CHAPTER 1

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 (1872/2004)

Psychotherapists are in the business of alleviating emotional suffering. Suffering arrives in innumerable guises: 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, such as 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 seemingly 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 ac-

complish this goal, although therapy does not necessarily proceed as expected.

For example, a young woman with panic disorder—let's call her Lynn—might call 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). Is there an essential ingredient active across various modalities that can be isolated and refined? Mindfulness may prove to be that ingredient.

MINDFULNESS: A SPECIAL RELATIONSHIP TO SUFFERING

Successful therapy changes the patient's *relationship* to his or her particular form of suffering. Obviously, if we are less upset by events in our lives, then our suffering will decrease. But how can we become less disturbed by *unpleasant* experiences? Life includes pain. Do the body and mind not instinctively react to 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 level of suffering is reduced and our sense of well-being increases.

To be mindful is to wake up, to recognize what is happening in the present moment. We are rarely mindful. We are usually caught up in dis-

tracting thoughts or in opinions about what is happening in the moment. This is mind*less*ness. Examples of mindlessness (adapted from Brown & Ryan, 2003) include:

- 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 have 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 are mindful, our attention is not entangled in the past or future, and we are not judging or rejecting what is occurring at the moment. We are present. 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 an example of 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 daydream, unaware that we are indeed daydreaming, our daily lives can become a nightmare. Some of our patients feel as if they are stuck in a movie theater, watching the same upsetting movie their whole lives, unable to leave. Mindfulness can help us to step out of our conditioning and see things freshly—to see the rose as it is.

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 to read these words. A teakettle whistling in the background may eventually command your attention when 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 being 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 requires the *intention* to disentangle from our reverie and fully experience the moment.

Therapeutic Mindfulness

The word *mindfulness* can be used to describe a theoretical construct (mindfulness), a practice of cultivating mindfulness (such as meditation), or a psychological process (being mindful). 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 Thera, 1972, p. 5); attentional control (Teasdale, Segal, & Williams, 1995); "keeping one's complete attention to the experience on a moment-to-moment basis" (Marlatt & Kristeller, 1999, p. 68); and, from a more Western psychological perspective, a cognitive process that employs creation of new categories, openness to new information, and awareness of more than one perspective (Langer, 1989). Ultimately, mindfulness cannot be fully captured with words, because it is a subtle, nonverbal experience (Gunaratana, 2002).

When mindfulness is transported to the therapeutic arena, its definition often expands to include *nonjudgment*: "the awareness that emerges through paying attention on purpose, in the present moment, and

nonjudgmentally to the unfolding of experience moment to moment" (Kabat-Zinn, 2003, p. 145). In her summary of the mindfulness and psychotherapy literature, Baer (2003, p. 125) defines *mindfulness* as "the non-judgmental observation of the ongoing stream of internal and external stimuli as they arise." Nonjudgment fosters mindfulness when we are dealing with difficult physical or emotional states. By not judging our experience, we are more likely to see it as it is.

Mindfulness and Acceptance

"Acceptance" is an extension of nonjudgment. It adds a measure of kindness or friendliness. When therapists are working with intense emotions, such as shame, anger, fear, or grief, it is essential that we maintain an open, compassionate, and accepting attitude. Empathy and positive regard are important relational aspects of successful therapy (Norcross, 2001, 2002) that overlap with acceptance. If either the therapist or the patient turns away from unpleasant experience with anxiety or revulsion, the ability to understand the problem is likely to be compromised.

From the mindfulness perspective, *acceptance* refers to a willingness to let things be just as they are the moment we become aware of them—accepting pleasurable and painful experiences as they arise. Acceptance is not about endorsing maladaptive behavior. Rather, acceptance precedes behavior change. "Change is the brother of acceptance, but it is the younger brother" (Christensen & Jacobson, 2000, p. 11). Mindfulness-oriented clinicians see "radical acceptance" as part of therapy practice (Brach, 2003; Linehan, 1993b).

Mindfulness in Psychotherapy

The short definition of *mindfulness* we use in this volume is (1) *awareness*, (2) *of present experience*, (3) *with acceptance*. These three elements can be found in most discussions of mindfulness in both the psychotherapy and the Buddhist literature. (For detailed consideration of the contruct of mindfulness within psychology, see Bishop et al., 2004; Brown & Ryan, 2004; and Hayes & Feldman, 2004.) Although our definition has these three distinct components, they are irreducibly intertwined in the experience of mindfulness.

The presence of one aspect of mindfulness does not automatically imply the presence of others. For example, awareness may be absorbed in the past, such as in blind rage about a perceived injustice. Awareness may also be present without acceptance, such as in disowned shame. Likewise, acceptance can exist without awareness, as in premature forgiveness; while present-centeredness without awareness may exist in a

moment of intoxication. All components of mindfulness—awareness, present-centeredness, and acceptance—are required for a moment of full mindfulness. Therapists can use these three elements as a touchstone for identifying mindfulness in therapy.

The value of a stripped-down, operational definition of *therapeutic mindfulness* is twofold. First, if mindfulness indeed reveals itself to be a key ingredient of effective psychotherapy (Martin, 1997), then clinicians will want a conceptual tool to guide their movements in the consultation room. Second, if outcome research continues to show mindfulness to be a promising treatment strategy (Baer, 2003), then researchers will need a definition with clearly defined component parts to design new interventions.

Mindfulness and Levels of Practice

Mindfulness has to 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 is possible to have mindful moments. We can momentarily disengage from our activities by taking a long, conscious breath. After gathering our attention, we can ask ourselves: "What am I feeling right now? What am I doing right now? What is most compelling to my awareness right now?" This is mindfulness in daily life, and it is how mindfulness commonly occurs in psychotherapy.

At the other end of the continuum we find monks, nuns, and laypeople who spend a considerable amount of time in meditation. When we have the opportunity to sit over sustained periods of time with closed eyes, in a silent place, and sharpen concentration on one thing (such as the breath), the mind becomes like a microscope and can detect minute mental activity. This is illustrated by the following meditation instruction:

> 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*. When the hand rests in its usual place touching the leg, *touching*. (Sayadaw, 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. 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. The actual moment of awakening, of mindfulness, is the same for the experienced meditator as for the beginner practicing mindfulness in everyday life. The experience is simply more continuous for experienced meditators. Mindful moments are:

- *Nonconceptual.* Mindfulness is awareness without absorption in our thought processes.
- *Present-centered.* Mindfulness is always in the present moment. Thoughts *about* our experience are one step removed from the present moment.
- *Nonjudgmental.* Awareness cannot occur freely if we would like our experience to be other than it is.
- *Intentional.* Mindfulness always includes an intention to direct attention somewhere. Returning attention to the present moment gives mindfulness continuity over time.
- *Participant observation.* Mindfulness is not detached witnessing. It is experiencing the mind and body *more* intimately.
- *Nonverbal.* The experience of mindfulness cannot be captured in words, because awareness occurs before words arise in the mind.
- *Exploratory.* Mindful awareness is always investigating subtler levels of perception.
- *Liberating.* Every moment of mindful awareness provides freedom from conditioned suffering.

These qualities occur simultaneously in each moment of mindfulness. Mindfulness practice is a conscious attempt to return awareness more frequently to the present, with all the qualities of awareness listed. Mindfulness per se is not unusual; *continuity* of mindfulness is rare indeed.

Everyday mindfulness allows us to develop insight into psychological functioning and to respond skillfully to new situations. Mindfulness in deep meditation provides insights into the nature of mind and the causes of suffering. These insights, such as awareness of how impermanent things really are, help us become less entangled in our ruminations and thereby foster more mindfulness.

PSYCHOTHERAPISTS AND MINDFULNESS

Clinicians are drawn to the subject of mindfulness and psychotherapy from a variety of directions: clinical, scientific, theoretical, and personal. In addition, psychotherapy patients are increasingly seeking therapists who might understand their meditation practice. These developments are not surprising given that Buddhist psychology and its core practice, mindfulness, have been growing in popular appeal in the West.

A Brief History of Mindfulness in Psychotherapy

The field of psychoanalysis has flirted with Buddhist psychology for some 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* (1930/1961b) that the "oceanic feeling" in meditation was an essentially regressive experience. Franz Alexander (1931) wrote a paper entitled "Buddhist Training as an Artificial Catatonia." Other psychodynamic theorists were more complimentary, notably Carl Jung (1939/1992), who wrote a commentary on the *Tibetan Book of the Dead* in 1939 and had a lifelong curiosity about Eastern psychology. Later, Erich Fromm and Karen Horney dialogued with Zen scholar, D. T. Suzuki (Fromm, Suzuki, & DeMartino, 1960; Horney, 1945). In 1995, Mark Epstein wrote *Thoughts without a Thinker*, which triggered new interest in Buddhist psychology among psychodynamic clinicians.

Many practicing therapists took to Eastern philosophy or meditation as a way of improving their lives before beginning their professional careers. Some started to meditate in the late 1960s, at a time when ideas of enlightenment followed the Beatles and other famous pilgrims back to the West from India. Former Harvard psychologist Ram Dass's book, *Be Here Now* (1971), a mixture of Hindu and Buddhist ideas, sold over 1 million copies. Yoga, which is essentially mindfulness in movement (Boccio, 2004; Hartranft, 2003), also traveled West at the time. Some therapists began trying to connect their personal practice of meditation with their clinical work.

Studies on meditation flourished, including cardiologist Herbert Benson's (1975) use of meditation to treat heart disease. Clinical psychology kept pace with numerous articles on meditation as an adjunct to psychotherapy or as psychotherapy itself (Smith, 1975). In 1977, the American Psychiatric Association called for an examination of the clinical effectiveness of meditation. The majority of the journal articles at the time studied concentration meditation, such as transcendental medita-

tion and Benson's program. In the last 10 years, the preponderance of studies has switched to mindfulness meditation (Smith, 2004). Jon Kabat-Zinn established the Center for Mindfulness in 1979, at the University of Massachusetts Medical School, to treat chronic conditions for which physicians could offer no further help. Over 15,000 patients have completed this mindfulness-based stress reduction (MBSR) program, not counting participants in over 250 MBSR programs around the world (Davidson & Kabat-Zinn, 2004).

An exciting, more recent area of integration for mindfulness and psychotherapy is in scientifically validated, mindfulness-based interventions. The original impetus seems to stem from the pioneering work of Kabat-Zinn's (1990) MBSR program and Marsha Linehan's Zen-inspired dialectical behavior therapy (1993a). The publication by Teasdale et al. in 2000 of an effective mindfulness-based treatment for chronic depression kindled interest in mindfulness among cognitive-behavioral researchers. The potential of these mindfulness and acceptance-based approaches is ushering in a new wave of empirically based treatments for familiar problems (Hayes, Follette, & Linehan, 2004; Hayes, Masuda, Bissett, Luoma, & Guerrero, 2004).

Where is the current interest in mindfulness heading? We may be witnessing the emergence of a more unified model of psychotherapy. We are likely to see more research that identifies mindfulness as a key element in treatment protocols, as a crucial ingredient in the therapy relationship, and as a technology for psychotherapists to cultivate personal therapeutic qualities and general well-being. Mindfulness might become a construct that draws clinical theory, research, and practice closer together, and helps integrate the private and professional lives of therapists.

THERAPIST WELL-BEING

Although mindfulness appears to enhance general well-being (Brown & Ryan, 2003; Reibel, Greeson, Brainard, & Rosenzweig, 2001; Rosenzweig, Reibel, Greeson, Brainard, & Hojat, 2003), therapists may be drawn to mindfulness for the simple reason that they would like to enjoy their work more fully. Psychotherapists choose to witness and share human conflict and despair many of their waking hours. Sometimes we are asked by a sympathetic patient, "How do you do it?" What *do* we do when a clinical situation appears impossible to handle? How do we stay calm and think clearly?

Doing psychotherapy is an opportunity to practice mindfulness in everyday life. The therapy office can be like a meditation room in which we invite our moment-to-moment experience to become known to us,

openly and wholeheartedly. As the therapist learns to identify and disentangle from his or her own conditioned patterns of thought and feeling that arise in the therapy relationship, the patient may discover the same emotional freedom. The reverse is also true; we can be moved and inspired by our patients' capacity for mindfulness under especially trying circumstances.

Practicing clinicians are reminded regularly about the importance of the therapy relationship in treatment outcome (Crits-Christoph et al., 1991; Luborsky et al., 1986, 2002; Wampold, 2001). Clinicians also struggle with "transfer of technology"—making a bridge between treatment protocols developed in our universities and their application in the field. When focused primarily on implementing an empirically derived protocol, to the exclusion of a vital, interesting, and supportive therapy relationship, therapists and their patients can both lose interest in the work. In the coming years, mindfulness practice may prove to be a tangible means for building empirically supported relationship skills. This may help return our focus to the therapeutic connection, since there is something we can *do* to improve it. How we plan interventions may even be guided by a common therapeutic principle—the simple mechanism of mindfulness.

A Word about Buddhism

Mindfulness lies at the heart of Buddhist psychology. Psychotherapists are likely to find Buddhist psychology familiar, because it shares with psychotherapy 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 highly-disciplined, systematic, first-person approach.

It cannot be overemphasized that Buddhist psychology is not a religion in the familiar, theistic sense, although some Eastern cultures continue to worship the Buddha's teachings and image. The historical Buddha 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 this 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, 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 the popular Indian culture. In his first sermon on the Four Noble Truths, he put forth four basic ideas: (1) The human condi-

tion 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; and, (4) there are eight general strategies (the Eightfold Path) to bring suffering to an end (see Chapter 2 and Appendix B). The Buddha died at age 80, probably from contaminated food 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 do so. He asked students to discover the truth of his teachings in their own experience—inviting them to "come and see." Belief in notions such as karma or rebirth are unnecessary to derive full benefit from Buddhist psychology (Batchelor, 1997). Buddhist psychology is primarily a practical way to know the mind, shape the mind, and free the mind (Nyanaponika Thera, 1965). 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*, may be considered the theoretical basis for mindfulness (Bhikkhu Bodhi, 2000; Nyanaponika Thera, 1949/1998).

Reading early Buddhist texts will convince the clinician that the Buddha was essentially a psychologist. William James, an American introspectionist psychologist, appreciated the Buddhist tradition. Epstein (1995) writes:

> While lecturing at Harvard in the early 1900's, James suddenly stopped when he recognized a visiting Buddhist monk from Sri Lanka in his audience. "Take my chair," he is reported to have said. "You are better equipped to lecture on psychology than I. This is the psychology everybody will be studying twenty-five years from now." (pp. 1–2)

William James's prediction may be coming true, although it is off by a number of years.

Chapter 12 of this book provides a more comprehensive historical and conceptual background to mindfulness practice, and resources for learning more about mindfulness in the context of Buddhist psychology can be found in the appendixes.

MINDFULNESS PRACTICE

Mindfulness is a naturally occurring event of everyday life but requires practice to be maintained. We all periodically wake up to our present ex-

perience, only to slip quickly back into ordinary discursive thinking. Even when we feel particularly attentive while doing therapy, we are only *intermittently* mindful. Our minds may become absorbed in associations to what our patients are saying or doing. We may then have a moment of awakening from our reverie, reorient our attention to the patient, and resume our exploration of what the patient is trying to communicate. 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. Other times it is not. Continuity of mindfulness requires commitment and hard work.

Formal and Informal Practice

Mindfulness can be learned. Mindfulness practice can be organized in two general categories: formal and informal. *Formal* mindfulness training refers to mindfulness meditation and is an opportunity to experience mindfulness at its deepest levels. Sustained, disciplined introspection allows the practitioner to learn how the mind works and to systematically observe its contents. More will be said about meditation in the next section.

Informal mindfulness training refers to the application of mindfulness skills in everyday life. Any exercise that alerts us to the present moment, with acceptance, cultivates mindfulness. Examples are directing attention to one's breathing, listening to ambient sounds in the environment, paying attention to our posture at a given moment, labeling feelings, and so forth. The list is endless. This sort of mindfulness practice is being developed by therapists to help particular patients disentangle from disruptive patterns of thinking, feeling, and behaving, and to feel the relief of moment-to-moment awareness. Each patient may get hooked in a particular way by particular thoughts or feelings, for which a special mindfulness exercise can be developed (see Chapter 6).

Two common exercises for cultivating mindfulness in daily life, which are also used in intensive practice, involve slow walking and slow 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. From the inside, we are silently noting "lifting . . . stepping forward . . . heel touching . . . toe touching . . . lifting. . . . " In eating meditation, we eat silently, more slowly than usual, and notice the sight of the food on the plate, the use of utensils to bring the food to the mouth, the feel 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 & Hallett, 1999).

Any mental event may be an object of mindful awareness. Traditionally, in Buddhist psychology, the mindfulness practitioner may focus on different parts of the body; the pleasant, unpleasant, or neutral quality of sensations; states of mind, such as distraction or the arising of pride; and various qualities that foster well-being, such as energy and tranquility, or qualities that inhibit wellness, such as anger and sloth. While the distinction between thoughts and emotions apparently did not exist in the East at the time of the Buddha, mindfulness of emotions is very important in psychotherapy.

Mindfulness and Concentration Meditation

Most therapists are familiar with meditation as a relaxation technique (Benson, 1975). Some meditation may be relaxing, but the style and the purpose of meditation partly determine its effect. Buddhist psychology distinguishes between two distinct methods of meditation: insight (*vipassana*) and concentration (*samatha*). Research suggests that the two forms of meditation are neurologically different practices (see Chapter 11). *Vipassana* meditation is usually called "mindfulness meditation" in the psychological literature, rather than "insight meditation," and we continue this usage here.

Concentration Meditation

Concentration meditation can be compared to a *laser* light beam, which illuminates whatever object to which it is directed. The benefit of concentration meditation is a calm, unruffled mind, detached from emotional and interpersonal involvement. (The Pali word, *samatha*, connotes both tranquility and concentration.) Any object of awareness, internal or external, may be an object of concentration. Examples of internal objects of meditation include words (mantra), an image (often religious), a spot on the body (such as the tip of the nose), or a kinesthetic feeling (such as the breath). Concentration is generally easier when the object is pleasant. Objects for external concentration might be a candle flame, a beloved image, a mandala, or even a dot on the wall. In concentration meditation, the mind is gently returned to the object of meditation when we notice that it has wandered.

Mindfulness Meditation

Mindfulness meditation can be compared to a *searchlight* that illumines a wider range of objects as they arise in awareness, one at a time. The benefits are greater awareness of the personal conditioning of our minds

and an understanding of the nature of mind itself. The meditation instruction is to "notice whatever predominates in awareness from moment to moment." Mindfulness meditation helps us to develop the capacity for relaxed, choiceless awareness in which conscious attention moves instantly and naturally among the changing elements of experience. (Even choiceless awareness includes intention; in this case, the intention not to choose, but to stay aware of where our attention resides.) Mindfulness meditation can also be somewhat more directed. For example, an early exercise in mindfulness is to "sit with closed eyes and listen to sounds, allowing them to come to you." (People who like to walk in the woods do this naturally.) Meditation can be practiced sitting, standing, lying down, or moving. Mindfulness meditation is not hard to learn; and anyone can practice it.

Beginning meditators often misunderstand what mindfulness meditation is and does. Mindfulness meditation is not a relaxation exercise; sometimes its effect is quite the opposite when the object of awareness is disturbing. It is not a way to avoid difficulties in life, because it brings us closer to our difficulties before we disentangle from them. It does not bypass our personality problems; 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 is about settling into our current experience in a relaxed, alert, and openhearted way.

Mindfulness practice may include any sense—sight, sound, touch, smell, taste, and hearing—as well as mindfulness of thoughts and feelings. However, due to the seductive and evanescent nature of thoughts and feelings, it is often easier to start mindfulness practice by exploring the five senses.

In typical practice, mindfulness meditation begins with concentration on the breath. When sufficient stability of mind has been achieved, after minutes or days, we direct awareness—ply the searchlight—to include other experiences. If the mind loses its stability by becoming entangled in the objects of perception, we can take refuge in the breath anytime, strengthening concentration. An unstable mind is like an unstable camera; we get a fuzzy picture.

The basic mindfulness meditation instructions are deceptively simple (see p. 17, Exercise 1). When we focus on the breath, we are focusing on a perceptual event in the present. It is sometimes difficult to *find* the breath through the continuous buzz of compelling thoughts and feelings. Counting breaths sometimes helps. The instruction given in Exercise 1, "Notice what it was that took you away," is the heart of mindfulness practice and is what distinguishes it from concentration meditation. The searchlight goes out to notice the distraction. The distraction is no more or less an opportunity for mindfulness than the breath, but in the begin-

Exercise 1

1. Assume a comfortable posture lying on your back or sitting; keep the spine straight and let your shoulders drop.
2. Close your eyes, if it feels comfortable.
3. Bring your attention to your belly, feeling it rise or expand gently on the inbreath and fall or recede on the outbreath.
4. Keep the focus on your breathing, "being with" each inbreath for its full duration and with each outbreath for its full duration, as if you were riding the waves of your own breathing.
5. Every time you notice that your mind has wandered off the breath, notice what it was that took you away and then gently bring your attention back to your belly and the feeling of the breath coming in and out.
6. If your mind wanders away from your breath a thousand times, then your "job" is simply to bring it back to the breath every time, no matter what preoccupies it.
7. Practice this exercise for 15 minutes at a convenient time every day, whether you feel like it or not, for 1 week, and see how it feels to incorporate a disciplined meditation practice into your life. Be aware of how it feels to spend some time each day just being with your breath, without having to *do* anything.

Exercise 2

1. Tune in to your breathing at different times during the day, feeling the belly go through one or two risings and fallings.
2. Become aware of your thoughts and feelings at these moments, just observing them without judging them or yourself.
3. At the same time, be aware of any changes in the way you are seeing things and feeling about yourself.

From Kabat-Zinn (1990, p. 58). Copyright 1990 by Jon Kabat-Zinn. Reprinted by permission.

ning, we first want to stabilize the mind by returning gently and quickly to the breath. Exercise 2 supports mindfulness throughout the day.

Concentration and mindfulness actually complement one another. Concentration requires more effort and may create tension if it is not blended with a mindful attitude of inviting and accepting whatever ap-

pears on our perceptual screen. Mindfulness may uncover difficult memories that can hijack the mind if we do not return to the refuge of concentration. Most of us can only practice concentration in quiet places, whereas moments of mindfulness may take place anywhere. Mindfulness meditation is a dance between mindfulness and concentration.

Mindfulness and concentration meditation practitioners both are actually learning mindfulness; they are learning to awaken from unconscious absorption in thoughts and feelings, and to intentionally redirect attention. The difference is that in mindfulness meditation, we are intentionally exploring a broader array of mental contents and, over time, may find it easier to recognize and disentangle from them in daily life.

Mindfulness-Oriented Psychotherapy

There many ways to integrate mindfulness into therapeutic work, and they are not mutually exclusive. A therapist may (1) personally practice mindfulness meditation or everyday mindfulness to cultivate a more *mindful presence* in psychotherapy; (2) use a theoretical frame of reference informed by insights derived from mindfulness practice, recent psychological literature on mindfulness, or Buddhist psychology (mindfulness-*informed* psychotherapy); or (3) may explicitly teach patients how to practice mindfulness (mindfulness-*based* psychotherapy). Collectively, we refer to this range of approaches as *mindfulness-oriented* psychotherapy.

Practicing Therapist

Mindfulness appears to be a cognitive style; part state and part trait (Sternberg, 2000). While different life experiences and genetic predispositions probably account for natural variance among individuals, mindfulness can be cultivated through daily meditation (ideally 20–45 minutes per day) and/or practicing informal mindfulness exercises.

Meditating therapists often report feeling more "present," relaxed and receptive with their patients if they meditate earlier in the day. While this effect has not yet been studied experimentally, indirect evidence for the benefits of meditation includes a study by Ryan and Brown (2003), who found that Zen meditators had higher levels of mindfulness than a matched sample of adults; and the work of Davidson et al. (2003), who discovered that mindfulness meditation practice increases activation in an area of the brain associated with compassion.

The meditating therapist can relate mindfully to his or her patients within *any* theoretical frame of reference, including psychodynamic,

cognitive-behavioral, family systems, or narrative psychotherapy. Chapter 3 of this book explores this topic further.

Mindfulness-Informed Psychotherapy

Mindfulness-informed psychotherapy borrows ideas from both Buddhist and Western psychology, as well as from the practical experience of practitioners. As mentioned earlier, direct experience is necessary to truly understand mindfulness because it is nonconceptual in nature. Therapists who practice mindfulness-informed psychotherapy may identify with a theoretical frame of reference based on mindfulness, but they do not explicitly teach patients how to practice mindfulness. There are a number of works that conceptually integrate Buddhist psychology and psychotherapy in this way, including those of Brazier (1995), Epstein (1995, 1998), Goleman, 2003), Kawai (1996), Ladner (2004), Magid (2002), Molino (1998), Rosenbaum (1999), Rubin (1996), Safran (2003), Segall (2003), Suler (1993), Watts (1963), Welwood (2000), and Young-Eisendrath and Muramoto (2002).

Mindfulness-Based Psychotherapy

The integration of mindfulness into cognitive-behavioral therapy has led to new mindfulness exercises and multicomponent treatment protocols. These mindfulness-based psychotherapies involve teaching patients specific mindfulness skills, such as breath awareness, mindful eating, and other ways of regulating attention (see Chapter 6). The proliferation of treatment protocols is encouraging clinicians to experiment with mindfulness techniques, even if therapists do not implement the entire protocol. Work in this category includes that by Bennett-Goleman (2001); Bien and Bien (2002); Brach (2003); Brantley (2003); Fishman (2002); Goleman (1997); Hayes et al. (2004); Hayes, Strosahl, and Wilson (1999); Kabat-Zinn (1990, 1994); Linehan (1993a, 1993b); Martin (1999); McQuaid and Carmona (2004); Schwartz (1996); Schwartz and Begley (2002); Segal, Williams, and Teasdale (2002); and Siegel, Urdang, and Johnson (2001).

AN EMERGING, NEW MODEL OF PSYCHOTHERAPY?

We may be on the threshold of a new, mindfulness-oriented model of psychotherapy. There is a clear philosophical paradigm that supports such a model (discussed later in this chapter). Treatment strategies can be derived from the basic elements of mindfulness—awareness, of pres-

ent experience, with acceptance. The strategies are distinguishable from those of other models and are beginning to be tested for effectiveness. A review of the empirical literature by Baer (2003) suggests that mindfulness-based treatments are "probably efficacious" and en route to becoming "well established."

We will have a developed new model of psychotherapy, if the outcome literature further confirms its usefulness, when we elaborate and refine relevant aspects of mindfulness for different settings and diagnostic categories, when we specify the limitations of the approach, and when the different areas of scholarly investigation are brought under a consistent theoretical umbrella.

The emerging mindfulness model offers intriguing possibilities to diverse areas of psychology and psychotherapy. Its scope is wide, because mindfulness is a very simple and universal human capacity, and because it can find its way into psychology both as a theoretical construct and as a practice. Mindfulness is already making strange bedfellows of far-ranging fields such as behaviorism, psychoanalysis, humanistic psychotherapy, brain science, ethics, spirituality, health psychology, and positive psychology.

Cognitive-Behavioral Therapy

There has been a surge of literature on mindfulness and acceptance-based cognitive-behavioral treatment (Baer, 2003; Campos, 2002; Hayes et al., 2004; Roemer & Orsillo, 2002). Unlike change-based therapies, mindfulness- and acceptance-based treatments cultivate a relaxed, nonadversarial relationship to symptoms, in which disturbing sensations, feelings, or thoughts are allowed to come and go. Acceptance-based therapies address the familiar paradox of symptoms intensifying when we try to remove them, such as when trying to go to sleep or struggling to relax.

The four leading approaches are (1) dialectical behavior therapy (DBT; Linehan, 1993a, 1993b), which has become the preferred treatment for borderline personality disorder and is being used for affect regulation in general; (2) mindfulness-based stress reduction (MBSR; Kabat-Zinn, 1990), an 8- to 10-week mindfulness training course with multiple applications to physical and mental health; (3) mindfulness-based cognitive therapy (MBCT; Segal, Williams, & Teasdale, 2002), an application of MBSR to cognitive therapy and depression, which teaches patients to observe their thoughts; and (4) acceptance and commitment therapy (ACT; Hayes, Strosahl, et al., 1999; Hayes, Strosahl, & Houts, 2005), which encourages patients to accept, rather than control, unpleasant sensations. For a review of the promising outcome literature,

see Baer (2003), Hayes, Masuda, et al. (2004), and Chapter 11 of this book.

Other mindfulness- and acceptance-based treatment programs include integrative behavioral couple therapy (Jacobson, Christensen, Prince, Cordove, & Eldridge, 2000), Roemer and Orsillo's (2002) treatment of generalized anxiety disorder, Schwartz's (1996) treatment of obsessive–compulsive disorder, Marlatt's (2002) work with substance abuse, Kohlenberg's functional analytic psychotherapy (Kohlenberg & Tsai, 1991), Kristeller and Hallett's (1999) approach to eating disorders, and Martell, Addis, & Jacobson's (2001) guided strategies for treating depression.

Cognitive psychology is undergoing a "second cognitive revolution": a new understanding that much of what we think, feel and do is the consequence of unconscious, "implicit" processes (Westen, 2000a). The task of therapy, then, is to *access* implicit, automatic, dysfunctional thought patterns (Friedman & Whisman, 2004; Palfai & Wagner, 2004). Mindfulness practice will probably grow in importance over the coming years as a "technology of access."

Psychodynamic Psychotherapy

As mentioned earlier, psychodynamic theorists saw the value of Buddhist psychology at least since the time of Carl Jung (1939/1992). More modern proponents are Mark Epstein (1995, 1998), Jeffrey Rubin (1996), Anthony Molino (1998), Barry Magid (2002), and Jeremy Safran (2003). Peter Fonagy's (2000) notion of "mentalization," or the capacity to think about one's own mental states or those of others, is a mindfulness skill. Daniel Stern's (2004) recent work on the "present moment in psychotherapy" highlights implicit processes within the intersubjective field, all notions related to Buddhist psychological principles.

It is understandable that psychodynamic psychotherapists discovered mindfulness before their behaviorist colleagues, because 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. Chapter 2 explores commonalities and points of divergence among these three traditions.

Humanistic Psychotherapy

Mindfulness practice was originally intended to alleviate the suffering associated with existential conditions, such as sickness, old age, and

death—not clinical conditions, as this category did not exist in the Buddha's time. According to Buddhist psychology, suffering comes from how we relate to these unavoidable challenges.

Mindfulness has much in common with humanistic psychotherapy, which broadly encompasses existential, constructivist, and transpersonal approaches (Schneider & Leitner, 2002). Like Buddhist psychology, the existential approach "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).

There are other points of concordance. The work of Eugene Gendlin (1996), especially his idea of the preverbal, bodily, "felt sense" of a psychological problem, is strikingly similar to mindfulness-oriented psychotherapy (see Chapter 7). Constructivist psychotherapies, such as narrative therapy (Leiblich, McAdams, & Josselson, 2004), share with mindfulness theory the notion that "reality" is created by the person in interaction with the environment. Transpersonal therapy and Buddhist psychology have the common assumption that the individual is essentially indivisible from the wider universe, a theme that recurs regularly in future chapters.

Brain Science

The convergence of brain science and mindfulness is particularly fertile. It was given an initial boost by the impressive work of James Austin, *Zen and the Brain* (1998). As brain imaging technology advances, such as in the expanded use of functional magnetic resonance imaging (fMRI), we can correlate the first-person reports of experimental subjects with objective images. It is noteworthy that the 2,500-year-old tradition of rigorous Buddhist introspection never revealed *where* in the brain mental events occur. That is now changing, as we shall see in Chapter 11.

"Neuroplasticity," including the ability of the mind to shape the brain, is an exciting field of inquiry. Jeffrey Schwartz (Schwartz & Begley, 2002) and Richard Davidson (2003) are exploring how mindfulness practice may change brain function. Ordinary people trained to meditate for 8 weeks showed left prefrontal activation while they were at rest and in response to an emotional challenge (Davidson et al., 2003). Schwartz (1996) found changes in the brain from mindfulness-based cognitive therapy of obsessive–compulsive disorder that were similar to those from psychoactive medication.

A fascinating bit of brain research by Benjamin Libet (1999) showed experimentally what many meditators have observed about

"free will"—that people become aware of the intention to act *after* (350–400 ms, to be exact) the brain has readied itself to act and *before* (200 ms) motor activity. In other words, we can "veto" an action, but our *intention* to act is formulated in the brain before we become aware of it! This kind of research, along with neuroplasticity studies, suggest that we may be able to change the brain itself through mindfulness practice, and that the individual has an opportunity to better control behavior by increasing mindful awareness of brain activity.

Ethics

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, while unwholesome actions increase suffering. Mindful attention allows us to observe carefully the consequences of behavior. This harming–nonharming ethical distinction is entirely consistent with a secular psychotherapeutic agenda.

Within mindfulness and acceptance-based psychotherapy, values have a high priority. ACT, for example, includes exercises for patients to discover their 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?"). Buddhist psychology also emphasizes how our intentions determine the direction our lives will take.

Spirituality

The integration of spirituality into mindfulness-oriented psychotherapy is a vast subject, beyond the scope of this book. Spirituality often refers to an appreciation of intangible yet meaningful aspects of our lives. The intangibles may be values (love, truth, peace), God, a life force, interpersonal connections, or perhaps a sense of transcendence.

Buddhism is an "immanent" approach to spirituality, suggesting that what we seek is happening right in front of our noses, within the actual experience of day-to-day living. The thrust of spiritual aspiration within the immanent approach is to embrace each moment more wholeheartedly. In contrast, a "transcendental" approach is a "trickle-down" methodology, in which repeated experiences of mystical union (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. Freedom from suffering occurs when no mental events can snag our awareness.

Health Psychology

The health benefits of mindfulness are becoming increasingly apparent (Carlson, Speca, Patel, & Goodey, 2003, 2004; Reibel, Greeson, Brainard, & Rosenzweig, 2001; Roth & Stanley, 2002; Speca, Carlson, Goodey, & Angen, 2000; Williams, Kolar, Reger, & Pearson, 2001). Most benefits seem to derive from a less reactive autonomic nervous system—feeling less stressed. Mindfulness practice may also help patients recognize health needs before they develop into illness. For example, patients with diabetes might be more conscientious taking their insulin, asthma patients may be able to detect sooner the emotional reactions that can trigger attacks, and patients with obesity may be able to identify food cravings before the urges become compulsive behaviors. Mindfulness meditation has also been shown to improve immune function (Davidson et al., 2003) and to help clear psoriasis (Kabat-Zinn et al., 1998).

Positive Psychology

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

Western psychology has made remarkable progress in understanding the biological, psychological, and social roots of a troubled mind, but it has neglected positive experiences, such as well-being, contentment, love, courage, spirituality, wisdom, altruism, civility, and tolerance (Seligman & Csikszentmihalyi, 2000). We also do not have a method for cultivating Olympic (i.e., extremely advanced, not competitive!) levels of positive mental health. Buddhist psychology is comprehensive program that cultivates happiness, and mindfulness is the basis of the program. There is a curious paradox in the Buddhist approach to positive psychology: The more fully we can embrace unhappiness, the deeper and more abiding our sense of well-being. A detailed discussion of mindfulness and positive psychology is presented in Chapter 12.

THE WORLDVIEW OF MINDFULNESS

Each of us has a dominant worldview, or inclination to perceive the world in a particular way. Worldviews seem to depend on the personality of the individual (Johnson, Germer, Efran, & Overton, 1988). For example, one parent may want to send a child to a school that empha-

sizes creative thinking, whereas another might want to send the same child to a school that focuses on reading, writing and arithmetic. People of different worldviews can argue about priorities, but the assumptions of worldviews are so fundamental that they cannot be easily validated, justified, or challenged.

All psychological theories and therapies are embedded in particular worldviews. Worldviews are also known as *paradigms* (Kuhn, 1970); *cosmologies* (Bunge, 1963), or *world hypotheses* (Pepper, 1942). Since the notion of mindfulness has endured for millennia and is currently inspiring clinical researchers and practitioners in diverse areas, we might expect to find a metatheoretical frame of reference for it in Western psychology. That frame is *contextualism* (Hayes, 2002).

Contextualism

The contextual worldview was first articulated by Stephan Pepper (1942). Worldviews explain the nature of reality (ontology), describe how we know reality (epistemology), account for causality, and contain a concept of personhood. 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 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. The most accurate causal description of an event is the *universe of causes* at a particular point in time.
- *Personhood.* The person is best described as a single moment of awareness or activity embedded in an unlimited field of interpersonal and impersonal events. A helpful metaphor is a fountain of water that is made up of different drops from one moment to the next but appears to hold its shape over time.

George Kelly's (1955) theory of personal constructs broke ground for psychology within the contextual worldview. Kelly, an early constructivist, said that the human being lives simultaneously in a primary, preconceptual reality, as well as in a world of interpretations about that reality. As we grow into adulthood, we continually "update" our day-to-day, preverbal experience with new personal constructs. Narrative

therapy (White & Epston, 1990) is a familiar example of modern constructivist psychotherapy, as are mindfulness- and acceptance-based psychotherapies.

Mindfulness-oriented psychotherapy may differ slightly from other constructivist therapies by emphasizing what the individual is *not* rather than what he or she *is*. Mindfulness guards somewhat against the human tendency to reify—to make something flowing like water into something hard like ice. This extends to our view of symptoms. Efran, Germer, and Lukens (1986) wrote that "the basic insight that contextualism offers to the field of psychotherapy theory is that complaints, problems, or symptoms are not objective *things*—stable entities that are to be diagnosed and then excised" (p. 171).

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"—key insights about life to which intensive mindfulness meditation often leads. The three characteristics are suffering, impermanence, and selflessness. Impermanence, or change, is precisely the ontology of contextualism, and selflessness is the contextual view of personhood. More is said about these subjects in the following chapters. Another key concept in Buddhist philosophy, "dependent co-origination," is a fancy expression for a multidetermined universe—the notion of causality in contextualism.

Buddhist psychology assumes that the way we construct our private realities is mostly delusional; we unconsciously elaborate on events as they emerge, based on our past experience, and this leads to unnecessary suffering. The antidote, mindful attention, allows us to see things more clearly. What we see, however, is not some absolute truth; rather, we see through the delusion of our conceptualizations. We learn to hold our constructions more lightly.

DOES MINDFULNESS MATTER TO THERAPISTS?

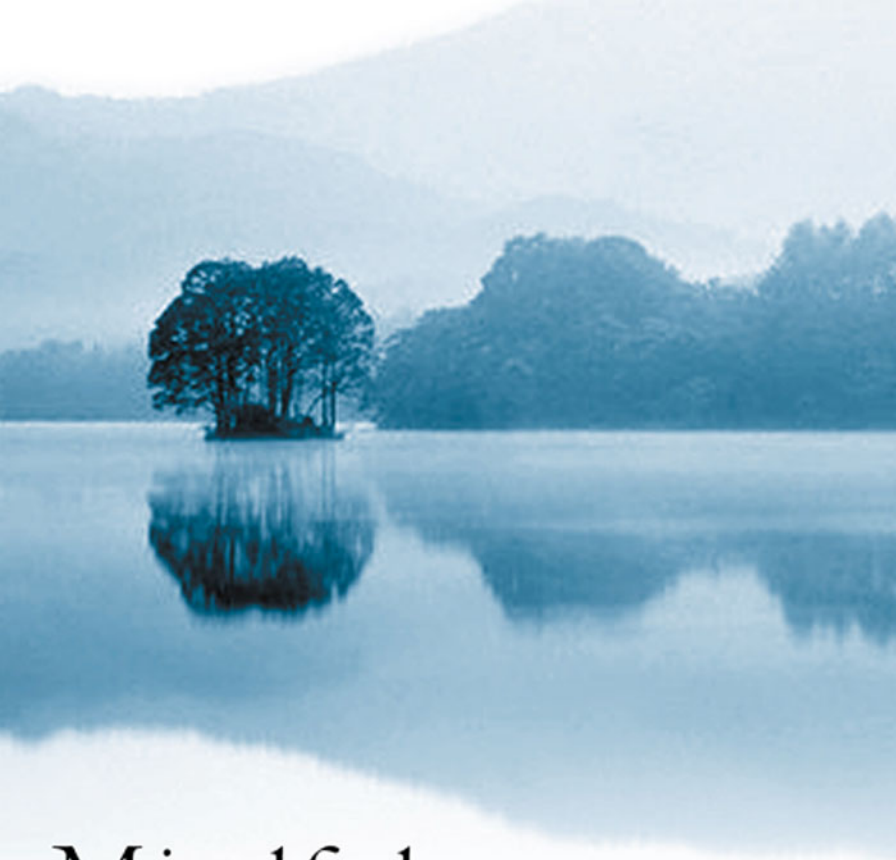
It is difficult to predict just what the impact of mindfulness on our profession will be. Padmasambhava, an eighth-century Tibetan teacher, said that "when the iron bird flies, the dharma [Buddhist teachings] will come to the West" (cited in Henley, 1994, p. 51). Although it is now over 100 years since Buddhist psychology made it to our shores (Fields, 1992), it is only fairly recently that the ideas have captured the imagination of the clinical and research communities in psychology. The grand

tradition of contemplative psychology in the East and the powerful scientific model of the West are finally meeting.

Scientifically, what we know is preliminary but promising. Clinicians are on the vanguard of exploration, and even marginal success in the consultation room can be an important beginning. We have many more questions than answers: We need to determine which mindfulness-based intereventions work, and for whom. We should explore the impact of a meditating therapist on therapy outcome. We may wish to understand better the cognitive, biochemical, neurological, emotional, and behavioral factors that contribute to mindfulness. It may also be fruitful to investigate the outer reaches of mindfulness—what human beings are capable of in terms of attentional control and emotional regulation, and how this translates into the way we live our lives.

To have psychological techniques at our disposal, drawn from a 2,500-year-old tradition, which 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 may be difficult for psychotherapists to ignore. Only time will tell what we make of it.

The remainder of this book explores how the simple human capacity for mindfulness may be able to enrich our understanding and effectiveness as psychotherapists. Chapter 2 considers commonalities and divergences between the Buddhist tradition of mindfulness and Western psychotherapy. Part II examines how mindfulness may 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 historical context and Buddhist teachings on mindfulness, as well as the potential of mindfulness for the future, within the emerging field of positive psychology. Finally, the appendices provide resources for clinicians and a glossary of Buddhist terms.



Mindfulness and Psychotherapy

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