

MINDFULNESS AND SELF-DEVELOPMENT IN PSYCHOTHERAPY

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ABSTRACT: This article explores how the Buddhist concept of mindfulness and techniques for fostering it can, when expropriated by Western clinical psychology, play a valuable role in self-development in psychotherapy. Mindfulness practice expands the field of awareness, allowing for improved monitoring of somatic and affective experiencing, and thereby enhancing the capacity for self-regulation of arousal, affect, and behavior. It facilitates the development of a sense of embodiment and the capacity to tolerate and accept painful experience. It promotes the self-monitoring and decontextualization of automatic thoughts that serve to sustain pathological structures. Mindfulness also facilitates the development of inner resources that help stabilize affect and reduce impulsivity. Case examples of the use of mindfulness-based techniques in individual and group therapy sessions illustrate these points.

Mindfulness is a skill derived from Buddhist meditative practice that the scientific literature suggests may be of benefit in the symptomatic relief of chronic pain (Kabat-Zinn, 1982; Kabat-Zinn, Lipworth, & Burney, 1985; Kabat-Zinn, Lipworth, Burney, & Sellers, 1985; Kabat-Zinn et al., 1986) and anxiety (Kabat-Zinn et al., 1992; Miller, Fletcher, & Kabat-Zinn, 1995; Roemer & Orsillo, 2002; Toneatto, 2002), the prevention of relapse in recurrent depression (Teasdale et al., 2000; Segal, Williams, & Teasdale, 2002; Ma & Teasdale, 2004), the treatment of addictive disorders (Marlatt, 2002; Breslin, Zack, & McMain, 2002; Kavanaugh, Andrade, & May, 2004; Marlatt et al., 2004), borderline personality disorder (Linehan, 1993; Robbins, 2002), binge eating disorder (Kristeller, 2003b), body image disorder (Stewart, 2004), posttraumatic stress disorder (Urbanowski & Miller, 1996; van der Kolk, 2002), and stress-related medical disorders such as psoriasis (Kabat-Zinn et al., 1998). Mindfulness may also be of value in improving quality of life in cancer (Specia et al., 2000; Carlson et al., 2003) and traumatic brain injury patients (Bedard et al., 2003), and in supporting immune system function (Robinson, Mathews, & Witek-Janusek, 2003; Davidson et al., 2003). It has also been of suggested value in increasing positive hedonic tone in non-clinical populations (Easterlin & Cardeña, 1999; Davidson et al., 2003), reducing stress in professional caregivers (Shapiro, Schwartz, & Bonner, 1998; Rosenzweig et al., 2003; Cohen-Katz et al., 2005a; Cohen-Katz et al., 2005b) and promoting changes in brain function (Davidson et al., 2003) and structure (Lazar et al., 2005). Efforts have also been made to extend the use of mindfulness meditation to populations that span the age spectrum from childhood (Ott, 2002; Wall, 2005) through old age (McBee, 2003; Smith, 2004).

Ruth Baer (2003) reviewed the experimental literature on the quantitatively assessed value of clinical mindfulness applications and concluded that “mindfulness-based interventions may help alleviate a variety of mental health problems and improve psychological functioning” (p. 139). A meta-analysis of mindfulness studies

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(Grossman et al., 2004) also supported the value of mindfulness-based stress reduction in a broad range of chronic disorders. Future quantitative studies of mindfulness will no doubt be aided by current efforts to develop scales for the measurement of mindfulness such as the Toronto Mindfulness Scale (Bishop et al., 2003) and the Kentucky Inventory of Mindfulness Skills (Baer, Smith, & Allen, 2004). In addition, several recent review articles have suggested directions for future research from both a cognitive-behavioral point of view (Dimidjian & Linehan, 2003) and a humanistic/transpersonal point of view (Shapiro & Walsh, 2003).

Transpersonal psychologists (c.f., Weide, 1973; Boorstein, 1983; Kasproff & Scotton, 1999) were the earliest pioneers in exploring how meditation and mindfulness practice might contribute to the process and outcome of psychotherapy. Boorstein (2000), for example, suggested that meditation could lower psychological defenses to repressed material, enhance awareness of psychological patterns, and provide glimpses of non-dual reality. Early explorers in this domain provided case histories which illuminated the potential of mindfulness meditation to facilitate aspects of psychotherapy or complement therapeutic efforts (Deatherage, 1975; Wortz, 1982; Boorstein, 1983). There are also authors who cautioned clinicians about the potential iatrogenic effects of meditation (Epstein & Lieff, 1981; Miller, 1993). Researchers have only just begun to supplement the theoretical and anecdotal exploration of the integrative and complementary effects of meditation on psychotherapeutic process and outcome through quantitative assessment (c.f., Weiss, Nordlie, & Siegel, 2005).

While the value of mindfulness as a self-control or symptom management strategy has been discussed at some length in the literature (Marlatt & Kristeller, 1999; Kristeller, 2003a), less has been said about its role in self-experiencing and self-development. Engler (1984) examined how persons with certain types of self-pathology might be drawn to meditation, and Epstein (1986) examined how mindfulness might counteract narcissistic tendencies, but these explorations were solely from within a psychoanalytic perspective, and dealt primarily with the conceptual tension between certain kinds of self-pathology and the Buddhist concept of *anatta*, or non-self. Relatively little attention has been spent on looking at a potential role for mindfulness in the remediation of the broader spectrum of self-pathology. One exception to this relative neglect can be found in the work of Brown and Lindsey (2001) who have explored the role of meditative techniques in stabilizing the sense of self and the self-concept, and I would like to extend my gratitude to them for helping to stimulate some of my own thinking in this area.

MINDFULNESS IN BUDDHISM AND IN PSYCHOLOGY

Mindfulness can be defined as a mode of bare attention to the process of experiencing. I have elsewhere described it as a practice in which:

... [one opens] oneself up and [is] receptive to the flow of sense perceptions, emotions, and thought processes in each given moment while attempting to hold judgment in abeyance. This is done with no other goal than to be as present as one can possibly be within each and every moment. One does this with an

intimate attention that is very different from a scrutinizing, objective stance. Rather than being a distant observer of a set of experiences, one is a participant-observer, and what one observes is not only the sense impressions of the “outside” world, but also one’s own subjective reactions to that world. (Segall, 2003, p. 79)

In Buddhist practice, mindfulness is the sixth aspect of the Eightfold Noble Path, one of the central teachings of Buddhism. As such, there are a number of excellent contemporary Buddhist texts that explicate the concept of mindfulness for Western readers. The interested reader is referred to books by Bhante Henepola Gunaratana (1991) and Thich Nhat Hahn (1987).

The development of mindfulness is fostered and nurtured by a variety of classical and novel meditative practices. These practices include: (a) formal sitting meditation with attention focused on the experience of breathing, (b) formal sitting meditation without single-minded focus, but with attention to the ever-changing field of consciousness, (c) formal sitting or lying supine meditations in which attention is focused on bodily sensations, (d) walking meditation with attention to changing bodily sensations in the feet, (e) stretching and movement meditations with attention to changing bodily sensations, and (f) informal meditations where the instructions are to maintain mindfulness during routine tasks such as eating, cooking, showering, dressing, conversing, and so on.

These practices support a greater depth of experiencing of one’s body, one’s emotional life, one’s felt senses (cf. Gendlin, 1996), one’s fantasy life, and, to the extent that they are available to consciousness, one’s conative and cognitive processes. Practitioners of mindfulness report a growing sense of their own embodiment, and an ever more precise and intricate awareness of their own experiential field. They also report becoming more aware of the ways in which this field and their responses to it are distorted by motivational processes. In the classic Buddhist analysis, percepts are accompanied by pre-reflective evaluations infused with an affective tone that occupy a borderland between affects and judgments. These pre-reflective evaluations are called *vedenas* (in the ancient Pali language of early Buddhism), and they lead the experiencer to try to prolong or truncate moments of experiencing based on the positive or negative hedonic tone of the evaluation. Buddhists identify this movement of the mind towards or away from experiencing as *attachment* and *aversion*. Mindfulness practitioners are encouraged to notice this process and see it transparently as part of the process of experiencing. As an observer of this process, it is believed that one can learn to occupy a different stance towards experience, one that is less enslaved to more primitive motivational factors.

Mindfulness serves a soteriological purpose in Buddhism. Within the Buddhist framework, mindfulness is one aspect of the path to liberation from existential suffering. Buddhism does not concern itself, however, with many of the issues that preoccupy modern psychology and psychotherapy. It is not concerned with increasing interpersonal intimacy, or with strengthening ego functions, or with increasing sexual pleasure, or with improving work efficiency, or with helping one to be more assertive or more popular, for example. In fact, the monastic ideal within Theravada Buddhism calls for abandoning the worlds of family life and work, and

for sexual celibacy. Nevertheless, it is not hard to imagine how mindfulness can be detached from the purpose it serves within Buddhism and put to other uses within psychotherapy. Any process that encourages embodiment and an enriched self-experiencing can play an important role in self-development within psychotherapy. The importance of this process is even more apparent when the process is one which can also lessen aversion to formally avoided contents of consciousness, and attachment to inadequate images of self. One might add that this process can also build a tolerance for and acceptance of unpleasant mental states that have hitherto been triggers for impulsivity, dissociation, and self-harming actions.

Discussing the value of mindfulness in self-development might, at first, seem paradoxical to readers who have a passing familiarity with the Buddhist teaching about non-self or *anatta*. There is really no paradox here, however. In positing the doctrine of non-self, the Buddha did not deny that human beings have personalities, or that it was valuable for human beings to develop their characters. The doctrine of *anatta* only denied certain kinds of ontological statements about the nature of the self (Engler, 2003) such as the immutability of the self, the separateness of the self from the body and the social, physical, and natural worlds, and the idea of a metaphysical soul. Traditional Buddhist practice can, in fact, be understood, in part, as an organized character development program designed to enhance moral development, and decrease egocentricity, narcissism, and emotional and attentional instability.

SELF-PATHOLOGY IN PSYCHIATRIC DISORDERS

A variety of disorders (dissociative disorders, borderline personality disorder, narcissistic personality disorder, posttraumatic stress disorder, affective disorders) have self-experiencing and definition problems as core features. This is most evident in the developmental failures of integration in the dissociative and borderline disorders, but can also be seen in the disrupted and damaged sense of selfhood in Post Traumatic Stress Disorder (PTSD), and the deflated or inflated sense of self in the affective and narcissistic disorders. At the base of all these self-distortions, however, are distortions in self-experiencing and self-definition.

In borderline, posttraumatic, and dissociative disorders, the difficulty in self-experiencing is at least partly due to a phobic attitude towards experiencing emotion, re-experiencing traumatic memories, and experiencing the body. These self-experiencing difficulties are often characterized by symptoms such as psychic numbing, emptiness, depersonalization, splitting, amnesias, and conversion anesthesias. Clients will also resort to a wide range of often impulsive and self-defeating actions designed to circumvent affective and somatic experiencing including substance abuse, overdosing, cutting, and engaging in high intensity risk-taking and consumatory behaviors which serve as distracters. At the base of these strategies and symptoms is the belief that experiencing of affects, memories, or somatic experiencing will be so intense and uncontrollable that the experience will be unendurable and intolerable. Overwhelming experiences of intolerable sensation and affect reinforce a sense of the self as weakened, depleted, and damaged, and undermine the development of beliefs and feelings of mastery, competence, and worth.

As is the case in all phobias, healing and recovery from these disorders of self-experiencing and self-definition depend in part on successful exposure to what is most feared under conditions that enhance the development of a sense of mastery and competence. Mindfulness can play an important role in the process of exposure; most importantly, exposure can take place under conditions that respect a client's limits, give the client a sense of control, and occur within an intention of self-acceptance and self-care.

When one examines the developmental level of self-functions in clients with complex PTSD, borderline personality organization, and dissociative symptomatology stemming from early childhood neglect and abuse, one quickly discovers that every developmental line has been disrupted: there are disturbances in the biological regulation of affective arousal, the hypothalamic-pituitary-adrenal axis, and the autoimmune system; in the stability and continuity of memory, attentional processes, and consciousness; in the regulation of sleep, appetite, and libido; in self-soothing, identity formation, and the regulation of self-esteem; in the planning, self-regulation, and performance of health-maintenance, house-keeping, budgeting, academic and vocational activities; in the self-regulation of intimacy and control, and the maintenance of boundaries and stable affectional bonds in interpersonal relations.

MINDFULNESS AND SELF-PATHOLOGY

Mindfulness and Self-Regulation

Mindfulness has a crucial role to play in the amelioration of the developmental disruptions outlined above. Many of these disruptions are disturbances of self-regulatory processes that require the conscious monitoring of subtle cues for their successful execution. For example, cortical, sympathetic, and adrenal hyper-arousal can be dampened if one is aware of the somatic and affective cues that signal their presence and can engage in self-soothing or assistance-seeking behaviors that can down-regulate them. Regulation of appetitive behaviors depends on awareness of states of hunger and satiety. The regulation of social behavior requires awareness of internal affective states such as attraction, anxiety, shame, or anger, and awareness of external cues such as facial expressions, body language, and vocal inflection.

Another domain of self-regulation is the regulation of self-concept and self-esteem. One's sense of adequacy and worth is based, in part, on cognitive appraisals that are internalizations of past feedback from significant others. These internalized appraisals are automatically triggered by a wide variety of events that provide information about momentary fluctuations in our competence or acceptability. A stable sense of adequacy and worthwhileness develops from aggregating social and environmental feedback across a broad range of experiences over time. Once a stable sense of self-worth and adequacy has been achieved, small fluctuations in feedback do not destabilize that system. If, on the other hand, a core sense of an adequate and good-enough self has not developed, small amounts of negative feedback can trigger a cascade of unduly negative self-evaluations. This core sense of an adequate and good-enough self can be developmentally derailed when the mirrors one relies on for its construction are inadequate and distorted. The resulting internalized negative

self-distortions often persist, even when more adequate mirrors are supplied in later life, partly because the feedback from these improved mirrors is not adequately sampled, and partly because when it is sampled, it is not trusted. If novel feedback is too discrepant from the cognitive model that is already in place, it tends to be disregarded. Mindfulness can be an important tool in rectifying a distorted self-appraisal process because: (a) it fosters the sampling of actual events rather than relying on previously formed cognitive models, (b) it allows one to transparently see in real time how the old appraisals that are triggered automatically replay in spite of discrepant new information, and (c) it allows the experiencer to experience appraisals as appraisals *per se* rather than mistaking them for reality.

Mindfulness and Contractions in the Field of Consciousness

Mindfulness also plays an important role in the amelioration of self-pathology by expanding the field of consciousness. The dissociative and somatoform symptoms of complex PTSD (van der Kolk et al., 1996) derive from a contraction in the field of awareness, and the active avoidance of cues that signal potential awareness of traumatic material. Janet (1907/1965) was the first to identify these contractions in consciousness, and to point out that the process of contraction of the field of awareness was similar, whether one talked about dissociation of sensation, affect, cognition, or behavior. Wickramasekera (1993) has pointed out that a similar contraction in awareness of somatic states is commonly encountered in many patients with psychosomatic disorders. These patients will exhibit a disjunction between their verbal descriptions of conscious awareness and what biofeedback instruments are reporting about their somatic arousal.

The resolution of somatoform, psychosomatic, and dissociative symptoms requires an expansion of the field of consciousness and either a restored, or a newly developed, ability to monitor the complete field of somatic and affective experiencing. Mindfulness practice provides direct training in this regard. Mindfulness practitioners uniformly report an increased ability to attend to and differentiate formerly ignored domains of conscious experience. For example, practitioners of the body scan meditation typically report that they notice increasingly subtle sensations within the body as they advance in their practice. While initially they may experience their bodies as relatively silent, as they continue their practice day after day, the body eventually becomes a continuous three-ring circus of vibrant sensation. They often report enhanced feelings of aliveness and vitality as a consequence. For patients who routinely feel numb, devitalized, or dead inside, a new sense of aliveness and vitality can be the cornerstone of establishing a vibrant sense of self.

Mindfulness and Automatic Thoughts

As Beck (Beck et al., 1979) and Ellis (1962), have pointed out, and as has been discussed above in the section on self-regulation, automatic thought processes play a crucial role in sustaining internal assessments of identity, adequacy, competence, and worth, as well as assessing the degree to which one values and trusts relationships with others. The thoughts that constitute the warp and woof of these mental

constructions and attributions require attention and monitoring if they are going to either be modified, or if one is going to have a changed relationship toward them. Mindfulness encourages the monitoring of thought processes as well as somatic and affective experiencing. It also encourages the monitoring of thoughts without attaching a truth value to the thoughts, i.e., to observe thoughts as transient phenomena rather than as objective statements about oneself or the world. Hayes, Strosahl, & Wilson (1999) have referred to this changed relationship to thinking as the “decontextualization” of thought. This is a little different than the correction of cognitive errors recommended by Beck, or the challenging of irrational thinking recommended by Ellis. One might add that in traditional Buddhist philosophy, thoughts are identified as *kusala* (skillful or wholesome) or *akusala* (unskillful or unwholesome) rather than as correct or incorrect, or rational or irrational. It is not so much their truth value that is important as the consequence of taking them for real that is important. The question to be asked is a functionalist one: “If one continues to think in this way, what will be the consequence of doing so?” Will one’s life, in the long run, be happier or better? The “happier” or “better” implied here takes into account that one’s happiness depends to some degree on the harmony of one’s relationships with others, and not simply on fulfilling one’s hedonistic impulses. In traditional forms of meditation, after observing thoughts as thoughts, one can also inquire as to their outcome if continued. If they are seen as unskillful or unwholesome, they can just be dropped. The idea that one does not have to believe all one’s own thoughts and that unskillful thoughts can be dropped allows patients to increase their own sense of self-control and self-efficacy. One may not be able to control what thoughts cross one’s mind, but one can control how one responds and relates to them.

Mindfulness and the Development of New Internal Resources

The practice of mindfulness allows one to cultivate an inner sense of stillness and quiet. The fact that there is an inner feeling of calm and peace that can be accessed under virtually any circumstance constitutes an important new internal resource for patients. It means that when one is roiled and tormented, one can pause, breathe, and within a few minutes find a safe port. Reaching that safe port does not depend on any assistance from outside oneself. Reaching that safe port also means that one does not feel impelled to act recklessly as a means of reducing inner tension. Marlatt (1994) has described this ability to ride out impulses as “urge surfing,” and it constitutes an important new skill for patients who have, in the past, seen their impulsivity wreak havoc with their lives. Knowing that one can be calm and responsive to situations rather than reactive to them helps patients to develop a greater sense of self-efficacy and self-competence. Knowing they can do this for themselves also lessens their degree of dependence on others for solace and succor.

TWO INDIVIDUAL THERAPY CASES: THE CASES OF MISS A AND MISS B

The following two case examples are intended to delineate the potential value of mindfulness-based interventions in the treatment of patients with severe self-pathology. Both patients have a history of significant dissociative and borderline pathology, posttraumatic stress disorder, and accompanying comorbid disorders. In both cases the primary treatment has been long-term individual psychotherapy, with

additional treatments including inpatient hospitalizations (Miss A & B), partial hospitalization (Miss B), and a variety of outpatient interventions including a DBT skills group (Miss A), an eating disorder program (Miss B), trauma-survivor groups (Miss A and B), Alcoholics Anonymous (Miss A), and supported housing and vocational rehabilitation (Miss B). Clearly, mindfulness-based interventions have constituted only a small part of the treatment these women have received, and yet in each case, mindfulness-based interventions have added to the successful outcome in a dramatic way. While neither of the women portrayed in these case histories could be currently classified as completely recovered or well, each has made substantial progress in her own way. They have left behind the kinds of troubling and impulsive behaviors that in the past would have gotten them labeled as “borderline” including suicide attempts, cutting, drinking, and purging. They have struggled to construct lives that are imbued with meaning and dignity. They have also struggled to create relationships that are well-bounded, fair, and equitable. People who know them are impressed by who they are as people: their humanity, their intelligence, their wisdom, and their good hearts. They demonstrate that even when residual pathology persists, there are healthy parts of the personality that can develop, grow, and offset pathology.

The Case of Miss A

Miss A is a middle-aged woman who spent her adolescence in facilities for wayward youth, and her early adulthood on the streets and in mental hospitals. When she was a preadolescent, her father was tried and convicted for sexually abusing her. The patient was sexually abused, not only by her father, but by other children in her neighborhood. Her home was a dangerous and violent place: she was often severely beaten by her father who would throw her against the walls, and her parents often fought. On one occasion, for example, her mother set her father on fire. After her father’s arrest, she was removed from her home and put in a residential facility, a move which began her downward spiral through a variety of state-sponsored institutions.

Miss A was diagnosed as a “sociopath” during one of her young adult hospitalizations. She drank and used drugs, and was married to a series of violent, substance abusing, and sexually degrading sociopaths. When she began therapy, she was divorced from her abusive husbands, and had already achieved prolonged sobriety through involvement with Alcoholics Anonymous. She was experiencing voices, however, which were inside of her head, and which she attributed to split-off childhood parts of herself. As we explored these voices, it became clear that she had poly-fragmented dissociative identity disorder, and that each of these child-fragment personalities were associated with different traumatic events in her development. Over a decade of continuing therapy she has managed to explore, re-experience, and understand these traumata, and she eventually developed a core sense of herself that is always present and is positively valued. She has remained substance free and abusive-relationship free, and has ceased engaging in any self-harming behaviors. She still has fragments of herself that are not fully integrated, and she still has occasional thoughts of suicide and self-harm which she is, however, able to resist acting upon. She is not on any medication. At the moment she is not depressed, but she still has occasional bouts of depression which last a month or so and then resolve. She has not been able to become competitively employed, but she has become an advocate for other patients,

has served on a variety of mental health and research committees, and has testified multiple times before the state legislature about issues affecting the mentally ill. She writes a column for a local mental health newsletter, and has appeared in a film about recovery from abuse which the state uses as a teaching resource for mental health workers. She attends therapy today on a once a month basis, and is about to transition to every other month. The content of therapy, more often than not, hinges on her continuing efforts to take good care of herself, manage her budget, shopping, laundry and other household activities, and explore being part of a church community. Other recurring issues include the ebb and flow of her interpersonal connectedness to family and peers, and her current spiritual search within the Christian community.

Mid-way through her treatment with me, and before joining her current church, Miss A found her way to a Buddhist meditation community run by a local minister at an Episcopalian church. The patient attended weekly group meditation sessions under his aegis, and practiced meditation at home. She also attended several all-day meditation retreats that were sponsored by a local Buddhist organization which I was a member of, and which I also attended. In so doing, Miss A struggled with a number of obstacles including her arthritic knees, which prevented her from joining her co-congregants on the cushion, and her doubts about whether this group of largely middle-class congregants genuinely accepted her as an integral part of their community. Her attendance at these sessions ended when the meditation community migrated from the church to another venue, and she was unable to attend due to transportation problems. It is notable that no one offered her a ride to the new site, perhaps confirming her sense of not really being a fully accepted member of the community.

In spite of these obstacles, Miss A found that mindfulness meditation and the intention behind it, namely, to trust in the ability to be with experience as it is, significantly helped her in being able to work with her own sadness without trying to medicate it away. She saw her sadness not as a clinical phenomenon that needed treatment, but as the core residual sadness of never having been sufficiently loved or cared for as a child. Her sadness was the mourning of the wished-for past relationships with parents and siblings that were finally being relinquished, and the complete acknowledgement that her earlier life really had been as bad as it had seemed.

Miss A writes of finally getting in touch with her sadness using her mindfulness skills:

I once got a glimpse of my sadness: its color, shape, and texture . . . From this glimpse, I learned that I can sit with my sadness, not push it away. I can touch it and not become absorbed by it. I can identify types of sadness and ask “what can I do to help?” My sadness usually occurs when I am learning new ways of being and letting go of old ways. My sadness is not always depression and is not always something to be avoided. As I learn to feel more and more, I become more present, whole, and alive. I can allow myself to become soft and vulnerable in more situations. I don’t have to be “on” or “off.” I can just be with whatever presents itself at that moment. I have made peace with my sadness and no longer fear that it will consume me; it is a part of me, and I am always changing. So sadness, as many other feelings, is not permanent, even when it feels like it will always be this way. It is an illusion. Sit with it and watch it change.

In the above paragraph, Miss A clearly illuminates many of the benefits of mindfulness for patients like herself, including: (a) the increasing ability to tolerate unpleasant affect, (b) the increasing ability to “feel more” in general, (c) the ability to become more interpersonally open once one can allow oneself to feel more and to tolerate what one feels, and (d) the appreciation that all mental states are transient.

More recently, Miss A wrote about the aftermath of another encounter with a dissociated part of herself:

My recent bout with my uninvited shadows left me feeling very exposed and vulnerable and emotionally raw. I allowed myself to feel what I needed to feel, to cry and to grieve, not only for myself but for others. My recovery has taught me to move beyond myself and self-centered fear. I am deeply connected to the greater whole of humanity and that which is spiritual. I am so glad to have a God that can stand whatever I take to him and understand, and who will not leave me. I am the one who is the wayward and rebellious child at times. I used my supports during this time even while feeling disconnected and confused. I have grown more in my recovery and I have changed, never to be the same, because I am more awake to the present moment, not stuck in the past.

Miss A’s sense of her own recovery is clearly linked to a number of themes that are important themes within the meditation and transpersonal literature: the movement from isolated ego to inter-connected self, and from past-stuckness to present-centeredness. Her sense of a God that can take whatever she brings to him and not desert her is also clearly linked to her own increased capacity to endure the unendurable and continue to stay with herself in a friendly manner. Miss A’s writing also points to the oft-noted paradox of needing to both develop self, in psychodynamic terms, and move beyond self in Buddhist terms, as one ameliorates suffering.

The Case of Miss B

Miss B is in her thirties and lives in a half-way house for psychiatric patients. She has made several failed attempts to go to a community college and to do retail work, and is currently embarked on a new attempt, so far successful, to sustain part-time employment in retail work for at least six months. She suffers from recurrent depressions, has had multiple paranoid episodes which are kept at bay with a neuroleptic, and struggles with an eating disorder. She also has multiple identities that are separated by amnesic barriers. Earlier this year she was shocked and dismayed to discover that she was working at night as a prostitute for a pimp; she did this work without any reimbursement for herself, but only to derive self-worth from feeling she was pleasing others as she had been forced to do as a preadolescent. Her host personality, who is asexual and who abhors any physical contact with others, including shaking hands, had no knowledge that this had been occurring. Miss B comes from a family in which she was sexually abused by her father, her brother, and her father’s friends. Her father was undoubtedly psychotic (he was hospitalized several times) and allegedly may also have been involved in a child pornography ring.

Miss B graduated from high school, and attempted a working career in retail, but following a rape by a co-worker was hospitalized with what was assumed to be schizophrenia, and spent her days hiding in a hospital dayroom under a blanket. Psychological testing revealed the presence of her dissociative disorder, and she was subsequently treated for several years within a specialized partial hospital program for persons with dissociative and posttraumatic disorders, where she showed considerable growth. She is currently in individual therapy with me on a twice-a-week basis.

Miss B has been pathologically unable to assert herself, say no to or displease others, or create interpersonal boundaries. She also reported that she had no internal feelings, and no sensory awareness of her body. Early in therapy she seemed to live in a perpetual fog, and her answer to most questions about herself was “I don’t know.” As therapy proceeded, she gradually and increasingly revealed herself to be a bright, curious, and lively individual. She began to become interested in the world of ideas and to develop her own opinions about things. She aspired to become a writer and help others.

Several years into her treatment I decided to directly address her complete lack of experiential contact with her body, which was adversely affecting her ability to identify her internal states. I suggested that she attempt a body scan at home, and handed her an audio-taped recording of a guided body scan that I had made several years earlier for a meditation class. The body scan is a therapeutic technique adapted by Kabat-Zinn (1990) and colleagues from a Burmese meditative practice. In it, the meditator slowly moves his or her attention from body part to body part as he or she gradually traverses the entire body over a forty-five minute period. The meditator is instructed to attend to the sensations (or lack of sensations) in each body part with bare attention, clearly noting the sensations with care, but neither prolonging, amplifying, nor avoiding whatever is noticed. In addition, the meditator attempts to hold judgment of the sensations in abeyance, and to avoid getting lost in discursive thought about them.

Miss B attempted the body scan, and immediately became aware that her torso and limbs were made of material substance and had weight to them. This sense of having mass and weight persisted for several days and was extremely troubling to her, intensifying her eating disorder. The sensation was so persistent, vivid, and disturbing that we considered increasing her neuroleptic medication to help re-close the door to bodily sensation. Fortunately, we resisted that urge, and the patient was instead encouraged to just allow the feelings to exist. Our patience was rewarded when a week or two later the patient reported sitting outside and becoming aware of a novel bodily sensation: she felt a warm Spring breeze brush against her cheek, and reported it felt as if she was being “kissed by God.” From that point on, the patient began increasing her awareness of internal bodily and affective states, even though she did not repeat the body scan.

Miss B’s gradual increase in her abilities to both experience herself and articulate that experience are clearly expressed in her private daily journal. In the therapy session previous to the diary entry included below, we discussed the idea that her experience of hatred did not make her a bad person. I have italicized portions of her

journal entry to emphasize those aspects of the passage which exemplify her new awareness of embodiment:

I always thought of anger as a bad thing. Now I'm thinking it's part of a human thing, which *makes me feel something inside*. I'm trying to figure out how to describe the feeling. *It's like something opened up inside of me*. It's like a little kid that opens a gift and discovers something she didn't know she wanted. *It's more like a feeling of being relieved*, or like you've just been forgiven for a sin and everybody still likes you. It's like telling someone you did something wrong, then finding out that it's not wrong and nobody is going to hurt you or hate you When you told me that feeling hate doesn't mean I'm bad, *it kinda touched me like kind of a tickle inside of me* that I've been feeling since therapy, *kinda like a weight being lift off of me*. *Feels like a kind of silly laughter inside of me*. You know what? That word "laughter," I think I've been using it or feeling it a lot lately. I think *I'm actually starting to thaw out . . . I feel like a part of me is coming alive* I feel like I'm becoming human. I don't have to hide my non-perfectness from other people any more. Maybe other people can see my dirtiness and my ugliness, but they don't notice because they're no different than me? We're all human. Wow, this human thing is cool! . . . I just had another thought: was my father human, too?

For Miss B the benefits of mindfulness are: (a) a new sense of embodiment, (b) a new sense of permission to feel, and (c) support for the therapeutic idea that feelings are tolerable, and in themselves are neither good nor bad. What she discovers when she actually allows herself to experience her inner world directly contradicts her core belief that she is indeed evil and dirty inside. She is then able to begin exploring the possibility that she might extend this new sense of humaneness to those who have hurt her as well. Lastly, there is a spiritual dimension to this growth, reflected in her experience of being "kissed by God." This was the beginning of a religious search that eventually led her to seek membership in her current Church.

TWO BRIEF CASE EXAMPLES FROM A CLINICAL MINDFULNESS GROUP

For several years I have been exploring the value of a mindfulness curriculum for severely disturbed psychiatric patients within group settings. For a period of two years I ran a one-hour-a-week mindfulness training program for a heterogeneous group of psychiatric patients who were attending an intensive outpatient program (IOP). Patients would attend the IOP for an indeterminate length of time, and would attend the mindfulness groups within the IOP anywhere from 2–10 times during their stay in the program. For the past two years I have also been running an extended mindfulness curriculum within a dialectical behavioral therapy intensive outpatient program (DBT-IOP) for patients with borderline personality disorder.

I should note parenthetically that not everyone thinks that teaching mindfulness meditation in DBT is a good idea. For example, while Dimidjian and Linehan (2003)

believe in the importance of *mindfulness skills training* in DBT, they are skeptical about the value of teaching *formal mindfulness meditation* because of their belief that “it is not possible for seriously disturbed clients to engage in meditation, because of lack of motivation, or capacity, or both” (p. 168). While I understand the reasons for their cautionary note, I have been interested in exploring the degree to which Dimidjian and Linehan may have underestimated the extent of patients’ motivation and capacities, or the ways in which the limitations of their motivation and capacity might be overcome.

In both the regular IOP and DBT-IOP groups, my curriculum has been similar to the curricula outlined by Kabat-Zinn (1991) for MBSR and by Segal, Williams, and Teasdale (2002) for MBCT, namely, the use of a variety of formal and informal meditative exercises including the body scan, mindful yoga, walking meditation, and both breath-centered and present moment-centered sitting meditations. Meditation periods themselves tend to be truncated (10–15 minutes for sitting meditations; 20–30 minutes for the body scan and yoga) with time for preparatory and follow-up discussion. The preparatory discussion often clarifies the reasons why mindfulness training might be helpful for the patients’ particular diagnoses and symptoms, while the follow-up discussion examines the difficulties the patients might have had while attempting the exercises, and suggests ways that patients can work with these difficulties. The philosophy that underlies these discussions is that all problems are workable, and that making the effort to work through these problems is, in itself, a pathway for self-development.

Dimidjian and Linehan’s (2003) cautions seem best heeded for patients with acute psychoses and severe affective episodes. Patients with flight of ideas, racing thoughts, or persistent auditory hallucinations find this kind of work to be arduous, challenging, and unrewarding. On the other hand, as the acute symptomatology of these same patients begins to abate under the influence of antipsychotic and mood stabilizing medications, they often begin to experience mindfulness meditation as grounding and restorative, and become ardent champions for these techniques. Severely depressed patients who try to sit with being mindful of unremitting depression hour after hour also find the practice pointless, and need to wait until they can experience some variation within their mood state in order to experience the benefits of meditation. Patients with PTSD-related flashbacks and anxiety states also find this work challenging within a group setting: as they quiet down internally, the feared affective states often spontaneously present themselves. With encouragement, however, many patients persist in the practice and find lasting benefit in it.

The following two brief case examples demonstrate how different patients can self-pace and titrate exposure to painful feelings based on their own inner wisdom as to what is presently tolerable. In these examples, meditation can be used for either exposure or distancing, depending on what is needed in the moment. The therapist must be attuned to the patient and must find that balance in which the patient is neither pushed to experience the intolerable, nor allowed to avoid what is merely painful. The painful experiencing must occur, however within the context of compassion: both the therapist’s compassion for the patient, and the patient’s growing capacity for self-compassion. The Case of Mrs. C involves a patient with a simple straightforward diagnosis of PTSD, whereas the Case of Miss D involves

a complicated patient with a bipolar disorder characterized by a severe intractable depression, and borderline personality disorder. The first case called for simple symptom abatement without any major issues of self-development beyond learning to tolerate unpleasant experience. The second case involved a more complicated process of learning of how to self-titrate exposure to unpleasant experience based upon discriminating judgment and self-caring.

The Case of Mrs. C

Mrs. C was a non-complex PTSD patient who had been involved in a motor vehicle accident in which the driver of the other automobile had been killed. When Mrs. C sat still to meditate, images of the automobile accident would repeatedly present themselves, and she would begin to sob. The group leader gave her permission to cry during the meditations, and the patient felt safe enough within the group setting to allow herself to do so. Mrs. C spent the next several weeks meditating and quietly crying with the group. After several weeks of this, she reported that her experience while meditating had begun to change: the images of the accident would come up, but they would only stay for a few moments and then pass. In addition, she no longer found herself crying when they came up. After discharge from the IOP program, Mrs. C. joined an outpatient PTSD group, and eventually regained her ability to drive her car. She also became involved in a variety of compassionate activities as part of her personal project of atoning for the loss of life in the accident.

The Case of Miss D

Miss D, on the other hand, was a complex patient who suffered from both rapidly cycling bipolar disorder and borderline personality disorder. She took to mindfulness meditation quite readily, and found that it helped her to become grounded when she was not severely depressed, but was painful to her when she was at the deepest point in her depressions. Encouragement to be active and use distraction techniques seemed more helpful at those moments.

Miss D had completed an outpatient DBT program, and was being treated in a regular (non-DBT) IOP due to cyclical recurrent depressions with suicidal ideation. At one point in her treatment, while she was in the midst of an ECT trial because of an unyielding severe depression, the patient received word that her daughter had been murdered. Her ECT treatment was stopped at that point because the patient could not remember her daughter's murder from day to day, and this was severely complicating the grieving process.

Miss D came to meditation group in an emotionally numb state with the question of whether she should engage in concentration meditation and use a focus on her breath as a distraction from her deep inner pain, or whether she should use mindfulness meditation to stay with her grief. The patient was told to use her "wise mind" and decide what she really needed in this moment. The patient decided that she needed to remain numb, and that she could not possibly tolerate beginning to grieve. For several months she came to group and focused on her breath as a distraction and

as a form of self-soothing. At the end of those months, she told the group that she was ready to begin grieving, and then used mindfulness meditation to allow herself to touch and remain with her sadness in a productive way. Miss D's example demonstrates the kind of complexity that is involved in using meditative techniques with severely ill patients, but also demonstrates how a deep understanding of mindfulness can help a patient to develop self-care skills and a friendly approach to inner experiencing that allows for an increased trust in one's own judgment, and an increased ability to self-titrate one's exposure to disturbing emotions.

CONCLUSION

Fritz Perls (1947/1969) used to say that awareness per se—by and of itself—was curative. While some might consider that an overstatement, the fact is that an expansion in the realm of awareness is believed to be an important curative factor in a wide variety of therapies; becoming aware of what has previously been implicit or unnoticed is a component of experiential and insight-oriented therapies, and also of cognitive and behavioral therapies that utilize self-monitoring and self-regulation techniques. In addition, the ability to tolerate exposure to disturbing mental contents by focusing and maintaining awareness on them is an important part of behavioral therapies that rely on the process of exposure and desensitization. Mindfulness, both as a philosophical approach to inner experiencing, and as a behavioral technology for modulating attentional processes, holds promise as an adjunct to all of these therapies. While it can be valued as a specific skill which can be acquired and used for the purpose of symptom reduction, it can also be appreciated for its broader role as a facilitating factor in personality development.

Human beings grow and develop by: (a) expanding their schemas through the incorporation of new information, (b) becoming increasingly hardy through a growing tolerance for the unpleasant, (c) increasing their ability to inhibit responding so there is sufficient time to detect and evaluate relevant information, (d) increasing the integration of previously disparate informational realms, and (e) a continuing process of self differentiation and integration. Mindfulness can assist in many of these developmental processes by encouraging alert observation, non-reactivity, and acceptance. In addition, it can assist its practitioners to develop an inner space that can be characterized by calm equanimity. This new inner space, in turn, serves as a venue for the integration of cognitive and affective processes, which Linehan (1993) calls "wise mind," and Buddhism identifies as our "true nature." Our ability to develop this space with practice over time takes us out of the realm of psychopathology and into the realm of positive and transpersonal psychology¹.

There has been a lengthy discussion within transpersonal psychology about the relationship between psychopathological, normal, and transpersonal psychological functioning, development and organization, and whether these lie along a single continuum or reflect orthogonal or semi-independent processes, and whether there might be discrete stages involved in the progression from one realm to another (c.f., Engler, 1984; Wilber, 1985; Rubin, 2003.) The model proposed here sidesteps the contentious issue of stages, but views human development as advancing along many separate continua which are semi-independent, but which exert mutual influence on

each other, similar to the view expressed by Wilber (1999). These developmental lines include the twin lines of self-definition and interpersonal relatedness (Blatt, 1990), multiple lines of cognitive (Sternberg, 1985) and moral development (Kohlberg, 1984), and the development of a variety of spiritual attitudes, capacities, and understandings involving: (a) multiple decentrations (in Piagetian terms) of the self, (b) an increasing awareness, balancing, and integration of the experiential and rational information processing systems (Epstein, 1994), (c) increasing capacities for mindfulness and sustained focused attention, (d) an increasing sense of intimate and immediate connectedness to Being, and (e) an increasing capacity to extend one's caring to ever widening circles of beings. It is perfectly possible for exceptional levels of functioning on one continuum to exist side by side with pathological levels of functioning on another, and unremarkable levels on yet a third. This lack of synchrony between functional attainments is commonplace in psychology. For example, Strauss and Carpenter (1977) have pointed to a similar functional asynchrony in recovery from schizophrenia in which the reduction of positive symptoms, improvement in ability to work productively, and improvement in social relatedness are semi-independent realms, or what Strauss and Carpenter term "open-linked systems." In the model proposed here, there can be genuine *décalages* between these semi-independent developmental lines, but the functional level of one line can assist or hinder progress in another. Recovery from psychopathology, therefore, is often the result not so much of curing basic faults within the organism, as in compensating for innate or experientially induced deficits in one or more lines by developing areas of compensatory strength in others. This is precisely what Patients A and B have done, and it is why they can be, at one and the same time, still suffering from residual symptoms of illness, and impressive and admirable human beings.

The Buddhist Yogacara tradition posits the existence of *bija*, or seeds, that can be planted, and either flourish or wither in the *alaya-vijnana*, or what Waldron (2003) has called the "Buddhist unconscious." One need not necessarily completely uproot harmful seeds if one is busy nourishing beneficial ones. This is very much like cultivating a lawn, providing the right conditions for a desired grass seed to grow; the crabgrass then has no place to multiply and take hold. Indeed, the Buddhist term for meditation itself is *bhavana*, an agricultural term meaning "cultivation." Mindfulness is an essential aspect of the cultivation process that enables healthy seeds to develop and thrive.

NOTES

¹ The terms "positive" and "transpersonal" in this sentence are not being used interchangeably. The positive psychology movement was launched five years ago (Seligman & Csikszentmihalyi, 2000) to counterbalance psychology's historic emphasis on psychopathology. Its aim has been to explore those factors that promote human flourishing and optimize human well-being and happiness. It emphasizes the development of positive human states and traits (e.g., love, wisdom, aesthetic appreciation, spirituality) and civic virtues (e.g., altruism, responsibility, tolerance). To the extent that positive psychology and transpersonal psychology share an interest in the cultivation of eudaimonic states, there is overlap between them. Taylor (2001) has pointed out, however, that positive psychology has taken up some of the themes that have been the traditional concerns of the humanistic and transpersonal psychologies, but that it has constrained them within a logical positivist methodological and philosophical orthodoxy. So far, positive psychology has been wary of exploring non-ordinary states of consciousness, or the specific claims of non-Western spiritual systems. For example, when Seligman et al. (2005) discussed the domain of transcendence, the traits that defined that category were "gratitude," "hope," "humor," and "religiousness." Religiousness was defined as "having coherent beliefs about the higher purpose and meaning of life" (p. 412). This is a watered down concept of transcendence in which nothing is actually transcended; not the ego, and certainly not dualistic consensual reality. It is still gratifying, however, that mainstream psychology is finally returning to the exploration of the possibilities of human potential, even within this limited and limiting view of what human potential is.

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