

A chapter in Briere, J., & Scott, C. (2012). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment, 2nd edition*. Thousand Oaks, CA: Sage.

Chapter 10

Mindfulness in Trauma Treatment

Meditation and mindfulness have been described at various points in this book as potentially helpful for trauma survivors. We explore this component more directly in this chapter, outlining the research, goals, and methodology of mindfulness-relevant trauma treatment. Most intriguing is the possibility that such interventions do not just duplicate the effects of standard therapy, but they also provide “new”¹ or incremental technologies and perspectives that are especially suited to those who have had adverse experiences.

A rapidly growing number of researchers and clinicians have come to integrate mindfulness approaches into their therapies, both cognitive-behavioral (for example, Hayes, Follette, & Linehan, 2004; Segal, Williams, & Teasdale, 2002) and psychodynamic (for example, Bobrow, 2010; M. Epstein, 2008). In fact, even when mindfulness-based interventions are not specifically employed, various other aspects of Buddhist psychology or practice (for example, compassion, metacognitive awareness, and appreciation of dependent origination, each discussed in this chapter) can be helpful in work with traumatized people (Germer & Siegel, 2012).

¹Constructs such as mindfulness and nonegocentric compassion are thousands of years old, most associated with Buddhism, but also found in Christianity, Judaism, and other contemplative traditions.

What Is Mindfulness?

Mindfulness can be defined as the capacity to maintain awareness of— and openness to—current experience, including internal mental states and impinging aspects of the external world, without judgment and with acceptance (for a range of definitions, see Bishop et al., 2004; Germer, 2005; Kabat-Zinn, 2003; D. J. Siegel, 2007). The ability to attend to the present moment and view oneself and the world nonjudgmentally—as opposed to being preoccupied with (and affected by) negative aspects of the past, or worry about the future—is thought to decrease psychological suffering (Kabat-Zinn, 2003) as well as, we will suggest, allow certain helpful psychological processes to occur.

In Buddhism, mindfulness is one of a variety of activities whose ultimate purpose is to increase existential insight, reduce suffering associated with unnecessary attachments, and, ultimately, provide spiritual enlightenment. Although not without controversy in the Buddhist community (see, for example, Kearney, n.d. Wallace, 2006), the last several decades have witnessed a more secular application of mindfulness: as a component of psychological treatment to reduce psychological symptoms and problems (Baer, 2003; Hofmann et al., 2010). As we will see, mindfulness-based clinical interventions have been shown in research studies to be helpful for a wide range of psychological issues and complaints. Mindfulness is more than psychotechnology, however; we encourage the reader to view the therapeutic applications of mindfulness as a relatively small and excised part of the much broader domain of Buddhist psychology, which, we believe, can offer rich existential lessons and insights for traumatized and nontraumatized people alike.

An important component of mindfulness is the notion of acceptance, which involves acknowledgment of and openness to current experience of oneself and of one's situation, without defining it as “good” or “bad.” In an online interview (Goldstein, 2009), Brach described this as “an honest acknowledgment of what is going on inside you, and a courageous willingness to be with life in the present moment, just as it is” (para. 10). Similarly, Germer (2009) refers to this process as “a conscious choice to experience our sensations, feelings, and thoughts, just as they are, moment to moment” (p. 32).

In his discussion of acceptance, Steven Hayes, the originator of Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 2011), suggests that a major basis of human suffering is the attempt to avoid or control unwanted thoughts and feelings (“experiential avoidance”), whereas mindful acceptance involves an active attempt to embrace one's self and one's experience, including unwanted states, in the here-and-now, without judgment. As evidenced by the success of ACT in the treatment of a range of symptoms and disorders (see

reviews by Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Ruiz, 2010), the acceptance component of mindfulness may be important, above and beyond the development of attention and awareness skills also found in mindfulness training models. The implicit contradiction involved in embracing acceptance as a way to change one's thoughts or feelings was articulated in another context, long ago, by Carl Rogers (1961), who said, "The curious paradox is that when I accept myself just as I am, then I can change" (p. 17).

The first part of this chapter describes the applications of mindfulness to psychological distress from a science perspective, summarizing research on empirically evaluated mindfulness-based treatments. The second part attempts to apply those aspects of mindfulness most relevant to trauma as well as some of the existential/philosophical lessons of Buddhist psychology.

Research

Empirically based, structured mindfulness interventions have been shown to significantly reduce a variety of psychological symptoms and disorders, including many associated with trauma exposure:

- Anxiety and panic
- Depression, or prevention of relapse into depression
- Substance abuse
- Disordered eating
- Attention deficit disorder
- Self-injurious behavior
- Aggression
- Low self-esteem and other cognitive distortions
- Chronic pain
- The psychological effects of cancer and other life-threatening medical conditions
- Symptoms of fibromyalgia

- Chronic affect dysregulation
- Borderline personality disorder
- Aspects of bipolar affective disorder ((See the following reviews or meta-analyses of studies on the clinical efficacy of mindfulness for these and other difficulties: Baer, 2003; Coelho, Canter, & Ernst, 2007; Grossman, Neimann, Schmidt, & Walach, 2004; Hayes et al., 2006; Hofmann et al., 2010; Lynch, Trost, Salsman, & Linehan, 2007). (

Current Mindfulness-Based Therapies (

A number of different empirically validated mindfulness interventions have been developed over the last several decades, all of which are relevant to trauma-related distress. These include *Mindfulness-Based Stress Reduction* (MBSR; Kabat-Zinn, 1982), *Mindfulness-Based Cognitive Therapy* (MBCT; Segal et al., 2002), *Mindfulness-Based Relapse Prevention* (MBRP; Bowen et al., 2011; Marlatt & Gordon, 1985), *ACT* (Hayes et al., 2011), and *Dialectical Behavior Therapy* (DBT; Linehan, 1993a). Two of the most popular of these, MBSR and MBCT, are described below as examples of how mindfulness can be taught to clients with good effect.

MBSR

Developed at the University of Massachusetts Medical Center by Jon Kabat-Zinn, PhD, MBSR is the best known and most commonly employed mindfulness intervention in the West. It typically involves eight weekly group sessions, each lasting approximately two and a half hours, as well as one day-long session during the sixth week. In addition to homework assignments, participants are asked to meditate 6 days a week for 45 minutes each day. CDs and books on MBSR-related topics are also often employed. A central component of MBSR is instruction on how to do mindfulness meditation, including (a) specific sitting and lying positions, (b) focusing one's attention on a single target (for example, the breath, or sensations in the body), and (c) when, inevitably, the mind is distracted by emergent thoughts, emotions, or sensations, noting these intrusions in a nonjudgmental way and then returning to the target of attention. In a related activity, the *body scan*, participants are led through a guided exploration of sensations arising from the body, starting at the feet and eventually ending at the head. Other exercises include gentle stretching and Hatha yoga positions, and teaching and group discussions on mindfulness, meditation, and mind-related contributions to stress. MBSR has been shown to be effective in many studies of chronic pain and other health conditions, as well as anxiety, depression, sleep disturbance, binge eating, and overall psychological distress (see reviews by Baer,

2003; Grossman, et al., 2004).

MBCT

MBCT is an adaptation of MBSR, specifically targeted to preventing relapse in individuals with a past history of major depressive episodes, although now being applied to other domains as well, including anxiety (for example, Evans et al., 2008; Semple & Lee, 2011). This intervention typically involves eight 2-hour sessions and teaches many of the same skills as MBSR, such as mindful, nonjudgmental attention to thoughts, feelings, and sensations, and the development of meditation skills. However, MBCT focuses to a much greater extent on participants' thought processes, based on the well-established fact that cognitive distortions and negative preoccupations may become self-perpetuating and contribute significantly to the development of depression (Beck, 1995). Participants are especially taught to develop a “decentered” or “metacognitive” perspective on their thoughts, whereby negative cognitions or depressive thinking patterns are recognized as merely thoughts—not necessarily as evidence of the true state of reality. When they occur, such cognitive intrusions (for example, “I am a bad person,” “things are hopeless,” or “I can't do this”) are not suppressed, but rather they are noted dispassionately and considered mindfully—that is, as emergent processes of the mind that inevitably come and go, but that do not have intrinsic meaning or truth. Typically prescribed for individuals who have had at least three bouts of major depression in the past, MBCT has been shown to be helpful in preventing or reducing the severity of future depressive episodes in many studies (see Piet & Hougaard, 2011). Although MBCT was developed to prevent depression relapse, it also appears to be helpful in the treatment of ongoing depression as well (Hofmann et al., 2010).

Applications to Traumatized Individuals

Surprisingly, despite considerable discussion in the literature regarding applications of mindfulness in the treatment of PTSD (for example, Cloitre et al., 2011; Follette, Palm, & Hall, 2004; Germer, 2005; Orsillo & Batten, 2005; Vujanovic, Niles, Pietrefesa, Schmertz, & Potter, 2011; Wagner & Linehan, 2006; Walser & Westrup, 2007), there are relatively few empirical studies of mindfulness interventions for trauma survivors (Follette & Vijay, 2009). It is not clear why this is true, although possibilities include (a) the notion that trauma and PTSD are somehow more severe clinical presentations, such that current mindfulness-based treatment models might be overwhelming to clients, or (b) the dominance of classic cognitive-behavioral approaches to PTSD, such that mindfulness researchers have avoided this area.

The first concern has some circumscribed merit. As described in Chapter 2, those

with severe trauma-related difficulties may suffer from significant intrusive symptomatology, comorbidity, and reduced affect regulation capacities, and are sometimes involved in problematic avoidance activities (for example, substance abuse and suicidality). These issues and problems mean that some traumatized people are more easily overwhelmed than others, and possibly more vulnerable to interventions that increase access to negative internal states. For this reason, we outline possible contraindications for mindfulness-based interventions for traumatized people later in this chapter. This issue is not restricted to mindfulness, however; asking anyone who is in significant psychological pain to be more aware of their feelings, thoughts, and memories is asking a lot—whether in the context of exposure therapy, psychoanalysis, or mindfulness-based treatment.

The second possibility, that cognitive-behavioral therapy for trauma-related symptoms somehow precludes the use of mindfulness-based components, is no longer a compelling argument. Various writers describe a “third wave” of cognitive-behavioral theories and therapies, involving the explicit compatibility of mindfulness with CBT (for example, Hayes, 2004; Hayes, Follette, & Linehan, 2004). Further, as we describe later in this chapter, some of the primary active ingredients of mindfulness are seemingly cognitive-behavioral in nature, involving, for example, exposure, cognitive restructuring, and affect regulation training.

Despite such research impediments, at least one mindfulness-based treatment, DBT, has a long track record of success with client populations in which trauma is overrepresented, especially borderline personality disorder (Kliem, Kröger, & Kosfelder, 2010; Öst, 2008), and several research-clinicians have developed mindfulness interventions for child abuse survivors (Kimbrough et al., 2010; Smith, 2009; Steil, Dyer, Priebe, Kleindienst, & Bohus, 2011). Further, the empirically oriented National Center for PTSD, of the U.S. Department of Veteran Affairs, notes that “research findings show that mindfulness can help with problems and symptoms often experienced by survivors. Mindfulness could be used by itself or together with standard treatments proven effective for PTSD” (U.S. Department of Veterans Affairs, 2011, para. 9). We anticipate that applications of mindfulness training to trauma will increase substantially in the future as the power of such interventions become more obvious.

Mindfulness and Trauma Therapy

Although the mindfulness-based interventions described above have been shown to be helpful for a range of symptoms and concerns, many of which can arise from adverse experience, they have a singular limitation for classic trauma treatment: They are generally not implemented in the context of individual psychotherapy,

which is a central modality in work with seriously impacted trauma survivors. In fact, empirically based mindfulness interventions, almost without exception, occur in group settings and tend to be relatively nonclinically oriented, focusing more on the development of skills (for example, mindfulness, metacognitive awareness, capacity to meditate) than on individual psychological symptoms, per se (Baer, 2003). This is entirely appropriate, and skill development groups such as MBSR or MBCT (as well as ACT and DBT) can be very helpful adjuncts in work with traumatized persons, assuming there are no obvious contraindications. At the same time, it is unlikely that a person suffering from some combination of the various issues and problems listed in Chapter 2 would have all or even most of their clinical needs addressed by mindfulness-based groups, or a meditation practice, alone (see a paper by Buddhist teacher and psychologist Jack Kornfield, n.d., that addressed this issue with prescience). Finally, because mindfulness is often best learned through meditation, which can be contraindicated for some trauma survivors, the potential impacts of the client's trauma history—including trauma symptomatology—must be taken into account and monitored on an individual basis, so that the survivor is not adversely affected.

In this context, we suggest a hybrid approach:

1. *Screening for the appropriateness of mindfulness (typically meditation) training.* Experience suggests that clients who are subject to acutely overwhelmingly intrusive flashbacks, rumination, or easily triggered trauma memories are sometimes more likely to experience distress or destabilization when meditating (Germer, 2005; D. H. Shapiro, 1992; Williams & Swales, 2004), probably because meditation and mindfulness reduce experiential avoidance and provide greater exposure to internal experience, including memories and painful emotional states (Baer, 2003; Germer, 2005; Hayes et al., 2011; Treanor, 2011). Furthermore, as described in Chapter 2, some survivors suffer from reduced affect regulation/tolerance capacities, meaning that triggered sensory or emotional material may be more overwhelming once activated in meditation. More obviously, trauma survivors experiencing psychosis, severe depression, bipolar mania, significant suicidality, or some instances of substance dependence should typically avoid meditation-based mindfulness training until these symptoms or conditions are resolved or are under better control. Interestingly, research suggests that even these higher risk groups may sometimes gain from carefully administered mindfulness training (for example, Deckersbach et al., 2011; Langer, Cangas, Salcedo, & Fuentes, 2011; Williams & Swales, 2004). Even in such controlled circumstances, of course, the decision to employ mindfulness training must be made on a case-by-case basis. See Germer (2005) for common-sense suggestions regarding the use and adaptation of mindfulness practice with symptomatic trauma survivors.

Given these concerns, we recommend that clients considering meditation in the context of trauma issues be assessed for possible risk factors beforehand. In most cases, there will not be any psychological impediment to undergoing meditation/mindfulness training, and multiple benefits may accrue. In the remaining instances, the issue may be less that the client cannot ever attempt meditation, but rather that he or she only do so when he or she is more stable and/or less debilitated.

*2. For those who can tolerate it, and wish to learn mindfulness, referral to an MBSR or MBCT group, or a qualified meditation training center, where basic meditation skills can be learned.*² Mindfulness training during psychotherapy sessions can be inefficient in some cases, since such skills development usually requires a significant investment of time, during which, presumably, trauma-focused therapy would have to take a back seat. In addition, qualified meditation teachers typically have devoted years of training and experience to acquiring meditation and mindfulness skills, as well as knowledge of how to teach them to others—a background that may not be fully available to the average therapist.

In some lucky circumstances, the clinician will, in fact, be sufficiently experienced in both domains—a situation that may allow the client to receive both therapy and meditation/mindfulness training from the same source (see, for example, Brach, 2003, in press; Germer, 2005). In other contexts, the clinician may introduce elementary mediation instruction to increase relaxation or metacognitive awareness, but not spend an inordinate amount of time doing so. In either instance, the therapist should make sure that standard trauma-focused psychotherapy is not receiving short shrift by virtue of too much attention given to the development of meditation or mindfulness skills.

Although the clinician is unlikely to be the client's primary meditation teacher, his or her personal experience with meditation nevertheless can be important. During the period when the client is simultaneously attending psychotherapy and mindfulness training, the meditation-experienced therapist can monitor and inform the process—helping the client to understand and integrate what he or she is learning and experiencing in both domains, and continuing to assess the appropriateness of mindfulness training over time.

3. As the client gains meditation and mindfulness skills, these capacities can be

²As specific mindfulness training groups for trauma survivors (for example, Kimbrough et al., 2010) become more routinely available, they will obviously be the best referral option.

called upon during trauma-focused psychotherapy. Minimally, this may involve the following:

□ The use of *settling skills* learned in meditation. The individual who is able to decrease his or her anxiety or hyperarousal through meditation (Baer, 2003; Ogden, Minton, & Pain, 2000)—for example, by attending to his or her breath, engaging the here-and-now, and occupying a less self-identified cognitive perspective—can use these skills at points when therapy involves painful memories and triggered emotional states. Similarly, mindfulness skills involving the ability to “let go” of intrusive or persistent mental content may be helpful when the client encounters upsetting thoughts, feelings, or memories that dominate his or her experience during trauma treatment.

□ *Exposure*, as described in Chapter 8. Multiple writers (for example, Baer, 2003; Germer, 2005; Kabat-Zinn, 2003; Treanor, 2011) note that the decreased avoidance associated with mindfulness can expose the individual to emotionally laden memories in the context of a relatively relaxed state and a less involved, nonjudgmental, and accepting cognitive perspective—a process that is likely to desensitize and countercondition such material and decrease its power to produce distress (Briere, 2012). In the therapy session, this process (described by Zen Buddhist writers as “inviting your fears to tea” [unknown original author] or “leaning into fear” [Brach, 2003]) may be engaged by asking the client to recall traumatic events, and feel the attendant emotions, while intentionally engaged in as mindful a state as possible.

□ *Metacognitive awareness*, as described in Chapter 7. During trauma therapy, the client can be invited to consider his or her trauma-related negative cognitions, feelings, and memories as “just” products of the mind that are not especially real in the current context, but rather vividly reexperienced history. Although the intent is not to convince the survivor that his or her memories are irrelevant or, worse yet, delusive, he or she may be able to gain from increased awareness that such phenomena represent the reflexive actions of the mind or brain, and are not necessarily accurate feedback on the current state of reality.

□ *Reduced reactivity and need to engage in tension reduction activities or other avoidance behaviors.* The client’s meditation experiences and mindfulness training may also increase his or her affect regulation capacity, by essentially changing his or her relationship to thoughts, memories, and feelings. For example, as the survivor engages metacognitive awareness during therapeutically activated trauma memories and in the outside world, there may be less need for him or her to act on (or emotionally respond to) catastrophic, trauma-related cognitions such as “he’s disrespecting me,” “I’m in danger,” or “I deserve this.” Instead of seeing these intrusions as data about reality, the survivor may come to interpret them as

“old tapes” or “movies from my past,” at which point their perceived acuity and overwhelming nature may diminish, requiring less emotional regulation and need for avoidance strategies.

Another option, derived from Mindfulness-Based Relapse Prevention, is “urge surfing” (Marlatt & Gordon, 1985; Bowen et al., 2011; see also Chapter 6), wherein the client learns to apply mindfulness skills to sudden, often trauma-related cravings or urges to engage in substance abuse or a tension reduction activity. Reflecting Kabat-Zinn’s (1994) reminder that “you can’t stop the waves, but you can learn to surf” (p. 32), the survivor is encouraged to see the need to tension-reduce as similar to riding a wave: The need starts small, builds in size, peaks (often at around 20–30 minutes), and then falls away. If the client can view triggered feelings as temporary intrusions that can be ridden like a surfboard—neither fought against nor acted upon—he or she may be able to avoid problematic or self-destructive behavior, whether taking a drink, using a drug, bingeing or purging, or engaging in self-mutilation.

4. *In the context of ongoing treatment, the therapist can encourage existential insight*, potentially changing the client’s perspective on situations and events that otherwise might produce greater distress. Such insight does not involve the development of a skill, as is true for mindfulness, but rather tends to occur as the client explores basic life assumptions in conversations with the clinician or, when relevant, in the context of meditation. Among these notions are *attachment*, *impermanence*, and *dependent origination*.

In Buddhist psychology, *attachment* refers to “grasping” or “clinging,” involving the desire to hang on to or overly invest in things that, ultimately, are impermanent.³ *Impermanence* refers to the fact that all things are in a state of flux, and that no thing or event lasts forever. The ubiquitous need for things that do not last, or may not even exist, is thought in Buddhism to increase human suffering. As a result, this perspective counsels against preoccupation with material possessions, wealth, or prestige, as well as rigid ideas or perceptions about oneself or others, since these things and ideas are inevitably unsustainable and unreliable, resulting in loss, disappointment, and unhappiness (Bhikkhu Bodhi, 2005).

Importantly, the proscription against undue attachment does not mean that one should not possess anything, maintain self-esteem, or enjoy various activities—

³Note that this Buddhist construct does not correspond to what is described as attachment in developmental psychology. The latter refers to a positive, interactive psychobiological function in humans that allows close and intimate relationships.

only that one should not be preoccupied with them, nor deceived that such things will last indefinitely. In a similar vein, there is nothing “wrong” with (and much that is good about) loving or caring for others and wanting to be cared for; on the other hand, it is probably helpful to acknowledge and accommodate the fragility of the lives and phenomena involved, the inevitability, at some point, of loss, and the not necessarily accurate expectations and perceptions that one can bring to close relationships. In fact, the appreciation of such transience and insubstantiality, given our need for succor and connection, may easily make our relationships more precious, not less so.

Trauma is a powerful threat to attachment, since it often involves the loss of people, possessions, social status, beliefs, hopes, self-esteem, and well-being. The burn survivor may have to grapple with disfigurement or diminished functioning; the disaster victim may have lost possessions, property, and perhaps loved ones; someone who has been raped or tortured may suffer the loss of belief in personal safety, justice, or the beneficence of others; and the heart attack survivor may have to confront previously unexamined assumptions about personal immortality. Thus, there may be two sources of distress associated with any given trauma—the event itself, and the interpretations and loss that follow from it.

One of the earliest Buddhist teachings describes this binary aspect of pain and reaction to pain in the parable of a person shot with two arrows, one immediately following the other. The first arrow is the objective pain felt when encountering an adverse event, such as a trauma or loss. The second arrow is the extent to which the pain is exacerbated by needs and responses that increase suffering—especially those involving nonacceptance (Thanissaro Bhikkhu, 1997). Although the original parable (at least in translation) appears somewhat judgmental of those afflicted by the second arrow, this is, of course, the human condition—it is unlikely that any person can entirely avoid triggered states or resistance when exposed to very hurtful events. Nevertheless, to the extent that treatment can reduce this second source of suffering by (a) loosening the survivor’s grip on beliefs, needs, and expectations that have been challenged or proven false and (b) redirecting his or her attention to more realistic, nourishing, and accepting ways of being, the survivor may be able to change what is possible to change—his or her perspective and understanding—as opposed to what cannot be changed—the trauma or its concrete impacts.

Finally, *dependent origination* holds that all things arise from concrete conditions and sustaining causes, which, themselves, arise from other causes and conditions (Bhikkhu Bodhi, 2005). In other words, all events occur because of the effects of previous events: No event occurs independently or in isolation. This view is in agreement with the basic principles of behavioral science—that people do things because of the influence of other things. Dependent origination and Western

psychology both suggest that attributions of badness, inadequacy, or even pathology to self or others may be due to insufficient information: If we could know about the logical *why* of a given person's (or our own) problematic behavior or painful history, we would be less likely to judge or blame him, her, or ourselves (Briere, in press).

In the typical instance, the clinician might encourage the client to explore his or her thoughts, feelings, and reactions, and provide nondirective opportunities for the *whats* of the traumatic event: What did the client believe about him- or herself before the trauma? What hurts the most now, after the trauma has passed? What is the client resisting that is nevertheless true? What was the first arrow? What was the second? When this process occurs in the absence of pressure from the clinician to decide on one version versus another, in the context of noncontingent acceptance and support, the client's detailed analysis may lead to a slow transition (a) from a view of self as weak or pathological to that of someone who was not responsible for what happened and whose responses (then and now) may be the logical effects of traumatization, and, in some cases, (b) from a view of the perpetrator or abuser as intrinsically evil to that of someone whose behavior arose from of his or her own problematic predispositions and adverse history. Importantly, this second notion does not mean that the victim should immediately or necessarily "forgive" the perpetrator, especially to the extent that doing so implies that the survivor is not entitled to negative feelings and thoughts (Briere, in press). In fact, as noted at various points in this book, social or personal pressure to block or avoid painful internal states (including anger) may inhibit the normal psychological processing necessary for recovery. Yet it is likely that the unabated experience of hate and deep resentment is bad for people, whereas being less involved in such states can improve mental well-being (Dalai Lama & Goleman, 2003). From this perspective, embracing dependent origination is not necessarily in the service of redeeming the perpetrator, but, rather, is for the benefit of the survivor (Kornfield, 2008).

The Mindful Therapist

Not only can it be helpful for the trauma client to increase his or her mindfulness and existential appreciation, as described above, the clinician's level of functioning in these areas is also important. A therapist who is able to focus his or her attention on the client in an alert, accepting, and compassionate way will almost inevitably increase the quality of the therapeutic relationship (Bruce, Shapiro, Constantino, & Manber, 2010). A positive client-therapist relationship, in turn, as described in Chapter 4, appears to be the most helpful general component of treatment—often exceeding the effects of specific therapeutic interventions (M.

J. Lambert & Barley, 2001; M. J. Lambert & Okishi, 1997; Martin et al., 2000). This is especially true for the trauma survivor in therapy, where a positive relationship can be both a minimal requirement and a powerful intervention (Cloitre, Stovall-McClough, Miranda, & Chemtob, 2004; Pearlman & Courtois, 2005).

Several aspects of therapist mindfulness may contribute to the positive therapeutic conditions that assist and comprise trauma therapy, as outlined in Chapter 4. These potentially include *empathic attunement*, *compassion*, *unconditional positive regard*, and *reduced transference-related reactivity*.

Because mindfulness involves the learned capacity to pay close and non-judgmental attention to internal and external phenomena, it can assist the clinician in maintaining a significant degree of attunement to the client (Germer, 2005; W. D. Morgan & Morgan, 2005; S. L. Shapiro & Carlson, 2009). In fact, D. J. Siegel (2007) suggests that mindfulness is, ultimately, a form of self-attunement that, in turn, allows the practitioner to attune to the internal experience of others. In their helpful discussion of the role of therapist mindfulness in the psychotherapeutic relationship, Bruce et al. (2010, p. 83) note that “through mindfulness practice, a psychotherapist comes to increasingly know and befriend himself or herself, fostering his or her ability to know and befriend the patient.” Not only does this state increase the capacity of the therapist to understand and “diagnose” the client’s ongoing experience, but it may help the client to process negative interpersonal schemas and emotional responses.

As described earlier, when attunement is continuously experienced by the client, especially if the clinician’s compassion is also evident, the client may enter a form of attachment activation, engaging psychological and neurobiological systems that encourage openness and connection, reduce expectations of interpersonal danger (and, therefore, defensiveness), and increase well-being. These positive feelings, elicited in an interpersonal context that might otherwise trigger fear in the trauma survivor, tend to countercondition relational distress, producing an increased likelihood of trust and interpersonal connection (Briere, 2012).

The therapist’s mindfulness not only allows him or her to foster attunement and compassion toward the client, but it also serves as a partial protection from his or her own excessive or inappropriate reactivity during psychotherapy. By facilitating greater awareness of his or her internal processes, mindfulness helps the clinician to better understand the subjective and multidetermined nature of his or her own thoughts, feelings, memories, and reactions—a form of the metacognitive awareness described in Chapter 7. As he or she is more able to recognize specific emotional and cognitive responses to the client as potentially triggered phenomena—as opposed to arising solely from the client’s clinical presentation—the therapist can place them in proper perspective before they result in significant

countertransferential behaviors or, potentially, vicarious traumatization.

Developing Mindfulness in the Therapist

If clinician mindfulness and compassion has positive effects, the obvious question is how this capacity can be developed or enhanced. In general, the best answer—as for the trauma client—appears to be a regular meditation practice. Although there are many books available to the clinician that teach *about* mindfulness, regular meditation provides the structure, repetitive opportunity for skills development, and, eventually, existential insights usually necessary to meaningfully increase mindfulness. Furthermore, most authorities on the clinical application of mindfulness (for example, Kabat-Zinn, 2003; Semple & Lee, 2011; S. L. Shapiro & Carlson, 2009) require that the therapist already have a regular meditation practice before attempting to teach mindfulness to others. This does not mean, of course, that important understanding of mindfulness and compassion cannot be gained by attending lectures or workshops, or by reading books by teachers such as Batchelor (1997, 2010), Boorstein (2002), Brach (in press), Chödrön, (2000), Hahn (1987), Kornfield (2008), or Salzberg (1995); in our experience, this information can be quite helpful. However, as various teachers suggest, mindfulness, in particular, is probably best learned experientially, in the same way that reading about riding a bicycle is usually insufficient for being able to actually ride one.

In Western cultures, there are generally two related ways in which clinicians can learn to meditate and cultivate mindfulness: by attending classes or trainings at an established meditation or retreat center, or by participating in a formal MBSR or MBCT training. In either case, we recommend the clinician attend a center that provides classes or trainings with experienced, accredited teachers. In the United States, there are high-quality retreat centers on both the West and East Coasts (for example, Spirit Rock [<http://www.spiritrock.org>] and the Insight Meditation Society [<http://www.dharma.org>], respectively), as well as city-based retreat and training centers (for example, InsightLA [<http://www.insightla.org>] in Los Angeles and the Zen Center of New York City [<http://mro.org/firelotus>]). The reader is referred to <http://www.dharmanet.org/listings> for other training locations in North America and beyond.

Suggested Reading

- Baer, R. A. (2003). Mindfulness training as a clinical intervention: A conceptual and empirical review. *Clinical Psychology: Science and Practice, 10*, 125–143.
- Batchelor, S. (1997). *Buddhism without belief: A contemporary guide to awakening*. New York, NY: Riverhead Books.
- Briere, J. (2012). Working with trauma: Mindfulness and compassion. In C. K. Germer & R. D. Siegel (Eds.), *Wisdom and compassion in psychotherapy* (pp. 265–279). New York, NY: Guilford.
- Bruce, N., Shapiro, S. L., Constantino, M. J., & Manber, R. (2010). Psychotherapist mindfulness and the psychotherapy process. *Psychotherapy: Theory, Research, Practice, Training, 47*, 83–97.
- Germer, C. J., Siegel, R. D., & Fulton, P. R. (2005). *Mindfulness and psychotherapy*. New York, NY: Guilford.
- Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. *Clinical Psychology: Science and Practice, 10*, 144–156.
- Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*. New York, NY: Guilford.