by

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West Meets East

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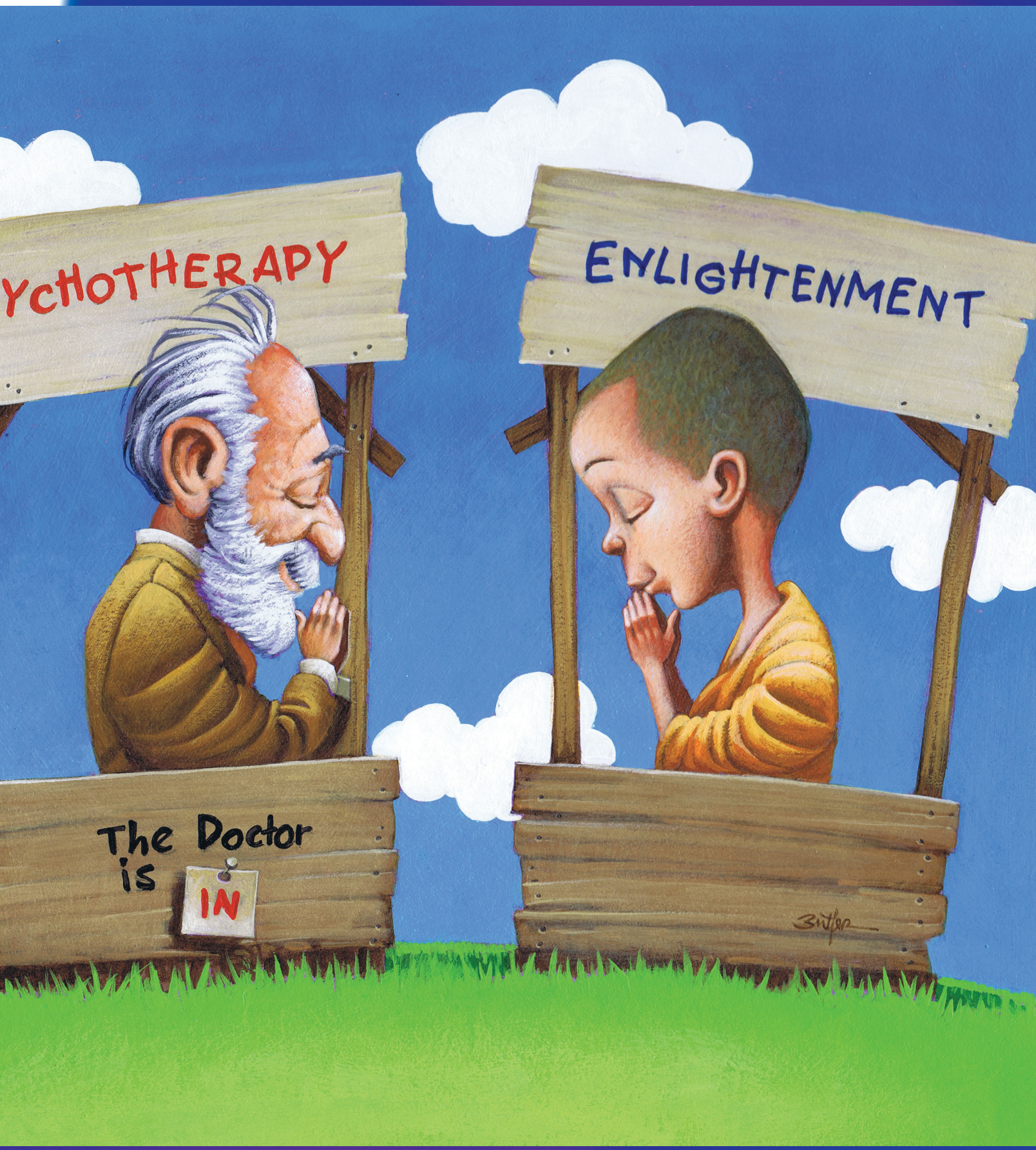
TWENTY-FIVE YEARS AGO, when our small group of Boston therapists began meeting to discuss how we might apply ancient Buddhist meditation practices in our work, we didn't often mention it to our colleagues. Most of us had trained or were working in Harvard Medical School facilities, and the atmosphere there was heavily psychoanalytic. None of us wanted our supervisors or clinical teammates to think of us as having *unresolved infantile longings to return to a state of oceanic oneness*—Sigmund Freud's view of the meditation enterprise.

CREATING A NEW WISDOM TRADITION

■ At that time, Buddhist meditation was becoming more popular in America, and intensive meditative retreat centers were multiplying. The new centers often were staffed by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Western teachers, many of whom had first encountered meditation in the Peace Corps and later trained in monastic settings in the East. Some of our group had studied in Asia; others had been trained by these newly minted Western teachers. Regardless of our backgrounds, what we shared was that we'd all experienced how radically meditation practices could transform the mind.

Therapists of the day typically viewed meditation as either a fading hippie pursuit or a useful means of relaxation, but of little additional value. Meditation teachers had their own biases toward psychotherapy, typically regarding it as a "lesser practice," which might prepare someone for meditation but couldn't really liberate the mind. So those of us who were involved in both domains, and viewed them as complementary, largely kept to ourselves.

During the subsequent decade, while the therapy and meditation communities continued to show little interest in each other, mindfulness meditation was making inroads into the medical community. This was largely through the efforts of Jon Kabat-Zinn, who, beginning in 1979, had adapted ancient Buddhist and yogic practices to create Mindfulness-Based Stress Reduction (MBSR) at the University of Massachusetts Medical Center in Worcester. This standardized, 8-week course couched meditation practices in Western, scientific terms. Their working definition of mindfulness—"the awareness that emerges through paying attention on purpose, and nonjudgmentally, to the unfolding of experience moment to moment"—made the concept readily accessible.

In its early years, MBSR was used primarily to augment the treatment of stress-related medical disorders, and was of particular interest to clinicians working in behavioral medicine. It wasn't considered a form of psychotherapy, and MBSR teachers weren't necessarily psychotherapists. In Boston and other psychoanalytically oriented cities, therapists were finding other developments more compelling. The zeitgeist was shifting toward biological psychiatry and short-term treatment. Cognitive-Behavioral Therapy (CBT) began to gain traction, along with a variety of systemic and humanistic approaches. Meditation practices received little attention.

Mindfulness Meets Psychotherapy

The first use of mindfulness in psychotherapy to capture widespread attention among clinicians was Marsha Linehan's Dialectical Behavior Therapy (DBT), introduced in the early 1990s to treat suicidal individuals with complex disorders for which little else seemed to work. The central dialectic in DBT is the tension between acceptance and change. In searching for a means of helping therapists and their clients to experience what she called "radical acceptance"—fully embracing helplessness, terror, losses, and other painful facts of life—Linehan drew on a number of mindfulness practices from Zen traditions and Christian teachings. Because she empirically demonstrated that DBT could help challenging and volatile patients, the method rapidly became popular. Interest in it grew throughout the 1990s, but even though mindfulness skills were a core part of its approach, mindfulness practices still didn't gain much acceptance within the wider therapy community.

The next big development came from Zindel Segal, Mark Williams, and John Teasdale, cognitive psychologists in the tradition of Aaron Beck, who were working on treatments for depression in the 1990s. They came across mindfulness practice through Jon Kabat-Zinn and MBSR, and were struck by its power. This led them to formulate a treatment, eventually called Mindfulness-Based Cognitive Therapy (MBCT), which combined elements of an 8-week MBSR course with cognitive therapy interventions designed to help patients gain perspective on their thinking and not identify with their depressive thoughts. The first results of their work, published in 2000, were dramatic: for patients who'd suffered three or more major depressive episodes, attending an MBCT group cut their relapse rate by 50 percent over the next year. Since not many interventions in our field cut anything in half, this caught the attention of the

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CBT community and piqued interest in mindfulness practices.

Around the same time, Steven Hayes and his colleagues had been developing behavior therapies based on a radical philosophical orientation that they called "relational frame theory." They didn't initially describe their work as mindfulness-oriented, but as the word began to be used in behavioral-research circles, they started to adopt it. Their treatment is called Acceptance and Commitment Therapy (ACT), which they describe as a psychological intervention that uses acceptance and mindfulness strategies, together with commitment and behavior change strategies, to increase psychological flexibility. ACT doesn't teach many formal meditation practices, but uses imagery, metaphor, and brief exercises to cultivate awareness of the present, loosen identification with thought, and increase openness to the experience of moment-to-moment change. Beyond these more traditional mindfulness practices, ACT encourages clients to identify and pursue activities that give life meaning.

Throughout this period, our study group in Boston was emerging from obscurity. In the mid-1990s, we formed The Institute for Meditation and Psychotherapy and began putting on small conferences and workshops for clinicians. During the first few years of the new millennium, interest grew rapidly, and by 2005, members of our group published the first comprehensive professional text on the subject, *Mindfulness and Psychotherapy*. In the same year, we approached Harvard Medical School with the idea of developing a conference on the topic. We worried that the committee that decides these matters would feel it was an unsuitable subject for such an august institution, but after being presented with peer-reviewed published studies on the topic (mostly coming from CBT circles), they agreed to let us try. Seven hundred people showed up, and the conference was a great success. It was clear that times were changing.

Today, the picture is dramatically different. In a 2007 survey conducted by the *Psychotherapy Networker*, 41.4 percent of the nearly 2,600 therapists who responded reported that they were practicing some form of "mindfulness therapy." Mindfulness-based treatments are now being introduced into graduate programs, are frequently discussed at academic conferences, and are a constant on the workshop circuit. Certificate programs are appearing. Books about mindfulness for the treatment of you-name-it are coming out weekly, and we've even gotten to the stage where we're beginning to see titles like "Beyond Mindfulness."

Is this just a passing therapy fad? If so, why has it taken off so rapidly? Is it another therapeutic bubble? Or has the field really stumbled upon something that has the potential to fundamentally change the way we practice?

Several explanations of the explosion of interest in the integration of mindfulness practices and psychotherapy have surfaced. One dates back to counterculture days: a lot of baby boomers back then experimented with consciousness-altering substances and practices, eventually turned to meditation, and later became psychotherapists or psychological researchers. Now that they're the elders, they're coming out of the closet in droves. (As Steve Hayes put it, "The crazies are driving the bus.")

Another explanation relates to the evolution of behavior therapy, which involves three major developmental phases. The first, behavior therapy proper, was classical conditioning and behavior modification. As time passed, behavioral clinicians realized that these approaches, based on animal learning, miss something vital about human beings: we think and feel a lot. So CBT was born, based on the idea that we can use learning theory to modify patterns of thoughts and feelings, and by doing so, improve both behavior and subjective experience. It soon came to dominate the psychotherapy world.

What both behavior therapy and CBT have in common is the intent to change overt or covert maladaptive behavior. Both have historically deemphasized elements of the psychodynamic and humanistic traditions from which they differentiated themselves—particularly the importance of an intimate therapeutic relationship and the need to accept, move toward, and be *with* difficult emotional experiences. Once mindfulness practices had been introduced to the CBT community through DBT and MBCT, they became a vehicle through which CBT clinicians could deliberately incorporate acceptance and therapeutic presence into their work. Interest in it took off, and research supporting its efficacy exploded.

Another factor behind the popularity of the mindfulness movement involves the mainstreaming of ancient mind-training disciplines like yoga and tai chi, which only "counterculture types" once practiced. Now virtually every health club and community center offers classes, and participants include athletes, artists, lawyers, and business executives. This trend has ushered in openness to ideas from Eastern wisdom traditions, which have trickled into the medical field.

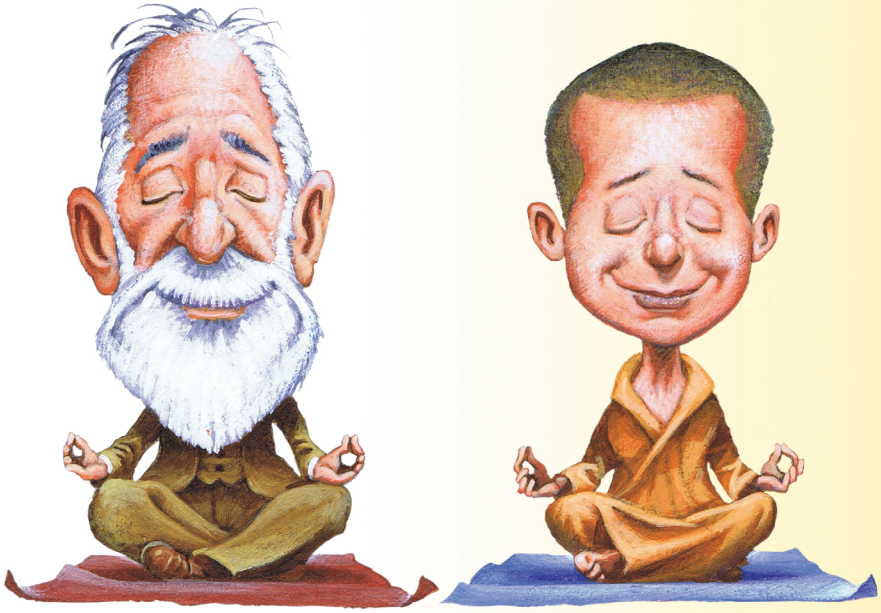
Our Troublesome Wiring

The most compelling argument supporting the use of mindfulness practices to treat a wide range of disorders is based on evolutionary psychology: *we didn't evolve to be happy*. In this line of reasoning, mindfulness practices were first developed in ancient times to counteract vestigial neurobiological mechanisms that make us miserable, and these same practices can be successfully adapted in modern psychotherapy to the same ends.

Biologists agree that natural selection favors whatever increases organisms' chances of survival to the age of procreation, allows them to mate successfully, and helps their offspring do the same. So this is what our minds evolved to do. If we imagine our ancestors on the African savannah several million years ago, they had little chance of survival relying upon their fingernails, teeth, hearing, sight, and smell. In most of these areas, they were much less well equipped than the competition, and in some, they were downright pathetic. (Imagine confronting a lion with your bare hands.) What we had, of course, was the ability to think, and hands with opposable thumbs with which to make

tools. So it's no accident that the first thing most of us discover when we take up mindfulness practice is that our minds are thinking machines—they just won't stop.

But evolutionary psychologists tell us that we didn't evolve to think just any thoughts. The ancient hominids who repeatedly thought about bad stuff—who remembered what they saw a lion do, or what happened when someone backed over a cliff—were likelier to survive. If they forgot the good stuff—a satisfying sexual encounter or the location of a luscious piece of fruit—they still lived another day. So we evolved minds that are like Velcro for bad thoughts and Teflon for good ones. Our ancestors weren't the happy hominids—they usually died before having kids.



Another product of natural selection is our remarkably effective stress-response system. Our fight-freeze-flight responses are reliably activated in response to any perceived danger. This frequently saved our ancestors and an astonishing variety of other mammals from perishing. It just doesn't work so well in tandem with highly evolved cerebral cortexes. While other animals' arousal systems reliably return to baseline shortly after danger has passed, ours get stuck in the "on" position as we think about what's coming next. All day long, we think about what went wrong in the past and might go wrong in the future, experiencing painful emotions each time. Mark Twain summed this up nicely near the end of his life: "I am a very old man and have suffered a great many misfortunes, most of which never happened."

Another hardwired evolutionary heritage that gets us into trouble is our predilection to seek pleasure and avoid pain. This, too, has been adaptive. Most things our ancestors found pleasurable, such as having sex, eating when hungry, finding warmth when cold, or cooling off when warm, contributed to survival. Similarly, avoiding pain usually meant keeping the body intact. What could be wrong with this? A lot, it turns out.

Several years ago, David Barlow, the prominent anxiety researcher, was talking at a conference about tension that had arisen between two groups involved in developing the *DSM-5*: the *splitters* and the *lumpers*. The splitters felt that the problem with the *DSM-IV* was that it didn't have sufficiently refined categories. Further subdivisions of diagnoses were needed to avoid mixing apples with oranges. The lumpers felt this approach was wrongheaded, missing the forest for the trees. Our separate diagnoses obscure the commonalities among different forms of psychopathology, they argued.

The splitters challenged them: "What commonalities?" they asked. "We don't see any." The lumpers replied: "experiential avoidance." All psychological distress, they said, involves trying to avoid unpleasant experiences, or trying to hold on to pleasant ones. Whether it's the drug addict numbing his sadness with a fix, the phobic person warding off anxiety by taking the train instead of the plane, the depressed individual sidestepping anger through emotional deadening, or even the psychotic patient becoming delusional rather than feeling the heartbreak of a loss, most emotional disorders involve trying to feel better by avoiding something unpleasant. So here again, an adaptation that's well-suited to survival contributes to our suffering.

It gets worse. As if all of these propensities weren't enough, we seem to be hardwired to try to enhance our self-esteem. Robert Sapolsky, a neuroscientist at Stanford, spent the last couple of decades hiding behind blinds of

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vegetation in Africa, watching baboon troops. He and his colleagues would wait for a particularly dramatic interaction among the baboons and then anesthetize the group, draw blood, and study their stress hormones. When he was being interviewed on the NPR program *Fresh Air*, Terry Gross asked him, "What did you learn?" Sapolsky wavered, emphasizing how much more complex stress responses are than we used to think. Wanting a memorable interview, Gross pushed him harder. "Well, we did discover one thing repeatedly," he said. *"It's particularly bad for your health to be a low-ranking male in a baboon troop."*

Now we, as the smart monkeys, may feel that this doesn't apply to us. But it's no accident that kids in middle school refer to their insults as "ranking" on one another. As adults, we constantly fill our minds with comparisons to others: who has the better body, mind, house, car, spouse, therapy practice, or children. Indeed, it makes sense that our minds are wired this way—only high-ranking hominids got to mate, so those who weren't concerned about rank didn't get to pass their genes on.

Unfortunately, this, too, makes us pretty unhappy, because none of us—except a select few, with really bad character disorders—always wins in these mental comparisons. Compounding this litany of ways we make ourselves feel bad is our terrible prognosis: we're all going to get sick and die, and on the way, we're likely to decline. No wonder we're so often upset.

Mindfulness as the Universal Elixir

Proponents claim that mindfulness practices actually address all of these evolutionary difficulties. First, they mitigate our propensity to dwell in painful thoughts by redirecting attention out of the thought stream toward awareness of sensory experience. Most practices begin by developing concentration: we direct our attention to the breath, the feeling of the soles of the feet contacting the ground, the sound of a bell, or some other set of sensations. Each time we notice that the mind has left its focus and been hijacked by a train of thought, we congratulate ourselves for noticing, and gently bring our attention back to the moment-to-moment sensory experience. We then repeat this about a billion times.

The result is that we begin to see thoughts as secretions of the mind, arising and passing like clouds moving across a vast sky. We stop believing in them as we once did. That, in turn, lessens their grip and reduces our emotional reactivity to them.

This is a significant departure from traditional CBT, which encourages clients to notice thoughts, and properly label them, but then try to replace irrational, maladaptive thoughts with more adaptive ones. Mindfulness practice is like CBT on steroids: we regard all thoughts as untrustworthy—a passing show, rather than representations of reality.

Mindfulness practices also take a different approach to unpleasant experiences in the body, such as physical pain and negative emotions. Rather than seeking ways to lessen these, or distract ourselves from them, we practice bringing open, curious, loving attention to the experiences—a sense of "what might this be?" We then allow them to stay as long as they like, trusting that painful feelings, like everything else, will eventually change.

This is why mindfulness practice is often described as the "third wave" of behavioral treatments, following behavior therapy proper and CBT. Instead of trying to control experience, it helps us learn how to be *with* experience and accept it. This can address our other evolutionary problems. Acceptance modulates our stress response. As we come to see our thoughts about everything that has and might go wrong as passing objects in the mind, they create less distress. Our system is quite good at returning to baseline when it isn't rearoused by thoughts of impending disaster. Most of us also have a robust tendency to become stressed out about our stress responses: "Oh my God, I'll never be able to give the speech. I already feel so nervous." By practicing acceptance of changing body sensations during meditation, we learn to ride the waves of unpleasant emotional responses during the rest of our day.

Thus, mindfulness is the opposite of experiential avoidance, the mechanism that the lumpers say accounts for most psychological disorders. It allows us to feel the urge to have an alcohol drink arise and pass rather than heading to the bottle, to get on the airplane and feel the fear rather than stay grounded, to be with the tight muscles and violent imagery of anger rather than shut down in depression, and to feel hurt rather than escape into delusion.

Finally, mindfulness practices can help us loosen our preoccupation with ourselves. Concerns about our rank, health, mortality, and all the rest are tempered as we see that there's ultimately no "me" there, but just the unfolding of neurology, moment by moment.

What's Wrong with This Picture?

As neurobiological research expands to show that mindfulness practices change brain structure and function in meaningful, measurable ways, and clinical research continues to show that it can be helpful in treating a wide range of disorders, how could it *not* be destined to revolutionize psychotherapy? The main reason is that it requires effort—often a lot more effort than clients, and sometimes even therapists, are willing to muster.

The most compelling positive results of mindfulness practice—the radical shifts in how we experience ourselves and the world—don't usually come about from casual dabbling. While there are mindfulness practices to fit every lifestyle, including informal practices like mindful walking, showering, driving, and dishwashing, which don't require taking extra time out of our day to meditate, most people need to set aside time for formal meditation practice to see substantial changes in psychological functioning. This means being willing to open up to unpleasant experience—whether anxiety or restlessness that draws us toward something more entertaining, or intimate encounters with previously split off emotions, including sadness, anger, loneliness, and vulnerability. Our culture doesn't provide a lot of support for this sort of

work. We're continuously offered distractions in the form of smartphones, iPods, and the like. All signs indicate that we're rapidly moving in the direction of nonstop entertainment, which will continue to distract us from the contents of our minds. Given this, mindfulness practices may never reach their promise of really transforming psychotherapy, and may remain the domain of a small group of therapists and their clients.

Regardless of whether there's a mindfulness revolution on the horizon, it's important to make the technique as clinically relevant as possible. To do so, we must bear in mind several things.

One Size Doesn't Fit All

My colleagues and I had the privilege a couple of years ago of having the Dalai Lama join us at Harvard Medical School for a conference on Compassion and Wisdom in Psychotherapy. At one point, my co-director, Christopher Germer, asked His Holiness to lead us all in a brief meditation. In his inimitable style, the Dalai Lama reacted as though the request was pretty funny: "I think some of you may want just one single meditation—a simple one, and 100 percent sort of positive. That, I think, impossible." He went on to explain that there are countless states of mind that lead to suffering, and, consequently, countless meditation practices needed to work with them skillfully. What a given person needs at a given time is a complex matter. He concluded, "Some other sort of companies, they always advertise some simple thing, or something effective, something very cheap. My advertising is just opposite. How difficult, and complicated!"

As with most catchy "new" ideas, integrating mindfulness into psychotherapy has involved reducing a complex set of insights and practices into "some simple thing." Now that mindfulness has become respectable in psychotherapy circles and is being taught at establishment institutions, we're beginning to see a more nuanced approach.

Most Western meditation teachers originally emphasized developing concentration (the capacity to step out of the thought stream and focus attention on a chosen object of awareness) and mindfulness per se (open-field awareness, which allows us to be conscious of what the mind is doing at each moment, and thereby see how it creates suffering for itself). Not surprisingly, these skills have been at the heart of the mindfulness practices incorporated into MBSR, DBT, and MBCT, out of which most other mindfulness-based treatments evolved. But these are only a couple of the skills that 2,500 years of systematic mind training in Asia has identified.

More recently, Western meditation teachers began emphasizing other practices, designed to develop different mental faculties, such as *metta* (loving-kindness practice, to cultivate an accepting, loving attitude toward oneself and others), *tonglen* (giving-and-taking practice, to allow us to work skillfully with painful emotions), and compassion practices from Tibetan and other traditions.

Following suit, Western clinicians and researchers are increasingly exploring how these and other practices can be adopted into psychotherapy, expanding the range of interventions loosely organized under the "mindfulness" banner. They're even beginning to pay attention to ethics, which in Buddhist traditions are seen as a necessary foundation for any meditation practice. For example, Barbara Fredrickson, who introduced the Broaden and Build model of well-being in Positive Psychology, has shown that loving-kindness (*metta*) practices make people demonstrably happier. This upward shift in positive emotions increases their environmental mastery, improves their relations with others, enhances their self-reported health and life satisfaction, and reduces depressive symptoms. Kristin Neff, a pioneer in studying self-compassion, has shown that people with more self-compassion are less anxious and depressed, have greater emotional intelligence, more capacity for perspective, and experience more happiness, optimism, curiosity, and positive affect. She and Germer have developed and tested a standardized 8-week Mindful Self-Compassion therapy group, incorporating a number

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of compassion practices, with promising results. On a related track, in the United Kingdom, professor Paul Gilbert, founder and president of The Compassionate Mind Foundation, has developed Compassion Focused Therapy. This method uses variations on mindfulness and Tibetan Buddhist compassion practices to treat a variety of difficulties, but especially depression, a disorder in which compassion toward oneself is sorely lacking.

Is Mindfulness for Everyone?

All this suggests that we're beginning to move away from a simple, generalized approach to a more customized one. And we're starting to ask more sophisticated questions: What effect does each practice have on the heart and mind? Who needs what practice when? Are there components of these traditions that we generally shouldn't adopt, or shouldn't adopt for particular individuals?

Perhaps the most important question is whether these practices are actually good for everyone. In our enthusiasm to develop mindfulness-based treatments, it's been easy to overlook their downsides. Understanding these will require us to be much clearer about the effects of different mindfulness practices.

The Buddhist teacher Sharon Salzberg has identified three major skills that have been loosely lumped under the title "mindfulness": concentration, mindfulness per se, and compassion toward oneself and others. Most meditation teachers suggest that concentration practices, in which one chooses an object of awareness and follows it closely, are generally a good place to start. These focus and stabilize the mind, forming a foundation for practicing other skills. Once the mind is somewhat focused, the more open-field awareness of mindfulness becomes useful for seeing how the mind creates suffering for itself. Open-field awareness helps reintegrate previously split-off or disavowed contents, and allows one to appreciate the richness of the moment.

But these things aren't always so benign in the clinical arena. Clients can get overwhelmed by the intensity of what arises during concentration and open-field awareness practices. This is particularly true with those who've repressed intense feelings or memories. They may feel panic when a specific image arises—their father standing at the bedroom door, for instance—or when they feel their sense of self beginning to disintegrate. Clients can also find themselves trapped in self-critical patter. In such distressing moments, loving-kindness and self-compassion practices may be needed for holding and soothing. Alternatively, returning to concentration practices, particularly those that focus on external phenomena, can also sometimes restabilize the mind when it's flooded by unwanted contents. We're just beginning to understand the effects of these different practices, and have little research evidence to guide us.

Intimately connected with deciding which skills to emphasize is the question of how forcefully or quickly to nudge a client toward greater awareness. Almost all clinicians are sensitive to the challenge of timing or titrating interventions. It can be counterproductive to push clients too quickly into uncomfortable, destabilizing waters. We have general agreement, born from past mistakes in treating trauma, that people need to establish safety before either uncovering repressed memories or moving toward disavowed feelings. So we have to learn which meditation practices generally enhance safety and which ones bring people toward their growth edge—what's called "moving toward the sharp points" in Tibetan Buddhist tradition.

Other forms of psychotherapy offer hints about how this might work, which mindfulness-oriented clinicians use for guidance. For example, some have observed that meditation practices that bring our attention to the body's center move us toward the sharp points, while those that focus on objects further away—such as the soles of the feet, sounds, the taste of food, or the natural environment—tend to be more stabilizing. This is similar to the observation informing Eugene Gendlin's Focusing, that paying attention to body sensations in the chest and belly connects us readily with memories and affects. Also, as mentioned earlier, clinicians are finding that loving-kindness and self-compassion practices can help move people toward safety.

Developing more detailed maps of how varied practices affect different people, as well as understanding when clients need more safety or would benefit from more emotional challenge, will be important if we're going to develop safe, effective mindfulness-based interventions appropriately tailored to individual needs. These are cutting-edge issues for advancing the use of mindfulness in psychotherapy.

But Will They Practice?

As clinicians move beyond their initial enthusiasm for mindfulness practice, they're encountering the problem that may well derail the whole enterprise: people find it hard to meditate regularly. It's one thing to take up these practices in a monastery, where the whole day is structured around meditation and everyone is doing it, and quite another to take time out from a busy day and a long to-do list. Figuring out the best ways to get clients to practice is another challenge that's just beginning to command the attention of researchers and clinicians.

Some people point out that cultivating mindfulness is like developing physical fitness. Without radically changing our lifestyle, we can take the stairs instead of the elevator or ride our bikes instead of driving, and develop some fitness. This is analogous to the informal mindfulness practices mentioned earlier: mindfully walking, showering, or driving. They don't require extra time, just a shift in intention. These practices are relatively easy to get people to do.

To become truly fit, however, we'd need to take time out of our daily routine and go to the gym or follow a regular program of exercise. This is like setting time aside for formal meditation practice, which greatly accelerates the development of mindfulness. However, it's harder to do regularly because it requires more commitment and usually brings us into contact with

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uncomfortable contents of the mind that we prefer to push out of awareness.

Deciding what to recommend to a given client is often guesswork. Too light a dose of mindfulness practices and he or she won't experience much benefit, and give up; too heavy and he or she may feel overwhelmed, and give up. In addition, while research generally shows that practice effects are dose related, we know little about whether the type of practice—formal or informal—makes a difference. Clearly, we'll need to know more if we're going to make these practices accessible to a full range of clients.

Then there's the related challenge of fine-tuning practices to make them optimally engaging and effective. For example, in concentration practice, we can choose to focus on subtle objects of attention, such as the sensation of the breath entering and leaving the nostrils, or more vivid, coarse objects, such as the sensations of the soles of the feet touching the ground when walking. When the mind is friskier and more distracted, coarse objects are easier to follow, and thus may make the practice more appealing. But we don't seem to develop refined concentration with such objects, which is why few people go to heavy metal concerts to meditate—it's easy to attend to the music, but not so easy to really notice what's happening in the mind. We're just beginning to understand more about which objects of attention are best suited to which mind states.

Related to this is the role of retreats in treatment. Intensive retreats, while potentially transformative, can be disastrous for the wrong person. In the mid-1970s, I worked at a psychiatric treatment facility near the Insight Meditation Center in Barre, Massachusetts. In those early days, meditation teachers didn't screen for psychological stability before allowing people to enroll in intensive retreats, and we treated quite a few meditators after they'd suffered a psychotic breakdown. Meditation centers have now developed guidelines to screen potential attendees, but evaluating who among our clients is most suited for such practice, beyond being cautious with fragile or rigid personality types, remains virgin territory.

"When the iron bird flies . . ."

Padmasambhava, the 8th-century lama who brought tantric Buddhism to Tibet, made the prediction some 1,400 years ago that, "When the iron bird flies . . . , the Dharma will come to the land of the Red Man." Some people think that the advent of ancient Buddhist understandings and practices being taken up enthusiastically in the West is the fulfillment of his vision. This meeting of East and West is proving to be a two-way street, where Buddhist practices are affecting Western traditions, while Western views are affecting Buddhist practice.

When he speaks to scientists, the Dalai Lama is fond of saying that if science discovers something that challenges basic Buddhist tenets, "We'll just have to change Buddhism." In addition to distinguishing his teachings from those of more doctrinaire religious traditions, his statement raises the question of whether Buddhism is changing as it comes to the West. Historically, as it moved from India to China, Japan, Korea, Tibet, and elsewhere, Buddhist teachings took on aspects of the host culture. The same thing seems to be happening here, now that the iron bird is flying regularly. This transformation is taking two obvious forms. First, aspects of traditional Buddhist teaching that, at least to date, don't appear compatible with modern scientific views are being deemphasized in the West. So it's not unusual to find devoted meditators here dismiss concrete, literal understandings of karma and reincarnation. Second, and perhaps more importantly, as it takes root in Western psychotherapy, Buddhism is taking on a relational dimension.

Originally refined by monks, nuns, and hermits in Asian cultures, Buddhist traditions have historically deemphasized the nuances of interpersonal interactions. While these traditions stress the importance of generosity, compassion, and goodwill, they haven't provided detailed maps for working out romantic, work, or family relationships. Developing the ability to explore these complex relational labyrinths in words and images has been a great contribution of Western cultures, particularly their psychotherapeutic and artistic traditions.

Recent books on relational meditation practices, such as Gregory Kramer's *Insight Dialogue*, and the work of Janet Surrey, Judy Jordan, and others in integrating mindfulness into Relational Cultural Theory, all represent new developments for both Buddhism and Western psychology. This particular integration of West and East seems to be a valuable adjunct to both traditions, and as such, will probably grow in its influence. We might even think of this as the beginning of a new integrated wisdom tradition.

Is This Really a Good Marriage?

The influence of Buddhist teachings on psychotherapeutic thought and practice is, of course, at the heart of the explosion of interest in mindfulness and psychotherapy. While the movement has been embraced by many, it's also raised eyebrows. I regularly hear concerns about the introduction of Buddhist ideas and methods in psychotherapeutic practice.

As a practical matter, it's important to consider whether to discuss with clients the Buddhist origin of these practices. When I present workshops in certain parts of the United States, clinicians regularly ask how they can introduce their religious clients to these Buddhist techniques, fearing that they'll reject anything that comes from another spiritual belief system and is called meditation. Indeed, many religious people do best with practices drawn from their own tradition. For them, we might offer centering prayer techniques from medieval Catholic monastic traditions, or suggest modern adaptations of Kabbalistic Jewish or Sufi Muslim practices.

The task of introducing meditation to secular, scientifically minded clients is getting easier as the body of neurobiological and clinical research we can refer to grows. For secular folks who'd be disturbed by the Buddhist roots of these practices, we can follow the lead of John Teasdale, Zindel

Segal, and Mark Williams, who initially simply called what they were offering Attentional Control Training.

There are bigger challenges to this marriage, however. For example, some Buddhist clinicians and teachers worry that mindfulness practices will be "denatured" by therapists who don't understand their true potential. They also point to the danger of relatively untrained clinicians functioning as spiritual teachers. Most wisdom traditions have strict criteria: one needs to attain certain levels of spiritual realization before guiding others. This realization is assessed in long-term, mentor-student relationships. So there's the real danger that by venturing into territory traditionally reserved for spiritual adepts, clinicians will either miss the point of the practice or do more harm than good. The field hasn't begun to address this problem yet, but it will have to if the integration of mindfulness practice and psychotherapy heads in a more spiritual direction.

From another angle, there's the concern that, by opening the way to the more radically transformative potential of these practices, we may unethically lead clients where they never asked to go. After all, most clients come in looking for symptom relief, not for a radical reordering of their consciousness. Yet what if a clinician believes that such transformative work is the only real way to alleviate suffering? This is another question we haven't begun to tackle.

The future of the integration of mindfulness and psychotherapy will depend on whether clinicians choose to use these practices for spiritual growth, inviting their clients to do the same, or teach these techniques to clients as a gateway to symptom reduction. If we head down the spiritual path, therapists will be faced with the question of how or when to address the transformative potential of these practices with their clients, or to speak of the insights they can yield. For example, if a client is grieving the loss of a love relationship, pointing out that everything changes and that there's no way to hold onto anything will probably result in a terrible empathic failure or encourage the client to perform what psychologist and Buddhist teacher Jack Kornfield calls a "spiritual bypass": escaping a painful emotion by defensively acting as though we've transcended such petty worldly reactions. Then again, there are moments in treatment when it may be beneficial to help clients understand that clinging to pleasure and pushing away pain multiplies our misery, or how transient life events and feelings really are. Figuring out when to stay empathically attuned to clients' narratives and when this keeps them stuck in a relative truth is beginning to enter clinical discussions, and is likely to be of continuing interest to therapists who want to use mindfulness for more than just symptom alleviation.

The Fruits of Mindfulness

In the Buddhist tradition, the path to emotional freedom or sanity involves cultivating two interrelated virtues—wisdom and compassion. Traditionally, wisdom and compassion are seen as two wings of a bird or two wheels of a cart—both necessary for awakened action. Wisdom involves seeing the world as it really is, being fully aware of the "three characteristics of existence." These are *anicca*, the observation that everything is a constantly changing flux of matter and energy; *dukha*, often translated as "life is suffering" but more accurately stated that the mind is always dissatisfied (or as the great sage Rosanne Rosannadanna put it, "If it ain't one thing, it's another"); and *anatta*, the realization that if we observe our experience carefully, there's no "I" to be found, just the unfolding moment-to-moment of experience along with the mind's running narrative commentary about it all. In the clinical arena, this manifests as seeing how all phenomena are interrelated and multidetermined, concern for the effects of our actions near and far, holding constructs lightly, not taking things personally, and being open to new experience. Buddhist compassion (*karuna*) involves recognizing and being open to suffering, and wishing to help others in their pain. In the clinical arena, this translates to nonjudgmental understanding, seeing others as fundamentally like ourselves, having the capacity to be with another's pain, and being able to be compassionate with ourselves when we suffer.

If we choose to use them this way, the array of practices gathering under the mindfulness umbrella can help us and our clients inch toward greater wisdom and compassion, with the ambitious goal of developing greater psychological awareness and freedom. This is the ultimate promise and challenge of the marriage between mindfulness and psychotherapy. ■

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