

CHAPTER ONE

Bringing Mindfulness into Psychotherapy

The faculty of voluntarily bringing back a wandering attention, over and over again, is the very root of judgment, character, and will.

—WILLIAM JAMES (1890/2007, p. 424)

Mindfulness is a deceptively simple way of relating to experience that has been practiced for over 2,500 years to alleviate human suffering. In recent years, clinicians are discovering that mindfulness holds great promise for both their own personal development and as a way to enhance therapeutic relationships. It is also the central ingredient in an ever-expanding range of empirically supported treatments, and it is proving to be a remarkably powerful technique to augment virtually every form of psychotherapy. Mindfulness is not, however, a one-size-fits-all remedy. Practices need to be tailored to fit the needs of particular individuals and situations. This chapter explores the varied roles that mindfulness can play in psychotherapy and the choices we clinicians face in fitting practices to our own and our patients' changing needs.

WHAT EXACTLY IS MINDFULNESS?

As used by Western psychotherapists, the term *mindfulness* is often understood to be a translation of the Pali term *sati* (Pali is the language in which the teachings of the historical Buddha were first recorded). *Sati* connotes *awareness*, *attention*, and *remembering*. Awareness and attention here are similar to how we use them in English—to be aware and to pay attention. *Remembering* is different, however. Rather than remembering what we had for breakfast or recalling childhood trauma, it refers to continuously remembering to be aware and pay attention.

As we use it in psychotherapy, mindfulness also includes another essential dimension. The Buddhist scholar John Dunne (2007) points out that a Special Forces sniper poised on top of a building aiming a high-powered rifle at an enemy would be aware and attentive, and each time his mind wandered, he'd remember to return his attention to the task at hand. But this kind of focus is probably not optimal for developing therapeutic presence or working effectively with emotional distress. What's missing for the sniper is acceptance or nonjudgment—adding an attitude of warmth, friendliness, and compassion. (We might think of this as adding in the Rogers—Carl and Mister.) So putting these elements together, we can think of mindfulness as “*awareness of present experience with acceptance*” (Germer, 2013, p. 7) or “the awareness that emerges through paying attention on purpose, and nonjudgmentally, to the unfolding of experience moment to moment” (Kabat-Zinn, 2003, p. 145). Of particular importance for psychotherapy is the attitude of acceptance: “active nonjudgmental embracing of experience in the here and now” (Hayes, 2004, p. 21).

THE ROLES OF MINDFULNESS

Mindfulness can play a variety of roles in psychotherapy. We can conceptualize these roles along a continuum, from implicit to explicit (Germer, 2013; Figure 1.1). At the most implicit end of the continuum is the practicing therapist. When we take up regular mindfulness practice, we naturally begin to relate differently to our patients. As the mind's capacity for attention increases, it becomes easier to truly show up in the therapy room and to focus the mind and notice the moment-to-moment unfolding of both our patients' and our own thoughts

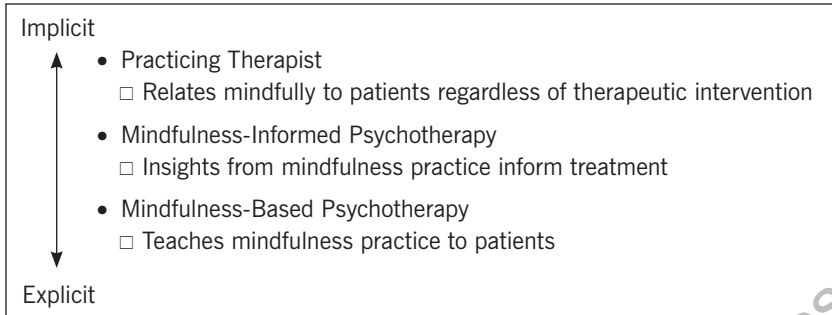


FIGURE 1.1. The roles of mindfulness.

and feelings. We also develop greater affect tolerance—an enhanced capacity to *be with* painful feelings. By being with and accepting both pleasurable and painful experiences during mindfulness practice, we increase our ability to sit with our patients’ difficulties, as well as our emotional responses to these difficulties (Fulton, 2013). And as we explore in Chapter 3, the therapist’s capacity to open to emotional distress is key to effective therapeutic relationships.

Next along the continuum is what we and our colleagues call *mindfulness-informed* psychotherapy. As our own mindfulness practice deepens, we begin to gain firsthand insight into how our minds create suffering. We notice, for example, that any experience or mental content that we resist tends to persist. We see how attempts at self-aggrandizement, clinging to pleasure, and trying to avoid pain all create distress. We see how much of our energies are spent seeking momentary distraction from discomfort. These and related observations begin to influence our models of psychopathology and treatment, as we notice that our patients’ minds create suffering in similar ways. Our treatments become increasingly oriented toward helping our patients open to and accept a wider range of experience.

At the most explicit end of the continuum is what we and our colleagues call *mindfulness-based* psychotherapy. Here we suggest to some of our patients, when clinically appropriate, that they try mindfulness practices themselves. Based initially on our own practice experience, we introduce techniques that are suited to each patient’s personality structure, level of distress, degree of support, and cultural orientation. Often these techniques are first practiced together in the office and then suggested as homework between sessions.

NOT ONE SIZE FITS ALL

We had the privilege some years ago of having His Holiness the Dalai Lama join us at Harvard Medical School for a psychotherapy conference. At one point our colleague, Chris Germer, asked His Holiness to lead us all in a brief meditation. In his inimitable style, the Dalai Lama (2009) reacted as though the request was funny: “I think some of you may want just one single meditation. And a simple one. And 100 percent sort of positive. That, I think, impossible.” He went on to suggest that there are countless states of mind that lead to suffering and, consequently, countless meditation practices that are needed to work skillfully with them. What a given person needs at a given time is a complicated 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!”

Whether we are choosing practices for ourselves or our patients, deciding which practice will be most useful at a given moment for a particular individual is indeed a complex matter. Clinicians are just beginning to map this territory, without much data to guide us. Practices that support the development of mindfulness can be found in many different cultures, and most of these practices have evolved extensively over time. Furthermore, individual clinicians will naturally experiment with mixing and modifying practices for the needs of particular patients. An extraordinarily wide variety of practices are therefore available to us.

While there are countless ways to categorize and describe these practices, based on our clinical experience we’ve identified seven considerations clinicians might keep in mind when choosing among them:

1. Which skills to emphasize—concentration, open monitoring (mindfulness per se), or acceptance?
2. Informal, formal, or retreat practice?
3. Which objects of attention—coarse or subtle?
4. Religious or secular practices?
5. Turning toward safety or sharp points?
6. Narrative or experiential focus?
7. Focus on relative or absolute truth?

Let’s examine these considerations, and see how we might use them to develop guidelines for when to choose which form of practice.

Which Skills to Emphasize?

Developing mindfulness involves at least three major skills: *focused attention* (or concentration), *open monitoring* (or mindfulness per se), and *compassionate acceptance* (Lutz, Slagter, Dunne, & Davidson, 2008; Germer, 2013). (These terms can be confusing because in Buddhist traditions, open monitoring is usually called “mindfulness,” whereas in the West we typically use the word *mindfulness* as an umbrella term covering a variety of interrelated practices.) Focused attention, in which we choose an object of awareness and follow it closely, is usually a good place for most people to start. These practices focus and stabilize the mind, forming a foundation for developing other skills. While the primary object of awareness can be virtually anything, including sensations of the breath, feet touching the ground, sounds, or a visual stimulus, overall instructions are usually similar. We bring our attention to the object, attempting to cultivate an attitude of interest or curiosity in moment-to-moment sensations. As thoughts enter the mind—which they invariably will—we allow them to arise and pass. When our minds get hijacked by a chain of narrative thought, or wander to other sensations, we gently redirect our focus back to the primary object of attention. (Note that “concentration” as described here is different from “concentrating” on a conceptual or creative task. It’s not about the focused application of analytical or artistic skill, or thinking through a problem, but rather careful, receptive attention to moment-to-moment experiences arising in consciousness.) Chapter 4 presents detailed instructions for these practices.

Without a certain degree of concentration, it becomes difficult to see the workings of the mind clearly. We tend instead to spend our days lost in thought. When involved in our verbal narratives, we usually both believe in their content and lose metacognitive awareness of what the mind is doing in each moment. Without concentration, it is also difficult to exercise choice in our behavior—we tend to act compulsively on impulses, not noticing that we have an opportunity to pause and consider our responses before pursuing pleasure or recoiling from pain. Finally, without concentration, it is also quite difficult to practice the other two skills necessary for developing mindfulness: open monitoring and compassionate acceptance.

Once a certain degree of focused attention or concentration has developed, and the mind can stay with an object for a little while and realize when it has wandered off, it becomes possible to practice open monitoring. Here, instead of returning repeatedly to one object of

awareness—such as the sensations of breathing or of the feet touching the ground—we turn our focus to whatever predominates in consciousness at the moment. Attention might shift from the breath to a sound, to a body ache, to the feeling of air on the face, or to sensations of sadness in the eyes and throat. Rather than thinking about or analyzing these sensations, we allow the mind to *be with* them, bringing an attitude of interest, curiosity, and acceptance to the experience. Until a person has spent some time developing concentration and knows what it is like to remain with a single object of attention for a period of time, it can be difficult to get a feel for open monitoring. The attitude is sometimes described as like sitting next to a still forest pool to which all sorts of creatures come to drink before they move on. Which creatures will arrive, and when they will leave, is quite beyond our control. We therefore try to welcome them all. Detailed instructions for these practices are presented in Chapter 5.

One way to understand the relationship between focused attention and open monitoring is by thinking about photography before cameras were automated. In those days, to get a clear picture, you first had to know how to focus the camera lens. Without this skill, a photographer was limited to abstract, impressionistic, blurry images. Learning to concentrate is like focusing the mind's lens—it allows us to see clearly whatever we turn our attention to. Once this skill is developed, we can use it to examine whatever might be happening at the moment.

Open monitoring can be useful for seeing how the mind creates suffering as it resists various sensory experiences as well as emerging thoughts or images. It is also helpful for reintegrating previously split-off or disavowed contents. These contents can include thoughts, feelings, and impulses that aren't sanctioned by our families or wider community, or memories of traumatic events that were too painful to experience fully when they occurred. Open monitoring helps us notice these contents as they arise in the mind, and as we practice greeting them with acceptance, they can become familiar and no longer feel like foreign intrusions. Just as in psychoanalysis, where if one lies on the couch and freely says whatever comes to mind, sooner or later a lot of material that we've tried to avoid will emerge—so too in mindfulness practice such contents will tend to return to awareness. What emerges can range from minor traumatic memories, such as moments of rejection or failure, to major ones, such as experiences of physical or sexual abuse. Aggressive, avaricious, and sexual impulses that we think of as immoral will often also arise. As we'll discuss shortly, such encounters

can be useful or damaging, depending on a person's readiness to accept and integrate these contents.

Yet another potential benefit of practicing open monitoring is enhancing our appreciation for the richness of the moment. When we practice attending to sensory experience in meditation, during the rest of our day we tend to taste, touch, see, feel, and smell things more vividly, increasing our capacity to savor experience and deeply enriching our day-to-day life.

Concentration and mindfulness work well together to cultivate attention and awareness. But in the course of these practices, people often become overwhelmed by the intensity of what arises or find themselves trapped in self-critical patter. In these moments, more acceptance is needed. Loving-kindness, self-compassion, and equanimity techniques can be useful at these times for holding and soothing, fortifying us to be able to bear whatever we might experience.

Acceptance practices take many forms. A common type involves imagining a loving and compassionate person or animal, directing love and care toward him or her, and then, once feeling this emotion, directing it as well toward oneself, loved ones, and larger communities. The feeling is often reinforced with phrases such as *May you be happy, May you be peaceful, May you be free from suffering*. Similar practices, with parallels to prayer, can be drawn from a variety of cultural traditions. They all help people to feel loved, held, and accepting of themselves and others. Other acceptance practices include compassion techniques designed to help us feel held during times of emotional pain and equanimity practices that enhance our capacity to bear or hold challenging experiences, cultivating stability amid storms of changing emotion. Detailed instructions for these various acceptance practices are presented in Chapters 6 and 7.

Finding an optimal balance among concentration, mindfulness, and acceptance practices at any given moment is an art. When the mind is particularly frisky and unfocused or tending to get lost in streams of thought, more concentration practice is often helpful. When it is flooded by difficult memories or emotions, or full of self-critical contents, loving-kindness, self-compassion, or equanimity practices often help. When the mind is more stable and accepting, open monitoring can move us toward greater insight and integration by helping us become conscious and accepting of a wide variety of thoughts, feelings, and memories that might otherwise escape our awareness (R. D. Siegel, 2010). Whether in our personal meditation practice or in

designing practices for patients, it is useful to be familiar with and willing to try these different sorts of practice. Sometimes we might spend an entire period of meditation with one type, while at other times we might move among them during the course of a single meditation session, adjusting as our state of mind shifts.

It can also be helpful to think of and use the three core skills as different ways to strengthen the three components of mindfulness (*awareness of present-moment experience with acceptance*). Concentration practice helps us stay connected to the present moment, open monitoring enables us to broaden and deepen our awareness of what's actually happening in that moment, and loving-kindness and compassion practices allow us to meet all that arises in consciousness with acceptance.

Informal, Formal, or Retreat Practice?

Cultivating mindfulness is a bit like developing physical fitness. Without radically changing our lifestyle, we could take the stairs instead of the elevator, or ride our bike instead of driving, and develop some physical fitness. To become more fit, however, we'd need to take time out of our daily routine and go to the gym, go jogging, or play a sport. If we really want to jump-start our fitness program, we might even go away for several days on a bike or backpacking trip or take a vacation at an exercise spa. Analogous options are available for developing mindfulness: informal, formal, and retreat practice.

Without taking extra time out of our day, we can adopt *informal* mindfulness practices such as mindfully walking, showering, eating, or driving. These only require a shift in intention. For example, in mindful walking, instead of having our attention focused on what happened in yesterday's meeting, or on planning dinner, we notice the moment-to-moment sensations of our feet touching the ground and moving forward through space. In mindful showering, we savor the intense sensual experience of thousands of drops of water—at just the right temperature—caressing our naked bodies. We take in the vivid sensations of washing, soaping, and rinsing ourselves, rather than reviewing our to-do list and reaching the end of our shower with no idea whether we have just washed our hair, “Or was that yesterday?” In mindful eating we try to taste our food, and in mindful driving we notice the appearance of the road, other cars, trees, houses, and so forth. In all of these activities, when thoughts enter the mind, we allow them to come and go, returning attention to the sensations of

this moment's activity. Anyone can develop some mindfulness through these sorts of informal practices since they require no extra time and are rarely destabilizing.

But if we want to deepen our mindfulness practice, we need the equivalent of the gym. This is time set aside for *formal* meditation. We choose a quiet place where we're unlikely to be disturbed to do some combination of focused attention, open monitoring, and acceptance practices. These practice sessions can range from brief periods of 10–20 minutes to more intensive ones of 30–45 minutes. Studies demonstrating changes in brain function and structure from mindfulness practice typically investigate the effects of such formal meditation practice, and most mindfulness-based clinical protocols include it (Lazar, 2013).

Many patients have difficulty engaging in formal practice. As we mentioned earlier, meditation can open the doors to all sorts of unwanted mental contents that can be difficult to bear. Longer periods of silent practice, particularly if focused on the breath, can become overwhelming. People also may feel they have no time—their lives are already too full with other commitments. Still others may see meditation as an alien practice that runs counter to their religious or cultural beliefs. As we'll see, however, most of these obstacles can be overcome by finding the right combination and intensity of practices and presenting them in a culturally sensitive, collaborative manner.

To really jump-start a meditation practice, there's nothing like an intensive silent retreat: spending a day or more alternating among sitting, walking, eating, and other meditation practices. We refrain from eye contact with others, speaking, reading, writing, texting, and checking e-mail. Retreats tend to shift our level of mindfulness significantly, and most participants find them to be radically transformational.

In fact, it is difficult to grasp the potential of mindfulness practice fully without experiencing a silent retreat. It is hard to develop sufficient concentration during the course of daily practice to observe the workings of the mind clearly. During everyday life we need to spend a lot of time thinking and planning to accomplish our goals. As a result, we dwell mostly in the thought stream, our continuous verbal narrative about our experience.

During an intensive silent retreat, however, there are few decisions needed and few goals, other than cultivating mindfulness, to pursue. As a result the mind tends to quiet down, and spaces often open up between thoughts. We get to see how the mind creates its understanding of reality out of the building blocks of sensation, perception,

feelings, and intentions. We see over and over how trying to hold on to pleasurable experiences and push away painful ones causes suffering. And we may even get a glimpse into the insubstantiality of our sense of self—how it is constructed each moment out of an endlessly changing flux of experience. These insights have enormous potential to change our understanding of psychological distress, whether as therapists or as patients.

But they also pose significant dangers. A few decades ago, Western meditation teachers rarely screened for psychological stability before allowing people to enroll in intensive retreats and quite a few meditators suffered psychotic breaks. There were many cases in which we and our colleagues were enlisted by meditation teachers or participants to provide consultation or treatment. For individuals with a fragile or rigid sense of self, significant unresolved or unintegrated trauma, or who might be suffering from psychosis, silent retreats are usually contraindicated. While some meditation centers have since developed guidelines for whom to allow to attend intensive retreats, many participants still become overwhelmed when their habitual defenses are challenged. Evaluating who among our patients is most suited for intensive practice requires both considerable personal retreat experience and a good understanding of our patients' strengths and vulnerabilities. This understanding can best be gathered through a treatment relationship in which we observe the extent to which our patient can open to and accept the varied contents of his or her mind, his or her affect tolerance, and how readily he or she can let go of cognitive frameworks through which to understand experiences. It is also important to consider patients' biopsychosocial resources, including the strength of the therapeutic alliance, availability of support from family and friends, degree of safety in daily life, quality of early attachment relationships, and genetic predisposition toward psychiatric disorders. The more risk factors that are present, the more cautious we should be about recommending retreat practice. Chapter 10 presents more details about screening for and participating in retreat practice.

Which Objects of Attention?

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 (see Figure 1.2).

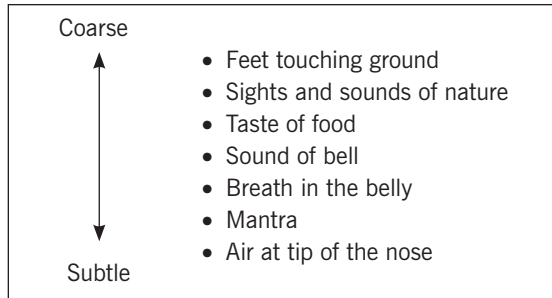


FIGURE 1.2. Objects of attention.

When the mind is friskier and more distracted, coarser objects are easier to follow. So why don't we always choose coarse objects of attention for formal meditation practice? Why do so few of us go to heavy metal concerts to meditate? After all, it's easy to attend to the principal objects of attention there, the sound and light. In fact, it's likely that many fans attend such concerts precisely because they enjoy the experience of absorption—of setting aside their usual thoughts and feelings and being engrossed in the loud music and compelling visuals. The problem is, we don't seem to develop refined attention with such vivid objects; we can attend to the stimuli, but it is not so easy also to notice what's happening in the mind and to attain insight. We don't readily see the mind's tendency to hold on to some contents while pushing away others, observe subtle feelings, or notice how the mind reacts to loss and gain.

So in clinical practice, as well as in our personal meditation, we need to choose when to select more subtle objects and when to select coarser ones. Many meditators find that coarser objects are useful when the mind has difficulty staying with a chosen object of awareness, when thoughts repeatedly pull attention away. They are also helpful when our arousal state is high, as in moments of increased anxiety or excitement. While different individuals may experience one or another object as more or less vivid, for most people, noticing the sensations of the feet in walking meditation, or the sights and sounds of nature, the taste of food, or the sound of a bell will help stabilize the mind when the mind is active or agitated. When the mind is more settled, less aroused, and less drawn toward thought, more subtle objects of attention such as the sensation of the breath entering and leaving the nostrils, the rising and

falling of the belly, or a mantra (silently repeated phrases) may allow for more refined attention.

Religious or Secular Practices?

Clinicians in many parts of the United States regularly ask, “How can I introduce my religiously conservative clients to these practices? They’ll reject anything that comes from Buddhism or is called ‘meditation.’” Some years ago, the Dalai Lama (2007) was talking to researchers studying depression. He suggested that if they discovered that particular Buddhist practices can help depressed people, the researchers shouldn’t emphasize that they come from Buddhism. He went on to say that the whole purpose of his tradition is to alleviate suffering, and if people think of these practices as Buddhist, such thinking will just get in the way.

All effective psychotherapy requires sensitivity to patients’ cultural background. This becomes particularly true when introducing practices that have been adapted from traditions that are alien to our patients’ beliefs. With secular, scientifically minded individuals, the path is relatively straightforward. We now have an impressive body of neurobiological and clinical outcomes research to point to that describe these mindfulness practices in Western scientific terms. And for secular patients who might be disturbed by the Buddhist roots of some of these practices, we can follow the lead of John Teasdale, Zindel Segal, and Mark Williams (1995), when they first published papers about using mindfulness practice as part of depression treatment, and simply call it *attentional control training*, which it is.

For more religiously inclined patients, deciding how to present these practices is more complicated. We need first to assess their openness to other traditions. Sometimes a practice adapted from another religious tradition is more appealing than one coming from a secular, scientific source. In this case presenting some of these practices as coming from a Buddhist tradition may not be a problem.

Alternatively, we can look for mindfulness practices related to our patient’s particular religious background. For example, we can offer *centering prayer* techniques from medieval Catholic monastic traditions (Pennington, 1980), as well as modern adaptations of Kabbalistic Jewish (Michaelson, 2006) and Sufi Muslim (Helminski, 1992) practices (see the Resources).

Of course, like secular individuals, some religious patients will

do best with a nonreligious presentation of these practices. If we avoid words with religious associations such as *meditation* and present these practices as the tools they are for cognitive development, mental training, or harnessing neuroplasticity, our patients can accept mindfulness practices as readily as other medical interventions or educational offerings. We've heard accounts, for example, of mindfulness practices being successfully introduced to patients in evangelical religious communities as attention training—a way to focus more clearly at church, work, and school.

Although these practices can be framed in many different ways, there may be a point when a mindfulness-oriented approach to treatment is difficult to reconcile with a particular faith tradition. This occurs most frequently when the religious tradition teaches that certain contents of mind are to be eliminated because they are “sinful.” Here it can be helpful to enlist the assistance of clergy who emphasize the more accepting or loving elements in their tradition, or to explore with our patient the pros and cons of a prohibitory approach to potentially problematic thoughts, feelings, and impulses.

Turning toward Safety or Sharp Points?

Most clinicians are sensitive to the challenge of titrating interventions—not pushing patients too quickly into uncomfortable, potentially destabilizing waters. We have general agreement, born from studying trauma, that people need to establish safety before either uncovering repressed memories or moving toward disavowed thoughts and feelings (e.g., Herman, 1992; van der Kolk, McFarlane, & Weisaeth, 1996).

As mentioned earlier, our interpersonal milieu often discourages us from acknowledging certain mental contents. A boy might grow up fearing that his longings for love and affection or feelings of vulnerability make him a “sissy,” whereas a girl might be concerned that her assertiveness makes her a “tomboy.” Many people are raised to feel that all sorts of sexual, acquisitive, or aggressive feelings are immoral. On top of this, most of us have had overwhelming experiences in which our hearts were broken or we were shamed, threatened, or physically injured. Such events may have been only partially experienced at the time because they were too painful to bear, and memories of them may now be only partly accessible. Exploring such material in therapy needs to be done thoughtfully so as not to overwhelm or retraumatize our patients.

It turns out that some meditation practices generally enhance safety and allow difficult contents to be kept at bay, while others move people toward thoughts, feelings, and memories that may have been disavowed—what is called in Tibetan Buddhist tradition *moving toward the sharp points*. While we don't yet have experimental data indicating which practices typically yield which effects, we can look to existing therapy traditions for some guidance.

Generally, it seems that meditation practices that bring our attention to the chest, belly, and throat (such as attending to the sensations of the breath) move us toward the sharp points, while those that focus on objects farther away (such as the soles of the feet, sounds, the taste of food, or the natural environment) tend to be more stabilizing. This principle is related to the observation from Eugene Gendlin's (1978) focusing method and other body-oriented psychotherapies, that paying attention to body sensations in the chest, belly, and throat connects us readily with salient memories and affects, turning our attention toward the sharp points. We've seen repeatedly in both personal and clinical experience how simply closing one's eyes and noticing sensations in the central core of the body can provide access to feelings that might otherwise be outside of awareness.

So if a patient is having difficulty tolerating the intensity of his or her affect or is feeling overwhelmed by intrusive thoughts or images, choosing "external" objects of attention and using them in concentration practice, can provide an experience of grounding or safety without intensifying awareness of challenging "inner" contents. All of these more "external" sensations involve a focus away from the core of the body and can be done as informal (during the course of other activities) or formal (setting time aside for meditation) practices. They include walking, listening, observing the outside environment, and eating meditations, practiced with the eyes open. In essence, we help our patients to realize that whatever may be arising inside, the relatively safe sensations of the outer world can provide a welcome refuge.

In addition to externally focused concentration practices, certain mindfulness-building techniques involving imagery can provide stabilization. Mindfulness involves awareness of present experience with acceptance and these practices are designed specifically to fortify our capacity for acceptance, for allowing painful feelings to come and go. The techniques don't bring attention either to the core of the body or to external sensations, but rather focus on cultivating particular feelings or perspectives. The loving-kindness and self-compassion practices

described in detail in Chapter 6 work in this way to help people feel soothed and comforted, particularly when overwhelmed by painful feelings. Similarly, guided imagery techniques, such as the mountain meditation (in which we imagine ourselves as a mountain being relatively steady as seasonal changes occur on and around us—see Chapter 7 for a description), can cultivate equanimity, providing a sense of stability amid changing emotional and environmental circumstances. Zen techniques used in dialectical behavior therapy (DBT; Linehan, 1993a, 1993b), such as coordinating the breath with footsteps, imagining the mind as a vast sky in which contents arise and pass, or adopting a serene half-smile, can also help people to feel safer.

When a patient is in a relatively stable life situation, has a good therapeutic alliance, and is not overwhelmed by affect or difficult memories, it may be time to help him or her move toward the sharp points: to confront troubling memories, explore uncomfortable feelings, or perhaps look at the consequences of problematic behaviors. This means approaching and reintegrating affects, impulses, images, and memories that may have been pushed out of awareness because of their painful nature. While there are many psychotherapeutic techniques useful for this kind of uncovering, certain mindfulness practices can be particularly effective.

As mentioned above, if a meditator spends sufficient time attending to an inner object of awareness, such as the breath, sooner or later a wide range of disavowed mental contents usually will come into awareness. While this reaction can occur during concentration practice, it is even more likely to happen with open monitoring.

Most people find that once they decide to shift their attention toward the sharp points, they are best able to open to and accept the fear, sadness, anger, longing, sexual feelings, and other contents that arise by focusing on how they are experienced, moment to moment, as sensations in the body, typically arising in the torso or throat. When we observe emotions objectively in this way, we notice that they involve the simultaneous arising of bodily sensations along with narrative thoughts and images. So if I'm angry, I might experience the tensing of muscles in my shoulders and chest, an uptick in my respiration and heart rate, and thoughts like, "I can't believe you did that to me after all I've done for you," passing through my mind. By staying with the bodily components of the emotion, rather than the narrative, I'm able to experience it more fully without feeling compelled to take action to "fix" the situation (as I might if I were attending primarily

to the narrative content). Most people can tolerate intense affects once they learn to be with them simply as bodily sensations while allowing the accompanying images and narrative thoughts to arise and pass. We can learn to adopt this attitude not only toward emotions but also toward urges for destructive behaviors such as addictions and compulsions (Brewer, 2013; R. D. Siegel, 2010; see also Chapter 7). Figure 1.3 summarizes practices that can be used to establish safety and practices that can be used to move toward the sharp points.

Narrative or Experiential Focus?

Most patients come to treatment wanting to share their stories. They've had good and bad fortune, giving rise to pleasurable and painful thoughts and feelings. Psychotherapy often focuses on this narrative, either to put it in perspective by exploring its origins and subsequent manifestations in the transference and daily life (in psychodynamic treatment); by examining it for irrational, maladaptive distortions (in cognitive-behavioral approaches); or by seeking to understand it in cultural or interpersonal context (in systemic therapies). Focusing on the narrative helps our patients to feel understood and held and can free them from unnecessarily painful mental constructions (Fulton & Siegel, 2013).

Mindfulness practices generally turn attention away from our narratives and toward moment-to-moment experience. Consequently, mindfulness-oriented psychotherapy usually focuses on what is happening here and now, grounded in attention to changing bodily sensations. As just mentioned, learning to pay attention to present bodily sensations can help patients develop greater equanimity and affect tolerance, for emotions are easier to embrace when we experience them in the body, separated from our narrative. Focusing on body sensations can also help to recover traumatic memories or blocked affects, as is done in body-oriented therapies such as somatic experiencing (Levine & Frederick, 1997), sensorimotor therapy (Ogden, Minton, & Pain, 2006), or approaches such as bioenergetics (Lowen, 1958, 1994) that grew out of the work of Wilhelm Reich.

Both approaches are useful. As mindfulness-oriented clinicians, we're regularly challenged to choose between a more traditional narrative focus and a more experiential one. For example, if a young woman is afraid to go to a party because of her social anxiety, practicing staying with the sensations of anxiety in the body, rather than trying to avoid

<p>Turning toward Safety</p> <ul style="list-style-type: none"> • Outer focus (distant from body core) <ul style="list-style-type: none"> <input type="checkbox"/> Walking meditation <input type="checkbox"/> Listening meditation <input type="checkbox"/> Outside environment meditation <input type="checkbox"/> Eating meditation <input type="checkbox"/> Open-eye practices generally • Inner focus <ul style="list-style-type: none"> <input type="checkbox"/> Mountain meditation <input type="checkbox"/> Guided imagery <input type="checkbox"/> Acceptance practices (loving-kindness, self-compassion) <input type="checkbox"/> DBT techniques
<p>Turning toward the Sharp Points</p> <ul style="list-style-type: none"> • Moving toward anything unwanted or avoided <ul style="list-style-type: none"> <input type="checkbox"/> How is it experienced in the body? • Pain, fear, sadness, anger, sexual arousal • Unwanted images or memories • Urges toward destructive or compulsive behaviors

FIGURE 1.3. Techniques for turning toward safety versus the sharp points.

them, can be quite therapeutic. Similarly, if an older man is agitated and shut down in depression, focusing on his underlying sadness and anger as bodily events can begin to reconnect him with his emotional life and traumatic memories that may be contributing to his distress.

Then again, sometimes just staying with moment-to-moment experience is less powerful than exploring the narrative. If a teenage boy is tormented by shame because he acted impulsively, and now fears that his community will shun him, reviewing what happened, examining the conditions that led to his impulsive action, and discussing exactly how he imagines others now see him can provide enormous relief—light and air can go a long way toward resolving shame. A narrative approach may be much more helpful to him than staying with how the experience of shame manifests in his body while he remains mired in self-critical thoughts.

Deciding on the optimal balance between these two approaches is an art. Sometimes we sense that a patient is in touch with feeling experience but is laboring under a particularly irrational, painful narrative—such as a parent who is devastated that his son wasn't

accepted at his alma mater. Exploring the story directly, examining what the rejection means to the parent, and how it resonates with other disappointments, may be most useful here. At other times, a person's narrative may not be particularly distorted, or he or she may be locked in patterns of avoidance, so practicing being with moment-to-moment experience may be more freeing. A mother who is afraid to feel her anger at her abusive adolescent daughter, for fear that the anger will further disrupt the relationship, may need to spend some time simply noticing the anger arising in waves in her body. Of course, both approaches might be helpful in any given session—our challenge is to discern when to emphasize one or the other.

While deciding on which approach to emphasize at any given moment will depend on many factors, an overriding consideration might be the extent to which an individual has gravitated toward one or the other mode of dealing with experience. Particularly if a patient seems to be stuck in a pattern of mental suffering, and he or she tends to explore this exclusively with either a narrative or experiential focus, investigating the other approach may help to move the therapeutic process forward.

Relative or Absolute Truth?

Clinicians who delve more deeply into mindfulness practices see a potential that extends far beyond symptom alleviation (see Germer & Siegel, 2012, and Chapter 10 for more details). After all, many of these practices were originally designed for a radical transformation of the mind, a liberation sometimes referred to as enlightenment. This awakening involves looking beyond our usual concepts to see the world as it really is, to be fully aware of what are called in the Buddhist tradition the three characteristics of existence: *anicca*—everything is a constantly changing flux of matter and energy; *dukkha*, often translated as “life is suffering”—the observation that the mind is always dissatisfied, clinging to pleasure and trying to avoid pain; and *anatta*, the realization that if we observe our experience carefully, there's no “I” to be found—no little homunculus inside—just the unfolding moment to moment of sensations and other experiences along with the mind's running narrative commentary about it all (or as the neuroscientist Wolf Singer, 2005, says, the mind is “an orchestra without a conductor”).

Directly understanding and embracing these existential realities,

which we can think of as absolute truth, brings about enormous freedom, as we become much less invested in trying to cling to pleasure and avoid pain, enhance our self-esteem, and insist on particular outcomes. Mindfulness-informed therapy has the potential to lead a patient to see these truths. The important clinical questions are how and when.

If a patient enters treatment grieving because his fiancé broke off their engagement shortly before the wedding, pointing out that everything changes, so he shouldn't have expected the relationship to last; that we can never hold onto anything; that the mind inevitably creates suffering during good and bad times anyway, so even if he had gotten married he'd have found something else to be distressed about; and that both he and his fiancée are really just changing constellations of matter and energy, with no real existence except as culturally conditioned constructs—this response would probably be experienced as a terrible empathic failure.

Nonetheless, there are moments in treatment when recognizing the futility of our conventional view can be quite useful. Many patients can benefit by seeing how fruitless it is to try to maintain positive self-esteem (we can't all always be above average), how clinging to pleasure and pushing away pain multiplies our misery, and how our experience of life really is all a passing show. In a rather striking example, a patient of ours who had lost her husband some months earlier to cancer and had grieved deeply, shared the following observation: "Sometimes when I'm talking with a friend, I have this realization that it doesn't actually matter that my husband died. While taking in the sight, sound, and feeling of my friend's presence, instead of having the thought 'He's back home,' I have the thought 'He's no longer alive.' All that's actually different in that moment is the thought; the rest of the experience of talking is actually the same." While of course we'd never want to prematurely coax a patient toward this perspective, opening to its possibility can be profoundly liberating.

Psychotherapy almost always needs to begin at the level of what we might call relative reality, which consists of the usual elements of the human story: success and failure, pleasure and pain, longing, hurt, anger, envy, joy, and pride. As therapists, we try to meet our patients where they are at the moment, empathically understanding their emotional and cognitive reactions to the ups and downs of life. But once we've established this empathic connection and explored the details of how a patient's particular circumstance might be causing him or her emotional pain, we can consider whether for this patient a broader

perspective, a focus on our shared existential predicament and how the mind creates suffering generally, or the realization that all that ever exists is the present moment, might be liberating.

Deciding between relative and absolute levels of understanding is another area in which therapy is more art than science, and we need to draw on the insights revealed in our own mindfulness practice, coupled with clinical experience, for guidance. In general, it makes sense to begin treatment at the level of relative truth and remain there until the patient has been able to explore multiple aspects of whatever experience is difficult, connecting to her or his thoughts and feelings about it. We might consider this exploration to have occurred when the thoughts and feelings that continue to arise feel familiar and are no longer resisted. Once this occurs, if our patient is flexible cognitively and able to entertain multiple viewpoints simultaneously, it could be helpful to explore his or her experiences from a more existential, constructivist vantage point that considers the reality of *anicca*, *dukkha*, and *anatta*.

MEDITATION PRACTICES AS COUNTERPRODUCTIVE DEFENSES

One of the remarkable qualities of the human mind is its creativity in devising psychological defenses. Like the primate who randomly encounters a stick and notices by chance that it's a wonderful tool for picking up tasty ants, our minds learn to use an astonishing range of tricks to avoid discomfort. While some of these are very helpful, in that they allow us to function during difficult circumstances, others get in the way of our growth, development, and optimal functioning. Meditation is no exception. It turns out that virtually all types of mindfulness practice can be used maladaptively as defenses.

Clinging to Concentration

A colleague of ours recalls taking enthusiastically to meditation practice as a young man:

Cliff was shy and awkward, had recently lost his mother, and often felt insecure in social situations. In his commitment to practice, he tried to be mindful throughout the day. So when he was at a party, he would bring his attention to the moment-to-moment sensations of breathing, and whenever his mind wandered off, such as into grieving over

his mother, he'd bring it back to his breath. Rather than opening to whatever arose in the mind (open monitoring), or allowing himself to pay attention to the people he was with, whenever painful emotions came up, he focused ever more tightly on his breath. Not surprisingly, he wasn't really able to connect with others or form deep relationships. For him, sticking narrowly to concentration practice had become a counterproductive defense.

Of course, there are times when taking refuge in concentration or another comforting practice (such a loving-kindness meditation) can be quite skillful. When painful emotions or intrusive thoughts or memories are destabilizing, being able to ground our attention in the sensations of the present moment can be a helpful temporary refuge. Our challenge is to sense when such safety is needed and when it stands in the way of growth or optimal functioning.

When a Retreat Becomes an Escape

Other practice choices can also be defensive. For example, while formal meditation and retreats can both be enormously liberating, some people devote their energies to meditation practice to avoid interpersonal commitments or vocational challenges:

Justin had just ended his third marriage due to “irreconcilable differences.” Even though he was in his late 50s, his behavior and rage was like that of a young adolescent. He was raised by a mentally ill mother and an alcoholic and physically abusive father. When he was growing up, other children would taunt and pick on him. He was used to being the victim.

Justin couldn't see his role in the demise of his relationships. It was always the fault of the other person. He would end friendships over minor misunderstandings, and his relationships with his mother and sister were also strained, often lapsing into periods without communication. When his therapist tried to make him aware of his contribution to these broken bonds, he saw this observation as aggression and a failure of empathy. He ended treatment, choosing to go to India for an extended meditation retreat. “Therapy” he said, “is not what my heart needs.”

Justin apparently hoped that meditation would provide a detour to avoid dealing with developmental and relational difficulties. While the adventure of practicing in India successfully distracted him for a time, painful images of failed relationships began to arise in his mind.

Eventually he realized that he needed to return home to work on connecting with other people.

Trying to discern when intensive practice will be counterproductive is a tricky matter. After all, most clinicians are not monks or nuns—they've chosen to live in a chaotic world of work and love and probably devote only limited time to meditation practice. Yet leaving the hubbub of life as a householder is a choice that has been made by countless renunciates in many spiritual traditions. The founders of most wisdom traditions are said to have taken this path. So when is a person's movement in this direction a considered choice to take his or her psychological and spiritual development to the next level, and when is it a detour to avoid developmental challenge?

As clinicians, we need to be open-minded and aware of our own values to be skillful in understanding such personal decisions. While most of us wouldn't automatically see a turn toward deeper meditation practice as an enactment of unresolved infantile longings to return to a state of oceanic oneness as Freud (1930/2005) did, we might nonetheless be skeptical of others who make major commitments to practice that we have not made ourselves. Or we could err in the other direction—in our enthusiasm for mindfulness practice we might not see how our patient's increased commitment to formal or retreat practice is actually being used to avoid engaging fully in life. Remaining mindful of both possibilities can help us avoid falling prey to either.

Avoiding Uncomfortable Objects of Attention

It is not uncommon to hear, "I really enjoy walking meditation, but I hate sitting practice" (or vice versa). When is it most skillful to choose comfortable objects of attention, and when should we push ourselves (or encourage our patients) toward practices that are more difficult? Some people tend to avoid discomfort and may, as a result, thwart their psychological progress. For example, the patient who prefers walking meditation because he or she doesn't feel anxious or restless while walking may never get to understand and learn to tolerate his or her anxiety or restlessness.

On the other hand, people can adopt an excessively rigid "no pain, no gain" attitude. In this situation, the individual doesn't notice when he or she could use a break from discomfort, when it would be more skillful to choose a practice that feels easier at the moment. Disciplined

meditation can be used as a defense against joy, against letting go and being at ease. Listening carefully to our patients' experiences with different techniques, and considering them in the context of their overall personalities, is important for finding a balanced approach to practice.

Downsides of Both Religious and Secular Beliefs

Discussions of how people's religious beliefs, or lack thereof, may support or hinder their psychological development are challenging. There is no objective platform on which to stand. A religiously observant clinician is likely to view these matters differently from a secular one. And yet, this too is an area in which approaches to mindfulness practices can either inhibit or support a patient's growth.

Religious beliefs clearly can provide all sorts of psychological benefits—meaning and purpose, safety, a moral compass, participation in community, and identification with something larger than the individual, to name a few. But they can also bring with them psychological challenges including negative judgments about sexual and aggressive urges, fears of punishment for unacceptable thoughts and feelings, concerns about ostracism, and rigid belief systems.

Strictly secular views often have costs and benefits that are more or less the inverse of those of religious beliefs. Downsides include lack of meaning and purpose, feelings of insecurity and isolation, lack of moral direction, and disconnection from the wider universe. Benefits include greater comfort with our mammalian nature, fewer fears of punishment or concerns about ostracism, and a more flexible or relativistic belief system.

It is possible to take up mindfulness practices in a religious way, which can bring with it the benefits and difficulties that can come with religious devotion. For patients who want to take up mindfulness practice in a religious context, it may be helpful to explore in an open-minded, sensitive manner how a person's religious understanding supports or interferes with his or her psychological development. Does it support him or her in becoming more open and flexible psychologically? Does it help him or her deal with the challenges of existential reality? Similarly, a person who takes up these practices in a rigidly secular way may benefit from seeing how secular beliefs may be helpful or problematic. It can be particularly interesting with more passionately secular individuals to examine how their views may cut them off from noticing their interdependence with the wider world, and how

mindfulness practices can be a doorway to the liberating aspects of experiencing this interconnection.

Too Much Safety?

We discussed how taking refuge in focused attention or concentration practice, sticking to comfortable objects of attention, or even devoting excessive time to formal meditation or retreat practice can be used defensively to avoid experiencing challenging life situations or mental contents. On the other hand, turning toward safety can be essential therapeutically, ensuring our practice doesn't traumatize or retraumatize us. Sensing whether more safety or challenge is needed usually requires considerable clinical experience. While it's possible to give rough guidelines as to when cultivating safety is important (unstable living situations; a lot of unintegrated trauma-related thoughts, feelings, and images; a weak therapeutic relationship), it is our experience of working intimately with a wide variety of people that helps us to sense when emotional challenges are too great versus when they're doorways to growth. When students ask us where to get trained as a mindfulness-oriented clinician, we usually suggest that they first become trained broadly as clinicians, working under a trusted supervisor, since developing a sense of when to move someone toward safety or invite him or her into new territory requires intuition informed by experience. We also suggest that they pursue their own mindfulness practice, so that they can see firsthand the effects of various practices while developing the ability to sit with intense emotional experience.

Interestingly, this is an area in which the clinician's own maladaptive defenses can play a big role. If a therapist is afraid of powerful affects, he or she may nudge patients toward safety to avoid his or her own discomfort; if a therapist is insecure about his or her therapeutic talents, and feels a need to show progress, he or she may nudge patients prematurely toward the sharp points.

Lurching Prematurely toward Absolute Truth

Another common danger in taking up mindfulness practice is what is sometimes called the "spiritual bypass." This defensive maneuver occurs most often when people see their practice as part of a spiritual or religious path, leading to wisdom, compassion, connection to God, or enlightenment. Having a purely intellectual understanding of what

we've called absolute truth—the changing nature of all phenomena, the way the mind perpetually creates suffering, and the insubstantial nature of our sense of separate self—we deny our human emotions, fooling ourselves into acting as we imagine enlightened or holy people do. So when our friend disappoints us, we immediately turn the other cheek, or notice the suffering behind our friend's behavior, not allowing ourselves to first feel our hurt or anger. The problem with this bypassing of relative reality, like all psychological defenses, is that it drives feelings underground. And when we bury feelings, we seem to bury them alive: they can come back in the form of somatic symptoms, passive-aggressive acts, compulsions, and other maladaptive behavior. Spiritual bypasses are actually moments of mindlessness masquerading as mindfulness—denying our not-so-noble reactions happening in the moment.

Sometimes spiritual bypasses are supported by profound mystical or transcendent experiences that seem to promise a shortcut through life's difficulties. Sooner or later, however, we face the challenges of our ordinary lives—as meditation teacher Jack Kornfield (2000) put it in a book titled *After the Ecstasy, the Laundry*. Unfortunately but understandably, some people would rather skip the laundry altogether:

Sandra had recently returned from a pilgrimage to sacred sites in Asia, where she had a deeply moving “spiritual” experience. She wanted mindfulness-oriented therapy to replicate her epiphany, as well as help with her marriage, her intrusive mother-in-law, and her challenging adolescent son. When her therapist suggested that she look within to begin to observe her mind and her reactions to her family, she became incensed. “I don't want to look within,” she said furiously, “I just want them to respect me.”

Sandra found that mindfulness practice didn't provide a reliable escape into supernatural or transcendental solutions—despite its potential to powerfully expand our awareness, it doesn't allow us to leapfrog over the challenges of our lives.

As in many of the clinical decisions we've been discussing, here too timing and balance are important considerations. While spiritual bypasses are often countertherapeutic, there is a role for cultivating “positive” emotional attitudes and responses that may not arise spontaneously. As we discuss in detail in Chapter 6, deliberately cultivating loving-kindness, compassion, or gratitude toward people for whom we also feel anger or contempt can indeed strengthen these salutary states

of mind. We need careful discernment to sense when we're using these practices as acts of avoidance because we have difficulty tolerating negative feelings, versus when we're using them to develop useful qualities of mind after fully experienced troubling emotions.

IT'S COMPLICATED, BUT WORTH IT

We've seen that bringing mindfulness into psychotherapy is, as the Dalai Lama (2009) suggested, "complicated." Human beings are multifaceted, and as a result no single practice or technique is going to be optimal for everyone at all times. The guidelines we've suggested in this chapter are just suggestions. Each therapist will need to discover, in the laboratory of the clinical hour, how various techniques affect different patients at different moments.

In the following pages, we examine in detail the many types of mindfulness practice described in this chapter. We present instructions for a wide range of techniques that you and your patients can try in different circumstances, along with clinical illustrations of how to apply them. Many of the practices we use most frequently are also available without charge online as reproducible patient handouts and as audio recordings at www.sittingtogether.com. Less frequently used meditation practices suited to the needs of particular individuals, along with guidelines for selecting practices for specific disorders and populations, can be found in the Appendix.

Our hope is that these practices will enliven your experience as a psychotherapist, while helping you and your patients to live richer, more rewarding lives.