulness in clinical settings include discovering commonalities found in various training programs (Carmody, 2009) or investigating what seems to be useful to patients in mindfulness-oriented treatment. In a consensus opinion among experts, Bishop and colleagues (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).

Although attention regulation has received the most consideration in the psychological literature over the past decade, the *quality* of mindful awareness is particularly important in clinical settings, characterized by nonjudgment, acceptance, loving-kindness, and compassion. Jon Kabat-Zinn (2005), the leading pioneer of mindfulness in health care, has defined mindfulness as "open-hearted, moment-to-moment, nonjudgmental awareness" (p. 24). We need a compassionate response to our own pain when we're dealing with intense and unremitting emotions (Feldman & Kuyken, 2011; Germer, 2009). If the therapist or the patient turns away from uncomfortable experience with anxiety or disgust, our ability to work with that experience significantly diminishes.

From the mindfulness perspective, *acceptance* refers to the ability to allow our experience to be just as it is *in the present moment*—accepting both pleasurable and painful experiences as they arise. Acceptance is not about endorsing bad behavior. Rather, moment-to-moment acceptance is a prerequisite for behavior change. "Change is the brother of acceptance, but it is the younger brother" (Christensen & Jacobson, 2000, p. 11). Mindfulness-oriented clinicians also see *self*-acceptance as central to the therapy process (Brach, 2003; Linehan, 1993a). In the words of Carl Rogers, "The curious paradox of life is that when I accept myself just as I am, then I can change" (Rogers, 1961, p. 17).

The short definition of mindfulness we use in this volume is *awareness* of *present experience* with *acceptance*. These three components can be found in most discussions of mindfulness in both the psychotherapy and Buddhist literature. The components are thoroughly comingled in a moment of mindfulness, but in ordinary life the presence of one element of mindfulness doesn't necessarily imply the others. For example, our awareness may be absorbed in the past rather than the present, such as in blind rage about a perceived injustice. We may also have awareness

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without acceptance, such as in the experience of shame. Likewise, acceptance can exist without awareness, as in premature forgiveness; and present-centeredness without awareness may arise in a moment of intoxication. Therapists can use these three elements as a measure of mindfulness in themselves and in their patients. Are we aware of what is arising in and around us, in this very moment, with an attitude of warmhearted acceptance?

MINDFULNESS AND LEVELS OF PRACTICE

Mindfulness must be experienced to be known. People may practice mindfulness with varying degrees of intensity. At one end of a continuum of practice is everyday mindfulness. Even in our often pressured and distracted daily lives, it's possible to have mindful moments. We can momentarily disengage from our activities by taking a long, conscious breath, gathering our attention, and then asking ourselves,

"What am I sensing in my body right now?"
"What am I feeling?"
"What am I thinking?"
"What is vivid and alive in my awareness?"

We don't even need to be calm to have some mindful awareness, such as when we discover, "I'm really angry right now." This is mindfulness in daily life—and how it commonly occurs in psychotherapy as well.

At the other end of the continuum we find monastics and laypeople who spend a considerable amount of time in meditation. When we have the opportunity to sit for sustained periods with closed eyes, in a silent place, sharpening concentration on one thing (e.g., the breath), the mind becomes like a microscope that can detect minute mental activity. The following instruction is an example of intensive meditation practice:

> Should an itching sensation be felt in any part of the body, keep the mind on that part and make a mental note *itching*. . . . Should the itching continue and become too strong and you intend to rub the itching part, be sure to make a mental note *intending*. Slowly lift the hand, simultaneously noting the action of *lifting*, and *touching* when the hand touches the part that itches. Rub slowly in complete awareness of *rubbing*. When the itching sensation has disappeared and you intend to discontinue the rubbing, be mindful of making the usual mental note of *intending*. Slowly withdraw the hand, concurrently making a mental note of the action, *withdrawing*.

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> When the hand rests in its usual place touching the leg, *touching*. (Mahasi, 1971, pp. 5–6)

This level of precise and subtle awareness, in which we can even detect "intending," clearly requires an unusual level of dedication on the part of the practitioner. Remarkably, the instruction above is considered a "basic" instruction. Mahasi Sayadaw writes that, at more advanced stages, "Some meditators perceive distinctly three phases: noticing an object, its ceasing, and the passing away of the consciousness that cognizes that ceasing—all in quick succession" (1971, p. 15).

Moments of mindfulness have certain common aspects regardless of where they lie on the practice continuum. In everyday life, the actual moment of awakening, of mindfulness, is roughly the same for the experienced meditator and the novice. Mindful moments are:

- *Nonconceptual*. Mindfulness is embodied, intuitive awareness, disentangled from thought processes.
- *Nonverbal*. The experience of mindfulness cannot be captured in words because awareness occurs before words arise in the mind.
- *Present-centered*. Mindfulness is always in the present moment. Absorption in thoughts temporarily removes us from the present moment.
- *Nonjudgmental*. Awareness cannot occur freely if we don't like what we are experiencing.
- *Participatory*. Mindfulness is not detached witnessing. It is experiencing the mind and body in an intimate, yet unencumbered, manner.
- *Liberating*. Every moment of mindful awareness provides a bit of freedom from conditioned suffering, a little space around our discomfort.

These qualities occur simultaneously in each moment of mindfulness. Mindfulness *practice* is a conscious attempt to return to the present moment with warmhearted awareness, again and again, with all the qualities listed above. Mindfulness itself is not unusual; *continuity* of mindfulness is rare indeed.

WISDOM AND COMPASSION

Mindfulness is not a goal in itself—the aim of fostering it is freedom from suffering. As mindfulness deepens, wisdom and compassion are likely to arise, and these qualities naturally lead to psychological

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freedom (Germer & Siegel, 2012). For example, mindfulness practice frees us from repetitive thinking, which, in turn, allows us to see how fluid and ever-changing our lives actually are, including our sense of self. This insight liberates us from the constant need to promote ourselves in society and defend ourselves from petty insults. That is considered *wisdom* in Buddhist psychology—insight into impermanence and the illusion of a fixed "self," and understanding how we create misery for ourselves by fighting present-moment reality.

The Greek philosopher Heraclitus wrote, "Applicants for wisdom do what I have done: inquire within" (Hillman, 2003, p. xiii). The Buddha said, "Come and see" (Pali: *ehipassiko*). The close association between contemplative insight and wisdom is why mindfulness meditation is also know as *insight meditation*—the practice of looking within to see things as they are, beneath our conditioned perceptions and reactions, to liberate the heart and mind.

Wisdom and compassion are "two wings of a bird" (Dalai Lama, 2003, p. 56; Germer & Siegel, 2012). *Compassion* refers to the ability to open to suffering (in ourselves and others) along with the wish to alleviate it. It emerges naturally out of wisdom—the deep awareness and acceptance of things as they really are. Compassion can also be directly cultivated through deliberate practices. As therapists, if we feel compassionately toward a patient but have no wisdom, we are liable to become overwhelmed with emotion, unable to see a path out of suffering, and conclude that the treatment is hopeless. Conversely, if we are wise—if we grasp the complex nature of a patient's situation and can see our way through but are out of touch with the patient's despair—our therapeutic suggestions will fall on deaf ears. Therapists need both wisdom and compassion, and can use mindfulness practices to develop them.

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PSYCHOTHERAPISTS AND MINDFULNESS

Mindfulness has gone mainstream in the United States (Ryan, 2012). In a 2007 survey, 9.4% of Americans said they practiced meditation in the past year, up from 7.6% only 5 years earlier (National Center for Complementary and Alternative Medicine, 2007). This is not surprising, given that science is highly influential in modern society and the science community has shown vigorous interest in meditation. In clinical circles, meditation has become one of the most researched psychotherapeutic methods (Walsh & Shapiro, 2006). Clinicians are drawn to mindfulness from a variety of directions: personal, clinical, and scientific.

A Brief History of Mindfulness in Psychotherapy

The formal introduction of Eastern thought to Western philosophy and psychology can be traced to the late 1700s when British scholars began to translate Indian spiritual texts such as the *Bhagavad Gita*. These teachings, along with Buddhist writing, took root in America through the writings of "transcendentalists" such as Henry David Thoreau, who wrote in *Walden* (1854/2012): "I sat in my sunny doorway from sunrise til noon, rapt in reverie. . . . I realized what the Orientals mean by contemplation" (p. 61). In the early 1900s, William James remarked to his class at Harvard College, "This [Buddhist psychology] is the psychology everybody will be studying twenty-five years from now" (Epstein, 1995, pp. 1–2). James's prediction has largely come true, although it was off by a number of years.

The field of psychoanalysis has also flirted with Buddhist psychology for a long time. Freud exchanged letters with a friend in 1930 in which he admitted that Eastern philosophy was alien to him and perhaps "beyond the limits of [his] nature" (cited in Epstein, 1995, p. 2). That did not stop Freud from writing in *Civilization and Its Discontents* (1961a) that the "oceanic feeling" in meditation was an essentially regressive experience. Franz Alexander (1931) added a paper entitled "Buddhist Training as an Artificial Catatonia." Other psychodynamic theorists were more complimentary, notably Carl Jung, who wrote a commentary on the *Tibetan Book of the Dead* in 1927 and had a lifelong curiosity about Eastern psychology.

World War II opened the minds of many Westerners to Asian psychologies, notably Zen Buddhism. Shoma Morita, in Japan, developed a Zen-based residential therapy for anxiety that encouraged patients to experience their fears without trying to change or stop them, very akin to modern, mindfulness-oriented psychotherapy (Morita, 1928/1998). Following the war, D. T. Suzuki dialogued with Erich Fromm and Karen Horney (Fromm, Suzuki, & DeMartino, 1960; Horney, 1945) and inspired visionaries and artists such as Alan Watts, John Cage, and the beat writers Jack Kerouac and Alan Ginsberg. (See McCown, Reibel, & Micozzi, 2011, and Fields, 1992, for more extensive historical reviews of Buddhist psychology in the West.)

The seed of mindfulness was planted in the minds of many therapists who were drawn as young adults in the 1960s and 1970s to Eastern philosophy and meditation as a path to emotional freedom. Fritz Perls (2012) studied Zen in Japan in 1962 and, though disappointed by his experience, remarked, "The experienced phenomenon is the ultimate Gestalt!." In the late 1960s, young people flocked to classes on

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Trancendental Meditation (TM; Mahesh Yogi, 1968/2001; Rosenthal, 2012) as ideas of enlightenment followed the Beatles and other famous pilgrims back from India. Former Harvard psychologist Ram Dass's book *Be Here Now* (1971), a mixture of Hindu and Buddhist ideas, sold over a million copies. Yoga, which is essentially mindfulness in movement (Boccio, 2004; Hartranft, 2003), also traveled west at the time. Gradually, clinicians began connecting their personal meditation practice with their clinical work.

Studies on meditation flourished; for example, cardiologist Herbert Benson (1975) became well known for his use of meditation to treat heart disease. Clinical psychology kept pace with research on meditation as an adjunct to psychotherapy or as psychotherapy itself (Smith, 1975). In 1977, the American Psychiatric Association called for a formal examination of the clinical effectiveness of meditation. The majority of the journal articles at the time studied concentration meditation, such as TM and Benson's *relaxation response*. During the 1990s, however, the preponderance of studies switched to mindfulness meditation (Smith, 2004). Jon Kabat-Zinn opened the Center for Mindfulness in 1979, at the University of Massachusetts Medical School, and taught mindfulness-based stress reduction (MBSR) to treat chronic conditions for which physicians could offer no further help. By 2012, there were over 700 MBSR programs offered worldwide (Center for Mindfulness, 2012) and MBSR had become the main mindfulness training program used in psychological research.

Whereas only 365 peer-reviewed articles on mindfulness appeared in the psychological literature (PsycINFO) in 2005 when the first edition of this book was published, by 2013 there were over 2,200 articles and over 60 mindfulness treatment and research centers in the United States alone (see Figure 1.1).

We now have mindfulness-based structured interventions for treating a broad range of mental and physical disorders, randomized controlled trials supporting these interventions, and reviews and meta-analyses of those studies. Furthermore, sophisticated neurobiological research is demonstrating the power of mind training to change the structure and function of the brain (see Chapter 15). (See *www.mindfulexperience.org* for a comprehensive, regularly updated mindfulness research database.)

We seem to be witnessing the emergence of a new, unified model of psychotherapy based on the construct of mindfulness. Mindfulness is both *transtheoretical* (it appeals to a wide range of therapists, e.g., behavioral, psychodynamic, humanistic, family systems) and *transdiagnostic*

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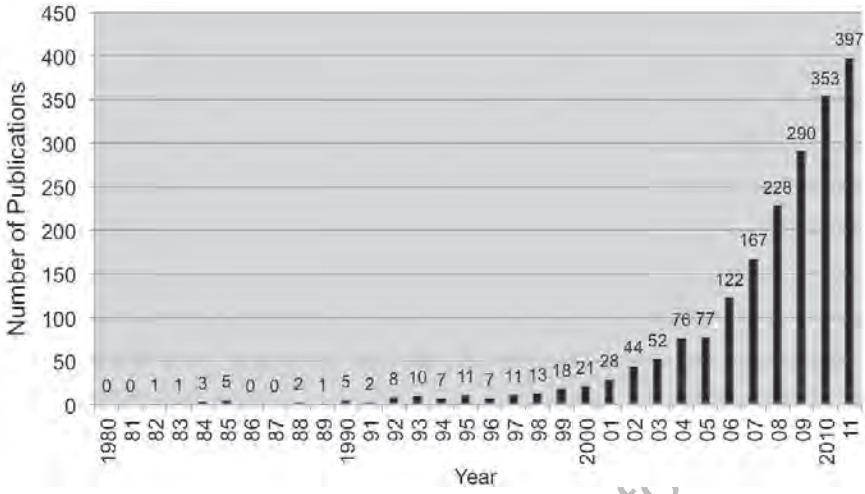

FIGURE 1.1. Number of mindfulness publications by year: 1980–2011. Figure provided by David S. Black, PhD, Institute for Prevention Research, Keck School of Medicine, University of Southern California, and reprinted by permission of the author (*www.mindfulexperience.org*).

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(it appears to alleviate diverse mental and physical disorders). Mindfulness is reconnecting practitioners to their scientific colleagues as empirically supported, mindfulness-based treatment programs and neurobiological research are illuminating how mindfulness alleviates suffering. Therapists are exploring meditation both for personal well-being as well as for cultivating beneficial therapeutic qualities (see Chapters 3 and 5), and patients are seeking therapists who meditate and have a compatible approach to emotional healing. In short, mindfulness appears to be drawing clinical theory, research, and practice closer together and helping to integrate the private and professional lives of therapists.

A Word about Buddhism

Mindfulness lies at the heart of Buddhist psychology. Psychotherapists are likely to find early Buddhist psychology compatible with their interests because it shares the goal of alleviating suffering and the value of empirical inquiry. Whereas Western science explores phenomena through objective, third-person observation, Buddhist psychology is a systematic, first-person approach relatively devoid of a priori assumptions (Wallace, 2007; see also Chapter 2).

It cannot be overemphasized that Buddhist psychology is not a religion in the familiar, theistic sense, although Buddhists in some Eastern cultures worship the Buddha's teachings and image. The historical Buddha (563–483 B.C.E.) is understood to have been a human being, not a god, and his life's work was dedicated to alleviating psychological suffering. According to Buddhist tradition, when he discovered a path to freedom, he decided (reluctantly at first) to teach others what he had learned.

According to legend, when people met the Buddha after his realization/enlightenment, he did not seem quite like other men. When they asked him who he was, he replied that he was "Buddha," which simply meant, *a person who is awake*. He reportedly taught for a total of 45 years and had many students, rich and poor. He spoke in simple language using stories and ideas from popular Indian culture. In his first sermon on the Four Noble Truths, he put forth these foundational ideas:

1. The human condition involves suffering.
2. The conflict between how things are and how we desire them to be causes this suffering.
3. Suffering can be reduced or even eliminated by changing our attitude toward unpleasant experience.
4. There are eight general strategies (the Eightfold Path) to bring suffering to an end (see Chapter 2 and the Appendix).

The Buddha died at age 80, probably from contaminated food eaten at the home of a poor follower.

The Buddha is said to have discovered how to end suffering without any props or religious rituals. Cultures have venerated his image, but the Buddha enjoined his students not to worship him. Students were asked to discover the truth of his teachings *through their own experience*. Belief in notions such as karma or rebirth are unnecessary to derive full benefit from Buddhist psychology (Batchelor, 1997), which is primarily a practical way to know the mind, shape the mind, and free the mind (Nyanaponika, 1965; Olendzki, 2010). Mindfulness is the core practice of Buddhist psychology, and the body of Buddhist psychology—including the Buddha's original teachings and later writings of the *Abhidharma*—can be considered the theoretical basis for mindfulness practice (Bodhi, 2000; Nyanaponika, 1949/1998). Reading early Buddhist texts will convince the clinician that the Buddha was essentially a psychologist.

Chapter 14 and the Appendix of this book provide a more comprehensive historical and conceptual background to mindfulness practice.

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MINDFULNESS PRACTICE

Mindfulness occurs naturally in everyday life, but requires practice to be maintained. We all periodically wake up to our present experience, only to slip quickly back into ordinary discursive thinking. Even when we feel particularly attentive while doing therapy, for example, we are only *intermittently* mindful. Our minds become easily absorbed in associations to what our patients are saying or doing. We may then have a moment of awakening from our reverie, reorient ourselves to the patient, and resume our exploration of what the patient is communicating. Soon, however, we again slip away in distracted thinking. Sometimes the content of our distraction is a meaningful clue to what is occurring in the therapy room. Sometimes it is not. Continuity of mindfulness requires a strong intention and persistence.

Formal and Informal Practice

Mindfulness can be learned through training that is either formal or informal. *Formal mindfulness practice* refers to meditation, and is an opportunity to experience mindfulness at its deepest levels. It's like going to the mental gym. Sustained, disciplined introspection allows the practitioner to train attention, systematically observe the mind's contents, and learn how the mind works.

Informal mindfulness practice refers to the application of mindfulness skills in everyday life. Any mental event can be an object of awareness—we can direct attention to our breathing, listen to ambient sounds in the environment, label our emotions, or notice body sensations while brushing our teeth. Two common exercises for cultivating mindfulness in daily life are mindful walking and mindful eating. In walking meditation, we attend to the sequential, moment-to-moment, kinesthetic sense of walking. From the outside, it looks like a slow-motion movie. On the inside, we are silently noting "lifting . . . stepping . . . placing. . . . " In eating meditation, we eat slowly and silently, noticing the sight of the food on the plate, the sensations of the food in the mouth, the muscle movements of chewing, the flavors of the food, and the process of swallowing. This can make an ordinary meal exceptionally interesting, and is used in mindfulness-based strategies to manage compulsive eating (Kristeller & Wolever, 2011).

There are four foundations of mindfulness in traditional Buddhist practice: (1) the *body*, including breathing and posture; (2) *feeling tone*, such as the pleasant, unpleasant, or neutral quality of sensations; (3)

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states of mind, such as distraction or the arising of pride; and (4) *mental objects*, which include qualities that foster well-being, such as energy and tranquility, or qualities that inhibit wellness, such as anger and sloth. Although the distinction between thoughts and emotions apparently did not exist in the East at the time of the Buddha, mindfulness of emotions is certainly very important in modern psychotherapy.

Three Types of Mindfulness Meditation

Three kinds of meditation are typically taught under the umbrella of *mindfulness meditation* in the West (Salzberg, 2011; see also Chapter 7): (1) focused attention (concentration), (2) open monitoring (mindfulness per se), and (3) loving-kindness and compassion. The first two types have been emphasized in the theory and practice of mindfulness in psychotherapy (Carmody et al., 2011) and in early Buddhist texts. However, the practice of loving-kindness and compassion has generated considerable interest in the last few years (Hofman, Grossman, & Hinton, 2011). Neurological evidence suggests that the mental skills cultivated by these three meditation types represent overlapping, yet distinct, brain processes (Brewer, Mallik, et al., 2011; Desbordes et al., 2012; Dickenson, Berkman, Arch, & Lieberman, 2013; Lee et al., 2012; Leung et al., 2013; Lutz, Slagter, Dunne, & Davidson, 2008; Tang & Posner, 2013), and preexisting brain function might even determine a preference for one practice over another (Mascaro, Rilling, Negi, & Raison, 2013). A common element in all mindfulness meditation techniques is the centrality of openhearted, moment-to-moment awareness.

Focused Attention

Focused attention, or concentration meditation, can be compared to a laser light beam that illuminates any object toward which it is directed. Examples of internal objects of meditation include the sensation of breathing, selected words or phrases, or a single location on the body. Objects of external focus might be an image, a sound, a candle flame, or even a dot on the wall. Concentration is generally easier when the object is pleasant. The instruction for this type of meditation is, "When you notice that your mind has wandered, gently bring it back to [the object of attention]."

Concentration meditation helps cultivate a calm, unruffled mind. (The Pali word for focused attention, *samatha*, connotes both tranquility and concentration.) Our attention becomes steady and relaxed when

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the mind is drawn to a single object, again and again, and away from the many concerns (real and imagined) that occupy us throughout the day. In psychotherapy, focused attention is a way of anchoring the mind when a person is buffeted with strong emotions. We might direct the patient's attention to feeling the sensation of his or her feet touching the floor, or air entering and leaving the lungs. Here is a simple concentration practice.

Breath Meditation

Find a quiet place and sit in a posture that is both upright and relaxed. Take a few slow, easy breaths to settle your body and mind. Then let your eyelids gently close, fully or partially.

- Explore your body with your awareness and try to discover where you can feel your breathing most easily. Some people feel it around the nostrils, perhaps as a cool breeze on the upper lip. Others notice the chest rising and falling most easily, and still others feel the breath in the abdomen as the belly expands and contracts.
- Just feel the physical sensations of breathing in and breathing out.
- When you notice that your mind has wandered, just feel the breath again.
- There is no need to control the breath. Let your body *breathe you*—as it does naturally.
- Don't worry how often your mind wanders. Each time you notice that your attention has gone elsewhere, simply return to the breath as you might redirect a toddler or puppy gone astray.
- When you wish to end your meditation, gently open your eyes.

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Open Monitoring

Open monitoring meditation can be compared to a searchlight (vs. a laser beam in concentration meditation) that illuminates a wider range of objects as they arise in consciousness, one at a time. Being receptive to *whatever* sound in the environment is most evident at a given moment is an example of open monitoring, whereas deliberately listening to the sound of a bell is focused attention.

We can use open monitoring to notice our intentions, sensations, emotions, thoughts, and/or behaviors. A common use of open monitoring in clinical practice is to develop interoceptive awareness of body sensations (Farb, Segal, & Anderson, 2012; Michalak, Burg, & Heidenreich, 2012). Other therapeutic practices label emotions (e.g., *sadness*,

shame, *fear*) and core beliefs (e.g., "I'm unlovable," "I'm defective"), which can help us get a little perspective on our distressing feelings and thoughts. In formal meditation, the transition from focused attention to open monitoring begins when we invite ourselves to "note what took our attention away" when the mind wanders from our chosen object of awareness (e.g., the breath), rather than simply returning to the object. *Noting* can involve a moment of recognition ("aha!") or naming our experience as *thinking*, *judging*, or *worrying*. The instruction for full open monitoring (also referred to as *choiceless awareness*) is to "notice whatever predominates in your field of awareness, moment to moment."

Open monitoring develops the capacity for relaxed awareness in which conscious attention moves naturally among the changing elements of experience. Over time, it helps us develop insight into our personal conditioning and how the mind functions. Whereas concentration calms the mind by focusing on a single object, open monitoring cultivates equanimity in the midst of random and unexpected life events.

Technically speaking, *mindfulness* refers to the skill of open monitoring. The Pali word for open monitoring is *vipassana*, which means *seeing clearly*. The unique feature of vipassana meditation, insight meditation, or mindfulness meditation is open monitoring. However, *mindfulness* is now used more broadly in mainstream Western culture to describe all three meditation skills being described here: (1) focused attention, (2) open monitoring, and (3) loving-kindness and compassion. The following exercise is an open monitoring practice that helps to regulate difficult emotions.

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Mindfulness of Emotion in the Body

Start by finding a comfortable position, close your eyes fully or partially, and take three relaxing breaths.

- Locate your breathing where you can feel it most easily. Feel how the breath moves in the body, and when your attention wanders, gently return to feeling the movement of the breath.
- After a few minutes, start to notice *physical sensations* of stress that you're holding in your body, perhaps in your neck, jaw, belly, or forehead.
- Also notice if you're holding any *difficult emotions*, such as worry about the future or uneasiness about the past. Understand that every human body bears stress and worry throughout the day.
- See if you can *name* the emotion in your body. Perhaps a feeling of sadness, anger, fear, loneliness, or shame? Repeat the label a

few times to yourself in a soft, kind voice, and then return to the breath.

- Now choose a *single location in your body* where stress may be expressing itself most strongly, perhaps as an ache in the heart region or tension in the stomach. In your mind, incline gently toward that spot as you might toward a newborn child.
- Continue to breathe naturally, allowing the sensation to be there, just as it is. Feel your breathing in the midst of your other body sensations.
- Allow the gentle, rhythmic motion of the breath to soften and soothe your body. If you wish, place your hand over your heart as you continue to breathe.
- When you're ready, gently open your eyes.

Loving-kindness and Compassion

Loving-kindness and compassion describe the *quality* of mindful awareness—the attitude or emotion—rather than the direction of awareness. Think of the difference between the light in an operating room versus candlelight at dinner. Loving-kindness warms up the experience of meditation, bringing in the qualities of tenderness, soothing, comfort, ease, care, and connection. These qualities are particularly important when we're dealing with difficult emotions that constrict our awareness and activate our defenses. An example of a loving-kindness (Pali: *metta*) meditation is the slow repetiton of phrases such as "May I be safe" or "May I be happy and free from suffering." The purpose of a loving-kindness meditation is to plant seeds of goodwill toward ourselves and others, over and over, which eventually sprout into positive thoughts, emotions, and behaviors. In the broadest sense, any meditation that evokes a sense of happiness and warmth can be considered loving-kindness meditation.

Loving-kindness is a "state of mind which aspires that all sentient beings may enjoy happiness," whereas compassion (Pali: *karuna*) is "the wish that all sentient beings may be free from suffering" (Dalai Lama, 2003, p. 67). Compassion occurs when loving-kindness meets suffering. Both loving-kindness and compassion are positive emotions that improve our health and well-being (Fredrickson, 2012; Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008; Klimecki, Leiberg, Lamm, & Singer, 2012). They shift our awareness from *worried* attention to *loving* attention and open our field of perception, helping us become more mindful.

In psychotherapy, compassion often takes the form of *self*-compassion. For example, a compassion meditation that includes oneself is the practice of inhaling warmth and tenderness for ourselves with each inbreath, and

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exhaling the same for others with the outbreath (see Chapter 4). This meditation can be practiced by clinicians during difficult moments in therapy, or by our patients in their daily lives. It is a modification of the Tibetan Buddhist *tonglen* meditation in which we breathe in the suffering of others and breathe out compassion for others (Chödrön, 2001).

To enhance self-compassion in traditional loving-kindness meditation (using phrases as the primary focus of attention), the words could change a little, such as "May I be kind to myself" or "May I accept myself as I am," to reflect the presence of suffering, or we can simply place a hand over the heart and feel the warmth and gentle touch (Neff & Germer, in press).

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Loving-kindness Meditation[1]

This exercise is designed to bring warmth and goodwill into your life. Sit in a comfortable position, close your eyes fully or partially, and allow your mind and body to settle with a few deep breaths.

- Put your hands over your heart to remind yourself that you are bringing not only attention, but *loving* attention, to your experience. For a few minutes, feel the warmth of your hands and their gentle pressure over your heart. Allow yourself to be soothed by the rhythmic movement of your breath beneath your hands.
- Now bring to mind a person or other living being who naturally makes you smile. This could be a child, your grandmother, your cat or dog—whoever brings happiness to your heart. Feel what it's like to be in that being's presence. Allow yourself to enjoy the good company.
- Next, recognize how vulnerable this loved one is—just like you, subject to many difficulties in life. Also, this being wishes to be happy and free from suffering, just like you and every other living being. Repeat softly and gently, allowing the significance of your words to resonate in your heart.

  May you be safe.
  May you be peaceful.
  May you be healthy.
  May you live with ease.
- Should you notice that your mind has wandered, return to the image of your loved one. Savor any warm feelings that may arise. Go slowly.

[1]This loving-kindness meditation is adapted from the mindful self-compassion training program codeveloped by Kristin Neff and the author.

- Now visualize your own body in your mind's eye and feel the sensations of your body, just as they are. Notice any discomfort or uneasiness that may be there. Offer kindness to yourself.
  May I be safe.
  May I be peaceful.
  May I be healthy.
  May I live with ease.
- If you wish to use different phrases that speak more authentically to you, please do so. You can ask yourself, "What do I need to hear right now?" Use language that inclines the heart tenderly toward yourself, as if you were relating to a beloved child or a dear friend.
- If and when emotional resistance arises, let it linger in the background and return to the phases, or refocus on your loved one or your breath.
- Whenever you are ready, gently open your eyes.

Practicing the Three Skills

Beginning meditators often have misconceptions about what mindfulness meditation is and does. Mindfulness meditation is not a relaxation exercise; sometimes its effect is quite the opposite, as when the object of awareness is disturbing. It's not a test of your concentration; the nature of the mind is to wander (see *default mode network* in the later section, "Mechanisms of Action"). Mindfulness is not a way to avoid difficulties in life; on the contrary, it brings us closer to our difficulties before we can "decenter" from them. And it does not bypass our personality problems; rather, it is a slow, gentle process of coming to grips with who we are. Finally, mindfulness meditation is not about achieving a different state of mind; it's about settling into our current experience in a relaxed, alert, and openhearted way.

Mindfulness practice may use any of the senses: seeing, hearing, listening, smelling, and touching. The mind itself is also considered a sense organ in Buddhist psychology because thoughts and images can be objects of conscious awareness, similar to the other senses. However, due to the seductive and evanescent nature of thoughts, it's much easier to start mindfulness practice by focusing on bodily sensations, later expanding to noticing emotions in the body or naming emotions, and eventually noticing repetitive thoughts, such as familiar attitudes or core beliefs about oneself.

Typically, mindfulness meditation begins with returning awareness to an object of attention, such as the breath, again and again. When the mind

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settles down, after minutes or days, we can direct our awareness—ply the searchlight—to include other experiences, such as other body sensations, emotions, or thoughts and images. If the mind loses its stability by becoming entangled in regret or worry, we can take refuge in a sensory object any time, perhaps by feeling the rhythmic motion of breathing. Finally, if we find that we're struggling with the process, we can offer ourselves a little compassion with a hand on the heart or kind words. The seasoned mindfulness practitioner may move flexibly from one technique to another, even within a 30-minute meditation, endeavoring to maintain warmhearted, moment-to-moment awareness. The three skills of mindfulness meditation help us to abide peacefully in the midst of all arising experience—pleasant, unpleasant, and neutral.

Many people wonder, "Which is the best practice for me?" Since mindfulness meditation is highly personal, the answer may be found by asking, "What do my mind and heart need at this moment to be more aware, present, and accepting?"

Mindfulness-Oriented Psychotherapy

There are three key ways, along a continuum from implicit to explicit application, to integrate mindfulness into therapeutic work. A clinician may (1) practice mindfulness, formally or informally, to cultivate therapeutic presence; (2) use a theoretical frame of reference informed by insights derived from mindfulness practice, the psychological literature on mindfulness, or Buddhist psychology (mindfulness-*informed* psychotherapy); or (3) explicitly teach patients how to practice mindfulness (mindfulness-*based* psychotherapy). Collectively, we refer to this range of approaches as *mindfulness-oriented* psychotherapy. (See the companion handbook to this volume, *Sitting Together: Essential Skills for Mindfulness-Based Psychotherapy* [Pollak, Pedulla, & Siegel, in press], for detailed guidelines on how to integrate personal practice, clinical theory, and meditation exercises into your clinical practice.)

Practicing Therapist

Aspiring clinicans often ask, "How do I become a mindfulness-oriented psychotherapist?" The simplest answer is, "Get the best clinical training you can find . . . and meditate." The psychological benefits of mindfulness meditation are now well established (Hill & Updegraff, 2012; Hofmann, Sawyer, Witt, & Oh, 2010; Hölzel, Lazar, et al., 2011; Keng, Smoski, & Robins, 2011), including benefits specifically for counselors and health care professionals (Irving, Dobkin, & Park, 2009; Krasner

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et al., 2009; Shapiro, Brown, & Biegel, 2007). Favorable effects include decreased stress and anxiety and enhanced counseling skills such as empathy and compassion (Buser, Buser, Peterson, & Serydarian, 2012; Christopher et al., 2011; Davis & Hayes, 2011). However, research on the impact of therapist mindfulness on patient outcomes remains inconclusive (Excuriex & Labbe, 2011; Ryan, Safran, Doran, & Moran, 2012; see also Chapter 3), perhaps because self-report mindfulness scales are used instead of examining how often a therapist actually meditates. Theoretically, practicing meditation should improve our clinical outcomes because meditation appears to activate brain pathways associated with therapeutic qualities such as body regulation, empathic attunement, balanced emotions, and response flexibility (D. Siegel, 2009a, 2010a).

Mindfulness practice seems related to *therapeutic presence*. Presence is a *way of being* in the consultation room (Brach, 2012a, 2012b; Bruce, Manber, Shapiro, & Constantino, 2010; Childs, 2007; Cigolla & Brown, 2011; Collum & Gehart, 2010; Geller & Greenberg, 2012). It is defined as "an *availability and openness* to all aspects of the client's experience, *openness to one's own experience* in being with the client, and the *capacity to respond* to the client from this experience" (Bugental, cited in Geller & Greenberg, 2002, p. 72). This process can lead a patient to "feeling felt" (Siegel, 2009a, p. 155). Carl Rogers (1961) considered therapeutic presence to subsume empathy, unconditional positive regard, and genuineness. Chapters 3–5 consider these important subjects in greater depth.

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Mindfulness-Informed Psychotherapy

Therapists who practice mindfulness-*informed* psychotherapy have a theoretical frame of reference that is influenced by insights from the practice and study of mindfulness, but they don't necessarily teach mindfulness exercises to patients. Their work usually includes a relational/psychodynamic understanding that values the therapeutic *relationship* as a central vehicle of transformation. Mindful awareness is taught to patients through language, facial expressions, voice tones, and other often subtle microcommunications. Therapists may pay particular attention to ways in which their patients resist mental or emotional experience and how their patients could bring more mindfulness and acceptance to their lives.

Mindfulness-informed psychotherapy borrows ideas from both Western and Buddhist psychology, as well as from the personal experience of practitioners. A number of books integrate mindfulness concepts into relational psychotherapy: see Epstein (2008), Hick and Bien

(2010), Magid (2002), Molino (1998), Safran (2003), Stern (2004), Unno (2006), Wallin (2007), Welwood (2000), and Wilson and Dufrene (2011). Of course, given the potential of human connections to heal emotional wounds (Cozolino, 2010; Karlson, 2011; D. Siegel, 2010a), the therapy relationship can be considered a key component of all forms of mindfulness-oriented psychotherapy.

Mindfulness-Based Psychotherapy

Mindfulness-*based* therapists teach their patients mindfulness exercises that can be practiced between sessions. It makes sense for patients to practice mindfulness between sessions because the benefits of mindfulness appear to be *dose-dependent* (Lazar et al., 2005; Pace et al., 2009; Rubia, 2009), and 1 hour per week of therapeutic mind training may not suffice for some troubled individuals. Daily formal and informal meditation practice could increase that number to 6 or 7 hours per week. Mindfulness-based clinicians often include techniques drawn from the cognitive-behavioral tradition, and mindfulness-based treatment protocols have been developed for a wide range of psychological conditions (see the section "Mindfulness Model of Therapy" below). The proliferation of structured treatments is encouraging clinicians to experiment with mindfulness exercises in therapy even if they utilize only a few elements of a given protocol.

There are now hundreds of excellent professional and self-help books that teach skills applicable to mindfulness, acceptance, and compassion-based therapy, including these: Brach (2012b, 2013), Didonna (2009), Forsyth and Eifert (2008), Germer (2009), Hanson and Mendius (2009), Harris and Hayes (2009), Hayes and Smith (2005), Kabat-Zinn (1990, 2005, 2011), Kabat-Zinn and Kabat-Zinn (1998), Koerner and Linehan (2011), Linehan (1993b), McCown and colleagues (2011), Neff (2011), Orsillo and Roemer (2011), Pollak and colleagues (in press), Salzberg (2011), Segal, Williams, and Teasdale (2012), R. Siegel (2010), Stahl and Goldstein (2010), Willard (2010), and Williams, Teasdale, Segal, and Kabat-Zinn (2007).

THE MINDFULNESS MODEL OF PSYCHOTHERAPY

When therapists are asked, "What is your theoretical orientation?", they typically respond by mentioning cognitive-behavioral, psychodynamic/psychoanalytic, humanistic/existential, or systems-oriented

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psychotherapy. Increasingly, however, the answer seems to be *mindfulness*. Therapists who have not felt entirely at home with existing theories of psychotherapy often remark, after discovering mindfulness-oriented therapy, "Oh, that's what I do already—I just didn't know it!" So is it useful to think of mindfulness (including acceptance and compassion) as a new model of therapy?

Theories or models of therapy are an attempt to cluster together different therapies based on common characteristics. A psychotherapeutic model generally includes the following elements (Gurman & Messer, 2011; Wampold, 2012): (1) a worldview, (2) an understanding of pathology and health, (3) an approach to the practice of therapy, (4) an understanding of the therapeutic relationship, (5) identifiable mechanisms of action, (6) a range of treatment applications, (7) ethical considerations, and (8) research support.

An argument can be made that mindfulness is not a model of therapy at all, but merely a curative process that underlies all therapies. For example, don't systematic desensitization of a snake phobia, emotion regulation in DBT, and free association in psychoanalysis share the common process of *awareness* of *present experience* with *acceptance*? Additionally, perhaps mindfulness should be left alone—allowed to be an elusive, preconceptual construct that inspires direct, personal inquiry. Why try to systematize it, creating a straw figure that we subsequently need to dismantle to keep mindfulness alive in the therapy room? Perhaps mindfulness is really a "model of no-model" (P. R. Fulton, personal communication, January 12, 2013)? With these cautions in mind, we invite our readers to explore a *middle way*. Can mindfulness as a model of therapy advance our understanding, even as we hold our constructions lightly and return regularly to the moment-to-moment, felt sense of being in the therapy room?

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Worldview

All psychological theories and therapies are embedded in metatheories or worldviews. Each of us has a world view, an inclination to perceive the world in a particular way (Johnson, Germer, Efran, & Overton, 1988). The metatheoretical frame of reference for mindfulness is *contextualism* (Hayes, 2002a; Pepper, 1942).

Worldviews explain the nature of reality (ontology), describe how we know reality (epistemology), account for causality, and contain a concept of personality. The contextual worldview makes the following assumptions:

- *Nature of reality.* Activity and change are fundamental conditions of life. The world is an interconnected web of activity.
- *How we know reality.* All knowledge of reality is constructed, created by each individual within a particular context. There is no absolute reality that we can know.
- *Causality.* Change is continuous and events are multidetermined. Apparent causality depends on its context.
- *Personality.* The personality is best described as single moments of awareness continuously cobbled together to form a functional, coherent whole.

Buddhist Psychology and Contextualism

The assumptions of Buddhist psychology closely correspond to the contextual worldview. We need only to turn to the three characteristics of existence in Buddhist psychology: (1) suffering (*dhukka* in Pali), (2) impermanence (*anicca*), and (3) no-self (*anatta*). *Suffering* refers to the dissatisfaction we inevitably feel when things are not as we wish them to be. Our likes and dislikes are co-constructed with the environment, but we can become substantially happier by changing our *relationship* to experience. The Buddhist notion of *impermanence* is precisely the ontology of contextualism—everything is constantly changing, including who we think we are. Finally, the condition of *no-self* (no fixed, separate self) is also the contextual view of personhood. The *self* is "an orchestra without a conductor" (Singer, 2005) consisting of many parts spontaneously co-arising and disappearing. (More will be said about these characteristics of existence in the following chapters.) Another key concept in Buddhist philosophy is *dependent co-origination*, which is a fancy expression for a multidetermined universe—causality in contextualism. The most accurate causal description of any event would be the *universe of interacting causes* at a particular point in time.

Pathology and Health

Buddhist psychology assumes that the way we construct our private realities is mostly delusional; we unconsciously elaborate on current events based on our past experience and current desires, leading to errors and unnecessary suffering. The antidote—mindful attention—allows us to understand our conditioning and to see things more clearly. What we see, however, is not some absolute truth; rather, we see *through* the delusion of our conceptualizations. Noticing this tendency toward

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delusionary thoughts and beliefs, we learn to hold our constructions more lightly.

This new, softer approach to our own conceptions extends to our view of symptoms. Complaints, problems, or symptoms are not stable entities that are to be diagnosed and then excised. What creates and sustains symptoms is *resistance*, that is, our instinctive, often preverbal tendency to ward off discomfort by tensing our muscles, thinking too much, drinking too much, or engaging defenses to reestablish our equilibrium. This kind of *experiential avoidance* (Hayes, Strosahl, & Wilson, 1999) may help in the short run, but it keeps us frozen in place and amplifies our difficulties in the long run. Consider the dictum, "What we resist, persists." A good example is "trying to fall asleep"—sustained efforts to fight sleeplessness are likely to result in chronic insomnia (see Chapter 10). Our level of emotional suffering can be measured by the gap between our expectations and reality (what *is*).

In contrast, consider this dictum: "What we can *feel*, we can heal." Psychological health in the mindfulness paradigm is the capacity to be with moment-to-moment experience in a spacious, deeply accepting way, even when it's difficult. This state of mind is accompanied by healthy psychological qualities such as psychological flexibility, resilience, authenticity, patience, connection, kindness, compassion, and wisdom.

Practice of Therapy

All patients come to therapy with a resistant relationship toward their symptoms. The two main questions in the mind of a mindfulness-oriented psychotherapist are likely to be:

1. What pain is the patient resisting?
2. How can I help the patient find a more mindful, accepting, and compassionate relationship to his or her pain?

Therapy can take an infinite variety of forms, such as an authentic, compassionate dialogue; exposure therapy; cognitive restructuring; meditation; engaging in healthy activities; or prescribing medication. Regardless of the form, from a mindfulness perspective we're not seeking a life free of pain, but rather greater emotional freedom through a mindful, accepting, compassionate relationship to our inevitable difficulties.

It's a tall order to expect our patients to embrace their emotional distress overnight. Rather, we want to help them gradually be open to

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what's bothering them, moving from *curiosity* (turning toward discomfort), to *tolerance* (safely enduring discomfort), to *allowing* (letting discomfort come and go), to *friendship* (finding hidden value in our difficulties). This process reflects progressively relinquishing resistance.

The Therapeutic Relationship

Mindfulness-oriented psychotherapy is *idiographic*—that is, the structure and process depend on the unique qualities and capacities of the individual patient in his or her world. Just as the instructions for mindfulness meditation are to "notice what is most vivid and alive in your field of awareness," the mindfulness-oriented therapist is attuned to what is most alive for the patient, as well as what is simultaneously transpiring in the therapist's moment-to-moment experience and the ever-changing therapeutic alliance. Part II of this book explores the therapeutic relationship in greater depth.

Mechanisms of Action

How does mindfulness work? Various processes have been proposed from theoretical and neurological perspectives. For example, Hölzel, Lazar, and colleagues (2011) have identified six mechanisms of action—effects of formal mindfulness practice—for which we have neurological evidence:

1. *Attention regulation*—stability of awareness in spite of competing input
2. *Body awareness*—noticing subtle sensations, being conscious of one's emotions
3. *Emotion regulation*—decreased reactivity, not letting emotional reactions interfere with performance
4. *Reappraisal*—seeing difficulties as meaningful or benign, rather than as all bad
5. *Exposure*—global desensitization to whatever is present in the field of awareness
6. *Flexible sense of self*—disidentification with emotions and increasing adaptivity

Additional mechanisms with empirical support include *self-compassion* (Hölzel, Lazar, et al., 2011; Neff & Germer, 2013), *values clarification (*sense of purpose) and *flexibility* (cognitive, emotional, and

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behavioral adaptiveness) (Hayes et al., 1999; Shapiro, Carlson, Astin, & Freedman, 2006); *emotion differentiation* (awareness of emotional experiences) (Hill & Updegraff, 2012); and *metacognitive awareness* (Cocoran, Farb, Anderson, & Segal, 2010).

An important neurobiological effect of mindfulness meditation is that it deactivates the *default mode network* (DMN). Even when the brain is at rest, several regions along the midline of the brain remain active (Gusnard & Raichle, 200; Mason et al., 2007). The DMN is active whenever our minds wander—which, according to one study, happens 46.9% of our waking lives (Killingsworth & Gilbert, 2010) and very often in meditation as well. What is the mind doing? Mostly it seems to be taking excursions into the past and the future, trying to resolve problems both real and imagined. These excursions are good for survival purposes but less helpful for happiness, and activity in the DMN correlates with anxiety and depression (Broyd et al., 2009; Farb et al., 2010). The DMN is responsible for *narrative processing* (I–me–mine). In contrast, the moment-to-moment awareness of mindfulness activates different brain structures associated with *experiential processing* (Farb et al., 2007; see also Chapter 15). All three forms of mindfulness meditation described earlier—focused attention, open monitoring, and loving-kindness/compassion—help to deactivate the DMN (Brewer, Worhunsky, et al., 2011) or change its functional connectivity (Taylor et al., 2013).

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Treatment Applicability

Mindfulness can be used to treat a wide range of disorders, from psychosis (Braehler et al., 2012; Langer, Cangas, Salcedo, & Fuentes, 2012) to stress management at the workplace (Davidson et al., 2003). And as a universal, healing capacity, mindfulness is making bedfellows of diverse approaches to mental health such as CBT, psychodynamic psychotherapy, humanistic/existential psychotherapy, behavioral medicine, and positive psychology.

Cognitive-Behavioral Therapy

CBT is the form of treatment that has been most extensively investigated empirically. We are currently in the "third wave" of CBT (Hayes, 2011). The first wave 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

wave is mindfulness, acceptance, and compassion-based psychotherapy, in which our *relationship* to our experience (intentions, sensations, emotions, feelings, behaviors) gradually shifts in the course of therapy.

The four pioneering, empirically supported, multicomponent, mindfulness-based treatment programs are mindfulness-based stress reduction (MBSR; Kabat-Zinn, 1990), mindfulness-based cognitive therapy (MBCT; Segal et al., 2012), dialectical behavior therapy (DBT; Linehan, 1993a), and acceptance and commitment therapy (ACT; Hayes et al., 1999). Many other mindfulness programs have grown out of these templates or were developed for specific populations, conditions, or skills training. These include mindfulness-based relapse prevention (Witkiewitz & Bowen, 2010); mindfulness-based eating awareness training (Kristeller & Wolever, 2011); MBCT for children (Semple, Lee, Rosa & Miller, 2010); MBSR for teens (Biegel, Brown, Shapiro, & Schubert, 2009); mindfulness and acceptance-based behavioral treatment of anxiety (Roemer, Orsillo, & Salters-Pedneault, 2008; see also Chapter 9); mindfulness-based relationship enhancement (Carson, Carson, Gill, & Baucom, 2004); mindful self-compassion training (Neff & Germer, 2013); and compassion-focused therapy (Gilbert, 2010a, 2010b).

Furthermore, the field of CBT has largely adopted the core concepts of mindfulness even in treatments where the word *mindfulness* isn't used, such as the "unified protocol for the transdiagnotic treatment of emotional disorders," by David Barlow and colleagues, which 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 (see Farchione et al., 2012).

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Psychodynamic Psychotherapy

As mentioned earlier, psychodynamic theorists have recognized the value of Buddhist psychology at least since the time of Carl Jung (1927/2000). Psychoanalysis has historically shared common features with mindfulness practice—they are both introspective ventures, they assume that awareness and acceptance precede change, and they both recognize the importance of unconscious processes. The next chapter explores more fully the commonalities and differences between a traditional psychodynamic/psychoanalytic approach to treatment and the mindfulness perspective.

Humanistic/Existential Psychotherapy

Mindfulness practice was originally intended to address the suffering of existential conditions such as sickness, old age, and death—not clinical conditions since this category did not exist in the Buddha's time. Mindfulness has much in common with humanistic psychotherapy, which broadly encompasses existential, constructivist, and transpersonal approaches (Schneider & Leitner, 2002). The existential approach, like Buddhist psychology, "emphasizes the person's inherent capacities to become healthy and fully functioning. It concentrates on the present, on achieving consciousness of life as being partially under one's control, on accepting responsibility for decisions, and on learning to tolerate anxiety" (Shahrokh & Hales, 2003, p. 78).

For example, Gestalt therapy emphasizes phenomenological exploration (e.g., "I see that you crossed your legs") without interpretation or valuation, leading to the goal of simple awareness (Yontef, 1993). Hakomi was one of the first therapies to explicitly train mindfulness through body awareness of feelings, beliefs, and memories (Kurtz, 1990). The *focusing* work of Eugene Gendlin (1996), especially his idea of the preverbal, bodily *felt sense* of a psychological problem, is strikingly similar to interoceptive awareness training in mindfulness meditation. Sensorimotor psychotherapy (Ogden, Minton, & Pain, 2006) and emotion-focused therapy (Greenberg, 2010) also carefully direct a patient's attention to arising emotional experience. Constructivist psychotherapies, such as narrative therapy (Leiblich, McAdams, & Josselson, 2004), share the mindfulness-oriented notion that each person's reality is co-created by the individual in interaction with the environment. Transpersonal therapy and Buddhist psychology hold the common assumption that the person is indivisible from the wider universe, a theme that is explored in later chapters.

Behavioral Medicine

The health benefits of mindfulness seem to derive from a less reactive autonomic nervous system—in short, being less stressed. For example, meditation training significantly reduces cortisol in response to acute stress, compared to relaxation training (Tang et al., 2007). Mindfulness practice may also help patients maintain healthy habits: Asthma patients may be able to detect emotional states that can trigger attacks, diabetes patients might be more conscientious taking their insulin, and obese patients may be able "urge surf" when they feel hungry rather than acting upon the urge to eat (Bowen, Chawla, & Marlatt, 2011).

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Mindfulness meditation has also been shown to improve immune function (Davidson et al., 2003) and both compassion meditation and mindfulness meditation have been shown to reduce stress-induced inflammation (Pace et al., 2009; Rosenkranz et al., 2013). Mindfulness training is even being integrated into biofeedback (Khazan, 2013).

Randomized controlled trails have demonstrated improvement through mindfulness training for a long list of ailments/conditions: irritable bowel syndrome (Zernicke et al., 2012), coping with diabetes (Gregg, Callaghan, Hayes, & Glenn-Lawson, 2007), coping with cancer (Hoffman et al., 2012), chronic pain (Wong et al., 2011), work stress (Wolever et al., 2012), chronic fatigue syndrome (Rimes & Winigrove, 2011), stress eating (Daubenmier et al., 2011), HIV quality of life (Duncan et al., 2012), smoking cessation (Brewer, Mallik, et al., 2011), hot flashes (Carmody et al., 2011), insomnia (Gross et al., 2011), effects of chronic medical disease (Bohlmeijer, Prenger, Taal, & Culjpers, 2010), and substance use disorders (Witkiewitz, Bowen, Douglas & Hsu, 2013). (See also Chapter 10.)

Spirituality

Spirituality has many meanings; we understand the word to refer to an appreciation of intangible, yet meaningful, aspects of our lives. The intangibles may be God, a life force, values (love, truth, peace), interpersonal connections, or perhaps a sense of transcendence.

Buddhist psychology offers an *immanent* approach to spirituality, suggesting that what we seek is happening right in front of our noses, in intimate contact with day-to-day experience. The thrust of spiritual aspiration within this immanent approach is to embrace each moment more wholeheartedly. In contrast, a *transcendent* approach is a "trickle-down" methodology in which repeated experiences of mystical union (e.g., closeness to God) gradually make our daily experience more complete. Although mystical states may occur during mindfulness meditation, they are still considered mental events and, hence, are not accorded special status. From the mindfulness perspective, freedom from suffering occurs when no mental events can snag our consciousness, even ecstatic ones. A balanced approach to spirituality probably entails both immanent and transcendent aspects—we live fully in our daily experience as we reach for what is beyond.

Positive Psychology

In Buddhist psychology, mental health is seen as complete freedom from suffering, generally referred to as *enlightenment*. From this perspective, we are all mentally ill!

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Western psychology has made remarkable progress in understanding the biological, psychological, and social roots of a troubled mind, but it has generally neglected positive experiences such as those characterized by well-being, contentment, love, courage, spirituality, wisdom, altruism, civility, and tolerance (Seligman & Csikszentmihalyi, 2000). Buddhist psychology is a comprehensive mind training program that cultivates happiness, and mindfulness is at the core of the program. There is a curious paradox in the Buddhist approach to positive psychology: The more fully we can embrace *un*happiness, the deeper and more abiding our sense of well-being. (Positive psychology is discussed further in Chapter 16.)

Ethical Issues

Buddhist psychology does not distinguish between "good" and "bad" actions, which are often merely social conventions, but rather between "wholesome" and "unwholesome" actions. *Wholesome actions* are those that diminish suffering for oneself and others, whereas *unwholesome actions* increase suffering. Mindful attention allows us to carefully observe the consequences of our thoughts, words, and deeds. This harming–nonharming ethical distinction is entirely consistent with a secular psychotherapeutic agenda.

Within mindfulness, acceptance, and compassion-based psychotherapy, *values* have a high priority. ACT, for example, includes exercises for patients to discover their core values ("What do you want your life to stand for?") and to identify obstacles to achieving those goals ("Are you willing to openly experience what gets in your way?"). Our *intentions* often determine our emotions, thoughts, words, and actions, so they are also an important object of awareness in both mindfulness training (Monteiro, Nutall, & Musten, 2010) and psychotherapy (see Chapter 6).

Research Support

In her 2003 review of the empirical literature on mindfulness, Ruth Baer wrote that mindfulness-based treatments are "probably efficacious" and en route to becoming "well established." Since then, numerous reviews and meta-analyses of the outcome research clearly indicate that mindfulness, acceptance, and compassion-based treatments effectively promote mental and physical health (Chen et al., 2012; Chiesa, Calati & Serretti, 2011; Davis & Hayes, 2011; Fjorback, Arendt, Ornbol, Fink, & Walach, 2011; Greeeson, 2009; Grossman, Niemann, Schmidt, & Walach, 2004;

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Hoffman et al., 2010, 2011; Keng et al., 2011; Piet & Hougaard, 2011; Rubia, 2009; Vøllestad, Nielsen, & Nielsen, 2012). However, although mindfulness research is quite advanced, there is still an urgent need for active control groups in outcome research and behavioral measures of mindfulness rather than reliance on self-report (Grossman, 2011; see also Chapter 15).

Exciting new areas of research are continuously emerging. Among them are topics closely associated with mindful awareness, such as the impact of compassion, wisdom, and ethical behavior on mental health. In the field of neurobiology, we might explore more precisely the links between specific, self-reported mind states and their neurological substrates, maybe even adding real-time functional MRI neurofeedback to augment the brain-changing effects of meditation. Can we learn to customize mind training techniques to alter dysfunctional brain patterns of individual patients? The impact of mindfulness practice on gene expression is another scientific frontier, perhaps even as stress prophylaxis for the next generation? We still need additional research on the short- and long-term effects of the meditating therapist on treatment outcome. Finally, it may be fruitful to investigate the outer reaches of mindfulness—to what extent can human beings actually regulate their attention, attitudes, and emotions, and how might these enhanced capacities impact the quality of our lives and society in general?

DOES MINDFULNESS MATTER TO THERAPISTS?

In light of the exponential increase in professional publications on mindfulness since the new millennium began, mindfulness clearly matters to clinical scientists and practitioners. Padmasambhava, an eighth-century Tibetan teacher, said that "when the iron bird flies, the dharma [Buddhist teachings] will come to the West" (cited in Henley, 1994, p. 51). We are currently witnessing an unprecedented convergence of the Eastern traditions of contemplative psychology with modern scientific psychology and psychotherapy.

Psychotherapists are on the vanguard of that important convergence. To have at our disposal psychological techniques drawn from a 2,500-year-old tradition that appear to change the brain, shape our behavior for the better, and offer intuitive insights about how to live life more fully, is an opportunity that is difficult to ignore. Only time will tell what we make of it.

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The remainder of this book explores how the simple human capacity for mindfulness may enrich our understanding and effectiveness as psychotherapists. The next chapter considers commonalities and divergences between the Buddhist tradition of mindfulness and Western psychotherapy. Part II examines how mindfulness can be cultivated by the psychotherapist and its effect on the therapy relationship. Part III explores the application of mindfulness to particular psychological conditions and patient populations. Part IV discusses the ancient Buddhist teachings on mindfulness, summarizes what we've learned about mindfulness from neuroscience, and explores the future of mindfulness within positive psychology. Finally, the Appendix provides a glossary of Buddhist terms.

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